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Multicultural Applications of Cognitive Behavior Therapy: A Psychosocial Review

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ABSTRACT

Cognitive behavior therapy is most widely used in the field of psychotherapy. The purpose of this research paper 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 of cognitive behavior therapy in relation to its use with culturally diverse populations are outlined.

Keywords: *CBT, strength of CBT, cultural diversity, CBT and cultural diversity, multicultural application of CBT*

Our global era increasingly brings together ethno-culturally diverse individuals, families, communities, and nations that differ in religion, economy, beliefs, and histories. Often, these groups also come together under conditions that are plagued by anger, fear, and distrust. Mental health services are the crucible in which many of the issues different groups face must be addressed. . Multiculturalism, diversity, and cultural competency are currently hot and important topics for mental health professionals (Pistole 2004, Whaley & Davis 2007). Originally conceptualized as cultural responsiveness or sensitivity, cultural competency is now advocated and, at times, mandated by professional organizations; local, state, and federal agencies; and various professions.

Cognitive Behavior Therapy (CBT)

CBT was developed by Dr. Aaron Beck, a psychiatrist at the University of Pennsylvania in the early 1960s. Beck's (1967) system of therapy is similar to Ellis's, but has been most widely used in cases of depression. Cognitive therapists help clients to recognize the negative thoughts and errors in logic that cause them to be depressed. The therapist also guide clients to question

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and challenge their dysfunctional thoughts, try out new interpretations, and ultimately apply alternative ways of thinking in their daily lives. Aaron Beck believes that a person's reaction to specific upsetting thoughts may contribute to abnormality. As we confront the many situations that arise in life, both comforting and upsetting thoughts come into our heads. Beck calls these unbidden cognition's automatic thoughts.

Cognitive behavioral therapy (CBT) can be used to treat people with a wide range of mental health problems. CBT is based on the ideas that how we think (cognition), how we feel (emotion) and how we act (behavior) all interact together. Specifically, our thoughts determine our feelings and our behavior.CBT aims to help people become aware of when they make negative interpretations, and of behavioral patterns which reinforce the distorted thinking. Cognitive therapy helps people to develop alternative ways of thinking and behaving which aims to reduce their psychological distress.

Two of the earliest forms of Cognitive behavioral Therapy were Rational Emotive Behavior Therapy (REBT), developed by Albert Ellis in the 1950s, and Cognitive Therapy, developed by Aaron T. Beck in the 1960s.

Strengths of CBT

1. Model has great appeal because it focuses on human thought. Human cognitive abilities has been responsible for our many accomplishments so may also be responsible for our problems.
2. Cognitive theories lend themselves to testing. When experimental subjects are manipulated into adopting unpleasant assumptions or thought they became more anxious and depressed (Rimm & Litvak, 1969).
3. Many people with psychological disorders, particularly depressive, anxiety, and sexual disorders have been found to display maladaptive assumptions and thoughts (Beck et al., 1983).
4. Cognitive therapy has been very effective for treating depression (Hollon & Beck, 1994), and moderately effective for anxiety problems (Beck, 1993).

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. Age or generational differences, Disability, Religion, Ethnicity, Social status, Sexual orientation, Indigenous heritage, Nationality, and Gender.

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).

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.

Multicultural Applications

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 in equivalencies that are more likely to occur in less behaviorally based therapies. 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.

REVIEW OF LITERATURE

There are 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).

CONCLUSION

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

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Conflict of Interests

The author declared no conflict of interests.

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