DEVELOPING A CLINICAL TOOL TO TREAT DEPRESSION IN SPANISH-SPEAKING LATIN AMERICAN IMMIGRANTS IN CANADA: APPLYING A GLOBAL MENTAL HEALTH PERSPECTIVE FOR IMPROVED MENTAL HEALTH OUTCOMES

by

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ABSTRACT

This dissertation considers the implications of applying a global mental health perspective to guide the development of culturally appropriate mental health services in Canada. Recognizing that forces of globalization can affect both determinants of health that vulnerable populations face and the kind of mental health services that are available, I focus on the situation of Latin American immigrants in the Greater Toronto Area, a population that has been prioritized for increased access to equity-driven health services. I draw on my personal and professional positionality with the issues examined. This study specifically examines Latin American immigrants, a group that has been identified as a high-growth population at-risk for mental health difficulties. An extensive and comprehensive review of social determinants of health as it relates to the mental health of Latin American immigrants in Canada is conducted. The availability and effectiveness of patient-centered care for Latin American populations is also reviewed, with particular attention to the standard delivery versus the cultural adaptation of cognitive behavioral therapy – currently regarded as the ‘gold standard’ in psychotherapeutic treatment. Social policy issues that may arise in providing culturally appropriate, patient-centered care are exemplified in the findings of a secondary qualitative analysis of focus groups that were conducted for a feasibility study for a culturally adapted cognitive behavioral therapy (CA-CBT) for Latin American immigrants in Canada. A key contribution of this work is the synthesis of the foregoing evidence to conclude that the provision of culturally adapted mental health services is necessary but not sufficient to promote the health equity of Latin American immigrant populations in Canada. Recommendations for policy, future research, and changes to the philosophy of psychiatric practice are discussed, and the findings are related to debates on the concept of “global mental health” that are currently underway.
PREFACE

The secondary data analysis component of this dissertation was approved by the Behavioral Research Ethics Board at the University of British Columbia in Vancouver, Canada (Certificate #: H11-01709).
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This is one of the most challenging aspects of writing this dissertation for there are so many people to thank along the way, including in the past. First among those I need to thank from the past is my father, a doctor in El Salvador who was ahead of his time, for all his countless words of support since I was a child. He was a doctor who fought for women’s rights and social justice. He was my greatest inspiration and motivation for doing this work. He died 27 years ago, but only physically, as his words and unconditional "cariño" (love) remain in my heart and will and until I die. After my father, my primary supervisor, Dr. Jerry Spiegel is who I believe God placed in my path. I never thought when taking his course on global health that I would fall in love with the field and that he would actually agree to be my primary thesis supervisor. I never thought this relationship would last since 2004. In all these nine years never once was Dr. Spiegel impatient with me, never once did he made me feel bad about my ideas, my mistakes or my poor writing skills, and this is admirable. His endless patience and soft manners can make any student feel that she or he can trust him and that everything is going to be okay at the end. Beyond that, Dr. Spiegel has the uncanny capacity to see things I cannot see, despite not being a psychiatrist, and most importantly understand the most intricate parts of the Latin American culture despite being Canadian born!

Then, Dr. Kwame McKenzie, my primary supervisor in Toronto. Without Kwame there simply would have not been the CBT study, funding or support from the Center of Addictions and Mental Health (CAMH). Kwame is the most knowledgeable psychiatrist that I know and he was my rock in Toronto since 2007 when I first met him. He helped me in the worst moments when I almost gave up. Finally my partner Felix and my mom have been both there for me in all these long years with instrumental and emotional support that only people that love me can actually provide to me.
PROLOGUE

One’s personal history, class, race, gender, religion, and other aspects of their identity interact to influence, limit and constrain production of knowledge (Scheurich, 1994). As a reflective researcher, I am constantly aware that my background and experiences have shaped my understanding of the world. Over the years, my evolving identity as a student, single mother, researcher, psychotherapist, psychiatrist, doctor, patient, immigrant, woman of color, adjunct professor in the department of psychiatry at the University of Toronto, and teacher of medical students and psychiatry residents has afforded me experiences that have proved many assumptions to be relative truths. This perspective has largely influenced my efforts to conduct research benefiting the Latin American community in Canada and other immigrant groups. With respect to this dissertation, it has put me in the unique position of being able to conduct ‘insider’ research (Ganga & Scott, 2006). On the one hand, I am a researcher studying the Latin American immigrant community; on the other hand, I am a Latin American immigrant.

While my social proximity to this research has had obvious practical advantages, my closeness to this dissertation has facilitated greater access to my private self (Ganga & Scott, 2006). Part of the process of generating a critical narrative required my engagement in self-discovery and critical reflexivity. I tried to understand how my different roles and identities have contributed to: my motivation, passion, and drive to complete this dissertation; insight into the research questions; the development of culturally appropriate interventions; articulating the collective impact of globalization on human beings, especially with regards to their mental well-being; and, finally, contemplating whether a global mental health perspective can allow for better mental health outcomes for the Latin Americans in Canada and also for other immigrant groups in this country.
Researcher Positionality

My positionality as a researcher in this doctoral program comes from a process of acquiring tacit knowledge and putting it into action at the same time as reflecting on the actions that were spontaneous when faced with situations that can be chaotic, unpredictable, messy, unexpected and surprising. The knowledge not only comes from my previous formal studies in medical school or in my further training in epidemiology and psychiatry, but also comes from my personal experiences as a Latina immigrant in Canada and as a cross-cultural psychiatrist caring for Latino patients for at least a decade in this country.

The exercise of reflection-in-action was described by Dr. Donald Schön who died in 1997. He was a philosopher who wrote seminal work about how different professionals basically know more than what they think they know and that this knowledge comes from their practices, not from formal education in institutions like universities. He wrote a book entitled: "The Reflective Practitioner: How Professionals Think in Action" (1983). According to him, knowledge is put into action in different situations, in this case with my own patients, or when teaching students or when conducting research and engaging in intellectual debates with other researchers, or when listening attentively to the research participants.

He explains that the "entire process of reflection-in-action that is central to the art by which practitioners sometimes deal well with situations of uncertainty, instability, uniqueness, and value conflict".

He further explains that in this process one reflects about this knowledge into action when one sees the "surprising outcomes" of this knowledge into action:

"much reflection-in-action hinges on the experience of surprise. When intuitive, spontaneous performance yields nothing more than the results expected for it, then we
tend to think about it. But when intuitive performance leads to surprises, pleasing and promising or unwanted, we may respond by reflecting-in-action. ...in such processes, reflection tends to focus interactively on the outcomes of action, the action itself, and the intuitive knowing implicit in the action” (page 56).

I have reflected on how I came to become interested in globalization, global mental health, cultural adaptation of psychotherapy and the Cuban mental health care system and from this reflection comes my positionality in this research. My positionality and changing identities can be grouped in four categories, demarcated by the different chapters of my life. The first chapter would be most aptly titled, A Child of Globalization. Born and raised in El Salvador, I was fifteen years old when a civil war began in the early 1980s. My father was a prominent physician in a position of power as the director of the Instituto Salvadoreño de el Seguro Social. He had strong socialist ideals and we had to flee the country to save our lives after a paramilitary organization, el escuadron de la muerte (Death Squad), persecuted my family and participated in the torture, disappearance, and murder of my relatives. Civil conflict of this kind is one of the main catalysts for the flow of people between countries that facilitates globalization. The salience of such events in understanding the lived experiences of Latin American immigrants, especially immigrants that fled to Canada to escape political persecution, is put into focus as part of the discussion of the pre-migration stressors such as previous history of trauma, violence, civil war, amongst other factors, considered social determinants of mental health for Latin American immigrants in Canada, found in chapter 3. My own involuntary migration after finishing medical school in Honduras, a country where my family and I lived in exile for ten years before coming to Canada, has provided me with the capacity to resonate with the qualitative data as more than just words. This experience has allowed for a discriminating analysis and interpretation of qualitative data from a feasibility study of culturally
adapted cognitive behavioral therapy (CA-CBT) for depression among Latin American immigrants in Canada, discussed in chapter 6.

My second identity is that of a Latina immigrant living in exile for the past thirty years. After leaving El Salvador I arrived in Canada as a foreign-trained doctor, as I had graduated as a physician in Honduras. The process of medical accreditation in Canada was a very difficult one, taking me about 10 years to obtain a license to practice medicine and then five more years to complete my post-graduate training as a psychiatrist at the University of British Columbia. I have lived through the acculturation process including learning a new language, understanding Canadian culture, and acquiring Canadian experience and formal training at the university level. In doing so, I have had first-hand exposure to many, if not all, of the social determinants of health described in chapter 2.

My personal experiences especially with the reality of these factors like being a welfare recipient, single mother, working for cash as a cleaning lady, not being able to speak English, being newly identified as a woman of color, and going through the refugee claimant process to "get the papers" in Canada. For five years, I was basically living in poverty in Hamilton, Ontario, the second most dangerous city in Canada. My neighborhood was particularly plagued by gangs, violence, prostitution, and drug trafficking. I experienced racism and social exclusion, both systematic and subtle, which left me vulnerable to being exploited and underemployed. For example, I cleaned an office for 2 dollars per hour from midnight to 6am in order to afford the medical books and the medical examination fees to obtain my license as a doctor in Canada. I accepted this work because my work documents were invalid and immigration officers were not likely to conduct surprise documentation checks at that time of night. These experiences have allowed me to understand and identify with the focus group participants who speak about their own process of adaptation and
acculturation in this country. These negative experiences sharpened my interpretation of the qualitative data from the CA-CBT study and are echoed in my reflections on what can be done from the mental health services perspective and the global mental health perspective to achieve health equity by optimizing clinical tools like psychotherapy treatments for disadvantaged groups, something I unfortunately never had 20 years ago. This is contained in chapters 3 and 6 respectively.

My third identity is as an epidemiologist. Having lived the social determinants of poor health, I felt inspired and decided to pursue post-graduate studies in epidemiology and biostatistics at the University of Western Ontario from 1996 to 1999. I used purely quantitative methods of research as this was deemed the work of a ‘real’ epidemiologist at the time. I wrote a thesis titled ‘The relationship between stress, social support and psychological distress among Latin Americans in Canada’, drawing from my position as a refugee from El Salvador and Honduras who came to Canada to be safe. These experiences motivated me to write the first epidemiological work on the mental health of Latinos here in Ontario. I conducted a feasibility study testing different, culturally appropriate ways to collect data about acculturative stress, social support and psychological distress among 134 participants in London, Ontario in preparation for a grant proposal for a survey on the mental health of Spanish-speaking Latin Americans in Canada.

After finishing the epidemiology Master's degree program, I worked as a research consultant at psychiatric hospitals in London and St. Thomas, Ontario. During my 5-year tenure, I frequently observed Canadian patients who had been hospitalized for years -- young, middle age and older patients, men and women. I vividly remember how depressed and lonely they looked. I was struck by their apparent suffering and lack of family support; winter holidays were the worst. But I often wondered, what about "my own" -- the Latino patients? Who would ensure their care?
Thanks to the encouragement and instrumental support of psychiatrists in those two hospitals and the sponsorship of a hospital located in northern Ontario, I was able to train as a psychiatrist from 2001-2006 at the University of British Columbia. During the second year of my psychiatry residency, I began my doctoral studies at the Individual Interdisciplinary Studies Program under the supervision of Dr. Jerry Spiegel. His course on "Global Health" was an *awakening*. Dr. Spiegel talked to me about how health was organized in Cuba and offered me an opportunity to go to Santa Clara, Villa Clara province in Cuba to work with a team of public health specialists and epidemiologists. The study looked at the effects of tourism on the health of inhabitants of coastal communities (Spiegel, Gonzalez, Cabrera, Catasus, Vidal, & Yassi, 2007). After that experience, I embarked on 29 trips to Cuba between 2004 and 2010 as I felt compelled to study this country, which could be considered to be at the *margins* of globalization processes (Spiegel and Yassi, 2004). Two of my comprehensive examinations detailed my observations and analysis of the Cuban mental health care system -- a paper that described the Cuban approach to mental health service delivery and a documentary film about *innovative treatment programs in Cuba for people with severe mental disorders* filmed at the National Psychiatric Hospital of Havana in 2008.

Interestingly, one of my first research supervisors commented that I am a complex person and I do everything differently from most people or most doctoral students (personal communication with Dr. Elliot Goldner, 2007). The course of my doctoral studies has been, like my life, characterized by a very complex, non-linear and unexpected series of events that now shape my opinion about the mental health of immigrants in the context of global mental health. This is also reflected in my current work, which is complex and different, as it articulates a deep-seated understanding privy to the few researchers who hold insider and the outsider positions. The resultant viewpoint is a combination of personal insight and professional acumen.
How I view the Canadian perception of Latin American immigrants is a critical filter for this work. My own experience as a Latina immigrant is that we are often associated with low paying jobs, low educational levels, and low socio-economic class. For the past twenty years, every time I meet someone new and tell them that I work in a hospital, the question that follows is invariably, "Are you a nurse?" This makes me wonder why it is never assumed that a Latina woman working at a hospital could be a doctor. Would it be different if I was White?

Being identified as a Latina everywhere I go is a source of pride, but it also makes me feel part of the "minority" populations in Toronto. I feel marginalized, even though I have held Canadian citizenship for years. Most of the time, I do not feel Canadian. My self-identification is still affected by my marked Spanish accent and my weak English writing skills. I am a "woman of color" and very often the only one in medical staff meetings or other professional meetings. There are fewer than ten Spanish-speaking psychiatrists in Toronto. In Canada, I am one of the only two psychiatrists from El Salvador; my colleague is retiring and not engaged in any academic work. In my daily work at the hospital and in completing this dissertation I often feel isolated and alone in my pursuit to contribute new knowledge to the world, which is what doctoral students are supposed to do. I have received many praises for my clinical work and many awards in Canada as a social activist, as a psychiatry resident, and as a teacher, but I feel that I have to constantly continue to prove myself. Is this because I am from El Salvador?

Such experiences are relevant to my discussion of discrimination and social exclusion. Though these experiences can cultivate biases, they can also lead to a closer understanding of how Latin Americans are seen in Canadian society including providers of mental health services. If providers view their patients as "second class citizens", this perception has implications for the kind
or the quality of services they receive. This perception has been validated by my colleagues and by the participants in the CBT focus groups.

My fourth identity is as a full-time cross-cultural psychiatrist practicing in Toronto -- the most diverse city in Canada with the largest proportion of immigrants in Canada, including Latin American immigrants. Having completed my post-graduate studies in psychiatry at the University of British Columbia in 2006, I am currently practicing in downtown Toronto at the Women's College Hospital. About 90% of my patients are Latin Americans, refugees and immigrants and 10% are Canadian born. I see myself in my patients. I, too, came to Canada presenting all the risk factors or pre-migration risk factors for mental illness described in chapter 2 – most notably, involuntary migration, history of exposure to violence, and coming from a country in civil war. Upon arrival, my family and I faced the social determinants of poor health – inadequate housing, food insecurity, unemployment, language barriers, refugee status, lack of recognition of non-Canadian medical licensure and experience, gender inequity, underemployment, lack of transportation, social exclusion and little access to health services much less mental health services. Every day I see Latin American patients in my practice at Women's College Hospital that encounter these same challenges, I remember the reasons why I believe that something has to be done to better the living conditions and the mental health of Latin American immigrants in Canada. The "moral case" of psychiatry on global mental health calls for psychiatrists to not just sit and watch but to do something for people who are suffering from mental illness (Patel & Prince, 2010). I truly identified with this concept and this was the main reason for pursuing my doctoral studies and envisioning the cultural adaptation of cognitive behavioral therapy for Spanish Speaking Latin Americans in Canada.
Trajectory of Doctoral Studies

Much like my life, the trajectory of my doctoral studies has had many unexpected turns and serendipitous events. The work you see before you distills a compilation of globalization experiences and lessons learned into a targeted analysis of the global mental health perspective as a viable way of closing the treatment gap for mental illness for Latin American immigrants and refugees in Canada. In many ways, I have truly lived a global health journey that I Endeavour to continue beyond these doctoral studies. Reflecting on the beginnings of this program of research has affirmed my resolve.

My overarching research question began back in Honduras, Central America. As described above, I have been living in exile for over 30 years since the civil war in El Salvador. Honduras, my first destination, is a country with one of the highest rates of violence in the world and is the second poorest country in the Americas, after Haiti. I lived there for 10 years before coming to Canada. I completed medical training in Honduras and conducted my first thesis project investigating diarrhea and respiratory infections in breast-fed versus formula-fed infants less than 2 years old from the municipio de Ajuterique (aldea). Ajuterique was not even a town, but a group of homes in a rural area where very poor people lived. I did a household survey by horse, as the roads were not paved. The results indicated that babies fed with formula presented more infections per year as compared to breastfed babies. Unwittingly, this was my first foray into globalization studies as I learned that media access (i.e., having a television in the house) influenced women’s decisions to feed their babies formula or breast milk. Many of the women who fed formula to their babies assumed that US-based commercials for baby formula were a reflection of best practices for infant nutrition and health. Their regard for the US as the ‘expert’ and themselves as the recipients of expertise in the transmission of health knowledge is a clear phenomenon of globalization.
I began my doctoral studies in 2004 while finishing the second year of my psychiatry residency at the University of British Columbia. After taking a Global Health elective with Dr. Jerry Spiegel, I was inspired to make global mental health the focus of my dissertation. Throughout my residency, I provided mental health services to many refugees and immigrants with post-traumatic stress disorder, panic disorder and depression from many different countries, including the Middle East, Africa and Latin America. At the same time, I had two other jobs to make ends meet. I worked for the British Columbia Sexual Assault Center for two years as a forensic examiner, conducting physical examinations and collecting evidence for court of men and women whom have been sexually assaulted. I also worked as a forensic physician at the British Columbia Forensic Psychiatric Institute conducting psychiatric assessments for people remanded by court. In working with victims of trauma and the perpetrators of crime, I became quite experienced in trauma psychiatry.

The context of my clinical practice since 2001 has shaped and fueled my research questions. As part of a health care system that has many gaps in services, global health meant providing culturally appropriate mental health services to recent immigrants and refugees suffering from intense emotional pain and loss. The patients I saw did not have a chronic mental illness such as schizophrenia. They were people, like any of us, who had endured extraordinarily traumatic situations such as having been raped repeatedly by guards or having had their family members killed in front of them. At the time, these new arrivals to Vancouver were coming directly from refugee camps in the Republic of Congo. Every week, they would come to a family practice office where they would be seen by a family doctor to rule out tuberculosis, HIV infection and other medical conditions for immigration purposes. Though this immigration medical examination would ask about “any anxiety, depression or nervous problems requiring treatment”, the examination
would not be used to direct patients to preventative services or follow-up care for an identified mental health problem – even in the face of many patients who were fully psychotic in the context of post-traumatic stress disorder.

I completed my residency training in June 2006, and successfully sat my examinations for the Royal College of Physicians and Surgeons to be able to practice psychiatry in Canada. During all this time, I was travelling to Cuba. Cuba was a completely different world to me, having been born in a capitalist country (El Salvador) that is notorious for its violence (i.e., a civil war that lasted eleven years where more than 300,000 people died and millions migrated to other countries including the US and Canada), government corruption, social injustice, violence against women and children, and where people died from malnutrition and infectious diseases that are rooted in social causes. Cuba was also different from Canada because it is a communist, low-income country; I observed that the social determinants of health identified in high income countries such as housing, food security, employment, education, migration did not apply in the same way as they do here.

Cuba, like any country, has its share of mental illnesses. I was puzzled by how they could treat mental illness if they lacked basic medications and their only electroconvulsive therapy machine was out of service half of the time because it needed parts that could not be found in Cuba. These questions and observations were the focus of my comprehensive examination -- a short documentary film titled *Global Mental Health: Innovative Treatments for People with Severe Mental Illnesses in Cuba*, and an accompanying paper. Through my work in Cuba, I gained the trust of the Director, Sub-Director and the Head of the Rehabilitation Program at the National Psychiatric Hospital of Havana. In 2008, it was the largest mental health hospital on the island hosting about 2,800 patients without locked doors, seclusion rooms, or any means for Cuban
psychiatrists to involuntarily admit patients at serious risk of harming themselves or others -- like the Mental Health Act in Canada. There was even a train that ran through the hospital, which made it easy for patients to elope\(^1\). All this was fascinating to me. How did they deal with agitated patients? How did they manage to admit people? The answer: by talking to the patients’ families and having their families convince the patients to stay.

Psychiatry in Cuba relies on the collective efforts of families and communities, which also includes neighbors, friends, and even political organizations. Even more interesting is that the psychosocial treatments capitalize on what Cuba does have and does best -- music and sports. My documentary showed the music therapy program and the sports therapy program as innovative methods to treat people with severe mental illness. Not only do patients do well with small doses of older generation antipsychotics, but they also experience much fewer side effects (e.g., extrapyramidal symptoms and metabolic syndrome characterized by obesity, high blood pressure, diabetes, strokes, heart attacks) because they practice sports and dance in the hospital.

As a follow-up to this work, the initial plan for my dissertation was to compare Canada and Cuba's mental health systems and recovery approaches for people with mental illness. In this context, I could examine how global forces and pressures associated with globalization (or not associated with globalization) had an impact on the mental health of populations and how they were addressed. Unfortunately, the Cuban government closed the door to foreign researchers after a tragic incident where 26 psychiatric patients died in the same hospital in 2010 from hypothermia. My work in Cuba could not continue. However, since my focus was global mental health, I believed I could do similar work in Canada inspired by the Cuban mentality I absorbed in my 29

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\(^1\) “Elope” is the term psychiatrists use when patients leave a psychiatric hospital without permission.
trips there. I told myself, “work with what you have, come up with effective but inexpensive culturally adapted and evidence-based interventions for patients that do not involve medications because most of your refugees and immigrant patients from other cultures will refuse them anyway”.

Coincidently, I had attended a course at the King's Institute of Psychiatry in London, England entitled *International Mental Health Research Methods for Psychiatrists* in 2007. This event was part of the launch of the Lancet series on Global Mental Health organized by Dr. Vikram Patel, a dedicated psychiatrist who initiated the global mental health movement. Attending this launch and meeting with researchers and clinicians committed to “close the treatment gap for people living with mental disorders worldwide, based on two fundamental principles: evidence on effective treatments and the human rights of people with mental disorders” (Patel et al., 2011, p. 88), changed the course of my doctoral studies.

One psychiatrist in particular, Dr. Summathipala, inspired the idea for the CBT study for immigrants in Toronto. Dr. Summathipala presented a study about medically unexplained symptoms among Tsunami victims in Indonesia. He explained that people who have lost everything were attending the local clinic with complaints of gastrointestinal illness, headaches, and other symptoms, but no organic causes could be found for these symptoms. The treatment for this condition is a form of psychotherapy, namely cognitive behavioral therapy (CBT). However, because doctors, psychiatrists, therapists, nurses were amongst the dead, there was almost nobody to administer CBT to these patients. So he did something very simple, logical and daring. He went into the community to figure out who among the survivors could be trained to deliver CBT and how to ensure the acceptance of these new therapists in the community (e.g., wear uniforms or doctor’s
gowns, use of ID, female vs. male therapists, safeguarding confidentiality), and the optimal logistics for treatment delivery (e.g., cost of treatment, location of treatment).

As Dr. Summathipala spoke, all I could think was the similarities between victims of Tsunami and the immigrant and refugee population in Toronto. The immigrant and refugee population in Toronto has largely experienced traumatic events and losses, pre- and post-migration. Consequently, many suffer from mood and anxiety disorders such as major depressive disorder, panic disorder, and PTSD. However, like Indonesia, the mental health system does not adequately address their needs. Upon returning from England, I shared my idea with the Director of International Health Programs at the Center for Addictions and Mental Health (CAMH), Akwatu Khenti. He was immediately on board and invited Dr. Kwame McKenzie, a psychiatrist and scientist renowned for his work in diversity, racism, social exclusion, and global mental health to be part the study. A team of investigators joined the project, and we eventually obtained funding from Citizenship and Immigration Canada to create culturally adapted cognitive behavioral therapy (CA-CBT) therapist manuals for English-speaking Caribbean, French-speaking Caribbean, and Spanish-speaking Latin American immigrants in Canada.

Through my involvement in this study, which took place between 2008 and 2011, it became apparent that the voices of the Latin American community who participated in the focus groups and key informant interviews in the development phase of the study provided a powerful and poignant lens through which I could examine the impact of globalization processes on global mental health.

My supervisory committee convened and agreed that the inclusion of a secondary analysis of this qualitative data would be highly illustrative of the conceptual components of the dissertation – bringing health equity and social determinants of health to life.
And just when I thought my dissertation journey was coming to an end, an unexpected path emerged. During a progress meeting intended for the final review of my near complete manuscript, a fulsome debate about the influence of globalization in the practice of psychiatry around the world unfolded between my primary supervisors, Dr. Jerry Spiegel and Dr. Kwame McKenzie. Dr. Spiegel rightly pointed out to me, "If you don't mention this, then it would have been a lost opportunity". This metanarrative, now woven throughout the dissertation but more closely examined in chapters 2 and 7, invokes questions beyond the scientific tradition and at the heart of the current discourse between the critical psychiatry and global mental health movements. The hope is that the work that follows breathes new life into the field of global mental health, allowing for a full appreciation of the relevant concepts and contexts that will unify efforts to actualize the global mental health agenda.

**Purpose of the Work**

The ultimate goal of the global mental health agenda is to improve the health equity for all individuals in all countries (Patel & Prince, 2010). According to WHO (2001), 5 out of the top 10 reasons for ‘years lived with disability’ were mental disorders. The most affected were the disadvantaged. Poor social and economic conditions, often referred to as the social determinants of health, have not only affected the health status of the disadvantaged but have also limited their access to effective, evidence-based mental health services. Given that the general package of effective services has already been identified, proponents of global health have argued that new research needs to focus on the process of implementing evidence-based programs and practices (Patel & Prince, 2010).

Migrant populations have been identified as particularly vulnerable to facing health inequities worldwide (WHO, 2008). In Canada, the majority of immigrants and refugees settle in
Ontario (Statistics Canada, 2008a). Ontario-based agencies serving immigrants and refugees have long recognized that racism, poverty, and economic inequality, more so than lifestyle choices, are powerful predictors of poor health (OCASI, 2005). For Latin American immigrants and refugees, pre-migration (e.g., war, trauma, displacement, family separation) and post-migration (e.g., food insecurity, underemployment, poverty, discrimination) factors pose a significant risk for poor mental health outcomes and a need for improved services.

Implementation research is a must, as there is a lot of uncertainty about how existing services should be delivered (Patel & Prince, 2010). In response to this call, this dissertation endeavors to examine whether a global health perspective can contribute to more culturally appropriate mental health care. In chapter 1, the introduction chapter, this overarching question is deconstructed into four main lines of inquiry operationalized by four primary objectives. Chapter 2 explores the impact of globalization processes on mental health, with particular attention to how this knowledge and resources (or lack thereof) are being used to meet global mental health challenges; the case of Canada vs. Cuba will be used to illustrate how disparities and concentration of power in globalization shapes the provision of mental health services. I also present current arguments that demonstrate how the actual practice of psychiatry, including the standardization of diagnosis and treatments, has been influenced by globalization processes.

Chapter 3 surveys the social determinants of health as they apply to the Latin American immigrants in Canada, with consideration of systemic barriers and pathways to care for the treatment of depression. Chapter 4 reviews the theoretical basis of cognitive behavioral therapy (CBT) as it is standardly delivered, presents an overview of process considerations based on previous efforts to adapt CBT for Latin Americans in the US, and explains why CBT needs to be
culturally adapted for it to work with other cultural groups other than a White Canadian-born or White, US-born populations.

Chapter 5 describes the existing literature in conducting qualitative research, emphasizing culturally appropriate methods of recruitment and conducting focus groups with Latin American populations. The chapter ends with a description of the methodology employed in the Toronto CA-CBT study. Chapter 6 presents the results of a secondary analysis of qualitative data from the ‘Cultural Adaptation of Cognitive Behavioral Therapy (CA-CBT) for Latin American Immigrants in Canada’ conducted in Toronto between 2008 and 2011. The data is organized in accordance with the social determinants of health. The analysis is founded in the global mental health perspective, which considers the experiences of pre and post migration of Spanish-speaking Latin American immigrants. This approach to methodology and analysis is the difference between culturally adapting CBT with a global mental health perspective and just culturally adapting CBT.

Finally, chapter 7 discusses whether this global health perspective to developing a culturally appropriate clinical tool (i.e., CA-CBT) adequately addresses health equity issues such as the social determinants of health. This chapter unites these lines of inquiry with current reflections regarding the practice of psychiatry in a globalized world, with a cautious eye toward the commodification of psychiatric knowledge and treatments. The chapter closes with a discussion of the strengths and limitations of this dissertation and recommendations for future research, including new questions that have arisen from this body of work that relate to the ever changing conceptualization of global mental health and the evolution of this field.
CHAPTER 1
Introduction

This dissertation proposes to examine the mental health care issues faced by Spanish-speaking Latin American immigrants in Canada by considering the implications of applying a global mental health perspective. For the purpose of this dissertation, a ‘global mental health perspective’ is an approach that critically examines globalization processes and its impact on psychiatric practice and the social determinants of health in the context of achieving health equity. It has been observed, for example, that increasing globalization has led to shifting population demographics and with that comes the challenges of providing mental health services that are responsive to multicultural societies (Nagayama Hall, 2001; Bernal & Scharron-Del-Rio, 2001; Miranda, Nakamura, & Bernal, 2003; Napoles-Springer & Stewart 2006). In particular, this dissertation considers whether it is acceptable to discount cultural factors when psychotherapy, and arguably psychiatry, is a cultural phenomenon (Nagayama Hall, 2001).

The population focus for the present dissertation has been narrowed to Spanish-speaking Latin Americans\(^2\) due to their similar cultural, historical and political traits. As such, the population of interest does not explicitly include Portuguese- or French-speaking Latin American populations from Brazil and some Caribbean nations, or Spanish-speaking people from Spain because, geographically, this country is not part of Latin America or the America continent. The Spanish-speaking Latin American population referred to in the present dissertation is specifically in reference to Latin American or Latino people of diverse Latin American national origins including:

\(^2\)Geographically, the term Latin America traditionally refers to regions of the Americas, south of the United States, whose official languages are Spanish, Portuguese and in some cases French.
Mexico, the countries of Central America (i.e., Guatemala, Honduras, Costa Rica, El Salvador, Nicaragua, Belize, and Panama), the Spanish speaking countries of South America (i.e., Columbia, Venezuela, Peru, Chile, Ecuador, Bolivia, Uruguay, Paraguay, Argentina), the Spanish-speaking countries of the Caribbean (i.e., Cuba, Dominican Republic), and the US territorial island of Puerto Rico.

In the US literature, which comprises the bulk of the existing knowledge base on Latin American mental health, the term ‘Hispanic’ is often used in accordance with the race\(^3\) and ethnicity\(^4\) categories utilized by the US Census Bureau\(^5\) (Humes, Jones, & Ramirez, 2010). The term ‘Hispanic’ is inclusive of people from Spain, and is thus not representative of the population focus of the present dissertation. As such, use of the term ‘Hispanic’ has only been retained in the present dissertation in reference to the extant mental health literature on US Latinos. While there is an ongoing debate about the appropriate use of the terms Latin American (or Latino) and Hispanic, reconciling this debate is not one of the objectives of this dissertation.

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\(^3\) The term race refers to a group of people with a constellation of similar biological traits and physical features deemed by society to be socially significant, in that they are treated differently due to the difference between them and other groups. For example, although differences and similarities in eye color have not been treated as socially significant, differences and similarities in skin color have (Sue et al., 1992).

\(^4\) Ethnicity refers to shared cultural practices, history, beliefs, language, and spirituality that distinguish one group of people from another. In other words, ethnicity is a shared cultural heritage -- qualities that are learned as opposed to inherited (Dana, 1998).

\(^5\) The definition of Hispanic or Latino Origin provided by the 2010 US Census indicated that Hispanic origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person’s parents or ancestors before their arrival in the United States and noted that people who identified their origin as Hispanic, Latino, or Spanish may be any race. Of note, the “Hispanic, Latino, or Spanish origin” category provided examples of six origin groups (i.e., Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard) and instructed respondents to indicate the country of origin (Humes, Jones, & Ramirez, 2010).
Statement of the Problem

The Latin American population in Canada is one of the largest and fastest growing immigrant populations in Canada (Statistics Canada, 2001, 2006a, 2006b). Numerous studies in the US and Canada have demonstrated that Latin American immigrants are particularly vulnerable to developing mood and anxiety disorders, including trauma sequelae (e.g., depression, post-traumatic stress disorder) arising out of pre-migration (i.e. poverty, political persecution, violence, trauma, war, losses) and post-migration stressors (i.e. family separation, language barriers, unemployment, immigration status, etc.) (Alegria et al., 2007a; Alegria et al., 2007b; Alegria et al., 2008; Escobar, Hoyos Nervi, & Gara, 2000; Hyman, 2001). Although it has been well documented that Latin American immigrants are at high risk for developing depression and other common mental disorders (National Alliance of Mental Illness [NAMI], n.d.), Latin Americans in Canada have limited access to specialized mental health services that can help improve their mental well-being. In the absence of specialized mental health services, the Latin American patients in Canada are being treated with mainstream therapy approaches that were developed for and validated with English-speaking US and Canadian born White populations, mainly under the assumption that a "one size fits all" approach to mental health treatments is perfectly appropriate for all people in Canada regardless of their ethnicity, culture, language spoken, country of origin, religion, or ancestry.

This dissertation has also been undertaken amid growing recognition that differences in health status among Canadians is largely linked to the social milieu in which people live and work. There is clear evidence that the character of social conditions shapes health outcomes and largely explains these health inequalities, even more so than medical treatments and lifestyle factors. These social conditions, notably income, education, unemployment, food insecurity, and social exclusion,
are referred to as the social determinants of health (Mikkonen & Raphael, 2010). That the health inequalities systematically burden socially disadvantaged populations denotes an unfair system that places marginalized populations at a further disadvantage with regards to their health (National Collaborating Centre for Determinants of Health, 2011). Indeed, the most disadvantaged populations and communities are at the lower level of the health gradient with very poor health and limited access to vital services and support. These apparent inequities have increasingly become the focus of health policy and service reform (Toronto Central Local Health Integration Network [LHIN], 2008).

With the goal of addressing health inequities at a local level, the Toronto Central LHIN (2008) has prioritized immigrant populations for improved equitable access to patient-centered care by enhancing language capacities, system navigation, and culturally competent care. However, targeting critical populations and diverting resources to address barriers is not sufficient to eliminate the disproportionately poor health of the health disadvantaged populations. An equity perspective facilitates recognition of and support for the administration of structural changes needed to provide equity-driven delivery of health services designed to offset the negative impact of limited health opportunities. In keeping with this view, patient-centered care does not aspire to provide equal health services for all but rather care that can “soften the harsh impact of wider social exclusion and inequality; take account of the long-standing and deep-seated nature of social and economic inequalities experienced by many marginalized communities and individuals; meet their resulting greater health needs and challenges” (Toronto Central LHIN, 2008, p. 31).

Perhaps inadvertently, mental health has been separated from the mainstream health equity discourse. The impact of mental disorders on overall health is likely underestimated because of the lack of appreciation of the interdependence of mental and physical health. Worldwide efforts to
prioritize mental health in health reform have identified globalizing forces as having a profound effect on health inequity. The scope of this matter is global and eclipses nation-specific class, race, ethnicity and cultural issues. As such, it may be best characterized as a global mental health issue. Global mental health differs from international mental health in that it focuses on collective action to address common, systemic health issues as opposed to primarily just disseminating practices, policies, and systems in various countries where need is assessed to exist (Prince et al., 2007). Basically the problem is that Spanish-speaking Latin Americans in Toronto are a large, very young and rapidly growing immigrant population who present risk factors for mental illnesses and are exposed to social determinants of health that warrant the provision of specialized mental health services. These specialized services must account for cultural factors as well as globalization forces (e.g., standardization of psychiatric diagnosis and psychiatric treatments developed for White, English-speaking mainstream populations) in order to effectively address the mental health needs of this population.

Study Objectives

Despite being at risk for developing mental illness, Latin Americans are half as likely as non-Hispanic Whites to utilize mental health services, tend to drop out of psychotherapy treatment more quickly, and tend to be over-represented in inpatient psychiatric facilities (Alegria et al., 2002; Alegria et al., 2007b; LaRoche, 2002). Although many researchers have argued that more culturally competent mental health services are required to improve accessibility, Latin Americans in Canada continue to have limited access to specialized services that can improve their mental well-being.

The overarching question for this dissertation is, “Can applying a global mental health perspective contribute to more culturally appropriate mental health care for Spanish-speaking Latin Americans in Canada?” As previously mentioned, for the purpose of this dissertation, a
‘global mental health perspective’ considers background globalization forces including how globalization forces affect the practice of psychiatry in Canada, the actual globalization of the practice of psychiatry, and social determinants of health that result in local health disparities and which necessitate the provision of culturally appropriate mental health services to immigrant groups in Canada. In this case, the immigrant group is the Spanish-speaking Latin American immigrant population.

In accordance with this overarching question and global mental health research priorities, the present study aims to address the following subordinate research questions:

1. How do globalization processes influence or affect the care immigrants receive in Canada, from the perspective of the population receiving mental health services that are standard for the Canadian-born population?

2. Can looking at the social determinants of health from the perspective of the Latin American community help develop a global mental health perspective that takes into account systematic barriers and pathways to care in the treatment of depression?

3. Can looking at health equity issues from the point of view of the Spanish-speaking Latin Americans in Canada contribute to an understanding of access to mental health services for this immigrant population in Canada?

4. Is the development of a culturally-adapted psychotherapeutic intervention enough to address issues of culturally appropriate mental health care?

In order to address these questions, the following objectives were met:

1. To conduct a literature review of globalization processes including how globalization processes affect the practice of psychiatry and social determinants of health, and impact
global mental health as illustrated by an appraisal of the practice of psychiatry and mental health service provision in Canada versus Cuba.

2. To conduct a literature review on the Spanish speaking Latin American population in Canada, their mental health concerns, their social determinants of health and their pathways and barriers to care.

3. To conduct secondary analysis of qualitative data from the study, ‘Cultural Adaptation of Cognitive Behavioral Therapy (CA-CBT) for Spanish speaking Latin American Immigrants in Canada’.

4. To discuss and reflect on the global mental health perspective that includes globalization forces and the globalization of psychiatry considering concepts related to health equity, including the social determinants of health, and looking toward culturally responsive clinical tools such as CA-CBT for Latin American immigrants in Canada to meet health equity goals.

Objective 4 includes a formal reflection based on three different perspectives. This reflection is found in the final chapter. The three perspectives are a form of triangulation where I attempt to understand the development of a culturally adapted psychotherapy intervention for Latinos in Canada from the reflection of three parts: the first is the issues related to globalization, global mental health and the practice of psychiatry; the second is the issues pertaining to culture, immigration and social determinants of health experienced by Latin Americans in Canada viewed through my personal and professional lens; and the third, the positioning of Cuba in dealing with mental health problems through innovative psychiatric treatments that do not involve the standard
pharmacotherapies of Western nations, and how this can provide insight into what is culturally appropriate when developing the cultural adaptation of this clinical tool for Latinos in Canada.
CHAPTER 2
Globalization and Global Mental Health

This chapter addresses the first objective of this dissertation, which is to review the literature on globalization processes including how globalization processes influence the practice of psychiatry itself and how social determinants of health affect the mental health and the provision of mental health care for Canadian immigrants and refugees. Using a global mental health perspective, evidence for the effect of globalization on the mental health of populations is discussed. This chapter also defines global mental health and describes the rationale for global mental health as a movement, giving special consideration to the global burden of disease, the mental illness treatment gap, and the World Health Organization’s mhGAP initiative to address these problems. Insights about the classification of psychiatric diagnosis are presented, which parallel the current tensions between the global mental health movement and a group of critical psychiatrists who oppose this movement. Following this discussion, a close examination of the practice of psychiatry in Canada versus Cuba is used to demonstrate the impact of globalization (or absence thereof) on the mental health of the respective populations and the mental health services available to them. Beyond the apparent differences in globalization forces and paradoxical mental health outcomes, what becomes clear is that the unequal burden of poor mental health is due to various dimensions of social disadvantage that are neither natural nor inevitable. The social determinants of health are presented as moderators of risk and resiliency for psychiatric morbidity.
Globalization: Contextualizing Global Mental Health

The implications of globalization have been long debated, as its potential benefits and consequences for human well-being have been viewed as inevitable and irreversible. Globalization has been defined as “a set of processes that intensify human interaction by eroding boundaries of time, space, and ideas that historically separated people and nations in a number of spheres of action, including economic, health and environmental, social and cultural, knowledge and technological, and political and institutional” (Lee & Dodgson, 2000, as cited in Mori, Meddings, & Bettcher, 2004, p. 183). These processes are catalyzed by changes in labor trends as a consequence of multilateral agreements and domestic policy in addition to mass displacement of people because of work opportunities, as demonstrated by the influx of rural migrants to urban areas. War, terrorism, and natural disasters also produce large displacements of refugees internally and from country to country for security as well as economic reasons. Although these elements of global migration are not new, economic globalization has intensified inequalities between and within nations to the extent that migration becomes a necessity rather than a choice (United Nations Platform for Action Committee, 2011).

Economic globalization has accelerated the integration of international economies through trade and financial flows in a manner that compels the movement of people (i.e., labor) and knowledge (i.e., technology) across borders. The unprecedented avenues for such opportunities have positioned certain developing nations such as China and India for increased prosperity – albeit alongside marked disparities for their populations. It has been argued that globalization primarily benefits economic development and, in turn, increases wealth, reduces poverty and improves health (Dollar, 2001; IMF, 2000). Proponents of this perspective suggest that economic growth benefits
the health of the poorest citizens as evidenced by health indicators related to income such as improved nutrition and decreased infant mortality (Dollar, 2001).

However, economic prosperity has not been the case for all, and this more positive assessment of globalization has been contested (IMF, 2000). Critics have argued that the process of globalization has in fact aggravated disparities and inequalities, thus increasing the gap between the rich and the poor and further reducing overall health -- especially for the poor (Cornia, 2001; Kleinman, 2001; Spiegel, Labonte, & Ostry, 2004). The IMF (2000) presents poignant statistics to support these concerns:

The story of the 20th century was of remarkable average income growth…The gap between the rich and the poor countries, and rich and poor people within counties, has grown. The richest quarter of the world’s population saw its per capita gross domestic product (GDP) increase nearly six-fold during the century. The poorest quarter experienced less than a three-fold increase…the strongest gains have been made by the advanced countries and only some of the developing countries (p. 1).

As income inequality has increased during this wave of globalization, there has been a profound effect on the health of individuals (Kleinman, 2001, 2003; MacLean & Sicchia, 2004). There is considerable evidence demonstrating that although globalization has improved the health of some individuals, the health of many less fortunate individuals has worsened; this is especially the case for countries in Latin America and Africa (MacLean & Sicchia, 2004).

Spiegel, Labonte and Ostry (2004) argue that globalization not only is related to economy but it can also be seen as a determinant of health. Spiegel and colleagues explain that the effects of economic globalization in population health can be further understood using Appadurai’s (1990) five ‘scapes’ framework for analyzing globalization.
These are: ethnoscapes (the flow of people—tourists, refugees, immigrants, guest workers, etc.); technoscapes (the export of technology); finanscapes (global capital transfer); mediascapes (mass media images); and ideoscapes (images invested with political–ideological meaning). This framework, depicted in relation to our emerging understanding of how social, economic, and environmental conditions affect health outcomes over the lifespans of individuals within larger community and national contexts. It provides a context for tracing influences that can affect and constrain the options available to individuals and social groupings (Spiegel et al., 2004, p. 361).

Thus, it is reasonable to argue that globalization forces affect determinants of health at transnational, national, community and individual levels resulting in health outcomes moderated by protective or risk factors. In this sense, global health and global mental health are fittingly positioned in the context of globalization.

Global health, as an interdisciplinary population health approach, aims to address transnational health issues and determinants in an effort to find solutions for domestic and international health disparities. For the purpose of this dissertation, the following comparative definition is the benchmark:

Global health is an area for study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide…Global mental health is the application of these principles to the domain of mental ill health (Koplan et al, 2009).
Patel and Prince (2010) have expanded this definition to include the effects of globalization on global mental health:

So far, the field of global mental health has been largely focused on the large treatment gaps in low- and middle-income countries, a clear moral and ethical priority. However, the field will reach maturity only when it recognizes its potential to bring about improved care and outcomes and reduced inequities in all world regions. There are many underserved subpopulations in high income countries [emphasis added] too, and the provision and quality of mental health care has been shown to vary widely. In a globalizing world, the field will increasingly need to address transnational influences on mental health; migration, conflict, disasters, and the effects of global trade policies are notable examples. Knowledge can and must flow in both directions [emphasis added] between high-income countries and low- and middle-income countries. Researching mental disorders and treatments in diverse populations and translating advances in neuroscience to the benefits of patient care in the global mental health context are major challenges for the field. Ultimately, the search for a better understanding of the causes of mental disorders and affordable and effective treatments is of importance to improving the lives of individuals living with these disorders in all countries. (Patel and Prince, 2010, p. 1976-1977)

Dr. Patel is a prominent figure in the global mental health movement, passionately raising awareness about the global burden of mental illness, the treatment gap, and the available options to address these problems. Although he may be the most notable psychiatrist for his efforts to address the treatment gap in low and middle income countries, he is not the first psychiatrist to take serious stock of the global burden of mental illness. In the 1995 edition of the book ‘World Mental Health:
Problems and Priorities in Low-Income Countries’, Desjarlais, Eisenberg, Good and Kleinman brought this emerging crisis in global mental health into sharp focus.

This timely volume…analyses the growing burden of mental, behavioral and social problems in low-income countries, examines the sources of the substantial morbidity rate and their relation to development, and assesses current efforts to cope with them. It identifies opportunities for effective mental health interventions, methods of treatment, culturally appropriate prevention programs, and sound policy formation. It relates the mental health consequences of violence, dislocation, poverty and the disenfranchisement of women to the most pressing economic, political and environmental problems of our times. Because many of the problems reviewed in this volume occur in both low and high income societies, fruitful comparison and collaboration between North and South can lead to mental health policies that can be applied in many settings (book jacket).

When researchers draw attention to the global burden of disease, they rightfully include the contribution of mental illness to the burden of global health. Neuropsychiatric disorders account for 14% of the global burden of disease being mostly depression, alcohol abuse, drug abuse and psychosis. This is an undeniable fact and quite possibly an underestimation (Prince et al., 2007). Despite the rapidly increasing wealth of nations, the prevalence of mental health problems in wealthy societies is observed to be twice that of lower income country settings. This pattern suggests that, unlike general health indicators such as infectious disease, increasing wealth of nations negatively impacts rather than improves their overall mental health statistics – or at least facilitates a more comprehensive observation of its presence. Further evidence also points to markedly worse mental health outcomes for poorer versus richer population strata (Kleinman,
Together, this evidence suggests, “globalization – that is, the latest phase of capitalism – is bad for mental health” (Kleinman, 2001, p. 46).

The National Institutes of Health, having recognized the impact of globalization on global mental health, declared rapid economic restructuring, financial crisis and economic insecurity, the increase in conflict worldwide, changes to social safety nets, and distinct patterns of migration and urbanization that in some instances have contributed to social and familial fragmentation adversely impact mental health. This is particularly true among the poorest and most marginalized segments of a given society, namely women and children from ethnic minorities, internally displaced persons, asylum seekers and refugees. Adverse mental health outcomes frequently associated with these conditions include an increase in the incidence of gender-based violence and ethnic conflict, addictions (alcohol and illicit drugs) particularly in men and boys; as well as depression, anxiety and post-traumatic stress disorder more commonly found in women and girls (Bonder, Maclean, McGregor, Oldham, Randriamaro, & Sicchia, 2004, p. 2).

Further evidence shows that changing labor trends have an impact on mental health. This is especially true for women as women are overly represented in lower skilled positions or unemployed. Women in lower skilled positions have less decision-making power over their work pace and schedule. This contributes to depression and anxiety. In countries experiencing major economic change such as Hungary, Thailand and China, unemployment is a common problem. Those who become unemployed have over twice the chance of being diagnosed with clinical depression. Women in lower skilled positions are most vulnerable to losing their jobs and this in
turn hampers their ability to cope. In the case of China, this is a contributing factor to high incidence of suicide attempts among women. Poverty is a ‘marker’ for a variety of social conditions that when combined with other conditions increase women’s risk of experiencing violence. This is especially true in countries suffering from economic instability and going through rapid social change characterized by increased unemployment, currency devaluation, and reduced public expenditures in response to global pressures (World Bank Policy Research Report, 2002).

In addition to medical care, individual health-related behaviors, and genetic and biological factors, positive and negative mental health outcomes have been linked to “social characteristics within which living takes place” (Tarlov, 1996) – also referred to as the social determinants of mental health (WHO, 2005). For example, the Public Health Agency of Canada (2004) found that psychosocial and demographic factors such as current levels of stress, social support, life events, education and childhood traumas are associated with mental health problems and inversely associated with the indicators of positive mental health. Such findings suggest that efforts to promote resiliency and psychological resources by targeting social determinants of mental health could result in prevention and symptom reduction. For instance, efforts to reduce childhood trauma and increase social support may foster resiliency and may lead to positive mental health states such as satisfaction and happiness.

In spite of a growing interest in the effect of globalization on the mental health of populations, surprisingly little has been published in the psychiatric literature about the effects of globalization on global mental health. In 2011, the Grand Challenges in Global Mental Health initiative was instituted to prioritize research addressing the prevention and treatment of mental health, neurological, and substance abuse disorders on the global health agenda. The major challenges identified by the largest international panel of scientists and clinicians on global health
were in the service of the following goals: identifying root causes, risk and protective factors; 
advancing prevention and implementation of early intervention; improving treatment and 
expanding access to care; raising awareness of the global burden; building human resource 
capacity; and transforming health system and policy responses. The recommended approaches for 
achieving these goals were distilled to a few guiding principles – use a developmental approach to 
the investigation, utilize evidence-based interventions, consider system-wide approaches to 
mitigating emotional distress, and consider environmental influences. These principles have been 
regarded as crucial for advancing the understanding of the etiology and treatment of psychiatric 
disorders (Collins, Patel, Joestl, March, Insel, & Daar, 2011) and the impact of mental health on 
overall health (Prince et al., 2007). It is these principles that are guiding the present research.

**Global Burden of Disease and Treatment Gap in Mental Health: Initiatives for Action**

According to the WHO constitution, mental health is an essential dimension of health 
(WHO, 2007). From this perspective, mental health not only refers to the absence of mental 
disease, but “a state of well-being in which the individual realizes his or her own abilities, can cope 
with the normal stresses of life, can work productively and fruitfully, and is able to make a 
contribution to his or her community” (WHO, 2007). This foundation is necessary for optimal 
functioning at an individual and community level. Fostering mental well-being is of paramount 
importance, and involves acting on the conditions in which people live.

Currently, mental health is a global health crisis, constituting approximately 14% of the 
global burden of disease (Prince et al., 2007). WHO (2005) reports that, every year, approximately 
40,000 deaths are attributed to mental disorders, 182,000 deaths are attributed to the use of alcohol 
and drugs, and 800,000 people commit suicide. Even these numbers may be an underestimation; 
given that unreliable reporting from low and middle income countries has been noted to be
unreliable, the numbers may be up to ten times higher (WHO, 2005). According to the World Health Report (WHO, 2001), about 450 million people worldwide suffer from a mental disorder, neurological disorder or substance abuse related problem. About 24 million people in the world have schizophrenia, 70 million people suffer from alcohol abuse and dependence, and 10 to 20 million people that attempt suicide in addition to the approximately 1 million people who commit suicide.

The lifetime prevalence of mental disorders is 25% in both low and high income nations. Approximately 90 to 95 percent of the cases of depression and 70 per cent of the cases of schizophrenia are untreated in the developing world. One in four families has at least one member currently suffering from a mental disorder. Major depression alone is the leading cause of disability and is the fourth leading cause of disease burden (WHO, 2001). However, a minority of people receive the treatment they need, especially in low income countries. In low income countries, and to a lesser degree in high income countries, the need for treatment of mental illness far outstrips the available funding and the evidence base for existing treatments is relatively poor compared to other illnesses. Most people suffer alone and do not receive the treatment that they need. Mental health-related stigma, exclusion, discrimination, shame, and human rights abuses are pervasive and present formidable barriers to accessing mental health services.

Numerous global organizations have joined the effort to reduce global mental health inequities by improving access to effective treatments for mental illness in middle and low income countries (WHO, 2012a). Using human rights advocacy and scientific evidence, these groups aim to identify and share promising practices and new strategies that will convince decision makers to invest in their population by scaling up mental health services (Movement for Global Mental health, 2012; WHO, 2012b). Key examples of these initiatives include the: Mental Health GAP
Action Programme which synthesizes evidence on what treatments are effective, task shifting to non-specialist health workers to deliver these treatments; the Movement for Global Mental Health’s attempts to build a common platform for professionals and civil society to advocate for their shared goal; and, the Grand Challenges in Global Mental Health which has identified the research priorities. These types of undertakings are needed to advance the global mental health agenda. However, they are not without their critics.

At the heart of the criticism is the disagreement over what constitutes a mental illness. The cross-cultural validity of clinical diagnoses outlined in psychiatric classification systems such as the Diagnostic and Statistical Manual-IV-TR (DSM-IV-TR) and the International Classification of Diseases-10 (ICD-10) has not been clearly demonstrated. Moreover, the diagnostic reliability of these classification systems is likely limited by faulty medical logic. Physical illness are defined by objective findings (e.g., physical exam, diagnostic tests) which support a clear pathology that lends itself to scientific classification. The same approach has been applied to the classification of mental illnesses, which assume that discrete psychobiological entities underlie groups of symptoms (or syndromes) despite scientific evidence that suggests this is not the whole story.

Other critics have pointed to a trend of proliferating diagnoses in each successive version of existing classification systems, citing concerns about the impact of medicalizing ‘understandable’ human emotions and behavior. For example, the chair of the DSM-III committee later criticized the paradigm shift in the classification of mental illness from broadly defined entities that were continuous with normality to symptom-based categorical disease that occurred during his tenure, stating that it led to the medicalization of 20 to 30% of the population who may not have had any serious mental disorders. Similarly, the former head of the DSM-IV task force has argued that the processes leading to DSM-V are flawed and run the risk of "serious, subtle…ubiquitous…"
dangerous" unintended consequences such as new "false epidemics", further remarking that the "the work on DSM-V has displayed the most unhappy combination of soaring ambition and weak methodology" (Frances, 2009, para. 6).

Kleinman (2012) poignantly expresses these concerns about the exploitation of human emotion and relationships in a heartfelt paper titled ‘The Art of Medicine: Culture, Bereavement, and Psychiatry’, in which he speaks about his own experience of bereavement after the death of his wife of 46 years in March 2011. For context, Kleinman references the DSM’s evolving notion of a normal grief period from one year in the DSM-III, to two months in the DSM-IV, to the present DSM-V controversy about including grief as a formal diagnosis in the new classification system. Kleinman (2012) then questions whether his experience should be considered pathological?

In March, 2011, my wife died and I experienced the physiology of grief. I felt greatly sad and yearned for her. I didn't sleep well. When I returned to a now empty house, I became agitated. I also felt fatigued and had difficulty concentrating on my academic work. My weight declined owing to a newly indifferent appetite. This dark experience lightened over the months, so that the feelings became much less acute by around 6 months. But after 46 years of marriage, it will come as no surprise to most people that as I approach the first anniversary of my loss, I still feel sadness at times and harbor the sense that a part of me is gone forever. I'm not even sure my care giving for my wife, who died of Alzheimer's disease, ended with her death. I am still caring for our memories. Is there anything wrong (or pathological) with that? the experience of loss, is never neat: that is, out of context. It is always framed by meanings and values, which themselves are affected by all sorts of things like one's age, health, financial and work conditions, and what is happening in one's life and in the wider world. The
collective and personal process we usually refer to as culture is one sort of framing: a kind of master framing. Historically, widows in many patriarchal societies were culturally framed as grieving for a lifetime or at least, a long time. The globalization of our era has brought in its wake an expectation of serial marriages with much shorter periods of bereavement. Still, *DSM-IV*’s framing of normal grief as lasting only 2 months must stand out in global perspective as a shocking expectation. We can say the same about the APA’s proposal in the next *DSM V* for treating any grief as depressive disorder [emphasis added], which must be seen as a radical cultural framing peculiar to American academic psychiatric research (p. 608).

Support of such criticisms have come from The British Psychological Society (BPS) and a coalition of psychology bodies led by the American Psychological Association. In an open letter to *DSM-V*, the BPS (2011) noted concerns about “the continued and continuous medicalisation of [the general public’s] natural and normal responses to their experiences… which do not reflect illnesses so much as normal individual variation” (p.1). The psychology coalition has claimed that “proposed changes to certain *DSM-V* disorder categories and to the general definition of mental disorder subtly accentuate biological theory. In the absence of compelling evidence, we are concerned that these re-conceptualizations of mental disorder as primarily medical phenomena may have scientific, socioeconomic and forensic consequences” (American Psychological Association, 2011, para. 21). Other critics argue that “psychiatry currently offers exaggerated interpretations of neurophysiological findings and understates the scientific importance of social-psychological variables” (Rice, n.d., para. 17).

The global mental health discipline has additional concerns about diagnostic classification in psychiatry because the current symptoms focus on mental illness rather than mental health.
These terms are conceptually different and the lack of clarity mires understanding of the magnitude of the disease burden and the problem areas that need to be targeted in order to successfully reduce mental health inequality. Although causation is a significant issue, context is equally important. The global mental health perspective considers whether globalization is also an important feature in defining the problem.

The Critical Psychiatry Network

Dr. Pat Bracken is one of the original members of the critical psychiatry network that was founded approximately 13 years ago. In the early years, the group was comprised of psychiatrists from the National Health Service in England who were dissatisfied with the way the profession was functioning and began to critically examine the assumptions behind the practice of psychiatry. Currently, Bracken estimates that the network has more than 100 members, primarily in the UK but also internationally, that share ideas, attend conferences, collaborate on research, campaign, and discuss the influence of the pharmaceutical industry in psychiatry. Bracken stresses that critical psychiatry is “different from anti-psychiatry [emphasis added] by any means. It is looking at the assumptions behind the theories and practices of psychiatry and looking at the values that are often unexamined and the nature of powers in the field of mental health more generally....it is a good thing, is a move away from dogma and towards transparency and I will go as far as saying that critical thinking is now a necessity in the field of mental health (Bracken, 2011).” Bracken urges psychiatrists to look for alternatives to pharmaceuticals to treat mental conditions, citing the long-term outcomes of psychiatric treatments such as antipsychotics (e.g., main cause of death identified as metabolic syndrome, a medication side effect; shortened life span of 16 to 20 years).

The DSM continues to certify psychiatric diagnoses – and the number of people with psychiatric diagnoses continues to grow as does the market for medications to treat these disorders.
How do these drugs affect people in the long term? Are we improving the long term outcomes? Another proponent of critical psychiatry is Dr. Robert Whitaker, a renowned American medical science journalist, has investigated the rise of the biological model of psychiatry from a historical perspective. Although Whitaker opines that the evidence supporting the serotonin and dopamine imbalance theory is wanting, he also concedes that there is a place for medications in psychiatry. Medications can provide short-term relief of symptoms. But do they have long term positive outcomes? Do the side effects contribute to *early death*? The vision for the critical psychiatry movement is a reversal of the current state of psychiatry practice whereby psychosocial treatments (e.g., psychotherapy, exercise, nutrition, social support services for home, etc.), currently viewed as adjunct interventions, become the primary treatment modalities, and medications are only advocated for short-term use.

The World Health Organization has adopted the biopsychiatry framework, which assumes that emotional distress is "universal" because it is biological and that this experience occurs independently of cultural context. If mental illness is indeed a brain disease as the biopsychiatric framework suggests, then standardized treatments can be used to treat these disorders of the brain (Timimi, 2011a, 2011b; Summerfield, 2004). Summerfield (2004) agrees that:

The psychiatric literature on the application of quantitative research methods to non-Western settings largely founders on the rocks of what Kleinman (1987) called a category fallacy. The fallacy is the assumption that because phenomena can be identified in differing social settings, they mean the same thing in those settings. The histories of terms like "depression" or "post-traumatic stress disorder" (PTSD), and the particular meanings (and responses) they mobilize in contemporary Western culture, are simply not straightforwardly reproduced elsewhere. There is
no equivalent to these terms in many cultures (Pilgrim & Bentall, 1999). The history of depression reveals the gradual incorporation of the Western cultural vocabulary of guilt, energy, fatigue, and stress (Jadhav, 1996). Thus depression or PTSD as they stand simply cannot be universally valid diagnostic categories. Yet the World Health Organization (1996) is claiming that "depression" is a worldwide epidemic that within twenty years will be second only to cardiovascular disease as the world’s most debilitating disease. This is a serious distortion, which could serve to deflect attention away from what millions of people might cite as the basis of their misery, like poverty and lack of rights. The UN Food and Agriculture Organization says that the number of chronically hungry people in the world is rising by 5 million a year. The one clear-cut beneficiary would be the pharmaceutical industry, with its vested interest in the biologization of the human predicament (p. 256).

Perhaps the efforts to classify mental illnesses need to be contained. In effect, the very essence of human experience (e.g., after loss, death, family separation, trauma) is being medicalised. Moreover, psychiatry is especially ripe for commodification because there are no tests or biological markers that confirm a diagnosis of depression or anxiety - only the expert opinions of psychiatrists are needed. The ultimate impact of medicalising normal feelings and behaviors may be the creation of a new era in society whereby physicians become agents of cultural change. In other words, doctors and psychiatrists may not just be generating new patients, but also changing the culture of future generations. Pharmaceutical companies are not only profiting from the creation of these markets but may be actually influencing the way society views normal feelings and behaviors -- overpathologizing them so that they can be targeted for treatment with medication. With these
considerations in mind, it is important to note that there is a place for pharmacological treatments for severe mental conditions; the question is really, within the profession of psychiatry, whether the case for morality will trump the case for self-interest (Kleinman, 2012).

A prime example of such advocacy is the critical psychiatrists network’s opposition to the WHO Gap Action Programme (mhGAP) initiative. Their members argue that the WHO is exporting diagnoses and treatments created in the West to the rest of the globe, creating new markets for pharmaceutical companies and eroding local indigenous ways of healing. They also argue that neoliberal policies that allow for commodification of medical care services like any other good not only affect the domestic availability of culturally appropriate mental health services for immigrants in developed nations but also the practice of psychiatry around the world.

Timimi (2010), a child psychiatrist, is a member of the critical psychiatrist network and is recognized as a strong opponent of the WHO mhGAP proposal for addressing the global mental illness treatment gap. Timimi argues that the treatments recommended in the proposal are actually an extension of globalization processes. Addressing the treatment gap using Western psychiatry practice implies the transfer of Western values, illness categories (e.g., anorexia, ADHD, schizophrenia, depression), and beliefs about the causes of symptoms and their treatments. This process of knowledge transfer has an undercurrent of neocolonialism, as it is based on the assumption that the standard practice of psychiatric diagnosis and treatment in developed countries is good for all, without pause for consideration of the deep differences in illness models, pathways to care, healing processes, or what simply is acceptable in any given community or culture. That is, by exporting Western-based diagnostic classification systems (e.g., DSM-IV or ICD) and treatment approaches (e.g., medication, psychotherapy) from the developed world to the developing world under the assumption that these practices are universal and applicable to all human beings, the
practice of psychiatry itself becomes a commodity that is ripe for exploitation by high income countries and in new markets located in low income countries. Indeed, Timimi contends that pharmaceutical companies have vested interests in the WHO mhGAP treatment packages and has implored psychiatrists to boycott this WHO initiative.

Timimi (2011a) adds that the biopsychiatric framework of WHO’s mhGAP initiative is based on the premise that any person diagnosed with a depressive disorder using standardized diagnostic classification systems like the DSM will respond similarly to the same treatments (e.g., anti-depressants or cognitive behavioral therapy). These assumptions imply that these systems of classifications are valid and reliable. However, Timimi asserts that this is not yet proven, not in developed countries and definitely not in developing nations. Timimi (2011a) further notes that it is "no accident that forms of practice predicated on the assumption that mental distress is something that belongs to individuals emerged most prominently in those countries that are the strongest advocates of neoliberal-market system" (p. 158). In Western society, capitalism has become fused with consumerism. Psychiatry is vulnerable to commodification because there are no biological markers or tests, only classification systems used by psychiatrists to make diagnosis and indicate treatments; new diagnoses and treatments (i.e., the commodity) can be marketed and sold to the new patients (i.e., the consumer). In his articles entitled Children's Mental Health in the Era of Globalization: Neo-Liberalism, Commodification, McDonaldisation, and the New Challenges they Pose (Timimi, 2011b) and The McDonaldisation of Childhood: Children's Mental Health in Neo-liberal Market Cultures (Timimi, 2010), Timimi articulates how the commodification of psychiatry is already being practiced in developed nations with children and their parents becoming new markets in a very aggressive neo-liberal free-market economy. He uses the examples of ADHD, autism and child depression to illustrate his points.
Although Timimi’s arguments regarding the commodification of psychiatry in the diagnosis and treatment of childhood behaviors is not the focus of the present dissertation, the discourse relating to the commodification of psychiatry in an era of globalization is certainly timely and relevant. Timimi (2011b) states:

The era of globalization has resulted in the global exchange of not only goods, but also ideas and values, resulting in new challenges. Aggressive free market global economic systems contribute to the creation of new dangers. The development of universalized therapeutic approaches has inadvertently replicated colonial dynamics by imposing Western notions of self, childhood, and family onto non-Western populations. Globalization also brings new opportunities for new identities, fusions and creative solutions. A variety of economic, political, and cultural pressures shape beliefs and practices around children and families. Policies that promote a particular form of aggressive capitalism lead to a narcissistic value system that permeates social institutions, including those that deal with children. Not only does this impact children’s emotional well-being, but it also shapes the way we conceptualized children and their problems. These beliefs and practices have facilitated the rapid growth of child psychiatric diagnoses and the tendency to deal with aberrant behavior or emotions in children through technical – particularly pharmaceutical interventions, a phenomenon I refer to as the ‘McDonaldization’ of children’s mental health. Diagnoses do not yet reveal the causes of mental difficulties or provide clear differentiators for treatment. As subjective constructs they are thus vulnerable to ‘commodification’ processes. Commodification can
distance people from a more considered in-depth understanding of the problems being experienced (p. 413).

Angell (2010), who served as editor of the New England Journal of Medicine for 20 years, wrote a powerful editorial critiquing the commodification of diagnosis and treatments titled ‘Big Pharma, Bad Medicine’. Of particular interest to this discussion, is Angell’s apparent discomfort with the development of clinical practice guidelines guided by panels of experts and experts advisors who have some affiliation to pharmaceutical companies or other type of conflict of interest that require disclosure. Angell’s concerns about the sale of academic medicine was prompted by a clinical trial of an antidepressant called Serzone that was published in the journal for which she served as editor. Angell noted, “The authors of that paper had so many financial ties to drug companies, including the maker of Serzone, that a full-disclosure statement would have been about as long as the article itself, so it could appear only on our Web site… the situation, while extreme, was hardly unique” (pg. 1). Even more alarming is Angell’s assertion that, “of the 170 contributors to the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), 95 had financial ties to drug companies, including all of the contributors to the sections on mood disorders and schizophrenia (pg. 1). Angell (2010) explains that the goal of pharmaceutical companies is to make profit for their stakeholders by using sophisticated marketing strategies that 'educate' doctors, parents, teachers and communities, influence doctors' prescribing patterns, and skew the literature to biological explanatory models of illnesses.

Angell’s book ‘The Truth About the Drug Companies: How They Deceive Us and What to Do About It’ (2012) has been harshly criticized by John Oldham, president of the American Psychiatric Association:
In its June 23 edition, The New York Review chose to review three books that are highly critical of modern psychiatry. We regret that a more balanced approach was not taken. Dr. Marcia Angell writes of a “raging epidemic” in mental illness, citing the fact that there are more individuals receiving disability payments for mental illnesses than ever before. While this is accurate, her article suggests that this is a false crisis that owes its existence to the discovery of psychotropic drugs starting in the 1950s. This creates the impression that Americans are over treated for mental illnesses. Nothing could be further from the truth. The National Institute of Mental Health reports that currently only 36 percent of those who suffer from mental illnesses actually seek and receive treatment. This is especially concerning given the fact that comprehensive, biopsychosocial treatment of mental illnesses is increasingly effective, comparable to or at times greater than the effectiveness of treatment for many other medical disorders, such as heart disease and diabetes. Dr. Angell and the authors she reviews also suggest that psychiatry, in general, regards mental illnesses through the reductionist lens of an imbalance of chemicals in the brain. Although psychotropic medications have been found to alter the balance of neurotransmitters in the brain, there is no consensus on whether these imbalances are causes of mental disorders or symptoms of them. The bottom line is that these medications often relieve the patient’s suffering, and this is why doctors prescribe them. It does not mean, as Dr. Angell suggests, that mental disorders were invented in order to create a market for psychotropic drugs. The disorders that these medications (and other therapies) treat have been around for all of recorded history. The difference is that today, thanks to medical and therapeutic
advances, there is real help for those who suffer the devastating effects of mental illness (pg. 1).

Thomas (2012), another founding member and co-chair of the critical psychiatry network, seriously questions who really benefits from the globally homogenized approach to treating mental illness. Thomas argues that the *pharmaceutical industry is second only to the arms industry in the US, Britain and Europe*. To further illustrate this point, Thomas points out that the pharmaceutical industry profits have risen by 33% to $37.2 billion following the onset of the economic crisis in 2001, while other industries have seen a 53% decrease in profits. Thomas notes that the global spending on medications amounts to 643 billion -- the US market accounts for about half of this profit. Thomas (2012) states that:

Global knowledge purports to be universal, relevant to all cultures at all times. Its epistemology is tightly defined, and protected by terminology, jargon and notions of expertise. Its interpretive systems include science and biomedicine, psychiatry and cognitive psychology, as well as sociology. It espouses the values and beliefs of global capitalism, demonstrated by the pharmaceutical industry’s vigorous marketing campaigns. It seeks to exploit human relationships and the environment for its own purposes, serving corporate interests such as those of the pharmaceutical industry, the World Health Organization, governments and professional elites like the World Psychiatric Association (pg. 6).

These dynamics have already begun to bristle the global psychiatric community. In an example that hits close to home, Dr. John Livesly, professor emeritus and former head of the department of psychiatry at the University of British Columbia and international expert on
borderline personality disorder, has formally resigned from the DSM-V committee on personality disorders alongside his Dutch colleague Dr. Roel Verheul. They published the following open letter explaining their resignation:

As it stands now, the DSM 5 personality section is not readable, much less usable, it will be ignored by clinicians and will do grave harm to research. This is the sad product of a small group of cloistered DSM 5 'experts' stubbornly ignoring the sharp criticism from within their own group and the near universal rejection of their proposals by everyone else in the field... We also regret the need to resign because we were the only International members of the Work Group which is now without representation from outside the US."

Figure 1 provides a summary of the discussions above, indicating how forces of globalization can exert pressures to commodify the practice of psychiatry at the same time that effects on the determinants of health of vulnerable populations are intensified. This is the framework that I apply in carrying out this dissertation research, examining mental health services for Latin American immigrant populations in Canada.
Globalization and the Practice of Psychiatry in Canada

Canada is not immune to globalization processes. Canada is a high-income capitalist country with a strong economy fully participating in the global market, even though it has a socialist health care system. The practice of psychiatry in Canada is heavily influenced by the American Psychiatric Association Diagnostic and Statistical Manual (DSM) system of diagnosis.
and the biopsychiatric explanatory model of mental illness that identifies biological causes of psychiatric disorders (e.g., chemical imbalance, molecular abnormalities of the brain, etc.). Accordingly, psychopharmacological treatments targeting brain abnormalities are the primary intervention for the treatment of mental illness in Canada, and is sometimes potentiated by psychotherapy treatments developed for and tested on Canadian or US born White populations.

As the corrosive effects of globalization can be felt at all levels of society, it is probably most felt at the community level where the ability of the existing social and health infrastructure to maintain the mental health and overall well-being of its members has been compromised (Lacroix & Shragge, 2004). Economic policy has trumped social policy, creating “tremendous destabilizing pressures on the social fabric of society” (Leicht, 1998, p. 197). Psychiatrists, and other helping professionals, are likely to encounter the individuals who bear the health burden of these consequences. These individuals tend to be the most vulnerable members of society, who are culturally, socially, politically, and economically marginalized (Lacroix & Shragge, 2004). Longitudinal studies have demonstrated that immigrants and refugees are among the most likely to be socially excluded (Shaw, Dorling, & Davey Smith, 1999) and face disproportionate health inequalities (Marmot & Wilkinson, 1999). Although Canadian-based empirical research in this area is constrained by the absence of a consistent data stream (Mental Health Commission of Canada, 2009), collateral evidence suggests that it is social, environmental, and economic circumstances rather than biological predisposition to illness that predominantly explains health inequity (e.g., Goldman, 2001; Mikkonen & Raphael, 2010).

Recent developments in Canadian immigration policy have contributed to the further marginalization of immigrants and refugees to Canada. The reality of the Immigration and Refugee Protection Act (IRPA), adopted in 2002, is that certain types of newcomers (e.g., refugees,
sponsored family members, temporary workers, caregivers, etc.) to Canada find themselves in a precarious position facing uncertain immigration status (Lacroix & Shragge, 2004). Marginalization is further reinforced in Canadian society by: enforced exclusion from the labour market and dependence on a third party (i.e., sponsor) or the social welfare system (Beiser & Hou, 2001; Bloch & Schuster, 2002); underemployment arising from the lack of recognition of foreign professional credentials and experience (Beiser & Hou, 2001); and racist attitudes toward newcomers (Kundnani, 2001). The emotional impact of these circumstances are moderated by the psychological effects of oppression and trauma (Kirk, Garrow & Mitchell, 2002; Rousseau, 2000), language barriers (Health Canada, 2001; Thomas, 1995) experiences of loss of identity, loss of social status, loss of country (Ward & Styles, 2003), and time wasted while waiting for status (Lacroix & Shragge, 2004) leading to significant psychological distress that contributes to the onset and exacerbation of mental disorders (Kirmayer et al., 2011).

The stakes for the Canadian mental health system are high, as immigration has been driving Canadian population growth (McKenzie, Hansson, Tuck, & Lurie, 2010). The 2006 Canadian census indicates that the visible minority population in Canada is more than 5 million in a country of almost 35 million people, representing 16.2% of the total Canadian population (Statistics Canada, 2006a, 2006b). The visible minority population has grown steadily over the last 25 years but even more so between 2001 and 2006 when the growth rate (27.2%) was five times greater than the growth of the Canadian population as a whole. This increase in the visible minority population in Canada is explained by an influx of immigrants coming to Canada from non-European countries. As indicated by the 2006 Census (Statistics Canada, 2006a), 83.9% of the immigrants who arrived in Canada between 2001 and 2006 were born in regions other than Europe. Each wave of immigration to Canada has increased the ethnocultural diversity of the nation's population. In fact,
more than 200 different ethnic origins were recorded in the 2006 Census. In contrast, just about 25 different ethnic groups were recorded in Canada in the 1901 Census.

Numerous factors have influenced international migration to Canada -- most notably globalization and globalizing forces such as technological advances, more affordable transportation, and political, economic, and social conditions both nationally and internationally (Citizenship and Immigration Canada, 2005). Immigration has in fact been assessed as being essential to Canada’s ongoing economic growth (Citizenship and Immigration Canada, 2005). Canada’s long-term immigration goal has been to reach annual immigration levels of approximately one percent of the population of Canada per year. For example, the 2012 Immigration Action Plan sought to bring approximately 250,000 immigrants to Canada. Critics of globalization have called for mental health impact statements to be issued alongside such economic policies (Kleinman, 2001). In order to implement such fail-safes, the true implications for globalization on global mental health need to be accurately characterized. In doing so, it is imperative to keep a “global mindset” that allows for cultural, social, environmental, and economic and anthropological explanations for the increasing prevalence of mental illness.

There is no question that all levels of the Canadian health system will need to develop an appropriate response to the health services needs of this increasingly multicultural population. Population studies have demonstrated that, upon arrival to Canada, new immigrants have lower rates of mental disorder than the general Canadian population (Hyman, 2004; Ali, McDermott, & Gravel, 2004). However, post-migration factors have been found to neutralize the ‘healthy immigrant effect’ such that the health of immigrants approaches that of the general population over the course of the years of residing in a country (McDonald & Kennedy, 2004; Newbold, 2005). Refugees have been identified as being at higher risk for mental disorders compared to the general
population, with elevated incidence of post-traumatic stress disorder, depression, chronic pain, and other somatic presentations (Steel, Silove, Phan, & Bauman, 2002). Certain immigrants groups have also been noted to have an elevated incidence of psychotic disorders after migration (Morgan, McKenzie, & Fearon, 2008).

Although social determinants of health have emerged as key factors in understanding such health inequities, the mental health system in Canada is still predominated by biomedical health discourse (Robertson, 1998). While there has been some shift in the mental health system based on best practices in recovery oriented care (i.e., holistic, person-centered, community-based), complete mental health reform has been thwarted by fiscal and service delivery restructuring that serves the agenda of decentralization of mental health care delivery in Canada. This competing force has been bolstered by Canadian governments that support neoliberal beliefs that endorse reductions in social expenditures and stiffer competition in the global marketplace through privatization – key features of economic globalization (Morrow, 2004).

The profession of psychiatry has been largely aligned with this approach to service delivery, overriding competing discourses about the causes of and treatments for mental disorders with arguments citing medical science and cost-effectiveness (Morrow, 2004); alternative models are typically tolerated as long as they remain subordinate to biopsychiatry paradigm. For instance, Ontario has a strong consumer/survivor movement that has conducted several successful peer-directed projects and economic development models outside the mainstream mental health system. Although the findings from such initiatives have indicated that mental health consumers benefit more from peer support workers than any other professional group and use less mental health services while engaged in these initiatives, support for this allied health service is not reflected in
the presence of these workers in the mental health system (Trainor, Shepherd, Boydell, Leff, & Crawford, 1997). Thus, Morrow’s (2004) conclusion is particularly astute:

If, as Warner says, “psychiatric ideology is influenced by economic conditions” (1994, p. xi), then how we understand mental illness is intimately tied to economic restructuring. Indeed, Deena White describes mental health as a “notoriously trying policy domain” in part because the “uncertainty and controversy about the causes and the very nature of mental disorders makes the most appropriate means for their social management a puzzle” (1996, p. 289). Certainly, in a climate of cutbacks and retrenchment, challenges to predominant discourses about mental illness and the power invested in these will be less welcomed (p. 45).

Perhaps more troubling is the undercurrent of colonial medicine in the contemporary practice of psychiatry. Colonial medicine was part of the larger ideological campaign of the empires, in which efforts to manage the health of developing regions was closely linked with the economic interests of the colonizers. Colonial practitioners did little to tailor treatments to non-Western populations, dismissing alternative models of illnesses and the knowledge of indigenous practitioners. Colonial treatments also tended to be quite narrow in their design and implementation (Davidovitch & Greenberg, 2007). Contemporary psychiatry has largely neglected social context variables, gender and class bias, sexuality, and cultural considerations (Lewis-Fernández & Kleinman, 1995; Morrow, 2004). The parallels lend support to arguments that the global mental health is not the end goal for psychiatry, but rather that psychiatry is a tool for globalization.

In the developed world, including Canada, the biopsychiatric framework of the causes and treatments for mental disorder focusing on genetic origins and neurochemical pathways predominates. However, there is a competing psychological model in the mental health marketplace
that emphasizes human contextual factors such as personality, behavior and other individual differences. The capacity for psychopharmacological treatments to address the specific needs of immigrant and refugee population is quite limited. Although cross-cultural psychopharmacology is a growing field, there likely remains an inherent disconnect between the basic assumptions of the biopsychiatric model and the patient’s explanatory model of illness.

By contrast, evidence-based psychological treatments developed in Western contexts such as cognitive behavioral therapy can also be used to effectively treat immigrant and refugee populations, as long as the conceptual underpinning of the intervention is culturally syntonic (Karasz, Garcia, & Ferri, 2009). Further, emerging evidence suggests that these psychological treatments offer more leeway in meeting the specialized needs of immigrant and refugee populations, allowing for linguistic and cultural adaptations that optimize treatment effectiveness for this patient group (Bernal, Jiménez-Chafey, & Domenech, 2009). Herein lies an opportunity for innovation in Canadian psychiatry practice.

**Globalization and the Practice of Psychiatry in Cuba**

Global health indicators have highlighted excellent health outcomes for the Cuban population despite severe economic crisis and five decades of US embargo that have excluded the nation from global trends in healthcare practice, commerce, and culture (Garfield & Santana, 1997; Spiegel & Yassi, 2004). Despite limited resources resulting from these conditions, Cuba’s achievements in child mortality, maternal mortality, life expectancy at birth, and the management and eradication of certain infectious diseases are reportedly on par or better than higher income and more technologically advantaged countries including the US (Cooper, Kennelly, & Ordunez-Garcia, 2006; De Vos, De Ceukelaire, Bonet, & Van der Stuyft, 2008; Spiegel & Yassi, 2004).
The Cuban health system has developed into a comprehensive public health system that emphasizes primary care, prevention, health promotion, and community participation (Spiegel & Yassi, 2004; Cooper, Kennelly & Ordunez-Garcia, 2006; De Vos, De Ceukelaire, Bonet & Van der Stuyft, 2008). While Cuba has been observed internationally to be producing "good health at low cost" in a global perspective, the country has invested considerably in its health care system - approximately 16% of its GDP on the national health system, or around 320 dollars per person (Cooper, Kennelly & Ordunez-Garcia, 2006). The Cuban health system is decentralized, free, and accessible to all. The system is also integrated vertically and horizontally, facilitating communication between primary, secondary and tertiary levels of care, with pertinent government departments such as the ministries of education and health, and with community stakeholders including political organizations led by the Cuban people such as the Committees for the Defense of the Revolution (CDRs) and the Federation of Cuban Women (Kates, 1987; Spiegel and Yassi, 2004).

The progression of the practice of psychiatry with the Cuban health system is intertwined with the history of Cuba itself. Psychiatry in Cuba dates back the 19th century and can be divided in three periods -- the colonial period ending with the Cuban independence from Spain in 1898, the republic period ending with the Cuban Revolution in 1959, and the revolutionary period that continues to the present day (Basauri, 2008). During the colonial period, people with mental illness were generally housed in asylums, poorhouses and charity homes. The patient advocacy efforts of Bishop Espada eventually led to the creation of first psychiatric hospital in Cuba in 1828 (Danielson, 1979). Although the hospital intended to be dedicated to the service of the mentally ill, patients with mental illness and leprosy patients actually shared the same space. About twenty six years later, the National Psychiatric Hospital of Havana (or Mazorra Hospital) was constructed and
the first patients were received in 1864. It was not until 1880 that Cuba established the Regulations of the General Center for Insane of the Isle of Cuba. Most psychiatrists in Cuba were trained in France. They found little academic and clinical opportunities in this hospital in the 19th century (Basauri, 2008).

During the republic period, the field of psychiatry, training programs in psychiatry, and psychiatric associations began to grow and consolidate. From 1933 to 1958, there were significant advancements in the field of psychiatry in Cuba. Heavily influenced by French models of mental health care services, psychoanalysis and other forms of psychotherapy were popular. The first psychiatric congress in Cuba took place in 1955 and provided opportunities for scientific exchange and debate. However, there was only one medical school and one university hospital. Sixty percent of physicians including those specializing in mental health care were located in the capital city, Havana, and were paid privately. Professional advancements and efforts did not improve the economic and geographic accessibility to mental health care (Basauri, 2008). Public health efforts consisted of ensuring basic sanitation, administering vaccinations, and providing health care in rural areas (Cooper et al., 2006).

The Cuban revolution began in 1959, prompting the flight of 3,000 to 6,300 physicians from Cuba to the US. Several milestones in psychiatry marked the revolutionary period in Cuba. The nation supported an overhaul of the health care system in general. The Ministry of Health was assigned the task of establishing a health care system that was universal, comprehensive, and free for all in order to address the enormous health inequities between the urban and rural areas of Cuba and to also address the fact that almost half of all the doctors left the island. Due to the shortage of doctors, Cuba initiated an accelerated plan of training medical professionals and adopted a community–based approach to the primary care model. ‘Polyclinics’ were implemented to help
support the family doctors in the community, providing quick access to medical specialists including internists, pediatricians, psychologists, gynecologists, physiotherapists, ophthalmologists, and laboratory and dental staff. This system was fully functioning by 1984 (Basauri, 2008).

The reorganization of psychiatric services after the revolution had four objectives: to decentralize and extend psychiatric services throughout the island, integrate existing mental health services in the national health care system, modernize and humanize the National Psychiatric Hospital of Havana, and diversify psychiatric services. Diversification meant the creation of psychiatric wards and outpatient units in general hospitals; the first two opened in 1962. It also meant increasing mental health clinics through the creation of crisis units in general hospitals that were linked to urgent care centers with short stay and 24 hour observation beds. This new network of mental health services was designed and coordinated by the local polyclinic and the mental health programs run by psychologists and psychometrists. In essence, there was a shift in the administration of mental health services from the institutionalization model to the community-based care model.

Fidel Castro’s revolutionary Cuba initially had the economic support of the Soviet Union and other countries in the socialist bloc and Western Europe. However, as a consequence of the fall of the Soviet Union, Cuba’s GDP fell by 60% and the loss of access to imported resources severely constrained import-reliant industries including health care (e.g., access to medications and technology) and diminished the health of the Cuban population by restricting Cuba’s ability to provide the basic necessities such as food and water (Barrett, 1993). Food shortages during this ‘special period’ (1990-1997) resulted in an average adult protein intake of 15 g to 20 g per day and an average adult weight loss of 5% to 25% – in effect, a famine (Canadian Medical Association Journal [CMAJ], 2008). The nutritional deficits during this period have been linked to increase in
the child mortality rate and the rate of low birth weight babies (Garfield & Santana, 1997). The US embargo, which began in 1961, also affected Cuba’s ability to provide clean water for its population. Chlorinated water supplies declined from 98% in 1988 to 26% in 1994, contributing to an increase in the mortality rate by diarrheal diseases per 100,000 from 2.7% in 1989 to 6.8% in 1993 (Garfield & Santana, 1997). Despite the apparent economic crisis, Cuba continued to increase health spending (absolute number and percentage of the GDP) in order to protect those who were most vulnerable to adverse health events (Chomsky, 2011). The emerging community-based care model was reinforced by the Caracas Declaration and the Havana Charter, approved in 1990 and 1995 respectively, which emphasized health promotion and prevention and the reorientation of psychiatry to the community care model with a focus on primary health care (Thornicroft, Alem, Drake, Ito, Mari, McGeorge et al., 2011).

The Cuban economy eventually recovered with financial assistance from Venezuela and the establishment of bilateral agreements with countries such as Venezuela and China, and the mental health system in Cuba continued to evolve. The current delivery of mental health resources is based on three levels of care. At the primary level are the mental health centers. The mental health centers have teams of mental health professionals including psychiatrists, psychologists, psychiatric nurses, general practitioners, educational specialists, psychiatric social workers, education specialists, occupational therapists, nursing assistants and psychometrists. The multidisciplinary teams work together with the polyclinics and with the family doctors in the community. In turn, they communicate and collaborate, not only providing mental health care but conducting a number of mental health promotion and prevention activities. The secondary level of care is the psychiatric services in the general hospitals and the children’s hospitals. The tertiary level of care is represented by the psychiatric hospitals. As of 2003, Cuba had 199 community mental health
centers, 28 psychiatric wards in general and pediatric hospitals, 22 psychiatric hospitals and 8,839 psychiatric beds in total for the island. There are approximately 1000 psychiatrists in Cuba, 200 of whom are child psychiatrists; 31,000 family doctors provide coverage to more than 90% of the population of 11.5 million. This is one the best doctor-patient ratios in the world (Collinson & Turner, 2002).

As a consequence of limited supply of psychotropic medications and information about international advances in the field (Collinson & Turner, 2002), Cuba has created its own rehabilitation programs for people with mental illnesses. This phenomenon is not only evident in the practice of psychiatry but also in the practice in family medicine. Complementary and alternative medicine integrated in the daily practice of family medicine in Cuba, including acupuncture, herbal medicine, trigger point injections, massage, heat therapy, transcutaneous nerve stimulation, yoga, meditation, exercise training, and music and art therapy (Dresang, 2005). At the National Psychiatric Hospital in Havana, Collinson and Turner (2002) noted that atypical antipsychotics were scarce even though psychiatric medications were generally available. Further, the practice of occupational therapy had been extended beyond ergotherapy (work therapy) and was “aimed at generating both emotional and social benefits, a major improvement, in [the Cuban psychiatrists’] view, to the more limited approaches used in North America and Europe” (p. 187). The use of novel treatments such as psychoballet, music therapy, and sports therapy were also noted.

More recently, Cuban psychiatrists and psychologists have begun to publish findings regarding the therapeutic effects of music therapy in Cuba. For example, Peraza and Zaldivar (2003) described the use of music therapy to decrease risk for depression and anxiety among patients diagnosed with high blood pressure. At a psychiatric conference in 2000, Dr. Luis
Calzadilla Fierro (former vice-director of the National Psychiatric Hospital of Havana and Secretary of the Cuban Psychiatric Association) described how the Occupational Health Department and the Rehabilitation Program was created at the National Psychiatric Hospital in Havana in 1962. The services provided gymnastics, literacy school, music therapy, cultural and artistic activities, and sports therapy for patients of both genders, tailored to their individual capacities. These therapeutic approaches are also conducted outside of hospital grounds and incorporated in the daily rehabilitation of these patients in the community, in other provincial hospitals, and the community mental health centers. He stated, “In this way, the patient feels welcome in his milieu, his society, especially the chronically ill…by transforming his own physical and social environment, he transforms others.”

Music therapy is also used in Cuba for the treatment of depressed elderly. The work of Dr. Rigoberto Oliva began in 1998 under the mentorship of Dr. Teresa Fernandez de Juan and shows great efforts and achievements toward the improvement of the mental health of 71 elderly patients between 60 and 78 years old with mood and communication disorders. According to Oliva and Fernandez de Juan (2003), “imagination, creativity and memory were stimulated by musical listening and improvisation, alongside physical expression through musical instruments and relaxation techniques”. A second study (Oliva & Fernandez de Juan, 2006) was conducted from 2002 to 2004 with 35 depressed patients between the ages of 60 - 83, in Havana. Oliva and Fernandez de Juan employed musical improvisation, psycho-dramatic techniques and interactive games as well as opportunities to listen to and participate in Cuban music. The authors reported a significant decrease in the use of medication among the sample.

Alfonso (2005) discussed the rehabilitation programs at the National Psychiatric Hospital in Havana. In addition to the aforementioned cultural and artistic activities, sports therapy is cited as a
very important factor in the rehabilitation of mentally ill patients. Sports therapy is a complex program that can range from simply doing exercises on the hospital grounds to actual sports competitions. For example, at the time of publication, patients were training to compete in an Interregional Mental Health triathlon in Martinique Island. Cuba sent patient representatives from the National Psychiatric of Havana and the Gustavo Machin Psychiatric Hospital of Santiago de Cuba. Participating patients reported decreased sleeping difficulties, requiring less psychotropic medications, and fewer side effects.

In terms of global health, Cuba presents an *uncommon learning opportunity*. One essential area of interest is the impact of a fully integrated mental health system on the prevalence of mental conditions, especially common mental disorders such as depression, anxiety, alcohol abuse and dependence. Another vital area of interest is the effectiveness of *innovative programs* used in Cuba for the rehabilitation of people with severe mental conditions such as music and sports therapy. The international mental health community may find it beneficial to further explore these interventions, as the lessons learned from Cuba could serve to optimize health care approaches worldwide.

**Global Mental Health: The Social Determinants of Health**

Health inequities within and between communities are at least partially attributed to the social determinants of mental health. The determinants more broadly refer to the social, economic, and physical conditions that impact a wide range of health, functioning, and quality of life outcomes including mental health (Raphael, 2004). There are a number of frameworks for understanding the social determinants of mental health available in the Canadian literature (e.g., Mikkonen & Raphael, 2010; PHAC, 2004). Currently, there is no expert consensus on a particular framework that should guide research and practice. However, at this stage in the progression of social determinants of health research, it has been deemed prudent to include all the social
determinants of health that have been proposed (NCCDH, 2011). Generally, these lists of
determinants include (Mikkonen & Raphael, 2010):

*Income and Income Distribution*

Income disparity, also referred to as “the growing gap” (Yalnizyan, 1998), is regarded as
one of the most powerful social determinants of health because it shapes overall living conditions,
psychological functioning, health-related behavior, and the other determinants of health. In a more
basic sense, income level is a pre-requisite for health (Mikkonen & Raphael, 2010).

*Education*

Education is positively associated with health. The mechanisms behind this strong
correlation are posited to be three-fold. First, education predicts other social determinants of health
such as income and job security. Second, these are empowering experiences in that they allow
individuals to adapt to changing environmental conditions (e.g., job loss and retraining), thereby
moderating disadvantageous societal factors that influence health. Third, education bolsters literacy,
which broadens access to resources pertaining to healthy living. While lack of education is not a
direct cause of poor health, it exposes individuals to gaps in public health services (e.g., lack of
affordable child care) that maintain the status quo (e.g., unable to afford child care that would make
time available to improve education and, in turn, income level; Mikkonen & Raphael, 2010).

*Unemployment and Job Security*

Unemployment is associated with material loss, social isolation, mental health problems
such as depression and anxiety, stress-related health condition, and use of maladaptive coping
behaviors (e.g., smoking, alcohol use). Job security has waned over the past few decades, giving
way to increased part-time job status, underemployment, and insecure (i.e., intense work, non-
standard hours) employment. These conditions serve to reduce income and deteriorate well-being (Mikkonen & Raphael, 2010).

**Employment and Working Conditions**

Aspects of employment and working conditions that influence health outcomes include job security, physical conditions at work, work pace and stress, working hours, and outlets for personal development at work. Unfortunately, individuals at risk for negative health outcomes due to low education and income levels are more vulnerable to exposure to poor working conditions that further depreciate their health and well-being (Mikkonen & Raphael, 2010).

**Early Childhood Development**

From a developmental perspective, early childhood experiences set the stage for good or poor health, late life circumstances notwithstanding. The principle of ‘cumulative effects’ states that increasing exposure to conditions of material and social deprivation leads to progressively adverse health and developmental consequences. The best indicator for deprivation in Canada is children living in households below Statistics Canada’s low-income cut-off (Mikkonen & Raphael, 2010).

**Food Insecurity**

Food insecure individuals cannot reliably obtain food through standard avenues. Food insecurity can lead to dietary deficiencies and malnutrition, which can pose long-term effects on individuals’ physical and psychological health. Indeed, food insecurity is a strong predictor of Canadians who report poor or fair health, poor functional health, and chronic disease (Mikkonen & Raphael, 2010).
**Housing**

The quality of housing impacts health in a variety of ways. Overcrowding facilitates the transmission of illness, housing costs reduce the available of monetary resources to sustain other social determinants, and poor housing exacerbates stress levels thereby increasing the likelihood of unhealthy coping strategies. The main factor influencing housing problems is income. Although Canada has committed to various human rights treaties guaranteeing the availability of shelter, Canada has been routinely called to task about neglecting these commitments (Mikkonen & Raphael, 2010).

**Social Exclusion**

Social exclusion impedes specific groups from participating in social, economic, and political life in Canada. According to Mikkonen and Raphael (2010), Aboriginal Canadians, Canadians of colour, recent immigrants, women, and people with disabilities are likely to experience social exclusion. Social exclusion systemically reproduces the living conditions and lived experiences that threatens physical health and engenders a sense of hopelessness and helplessness for inclusion in Canadian life (Mikkonnen & Raphael, 2010).

**Social Safety Network**

Social benefits, programs, and supports serve a protective function in maintaining health against destabilizing life events such as job loss, illness, and disability. The social service provisions offered by the Canadian government ranks 24 out of 30 among the industrialized nations (Organization for Economic Co-operation and Development [OECD], 2009a, 2009b).
Health Services

Canada’s universal health care system aims to protect the health of its citizens by providing access to health services unfettered by financial barriers, achieved by distributing the cost of health care services across society. However, there remain issues pertaining to access to care, as the bottom third of Canadian income earners are “50% less likely to see a specialist when needed, 50% more likely to find it difficult to get care on weekends or evenings, and 40% more likely to wait five days or more for an appointment with a physician” (Mikkonen & Raphael, 2010, p. 38) as compared to their counterparts in the top third.

Aboriginal Status

Aboriginal Canadians are more likely to have lower income levels, lower educational attainment, poor housing, lower employment levels, higher food insecurity, and poorer housing conditions than their non-Aboriginal counterparts. The disproportionate impact of adverse social determinants on the health of this community is undoubtedly linked to their history of colonization (Mikkonen & Raphael, 2010).

Gender

In Canada, women are more likely than men to be negatively impacted by the social determinants of health. For instance, women are more likely to earn less and experience job insecurity. Moreover, due to the lack of affordable, high-quality daycare, women are compelled to spend more time in the household tending to family responsibilities such as daycare. Single mothers, in particular, run the risk of poverty due to lack of affordable childcare that impedes their ability to enter work life and the lower wages paid to women in general (Mikkonen & Raphael, 2010).
Race

One third of racialized Canadians (i.e., members of visible minority groups) are Canadian born; the remaining two-thirds are immigrants. Regardless of their immigration status, racialized Canadians encounter adverse circumstances that pervade their everyday lives. Experiences of racism have been identified by racialized Canadians in institutional, interpersonal, and individual contexts. Although past surveys demonstrated a ‘healthy immigrant effect’ for both European and non-European immigrants, more recent surveys have found that the health of non-European immigrants of colour declines over time as compared to their European counterparts and Canadian residents (Mikkonen & Raphael, 2010).

Disability

Disability as a social determinant of mental health pertains to the willingness of a society to provide the supports required to participate in Canadian life (Mikkonen & Raphael, 2010). Compared to other industrialized nations, Canada’s level of benefits to people with disabilities and support for integration of people with disabilities into society is below average (OECD, 2003).

Together, the social determinants of health represent targets for remediable areas in public health service delivery. On a policy level, the current focus on the social determinants of health represent a new era in health equity practice. However, at the service delivery level, there is little specificity around the implementation of social determinants of health directives for the priority populations including immigrants to Canada. For the purpose of the present dissertation, subsequent discussion and analysis of the social determinants of health will focus on those proposed by the Public Health Agency of Canada (2004). These social determinants of health include: income and social status; social support networks; education and literacy; employment and working conditions;
social environments; physical environments; personal health practices and coping; healthy child development; biology and genetic endowment; health services; gender; and culture.

While the majority of these determinants overlap with those proposed by Mikkonen and Raphael (2010), the determinants of health outlined by the Public Health Agency of Canada have informed public health action on the social determinants of health to date including the Toronto Central LHIN objectives, which has directly applicability for the present study. Table 1 depicts the parallels between the two chief ‘social determinants of health’ frameworks listed in a recent environmental scan conducted by the National Collaborating Centre for the Determinants of Health [NCCDH] (2011). Among the Public Health Agency of Canada [PHAC] factors, personal health practices and coping as well as biology and genetic endowment appear to lie outside Mikkonen and Raphael’s framework (2010). However, this apparent inconsistency is likely due to Mikkonen and Raphael’s exclusive focus on ‘social’ determinants and their inclusion of personal health practices and coping considerations for each of their proposed social determinants.

Table 1. Comparing Social Determinant of Health Frameworks

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In summary, this chapter has provided working definitions of *globalization* and *global mental health*, as it pertains to the mental health challenges that extend beyond national boundaries. *Mental health* is established as a central component of the well-being of all individuals, requiring global cooperation for the development and implementation of health equity solutions. The globalization of psychiatry has influenced greatly the practice of psychiatry in Canada and also in other parts of the world. The notion that the "one size fits all" for Canadian-born populations and immigrants alike is founded in the *biomedical model of treatments* particular of capitalist nations and neo liberal policies. Being in the margins of globalization, Cuba provides a contrasting picture that allows for insights in the critical consideration of global and local impacts on mental health service delivery. The provision of mental health services in Cuba is based mostly in a *collectivist approach* where patients, community and government work together with mental health service providers; most treatments are innovative and psychosocial with a great emphasis on prevention, health promotion and early treatments, contrary to the *individualistic approach* typical of high income capitalists nations that rely on pharmaceutical treatments.

It is argued that acting on the social determinants of health is needed to achieve health equity. The following chapter (chapter 3) presents an evaluation of health equity considerations from the perspective of the Spanish-speaking Latin American immigrants at risk for mood disorders such as depression (research question 2) via a review of the status of this population in Canada, their mental health concerns, the social determinants of health that they face, and their pathways and barriers to care (objective 2). Chapter 4 reviews the psychotherapeutic intervention proffered as an important vehicle for addressing the questions proposed in this dissertation, cognitive behavioral therapy (i.e., CBT), and its use among Spanish-speaking populations.
After reviewing the concepts of globalization and global mental health, examining how globalization has affected the practice of psychiatry in the globe, comparing the cases of Canada and Cuba with regard to the differential effects of globalization (and marginalization) on their respective health care systems, and highlighting the growing Spanish-speaking immigrant population in Canada and their specialized mental health service needs, the glaring question at hand is, *what can the psychiatric profession do about this?* Chapter 5 reviews this writer’s research efforts to culturally adapt an evidence-based treatment for depression for this community. The findings from a secondary analysis of qualitative data from this Endeavour are presented in chapter 6. Chapter 7 synthesizes all the concepts and findings presented in the course of this dissertation using a critical perspective based in this writer’s unique positionality.
CHAPTER 3
Latin American Immigrants in Canada: Applying a Global Mental Health Perspective

The second objective of this dissertation was to conduct a literature review on the Latin American population in Canada, their mental health concerns, their social determinants of health and their pathways and barriers to care, in line with the global mental health perspective of this dissertation. This chapter presents the literature pertaining to prevalence of mental disorders and pathways to mental health care for Latin American immigrants, with particular attention to the ways the social determinants of health have shaped their mental health care needs and the ability of current evidence-based treatments to appropriately meet the needs of this rapidly growing immigrant group. Patterns of mental health service utilization among Latin American immigrant populations are reviewed, and factors that potentially facilitate and hinder access to services are considered. These influences are further examined in a local Canadian context.

Latin American Immigration to Canada

Latin Americans represent one of the fastest growing cultural groups (Statistics Canada, 2006a). For instance, between 2001 and 2006, the number of people living in Canada reporting Latin American origins rose by 40.2% (59,515), while the overall population grew by only 5.4%. The number of immigrants from Latin American countries has increased 121% from 1996 to 2006 (Houpt, 2011). Consequently, the Latin American population in Canada is primarily composed of first generation immigrants (i.e., born outside Canada).

The Latin American community in Canada consists of approximately 304,245 people (Statistics Canada, 2006a). It is one of the five major visible minority groups in Canada, most of whom arrived to Canada in five major waves. The first wave of Latin American immigrants in the 1950s was led by ‘Euro-Latinos’ from Spain and Southern Cone Latin American countries.
Beginning in the 1970s, the subsequent waves of immigrants are characterized by migration from Andean countries (e.g., Colombia, Ecuador, Bolivia and Peru), followed by the ‘Chilean coup’ wave, refugees from areas of civil unrest in Central America (e.g., Peru, Nicaragua, Honduras, Guatemala and El Salvador), and the more recent migration of the technological/professional class. These waves of immigration, primarily from South and Central American countries, dramatically increased the Latin American population in Canada (Garay, 2000). Although each wave had distinct characteristics, motivations for migration for members of all waves included political and economic reasons (Ginieniewicz, 2010).

The Latin American community primarily resides in Ontario, Quebec, British Columbia and Alberta, although the largest concentration can be found in Ontario (147,135). Most of them are specifically located in the Toronto Census Metropolitan Area (99,290; Statistics Canada, 2006a). El Salvador (18.6%), Colombia (15.1%) and Mexico (10.3%) are the most common countries of origin (Statistics Canada, 2006a). Two of these three nations have a history of political violence; greater exposure to pre-migratory trauma and multiple losses places migrants from these countries at higher risk for mental illness such as depression, post-traumatic stress disorder, and substance dependence.

**Addressing the Mental Health Needs of Latin American Populations**

Mental health problems among Latin American populations are generally understudied, even in the US where Latin Americans represent the largest minority group or 20% (31.3 million) of the total population and are estimated to reach 81 million (LaRoche, 2002). Despite this criticism, three large mental health surveys have been conducted in the US in the last twenty years. As the Canadian context is quite different from the US context (e.g., societal attitudes, politics,
health care, education, immigration law, social services), the current state of mental health research among Latinos in Canada is not known and has a comparably long way to go.

In the last two decades, epidemiological research of depressive symptoms and depressive disorders among the Latin American population has been carried out in the United States. The Hispanic Health and Nutrition Examination Survey (HHANES; 1982-1984) evaluated the physical health, mental health, and nutritional status of the three largest groups in the fastest growing minority population in the United States at the time: Mexican Americans, Cuban Americans and Puerto Ricans. The study included personal interviews with 8,554 Mexican Americans, 1,766 Cuban Americans, and 3,369 Puerto Ricans (Karno, 1992, as cited in Vidal, 1999). One of the major findings was high levels of depressive symptoms among Puerto Ricans as compared to Mexican Americans and Cuban Americans (27.7%, 13.3% and 10.2%, respectively) (Moscicki, Locke, Rae, & Boyd, 1989; Narrow, Rae, & Moscicki, 1990; Potter, Rogler, & Moscicki, 1995). Across the three groups, common risk factors for depressive symptoms were: female gender, low income, low educational level, and being U.S.-born with Anglo-oriented acculturation (Moscicki et al., 1989). For Puerto Ricans, disrupted marital status, poor health, and unemployment were identified as specific risk factors (Potter et al., 1995).

The Epidemiologic Catchment Area study (ECA) in Los Angeles from the National Institute of Mental Health evaluated the lifetime prevalence of major mental disorders in household interviews (n=3132). Approximately 50% of the sample was of Mexican origin (Mexico or U.S. born) and the other half were non-Hispanic whites. The Diagnostic Interview Schedule (DIS) was used to evaluate DSM-III diagnoses. It was found that higher levels of acculturation were associated with higher prevalence rates for alcohol abuse and dependence, drug abuse and dependence, phobias and antisocial personality disorder. When compared with non–Hispanic
whites, Mexican-born immigrants were significantly less likely to have a lifetime diagnosis of major depression, obsessive-compulsive disorder or drug abuse or dependence. U.S.-born Mexican Americans had prevalence rates of alcohol abuse/dependence more than five times as high as those observed among the Mexico-born subjects (Escobar et al., 2000; Burnam, Hough, Karno, Escobar, & Telles, 1987).

In the data collected from the National Latino and Asian American Study (NLAAS; 2002-2003) (n=2554) the sample was composed of English as well as Spanish-speaking Latinos from Mexico, Puerto Rico, Cuba and other Spanish speaking countries. This study provided information regarding psychiatric conditions (e.g., depression, anxiety and substance use disorders) and information on demographics, immigration, contextual and social characteristics of Latino populations from the above-mentioned countries. The results showed higher lifetime psychiatric disorder prevalence estimates for women (30.2% vs. 28.1% for men). Among the Latino ethnic groups assessed, Puerto Ricans maintained the highest overall prevalence rate. Increased rates of psychiatric disorders were observed among U.S.-born, English-language proficient and third generation Latinos (Alegría et al., 2007a). According to the results reported from the National Comorbidity Survey Replication (NCS-R), the risk of substance use disorders was similar for Latinos and non-Latino white subjects. However this was not the case for lifetime anxiety and mood disorders where the risk for Latinos was significantly lower when compared with the non-Latino white sample (Kessler & Merikangas, 2004). Nevertheless, NCS-R data was limited to English-speaking Latinos and was not separated into ethnic subgroups.

Alegría and colleagues (2008) investigated if the widely reported “immigrant paradox” (i.e., foreign nativity protects against psychiatric disorders) could be applied to all Latino groups by comparing estimates of lifetime psychiatric disorders among immigrant Latinos, U.S.-born Latinos
and non-Latino white subjects. The researchers combined and analyzed data from the NLAAS and the NCS-R. When comparing Latino to non-Latino white subjects, the risk of most psychiatric disorders was lower for Latinos. In regards to the immigrant paradox, the rates for most psychiatric disorders were higher in the U.S.-born Latino group than in Latino immigrants. The findings supported the immigrant paradox for Mexican participants across mood, anxiety, and substance disorders. However, this pattern was only evident for substance use disorders between Cuban and other Latino participants; no differences in lifetime prevalence rates were found between migrant and U.S.-born Puerto Rican subjects. The authors concluded that generalization of the immigrant paradox to all Latino groups and to all psychiatric disorders might be done but with caution, due to the fact that the rates of psychiatric disorders among certain ethnic subgroups (e.g., Puerto Ricans) are similar with the non-Latino white subjects. Their findings suggest that immigrants “benefit from a protective context in their country of origin, possibly inoculating them against risk for substance disorders, particularly if they immigrated to the United States as adults” (p. 359).

**Latin American Immigrants in Canada and the Social Determinants of Health**

Given the growing mental health inequities that Latin American immigrants face upon migration throughout the diaspora, it is prudent to take a close look at how the mental health status of this immigrant population residing in Canada is impacted by their socioeconomic position in this country. The following section discusses how the social determinants of health, as recognized by the Public Health Agency of Canada, impact the mental health of Latin American immigrants, with particular attention to the Canadian context.

**Income and Social Status**

High socioeconomic position has been linked to better health outcomes (Syme, Lefkowitz, & Krimgold). More specifically, the declining health of immigrants has been attributed to low
social position (e.g., poverty) and perceived social status (Marmot, 2007; William & Collins, 1995).

According to the 1996 census, the incidence of family poverty for Latin American ethno-racial groups in Toronto was 41.1% -- approximately three times the poverty rate of families of European origin (Ornstein, 2000). Thus, it would be reasonable to expect that the mental health of Latin Americans in Canada, the highest concentration of whom reside in Toronto, be considerably impacted by their socioeconomic status.

Social Support Networks

A high level of social support among Latino families and close others has been associated with positive mental and physical health outcomes among Latino populations (Kawachi & Berkman, 2000; Page, 2004). Conversely, the breakdown of the family unit (Rogler, Cortes, & Malgady, 1991), intergenerational conflict, excessive demands by extended family (Alegría et al., 2007b), and family separation (Miranda, Siddique, Der-Martirosian, & Belin, 2005) has been associated with increased risk for depression and anxiety disorders. High levels of community social network density within poor ethnic enclaves have been linked to positive outcomes for well-being by way of increased exposure to economic opportunities as well as negative outcomes such as constrained social mobility due to limited connections with outside communities and increased mortality attributed to higher rates of crime and low socioeconomic status (Portes, 1998; Wen, Cagney, & Christakis, 2005).

Education and Literacy

The overall high school drop-out rate has steadily declined throughout Canada since 1991 (Statistics Canada, 2008b). However, the high school drop-out rate of certain subgroups has not realized this progress. In the Toronto District School Board, the drop-out rate for Spanish-speaking
high school students is 40%, almost twice the average dropout rate of 20% (Brown, 2006). The consequences of school incompletion are grave, as these youth are likely to become entrenched in low-skilled, low-paid positions and face enormous challenges in underemployment and unemployment throughout the course of their lives. Further, Brown (2006) found that the dropout rate for those students from lower income neighbourhoods was three times that of higher income neighbourhoods. Among Spanish-speaking immigrant youth, additional psychosocial issues related to displacement from their country of origin, low levels of acculturation, a new school and new language all exacerbate the problem, further contributing to poor school performance and dropout rates (Schugurensky, 2009).

These findings suggest that education can play a critical role in reproducing social inequalities among Spanish-speaking people in Canada, as their children’s truncated educational trajectories perpetuate socioeconomic disadvantage from generation to generation. That is, education is likely a buffer for mental health consequences among immigrant populations, ostensibly serving a protective function via enhanced social status and access to resources (Ailinger, Dear, & Holley-Wilcox, 1993). However, in Canada, many immigrants are unable to attain recognition of their foreign credentials. The reality of being “poor but with a professional degree” (Betancourt, 2009, p. 26) in Canada likely delimits the protective effects of educational background.

Employment and Working Conditions

The Chilean and recent technological wave of Latin American immigrants tended to have high educational achievement and belonged to a professional class in their countries of birth (Viswanathan, Shakir, Chung, & Ramos, 2003); these groups are highly represented among Latin American professionals in Canada (Turchick-Hakak, Holzinger, & Zikic, 2010). However, other
waves of Latin American immigrants with less educational achievements lack English or French language fluency, which limits their opportunities in the Canadian labour market; time and resources to develop and hone language skills for reentry into a job market are deprioritized to meet competing demands for the necessities of life (Saphir, 2008). Poor language skills further contribute to lack of information about resources and opportunities, including employability. Compared to the general Canadian population, eligible workers of Latin American descent are more likely to be unemployed – 7.4% vs. 10%, respectively (Statistics Canada, 2001).

There is little available Canadian literature examining the work conditions experienced by Latin American workers in Canada. However, the Canadian occupational health literature strongly suggests that the type of jobs available to new and low-skilled immigrants, in general, lead to poorer health outcomes (Health Canada, 1999). They are likely to accept employment in the form of shift and weekend work, which has been associated with high job stress, job dissatisfaction, and less time for leisure and recreation (Jamal & Badawi, 1995). They are likely to be overrepresented in manufacturing, construction, garment, agricultural, and domestic industry where safety risks and health hazards are high (Bolaria, 1990; Krahn, Fernandes & Adebayo, 1990). They are also likely to be overqualified for their position, engage in physically demanding work, and work fewer hours than desired; perceived overqualification has also been linked to depression (Johnson & Johnson, 1996). The individuals who are most affected are those who are a visible minority, whose first language is not English, and who carry advanced degrees from outside Canada (Smith, Chan, & Mustard, 2008).

**Social Environments**

As globalization has quickened, rapid urbanization has been cited as the backdrop for social exclusion (McKenzie, 2000). Linked to both negative mental health consequences and inadequate
access to health care, rapid urbanization simultaneously exposes immigrants to the social
determinants of mental illness and overwhelmed social infrastructure that cannot adequately
respond to the risk factors presented by the social environment (Boydell & McKenzie, 2008). Thus,
social conditions disproportionately impact the mental health of immigrant populations above and
beyond the individual vulnerabilities and personal risk factors that dictate prevalence rates similar
to that of the general population. Research has associated neighborhood context with risk for
psychiatric disorders. For example, perceived neighborhood safety has been identified as an
important factor in mitigating risk for substance disorders (Alegría et al., 2007a). It may be that safe
neighbourhoods symbolize continuity of primary relationships and stable support networks
(Sampson & Groves, 1989), constructs that are well-known to either buffer or negatively impact
mental health.

*Physical Environments*

Characteristics of the physical environment also impact mental health, as well as help-
seeking behavior (Isaacs, 2008). Recent immigrants and refugees in Canada tend to settle in low
income neighborhoods (Hadi & Labonte, 2011), which typically have fewer structural opportunities
that support healthy behaviors and promote health such as grocery stores, avenues for exercise, and
quality health care. In a study of food security among Latinos in the Greater Toronto Area, 56% of
household were identified as food insecure; access barriers (e.g., where to get ethnic food, where to
purchase food inexpensively) were cited among the reasons for food insecurity (Vahabi, Damba,
Rocha & Montoya, 2011). Due to the inadequacy and unaffordability of quality housing, recent
immigrants may also be exposed to high population density in urban ethnic enclaves and residential
overcrowding, which has been associated with risk for mental illness (Access Alliance, 2005;
Schulz, Williams, Isreal, & Lempert, 2002). For Latinos living in rural communities, social
isolation and poor access to transportation has been linked to lack of information concerning, and thereby underutilization of, mental health services as compared to Latinos in communities with rich transportation infrastructures (Barrio et al., 2008). Reciprocally, mental health organizations remain disengaged from the community as organizational beliefs about the use of services by communities in their catchment area have an effect on the services provided (Callejas, Hernandez, Nesmann, & Mowery, 2009).

*Personal Health Practices and Coping*

Due to the dearth of available information about the personal health practices of immigrant sub-populations living in Canada, researchers have called for more attention to the cultural and social factors affecting healthy behaviours (Health Canada, 1999). Mental health and well-being ultimately depends on how the individual appraises the stressors encountered and the individual’s resources for coping with the associated emotional distress. Further, when personal coping resources are overwhelmed, cultural and social factors shape individuals’ understanding of their problem, acceptability of available resources to assist in coping with the difficulty, and where to seek those resources. Among people of Latin American origin, spiritual beliefs about faith and fate influence perceptions of the causes and treatment of poor mental health. Faith is touted as a coping skill; the Catholic Church and other religions play a major role in offering hope, strength, and support in Latino communities. Further, help-seeking for mental health issues such as anxiety, stress, and depression are often presented to ministers in the church for consultation (Jurkowski, Kurlanska, & Ramos, 2010). People of Latin American origin may also seek assistance from curanderos, who are regarded as healers with special expertise in addressing the spiritual etiology of disease (Vega, Kolody, & Aguilar-Gaxiola, 2001).
Healthy Child Development

For Spanish-speaking families, political violence and economic strife are often times the main impetus for their migration to Canada. These circumstances have often contributed to serious disruption to their family life and child-rearing practices, as many children were left in their countries of origin under the care of relatives. The unexpectedly long periods of separation contributed to profound negative emotional consequences for the children, as well as the parents (Bernhard, 2009). Although later reunited with their parents, these children often displayed anger and resentment (Bernhard, 2009), report symptoms of depression, demonstrate difficulty adapting to popular and school culture, and report to having difficult relationships with parents and siblings from whom they were separated (Gindling & Poggio, 2010).

In addition to the trauma associated with family breakdown, children from immigrant families may have also experienced violence as a result of war and civil unrest prior to their migration. The emotional consequences of these experiences may manifest in a variety of forms of stress, the most extreme being posttraumatic stress disorder (PTSD). Empirical research has demonstrated that children who meet the DSM-IV criteria for PTSD can experience adverse proximal effects (e.g., difficulties in academic achievement, impairment in interpersonal functioning, display aggressive behaviors) as well as distal effects in adulthood (e.g., personality disorders, perceptions of danger, representations of self and others and regulation of cognition and affect; Davis & Segal, 2000).

Biology and Genetic Endowment

Although heredity and biological have been identified as an important determinant of health, there is strong evidence to suggest that that these factors are not a sufficient cause of mental illness but may interact with social and physical environmental risk factors (PHAC, 1999).
Individual members of groups who face social inequities and injustices, such as immigrants and refugees, have been identified as being at risk of developing mental illness in response to environmental stressors (e.g., migration stress, acculturative stress, racism in host country, etc.) (Bhugra & Jones, 2001). While there is no intrinsic biological or genetic vulnerability for mental disorders specifically associated with being of Latin American origin, research strongly suggests that migration and settlement circumstances moderate individual mental health outcomes.

Furthermore, neurobiological research has demonstrated that the first few years of life is a critical period during which a person’s capacity to be healthy, learn, and cope with life’s challenges is established. Brain development that occurs prior to birth up to age 5 can have enduring effects that shape life outcomes. The long-lasting effects of this major developmental period underscores the added importance of providing adequate services for parents during this period, including: effective health care throughout the prenatal, neonatal, and toddler years, treatment of maternal depression, and support for families who face the challenges of poverty and concomitant social problems (PHAC, 1999).

*Health Services*

The federal government provides government sponsored refugees and refugee claimants with health care assistance for the first 12 months of their stay, comparable to the programs available to the Canadian-born population. These health services are covered by the Interim Federal Health (IFH) Plan administered by Citizenship and Immigration Canada (2005). The program allows for essential health care including the treatment and prevention of serious medical and dental conditions, contraception, obstetrical care, prescription medications, and the Immigration Medical Examination based on financial need. However, this coverage does not include mental health services. Chapter 7 contains further discussion of recent cuts in the IFH plan as of July 1, 2012.
Research has shown that refugees, especially women and children, are at high risk for developing mental illness. Timely intervention is essential for the prevention and treatment of these symptoms. To date, there is no specific mental health policy in Canada that particularly addresses immigrants’ and refugees’ mental health needs and services other than the IFH plan. The IFH plan does not have a mental health component per se, but it allows for newly arrived immigrants and refugees to be referred to specialized mental health services. However, barriers to accessing mental health services have been reported (Hyman, 2001).

*Gender*

Culture-based gender roles likely impact the risk for psychiatric disorders among Latino men and women. A robust gender effect has been found for depressive and anxiety disorders among Latinos. For example, Latinas report higher rates of depressive and anxiety disorders in the past year than their male counterparts (Alegría, Shroud, Woo, Guarnaccia, Sribney, Vila, et al, 2007b). Furthermore, female gender has been identified as a significant risk factor for suicide attempts among Latinos, even among women with known psychiatric disorder (Fortuna, Perez, Canino, & Alegría, 2007). These female-specific effects have been attributed to shifting gender roles among Latino immigrants and resultant gender role conflict. Among Latino men, sociostructural disadvantage (e.g., low educational achievement, high unemployment, poverty) has been identified as a significant risk factor for mental illness, especially substance use, depression, and anxiety. Consistent findings were also found among men who experiencing marital conflict as compared to their maritaly satisfied counterparts (Polo & Alegría, 2010; Alegría & Woo, 2009)
Overall, Latino cultural values tend to support positive mental health outcomes among Latino populations, as the tenets reinforce a cultural identity based on strong relationships and interconnectedness which may serve to bolster the individual sense of purpose, meaning, and belonging (Alegría & Woo, 2011). However, in immigrating to Canada, this cultural capital can be eroded by barriers to accessing resources and attaining education and retraining that limits social mobility and perpetuates socioeconomic inequities. This disorienting experience can be stressful and result in the onset of emotional difficulties and psychiatric symptoms that disrupt functioning. Culture plays a significant role in the recognition and explanation of these phenomena, when one should seek help, what kind of help and from whom, if it is even considered a problem (Sussman, 2008). The accumulation of the literature on Latino populations largely suggests that Latinos maintain a dual framework of beliefs and practices with respect to mental and physical health problems: Western approaches (e.g., biomedical approaches, psychological treatments) and traditional folk-oriented approaches (e.g., supernatural, curandismo, religion) (Falicov, 1998).

The next two chapters (chapters 4 and 5) will address objective number 3, which is to conduct a secondary analysis of qualitative data from the study ‘Cultural Adaptation of Cognitive Behavioral Therapy (CA-CBT) for Latin American Immigrants in Canada,’ conducted in Toronto between 2008 and 2011. Chapter 4 will present the theoretical principles of CBT and the major considerations in culturally adapting this psychotherapy modality for Latin American populations.

Chapter 5 presents the methodology employed in the Toronto CA-CBT study, from which the data was obtained and analyzed using a global mental health perspective – that is, consideration of background globalization forces and social determinants of health that result in local health
disparities and what this means for the provision of culturally appropriate mental health to immigrant groups in Canada.
CHAPTER 4
Adapting Cognitive Behavioral Therapy for the Treatment of Depression among Latin American Immigrants in Canada

This chapter reviews the fundamental characteristics of CBT, as it is conventionally delivered in the general population, with the intention of integrating the extant knowledge of Latin American cultural influences to inform culturally adapted practice guidelines for delivering CBT to Latin American immigrants in Canada. Due to the lack of Canadian-based sociological and mental health research on Latin American populations, most of the literature presented is based on US research. The suitability and effectiveness of CBT for Latin American immigrants is explored through consideration of theoretical advantages and limitations, and an examination of CBT outcome studies. This chapter provides background information for the next chapter, which describes the methodology used for the cultural adaptation of CBT for Latin Americans in Canada.

Fundamental Characteristics of CBT for Depression

Cognitive Behavior Therapy (CBT) adheres to the cognitive theory of depression, in addition to behavioral and social learning models, to explain human functioning as interactions between a person and their environmental context. The underlying theme of this approach is that maladaptive thoughts are learned. Although it is understood that problematic thoughts and behaviors were learned in the past, CBT focuses on helping the client make changes in the present. In keeping with this model, the primary mechanism of change in CBT involves unlearning maladaptive thoughts and learning more adaptive thoughts in order to decrease depressive emotions (e.g., hopelessness, helplessness) and behaviors (e.g., social withdrawal, suicide attempts). In addition to demonstrating non-specific therapeutic competencies (i.e., warmth, empathy, caring,
positive regard, competence) that are critical in developing a therapeutic alliance necessary for the
effective delivery of any therapeutic modality, the CBT therapist aims to implement the following
treatment components that are specific to CBT:

**Psychoeducation: Cognitive Theory of Depression**

An important goal of CBT is to teach patients how to become their own therapist. In doing so, one of the early goals of the CBT therapist is to educate the patient about the cognitive theory of depression and to inform the patient about how their difficulties fit into this model (Beck, 1995). The cognitive theory of depression stipulates that depressed patients show dysfunctions in the processing of information, which lead to or maintain depressed affect and behavior (Beck, 1995). In particular, depressed patients tend to harbor negative views of the self, world, and future, which are referred to as the ‘negative cognitive triad’. Negative views of the self are manifested in the self-derogatory perceptions. Depressed patients likely believe that they lack the qualities that are desirable or necessary to achieve the goals they desire. Negative views of the world affect how depressed patients see their life situation and the environment they live in. They tend to see their circumstances as insurmountable and the world as rife with misery and unhappiness. Depressed patients are also prone to negative views of the future. They tend to believe that their current difficulties will never end and feel hopeless and helpless about their perceived lack of ability to make any changes (Blackburn & Davidson, 1995).

Psychoeducation is an ongoing process in CBT. In the spirit of a collaborative therapeutic relationship, the CBT therapist wants the client to understand the treatment plan and actively participate in establishing the course of treatment (Dobson, 2008). Thus, it is important for patients to understand that the cognitive theory of depression is based on the basic principle that thoughts can lead to feelings and behavior. Accordingly, negative thinking can lead to negative feelings and
unhelpful behaviors. For example, if a client tends to hold a negative view of themself, interprets their experiences in a negative manner, and assumes that the future is not going to get any better, the patient is more likely to be depressed and remain depressed until these negative thought patterns (or cognitions) are modified (Curwen, Palmer, & Ruddell, 2000). Typically, the CBT therapist will recommend interventions that might be helpful to overcome the patient’s difficulties and then obtain feedback from the patient about these suggestions. If the patient understands the rationale for the interventions, then they are capable of assuming a more active role in the treatment process, and eventually becoming their own therapist (Dobson, 2008).

**Treatment Process**

Although the content of the treatment often differs between patients, the process of CBT is relatively invariant (Dobson, 2008). Conventional CBT treatments are characterized by weekly, 50-minute individual treatment sessions for a total of 16 to 20 sessions (Craighead & Craighead, 2003; Fava, Rafanelli, Grandi, Conti, & Belluardo, 1998; Summerfield & Veale, 2008). Each session has a common format that is applied across all sessions, except for the first (intake) session, and typically proceeds in the following order: check client’s mood, briefly review the week, set agenda for the current session, bridge current session with previous session, review homework, discuss agenda items, set homework, summarizing lessons learned from the session and seeking feedback. Although the structure of each session is directed by the therapist, the content of the agenda is collaboratively agreed upon by therapist and patient (Curwen, Palmer, & Ruddell, 2000). Rigid adherence to the structure of each session is not indicated, as process-outcome research has found that treatment adherence has a marginal influence on depressive outcomes (Beutler et al., 2004; Miller & Binder, 2002). However, following the session structure allows for the efficient use of
limited session time, ensures that important material is not neglected, and fosters a sense of forward momentum toward the patient’s goals (Curwen, Palmer, & Ruddell, 2000)

Course of Treatment

Generally speaking, the course of treatment is defined by three phases that tend to have different treatment targets but can overlap considerably. The early phase of treatment (i.e., first third of the sessions) is focused on understanding the patient’s difficulties (i.e., developing a case conceptualization), normalizing the patient’s difficulties and instilling hope, developing a therapeutic alliance, enlisting the patient as a collaborator in the treatment process by orienting him or her to the CBT treatment model (i.e., psychoeducation), and improving the patient’s engagement with their environment through behavioral interventions. Once the patient’s everyday functioning has begun to improve, the focus of treatment shifts to identifying and modifying negative thinking through cognitive interventions (Curwen, Palmer, & Ruddell, 2000).

In transitioning into the middle phase of therapy, the patient has usually experienced success in identifying and modifying their negative thoughts, resulting in a positive impact on their mood. The therapist continues to assist the patient in further refining his or her ability to independently construct alternative responses to their negative thoughts. In addition, the therapist moves toward challenging more deeply held beliefs systems that are often discovered, but not specifically targeted, in the process of conducting earlier cognitive work. The developmental history of the patient is discussed in order to help him or her understand the influence of their life experiences on their current attitudes and concerns. This exploration often provides valuable information for further cognitive interventions aimed at modifying these ingrained thought patterns (DeRubeis, Tang, & Beck, 2001).
The final phase of treatment is focused on preparing the patient for the end of the therapeutic relationship, summarizing the therapeutic gains and solidifying the techniques and tools learned in treatment, encouraging the patient to continue the therapeutic process by becoming their own therapist, and addressing relapse prevention through the development of an action plan for potential problems (Curwen, Palmer, & Ruddell, 2000). During this phase, it is important for the therapist to demonstrate to the patient that his or her treatment gains are due to their own efforts, as many patients tend to attribute their recovery to changes in their environment or to the therapist. In doing so, the therapist transfers more of the responsibility for the treatment to the patient, assuming more of a consultant than a therapist role. This shift provides a supportive context for the patient to test and demonstrate their ability to manage difficult situations and maintain their treatment gains following the end of treatment. The therapist may also offer “booster sessions”, which are typically scheduled at monthly intervals for an agreed upon period of time after treatment discontinuation. These extra sessions are used to follow-up on new issues that may have emerged and to reinforce the techniques and tools learned in treatment, thus reducing the risk of relapse and recurrence (DeRubeis, Tang, & Beck, 2001; Dobson, 2008).

Assessment and Case Conceptualization

In the early phase, the therapist gathers information about the patient and his or her problems based on the patient’s self-report and the therapist’s own observations. The chief function of the case conceptualization is to assist the therapist in devising a treatment plan (Needleman, 1999). As a rule, it is important for the clinician to first assess for the presence of co-occurring Axis I disorders (e.g. anxiety, substance abuse), medical conditions (e.g., hyperthyroidism, dementia), and social problems (e.g., homelessness, unemployment). Consideration of these factors is crucial in formulating recommendations for the most effective way to address the presenting problem,
which may necessitate referrals to more appropriate treatment modalities (e.g., substance abuse treatment program) or referrals to adjunct services (e.g., employment counseling, medical consultation, support worker) that are delivered concurrently with the CBT protocol (Whisman & Weinstock, 2008).

When a patient is deemed suitable for CBT, one of the main tasks of the therapist is to understand his or her problems in cognitive terms. Of particular relevance are unhelpful thoughts that may be associated with and maintain problematic emotions and behaviors, precipitating factors that are connected to the current problem and may help reinforce unhelpful beliefs, and the patient’s unhelpful interpretation of major developmental events (Curwen, Palmer, & Ruddell, 2000). Beyond a DSM-IV diagnosis, the problem-focused orientation of CBT requires the identification of specific problems that are affecting the patient and targeted areas that are in need of improvement. The patient and therapist work together to generate an exhaustive list of these difficulties described in concrete, behavioral terms and set goals for each problem. The therapist also makes note of the patient’s strengths and resources that can enhance the treatment plan (Whisman & Weinstock, 2008). This information is then organized to formulate an individualized theory of the patient’s difficulties that is based on the cognitive theory of depression, referred to as the cognitive case conceptualization. This conceptualization describes the external events and active cognitive schema, and hypothesizes relationships among these components and the patient’s problems. A treatment plan is derived from this formulation and should target treatment goals, capitalize on the strengths and assets of the patient, and demonstrate consistency with the working hypothesis (Persons & Davidson, 2001).

The case conceptualization is an ongoing process and is revised as new information becomes available. Given that the case conceptualization is so closely linked with the treatment
plan, the validity of the conceptualization is determined by the outcome of the interventions. If an intervention derived from the conceptualization is successful, then the intervention is supported. However, if an intervention that follows from the conceptualization is unsuccessful or ineffective, the conceptualization is not supported. This disconfirmatory evidence would suggest that the case conceptualization needs to be revised and alternative interventions implemented. Furthermore, the therapist is transparent about their formulation of the patient’s problems and usually shares the case conceptualization with the patient for discussion, feedback, and further development. Thus, the case conceptualization not only serves as a clinical tool for individualizing treatments for patients but is also useful as a psychoeducational aid that encourages clients’ insight and understanding into their difficulties.

**Therapeutic Alliance**

In CBT, the therapeutic alliance is communicated via principles of collaboration and egalitarianism but is likely experienced as much more than this. The therapeutic relationship is the foundation of therapy that is, at once, the essence of trust, security, risk, vulnerability, sharing, commitment, and reciprocity (Parham, 2002). Although the therapeutic alliance is a common element of all therapeutic modalities, it is the most powerful predictor of therapeutic outcomes and thus deserves mention. To some extent, ruptures in the therapeutic alliance are inevitable; thus one of the most important skills for a CBT therapist is dealing with breakdowns in their relationship with the patient (Binder & Strupp, 1997).

**Cognitive Interventions**

The cognitive interventions employed by CBT therapists focus on identifying and modifying self-statements and cognitive patterns that elicit negative thinking (Coady, 2008). Three
components of cognition targeted by these cognitive interventions are automatic thoughts, intermediate beliefs, and core beliefs. Automatic thoughts (or self-talk) are the situation-specific thoughts and images that occur involuntarily and comprise the running commentaries that take place in our minds while we live our lives (e.g. ‘I’m not good enough for him’). Core beliefs and intermediate beliefs are the underlying principles and assumptions that generate the thoughts and images forming the content of automatic thoughts. Core beliefs are the most central component of cognition because they give meaning to cognitive schemas, which are the abstract mental plans that serve as guides for action, structures for remembering and interpreting information, and a framework for solving problems. These schemas assist individuals in making sense of the world and thus shape how people think, feel, and behave in relation to themselves, others, and the world. Culture is a powerful medium for transmitting core beliefs, in that through culture people learn important lessons that provide meaning and direction for their lives. An example of a core belief that contributes to depression among members of the dominant North American culture is ‘material wealth defines worth.’ Intermediate beliefs are the attitudes, rules, and assumptions that are derived from core beliefs and directly influence people’s view of a situation by generating automatic thoughts (e.g., ‘If I’m successful, I will be loved’; Needleman, 1999).

Cognitive interventions aim to identify and modify situation-specific negative thinking. Typically referred to as cognitive restructuring or reframing, these clinical tools are used to challenge distorted automatic thoughts and to help the patient experience how automatic thoughts influence their emotional and behavioral responses to events. Some therapists find it useful to teach this principle to the patient by using the principle ABC (Ellis, 1977), where A means Activating Event, B means Belief, and C means Consequence. Much of the work in CBT centers around the use of a dysfunctional thought record (DTR), which is used to demonstrate how the principle of
ABC applies to the client's everyday life. In using the DTR, patients are encouraged to write down events (A) that trigger negative automatic thoughts (B) and record their emotional and behavioral responses (C).

Once the patient is familiar with this model, patients are prepared with interventions that help them reconsider their negative automatic thoughts. These interventions are generally presented as three sets of questions: “What’s the evidence?,” “Is there an alternative?,” and “So what?” The first question requires the patients to evaluate the fact, data, or evidence related to each negative thought. The objective of these interventions is for the patient to learn that their negative thought is inconsistent with the facts and/or that a thought is not a fact. The second question requires the patient to consider alternative explanations of the facts, which helps the patient generate and utilize a more realistic and beneficial alternative thought. The third question requires the patient to explore the meaning they assigned to their original negative thought and to determine whether this is the only possible meaning.

*Behavioral Interventions*

The behavioral interventions employed by CBT therapists are aimed at bolstering the patients’ sense of self-efficacy and competence (Coady, 2008). Behavioral interventions specifically target the procedural memory and behavioral strategies that contribute to, maintain, or exacerbate the clients’ depression. Procedural memory refers to the learned connections between stimuli and responses while behavioral strategies refer to learned coping responses. For example, depressed patients, because of their loss of self-confidence, motivation, and neurovegetative symptoms (e.g., problems with sleeping, eating, weight), often blame themselves for their difficulty starting and completing tasks. In such cases, patients have often decreased or completely abandoned activities that would give them a sense of mastery, pleasure or achievement. This withdrawal from
activity not only serves to extinguish the learned connection between engaging in these activities and feeling good but further decreases their motivation to engage in these activities in the future. In addition, such patients tend to cope with their sense of failure by blaming themselves, which serves to increase the depressive symptoms that made it hard for them to complete the tasks in the first place (Blackburn & Davidson, 1995).

Behavioral activation is one behavioral intervention that is indicated for the relief of low mood and for loss of pleasure caused by lack of activity. This simple intervention involves working with the patient to schedule activities that they used to consider rewarding and pleasurable (e.g., working out, going out with friends). Patients are asked to attempt these activities and to record their mood and sense of pleasure for every activity. Typically, patients begin to recognize that their mood fluctuates throughout the day and, most importantly, they notice that what they do throughout the day has a strong, positive influence on how they feel. After gaining this insight, patients are encouraged to identify activities that they usually use to cope with their depression but actually make them feel worse (e.g., blaming themselves, withdrawal from activity). Patients are encouraged to consider and incorporate pleasurable and rewarding behaviors as an alternative to these maladaptive coping strategies (Addis & Martell, 2004). Examples of other behavioral techniques also involve training in alternative coping responses such as thought-stopping, relaxation training, assertiveness training, stress inoculation training and anger management (Dobson, 2008).

Homework

Given that CBT is a time-limited therapy, what happens between treatment sessions is at least as important as what happens during the treatment sessions (Tompkins, 2004). Whereas the actual sessions are essential for identifying problems and teaching strategies to manage these problems, it is the actual implementation of these strategies in the patient’s everyday life that
defines success. In this view, even insight gained within a session is relatively meaningless unless it can be adapted into a concrete plan. Consequently, the use of homework in CBT (e.g., reading, written assignments, behavioral tasks) for depression has become a trademark of the treatment protocol.

**Effectiveness of CBT for Depression**

Numerous studies and meta-analyses of randomized controlled trials have found strong evidence for the effectiveness of CBT for the treatment of mild to moderate depression. In a recent and extensive meta-analytic review of the effectiveness of CBT, Butler, Chapman, Forman, and Beck (2006) reconfirmed that CBT is both “highly effective for adult unipolar depression (p. 28)” and “somewhat superior to antidepressants” in the treatment of adult unipolar depression (p. 28). The review of meta-evidence further asserted that the CBT showed “vastly superior long-term persistence of effects, with relapse rates half those of pharmacotherapy” (Butler et al., p. 28).

Furthermore, concurrent CBT and pharmacotherapy has been found to demonstrate a significant synergistic effect – retaining both the advantages of each monotherapy administered alone (Hollon & Shelton, 2005; Hollon, Thase, & Markowitz, 2006). Combined treatment can enhance the probability that individuals will experience clinically meaningful treatment outcomes (Pampallona, Bollini, Tibaldi, Kupelnick, & Munizza, 2004), increase the degree to which the average patient responds to treatment, and provide both acute and long-lasting effects with regards to symptom reduction and return to normal functioning (Friedman, Detweiler-Bedell, Leventhal, Home, Keitner, & Miller, 2004). Current practice guidelines outlined by the Canadian Network For Mood and Anxiety Treatments [CANMAT] support the use of combined CBT and pharmacotherapy based on empirical evidence demonstrating that combined treatment is superior to pharmacotherapy alone (Parikh et al., 2009). Although it is noted that many patients and providers
would accept combined treatment as a first-line intervention for mild to moderate major depressive disorder among adults, it is noted that the practicality, availability, and cost of this approach downgrades it to a second-line intervention.

**CBT for Latin American Populations**

The results of such randomized controlled trials have become generally accepted as the benchmark for determining the effectiveness of CBT. While the reputation of empirically supported therapies (ESTs) such as CBT rest on this quantitative evidence, the absence of mixed methods and ethnoracially diverse samples dilute the utility of psychotherapy outcome research in informing everyday practice. The homogeneity of the existing psychotherapy evidence base, often regarded as an inconsequential limitation of this body of research, has heavily influenced the delivery of psychotherapy services in high-income countries such as the United States and Canada. At the same time, these counties are experiencing shifting population demographics and with these changes come the challenge of providing mental health services that are responsive to diverse societies (Bernal & Scharro-Del-Rio, 2001; Miranda, Nakamura, & Bernal, 2003; Nagayama Hall, 2001; Napoles-Springer & Stewart, 2006; Sue, 1998; Sue, Arrondondo, & McDavis, 1982).

In 1998, the American Psychological Association (APA) Task Force on Promotion and Dissemination of Psychological Procedures identified a list of psychological interventions that met the criteria for demonstrating treatment efficacy (Chambless & Hollon, 1998). Generally speaking, therapies were considered efficacious if they had demonstrated a) superiority to psychological placebo, another treatment, or equivalence to a well-established treatment in at least two methodologically rigorous group design studies (i.e., at least 30 participants per group), or b) efficacy in a large number of single-case design studies that used good experimental design in comparing the intervention to psychological placebo or another treatment. Furthermore, the
intervention needed to be outlined in a treatment manual and the characteristics of the client samples needed to be clearly specified. The resultant provisional list of ESTs primarily included interventions based on Cognitive-Behavioral Therapy (CBT), Interpersonal Psychotherapy (IPT), and Psychodynamic therapeutic approaches.

Although it has been acknowledged that none of the empirical studies that met the criteria included tests for efficacy among ethnic minority populations, the continued use of these therapies among ethnic minority clientele was promoted based on a “leap of faith” – the assumption being that ESTs should work with anyone, including ethnic minorities. Critics have argued that there is a need for empirically supported therapies that are also culturally sensitive therapies (CSTs), which “involves the tailoring of psychotherapy to specific cultural contexts” (Nagayama Hall, 2001, p. 502). The crux of the problem is that ESTs do not take cultural factors into account, whereas psychotherapy is a cultural phenomenon itself. Proponents of CSTs have asked, “if the ESTs were developed with Native Americans, African Americans, Latinos/Latinas, or Asians, would researchers be advocating for their use with the general population?” (Bernal & Scharro-del-Rio, 2001, p. 330).

The general consensus among researchers and policy makers alike is that more scientifically robust psychotherapy research studies need to be conducted with ethnoracially diverse populations (Nagayama Hall, 2001). However, even the most avid proponents of this call for research recognize the inherent challenges in conducting research in these populations that meet the ‘gold standard’ of scientific rigour. Most notably, researchers studying psychotherapy outcomes in ethnoracial populations have struggled with the task of maintaining the integrity of the research process and their credibility in the communities participating in the research. These considerations have a major impact on the recruitment and retention of participants, as a critical mass of participants are
required for random assignment to different treatments and the methods used to evaluate treatment efficacy, especially considering that multiple, culturally cross-validated quantitative measures are largely unavailable.

**Potential Applicability of CBT to Latin American Immigrants**

Despite the lack of attention to issues pertaining to culture in the mainstream CBT research literature, the therapy-specific components of CBT are amenable for use with patients with diverse backgrounds. However, the notoriety of CBT as a scientifically supported approach has had implications for the perception of this treatment as neutral, value-free, and universally applicable. The widespread empirical support for CBT for depression can lead to the assumption that the CBT-specific components are universally effective and thus sufficient for successful treatment regardless of the specific cultural, historical, and political contexts in which clients live their lives (Bhui & Morgan, 2007). This perspective encourages a “colour blind” approach to treatment that does not ensure adequate consideration of cultural influences on human behavior to support optimal effectiveness (Hays, 2006).

One of the major strengths of CBT is its emphasis on the uniqueness of the individual. Although CBT is based on a nomothetic theory of depression (i.e., cognitive theory of depression), it in fact allows for an individualized understanding each client’s difficulties to increase the appropriateness and effectiveness of therapy for each patient (Hays, 2006). An accurate and rigorous assessment of patients’ difficulties should consider cultural in addition to individual differences and influences (Fudge, 1996). Secondly, CBT stresses the importance of explicit recognition and respect for patients’ experiences. The CBT approach helps both therapists and patients to adopt a nonjudgmental stance toward differences (Jacobson & Christensen, 1996). For instance, behavior is typically explained by observable ‘data’ (e.g., client’s self-report on thoughts
and emotions) rather than interpretations that are more easily subject to bias (e.g., assumptions about motivation, intelligence; Fudge, 1996). Furthermore, CBT embraces the principle of ‘collaborative empiricism’. Accordingly, patients are identified as experts on themselves and their problems who possess certain strengths and resources. CBT works to build upon these strengths and resources in order to help patients independently apply newly learned skills that will help them meet their goals more effectively. Thus, CBT aims to engage patients as active agents in his or her own change, empowering clients with tools to help themselves (Hays, 2006).

Adapting CBT for Depression among Latin American Populations

Although CBT is regarded as the gold-standard psychological treatment for depression, few studies have examined the effectiveness of CBT for major depression in Latin American populations. There are only five studies available in the peer-reviewed literature since the 1980s and, out of those five, only two had samples that were exclusively Latino (Comas-Diaz, 1981; Rosello & Bernal, 1999); the remaining three included a significant proportion of Latinos (Miranda, Azocar, Organista, Dwyer, & Areane, 2003; Miranda, Chung, Green, Krupnick, Siddique et al., 2003; Organista, Muñoz, & González, 1994).

According to these studies, CBT for major depression demonstrated efficacy but the degree of symptom reduction was lower than that reported in non-Latino samples, with post-treatment symptom reduction ranging from 20% to 64%. Also, there were significant differences in treatment retention, which was only 62% for the Latino population as compared to 95% for the non-Latino population (Interian, Allen, Gara, & Escobar, 2008), thus highlighting the challenges of retaining psychotherapy patients in treatment.

In a study of CBT compared to CBT supplemented with case management (i.e., ongoing support with psychosocial stressors), the results showed that the treatment retention rate was 60%
for CBT alone versus 83% for CBT plus case management. The level of depressive symptoms reduction was higher among participants who received the supplemented CBT (30% vs. 18% CBT alone). However, further research is still required to enhance the application of CBT for Latinos with major depression (Miranda, Azocar, Organista, Dwyer, & Areane, 2003).

Rosselló & Bernal (1999) conducted a CBT study that randomized a sample of 71 Puerto Rican adolescents diagnosed with depression to one of three conditions: CBT, interpersonal psychotherapy (IPT), or wait list (WL). Pre-treatment, post-treatment, and 3-month follow-up measures of depressive symptoms, self-esteem, social adjustment, family emotional involvement and criticism and behavioral problems were completed. Results suggest that IPT and CBT significantly reduced depressive symptoms when compared to the WL condition. The data analysis indicated that 82% of adolescents in IPT and 59% of those in CBT were functional after treatment. The results suggest that both IPT and CBT are efficacious treatments for depressed Puerto Rican adolescents.

However, recent studies of psychotherapy with Latin American populations show that empirically supported therapies can improve treatment outcomes when culturally adapted (Markowitz et al., 2009). For example, Interian et al. (2008) pilot tested a 12-session culturally adapted CBT protocol for major depression in Latin Americans. Post-treatment and 6-month follow up evaluations showed a significant reduction in depressive, anxious, and somatic symptoms representing a mean reduction in the severity of depressive symptoms by 57%. In such adaptations, the term ‘culture’ refers to a community of people who share similar meaning systems used to make sense of what is happening in their world (e.g., values, beliefs, norms, roles). These considerations combined with individual- and family-specific cultural contexts create a unique variation on major
cultural themes (Falicov, 1998) that must be recognized in order to best conceptualize and treat the difficulties at hand (Organista, 1996).

Successful adaptations require balancing both these emic (i.e., cultural values, beliefs, traditions, metaphors, level of acculturation) and etic (i.e., components of the treatment that have been found to effect clinically significant change and are presumed to be culturally neutral) considerations. While there is no empirical evidence to suggest that certain therapeutic modalities are better than others when treating Latin Americans, the components of CBT appear to be consistent with the cultural and social features of Latino patients (Organista, 1996). Positive outcome findings from clinical research evaluating the effectiveness of standard CBT for Latino patients suggest that bicultural and assimilated Latin Americans, who have integrated mainstream culture in their systems of meaning, are likely to benefit from CBT. It has also been argued that the delivery format of CBT appeals to Latin American populations of low socioeconomic status, low levels of acculturation (i.e., isolation, adaptation), and traditional worldviews, as they are more likely to “prefer short-term interventions, immediate symptom relief, guidance and advice” (Organista & Munoz, 1996, p. 259). Organista (1996) explained that the psychoeducative component of CBT facilitates mental health promotion and demystifies the process of psychotherapy in a way that does not invalidate Latino experiences and perceptions of mental health problems and the possible solutions. The psychoeducative component of CBT allows patients to reflect and gain insight into their difficulties, understand how CBT may help address their difficulties, and to learn what is expected of them and what they can expect from the therapist during the course of therapy, thus mitigating premature termination and facilitating treatment compliance. Therapy goals of learning to be one’s own therapist, the use of a manual, assignment of homework, and written monitoring tools emulate a classroom experience and help to alleviate the
stigma of psychotherapy in the Latino community. Further, more traditional Latinos tend to expect helping professionals to make specific recommendations to improve their health, which can be accommodated via the active involvement of the CBT therapist (Organista & Munoz, 1996).

In order to culturally adapt any psychological treatment, the goals, language, content, and process of the intervention are attuned to the differing beliefs, sociopolitical influences, socioeconomic resources, and health knowledge of the target population in order to improve treatment relevance, credibility, and efficacy (Bernal, Bonilla, & Bellido, 1995). Bernal and colleagues (1995) posited eight different therapy elements that can be targeted for the cultural adaptation of treatment for Latino populations: language, persons, metaphors, content, concepts, goals, and methods. The language dimension refers to the language in which the intervention is delivered. Beyond the obvious problem in delivering a treatment in a language that the client does not understand (Bernal & Flores-Ortiz, 1982) is consideration of the cultural knowledge that comes with language familiarity (Sue & Zane, 1987). Language-appropriate interventions are preferred over mechanical translations because cultural syntonic language maintains the integrity of the treatment. The persons dimension refers to the individual therapist and client factors, and their relationship dynamics. While racial and cultural similarities between the client and the therapist are not required to achieve positive treatment outcomes, openness and flexibility toward considering the impact of racial and cultural similarities and differences on clients’ presenting problems and the therapeutic relationship is paramount. The metaphors dimension speaks to the shared concepts and symbols of a certain population. For Latino populations, this may consist of the inclusion of culturally consonant idioms, sayings, beliefs, images, and environmental artifacts (e.g., décor) that strengthen treatment engagement (Zuniga, 1992).
Content, the fourth dimension, more generally refers to cultural knowledge of values, customs, and traditions and how this is incorporated in the treatment process. For the Latino populations, individual experiences are steeped in cultural values most notably -- familismo, respeto, confianza, simpatía, marianismo, machismo, personalismo, religion and spirituality. The term ‘familismo’ denotes collectivistic preferences for cohesiveness and close relationships between immediate and extended family, as well as close family friends (Marín & Triandis, 1985). ‘Respeto’ encourages deference to hierarchical relationship order and consideration of boundaries based on this relationship hierarchy (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). ‘Confianza’ means trust and confidence, but is typically used in the context of personal relationships (McKean Skaff, Chelsea, Mycue, & Fisher, 2002). Simpatía, or kindness, stresses the importance of being polite and pleasant even when confronted by hardship, and thus reinforces conflict avoidance (Triandis, Marín, Lisansky, & Betancourt, 1985). ‘Marianismo’ and ‘machismo’ infer gender-specific virtues for Latinas and Latinos, respectively; marianismo encourages women to be self-sacrificing, morally superior, nurturing, and spiritually strong (Lopez-Baez, 1999) while machismo underscores male responsibility to protect, provide for, and defend his family (De La Cancela, 1986). ‘Personalismo’ emphasizes the value of establishing warm interpersonal relationships as compared to impersonal or formal relationships (Santiago-Rivera et al., 2002). Religiosity and spirituality is a core institution in many Latin American communities, playing a large role in guiding many aspects of their everyday living (Pajewski & Enriquez, 1996). Regardless of whether or not individuals of Latin American heritage strongly identify with these cultural values, familiarity with this cultural content allows practitioners to establish a shared understanding of the individual’s context (Bernal et al., 1995).
The concept dimension refers to the theoretical constructs of the treatment modality that dictates how the problem is conceptualized, communicated to the patient, and treated. If the conceptualization of the presenting problem is culturally dystonic, the credibility of the therapist may be undermined and the efficacy of the treatment will likely be reduced. The goals of therapy should also aim for cultural synchrony; cultural knowledge allows the practitioner to position individual goals in alignment with positive, adaptive cultural goals (Rogler, Malgady, Constantino, & Blumenthal, 1982). The methods for achieving these treatment goals should be culturally compatible. Although family or systems therapies have been regarded as the most cultural compatible treatment modality for Latin Americans (e.g., Bernal, 1982; Flores-Ortiz & Bernal, 1989), other research has shown that culturally sensitive hypothesis-testing modeled after the scientific method can be effectively incorporated into any treatment modality (López, Grover, Holland, Johnson, Kain, Kanel et al., 1989). Lastly, the larger social, political, and economic context is key to understanding the interplay between the individual’s difficulties and the social determinants of health. A similar hypothesis-testing procedure can be applied to fully appreciate the link between the individual’s presenting problems and socioeconomic conditions such as pre- and post-migration factors and underemployment (Bernal et al., 1995).

While adapting CBT for Latino immigrant and refugee populations has its merits, differences in the epistemological underpinnings of cognitive behavioural therapy and Latino culture should also be considered for the purposes of anticipating potential obstacles. One major limitation in adapting CBT for Latino populations is that CBT has been developed out of the behavioural science tradition, targeting individual-level variables to generate behaviour change. Even though clients may be equipped with new knowledge, insight, and skills, their mental health and overall well-being will continue to be influenced by the social determinants of health. It is clear
that systemic changes in social policy will be needed in addition to individual-level therapeutic interventions in order to support and improve the mental health of Latino populations (Organista, 1996).

Another major limitation in adapting CBT for Latino populations is the dissonance between traditional Latino values and the core Western values on which CBT, and the general delivery of Western medicine, has been built (e.g., formality in professional relationships, individualistic orientation, verbal expressiveness, assertiveness, egalitarian relationships, scientific reasoning). First and foremost, successful engagement in the therapeutic process is the foundation of positive treatment outcomes. The main tool of client engagement is the therapeutic relationship. In Latino culture, personalismo (i.e., warmth in interpersonal relationships) is an important dimension of both personal and professional relationships. As opposed to the task-oriented formality commonplace in professional relationships in Western health care, Latino clientele will likely be more responsive to a balance of warm, personalized attention (e.g., small talk, judicious self-disclosure) and professionalism. The mainstream practice of immediately discussing the presenting problems will likely be perceived as impersonal by Latino clientele, and may undermine practitioners efforts to establish confianza (i.e., trust).

Second, treatment compliance and outcomes may be enhanced when cognitive and behavioural interventions are modified according to Latino cultural values and socioeconomic considerations. For instance, CBT practitioners can adjust motivational interviewing strategies to include both self- and family-oriented benefits for making changes (e.g., instead of providing the rationale “You need to take care of yourself first”, state “You can take better care of your family by taking care of yourself”). When engaging patients in activity scheduling, CBT therapists can recommend activities that the patients can do with and without family members. Such
modifications are more compatible with the collective or familial (i.e., familismo) orientation of Latin American people. Training in assertive communication should consider culture-based social hierarchies founded on gender or age group roles (i.e., respeto) and the cultural script of smooth as opposed to confrontational relationships (i.e., simpatía); assertive communications may be prefaced with statements that acknowledge deference (e.g., “With all due respect…”; “Would you permit me to express how I feel about that?”; Comas-Díaz & Duncan, 1985). Further, CBT therapists should view Latino patients’s spiritual and religious perspectives as resources that can complement conventional CBT interventions. Religion and spirituality are salient coping strategies in maintaining health in Latino communities (Campesino & Schwartz, 2009). During times of adversity, social isolation, and life changes, Latinos can be drawn to seek meaning and comfort in tradition and rituals (e.g., prayer, folk medicine; Harwood, 1981); even Latinos who are not typically traditional may resonate with core cultural beliefs during times of stress or uncertainty (McKay & Fanning, 1991). Taken together, these considerations lay the groundwork for adaptations of any psychosocial intervention for Latin American populations. For CBT in particular, both adapted and standard applications have been found to be effective, however standards of care for Latin American populations in Canada are not yet available.

The following chapters, Culturally Adapted Cognitive Behavioral Therapy (CA-CBT) for Latin American Immigrants in Canada: A Secondary Data Analysis (Chapter 5) and Results of CA-CBT Study (Chapter 6), describe a leading initiative to generate exactly such guidelines for Latin American immigrants and refugees in Toronto, Canada. Using secondary data analysis of focus groups conducted during the development phase of this initiative, general Latino cultural themes and considerations for culturally sensitive service delivery discussed in this chapter are
deconstructed in the context of the lived experiences and mental health needs of Latino immigrants and refugees living in Canada.
CHAPTER 5
Culturally Adapted Cognitive Behavioral Therapy (CA-CBT) for Latin American Immigrants in Canada: Secondary Data Analysis Utilizing a Global Mental Health Perspective

This chapter outlines the steps involved in conducting a secondary analysis of qualitative data gathered from the ‘Cultural Adaptation of Cognitive Behavioral Therapy (CA-CBT) for Latin American Immigrants in Canada’ study\(^6\). Ethics Review Board approval to conduct a secondary data analysis was obtained from the University of British Columbia, after the study’s completion. The approval was granted in August 2011; data preparation and analysis were conducted from November to February 2012. The qualitative data consisted of focus group transcripts.

An overview of the study design and the recruitment process for the focus groups used in the development of the culturally adapted CBT (CA-CBT) are provided here for reference only, as this information underscores the cultural considerations that are required for the successful development of the protocol and can be extrapolated to inform the implementation and delivery of a culturally adapted clinical tool for Latino immigrants and refugees in Toronto. This review of the study is followed by a detailed plan for the secondary data analysis.

\(^6\) Ethics approval for secondary data analysis of these materials was obtained from the University of British Columbia Ethics Review Board in September 2011 (see Appendix #).
CA-CBT Study Background

The CA-CBT study was carried out in Toronto with funding from Canada Immigration and Citizenship. The full study actually involved the cultural adaptation of CBT for three immigrant groups in Canada: Spanish-speaking Latin Americans, English-speaking Caribbean, and French-speaking Caribbean. CIC has identified these three immigrant groups as being at high risk for mental health problems.

The main objective of the CA-CBT study was to elaborate three manuals on the cultural adaptation of CBT in the three aforementioned immigrant groups for use by therapists in the community. I was the principal investigator of the Spanish-speaking Latin American arm of the study.

The study was conducted at the Center for Addictions and Mental Health (CAMH) after obtaining approval from the Research Ethics Board at that institution. CAMH is the largest psychiatric hospital in Canada and a University of Toronto-affiliated hospital that is renowned for its clinical and academic activities.

The official launch of the manuals, which involved a formal ceremony at CAMH, took place in early 2011 followed by conference presentations on the study findings and two formal therapist training workshops. The use of CA-CBT in the day-to-day practice of these workshop participants is out of the scope of this dissertation.
The CA-CBT study was conducted in several stages, as illustrated in Figure 2.

Figure 2. The Cultural Adaptation of Cognitive Behavioral Therapy for Latinos in Canada: Study Design

Focus Group Methodology

Focus groups have been described as ideal when trying to develop theory or when exploring experiences of certain groups such as people of colour, immigrants or minorities. This method was best-suited for the CA-CBT study, which aimed to tailor a psychological intervention to immigrant groups that have been understudied in a Canadian context. For these reasons, seven pre-development focus groups served the purpose of elaborating the first draft of the CBT manual and informing its delivery to Spanish-speaking Latin American immigrants in Canada. The objective of the focus groups was to explore the participants’ views on mental health, especially depression, coping with depression, acceptable treatments (i.e., medications, psychotherapy, or both), and
culturally acceptable ways of conducting psychotherapy with Spanish-speaking Latin American immigrants like themselves. Post-development focus groups were also conducted with the therapists and clients who participated in the pilot testing to evaluate the effectiveness of the intervention, discuss challenges in its implementation, and seek recommendations for improving the delivery of the intervention. The post-development focus groups were conducted after the CA-CBT protocol was pilot tested, with the goal of evaluating whether the participants benefitted from the intervention, and identifying which components of the interventions did or did not work for the participants.

For the purpose of this dissertation, transcripts from both the pre-development (e.g., to elaborate the manual) and post-development (i.e., to evaluate responsivity to components of the manual) focus groups were analyzed. Although the pilot phase of the CA-CBT intervention was supplemented with pre- and post-treatment quantitative measures\(^7\), this chapter focuses on the findings from focus groups that informed the culturally adapted protocol, the methods used to recruit and retain participants from the Latino community, and the participants’ perceived benefits and drawbacks of this culturally adapted intervention.

**Pre-Development Focus Group Recruitment**

In recruiting Spanish-speaking Latin American immigrants to participate in the pre-development focus groups, the research team began earning the trust of the community prior to the official recruitment efforts. Community leaders (e.g., priests, pastors, doctors, ESL teachers, community mental health providers) and organizations such as community centers were contacted

\(^7\) The Centre for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977), a 20-item Likert type scale, was only used to supplement the treatment phase by providing an objective indicator of pre- and post-treatment depressive severity.
to provide them with information about the study and to obtain their support in referring potential participants. The study information was presented by two Spanish-speaking, Latin American immigrant bilingual project coordinators already known and trusted in the community at churches of different denominations (e.g., Catholic, Evangelical, Baptist, etc.), high schools and community centers frequently attended by the Latino community. One project coordinator was a social anthropologist who had collaborated in many projects relating to indigenous populations in Mexico and in Canada through one of the churches; the other project coordinator was a female psychiatrist from Mexico who was a regular attendant at one of the churches and a radio host for issues relating to mental health in Spanish. Best efforts were made to be inclusive of all major sources of potential participants in order to avoid selection biases.

This community engagement phase was followed by a snowball recruitment technique (Kuper, Lingard, & Levinson, 2008). After the study was presented in a community forum, people who were interested in participating in the focus groups that would inform the cultural adaptation were invited to provide their contact information. The project coordinators followed up with potential participants and inquired as to whether they knew anyone else who might be interested in participating in the focus groups, and about other avenues of informing the Latino community about the focus groups for the study. Recruitment advertisements for the study were posted in areas and facilities frequented by Spanish-speaking Latin American immigrants. The English language version of the recruitment advertisement for pre-development focus group participants can be found in Appendix A. Potential participants were screened over the phone, and those who met the target demographic and sampling goals for the focus groups were invited to attend. At the beginning of every focus group, participants were provided with an information letter about the study (Appendix B, C), a handout summarizing cognitive behavioral therapy (Appendix D), a demographic
questionnaire (Appendix E), and a consent form (Appendix F) -- all made available in Spanish and English. The consent form was signed by all participants prior to beginning the focus groups.

**Pre-Development Focus Group Design**

The initial plan was to conduct eight pre-development focus groups (i.e., men only, health professionals, younger women aged 16 - 24, older women aged 25 – 65, elderly, indigenous people, a mixed male and female group with representation from the most common Latin American countries [community group], and Black Latin Americans) to inform the cultural adaptation. These groups were selected based on purposive and saturated sampling approaches. Based on a review of the literature, the groups were chosen in accordance with our sampling goals to a) obtain participants with a range of beliefs and experiences that were relevant to the research question and b) produce data sufficient to derive the optimal number of themes, respectively. Furthermore, we grouped the participants according to salient cultural and demographic characteristics that are known to have relational implications that may affect group cohesiveness. For example, older versus younger participants likely exhibit different levels of acculturation and face different issues (e.g., being mothers and caregivers of the elderly, single with no children, attending High School).

Although it was the research team’s intention to recruit Black Caribbean and South American Spanish-speaking participants (e.g., Dominicans, Cubans, Black Peruvians) in the focus groups, no members from these groups agreed to participate. Accordingly, the Latino research team only conducted seven of the eight planned pre-development focus groups due to the absence of the Black Latin American participants. Social characteristics of the participants are important variables to consider when analyzing data generated from focus groups (Umaña-Taylor & Bamac, 2004). Table 2 shows the social characteristics of the participants involved in the pre-development focus group.
Table 2. Social Characteristics of Pre-Development Focus Group Participants

<table>
<thead>
<tr>
<th>Focus Group Type</th>
<th>Sample Size (Total N=65)</th>
<th>Age (Years)</th>
<th>Gender</th>
<th>Country of Origin</th>
<th>Years in Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>N=12</td>
<td>Range: 33-57 Age: 45</td>
<td>Female: 0 Male: 12</td>
<td>El Salvador: 2 Mexico: 1 Peru: 3 Chile: 2 Argentina: 1 Colombia: 2 Not specified: 1</td>
<td>20-25 years</td>
</tr>
<tr>
<td>Women</td>
<td>N=9</td>
<td>Range: 33-57 Age: 44</td>
<td>Female: 9 Male: 0</td>
<td>Mexico: 3 Ecuador: 1 Guatemala: 1 Peru: 1 Chile: 1 Colombia: 2</td>
<td>9/9 women: 2 to 28 years Most participants 8-28 years Average: 12 years</td>
</tr>
<tr>
<td>Young women</td>
<td>N=7</td>
<td>Range: 17-24 Age: 21</td>
<td>Female: 7 Male: 0</td>
<td>Canada:1 Mexico: 1 Ecuador: 1 Guatemala: 1 Colombia: 3</td>
<td>5/7 participants: 2 to 7 years 2/7 participants: 20 and 22 years</td>
</tr>
<tr>
<td>Community</td>
<td>N=9</td>
<td>Range: 38-64 Age: 44</td>
<td>Female: 6 Male: 3</td>
<td>Mexico: 3 Peru: 1 Colombia: 5</td>
<td>1/9 participant: 35 years 8/9 participants: 2 to 9 years Average: 3 years</td>
</tr>
</tbody>
</table>
Table 2. Social Characteristics of Pre-Development Focus Group Participants (Continued)

<table>
<thead>
<tr>
<th>Focus Group Type</th>
<th>Sample Size (Total N=65)</th>
<th>Age (years)</th>
<th>Gender</th>
<th>Country of Origin</th>
<th>Years living in Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous people</td>
<td>N=8</td>
<td>Range: 29-61 Average: 41</td>
<td>Female: 5 Male: 3</td>
<td>Mexico: 3 Argentina: 1 Nicaragua: 1 Ecuador: 2 Bolivia: 1</td>
<td>1/8 participant: 39 years 7/8 participants: 9 to 22 years Average: 14 years</td>
</tr>
<tr>
<td>Elderly</td>
<td>N=12</td>
<td>Range: 65-74 Average: 69</td>
<td>Female: 9 Male: 3</td>
<td>El Salvador: 2 Uruguay: 1 Peru: 3 Ecuador: 2 Guatemala: 1 Chile: 1 Colombia: 2</td>
<td>3/12 participants: 37, 40 and 41 years 9/12 participants: 2-30 years Average: 14 years</td>
</tr>
<tr>
<td>Health Providers</td>
<td>N=8</td>
<td>Range: 40-60 Average: 48</td>
<td>Female: 7 Male: 1</td>
<td>Mexico: 2 Cuba: 1 Chile: 2 Argentina: 1 Colombia: 1 Uruguay: 1</td>
<td>8/8 participants: 5 to 36 years</td>
</tr>
</tbody>
</table>

While demographic variables such as gender, age, socioeconomic status, race, ethnicity, country of origin need to be taken into consideration, it is also important to be aware of other power dynamics that may influence the focus group process. The Latin American population in Canada is a very heterogeneous group with different countries of origin, races, and ethnicities. In addition, there is widely varied educational attainment, acculturation levels, immigration status, and immigration history, which can influence disclosure and comfort in expressing perspectives and
opinion in a group setting; because these differences shape individual experiences, homogenous groups may facilitate the expression of thoughts and feelings (Umaña-Taylor & Bamaca, 2004).

For instance, the research team decided to conduct one male-only focus group and two female-only (younger women and older women) focus groups in developing the intervention. Without playing into stereotypes, some Latina women may feel reluctant to express themselves in the presence of men (O’Connell, 1994; Mayo & Resnick, 1996) or men may try to dominate (Wood, & Price 1997) the focus group discussion. Such gender relations may be a reflection of culture-based gender roles of marianismo (i.e., virtues of purity, motherhood, moral fortitude, feminine passivity, subservience to men) and machismo (i.e., virtues of honour, dignity, courage, physical prowess, the right to dominate and control). Separate focus groups were also arranged for young women (ages 16 to 24 years old) because their individual and collective experiences with depression, barriers and thoughts about psychotherapy treatments may be completely different from older women (over 25 years of age and likely married with children). The younger women were also more likely than the older women to have different language preferences (e.g., more proficient in English) and to be more highly acculturated. A separate focus group for health professionals was also conducted because of concerns about culturally-sanctioned power differentials that exist between health providers and patients in the Latino culture and how this dynamic would impact a group comprised of both health professionals and other community members (Julliard, Vivar, Delgado, Cruz, Kabak, & Sabers, 2008).

The social characteristics of the focus group facilitator/researcher and note taker are equally as important in focus group design (Umaña-Taylor & Bamaca, 2004). These characteristics include Latino origin and ability to speak in Spanish during the focus group. Yet, other characteristics related to the focus group context such as hospitality, adjusting to focus group participants’ literacy
levels, and concerns about confidentiality are of paramount importance to Latinos. For example, the team’s male project coordinator (an anthropologist from Mexico) was assigned to conduct the men’s focus group and the indigenous focus group because we predicted that male participants may be more likely to respond to a male facilitator who, in taking the lead of the focus group, would model that discussion of this potentially sensitive subject was not a sign of weakness or cowardice and diminishing the influence of gender roles in the participant-facilitator interaction (i.e., male-male versus male-female). This project coordinator also had extensive experience working with indigenous populations in Chiapas, Mexico and in Toronto and was well-versed in building rapport with this segment of the Latin American community. For similar reasons, our female project coordinator (a psychiatrist from Mexico) was assigned to facilitate the two women’s focus groups and an elderly focus group. We predicted, in accordance with Madriz (1998), that the all-female atmosphere would support the participants’ engagement in the discussion; furthermore, the female project coordinator had experience working with older adult populations and was familiar with the interactional style that would help build rapport with members of this segment of the population.

The pre-development focus groups lasted 2 to 2.5 hours each, and the participants were provided with a $30 honorarium for their time. Appendix G and H contain the facilitator’s guides for conducting the focus groups with the community consultants and health providers, respectively. As the principal investigator for the Latino component of the project and a practicing psychiatrist in the community, I did not conduct any recruitment calls or attend the focus groups in an effort to avoid eliciting socially acceptable answers from participants who may be influenced by the cultural value of *sympatia*. Even though the research team was aware that it would be most appropriate to conduct the focus groups at locations in the communities where the participants lived and not a psychiatric hospital, this was not possible because the hospital Ethics Review Board required the
focus groups to be conducted on hospital grounds due to insurance issues. To counteract participants’ possibly negative attitudes toward attending a psychiatric hospital, it was explained that it was necessary for the focus groups to be conducted at the hospital but that this did not mean they were *locos* (i.e., “crazies”).

The focus groups were conducted during the day or after 5 pm to accommodate all participants. Flexibility is an approach that has been valued by other investigators that have proven successful (Napoles-Springer & Stewart, 2006; Madriz, 1998; Miranda, Azocar, Organista, Munoz, & Lieberman, 1996; McKean Skaff, Chesla, Mycue, & Fisher, 2002). Transportation was identified as a barrier to attending the focus group sessions and was dealt with by providing tokens for public transportation. The research team also arranged for child care as much as possible. The elderly focus group was the only focus group that did not take place in the hospital because of participants’ mobility issues. This group took place at the local Catholic Church during their regular church visits, as to not inconvenience them further. The research team also had concerns that elderly Latino participants could get lost or hurt in the process of finding the psychiatric hospital; they were all monolingual Spanish speakers. Similar to the experiences of US investigators (Napoles-Springer & Stewart, 2006; Madriz, 1998; Miranda et al., 1996; McKean Skaff et al., 2002), all focus groups were conducted in Spanish with the exception of the young women’s group that was conducted in both English and Spanish. The project coordinators who facilitated the groups tried their best to minimize any regional accent or jargon. At the end of each focus group, we provided a light dinner catered by a local organic Latin American restaurant and the participants seemed to appreciate this gesture.
Development of Culturally Adapted CBT (CA-CBT) Intervention

The focus groups were all tape-recorded and a third person, a bilingual research assistant from Mexico, took notes, helped distribute and collect administrative forms, and distributed tokens for public transportation and participants’ honorariums. All seven focus groups were transcribed verbatim by this bilingual research assistant and a report was elaborated containing the themes that emerged from the focus group data. The results of the pre-development focus groups were used to inform a draft manual of the culturally adapted CBT protocol for individual treatment and preliminary guidelines for its delivery. The individual CA-CBT protocol was modified for delivery in a group format, which was also pilot tested.

The participants in the treatment phase of the CA-CBT study were completely different from the participants who took part in the seven focus groups. These new participants were recruited using the same culturally sensitive approach implemented for the pre-development focus groups. The English language version of the recruitment advertisement for the treatment phase participants can be found in Appendix I. The research team recruited 12 Latino participants that met the inclusion criteria for the treatment phase of the study (i.e., not currently in treatment for depression, met the cut off score for clinical depression according to an interview-style administration of the CES-D, 16 years of age and older, living in the Toronto area, non-psychotic and non-suicidal). Three bilingual, bicultural CBT therapists were hired -- a female therapist from Uruguay with a doctorate in psychology, a female therapist from Argentina with a doctorate in clinical psychology, and a female Mexican therapist with a master’s in social work and extensive experience as a CBT therapist in hospitals and the community. The therapists recruited for the study all had between 8 and 15 years of CBT experience. The information letter distributed to the
treatment participants can be found in Appendix J. All participants signed a consent form prior to beginning treatment.

Five participants attended 16 individual sessions and the other five participants attended 16 group sessions. The overall retention rate for the pilot phase of the study was 10 out of 12 subjects (80%) that were initially recruited. One participant discontinued treatment after two sessions because he was apprehended by police; the other participant dropped out of treatment because she was overwhelmed by extreme psychosocial stressors (i.e., housing issues).

Although it was the research team’s intention to closely follow all recommendations for treatment delivery offered by the literature and the feedback from the initial focus groups (e.g., delivery of treatment in community based settings), the research team was again obligated by hospital policy to deliver the treatments at hospital-affiliated sites. However, the treatment sites selected were primarily smaller clinics located in the community, with the exception of the group intervention that was delivered in the new wing of the psychiatric hospital.

**Post-Development Focus Group Design**

In order to evaluate the culturally adapted protocol (see Appendix K), the research team held three post-development focus groups to discuss the successes, challenges and concerns related to the pilot version of the intervention – two with the participants who received the CA-CBT intervention and the other with the therapists who delivered the CA-CBT intervention. Table 3 shows the social characteristics of the post-development focus group participants including the recruited therapists for a total number of 13 participants (10 people that received the treatment and 3 therapists).
Table 3. Social Characteristics of Post-Development Focus Group Participants

<table>
<thead>
<tr>
<th>Focus Group Type</th>
<th>Sample Size (Total N=13)</th>
<th>Age (Years)</th>
<th>Gender</th>
<th>Country of Origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Therapy Participants</td>
<td>N=5</td>
<td>Range: 17-50 Average: 36</td>
<td>Female: 5 Male: 0</td>
<td>Mexico:2 Argentina:1 Peru:1 Uruguay: 1</td>
</tr>
<tr>
<td>Group Therapy Participants</td>
<td>N=5</td>
<td>Range: 24-52 Average: 37</td>
<td>Female: 0 Male: 5</td>
<td>Colombia: 3 Mexico: 1 Ecuador: 1</td>
</tr>
<tr>
<td>Individual and Group Therapists</td>
<td>N=3</td>
<td>Range: 37-55 Average: 45</td>
<td>Female: 3 Male: 0</td>
<td>Uruguay: 1 Argentina: 1 Mexico:1</td>
</tr>
</tbody>
</table>

Note: Participants who dropped out of treatment (N=2) are not represented in Table 3.

The post-development focus groups were supplemented by a quantitative measure, instructing the therapists to rate the usefulness of some of the tools outlined in the manual (e.g., stress diaries, assertiveness training, thought records). This component of the focus group data was not included in the secondary analysis conducted for the purpose of this dissertation.

Data Analysis

Although causal modeling using quantitative measures of independent and dependent variables are now favored in psychotherapy research, there continues to be a place for qualitative methods. Especially in the absence of multiple, reliable quantitative measures that have been validated among the ethnoracial populations, qualitative methods such as detailed interviewing and focus groups can provide valuable data to further develop more conceptually sound quantitative psychotherapy research studies and inform evidence-based mental health services (Denzin & Lincoln, 2008).
In conducting qualitative analyses, two coders can help to ensure greater accuracy of the results. This writer conducted data analysis with the assistance of a postdoctoral fellow in the Social Aetiology of Mental Illness (SAMI) program at CAMH, a sociocultural anthropologist who is fully bilingual in English and Spanish. Both coders gave the focus group transcripts an initial reading and created a coding structure using Nvivo 9, a computer program that assigns codes to the sections of text selected by the researcher. Test coding was performed on two transcripts to determine whether the coding structure was appropriate and/or required modification. All focus group transcripts were coded after testing the coding structure. Coding was discussed among the two coders to settle any coding disagreements. Following the coding of all transcripts, myself and the post-doctoral fellow discussed the codes that could be clustered under particular themes; for instance, social determinants of health, perceived causes of depression, perceptions of CBT, and pathways to care. Finally, based on the salient themes that emerged in the transcripts and drawing on several bodies of literature in psychiatry, social sciences and global mental health as discussed earlier, it was possible to develop the arguments that follow in this dissertation.

The textual evidence was analyzed in three separate phases in order to identify different layers of meaning. In the first level of interpretation, I gave meaning to the text from the perspective of the people being studied (i.e., first order interpretation) (Neuman, 2011). In reporting these interpretations, the data was organized according to the categories that emerged during the content analysis. Interpretations were supplemented with relevant quotations that illustrate the point, while keeping in mind the importance of presenting a balanced picture of the data as a whole. A cyclical research path was used during the first-order interpretation, which involved questioning interpretations, possibly modifying and creating new categories, and arriving at new explanations (Litoselliti, 2003).
I then proceeded to second-order interpretation, identifying underlying themes contextualized by the experiences of the focus group members making sure to reserve assumptions that the most important themes were the ones that are most frequently mentioned (Neuman, 2011). The focus group participants’ comments were considered in the context of the speaker, the point in the discussion when the comments occurred, the tone of the comment, nonverbal cues accompanying the comment, and the sociocultural context of the focus group (Litoselliti, 2003). Then, I proposed a third-level interpretation that linked these themes to theoretical constructs or conceptual frameworks (Neuman, 2011). These findings are presented in the following chapter.
CHAPTER 6
Results of the CA-CBT Study

This chapter addresses objective 3, which is to conduct a secondary analysis of qualitative data from the ‘Cultural Adaptation of Cognitive Behavioral Therapy (CA-CBT) for Latin American Immigrants in Canada’ study. The central findings of the qualitative component of this research study are presented. In accordance with a qualitative approach, meaning was gathered from the data collected as opposed to collecting data with responses keyed to predefined meanings (i.e., deductive process), as is often the case in quantitative research. The data was interpreted in the context of the participants’ perspective. Due to the various levels of interpretation, iterative methods of qualitative analysis were utilized. The findings illuminate how the social determinants of health emerged in the perspectives of the research participants. Further, it is concluded that the content of CA-CBT must incorporate the social determinants of mental health. This chapter completes the set of evidence for consideration in addressing the research questions proposed in this dissertation (see pg. 22 for reference). Together, they set the tone for reflection on and discussion of the global mental health perspective in the last chapter (i.e., Chapter 7).

CA-CBT and the Social Determinants of Health

One of the key determinants of health addressed by CA-CBT is that of culture, making it of great therapeutic use. Adapting CBT for Latin American populations in Canada is guided by the principle of making CBT relevant to Latin Americans by acknowledging, respecting, and incorporating their cultural practices, language and beliefs into therapy. The focus group discussions conducted for this study provide ample evidence that, for Latin Americans, having a therapist who respects and understands their culture and language is a key component of an
effective service delivery model. Among the motivating factors for seeking therapy identified by the participants, *characteristics of the therapist* was the most frequently cited (101 references); *therapist’s ethnic similarity* (17 references) and an *understanding of the culture* (14 references) were among the top four preferred therapist characteristics. For instance, a participant in the indigenous focus group stated, “I think it is very important that the therapy be given in the patients’ same language, with a person that understands us”. A participant in the community focus group similarly stated, “It’s not only about the language but also the customs that they [the therapist and patient] can share”. When asked about barriers to seeking mental health services, *language barriers* were most frequently cited (14 references). Language barriers were also the number one perceived cause of depression among the participants (29 references).

In addition to language, participants described understanding the customs and beliefs, for example around religion (i.e., that many Latin Americans have strong Catholic or Christian beliefs), as central to receiving good care. *Seeking a spiritual leader* was the number one pathway to care cited by participants (31 references) compared to *going to a psychiatrist* (7 references) or a *psychologist* (8 references). A friendly demeanor and ability to establish an atmosphere of trust (confianza) were identified by research participants as good therapist qualities and central aspects of receiving good care. Confianza is a powerful concept for Latin Americans reserved for family, friends and acquaintances a person can confide in, deems trustworthy, and will keep matters confidential.

While having a therapist that understands their culture and language was identified as a major draw motivating Latin Americans to more readily seek and stay in therapy, it was only one among a number of factors mentioned by participants. The perspectives of the research participants – their experiences of migration, resettlement, and poor mental health – underscored the need for
CBT to address all of the social determinants of health and not merely address the cultural aspects. Migration to a new country, experiences of political violence, social isolation, discrimination, unemployment and under-employment, poor working conditions, financial worries, poor health services and lack of information on services available to them were among the themes raised by Latin American men and women in this study. The following quote captures the various ways in which migrating to a new country may adversely impact the mental health of Latin American immigrants and refugees.

Everything is so different. The physical environment, the human environment, the educational environment, everything, it is all different. So, you have some people that come on their own free will others because they have to leave, some come with all of their family others come alone [...] all of these factors affect the well-being of the person. The education level with which the individual arrives also affects a person’s well-being. Because it’s as if you are replanting a plant into new soil. Is that plant ready to be planted here? What knowledge of what is like to be here do they have? Of the educational system? Of the society? It is a number of factors that affect the emotional side of individuals. (Indigenous focus group participant)

**What do the Social Determinants of Health mean for the content and practice of CBT?**

Incorporating the social determinants of health framework into CA-CBT implies a number of changes to how CBT is carried out (the process) as well as what issues are discussed, analyzed and processed in the context of CBT (the content). It involves moving beyond simply altering individual patterns of negative thought to examining and addressing the social inequities and barriers that contribute to poor mental health among different populations. CBT works with the underlying principle that the way an individual feels and behaves is influenced by the way he or she
structures his or her experience. Incorporating the social determinants of health in CBT means taking CBT one step further to examine how social, community, and institutional level influences impact the ways individuals feel and how they structure that experience.

Content

For the participants of the focus groups and those who underwent the CA-CBT treatment, issues of social inequity particularly related to migratory experiences were the top themes raised in relation to perceived causes of depression. The results of the analysis are consistent with the literature, which shows that immigrant and refugee populations are at risk of developing depression and common mental health problems due to the stressors associated with migration and resettlement, including discrimination, language, cultural barriers, loss of social status, and social isolation that threaten their mental well-being (Kirmayer et al., 2011). When asked about the causes of depression, the most frequent response was language barriers (29 references made by participants), followed by changes to family relations (15), racism (14), lack of a social network (e.g., “not knowing anyone or having friends”), discrimination (13), and change in work (11). These themes were identified repeatedly by participants as factors that negatively impacted the mental well-being of Latin American immigrants and refugees. The participants’ perspectives signal the need for CA-CBT with Latin Americans to incorporate a discussion of the social and structural forces that shape their experiences and emotional functioning.

Social Environment/Physical Environment/Social Support

The theme of migration and the lived experience of immigrants emerged as a central point of discussion. Participants’ perspectives indicated that the migration experience is a key factor shaping many aspects of their lives in Canada, including family, work, economic and social status, and experiences of racism and discrimination -- all of which, in turn, impacted their emotional well-
being and mental health. With regard to migration, participant reflections included comments such as the following:

Migration causes depression, at least I think so because that happened in my family, because there is no support, or there is support but one doesn’t know how to inform oneself about the support there is out there. (Young women’s focus group participant)

Another important factor is your status in Canada, your migration issues, these all influence you a lot because you are with all that tension of, “will I stay?” or “will I have to return?”, “what will happen with me?”, “am I staying or leaving?” (Men’s focus group participant)

When one goes from one country to another it is like taking a plant from one place to another, from cold to warm or the reverse, so for there to be that adaptation, which maybe never arrives, it’s a long process. (Indigenous focus group participant)

**Social Exclusion**

Themes of discrimination and racism were raised frequently by participants of this study. A participant in the men’s focus group remarked, “I was going to mention discrimination. Many times people come here from many places […] and I have seen in construction how they [the Portuguese and Italians in Toronto] treat you as if you were a slave, and they yell at you and they treat you very badly”. Similarly, a woman who participated in the seniors focus group stated, “I worked for many years and I don’t know English 100% but they discriminated me because I didn’t pronounce words properly.”

Participants described experiencing discrimination and racism in different spheres of their lives – in the workplace, in their neighborhoods, and in interactions with others including
health professionals and the police force. The quote below succinctly captures the experiences of everyday racism encountered by Latin Americans in Toronto.

And racism too […] in my building I have felt this greatly. I have also suffered this from the police and from medical doctors too, especially with my dad. I myself had to fight with our family doctor because of how he treated my father as if he is worth nothing, and so I confronted him and said, “what is your profession? You as a doctor should help him, not bury him and stomp on him as you are doing. And I am going to put in a complaint because this is not fair, that just because he doesn’t speak English or he can’t express himself you want to stomp all over him.” (Women’s focus group participant)

Others described the experience of being racialized and always regarded as “visible minorities” rather than as individuals. “I have faced many forms of discrimination. Obviously I am not very fair skin, and people see your skin tone and box us in the “other side”. If we are white and blue-eyed we are placed in another category. In other words we are placed in categories based on if we are whiter or darker than others. […] you are classified as ‘white’ or ‘brown” (Community focus group participant). A participant in the women’s focus group commented, “In this country you are made to feel as though you are always an immigrant. There are many people and we have lived here for many years but you are always a visible minority. You are the immigrant and that is never going to change.”
Employment and Working Conditions

Participants identified changes in the type of work, not being able to work in the same field as they did in their country of origin, and poor work-conditions as factors leading to depression in Latin American immigrants. As a participant in the men’s focus group put it,

Sometimes ones comes from a country where you have your careers and a certain economic level and when you come here and you can’t find work or subsidies, then depression begins, because I have to work washing dishes if I am a doctor, I have to drive a taxi if I am an engineer. So they stay there and they are sort of drowning and beating their heads against a wall. (Men’s focus group participant)

An indigenous man described the feeling of being dislocated and difficulties in finding work. He described, “In a developed country we face great pressure. We have to measure ourselves against the big trees, with the small trees and dance the same tango. And there we have bad luck. Many of us lose our jobs and this is the first problem we encounter here”.

Social Support Networks

Changes to the family life, including changing roles and demands placed on family members by length of hours spent working were frequently raised as contributing factors to depression for Latin American immigrant men and women. In the words of an indigenous participant, “family disintegration is one of the factors that leads to mental illness for those who migrate to Canada.” A participant of the men’s focus group described possible change in emotional stability due to longer work hours for both men and women. He indicated that when a husband cannot provide for his family, “emotional instability begins as he begins to get jealous, the bad nights begin because he can’t sleep, thinking about what his wife may have done. Why? Why does she have to work 8, 10, 12 hours to support the family?”
Another participant indicated, “I think family life is totally linked to mental well-being. […] The pace of life here is so different and each member of the family may take on a certain attitude, that maybe is not the best one, and this can cause more depression or more sadness for the parents” (Indigenous focus group participant).

Participants also raised the issue of family separation and spoke of the difficulties of living in Canada without family. For example, one senior indicated, “Well, some of us live here in Canada and many of us don’t have family here, and sometimes it’s just a mother with her children, sometimes a woman by herself, sometimes a man by himself. There are many people in our community that live without any family whatsoever”.

**Income and Social Status**

Income and social status were also raised in relation to depression among Latin Americans in Canada. One community mental health professional shared, “I think emotional stress is caused by many factors, but I find that financial circumstances causes a lot of stress”. Similarly, a participant of the community focus group indicated, “My children are grown. For the boy it is a bit difficult finding work, and he is studying so what he can bring home is limited, and it is not enough and so since he gets depressed and is in low spirits, I get depressed too”.

Several participants also reported that financial worries contributed to the decline of their mental health because they are unable to afford services. “I think that many of us immediately rule out seeking a specialist that could help us with our troubles because due to our economic situation, it is an obstacle for getting the necessary help”, one participant stated (Community focus group).
The perspectives of the research participants signify the importance of incorporating various social determinants of health into the content of CA-CBT. Participants’ viewpoints and experiences reveal that, for Latin American immigrants and refugees in Toronto, the process of migration and resettlement and the social and structural conditions under which they take place influence their community, family and individual lives and well-being. The content of CA-CBT must recognize and explicitly address how the social determinants of mental health operate to shape the experiences of mental illness and health for Latin Americans.

**Practice vs. Process: An Equity Vision and Practice for CA-CBT for Latin Americans**

While the participants’ perspectives evidence the need to incorporate the social determinants of health into CA-CBT, they also highlighted the need for CA-CBT to be practiced within the context of a health equity vision. Divorced from real efforts to reduce the inequalities that produce uneven health outcomes, CA-CBT can only go so far. According to the Toronto Central LHIN (2008), “There are persistent and significant differences in people’s health depending upon their income and wealth, where they live, the work they do, where they come from, their race and gender, and other social and economic factors” (p. 2). The Toronto Central LHIN has proposed that Toronto build a system of health care whereby, “systemic and avoidable health disparities are steadily reduced so that the gap between the best and worst off is narrowed” (Toronto Central LHIN, 2008, p. 2). This can be accomplished though ensuring all residents have equitable access to a full range of high-quality healthcare and support, and that they have equal opportunities for good health and well-being (Toronto Central LHIN, 2008).

The study findings suggest that CA-CBT for Latin Americans, if it is to be effective in improving the mental health of this population must be practiced with a vision of health equity. Thus the process of conducting CBT, not merely its content, must move beyond a focus on the
individual and immediate causes of ill health to focus on the “causes of the causes —the fundamental structures of social hierarchy and the socially determined conditions these create in which people grow, live, work and age” (Marmot, 2007). The perspectives of the research participants provide insights into lines of action towards building health equity into the practice of CA-CBT.

Language and Culture

Language barriers were the number one cited perceived cause of depression among participants of this study as well as the major barrier to seeking mental health services. Among the motivating factors for seeking help was having a therapist that understood their culture and had the same ethnic background. Thus, from a health equity perspective, reducing the gap in help-seeking in mental health services for Latin American immigrants and refugees will mean offering culturally-sensitive services in the language of the targeted population -- in this case Spanish.

Because of English they are more limited because there are not a lot of Latin American professionals, that is a problem and we have to start calling people and asking, “Do you know a Latino doctor that speaks Spanish?” I don’t understand English and this is one of our greatest barriers. (Women’s focus group participant)

Cost of Therapy

Another theme that emerged in this research as a barrier to Latin Americans seeking mental health services is the costs associated with therapy. From a health equity perspective it would be crucial to remove financial barriers to seeking care that many immigrants experience in Canada. A participant of the women’s focus group stated
When I arrived I noticed that I went into a strong depression, and I was aware I had depression. One [obstacle] was English the other was that I knew I needed therapy in that moment but I didn’t have money. In other words, you don’t have money to receive therapy here; they charge you like $100.00 for a consultation.

**Gender**

The practice of CA-CBT within a health equity framework also requires health care professionals to be aware and accommodate the patients’ preference for a male or female therapist. Understanding and respecting the preference for a male or female therapist emerged as an important aspect in this research for promoting the mental health of Latin Americans and other minority populations in Canada. Along with understanding the culture and language, the gender of the psychotherapist was recognized in this analysis as a significant motivating factor for seeking and staying in therapy. In particular the female participants described the significance of having a female therapist. A woman who participated in the community focus group indicated, “For me it’s better if the therapist is a woman. In other words, if the patient is a woman then the therapist should be a woman, or if it’s a male patient I imagine it would be the same [that they would prefer a male therapist] because that way one is more comfortable -- one has more confianza [trust]”. Several participants commented that in cases where there has been abuse, it may be important for a woman to have a therapist of the same sex. Other participants described that it was important to have the option—to be asked their preference for a male or female therapist. Others indicated that it would be important that “baby sitting be offered to women because many of them probably have no way of coming otherwise.” (Women’s focus group participant)
Flexible Hours for Therapy

Another theme that surfaced many times was that of busy work schedules. Participants questioned how one can participate in ongoing therapy when juggling busy schedules and multiple jobs. In the senior’s focus group, certain participants discussed wishing someone in their family had more time to accompany them to their doctors’ appointments. For example, one participant stated:

I have had this trouble with time here, everyone works and there is no one who can help the sick person, to take them to the doctor, if you have family members maybe some of them would be willing to help you out, but many can’t due to a lack of time. Here everyone has to work and the sick person has to go alone to find out where to go and what to do, and that is where there is a lack of support. (Senior’s focus group participant)

Emerging from the points of views of the participants was the need for therapeutic services such as CA-CBT to be offered with consideration for the ‘real life’ circumstances of clients, and how this affects their help-seeking patterns and ability to attend multiple therapy sessions. For instance, individuals may be more inclined to go to treatment if it is close to their home or work, as they may not have a lot of time to spare to spend travelling to sessions. Therapists offering CA-CBT need to be cognizant of the demands on time placed by long or irregular working hours on Latin American immigrants and refugees who are often unable to negotiate different hours.

Location of CA-CBT

Stigma of mental illness was raised frequently in the focus group discussions. Participants indicated that the facility where CA-CBT is delivered is important to them. One participant indicated, in regard to the therapy location, “the last thing one would want is for anyone to know we went to see a therapist, the fear of being called "loco" (crazy), also the therapy needs to be given
in a quiet, private space [...] somewhere where you can express yourself without thinking that others will hear you” (community focus group). Other participants mentioned the importance of a “welcoming space” that may “have plants, a fountain” and be “well decorated -- not so cold like doctors' offices”.

*Group versus Individual Therapy*

Participants’ responses with regard to their preference for individual or group therapy were mixed, with almost an equal number saying they would prefer individual sessions, group sessions, and a mix of group and individual sessions. Participants indicated this preference depended on the circumstances. For instance, in some cases, such as when one is disclosing abuse in the family, individual sessions would be preferable. Other participants described learning a great deal from group sessions and feeling supported in a group setting. Reducing social isolation was the second most cited pathway to care among research participants (18 references) after seeking a spiritual leader. Thus, in many cases, group therapy worked to break the isolation experienced by participants. One participant of the senior’s focus group attributed being drawn to group therapy to knowing, “You are not the only one with a certain problem. There are many that have the same problem…hearing about the other’s problems helps us”.

The appeal of group therapy was a theme in the post-development focus groups. The participants opined that the group format promoted social support building and facilitated a sense of social cohesion. This interesting phenomenon indicated a high level of trust and support during the group therapy sessions, as well as a sense of social solidarity. The therapist that conducted the group therapy sessions commented:

Look, I believe that working with a group was very positive. All the patients, the five patients that I had, are here for different reasons -- a lot of loneliness, a lot of
isolation. So, despite the fact that some have family, are married, and, in truth, aren’t totally alone, um… somehow there is an isolation caused by depression. So, to suddenly come into a group, and just to be in a group in which you speak the same language, and I’m not just talking about Spanish, but on a cultural level there was understanding… because there were people from different parts of Latin America. This was extraordinary. And also, it was very useful for the patients to have a structure. It wasn’t only a therapy based on socialization, nor was it eclectic, there was a structure that they knew; that in every session we start like this and there was a structure. So they were… in a sense, the mental discipline in addition to the social support that was developed was very positive.

She continued:

And on the other hand, connecting on an emotional level with other peers of different ages, from different countries and suddenly be able to say – I am not so alone. I see my problem reflected in him or in him. So, this situation was truly important. Also, it seemed to me… I believe that the… the… what [Therapist 2] said about… being culturally competent is fundamental. You couldn’t put someone who just speaks Spanish in there. They must be culturally competent to do therapy, from my point of view. Adapted CBT. It can’t be a person who isn’t totally immersed in the culture; who has lived there, who knows, in depth, the history, the cultural roots. So, for me, this was one of the most important things because in the group, despite there having been two men who didn’t speak much, it was super positive. So, you’d have to see; on an individual level, maybe, this person isn’t a good candidate for CBT, but in a group, I saw a transformation in one of them, especially in one that
was… he spoke… he arrived and he said that he was so anxious he didn’t want to talk, that no, that he was scared, but that he was going to try, going to try. From this, I saw… I noticed how he opened up, this man. He opened up at the end. And he recognized it too. So, I believe that the support of the group was important.

In conclusion, CA-CBT seems promising as a psychotherapy modality that is acceptable and even welcome by the Latin American community. Interestingly all participants in the therapy had the same recommendation for future delivery of the CA-CBT protocol -- more sessions (i.e., 16 to 20 sessions rather than 12 sessions) and a mix of individual and group sessions. The embracement of this cultural adaptation of CBT is somewhat contrary to what has been found in the US literature. Canada and the US are quite different in many respects, not only in economic, migratory, political, health and educational spheres but also with respect to weather conditions, cultural composition, and most importantly the size of the Latin American population (i.e., 30 million legal Latinos in the US versus about 350,000 total in Canada). It is possible that the sense of isolation that Latin American immigrants experience in Canada is more palpable than Latin American immigrants residing in the US, as Latinos are fewer in number and more sparsely distributed across Canada. These factors may have an impact on the occurrence of depression, what works for the psychological treatment of depression for Latin American immigrant population, how to improve treatment retention among Latin American immigrant therapy clientele, and why therapy may benefit Latin American immigrants in Canada.
CHAPTER 7
Discussion

This chapter addresses the last objective of this dissertation -- to discuss and reflect on the global mental health perspective, which is founded in concepts related to health equity such as the social determinants of health and looks toward culturally responsive clinical tools such as CA-CBT for Latin American immigrants in Canada to meet health equity goals. In concluding this dissertation, future directions for policy and research, strengths and limitations of the study and other implications are considered.

The reflective exercise in this chapter is actually a reflection on all the parts of this dissertation. This reflection is based and explained by Dr. Donald Schön in his seminal book: "The Reflective Practitioner"(Schön, 1983). He explains that the practitioner usually knows more than he can say. And when the practitioner uses his or her knowledge in practice and is taking action he is also reflecting in a parallel process. The reflection is mostly based on the surprising outcomes or the positive outcomes that one accomplishes by putting knowledge into action and reflecting about it.

The main outcome of my reflection is how to culturally adapt CBT for Latinos. The central exercise in this dissertation is how to develop a culturally adapted clinical tool to treat depression in Latinos, namely CBT, by informing myself through the reflection of the three perspectives as if it were a triangle. I call this triangulation, that is, to see the same problem from three different perspectives. Each point in the triangle merited a great deal of knowledge acquisition, immersion and further reflection through practice. The first point of the triangle is the direct immersion in the concept of globalization and global mental health including the debate about how globalization has affected global mental health and how it has affected the practice of psychiatry; the second angle is
my direct immersion in the Cuban mental health care system with a deep understanding of their history, politics, their social determinants of health and their innovative treatments for people with mental conditions as they have not been globalized with the rest of the world. The third angle is my own positionality as a researcher, reflective cross-cultural psychiatrist, but also at a personal level, as a Latina immigrant in Canada who lived, in her own flesh, all the social determinants of health in this country, and who is still reflecting about them.

The next sections in this final chapter will be a discussion of my "triangulated reflection" that has helped me understand the complexities of cultural adaptation of a psychotherapy when taking a global mental health perspective that I find as absolutely necessary for the conceptualization and early treatment of depression among Latinos in Canada.

It is also necessary to keep in mind that the lines of exploration in the present dissertation convincingly point to global, and not solely Western, practices in psychiatry as promising inroads to change. The implicit goal of this dissertation is to bring together current issues and complexities in global mental health in order to generate different options to address the burden of disease. My hope is that this dissertation evokes an interesting debate between academics, service providers and most importantly, the people who are actually receiving the treatments. Ideally, these conversations will contribute to a shift in the way psychiatrists perceive their patients and promote a more balanced psychiatry practice that accounts for all the factors explored from globalization, symptom presentation, and indigenous ways of healing. If these interventions achieve relief from symptoms and yield a normal level of functioning, psychiatry needs to be open to all options.

**Reseacher Positionality and the Global Mental Health Perspective**

In addition to considering such issues, my positionality as a researcher is one of the three angles of reflection in practice and quite important in this dissertation as it allows me to see the
global mental health perspective and the mental health of Spanish speaking Latin American immigrants in Canada through a lens that is colored by my very own professional and personal experiences: my origins in El Salvador and immigrating to Canada as a refugee experiencing the social determinants of health first-hand; my current psychiatry practice in downtown Toronto with a caseload comprised of about 90% Spanish speaking Latin Americans with a myriad of diagnoses and limited resources; the themes in my patients’ narratives about their life histories that are similar to my own, related to acculturative stress and the social determinants of health that have shaped futures and the development of mental illnesses.

As an immigrant doctor I feel that I have a strong sense of kinship with my Latin American clients, perhaps because of identification with their experiences, and this allows for a reflection process during practice. I also feel grateful for my difficult experiences as an immigrant woman that have allowed me, as a researcher and as a cross-cultural psychiatrist, to ask relevant clinical and research questions, design studies that use culturally appropriate methodologies, and deepen my capacity to understand and reflect upon the data for the betterment of the Spanish speaking population in Toronto. I especially noted this capacity in the context of evaluating a culturally adapted clinical tool for depression (i.e., CA-CBT), these lived experiences allow me to fully consider the strengths and limitations of the current debates within the global mental health field.

This capacity of reflection on my personal and professional experiences is also occurring and is changing me as a cross cultural psychiatrist when observing and reflecting on the recent changes or movements in the global mental health field that form part of my definition of a global mental health perspective. The global mental health perspective is captured by the opposing agendas of the two major movements that have emerged in the global health field: a) the global health movement as exemplified by WHO, having declared “mhGAP (Mental Health Global Action
Programme) as its flagship program in mental health and will publish evidence-based guidelines for non-specialist health care workers to provide treatments for 8 mental, neurological, and substance use disorders in routine health care settings” (Patel & Prince, 2010, p. 1976); and, b) the critical psychiatry network movement that calls for a boycott of this plan, arguing that the strategy caters to the interests of pharmaceutical companies poised to create new markets in low and lower middle income countries. While the undercurrents of colonialism and the medicalization of human suffering are the key sources of this tension, both movements agree that there is a strong moral case for global mental health that calls for innovation.

The global mental health perspective has begun to modify the practices of psychiatrists and mental health researchers. Since starting this PhD program in 2004, there have been many important events that have catapulted the global mental health agenda to a top international priority: the launch of the Lancet Global Mental Health series (Horton, 2007; Kleinman, 2009; Patel, 2006); the WHO mental health report (2010a); and the efforts of the global mental health community, such as the mhGAP programme and the Movement for Global Mental Health to address the treatment gap.

This dissertation examined advancements in the global mental health field to date, including more recent concerns surrounding the commodification of psychiatric practice and what this may mean for a global mental health movement that is in many ways a reaction to the narrow biomedicalism that represents the current status quo in health care.

This dissertation began with an introduction of the problem and then moved to exploring and defining important processes of globalization (e.g., neo-liberal policies, the opening of free markets, transfer of knowledge and ideologies, mass migration of people, technology, etc.), as they directly affect the health of populations and the way psychiatry provides mental health services to
these populations. This was a *reflective exercise* using different methods to explore the different issues at hand. First, a literature review describing the current burden of disease, the treatment gap, the global mental health movement and the opposing arguments to this movement that unearthed a number of issues. The issues include the ‘medicalization of human suffering’ via the DSM nosology, the practice of biological psychiatry in high income countries, the exportation of biological psychiatry to the rest of the world (i.e., globalization of psychiatry) and the creation of new markets for pharmaceutical companies. Related to these issues is the argument that psychiatry and psychiatric treatments are becoming commodified. The second method was immersion in the Cuban mental health care system over the course of three years, to study the use and impact of psychiatric treatments occurring at the margins of globalization. Based on this experience, I produced a documentary on innovative treatments for severe mental illnesses at the Havana National Psychiatric Hospital. The third method was an in vivo examination of the social determinants of health and health equity issues that arose during the CA-CBT study conducted in Toronto between 2008 and 2011 to reflect further on how migration (a globalization phenomenon) and social determinants of health play a role in the perception of depression in an immigrant population and assess the feasibility of culturally adapted treatments as a solution.

Patel and colleagues (e.g., Patel, Saraceno, & Kleinman, 2006) have implored the psychiatry profession to stop waiting for more research while people continue to face inhumane circumstances in low income countries due to the unavailability of psychiatric treatment. Psychiatry needs to do something. There are effective medications and models of psychological intervention in the Western world that can be made available in low income countries. The mhGAP plan aims at making packages of mental health treatments based on best practices in Western medicine available to people around the world. On the other hand, the critical psychiatry network movement is asking
to take "pause" to consider the assumptions of and the benefits to the pharmaceutical companies invested in the standardization of psychiatric diagnosis and the standardization of treatments without any regard to culture or the contexts in which people live.

The "pause" initiated by the critical psychiatrists demands attention to the actual science or validity of the DSM system of classification of mental illnesses and the history of its development. Who benefits from creating more and more diagnoses or decreasing the symptom threshold for diagnosis? Pharmaceutical companies are one obvious and undeniable beneficiary of "new" markets for medications for mental disorders from children (e.g., ADHD, childhood depression) to newly diagnosed population in low income countries. Furthermore, evidence-based psychological treatments such as CBT for mood disorders and anxiety disorders are being commodified in the same fashion. A standard, 16-week course of CBT conducted by a psychologist will cost between $1,760 to $3,520 CAD, on a sliding scale ($110 to $220 CAD per hour times 16 sessions). With additional cultural adaptation and specialized interventions required for immigrant and refugee populations, CA-CBT will likely cost more. The question is who is going to pay for it, especially considering that immigrant and refugee patients who may need treatment may not immediately enter the Canadian workforce (e.g., they first need to learn the language) but are more likely to contribute to the Canadian economy after receiving effective treatment?

At first glance, the global mental health movement makes a lot of sense. Why wait for more research when we know that people with mental illnesses are suffering because the lack of treatments or medications? After all, I may be a Salvadorian immigrant but I trained in the Western psychiatric tradition at Canadian Universities. So I began to ask myself: Who are these critical psychiatrists and what is critical psychiatry exactly? How does this help me understand the global mental health perspective given who I am and what I already know and the cultural adaptation of
CBT as an effective psychosocial alternative to the pharmacological treatment of Spanish-speaking Latin American immigrants in Canada presenting with mental illness? How can I further understand the two opposing arguments within global mental health perspective by examining my immersion in the Cuban mental health system and working in the Canadian mental health system? *How can we create a new practice of psychiatry or provide mental health treatments to patients in a more balanced way that makes sense to the patients while relieving their symptoms and promoting their mental health?*

This dissertation has been a journey that began with my own personal experience as a refugee in Canada, continued through my epidemiology and psychiatry studies, and now my provision of clinical services to the Spanish speaking population in Toronto. In the process, I have developed insights into global mental health issues and understand how they directly relate to globalization phenomena, and tenable questions for future research. It has taken seven years of research and immersion in two distinct mental health care systems (Cuban and Canadian) as a psychiatrist to be able to construct meaningful objectives for the global mental health agenda – the ones that I have explored in this study:

1. **How do globalization processes influence or affect the care immigrants receive in Canada from the perspective of the population receiving mental health services and also from the mental health systems providing these mental health services?**

2. **Can looking at the social determinants of health from the perspective of the Latin American community help develop a global mental health perspective that takes into account systemic barriers and pathways to care in the treatment of depression?**
3. Can looking at health equity issues from the point of view of the Latin Americans in Canada contribute to an understanding of access to mental health services for this immigrant population in Canada?

4. Is the development of a culturally-adapted psychotherapeutic intervention enough to address issues of culturally appropriate mental health care?

Only question four can be confidently answered at the current level of mental health discourse. The answer is definitively not enough. So what do we do about it?

Figure 3 provides a schematic representation of the issues explored in this dissertation, situating the central arguments and questions.
Given that we know the globalization processes like mass migration of people, transfer of knowledge, transfer of ideologies, neo-liberal policies, free markets, etc that affect us all.

Given that we know that there are parallel processes of globalization that act at different levels creating different situations in different countries that react depending on their economic power or ideologies, we have:

**we have that:**
- Psychiatry is not immune to globalization processes
- In Canada there is a harmonization or universalization of diagnosis that leads to universalization of psychiatric treatments
- Psychiatric treatments in Canada are claimed to be evidence-based
- Hence there is a production of individual commodities of
  
  *meds and psychotherapy treatments including CBT for depression*

**on the other hand:**
- In Canada there are populations in need for specialized mental health services: i.e. immigrant populations
- Immigrant populations are currently receiving standard treatments (meds and psychotherapy) that were developed and tested for Canadian or US born White populations assuming a "one size fits all" ideology
- Evidence-based treatments in Canada are not culturally adapted to other ethnic groups
- These solutions or treatments do not take into consideration globalization processes

**hence the problems posed in this dissertation:**
- What do we do to decrease the impact of globalization and social determinants of health to provide equitable mental health to populations in need?
- What do we do here in Canada to maximize an individual commodity such as CBT and how can the community try to maximized the benefits of this individual intervention?
Indications of the Impact of Globalization on Spanish-Speaking Latin Americans

In our reliance on the science of psychiatry are we losing the art of psychiatry? If there are no biological markers, only theories that for the most part disregard culture, *how strong is the science behind psychiatry?* How reliable are we as experts if we only base our *expert* opinion in the science of the DSM system or the biomedical model of psychiatry in Canada without taking into consideration the *social determinants of health*, which are based on strong and rigorous science?

My reflection in action as a psychiatrist informed about the forces of globalization has helped me to understand why Latin American patients in my own practice, and most participants in the CA-CBT study, tend to refuse medications for the treatment of their mental health conditions. The concepts of *colonialism* in medicine are alive here in our own backyard. The *medicalization of human suffering*, strongly influenced by the biopsychiatric model, excludes the social causes of disease and uses an individualist approach to the management of mental illness. This approach does not fit the *collectivist worldview* of Spanish-speaking Latin Americans and other immigrant groups such as the people from the Caribbean and Africa.

Immigrant groups in Canada may bring with them their own explanatory models of mental illness as well as their own ways of healing using a collectivist approach whereby mental illness is a family and community matter, not an *individual* matter. At least 80% of my patients refuse medication treatments unless they have very severe symptoms and substantially diminished functioning. After I conduct a psychiatric assessment and propose pharmacological treatments, the typical sentiments is, "You know what doctor? I want to try to get better on my own before trying any meds".

My positionality as a psychiatrist attending to Latin American patients in Toronto places me in a privileged position of trust where I can listen, take action and reflect actively. For example,
most of my patients are female immigrants and refugees, who have been raped at one point in time in their lives, have suffered violence by their own parents or partners, or have experienced loss in the form of their loved ones being murdered in horrendous ways. How can I tell these patients that their problem is a "chemical imbalance" and not the result of severe loss and trauma plus the social conditions in which they live characterized by profound poverty?

With the medicalization of human suffering, it has become too easy for mental health practitioners to provide a diagnosis of Posttraumatic Stress Disorder (PTSD). Not everyone who has suffered a traumatic experience will meet the clinical threshold for this diagnosis; there are many factors that influence the development of such psychopathology such as family psychiatric history, previous psychiatric conditions, personal coping resources, social support, etc.

For example, one of my psychotherapy patients is a refugee, welfare recipient, and a trauma survivor; I also see her teenage daughter who was raped in a refugee camp in Ecuador. As she can only afford one public transportation pass (costing $126 dollars per month) for her entire family, she attends her psychotherapy session in the morning and then gives the transportation pass to her daughter to attend an afternoon psychotherapy session. What is interesting is that in spite of symptoms of post-traumatic stress disorder in both the mother and daughter, they function extremely well considering the level of trauma they have suffered. They attend English as a Second Language (ESL) classes every day, tend to their basic needs, attend church, socialize, participate in psychotherapy, tend to self-care and household maintenance, abstain from drugs and alcohol, and have never had more than fleeting suicidal thoughts.

My patients’ traumatic experiences are similar to my own experience of having many close family members disappear, tortured and killed during the persecution of my family in El Salvador. Of course, I felt (and still feel) sad, have experienced occasional nightmares, and could not sleep
with the lights off for five years after arriving in Canada out of fear that my daughter and I would be kidnapped, raped, tortured and killed. Was this reaction abnormal or pathological, or an ordinary reaction to an extraordinarily traumatic experience? Although I have never seen a counselor, therapist, or psychiatrist in my life, I have remained high functioning and the symptoms remitted over time and with improvements in my social determinants of health in Canada.

There is likely some aspect of personal coping resources, natural ways of healing, religious faith or beliefs that actually help a person remain functional in the wake of severe trauma. Even fatalist-catholic views can be protective, especially for me when I tell myself that "it was God's will that all these bad things happen to my family because my fate was to become a psychiatrist one day in Canada to help others that have suffered like me." This fatalist perspective is common in the Latin American culture and, even though is not instrumental in CBT and is actually not helpful in CBT, it may help activate a recovery-oriented path by supporting the process of acceptance and by reinforcing the positive aspects of the personal transformation that accompanies trauma.

CBT is not the only treatment that makes sense to Spanish-speaking Latin Americans. There are other treatment options that are not evidence-based that may be consonant to Latin American culture, such as interpersonal psychotherapy and the innovative treatments for people with severe mental disorders developed in Cuba. The next section sheds some insights into these other innovative treatment forms that are not within the reaches of globalization and are not part of the larger scientific literature typically referenced by psychiatrists practiced in Canada.
The Practice of Psychiatry in Canada and Cuba: The Impact of Globalization and Marginalization on the Practice of Psychiatry

One of the distinguishing features of this body of work is my immersion in the very processes that are at the heart of the research questions – the impact of globalization on mental health service delivery and the appropriateness of culturally adapted psychological treatments. By virtue of the process of becoming a psychiatrist in Canada, I have become closely aware of the scope of psychiatry in treating immigrant and refugee populations. My involvement in a number of medical projects in Cuba has also allowed me to become closely acquainted with the delivery of psychiatric interventions in Cuba. Although Canada and Cuba occupy the extreme ends of the income category continuum (i.e., high income versus low income, respectively), both countries show some of the best health care indicators in the world.

Cuba’s health care system is similar to the Canadian health care system in one fundamental way – they are structured based on the premise that health care should be universal, accessible and free for all. However, the current Canadian government touts capitalism, an approach that is economically aligned with the predominantly biomedical model of psychiatric practice. The Cuban government, on the other hand, supports communist ideology and has actively resisted the forces of globalization since the US embargo began following the 1959 Cuban Revolution (Spiegel, Labonte & Ostry, 2004; Spiegel & Yassi, 2004). Despite limited access to the newest medication or technology, Cuba has a very strong primary care health care system with great vertical and horizontal integration and a surplus of psychiatrists, psychologists and other mental health professionals. The slow transfer of medical knowledge, a byproduct of the US embargo (along with freedom from the hegemony of market forces that promote “commodification”), has created space for the development of innovative psychosocial treatments to treat people with mental
conditions through *music therapy* and *sports therapy* in both psychiatric facilities and the community. However, there is *little data available* concerning what appears to be working in Cuba, which can be mostly attributed to poor availability of funding resources for local researchers to conduct efficacy trials, which tend to be costly, and to support the dissemination of their research beyond Cuba (e.g., publication in high impact-factor journals that primarily publish in the English language). National and local Cuban doctors have immense work demands for a salary of $20 dollars per month, just like anyone else on the island. In order to publish, they require affiliation with academic institutions like universities, internet access, access to scientific journals mostly published in English, information about state of the art methodologies and, of course, the resources to actually conduct the effectiveness trials. This level of research support is scarce, at best, in this low-income communist country.

The lack of scientific evidence for the effectiveness of *innovative* programs is not only characteristic of Cuba but also most *indigenous programs of* Latin America and Africa. In the case of foreign researchers like Spiegel, Yassi, me and others, conducting research on the island can be halted at any time because of previous negative experiences with US researchers, the portrayal of the findings in the media, and for security reasons. However, from the few yet methodologically rigorous research studies conducted by Spiegel and others, we can summarize the differences and similarities between the practice of psychiatry in Cuba and Canada as shown in Figure 4.
Figure 4. The Effects of Globalization (and Marginalization) on Mental Health

CUBA

very low degree of integration with globalization
low-income country
communist ideology
socialist health care system (universal and free for all)

relatively small gap between rich and poor
different social determinants of health

collectivist approach to mental health
(patients, families, neighbors, community, political organizations, women organization, ministry of education, ministry of culture, and other ministries).

approach to mental health includes action on social determinants of health

great emphasis on health promotion, disease prevention and early detection and treatment of mental illnesses

world literature in English from the US is almost non-existent, at least is not available to students and professors of psychiatry

Having their own diagnostic system, mostly ICD based but culturally adapted: "glosario de psiquiatria cubana".

decrease availability of technology (Electroconvulsive Therapy) and pharmaceuticals to treat mental health patients leading to the

development of innovative treatments in psychiatry (music and sports therapy) and other psychosocial treatments

CANADA

very high degree of integration with globalization
high-income country
capitalist ideology
socialized health care system (universal and free for all)

present and increasing gap between rich and poor
social determinants of health are a prominent public health concern

individualistic approach to mental health

universality of psychiatric diagnosis based on DSM IV system
universality of psychiatric treatments especially medications and electroconvulsive therapy
psychiatric treatments are based on biomedical model
biomedical model is based on evidence-based treatments only

ideology of treatments in psychiatry in Canada is heavily influenced by the world literature that is in its majority English literature
most world literature (scientific journals) come from the US
heavily influenced by pharmaceutical companies
heavily influenced by scientific conferences (APA, CPA) where the official language is English and attendees are English speaking psychiatrists
The field of psychiatry needs to reflect and learn from what we know of the Cuban experience (e.g., Collinson & Turner, 2002; Cooper, Kennelly, & Ordunez-Garcia, 2006; De Vos, De Ceukelaire, Bonet, & Van der Stuyft, 2008; Dresang, 2005) and other low income countries’ experiences in treating people with mental health problems. An unintended outcome of the marginalization of Cuban medicine from the international scientific community has been the willingness of the Cuban medical establishment to develop and implement local innovations in treatment such as music therapy and sports therapy (Oliva & Fernandez de Juan, 2003 2006; Paraza & Zaldivar, 2003). According to personal communications with Cuban colleagues, psychiatrists in Cuba have developed their own therapeutic interventions that are similar to CBT as well as other psychotherapies. Although there is little record of who is doing what kind of psychotherapy, with what patient population, and where, there are talks about conducting a national survey to address these questions. Ironically, in the controlled economy of Cuba, psychiatrists have flexibility and are not tied to standardized treatments designed for a homogenized global culture; by contrast, Canada’s acceptance of a free market economy has set the stage for increasingly restrictive and prescriptive mental health care services that do not meet the mental health needs of migrants in this era of unprecedented globalization. Cuba's emphasis is on primary care -- that is health promotion, disease prevention and early treatment as explained in detail in chapter 2. They do this together, with families, neighbors, political associations, and the different ministries (e.g., health, education, etc.) which represents a truly ‘collectivist approach’ to health care.

In sum, Cuba does not need to culturally adapt the treatments they are currently pursuing because they already do what is culturally consonant with their culture, logical and within their budget or available resources. They capitalize on what they do best: music and sports. Basically they do what makes sense with what they have, resulting in programs that are innovative and
inexpensive. For instance they use dancers, musicians, drama teachers, and school teachers to volunteer in rehabilitation hospitals, community centers and even centers for the "people of the third age" (i.e., senior day care programs).

Yet, Cuba is not a paradisiacal island where everything is right and equitable. Cuba still has its fair share of social ills such as accusations of human rights violations, prostitution (also called "jineterismo"), housing inequality, abuses of power, government corruption, and racism despite the prevailing socialist-communist ideologies. But, the practice of psychiatry in Cuba provides an interesting example demonstrating the efficacy of an equitable practice of psychiatry, and as such provides a valuable experience that unfortunately is not being adequately appreciated in world knowledge. In Cuba, psychiatry emphasizes equity, taking action on social determinants of health, and innovating rehabilitative treatments for people with mental conditions, relatively independent of pressures to commoditize services with regard to proprietary pharmaceutical industry or professional interests.

Where Does CBT Fit in Global Mental Health?

Global mental health considerations are now more important than ever in conversations about mental health care delivery in Canada, as the mental health needs of immigrants and other vulnerable populations seem to be increasingly at odds with Canadian health policy, and as millions of people migrate to and within Canada (Kleinman, 2003; Kirmayer et al, 2011). Recently, the Canadian government announced that refugee claimants will no longer be able to receive vital, basic services like prenatal care, vaccinations for their children, or treatment for tuberculosis in order to cut health care costs. These changes took effect June 30th, 2012 (Citizenship and Immigration Canada, 2012) and are anticipated to bring about a public health catastrophe that will
likely cost the Canadian government and taxpayers more in the long run, not to mention depriving legitimate refugees of what Canadian society has deemed as a basic human right. Such changes to health policy beg the question – can free-market driven health reform be moral?

One of the major challenges that we are facing in Canada, as in other high income countries that receive immigrants and refugees, is meeting the needs of diverse people. There is a pressing need to discover how we can make these new homogeneous practices meet the needs of diverse populations. Cultural adaptation is necessary not only because the migration has created a diverse Canadian population but also because the practice of psychiatry in high income countries has become one size fits all. What is good for mainstream, White, Canadian-born individuals is presumed to be the gold standard treatment for all. People from non-European countries (e.g., African, Latin American, South East Asians and Caribbean) are being treated with psychotherapies created for populations of White, European descent, without any sincere consideration of cultural values, belief systems, language or the influence of therapist-client racial or cultural dissimilarity on the therapeutic dynamics and the social determinants of health that they experience.

Social determinants of health were central in the content of CBT, especially social support, family separation, inclusion and exclusion (racism and discrimination) in the Canadian society as explained in the results chapter. For Latin Americans social support is extremely important not only in the development of depression but also in the treatment of depression. In other words, for Latin Americans to be socially isolated can be devastating because it is one of the most important values and beliefs in the Latino culture, as explained before.

This was later confirmed when analyzing the data. For example, in the results chapter, the people who attended group therapy requested more sessions as they seem to have greatly benefited by the socialization aspect of CBT. This provokes reflection as to what actually worked in CBT.
Was it the cultural adaptation, *per se*, or also was it that we inadvertently addressed social isolation, family separation and social exclusion with CBT? Is this a therapeutic way to address painful social determinants of health, especially social isolation? Is this the ingredient of CBT that made the difference? By talking during the sessions about the experiences of migration (the central topic for all the participants) with a therapist who was actively listening, was not judgmental, was empathic and compassionate, and who facilitated the participants an opportunity to reflect themselves onto others and validate their feelings together in a group, did this promote social cohesion and social solidarity, an element so important for this particular population?

This takes us back to the initial question -- how can we do things differently? How can we apply principles of global mental health that include social determinants of health like social support to address these new paradigms? The over-riding question for this dissertation is, “*Can applying a global mental health perspective contribute to more culturally appropriate mental health care?*

The evidence for a need to move psychiatry toward a global mental health perspective is clear and undeniable for low, middle and high income countries alike, including Canada, the US and European countries that receive immigrants and refugees. Although a consensus on the definition of ‘global mental health’ still has not been reached, the conceptualization offered in this dissertation shows that the working definition offered by Patel and Prince (2010) is indeed viable:

*Global health is “an area for study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide”* (Koplan et al., 2009). Global mental health is the application of these principles to the domain of mental ill health (p. 1976).
Global mental health can have a very individual meaning to every psychiatrist involved in this kind of work. Using their *positionalities and reflection in action* these clinicians and researchers will add their own contribution to both research and clinical practice, especially when providing mental health services to immigrants and refugees in Canada. The key word of this definition is *equity*. For me, equity means that everyone, independent of their position on the socio-economic gradient, sex or gender, skin color, race, ethnicity, education, employment, language of preference, country of birth, place of residence, immigration status and disability status, should receive the same quality of health care as anyone else in this country.

By linking globalization processes to mental health outcomes on Spanish-speaking LA immigrants in Canada, I am examining health equity issues through a global mental health perspective; *the consideration of social determinants of health is an outgrowth of this process*. This perspective is necessary for the achievement of better mental health outcomes in this fast growing, very young and potentially productive Spanish-speaking Latin American population in Canada.

Recently, Toronto Central LHIN became a model for the operationalization of this approach, having outlined a direct and actionable approach to reducing health disparities or inequities by: identifying and reducing barriers to services; targeting investments to disadvantage populations; building equity, diversity and gender analysis into all service planning and delivery; focusing on *primary care* and chronic care; and, building cross-sectoral collaborations to address *social determinants of health*. The disadvantaged populations that are targeted are “immigrants or people that face language or cultural barriers to access health, homeless people, people living with diabetes and other chronic conditions from less advantaged social and economic positions, etc.” (pg. 14).

The CA-CBT protocol for Spanish-speaking Latin American immigrants in Canada meets these targets, by providing a *culturally adapted, locally developed therapy based on scientific*
evidence, where the patients or the or the community have been part of the process of creating them as priorities and as interventions that can actually make a change in mental health outcomes (Collins et al., 2011).

While these principles, consistent with the global mental health perspective, were the driving force to culturally adapt CBT, there were also reasons pertinent to the population of interest -- in this case, the Spanish-speaking Latin Americans living in Canada. CBT had been previously adapted for Latin American populations in the US (or US people of Hispanic origin as they refer to themselves), which facilitated the process of adaptation and also provided benchmarks for comparison. Although there are few studies examining the effectiveness of CBT or culturally adapted variants of CBT for depression among Latinos or Hispanics in the US, much of the available research utilized rigorous methodologies that suggest CBT-based methodologies provide improved symptom relief compared to placebo or other treatments. In other words, the active ingredients of CBT seem to be effective for the treatment of depressed Hispanics in the US. This was an important consideration in gauging the feasibility of incorporating culturally adapted CBT in the existing Canadian mental health system. In Canada, CBT is a first line treatment for depression (Parikh et al., 2009). Furthermore, CBT is a manualized treatment; the manuals can be used to train people in the community that are not necessarily psychiatrists or psychologists. Risks of this therapy are also minimal, especially as compared to medications.

Other compelling reasons to culturally adapt CBT include research findings that suggest Latinos or Hispanics prefer short-term therapies that are problem-oriented, and that CBT may be de-stigmatizing because it feels like a classroom experience (Organista & Munoz, 1996). Interestingly, US researchers faced challenges keeping patients in therapy (Bein, Torres, & Kurilla, 2000). In the CA-CBT study in Toronto, all participants completed the treatment and all requested
more sessions as they felt that the length of treatment was too short to deal with all the concerns that they had.

That being said, the dissemination of CBT may be perceived as a classic example of a commodification. CBT is now available around the world not only for the treatment of depression but also for psychosis, anxiety disorders such as PTSD, panic disorder and OCD, and even for weight loss. CBT is quite acceptable to the medical establishment and is lauded as the therapy of choice, especially in conjunction with medications. Psychiatrists usually adhere to and follow the clinical guidelines for the treatment of mood disorders developed in the US, Canada and the UK, which currently indicate that CBT is as effective as medications alone for the first-line treatment of mild to moderate depression.

If one thinks of psychiatry as a business, there is a fertile market for CBT. Payment for CBT can be arranged through insurance companies or individual payers. CBT can also be exported to other markets where these illnesses exist at high rates, especially to low income countries. This is an issue that warrants continued reflection. Certainly, when the CA-CBT study was envisioned, economic reimbursement for the therapy was never a consideration. On the contrary, funding of CA-CBT is the next step or, perhaps better said, the next barrier. The actual question is who is going to pay for this? What hospitals or what government agency will pick up the cost and for whom?

Culturally Adapted CBT: Building on Findings from the Secondary Data Analysis

The results of the secondary analysis of the pre- and post-development CA-CBT focus groups were rich, bringing to light the great potential as well as limitations of CA-CBT for the Spanish-speaking Latin American population in Canada. As revealed in the focus group discussions, the cultural adaptation of CBT for Spanish Speaking Latin Americans in Canada was a
worthwhile endeavor leading to improved self-reported mental well-being of participants. Participants highlighted the importance of having a Spanish-speaking therapist and therapists who understood their culture, customs and practices. Given what we know about the importance of culture in shaping our experience of mental illness and treatment preferences (Bass, Bolton & Murray, 2007), CA-CBT offers valuable tools for treating depression in Spanish-speaking Latin American populations. At the same time, participants offered important insights into the limitations of CA-CBT when only culture is taken into account. The research participants’ experiences spoke to the need for CA-CBT to move beyond merely addressing culture by also targeting the social determinants of health like income and social status, social support networks, employment/working conditions, migration, social environments, health services and gender. In other words, CBT needs to not only be culturally adapted but also socially adapted, to account for the social determinants of health.

What emerged from the focus groups discussions was that, for Spanish-speaking Latin American immigrants and refugees in Canada, a culturally appropriate adaptation of CBT necessitates the recognition of a health equity framework. Addressing culture and language without acknowledging and addressing the deep social inequalities, such as poverty, poor work conditions, time and cost of therapy, location of therapy, gender of the therapist and social isolation (group versus individual psychotherapy) that immigrant and refugee populations encounter, the therapy will not go far in treating and preventing mental health problems of Spanish-speaking Latin Americans. The data from this study illustrates that these barriers go beyond any “cultural” attitudes toward therapy that prevent Spanish-speaking Latin Americans from seeking and staying in care. In fact, when asked what helps individuals overcome depression, psychotherapy was the number one participant response (16 references). Furthermore, in the feedback received from those
who underwent the CA-CBT treatment for this research, participants requested *more sessions*, as previously mentioned. In other words, there was a desire on the part of participants for ongoing therapy. Thus, it is not a lack of desire that prevents Spanish-speaking Latin Americans from seeking care, rather the numerous other obstacles they encounter.

Reducing and eliminating barriers for receiving mental health care such as language, culture, gender, transportation and financial barriers, and provider location are among the measures that could be taken to begin to more adequately address the *social determinants of mental health* for Spanish-speaking Latin Americans in Canada. Given that Spanish-speaking Latin Americans are one of the fastest growing immigrant populations in Canada, and also one of the groups with the highest levels of stress, CA-CBT has enormous potential.

In a multi-ethnic city like Toronto, access to culturally-sensitive mental health services for diverse populations that is patient-centered and community-developed goes far in beginning to address the mental health needs of immigrants and refugees. However, as much as cultural adaptation of therapies including CBT may promote better mental health outcomes for Spanish-speaking Latin Americans in Canada, cultural adaptation alone *is limited*. As presented here, the perspectives of the Spanish-speaking Latin American research participants themselves underscore the importance of incorporating the other social determinants of mental health into the process and content of CBT.

Finally, in addition to reducing and eliminating obstacles to mental health services, promoting health equity for Spanish-speaking Latin Americans will entail *policy-level changes* aimed at improving the social and living conditions of immigrants and refugees in Canada. Reducing income, educational, work and housing disparities and facilitating family reunification will go far in promoting the mental health of Spanish-speaking Latin Americans in Canada. In
other words, CA-CBT seems to be creating space for Spanish-speaking Latin American immigrants to talk about their immigration experiences, the hardships they and their families face or the social isolation they seem to fall in to and the social conditions in which they live. Talking about these lived experiences, especially in the group psychotherapy setting that seems to validate their feelings and decrease the sense of solitude (a word used as a synonym for depression), increased the perceived availability of social support, and fostered solidarity. The therapy setting was likely a safe, familiar place to retreat from the acculturative stresses of larger Canadian society, which sits in stark contrast to much of Latin American culture including food, climate, language, values, modes of relating to each other, worldview, help-seeking, and ways of healing. However, the therapy did not directly address the social determinants of health and is no "magic bullet''.

Was the Cultural Adaptation of CBT enough?

Having conducted a three-year study in Toronto from 2008 to 2011, many of my initial concerns about the impact of the social determinants of health on the mental health of the Spanish-speaking Latin American immigrant and refugee population living in Toronto were corroborated. The voices of the community fully validated what we already know about social determinants of health for Latin Americans, their pathways to care, barriers and access to care and what treatment approaches may be more acceptable to them (i.e. culturally appropriate psychotherapy interventions versus medications or standard CBT).

However, it came very clear that this newly created tool (i.e., CA-CBT for Latin American immigrants in Canada) is not enough to improve the mental health outcomes of common mental disorders like depression and anxiety at a primary care level. While it is definitely an improvement on the treatments available for this population, the issues surrounding the provision of mental health services for ethnic minorities in Canada are complex. It makes absolutely no sense to provide
state-of-the-art psychological treatments for depression, for example, to a Spanish-speaking single mother of three, coming to Canada as a refugee from Colombia, living in poverty, separated from her family, uneducated, feeding her children from food banks because the welfare check is not enough, with a previous history of physical and sexual assault in a domestic context. Adding medications to her regime and or CA-CBT can be helpful but, again, not enough.

Until Canada takes action to address the social determinants of health and situations that arise because social determinants of health like inadequate and unsafe housing, transportation (e.g., subsidy for public transportation, because currently social service recipients take money from their food budget to afford tokens to get to doctors’ offices and to English school), food security, family reunification, child care, decent employment according to qualifications, improved ESL language lessons, and better access to specialized mental health services, no psychotherapy or pharmacotherapy will have a therapeutic effect on their mental health.

Spanish-speaking Latin American immigrants often speak about what it is like to be in Canada: feeling safe but alone without their families; living in poverty in dangerous neighborhoods where shootings and drug dealing happens every day; struggling every day to make the welfare money cover food and the transportation expenses; and going to "cash work" in cleaning and construction with employers that pay them cash for work that Canadians would never do without the proper training, safety equipment, union membership, and health benefits. For these reasons, the health system-wide promotion of a clinical tool for the treatment of depression, even if it has been culturally adapted for this population, will likely amount to nothing more than a "band aid solution" to this serious health system gap. It will be necessary to also address the social determinants of health among diverse Canadian populations, including immigrants and refugees, in conjunction
with other pertinent ministries (e.g., Social Services, Ministry of Education, Canada Immigration and Citizenship, etc), like Cuba does.

Currently, Canada is ill-prepared to provide equitable, culturally appropriate, patient-centered interventions to its immigrant and refugee populations. Tremendous social gradients and income disparities exist alongside health inequities. We can actually pinpoint the areas where immigrants cluster and live in the US and Canada through geographical and sociological studies (CUCS, 2007; Toronto Central LHIN, 2008). These areas are characterized by poor housing, high crime rates, high rates of drug trafficking, poor transportation, and high rates of domestic violence, etc.

**The importance of the social and cultural adaptation of CBT**

CBT offers patients empowerment through the promotion of active acquisition of coping skills. CA-CBT had the added benefits of facilitating a *sense of available social support*, or *collective effort*, which was especially important for immigrant patients who often suffer from social isolation in Canada. The results further suggested that CA-CBT in group format helped to generate a *sense of social solidarity and collectivism* among the participants. For Latin Americans accustomed to living in collectivist societies with neighbors, family, friends, etc. coming to Canada and having to get accustomed to living often in social isolation, separated from their families and friends, can be detrimental for their mental health. The standard delivery of CBT in group formats in Canada discourages the development of relationships (outside of therapy) with other members of the group. We ask them not to give their phone numbers or last names to protect privacy and to keep limits and boundaries very clear. As a psychiatrist who has worked in psychiatric hospitals for 8 out of 10 years of my practice, many times I have felt that we are not supposed to be *human or appropriately social* in psychiatry because of the potential problems that may arise if a patient
complains to the College of Physicians and Surgeons. However, as a Latina psychiatrist having practiced with and recruited Spanish-speaking Latin Americans for research studies, I attest that Latin Americans are quite expressive and very affectionate; this is part of the culture. Maintaining *rigid boundaries and an emotionally distant therapy* stance is not going to be received well with this population. Compassion, empathy, and practicing *simpatia* is one of the cultural ingredients in the adaptation of CBT for Latinos.

Without stereotyping, the socialization aspect of Latin American culture helps to foster *socioemotional connectedness*, which can also carry a lot of weight when establishing the *therapeutic alliance and is of great importance at different levels in the therapeutic process*. The connectedness between therapist and patients (and between patients in group therapy settings) likely accounts for most of the *healing process* in culturally adapted CBT. This therapeutic process is culturally consonant and resonates powerfully against the backdrop of adjustment to Canadian individualistic societal values and migration-related stressors such as family separation and family disintegration.

If we could open up our rigid British medical rules of conducting CBT with zero socialization we could maximize the therapeutic effect of CBT in Latinos in Canada. For example, in Cuba, psychiatrists provide affectionate and compassionate care to patients in a way that is culturally consonant, trust-instilling, healing and de-stigmatizing for the patient. The ease in which they do so suggests that the interpersonal relationship orientation has been untouched by *harmonized, and globalized practices of psychiatry*. Cuban psychiatrists actually do what makes sense from a moral or a humanitarian perspective and without the fear of being sued by patients.
Recommendations for Future Research

This dissertation has produced *new areas of inquiry* at different levels. For example, at the global mental health level, how has the practice of psychiatry (i.e., diagnosis of mental illnesses, treatment offered to patients, medications prescribed, different psychotherapy modalities) been influenced by the pressures of globalization? Is this a matter of power and the ideologies of people who benefit from the new markets created for pharmaceuticals? What is it that *the ‘treatment gap’ is really measuring – an actual gap in treatment for people suffering from psychiatric illnesses in low and middle income countries, or is it measuring a gap in commodified treatments for people suffering from psychiatric illnesses*?

Can we consider traditional healers, priests, shamans, counselors, etc. as options for the treatment of common mental disorders like depression, anxiety, alcohol abuse and dependency? If so, do local and global treatment gaps also exist for these treatments? We know from the CA-CBT study that Spanish-speaking immigrants will consult a natural healer, social worker, ESL teacher, and even the massage therapist before consulting with a doctor or a psychiatrist. To date, there is no available data as to the mental health outcomes of the people that sought and received treatment from these other sources. We have no idea if these community resources are effective in decreasing symptomatology and increasing levels of functioning in those affected. How can the discipline of psychiatry cultivate a more *balanced practice* that takes into consideration the important role medications play in the treatment of severe mental illnesses but also respects the local cultures of people around the globe and the treatments they have deemed effective despite the absence of a scientific evidence base? This is a new area of inquiry that can be explored right here in Toronto and in low-, middle-, and high- income countries alike.
The two opposing debates presented in this dissertation leave me with more questions and ideas for future research. Has the cross-cultural validity and reliability of the DSM-IV, developed for English-speaking Western populations (see Chapter 2), been absolutely established? Is there any certainty that depression symptoms in Canada have exactly the same clinical presentation as depression in El Salvador? Given similar symptom presentations, will the same treatments for depression in Canada effectively treat a person in El Salvador who is depressed? Does it work like a heart attack? Heart attacks indicated by clinical symptoms but confirmed by an electrocardiogram and blood test (i.e., troponin) present similarly in Canada as they do in any country; the treatment for heart attacks is equally as effective in any countries. Perhaps this is an area for future investigation because mental illnesses are not analogous of physical illness. Even if mental illness can be localized to the "brain", they are diseases of the "mind" and depend on a number of factors like childhood experiences, culture, ethnic background, personal coping resources, social support, resiliency, personality, problem-solving abilities and many others.

Especially in the context of the social determinants of health, these "mind diseases" may respond differently to treatments depending on the cultural resonance of these interventions among other things. Perhaps this question is more applicable to depressive conditions and states of grief than schizophrenia or bipolar illness that certainly have more clear biological markers.

With regards to the cultural adaptation of psychotherapies, this dissertation also raises questions about globalization and globalization of psychotherapy treatments. For example, how can one psychological intervention effectively treat a range of difficulties around the world, when it is not culturally adapted?

There are further questions stemming from the local feasibility study of CBT presented in this dissertation. How can the effectiveness or efficacy of CA-CBT for depression developed for
Latin American immigrants be tested? Was CA-CBT effective or efficacious in decreasing the symptoms of depression among pilot study participants because it had culturally adapted the ‘active ingredients’ (e.g., cognitive restructuring, behavioral activation) of CBT or because it fostered social support, empowerment, and validation of lived experiences? Or was it the power of ‘desahogo’ (or getting things off one's chest) referenced by the participants? What components of the culturally adapted content (e.g., topics of interest to the patients like social exclusion, racism in Canada, living in poverty, family separation, language barriers, parenting challenges, difficulties in their workplace and immigration status or upcoming refugee hearings) resonated best for which patients? What is the relative contribution of core CBT interventions and the experiential component of CA-CBT to CA-CBT treatment outcomes? Finally, who may be making better use of CBT? Latin Americans who are more acculturated with higher levels of education and English proficiency? CBT requires a great deal of recording thoughts, emotions and behaviors, and many hours of practice and homework between sessions. Should CBT have different levels of intensity according to patients capacities based on different levels of education and acculturation and capacity to practice and do the homework?

The CA-CBT initiative discussed in this dissertation was no more than phase one. Phase two will involve an evaluation of the effectiveness and the implementation of this culturally adapted psychotherapy in a broader scale.

Discussions of next steps raise some pragmatic questions. Can this treatment be provided by therapists trained in CA-CBT who are not psychologists or psychiatrists but who are compassionate, have a good understanding of CA-CBT principles, are culturally competent and who understand patients’ issues related to adjusting to Canada?
Moreover, can we use information and communication technology to address barriers to care or social determinants of health to deliver culturally adapted psychotherapies across Canada? Is online CA-CBT or telephone CA-CBT a viable and health-equitable option to remove barriers like transportation, child care, and therapy location (at home versus at a psychiatric hospital)?

Can CA-CBT be a template to address mental health needs to other immigrant groups in Canada and other high-income countries that receive immigrants? One of the hard realities in moving forward is acquiring the funding needed to address the needs of disadvantage populations.

The ultimate question is whether Canadians are willing to support the high health care standards and multicultural policies that this country is so proud of having, for the sake of immigrant and refugee populations? Why are we so willing to pay excessive cost for pharmaceuticals, but not for culturally-adapted psychotherapy?

**Recommendations for Policy**

The findings of this dissertation allow for several recommendations in the area of policy. First and foremost, the federal and provincial governments need to provide funding to address the prevention, health promotion and early treatment of mental illness in large ethno-cultural populations in Canada, in particular the Latin American population. Mood disorders have a major economic impact on society through associated health care costs as well as lost work productivity. In 2000, the economic cost of lost productivity due to depression in the province of Ontario, as measured by short-term and long-term disability days, is estimated to have been $8.8 billion (CMHA 2007). As this dissertation has argued, attending to the health of Latin American immigrants in Canada not only requires action within and financial support for the mental health sector, but also requires addressing the social determinants of health, for instance, reducing the wait times for new immigrants to receive health care, making housing and transportation affordable,
ensuring food security, creating programs for family reunification, recognizing credentials of immigrants and providing valuable work opportunities, having a venue to report workplace racism and discrimination in different languages, offering accessible childcare and afterschool programs for children, and making post-secondary education accessible to new immigrants and their children. Thus, the federal government should adopt a broader framework and invest more heavily in addressing social determinants of health.

It is also strongly recommended that the federal and provincial government provide funding to address the management of mental illness in the population through support of culturally appropriate services. At a provincial level, this could mean that the Ministry of Health and Long-Term Care and the LHINs increase their investment in community mental health initiatives in order to strengthen the capacity of primary care workers and specialized mental health providers to work with Latin American immigrants presenting with mental illness. Supporting the management of mental illness in the Latin American population means making both ‘mainstream’ psychiatric services and medication accessible to those who may need it and supporting culturally adapted treatments or ‘non-traditional’ culturally specific treatments that may be just as effective in treating mental health problems among Latin Americans.

Strengths and Limitations

A major limitation of this dissertation is that it was not possible to directly compare the mental health of Spanish-speaking Latin Americans in Canada and Cuba. This is due to the fact that the Canadian health system does not count Spanish-speaking Latin Americans in national mental health surveys, at least not in sufficient numbers; as such, it is not possible to estimate the prevalence of mental disorders in the Spanish-speaking Latin American population in Canada.
Similarly, Cuba provides rates of suicide to the WHO but these rates do not tell the picture of the mental health of the Cuban population either.

Another major limitation was that the CA-CBT study was essentially only a feasibility study; important questions about efficiency, effectiveness and generalizability could not be answered. However, this was not the aim of this dissertation. The aim was to understand issues relating to global mental health by conducting secondary data analysis from the CA-CBT study.

One of the main strengths of this study is that it is the first study of this kind to be conducted in Canada with a sample of Spanish-speaking Latin American immigrants. Most mental health research, including psychotherapy research involving Hispanic or Latin Americans has been conducted in the US with samples of *Hispanics or Latin Americans* living in the US. The US and Canadian contexts are extremely different, especially with respect to immigration policies, social services and access to health care services. These fundamental differences are factors that affect the mental health of immigrants in the respective host countries.

Other strengths included the use of culturally appropriate research methods and a mixed methods approach to the evaluation process. In addition, the initial seven focus groups were comprised of a representative sample of Spanish-speaking Latin Americans in Canada of varying ages, gender, migration histories, educational levels, countries of birth and ethnicities (e.g., aboriginal). Furthermore, the *cultural adaptation process* developed for the present study can also be used as a model for culturally adapting CBT for other common mental disorders like anxiety syndromes, or culturally adapting other therapeutic interventions.

It should also be explicitly noted that the undertaking of this study as an interdisciplinary Endeavour has enabled a more comprehensive consideration of the complexities that are integral to understanding mental health in an era of globalization. In particular, while attention has been given
to examining how health determinants are grounded in global forces, the inclusion of influences on how health services are themselves affect by these forces represents a more novel contribution that should be more systematically replicated in other studies.

In terms of limitations, despite great efforts, we were not able to recruit Spanish-speaking Latin Americans that self-identify as Black. Although we were not offered input as to reasons why they did not participate, the research team speculated a number of potential reasons why this segment of the Latin American immigrant population in Canada may be guarded about participating in the focus groups: trust issues (e.g., mistrust of dominant culture and institutions, mistrust of other people in the community), lack of interest in contributing to the community, immigration status (e.g., illegally residing in Canada), associating mental illness with weakness and avoidance of perceived stigma, negative attitudes toward psychotherapy, or belief in other interventions to treat mental health problems (e.g., spirituality, religion). The literature also indicated that the race of the investigators (i.e., White) and the country of origin of the research coordinators (i.e., Mexico) may have also contributed to distance between these communities and the project, as cultural mistrust of dominant culture and institutions and prejudiced attitudes toward Mexicans are not uncommon in these communities (Umaña-Taylor & Bamaca, 2004). Another limitation was that the participants recruited for the pilot testing were mostly from Mexico and Colombia and underrepresented people from El Salvador, one of the largest groups of Spanish-speaking Latin American immigrants in Canada.

Lastly, the pilot therapy group was composed entirely by men. Given the mixed literature on the gender composition of therapy groups, this circumstance could be framed as a weakness or strength. For example, it can be argued that therapy groups composed of women and men encourage a more expressive, less competitive interpersonal style for men but restrict the
interpersonal style of women (e.g., more submissive) (Burlingame, Fuhriman, & Johnson, 2002). Group psychotherapy for men also has the added psychosocial benefits of decreasing social isolation and validating the lived experiences of immigrants in Canada (e.g., feelings of distress associated with not speaking an official language, unemployment or under-employment, and loss of traditional roles in traditional Latin American families such as being the breadwinner of the family).

Implications of the Study

The most important implication of this study is the *health benefits of treating depression* early in the course of the illness. While the CA-CBT treatment may have side effects, they are similar to those of other psychotherapies. The most common side effects are the recollection of painful situations or memories during the sessions and, rarely, suicidal thoughts; these occurrences can be dealt with by the therapists who are well-trained and have the support of a health care team. These side effects are much fewer and are more acceptable to Spanish-speaking Latin Americans as compared to side effects produced by medications. If depression is treated while at a mild or moderate level of severity, the prognosis may be more favorable and the level of disability due to diminished functioning will be abated. This is especially important when dealing with young immigrant populations who have the potential to achieve optimal functioning if they receive mental health services early in the process of acculturation.

The CA-CBT manual is amenable to use in primary care settings. The settings may range from health care centers to hospitals with primary care clinics but can also be used in general hospitals and psychiatric hospitals that offer psychotherapy treatments to patients. This manual may also be used across Canada even though the field work was conducted in Toronto. The process of culturally adapting psychotherapy treatments can also be a model for culturally adapting other evidence-based clinical tools such as interpersonal psychotherapy. From a scientific perspective,
this is a very important implication because it stimulates scientific inquiry about what other treatments can be culturally adapted for our migrant populations in high-income countries like Canada. In line with the global mental health perspective, the cultural adaptation of effective treatments has significant international, clinical, and policy implications as it can be delivered in a number of settings and adapted to many cultural or geographical contexts.

Latin American immigrants are now part of North America, and an important segment of the population because they ultimately contribute to the economy and will have increasing political strength. Take the case of US Hispanics, a group larger than the total population of Canada, amounting to 55 million (or 80 million if accounting for ‘illegal aliens’) and representing the second largest minority group in the US. The Spanish-speaking Latin American immigrants in Canada are one of the five fastest growing groups of immigrants and represent a very young population with great potential to contribute to the Canadian economy, providing that they are in good health. These are moral and economic implications of this dissertation that I am hoping will stimulate a lively and active discussion among scholars, service providers, people in need of treatment and their advocates.
REFERENCES


consumers, family members, advocates, and service providers. *Community Mental Health Journal, 44*, 57–74. doi: 10.1007/s10597-007-9112-9


Appendix A: Recruitment Ad for Community Consultants

A Study of Culturally-Adapted Cognitive Behavioral Therapy for Spanish-speaking, Black Anglophone Caribbean and Black Francophone Caribbean populations in Toronto

A study is underway to test culturally adapted psychotherapies for people from the following communities in Toronto:

- Spanish-speaking
- Black French-speaking Caribbean
- Black English-speaking Caribbean

The psychotherapies are based on Cognitive Behavioural Therapy (CBT) a highly effective psychotherapy for treatment of depression and other emotional disorders. They have been culturally adapted to make them more suitable for people from these three communities. Cultural adaptation of the treatment involves making changes such as creating examples that are relevant to the specific communities, changing language to make it more easily understood, and adding exercises that are similar to familiar cultural activities.

Volunteers are needed to provide advice on, and review, the adaptations. You must be 16 years or older to participate and identify yourself as a member of one of the three communities.

If you would like to hear more about the study, please:

Call the Project Coordinator at (416) 535-8501 Extension XXXX

Or, write your name and phone number below and leave this form with your health care provider.

Name: ________________________________

Phone Number: __________________________
Appendix B: Information Letter for Community Focus Group

**Name of the Study:** A feasibility Study for the Development of Culturally Adapted Cognitive Behavioural Therapy for the Spanish-speaking, Black Anglophone Caribbean and Black Francophone Caribbean populations in Toronto

**Principal Investigator:** Akwatu Khenti 416-535-8501 x 6684  
**Collaborating Agency:** Centre for Addiction and Mental Health  
**Sponsor/Funder:** Citizenship and Immigration Canada

**Purpose:**  
The purpose of this study is to develop culturally adapted cognitive behavioural therapy (CBT) for the Spanish-speaking, Black Anglophone Caribbean and Black Francophone Caribbean immigrant populations in the Greater Toronto Area. CBT is a type of psychotherapy that has proven effective for the treatment of depression. Culturally adapting this therapy for different ethnic groups may make it more effective for people from those groups.

Volunteers are needed to provide advice on, and review, the adaptations. If you agree to volunteer in this study as a community consultant, you will be asked to participate in a focus group about the adaptation of the therapy.

Information describing cognitive-behavioural therapy and its cultural adaptation is attached to this form.

**Procedure:**  
Participants in the study to adapt the therapy will meet with interviewers and participate in a 2-hour focus group that will be audio-taped. After the interview is over, professional typists will transcribe the tapes so the project team can summarize the information.

All participants will be asked to fill out a short form providing some general information about themselves, e.g., age, sex, languages spoken, etc. This information will not be shared with anyone who is not on the project team.

**Eligibility:**  
All participants in the study must be at least 16 years of age and capable of understanding the study procedure so they can consent to participate. They must also be able to communicate in one of the three languages being used for this project (English, French or Spanish).

**Compensation:**  
You will receive compensation for potential expenses associated with your participation and you will receive TTC tokens to offset your travel expenses. For your participation in the focus group you will receive a $30.00 honorarium.
Benefits and Risks
Participants in the consultation interviews will not receive direct benefit but may feel some satisfaction from contributing to the development of culturally adapted therapy for people in their community.

Voluntary Participation
Your participation in any aspect of this study is voluntary. You may choose to withdraw from the study at any time without any consequences. If a member of the project team ends your participation in the study, you will be compensated for your participation up to that point. Your choice to participate, not participate or withdraw participation will not affect any services you receive at the Centre for Addiction and Mental Health now or in the future.

Additional Information:
You are free to ask any questions about the study or your participation in the study. Questions can be directed to the research coordinator or principal investigator named on the first page, or to any of these other members of the project team:

Dr. Kwame McKenzie 416-535-8501 x 2616; Dr. Carolina Vidal 416-535-8501 x 4442; Mr. Antoine Derose 416-535-8501 x 6904; Dr. Diane Whitney 416-535-8501 x 4241.

You may also contact the Chair of the CAMH Research Ethics Board, Dr. Padraig Darby, to discuss your rights as a research participant: 416-535-8501 x 6876.
Appendix C: Information Letter for Health Provider Focus Group

Name of the Study: A feasibility Study for the Development of Culturally Adapted Cognitive Behavioural Therapy for the Spanish-speaking, Black Anglophone Caribbean and Black Francophone Caribbean populations in Toronto

Principal Investigator: Akwatu Khenti 416-535-8501 x 6684
Collaborating Agency: Centre for Addiction and Mental Health
Sponsor/Funder: Citizenship and Immigration Canada

Purpose:
The purpose of this study is to develop culturally adapted cognitive behavioural therapy (CBT) for the Spanish-speaking, Black Anglophone Caribbean and Black Francophone Caribbean immigrant populations in the Greater Toronto Area. CBT is a type of psychotherapy that has proven effective for the treatment of depression. Culturally adapting this therapy for different ethnic groups may make it more effective for people from those groups.

Health professionals are needed to provide advice on, and review, the adaptations. If you agree to volunteer in this study as a health professional consultant, you will be asked to participate in a focus group, and/or key informant interview, about the adaptation of the therapy.

Information describing cognitive-behavioural therapy and its cultural adaptation is attached to this form.

Procedure:
Participants in the study to adapt the therapy will meet with interviewers and participate in a 2-hour focus group that will be audio-taped. After the interview is over, professional typists will transcribe the tapes so the project team can summarize the information.

All participants will be asked to fill out a short form providing some general information about themselves, e.g., age, sex, languages spoken, etc. This information will not be shared with anyone who is not on the project team.

Eligibility
All participants in the study must be at least 16 years of age and capable of understanding the study procedure so they can consent to participate. They must also be able to communicate in one of the three languages being used for this project (English, French or Spanish).

You must be a health professional with at least 5 years experience working with the population(s) of interest and using CBT methods.
Compensation:
You will receive compensation for potential expenses associated with your participation including TTC tokens to offset your travel expenses and a $50.00 honorarium.

Benefits and Risks
Participants in the consultation interviews will not receive direct benefit but may feel some satisfaction from contributing to the development of culturally adapted therapy for people in their community.

Voluntary Participation
Your participation in any aspect of this study is voluntary. You may choose to withdraw from the study at any time without any consequences. If a member of the project team ends your participation in the study, you will be compensated for your participation up to that point. Your choice to participate, not participate or withdraw participation will not affect any services you receive at the Centre for Addiction and Mental Health now or in the future.

Additional Information:
You are free to ask any questions about the study or your participation in the study. Questions can be directed to the research coordinator or principal investigator named on the first page, or to any of these other members of the project team:

Dr. Kwame McKenzie 416-535-8501 x 2616; Dr. Carolina Vidal 416-535-8501 x 4442; Mr. Antoine Derose 416-535-8501 x 6904; Dr. Diane Whitney 416-535-8501 x 4241.

You may also contact the Chair of the CAMH Research Ethics Board, Dr. Padraig Darby, to discuss your rights as a research participant: 416-535-8501 x 6876.
Q & A about Cognitive-Behavioral Therapy

What is cognitive behavioral therapy (CBT)?

Cognitive-Behavioral Therapy (CBT) is a research-supported psychotherapy that focuses on changing patterns of thinking (called cognitions) and changing the actions (called behaviors) that make people feel emotional distress.

For example, a person who is depressed may have the belief, "I'm no good to anyone" (the cognition) and, based on that belief, they may avoid their friends and family (the behavior), making them feel sad and lonely. Those feelings feed into the negative thoughts and make them continue avoiding people. It becomes a vicious cycle that makes them continue to feel bad. The cycle as described here begins with the thoughts, but it could just as easily begin with the sad feelings, or with the avoiding behavior.

\[
\begin{align*}
\text{I'm no good (thoughts)} & \quad \text{Sad and lonely (feelings)} \quad \text{Avoid everyone (behavior)} \\
\text{Sad and lonely (feelings)} & \quad \text{I am a good person (thoughts)} \\
\text{Start seeing people} & \quad \text{less sad & lonely (feelings)} \quad \text{(behavior)}
\end{align*}
\]

A therapist can help this person to challenge that belief and change their way of behaving so they start to feel better. More positive thoughts and changing behavior in a positive way will lead to more positive feelings. This is called therapy instead of counseling because the therapist has a clear set of procedures to follow during the treatment period. These procedures have been shown to help people reduce the symptoms of depression, anxiety and other mental disorders.
What does the therapist do and what do I do?

The therapist will talk to you about situations in your life that are causing you distress and ask questions to help you break them down into the thoughts and actions behind them. The therapist will work with you to help identify new ways of thinking and/or new behaviors that will help you feel better.

The client describes situations to the therapist and answers his or her questions so they can work together to figure out the existing thoughts and behaviors involved and new ways of thinking and behaving that could improve the situation. The client also uses time between the sessions to try out activities suggested by the therapist to help them feel better. This “homework” is very important to the therapy because practicing the new skills you learn and applying them in your daily life will help you get better and stay better.

You will work together to find ways of solving the problems you discuss. The therapist uses his or her expertise to provide you with information about what is causing your symptoms and what can be done to help you feel better. You help your therapist by providing your perspective about what is not working well and what is working well. This therapy works best by building on the strengths that clients have, and ways they know and can discover, to make themselves feel better.

Will I be in therapy for a long time?

CBT is typically delivered in 12-16 sessions held once a week, so you would be seeing the therapist for 3-4 months. Each session is one hour long.

In the early sessions you will be talking a lot with your therapist about the experiences you are having, but as you get into the treatment you will start to have a regular routine of reviewing the week and any homework you did, learning new information and skills to help you deal with your problems, and deciding together what will be your homework assignment for the next week.

Is 3 or 4 months enough time for me to get well?

CBT usually focuses on choosing one thing to improve over the 12 to 16 weeks. Usually improvements in one area lead to improvements in other areas. The therapist will also be teaching you skills to break down and solve your problems so you can use them on your own in-between sessions and after the sessions are finished.

Will I be expected to talk about my childhood or my family?

CBT is focused on what is happening with you right now and in your current life. If you think that something from your past helps explain what is going on with you now, it is fine to bring that up, but the therapy will focus more on the present than the past. As you talk about your situation your relationships with friends, family and others will probably come
up. You will decide with your therapist how much time you want to spend on such discussions and how you want to involve friends or family in your therapy.

**Do I have to take medication as part of my treatment?**

CBT is used alone and with other treatments. You may discuss taking medication with your doctor, but it is not required as part of CBT. You may also discuss other therapies with your therapist like meditation, nutritional changes, yoga or other exercise.
Appendix E: Demographic Form

The information collected on this form is only for the purpose of the study and will not be viewed by anyone outside of the project team.

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Address</td>
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<tr>
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<td>Daytime:</td>
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<tr>
<td></td>
<td>Evening:</td>
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<tr>
<td>Date of birth:</td>
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<tr>
<td>Sex:</td>
<td></td>
</tr>
<tr>
<td>Country of Birth</td>
<td></td>
</tr>
<tr>
<td>If applicable, country where you lived before coming to Canada</td>
<td>What year did you arrive in Canada? _________________</td>
</tr>
<tr>
<td>What is your first/preferred language?</td>
<td></td>
</tr>
</tbody>
</table>
Appendix F: Consent Form

Agreement to Participate

I, ___________________________________________ (name/initials) have read the attached form or had it read to me. All of my questions have been answered to my satisfaction. I understand that when I sign this form I do not waive any of my rights.

I agree to participate.

Signature: ______________________________________

Date: ___________________________________

Person obtaining consent:

Name: ______________________________________

Signature: ______________________________________

Date: ______________________________________

Appendix G: Focus Group Guide for Community Consultants

Introduction:
1. Prevalence of depression
2. Psychotherapy as a treatment for depression
3. CBT – evidence-based treatment
4. Seeking help with making CBT fit with what cultural groups think and know about emotional problems, issues faced by the community, ways they think about dealing with emotional stress

Content:
1. What words or phrases do people use to talk about having emotional problems?
   Probes:
   - What kind of experiences or feelings are people describing when they use those words?
   - Do people talk to their friends and families about those kinds of feelings?
   - Do people ever use the word depression – what does it mean to them, when would they use it?
   Facilitator: Use the words that come from the group in other questions (e.g., stress, nerves).

2. What places or people do people seek out when they are having problems with emotions or stress? Who would they go to first? Would they combine things?
   Probes:
   - family, clergy, traditional healers
   - counselors, psychotherapists
   - Doctors, western medicine? How do people feel about taking medications for emotional problems
   - Differences for men/women, young/old, new/established
   - What do people do to prevent emotional problems?
3. What do you think are the major issues that are causing people in your community to feel emotional stress? *Facilitator: Get examples*

**Probes:**
- Immigration, making life in Canada
- Worries about family or problems back home
- Family issues (including conflict and violence)?
- Racism? Sexism? Discrimination?
- Historical issues (e.g., slavery, colonization, war…)
- Substance use?
- Especially bad or different for men/women, young/old, new/established, other groups

4. What do you think people in your community think about psychotherapy or counselling?

**Probes:**
- Who goes? What do they go for?
- What is it for? Does it work?
- Can you tell other people you are getting counselling or psychotherapy?
- Have people heard of CBT? Heard of other psychotherapies?

*Facilitator: use the words that come from the group to describe psychotherapy (e.g., counselling, talking therapy)*

5. How important do you think religion and spirituality are to how people deal with emotional problems?

**Probes:**
- Is it different for different groups in the community?
- Ways it encourages or discourages seeking help from a psychotherapist?
- Would people want to discuss their religion or spirituality with a therapist or doctor?
6. How do you think family members would feel about a relative going for counselling or psychotherapy?

Probes:
- Is it different for men/women, other groups in the community?
- Would people discourage or prevent?
- Would people encourage or help? Want to be part of it?

7. CBT is built on a belief that the way we think affects our emotions and what we do, so if we change how we think and try new behaviours, then our emotions will change too. **Facilitator:** Use the large version of this visual and step group through it.

What do you think of that idea? What would others think?

Probes:
- How similar/different from ways people talk about problems (**Facilitator: refer back to earlier content provided in this area**)
- How does it compare to ideas in your community about what causes unhappy feelings and how you get rid of them?

8. CBT is usually given in weekly sessions for 12-16 weeks and clients are asked to work on “homework” in between the sessions. Do you think that would work for people in your community?

Probes:
- Reactions to 12/16 week commitment; what makes it easier or harder
- Reactions to homework; what makes it easier or harder? How would it make sense to you that you have to do therapy work between sessions? What would be the best way to explain the idea of trying things on your own between sessions?
- How long do you think people expect to be involved in counselling or psychotherapy? What affects how long they can?
- What kind of things would people be able to do in between sessions?
9. What kind of relationship do you think people expect to have with a counsellor or psychotherapist?

Probes:
- Formality/informality
- Sharing personal information, answering personal questions
- Active talking a lot vs. quiet, listening a lot
- Non-verbal: eye contact, physical contact, closeness of chairs etc.

10. What do you think we could do to make the counselling we are offering attractive to people in your community? What might increase/decrease the number of people who would be interested?

Probes:
- Individual vs. group? (Who could be in a group?)
- Languages offered? Interpreters offered? English only?
- Therapist: same ethnic group vs. different ethnic group, professional background, male/female?
- Different needs for men vs. women? Young people vs. older people? New immigrants vs. more established people?
- Offering social services in addition to psychotherapy? Specifics?
- Location/hours?
- Artwork, decorations
Appendix H: Focus Group Guide for Health Providers

Introduction:
- Seeking help with making CBT fit with what cultural groups think and know about emotional problems, issues faced by the community, ways they think about dealing with emotional stress

Content:
1. What words or phrases do people in this community use to talk about feeling emotional problems?
   Probes:
   - What kind of experiences or feelings are people describing when they use those words?
   - Do people ever use the word depression – what does it mean, when would they use it?

2. At what point do you think people in this community would consider seeking help from a counsellor or psychotherapist?
   Probes:
   - Would they go to others first? Who?
   - Would they go to others at the same time? Who?
   - What are the attitudes to taking medication?
   - What do people do to prevent emotional problems?
   - Differences for men/women, young/old, new/established

3. What do you think are the major issues that are causing people in this community to feel emotional stress? **Facilitator: Get examples**
   Probes:
   - Immigration, making life in Canada
   - Worries about family or problems back home
   - Family issues (including conflict and violence)?
   - Racism? Sexism? Discrimination?
   - Historical issues (e.g., slavery, colonization, war…)
   - Substance use?
• Especially bad or different for men/women, young/old, new/established, other groups

4. What do you think people in this community think about psychotherapy or counselling?
• Who goes? What do they go for?
• What is it for? Does it work?
• Stigma in the community against mental illness? Against counselling/psychotherapy?
• Familiarity with CBT? Other psychotherapies?

5. How important do you think religion and spirituality are to how people in this community deal with emotional problems?
Probes:
• Is it different for different groups in the community?
• Ways it encourages or discourages seeking help from a psychotherapist?
• Do people want to discuss their religion or spirituality with a therapist or doctor?

6. How do family members react when a relative is going for counselling or psychotherapy?
Probes:
• Is it different for men/women, other groups in the community?
• Do clients talk about family discouraging/preventing?
• Do you find family may encourage or help? Want to be part of it?
• Do you involve family members in therapy in some way? Other strategies?

7. How compatible do you find the CBT method with the cultural beliefs in this community?
• Connections, areas of disconnect
• Strategies: use of cultural metaphors or understandings, specific ways of explaining things
• What would you recommend adding or taking away from CBT to make it work for this group?
• What do you think should never be changed in CBT, no matter who is receiving it?
8. CBT is usually given in weekly sessions for 12-16 weeks and clients are asked to work on “homework” in between the sessions. Do you think that would work for people in this community?

- Thoughts on what makes it possible or difficult for people to complete the full treatment?
- Thoughts on what make the homework more manageable or less manageable? Acceptable?
- Strategies for engaging people to work between sessions?

**Process:**
9. What considerations would you suggest are important for building a therapeutic alliance with people from this community?

- Expectations from clients
- Activity level of therapist
- Formality/informality
- Role of self-disclosure
- Non-verbal e.g., eye contact, physical contact, set-up of room

10. What do you think we could do to make the counselling we are offering more attractive to people in this community? What might increase interest or decrease interest?

- Individual vs. group? (Who could be in a group?)
- Languages offered? Interpreters offered? English only?
- Therapist: same ethnic group vs. different ethnic group, professional background, male/female?
- Different needs for men vs. women? Young people vs. older people? New immigrants vs. more established people?
- Offering social services in addition to psychotherapy? Specifics?
- Location/hours?
- Artwork, decorations

11. How important do you think religion and spirituality are to how people in this community deal with emotional problems?
Probes:
- Is it different for different groups in the community?
- Ways it encourages or discourages seeking help from a psychotherapist?
- Do people want to discuss their religion or spirituality with a therapist or doctor?

12. How do family members react when a relative is going for counselling or psychotherapy?

Probes:
- Is it different for men/women, other groups in the community?
- Do clients talk about family discouraging/preventing?
- Do you find family may encourage or help? Want to be part of it?
- Do you involve family members in therapy in some way? Other strategies?

13. How compatible do you find the CBT method with the cultural beliefs in this community?

- Connections, areas of disconnect
- Strategies: use of cultural metaphors or understandings, specific ways of explaining things
- What would you recommend adding or taking away from CBT to make it work for this group?
- What do you think should never be changed in CBT, no matter who is receiving it?

14. CBT is usually given in weekly sessions for 12-16 weeks and clients are asked to work on “homework” in between the sessions. Do you think that would work for people in this community?

- Thoughts on what makes it possible or difficult for people to complete the full treatment?
- Thoughts on what make the homework more manageable or less manageable? Acceptable?
- Strategies for engaging people to work between sessions?
Process:
15. What considerations would you suggest are important for building a therapeutic alliance with people from this community?
   - Expectations from clients
   - Activity level of therapist
   - Formality/informality
   - Role of self-disclosure
   - Non-verbal e.g., eye contact, physical contact, set-up of room

16. What do you think we could do to make the counselling we are offering more attractive to people in this community? What might increase interest or decrease interest?
   - Individual vs. group? (Who could be in a group?)
   - Languages offered? Interpreters offered? English only?
   - Therapist: same ethnic group vs. different ethnic group, professional background, male/female?
   - Different needs for men vs. women? Young people vs. older people? New immigrants vs. more established people?
   - Offering social services in addition to psychotherapy? Specifics?
   - Location/hours?
   - Artwork, decorations
Appendix I: Recruitment Ad for Treatment Participants

A Study of Culturally-Adapted Cognitive Behavioural Therapy for Spanish-speaking, Black Anglophone Caribbean and Black Francophone Caribbean populations in Toronto

A study is underway to test culturally adapted psychotherapies for people from the following communities in Toronto:

- Spanish-speaking
- Black French-speaking Caribbean
- Black English-speaking Caribbean

The psychotherapies are based on Cognitive-Behavioural Therapy (CBT), a highly effective psychotherapy for treatment of depression and other emotional disorders. They have been culturally adapted to make them more suitable for people from these three communities. Cultural adaptation of the treatment involves making changes such as creating examples that are relevant to the specific communities, changing language to make it more easily understood, and adding exercises that are similar to familiar cultural activities.

If you are selected for the study, you will receive 12 - 16 weeks of psychotherapy and will be asked to participate in a group interview to tell the project team what you think of it. You must be 16 years or older to participate.

If you would like to hear more about the study and/or to set up a screening interview, please:

Call the Project Coordinator at (416) 535-8501 Extension 4442

Or, write your name and phone number below and leave this form with your health care provider.

Name: ________________________________

Phone Number: ________________________

Appendix J: Information Letter for Treatment Participants

<table>
<thead>
<tr>
<th>Name of the Study:</th>
<th>A feasibility Study for the Development of Culturally Adapted Cognitive Behavioural Therapy for the Spanish-speaking, Black Anglophone Caribbean and Black Francophone Caribbean populations in Toronto</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Investigator:</td>
<td>Akwatu Khenti 416-535-8501 x 6684</td>
</tr>
<tr>
<td>Collaborating Agency:</td>
<td>Centre for Addiction and Mental Health</td>
</tr>
<tr>
<td>Sponsor/Funder:</td>
<td>Citizenship and Immigration Canada</td>
</tr>
</tbody>
</table>

**Purpose:**
The purpose of this study is to develop culturally adapted cognitive behavioural therapy (CBT) for the Spanish-speaking, Black Anglophone Caribbean and Black Francophone Caribbean immigrant populations in the Greater Toronto Area. CBT is a type of psychotherapy that has proven effective for the treatment of depression. Culturally adapting this therapy for different ethnic groups may make it more effective for people from those groups.

If you **agree** to participate in this study you will be asked to participate in a session of psychotherapy and a focus group after the sessions are completed. You will receive the culturally adapted psychotherapy.

Information describing cognitive-behavioural therapy and its cultural adaptation is attached to this form.

**Procedure:**
Participants in the therapy will meet with a therapist once a week for 12 to 16 weeks. Before and after you complete these sessions, you will be asked to fill out a brief questionnaire asking you about how you are feeling emotionally. After you have completed the sessions, you will also be asked to participate in a group interview with other people who have received the same therapy and answer questions about your experience. The focus group interview will be audio-taped and a professional typist will transcribe the tape so the project team can summarize the information.

All participants will be asked to fill out a short form providing some general information about themselves, e.g., age, sex, languages spoken, etc. This information will not be shared with anyone who is not on the project team.
Eligibility
All participants in the study must be at least 16 years of age and capable of understanding the study procedure so they can consent to participate. They must also be able to communicate in one of the three languages being used for this project (English, French or Spanish).

There are specialized eligibility criteria for participation:

- Participants in the intervention must exhibit symptoms of depression, as measured by the questionnaire that is used in the study.
- You cannot participate in the study if you are experiencing severe symptoms of mental illness like feeling suicidal or psychosis.

Privacy and Confidentiality
Information will be kept confidential in conformity with legal requirements. Every effort will be made to protect your privacy and confidentiality during this study. Any personal information that is collected from you will be stored separately from information that identifies you. All information will be stored in locked file cabinets or password-protected computer files at the Centre for Addiction and Mental Health. Information made public from the study will not include identifying information and will only be released in summarized form.

Identifying information that is revealed during the taped interview will be deleted from the transcript.

Compensation:
You will receive compensation for potential expenses associated with your participation and TTC tokens to offset your travel expenses. At the beginning of the process, you will receive $30.00 for participation in the screening interview. At the end, another $30 will be provided for participation in a final focus group where you will be asked to share your experiences with this type of psychotherapy.

Benefits and Risks
Participants in the therapy sessions may receive direct benefit through relief of symptoms of depression. They may also derive satisfaction from contributing to the development of the culturally adapted therapies.

There are no anticipated risks to participation; however, participants in the therapy may experience some emotional discomfort from talking about their problems. These individuals will be working with highly trained and experienced therapists who will know how to provide assistance or seek assistance if needed. If a participant became highly distressed, a therapist may take action to have them seen by an attending physician or another doctor.
**Voluntary Participation**
Your participation in any aspect of this study is voluntary. You may choose to withdraw from the study at any time without any consequences. If a member of the project team ends your participation in the study, you will be compensated for your participation up to that point. Your choice to participate, not participate or withdraw participation will not affect any services you receive at the Centre for Addiction and Mental Health now or in the future.

**Additional Information:**
You are free to ask any questions about the study or your participation in the study. Questions can be directed to the research coordinator or principal investigator named on the first page, or to any of these other members of the project team:

Dr. Kwame McKenzie 416-535-8501 x 2616; Dr. Carolina Vidal 416-535-8501 x 4442; Mr. Antoine Derose 416-535-8501 x 6904; Dr. Diane Whitney 416-535-8501 x 4241.

You may also contact the Chair of the CAMH Research Ethics Board, Dr. Padraig Darby, to discuss your rights as a research participant: 416-535-8501 x 6876.
Appendix K: CA-CBT Manual for Spanish-speaking Latin American Immigrants

English and Spanish language versions of this manual can be accessed at: http://knowledgex.camh.net/amhspecialists/specialized_treatment/CBT/Pages/default.aspx