Professional Psychology: Research and Practice
1995, Vol. 26, No. 3, 309-315

0735-7028/95/$3.00

Multicultural Applications of Cognitive-Behavior Therapy

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The purpose of this article is to discuss the need for greater attention to cultural influences and minority cultures in the field of cognitive-behavior therapy. Ethnic minority cultures and concerns are emphasized, although consideration is also given to a range of cultural influences including age, religion, socioeconomic status, gender, sexual orientation, and disability. The strengths and limitations of cognitive-behavior therapy in relation to its use with culturally diverse populations are outlined. Finally, suggestions are offered for integrating cultural concerns and addressing cultural influences in cognitive-behavioral practice with diverse clients.

I recently gave a 1-day workshop aimed at introducing cognitive-behavior therapy to a class of graduate counseling students. The first portion of the class consisted of a lecture on multimodal assessment, including an outline of the seven major modalities in a person's life: behavior, affect, sensation, imagery, cognition, interpersonal relations, and drugs/biology (Lazarus, 1985), referred to as the BASIC ID. Cultural factors and influences across all of these modalities were discussed, and, in small groups, students were asked to develop an assessment of the following client:

> Sheryl is a 30-year-old, single, Japanese American woman currently enrolled in a counseling psychology program here in Seattle. She comes to you with complaints of depressed mood, anxiety, and low self-esteem. As you talk, it becomes apparent that much of her worry revolves around her work as a beginning intern at a local mental health center. Sheryl tells you that she knows that her supervisor Joe (a White, 40-year-old married man) does not think that she is competent. She says that she feels she cannot do anything correctly. According to her, he has told her that she is "not directive enough with clients in obtaining information during assessments" and "seems disengaged from supervision." Sheryl says she feels emotionally frozen when her supervisor gives her this feedback, and when she gets home, she cries and feels "terrible." She's beginning to think that she won't be able to finish the internship, although she says, "I can't drop out now."

After reading the case description, the class became quite engaged in mapping out Sheryl's situation using the BASIC ID. When we pooled the entire group's ideas, the result was a very thorough assessment that included questions about cultural influences important to the client, the possibility of gender and ethnic biases on the part of the supervisor, and the class's assumptions about the concept of assertiveness.

As I was congratulating myself during our break on how well this discussion had gone, a White male student (about 40 years old) asked to speak with me. He told me that he was enjoying the class overall but thought that the multimodal section would have been much more effective if I had just given a case example of "a person, generally, without the part on culture, so that we could have spent more time on actually learning the multimodal approach." He went on to explain that, from his perspective, cultural differences only complicated the case (I assume he meant differences in relation to himself), and in the beginning it would make more sense to just leave that part out until later.

I begin with this example because I think it illustrates so clearly the dominant way of thinking about culture in North America. Culture is seen as a separate category of human experience that only complicates one's understanding of people. Furthermore, because the discussion of culture is so closely tied to issues of politics and power, in a group setting it may seem safer and even reasonable to simply "leave it out."

Such marginalization of cultural considerations—particularly those related to minority groups—pervades the field of psychology. Mainstream psychological research still ignores the centrality of culture and separates studies that include cultural minorities (or that simply address cultural influences) into the separate domain of cross-cultural or multicultural psychology (Clark, 1987). Concomitantly, the most influential psychotherapies (i.e., psychodynamic, behavioral, cognitive-behavioral, humanistic, existential, and family systems) were developed with little and/or highly biased consideration of people seen as being different from the majority of psychologists (whether by ethnicity, nationality, religion, age, sexual orientation, disability, or gender).

The purpose of this article is to offer suggestions for the integration of cultural considerations into the particular domain of cognitive-behavior therapy. Herein, cognitive-behavior therapy refers to the wide range of therapies that aim to change behavioral problems by modifying cognitive processes and structures; these approaches include coping skills therapies, problem-solving therapies, and cognitive restructuring methods (Dobson, 1988). Beginning with a definition of cultural diversity, a brief

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I WOULD LIKE TO THANK Peg LeVine and Susan Goldstein for their critical comments and recommendations.

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overview is provided of the cognitive–behavior therapy research concerning cultural minorities (i.e., groups that have traditionally been neglected in cognitive–behavior therapy research). Next, the strengths and potential limitations of cognitive–behavior therapy are discussed in relation to its use with culturally diverse clients. Finally, suggestions are offered for the culturally responsive practice of cognitive–behavior therapy.

Defining Cultural Diversity

At present, the multicultural literature in clinical and counseling psychology defines culture almost solely in terms of ethnicity. This focus has been important in the development of multicultural applications because it has drawn attention to the prevalence of racism and to the systematic exclusion of ethnic minority cultures in psychology. However, although similar areas of research and practice have emerged concerning minority populations of older people, women, people with disabilities, gay men, lesbians, bisexual people, and religious minorities, there has been little conversation between researchers and practitioners across these various "population specializations." For clinicians, educators, and students, such compartmentalization of cultural influences, groups, and types of oppression is problematic (for example, when sexist and heterosexist attitudes persist despite increased awareness of ethnic minority concerns).

A number of multicultural psychologists have called for the need to consider more complex cultural influences and identities (Larson, 1982; Margolis & Rungta, 1986; Speight et al., 1991; Pedersen, 1991; Reynolds & Pope, 1991), but there is currently no agreement on which influences and cultures should be included. Elsewhere I have outlined a model that highlights specific minority groups in relation to eight key cultural influences: Age or generational differences, Disability, Religion, Ethnicity, Social status, Sexual orientation, Indigenous heritage, Nationality, and Gender (which form a useful although imperfectly spelled acronym of those cultural factors that therapists need to be "ADRESSING"; see Hays, in press). The ADRESSING model focuses on the age, religious, socioeconomic (and so on) diversity of ethnic minority cultures but also calls attention to nonethnic minority groups including sexual minorities, Muslims, older people, and people with disabilities (with the term *minority* referring to those groups that have experienced systematic marginalization and oppression from the dominant culture).

Because cognitive–behavior therapy's exclusion of ethnic minority cultures has been the most enduring and widespread, the greatest emphasis herein is placed on people of color. However, because the consideration of diverse cultural influences adds to the understanding of ethnic minority cultures, cognitive behavior therapy studies of nonethnic minority groups are also included.

Cognitive–Behavior Therapy and Cultural Diversity

Although ethnic minorities make up nearly 25% of the U.S. population, the percentage of ethnic minority psychologists in clinical practice is estimated at 5.1% or less (Hammond & Yung, 1993). Although the representation of people of color in cognitive–behavioral practice has yet to be assessed, a look at the literature suggests that cognitive–behavior therapy as a field is similarly dominated by Euro-American perspectives.

For example, as recently as 1988, Casas reviewed psychological abstracts of the preceding 20 years, looking for studies of cognitive–behavioral treatments of anxiety in people of racial or ethnic minority groups. He found only three empirically based outcome studies, two of which had samples of only 2 persons each. Renfry (1992) conducted a similar search for cognitive–behavior therapy studies involving Native American participants; his review of 11 major behavioral and cognitive–behavioral journals (from their beginnings to the end of 1990) yielded 1 case study of 1 Native American client. In recent updates on the state of cognitive therapy (Beck, 1993), rational-emotive therapy (Ellis, 1993; Haaga & Davison, 1993), and cognitive–behavior modification (Meichenbaum, 1993), there was no recognition of the need for special attention to ethnic, racial, or other cultural minority groups. Moreover, to my knowledge there is currently no cognitive–behavior therapy textbook that includes cultural influences and minority groups in an integrated way (although there are a number of books on behavior therapy with specific populations—e.g., with African Americans, Turner & Jones, 1982; women, Blechman, 1984; older people, Hussian, 1981).

Using the inclusive definition of minority populations, however, there is a growing number of articles on cognitive–behavior therapy with minority populations, most of them published within the last few years. These studies include investigations of the usefulness of cognitive–behavior therapy with Puerto Rican women (Comas-Diaz, 1981) and religious Christian clients (Johnson & Ridley, 1992); a feminist critique of cognitive–behavior therapy (Kantrowitz & Ballou, 1992); discussions of special considerations in conducting multimodal assessment with Mexican Americans (Ponterotto, 1987) and cognitive therapy with gay men (Kuehlwein, 1992), lesbians (Wolfe, 1992), women (Davis & Padesky, 1989) and battered women (Douglas & Strom, 1988), Native Americans (Renfry, 1992), and older people (Glantz, 1989; Thompson, Davies, Gallagher, & Krantz, 1986). In addition, there have been articles published on assertiveness and social skills training with ethnic minority groups (LaFromboise & Rowe, 1983; Wood & Mallinckrodt, 1990) and women (Gambrill & Richey, 1986); a discussion of creative problem-solving with people who have new disabilities (Frieden & Cole, 1984); and a case study of rational-emotive therapy with an unmarried, pregnant Mormon client (by Ellis, summarized in A. E. Ivey, M. B. Ivey, & Simek-Morgan, 1993).

When one considers the range of populations that these studies address (i.e., those minority groups that are otherwise omitted from the mainstream of cognitive–behavior therapy research), this list is quite small. Despite the apparent disinterest in culture and minority groups among cognitive–behavioral researchers, however, there is nothing inherent in cognitive–behavior therapy that would preclude its use with diverse people. On the contrary, several key features of cognitive–behavior therapy suggest that it might be particularly useful multiculturally.

Cognitive–Behavior Therapy's Potential Strengths With Culturally Diverse Clients

One of cognitive–behavior therapy's strengths is its emphasis on the uniqueness of the individual. Cognitive–behavior therapy is rooted in the behavioral principle that therapy must be adapted to meet the needs of the individual (Rimm & Masters, 1979), and the large and eclectic range of cognitive–behavioral techniques provides the tools for such adaptations. Although a multicultural perspective tends to emphasize cultural (rather than individual) differences and influences, its purpose in doing so is to increase the appropriateness and effectiveness of therapy for each client. Thus, multicultural and cognitive–behavioral approaches both place importance on tailoring the therapy to the particular situation of the client.

A second feature of cognitive–behavior therapy that lends itself to multicultural applications is the focus on client empowerment. Cognitive–behavior therapy views clients as being in control of their thoughts and emotions and thus able to make changes themselves (Dobson & Block, 1988). In recognizing the expertise that people hold about themselves, cognitive–behavior therapy empowers clients to apply newly learned skills as independently as possible so that, in future situations, these skills can be used without the therapist. Such respect for the client's abilities and understanding of her or his situation contributes to the creation of a collaborative relationship in which individual and cultural differences are appreciated rather than negated.

Third, cognitive–behavior therapy's attention to conscious processes and specific behaviors (i.e., over unconscious processes and abstract explanations) may be more appropriate when therapy is conducted in a client's second language or with an interpreter. It is well-known that emotional distress decreases fluency in a second language (Bradford & Munoz, 1993); for the distressed client attempting to describe and understand her or his situation, the use of complicated theoretical constructs can add to misunderstandings. Cognitive–behavior therapy's emphasis on specific events, behaviors, thoughts, and emotions minimizes the literal and conceptual inequivalencies that are more likely to occur in less behaviorally based therapies. (In contrast, consider the highly abstract concepts of projective identification, splitting, and introjection used in object relations therapy—Okun, 1992.) This is not to say that speakers of English as a second language are incapable of understanding or benefiting from psychodynamic approaches; rather, it is to say that the potential for misunderstandings may be greater when therapy is dependent on more abstract theoretical constructs (Casas, 1988).

A final strength of cognitive–behavior therapy is its integration of assessment throughout the course of therapy (Kirk, 1989). Cognitive–behavioral assessment emphasizes the client's progress from the client's perspective. In addition, cognitive–behavior therapy's value on multiple measures can be adapted to include measures important to the client (e.g., the family's views of the client's progress). Furthermore, the ongoing nature of cognitive–behavioral assessment demonstrates the therapist's commitment to a collaborative process, respect for the client's opinions, and consideration of financial and time constraints. Although important in all therapeutic relationships, these advantages seem especially important for the client and therapist whose cultural backgrounds differ.

Cognitive–Behavior Therapy's Limitations

Having outlined these advantages to using cognitive–behavior therapy with culturally diverse groups, there are several potential limitations that need to be considered. To begin, cognitive–behavior therapy is often presented as a value-neutral approach to helping people (Kantrowitz & Ballou, 1992). The fact is that there are no value-neutral psychotherapies; any intervention represents at the least a valuing of change. The originators of cognitive–behavior therapy have been primarily individuals of socially dominant groups (i.e., university-educated, Euro-American men). This does not mean that cognitive–behavior therapy is irrelevant to people of other backgrounds. However, in psychology, in cognitive behaviorism, and in the world, the dominant social group's values are often assumed to be universal, because the values of marginalized groups are either not as well-known or are actively suppressed. Assertiveness, personal independence, verbal ability, and change are highly valued in the United States, but these are far from universal priorities (although it would be difficult to tell this from the psychological literature).

Although cognitive–behavior therapy has the potential to help clients with other values as well, psychotherapists must work hard to see therapy's subtle biases toward values supported by the status quo. For example, although cognitive–behavior therapy's emphasis on self-control fits with the Euro-American value of personal autonomy and may even be seen as empowering (as described earlier), it can also imply placing blame on the individual for problems that are primarily a result of unjust societal conditions (A. E. Ivey, M. B.Ivey, & Simek-Morgan, 1993). Cognitive–behavior therapy does not exclude the consideration of sociocultural influences, but because it has not been explicit about the impact of racism and other forms of oppression on clients, these forces are easily overlooked, particularly by therapists of dominant cultural groups.

A second limitation of cognitive–behavior therapy concerns a lack of attention to the client's history. With such a focus on the present, cultural differences in the client's upbringing and experiences in the world (including experiences of discrimination and oppression) may not be readily apparent to the therapist of another culture or generation. Beck's investigation of the client's developmental history to understand her or his cognitive schemas is an exception that could be modified to specifically address the client's cultural heritage.

A third limitation of cognitive–behavior therapy is its emphasis on rational thinking and the scientific method. Kantrowitz and Ballou (1992) suggest that a cognitive–behavioral orientation reinforces a view of the world and a way of interacting that are stereotypically Euro-American and masculine; alternative cognitive styles (e.g., less linear styles), worldviews (e.g., more spiritually oriented views), and ways of interacting (cooperative rather than confrontational) tend to be devalued. Although this bias does seem to hold in general, the extent to which alternative styles, views, and behaviors are acknowledged can still vary de-

pending on the particular therapist's sensitivity to diverse perspectives and ways of being. For example, therapists might emphasize the collaborative aspects of cognitive restructuring (e.g., weighing the evidence for and against a particular belief together—DeRubeis & Beck, 1988) over a more confrontational approach.

Given these limitations, cognitive–behavior therapy will not be useful for every individual and every problem, but it has the potential to help many more people than are currently being served in the mental health system. The following suggestions are offered toward the goal of making mental health services more accessible and culturally responsive to people of minority cultures and groups.

Integration of Culture Into the Practice of Cognitive–Behavior Therapy

The multicultural counseling and clinical literature and guidelines endorsed by the American Psychological Association (APA) state clearly that competent psychotherapists are knowledgeable about and sensitive to cultural, gender, and sexual minority issues (APA, 1978, 1991, 1993; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982). Thus, although the following studies focus on cognitive–behavior therapy with minority groups, the information they provide aims to increase therapists' overall competence with clients of diverse cultural identities and contexts.

For example, in reference to cognitive–behavior therapy with older people, Thompson and colleagues (1986) offered several suggestions that may be equally relevant for clients who are younger or of diverse minority cultures. Because older clients may be less familiar with psychotherapy, it is useful to begin with an explanation of the purposes and general approach of cognitive–behavior therapy, emphasizing the active role played by the client in defining the problem, deciding on a plan, and carrying out homework (in contrast to the more passive role of a medical patient who is treated by the physician). Clients may wish to audiotape sessions or make summary notes at the end of sessions, which can then be reviewed at home. For clients sensitive to the stigma of mental health treatment, psychoeducational groups framed as classes may provide both education and support in a less threatening context (Gallagher & Thompson, 1983). In addition, because the technical language of cognitive–behavior therapy can be intimidating, it is preferable to use terms that are clear to everyone (e.g., "unhelpful thoughts" in place of "cognitive distortions").

Beginning in the initial assessment, the therapist will want to consider the importance of cultural influences in the client's life. Using the multimodal assessment approach, Ponterotto (1987) recommended building in a consideration of the client's "interaction with an oppressive environment," specifically in relation to the category of interpersonal relations. He described the hypothetical situation of a Mexican American man who experienced anxiety because of financial problems that were compounded by the difficulty he had expressing his needs in English to an unresponsive social service agency. Although the therapist would normally engage the client in a range of cognitive–behavioral treatments specific to each BASIC ID modality, Ponterotto suggested that a consideration of societal oppression might also lead the therapist to develop a plan, along with the client, to pressure the agency to hire a bilingual employee from the Spanish-speaking community. This latter intervention represents an area in which cognitive–behavior therapy has rarely tread, that is, the challenging of dominant cultural institutions that limit opportunities for people of minority cultures.

Although addressing the impact of oppression is important with regard to clients of minority groups, a more holistic perspective includes the consideration of culture-specific strengths and coping strategies too (Stevenson & Renard, 1993). Positive aspects of membership in a minority culture can include social support and practical help from culture-specific networks, an emphasis on religious and spiritual growth, opportunities for leadership and social action, and a sense of community and historical connection to previous generations. Although cognitive–behavioral research has been neglectful in investigating the strengths of minority cultures, it does offer a systematic method for eliciting such information in therapy. By way of a thorough cognitive–behavioral assessment, the culturally sensitive therapist can learn what the client has already tried in her or his attempts to solve the problem, what has worked and what has not worked, what conditions (intrapersonal, interpersonal, and environmental) might be reinforcing and maintaining the problem, and what consequences result from the particular strategies being used.

An example of the therapeutic use of cultural strengths (as defined by the culture) has been described by Johnson and Ridley (1992) in their adaptation of rational-emotive therapy to the needs and values of Christian clients. The resulting therapy, known as Christian rational-emotive therapy, was unique in three respects. One, it encouraged participants to challenge their irrational beliefs by using Biblical scriptures to define the "ultimate truth"; for example, the belief that "I must be thoroughly competent, adequate, and achieving in all possible respects if I am to consider myself worthwhile" was disputed in Isaiah 64:6: "All of us have become like one who is unclean and all our righteous acts are like filthy rags" (p. 225). The second characteristic of the Christian rational-emotive therapy approach was its emphasis on prayer and Christian content throughout the therapeutic work. The third element involved a prayer at the end of each session, "focusing on the session content and asking for Christ's empowerment in overcoming IBs [irrational beliefs]" (p. 225).

In their comparison of two groups of depressed Christian clients (one receiving standard rational-emotive therapy and the other Christian rational-emotive therapy), the researchers found that both approaches reduced clients' self-reported depression and automatic negative thoughts, although Christian rational-emotive therapy was also effective in reducing self-reported irrational beliefs. They concluded that rational-emotive therapy can be effectively adapted to the culture-specific values of Christian clients, although they acknowledged that what may have been of critical importance to the clients was having a competent professional who showed respect for their values and delivered quality service.

One of the more difficult aspects of using cognitive–behavior therapy cross-culturally concerns decisions about what is adap-

tive and functional and what is not. Consider the situation of a university-educated Tunisian (Muslim) woman who has recently immigrated to the United States; she works in the home and is not currently interested in outside employment, but she does want help in overcoming her increasing loneliness and unhappiness. She is referred to a feminist therapist who sees her difficulties as being attributable to emotional and financial dependence on her husband. The client does not see her problem in terms of dependence or independence, however; she considers her marriage to be a healthy relationship to which she and her husband contribute equally. Rather, she defines her problem as one of social isolation and difficulty making American friends. Clearly, the client's ideas about what is adaptive and what is not are quite different from those of the therapist. Furthermore, the prevailing definition will determine the focus of psychotherapy: From the therapist's perspective, the client might benefit from cognitive restructuring of those beliefs that maintain her "dependence," whereas, from the client's point of view, a social skills group would be more likely to meet her needs.

The culturally responsive practice of cognitive–behavior therapy demands that the client's values be recognized and respected, which in turn means that the problem must be defined in relation to the client's cultural norms (Tanaka-Matsumi & Higginbotham, 1989). In the preceding case, this would require the therapist's acceptance of the client's conceptualization of the problem, including respect for her opinion about her own marital relationship. However, although cognitive–behavior therapy theoretically acknowledges variability in definitions of adaptive and maladaptive behavior, in reality, Euro-American norms and values have dominated its practice.

For example, Euro-Americans value assertiveness and have determined that a certain degree of it is essential for one's mental health, and not having enough of it constitutes a problem. Thus, psychotherapists offer assertiveness training for clients who are "deficient" in this important quality. Although there are ethnic groups, including many Native American, Latino, Asian, and Arab cultures, in which the quality of respect is more highly valued than that of assertiveness, psychotherapists have yet to develop "respect training" for individuals who lack this quality in their interactions with others.

Not only does assertiveness represent a culture-specific value, it also carries significant risks for individuals of minority cultures. For example, members of a dominant ethnic group may react angrily to assertiveness from a member of a nondominant group (Wood & Mallinckrodt, 1990). This is not to say that assertiveness training is never useful; rather, it is to say that therapists must carefully consider the implications and consequences of targeting any behavior for change. It is the therapist's role to help the client expand her or his repertoire of coping behaviors and understand how such behaviors may be perceived in the dominant culture, but it is the client who decides which behaviors to use and when and where to use them (Wood & Mallinckrodt, 1990).

LaFromboise and Rowe (1983) have suggested the use of a concept known as bicultural competence to avoid the Eurocentric conceptualization of members of ethnic minority cultures as being deficient in (Euro-American) social skills. In their work with American Indian clients, the researchers emphasized the utilitarian aspects of competence in both the Indian and Euro-American cultures. Situations targeted for change were defined by the Indian community by way of consultations with tribal leaders, groups, and agencies and included a range of skills desired for effective communication with both Euro-Americans and American Indians. Concomitantly, interventions were designed in the form of social skills training groups that the authors noted parallel "the American Indian traditions of role modeling, apprenticeship training, and group consensus" (LaFromboise & Rowe, 1983, p. 593).

Cognitive restructuring is another commonly used cognitive behavioral technique that has been shown to help some individuals of cultural minority groups. Kuehlwein (1992) used cognitive therapy to help gay male clients examine and correct internalized heterosexist beliefs and thoughts. Wolfe (1992) described the use of rational-emotive therapy with a lesbian client who was helped to deal with her anger and depression about parental and societal discrimination; following individual therapy, a rational-emotive therapy women's group was also useful in providing the client with both social support and the opportunity to practice newly learned behaviors. In addition, Douglas and Strom (1988) outlined the usefulness of cognitive therapy in changing dysfunctional beliefs that inhibit a battered woman's ability to leave an abusive relationship (e.g., "I deserved to be hit").

By now, it should be apparent that one of the unique characteristics of a multicultural therapy is its emphasis on changing the political and social inequities that continue to marginalize, exclude, and oppress large numbers of people. Until recently, cognitive–behavior therapy as a field has shown little interest in such issues (neither, for that matter, has any other major psychotherapy theory). However, cognitive–behavior therapy does offer a range of tools that can be used to empower people, change unfair practices, and facilitate community-level change. For example, with both individuals and groups, cognitive restructuring offers a useful framework for addressing prejudiced (i.e., illogical and automatic) beliefs and for changing racist, sexist, and other discriminatory behaviors. Concomitantly, problem-solving and skills training can be taught and used in ways that challenge rather than accept dominant cultural assumptions and institutions. The key to multicultural applications of cognitive–behavior therapy lies in the need for explicit attention to cultural influences and minority populations that have traditionally been ignored.

Conclusion

As the number of psychologists of minority cultures and groups increases, it is likely that cognitive–behavior therapy will become increasingly attentive to cultural influences and minority groups. This attention will no doubt lead to the recognition of an even more diverse range of helping strategies. Moreover, it should contribute to the improved effectiveness of cognitive–behavior therapy with specific groups of people whose mental health needs have been neglected. In the meantime, given the current dearth of cognitive–behavior therapy research with minority groups, flexibility and creativity will be necessary attri-

butes for cognitive-behavior therapists who wish to apply cognitive-behavior therapy in a culturally sensitive manner with diverse clients.

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Received February 17, 1994
Revision received August 8, 1994
Accepted December 19, 1994 ■