

# INTRODUCTION

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Shelby<sup>1</sup> is a 28-year-old, recently divorced woman who was referred for counseling by her physician who could find no medical reason for her frequent digestion problems and stomachaches. At your first meeting, Shelby tells you she is a nursing student and hospital health aide, and she lives with her parents, who babysit her 3-year-old daughter while she is at work or in school. She reports that she has always been a good student and likes her job, but the workload now feels overwhelming, and her supervisor is frequently upset with her for being late and for occasional mistakes she makes when tired. In addition, she says a couple of her coworkers have “turned against” her and report any little mistakes she makes to the supervisor, which makes matters worse. She has only 1 year left to obtain her nursing degree, but she is starting to wonder whether she can do it all. She says her parents criticize her parenting skills and were disappointed with her divorcing her husband, telling

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<sup>1</sup>Case material in this chapter and throughout the book has been disguised to protect client confidentiality.  
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her, “Marriage isn’t always easy—that’s just the way it is.” She says that sometimes she feels so low about herself that she does not see the point in trying, although she quickly admits she would never kill herself because she cares about her family too much.

If you already use cognitive behavior therapy (CBT), you are probably thinking about Shelby’s situation in terms of the five key components of CBT—namely, cognition, emotion, behavior, physical symptoms or sensations, and environmental influences (Greenberger & Padesky, 2015). You may also be looking for factors that contribute to Shelby’s distress, including those that are external to Shelby (i.e., environmental) and internal, in the form of unhelpful beliefs and thoughts. You might consider interventions aimed at helping Shelby take specific actions to decrease the external stressors—for example, talking directly with her coworkers, proactively meeting with her supervisor, or practicing self-care activities. And you might consider cognitive restructuring as a way to help Shelby engage in more helpful self-talk and change beliefs that may contribute to her stress.

But what if I told you that Shelby is short for Shelbiya, and Shelby is Arab American? Would this information raise questions or additional hypotheses you had not previously considered regarding her distress? For example, could her supervisor’s and coworkers’ attitudes toward her be related to her ethnic identity or, if she is Muslim, to her religious identity? Did her parents immigrate to the United States, and if so, are there language, political, value, or other differences between Shelby and her parents that might contribute to their family conflicts? Given the dominant culture’s fear of and hostility toward Arab people today, could Shelby’s experience of stress be aggravated by sociopolitical events, as well as microaggressions and other forms of racism directed at her and her family? Could her self-doubts be aggravated by experiences of prejudice and discrimination?

Shelby’s ethnicity was omitted initially to make the point that when cultural information is left out, the assumption is often made that the client is of European American heritage. This assumption can occur even when face to face with clients who appear to be White. As a result, important questions and hypotheses may not even be considered. When a therapist does not consider the possibility of minority or cultural identities, it is more likely that the therapist will use language and engage in behaviors that reflect this lack of consideration. Furthermore, this tendency holds true with regard to other minority identities too. For example, a therapist who does not consider the possibility that a client is gay or bisexual is more likely to use non-inclusive pronouns when asking about partners and spouses, a therapist who does not consider nonvisible disability may make assumptions about the supportiveness of a client’s environment and the challenges the client faces,

and a therapist who does not consider the possibility that a client is biracial may overlook important influences and experiences relevant to the client's situation.

Unfortunately, the omission of ethnic and other cultural information is the rule rather than the exception in clinical and counseling research, including CBT. This neglect is due in part to the cultural homogeneity of the field. People of color currently comprise over one third of the U.S. population yet constitute only between 11.5% and 14% of health service providers (Hamp, Stamm, Lin, & Christidis, 2016). Psychology faculty who educate these providers are similarly nonrepresentative of the larger society: Only 15% are people of color (Kohout, Pate, & Maton, 2014) and few are people with disabilities, immigrants, transgender, or members of minority religions.

In many cases, therapists of dominant cultural identities may simply not perceive cultural influences because they do not have experience with minority cultures or with any culture that might provide a contrast to their own. However, the dominance of European American perspectives and assumptions in CBT is not due solely to the disproportionate number of European American faculty and providers. It is also related to the reinforcement of dominant cultural values and perspectives by the larger society, of which psychotherapy is a part. Consider, for example, the social and therapeutic emphasis placed on the European American values of assertiveness in social interactions (over subtlety), change (over acceptance, perseverance, and patience), personal independence (over interdependence), and open self-disclosure (over protection of the family's reputation; Kim, 1985; Pedersen, 1987; Wood & Mallinckrodt, 1990).

CBT research has historically focused almost exclusively on European Americans, with little to no attention given to cultural influences related to ethnicity, religion, sexual orientation, disability, or social class. In 1988, a review of the preceding 20 years found only three empirically based outcome studies of cognitive behavioral treatments of anxiety in people of racial or ethnic minority groups (two of which had samples of only two people; Casas, 1988). In 1996, a survey of three leading behavioral journals found that only 1.31% focused on ethnic minority groups in the United States (Iwamasa & Smith, 1996). And over the past 15 years, research on race, ethnicity, and diversity has made up less than 4% of the articles published in the *Journal of Consulting and Clinical Psychology*, *Developmental Psychology*, and the *Journal of Personality and Social Psychology* (Hall, Yip, & Zárate, 2016).

Upon publication of the first edition of *Culturally Responsive Cognitive–Behavioral Therapy* in 2006, we had hoped that research in this area would grow as rapidly as it has in the relatively separate fields of CBT and multicultural

practice, but this has not been the case. The field of multicultural therapy or MCT<sup>2</sup> has expanded to include a greater number of minority cultures, aided in part by the gradually increasing numbers of psychologists of minority identities. There is now an enormous number of books on MCT, and MCT researchers are calling attention to the exclusion of minority groups from most evidence-based practice research. However, the bulk of the multicultural literature does not address the integration of multicultural perspectives into major theories in psychotherapy (i.e., behavior therapy, CBT, psychodynamic, interpersonal, dialectical behavior therapy, acceptance and commitment therapy, humanistic, existential, client-centered therapy).

At the same time, the field of CBT has also grown, facilitating and facilitated by at least two significant developments: the societal and clinical interest in mindfulness-based approaches (Davidson & Kaszniak, 2015) and the profession's emphasis on evidence-based practice research (more on this later). However, here again, the majority of these CBT studies do not integrate multicultural perspectives into the theory or practice.

The relatively slow integration of multicultural perspectives into CBT is surprising for several reasons. First, CBT and MCT share a number of basic premises. Both emphasize the need to tailor therapeutic interventions to the unique situation of the individual. Both emphasize the empowerment of clients—MCT through its affirmation of clients' cultural identities and CBT through recognition of each client's expertise regarding their own needs and situation. Both MCT and CBT also emphasize the therapeutic aspects of clients' strengths and supports. And the CBT field has a great deal to gain from multicultural considerations. Understanding how CBT works and does not work with minority populations offers a multitude of opportunities for CBT researchers to challenge, expand, and refine their theories. Such work could lead to creative approaches that help a much wider range of people.

But recognizing such possibilities also requires a consideration of the potential limitations of CBT with minority cultures. CBT is as value-laden as any other psychotherapy. Its emphasis on cognition, logic, verbal skills, and rational thinking strongly favors dominant cultural perspectives, including definitions of rationality (Kantrowitz & Ballou, 1992). This cognitive emphasis can easily lead to an undervaluing of the importance of spirituality. The focus on changing oneself may contribute to the neglect of important cultural influences, and if not balanced by a behavioral perspective that recognizes the power of environmental influences, may contribute to blaming the client for problems that are primarily environmentally based (e.g., racism,

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<sup>2</sup>I use the term *multicultural therapy* (MCT) as shorthand for the field of clinical and counseling psychology that focuses on diversity. However, I do not consider MCT a therapy in the sense that CBT is a therapy; rather, I see it as an orientation to all therapeutic approaches.

heterocentrism, ableism). However, such limitations are not insurmountable, and figuring out ways to address them is part of the process of making CBT more responsive to people of diverse cultural identities.

## EVIDENCE-BASED PRACTICE, COGNITIVE BEHAVIOR THERAPY, AND MULTICULTURAL THERAPY

In 2006, the American Psychological Association (APA) published a formal definition of evidence-based practice in psychology. Before this, the assumption was frequently made that evidence-based practice was synonymous with randomized, controlled, empirically supported treatments. This assumption excluded the case study, qualitative, and expert opinion research that makes up most of the multicultural literature. The APA definition corrected this assumption by clarifying that evidence-based practice consists of “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). This definition acknowledges that when there are relevant randomized, controlled, empirically supported treatments, the clinician certainly considers these approaches. However, this consideration must take into account the particular patient’s characteristics, preferences, and culture. The MCT research is a wellspring of information regarding the latter.

Although the integration of CBT and MCT has not occurred as rapidly as we had hoped, there has been a slow but steady increase in the number of culturally adapted CBT studies, along with a broadening of the definition of diversity. For example, using the term *ethnic* to search from 2006 to 2016 in one of the primary CBT journals published by the Association of Behavioral and Cognitive Therapy, *Cognitive & Behavioral Practice*, I found 90 studies, several of which were grouped within special sections of the journal. These 90 studies addressed ethnic and racial influences and minority groups (e.g., Fuchs et al., 2016; and a special section on Latinx families, 2010, Volume 17, Issue 2) but also a number of related cultural influences and minority groups. Specifically, they included articles regarding multiethnic and international populations (Friedman, Braunstein, & Halpern, 2006; Hinton & Jalal, 2014), sexual minorities (special section, 2010, Volume 17, Issue 1), members of religious groups (special section, 2010, Volume 17, Issue 4), older adults (2012, Volume 19, Issue 1), gay youth (Lucassen, Merry, Hatcher, & Frampton, 2015), rural populations (Shealy, Davidson, Jones, Lopez, & de Arellano, 2015), refugees (Hinton, Pich, Hofmann, & Otto, 2013; and a special section, 2006, Volume 13, Issue 4), Deaf and hearing persons with language and learning challenges

(Glickman, 2009), and attention to the influence of socioeconomic status and gender (Neblett, Bernard, & Hudson Banks, 2016).

Moreover, there are now at least five books in addition to this one that focus on diversity and evidence-based interventions (which are often CBT or contain cognitive behavioral components): *Evidence-Based Psychological Practice With Ethnic Minorities* (Zane, Bernal, & Leong, 2016), *Cultural Adaptations: Tools for Evidence-Based Practice With Diverse Populations* (Bernal & Domenech Rodríguez, 2012), *Cognitive Behaviour Therapy in Non-Western Cultures* (Naeem & Kingdon, 2011), *Psychological Assessments and Interventions With Children of Color* (Graves & Blake, 2016), and *Treating Depression, Anxiety, and Stress in Ethnic and Racial Groups: Cognitive Behavioral Approaches* (Chang, Downey, Hirsch, & Yu, 2018). Of these, *Culturally Responsive Cognitive Behavior Therapy* is still the only one that uses a broad definition of culture, with attention to older adults, people with disabilities, religious and sexual minorities, and ethnic/racial minority cultures.

## CULTURAL ADAPTATIONS OF COGNITIVE BEHAVIOR THERAPY

The results of three recent meta-analyses suggest that cultural adaptations to CBT are helpful, and the more specific the adaptation to the culture, the more effective therapy is with regard to psychotic, mood, and behavioral disorders (Benish, Quintana, & Wampold, 2011; Huey, Tilley, Jones, & Smith, 2014; Smith, Domenech Rodríguez, & Bernal, 2011). In a systematic review of 20 years of research, Chu and Leino (2017) looked at the specific types of changes being made in “evidence-based intervention” adaptation studies. Although the authors did not focus specifically on CBT, their findings are relevant because many adaptation studies integrate cognitive behavioral concepts and practices. The authors found that only about 11% of the studies involved changes to the actual core components of the therapy, although substantial changes were made in the form of additions, delivery, and contextualization. One of the exciting aspects of cultural adaptation research is the creativity of these changes. Here are just a few examples of studies that focus specifically on adapting CBT to diverse cultural groups:

- Fuchs et al. (2016) interviewed an ethnically diverse group of participants about their experience of acceptance-based behavioral therapy and found that most individuals reported positive experiences and many gave detailed descriptions that could be helpful with others. For example, one African American

woman from a working-class background did not find a mindfulness exercise with imagery to be helpful, noting,

So, when my sister is leaving her kids alone in a house for some unknown reason, and I'm trying to convince her . . . don't do that, it's irresponsible. I'm supposed to believe that my nieces are like floating on a leaf as the police get called? (Fuchs et al., 2016, p. 478)

However, the same woman found the mindfulness exercise of chewing a raisin slowly with nonjudgmental awareness to be helpful in slowing her tendency to make assumptions about what other people were thinking about her.

- *Taoist cognitive therapy* is a manualized adaptation of an indigenous Chinese psychotherapy that conceptualizes anxiety and worry as the result of rigid attachments to beliefs, goals, and desires that do not reflect the natural order of the universe. Emphasis is placed on the eight Taoist principles of collective benefit, noncompetition, moderation, acceptance, humility, flexibility, *wu wei*, and harmony with the laws of nature (p. 205). *Wu wei* is described as more than simply accepting the way things are but, rather, as consisting of “an attentive awareness and spontaneous responding to situations, opportunities, and changing events as they present themselves” (Chang et al., 2016, p. 214).
- Recognizing the social orientation of many Latinx people, La Roche, D’Angelo, Gualdron, and Leavell (2006) found that a visual imagery exercise worked better when therapists changed the instruction from “Imagine yourself alone in a beautiful place” to “Imagine sharing a moment with a person who makes you feel at peace” (p. 558).
- In their work with Maori New Zealanders, a group of psychologists, in cooperation with a Maori advisory group, used the concept of the *whare* (house) to explain how thoughts contribute to emotions and behaviors. The foundation of the house represents early childhood experiences; the first floor, core beliefs; the second floor, intermediate assumptions and rules for living; and the roof, coping strategies, which may or may not be protective. The psychologists also integrated prayer and Maori sayings that could be used as helpful self-talk (Bennett, Flett, & Babbage, 2014).
- Beau Washington, a psychologist and member of the Eastern band of Cherokee Indians, used the trickster coyote as a metaphor for how cognitive distortions can trick people and mislead

them. Noting that one coyote thought “isn’t much of a problem,” but “a pack of coyotes will take you down,” he explained cognitive restructuring as

When we dwell on things, the coyotes start to gather, creating bigger and bigger problems. . . . Knowing the names of the coyotes brings them out of the dark into the light. Recognizing them is our best chance of ending the darkness and pain they bring. (Washington, 2012, para. 8)

- In their work teaching behavioral interventions to Mexican American parents, psychologists noted that given the high value placed on family relationships, when using rewards to reinforce children’s good behavior, opportunities for family rewards were just as important as individual rewards (Barker, Cook, & Borrego, 2010).
- Also with regard to the use of reinforcement, therapists working with transgender clients created the idea of a “Trans-Affirmative Hope Box” filled with inspiring items the client chooses, such as photos of caring people, symbols of joy and safety such as a gender-queer rights button, a lesbian, gay, bisexual, transgender, and queer logo, favorite songs, and poems (Craig, McInroy, Alaggia, & McCreedy, 2014). A smartphone app has been developed that allows the client and therapist to cocreate a Virtual Hope Box (see <http://www.t2health.dcoe.mil/apps/virtual-hope-box>).
- Recognizing the challenges in using exposure therapy with ethnic groups that have experienced high levels of trauma, Hinton and Jalal (2014) used culturally specific metaphors with Iraqi clients to create positive expectancy. For example, they used the metaphor of the fear many women have of making bread on an open fire because over time and with repeated exposure to the task, the fear diminishes. In another example, they described learning the cognitive triangle as “a spoonful of treatment” because taking medications for ills was a common local expectation (Hinton & Jalal, 2014, p.141).
- With individuals who were less verbally oriented, Malchiodi and Rozum (2012) integrated CBT with art therapy. Examples of this integration included asking clients to “create an image” of their sadness, anxiety, depression, or anger. The words *art* and *draw* were avoided because many people are intimidated by both. Clients were then asked to create an image that would counter the painful one. In one case, a female client created a hurt-filled picture of her body, which she reported hating. Then



in response to the therapist's request to create a healing image, the client drew her husband's loving arms wrapped around her body. Art was also used as a stress reduction strategy—for example, as a sort of time out via the project of collecting magazine photos to create a visual journal.

## COGNITIVE BEHAVIOR THERAPY: AN OVERVIEW

In the 1950s and early 1960s, the field known as behavior therapy called attention to how environments could be manipulated to elicit, shape, and reinforce desired behaviors. A number of behavioral researchers subsequently became interested in the influence of cognition on behavior, and it was out of this interest that the field of CBT developed.

CBT involves a consideration of five components to any problem: cognitions, emotions, physiological reactions (e.g., physical sensations and symptoms), behavior, and the environment (Greenberger & Padesky, 2015). CBT presumes that cognitions (which include perceptions, beliefs, images, and self-talk) mediate one's emotions, behavior, and physiological reactions in response to the environment (Beck, 2011). Dysfunctional cognitions are believed to contribute to maladjustment, whereas functional cognitions contribute to healthy adjustment (Dobson, 2001).

It is the role of the cognitive behavior therapist to help clients become aware of the relationships between these five areas. Clients learn to recognize how certain negative, unhelpful, or unrealistic thoughts can generate distress in the form of uncomfortable physical sensations, maladaptive behavior, and emotions that feel uncontrollable or out of proportion to the situation. Clients also learn that social and physical aspects of their environment can contribute to their distress. Once the client understands these connections, the therapist then helps the individual to recognize steps they can take to either change the problem or cope more effectively with it. Solutions may involve changing one's behavior or the environment (what I call *action steps*) or internal cognitive changes.

With regard to changing the environment or behavior, in my work with clients, I use an acronym that spells the word CLASS to summarize the types of action steps one can take:

- Change something in one's environment (or create a healthy environment);
- Learn a new skill or behavior;
- Assertiveness, conflict resolution, and other communication skills;

- Social support; and
- Self-care activities (emotional, physical, spiritual; Hays, 2014).

In addition, the internal cognitive changes, called *cognitive restructuring*, involve more than simply thinking positively. Rather, clients learn to recognize common cognitive errors, automatic dysfunctional thoughts, and cognitive tendencies related to the schema (a sort of cognitive template) by which human beings take in and organize their experience. By considering a broader range of possible interpretations of events and beliefs that one may never before have considered, clients learn to see themselves, the world, and the future more fully and realistically (Beck, 2011; Beck & Beck, 2011; Greenberger & Padesky, 2015; Wenzel, Dobson, & Hays, 2016).

### **Making Cognitive Behavior Therapy More Culturally Responsive**

A *culturally responsive* approach to CBT begins long before the start of one's therapeutic work with clients. It begins with therapists' attention to those areas in which they may hold biases. Cognitive scientists recognize that, from birth, we humans are wired to create categories as a way of organizing and making sense of our experiences. We then make generalizations based on subsequent experiences using these categories (Tropp & Mallett, 2011). This process of categorizing and generalizing is normal and can even be helpful when it facilitates our relationships, but when the categories become too rigid and the generalizations too broad, there are problems. Bias can also develop in the absence of experience with specific groups because dominant cultural messages about minority groups (which are usually negative) exert a subtle yet powerful influence, often without the perceiver's awareness.

What is important to recognize (and which keeps us humble) is that we all have biases. The first step is to begin to look for them, while recognizing that some biases exert more power than others, resulting in systems of privilege and oppression. Once we understand how this works, we can then actively work to replace our inaccurate beliefs and assumptions with reality-based information. This type of work is personal, and it cannot be accomplished in one course or even in several cross-cultural encounters. Rather, it is an ongoing process that involves exploring the impact of cultural influences on one's beliefs (i.e., cognitions), behaviors, and identities.

One way to begin this process is with a cultural self-assessment. In the workshops I teach, I start with an exercise that uses the acronym ADDRESSING to call attention to nine key cultural influences and related minority and dominant cultural groups: Age and generational influences, Developmental or other Disability, Religion and spiritual orientation, Ethnic and racial identity, Socioeconomic status, Sexual orientation, Indigenous

TABLE 1  
ADDRESSING Cultural Influences

Cultural influences	Dominant group	Nondominant/minority
Age and generational influences	Young or middle-aged adults	Children, older adults
Developmental or other Disability <sup>a</sup>	Nondisabled people	People with cognitive, intellectual, sensory, physical, and/or psychiatric disabilities
Religion and spirituality	Christian and secular	Muslims, Jews, Hindus, Buddhists, and other religions
Ethnic and racial identity	European Americans	Asian, South Asian, Latinx, Pacific Islander, African, Arab, African American, Middle Eastern, and multiracial people
Socioeconomic status	Upper and middle class	People of lower status by occupation, education, income, or inner city/rural habitat
Sexual orientation	Heterosexuals	People who identify as gay, lesbian, or bisexual
Indigenous heritage	European Americans	American Indians, Inuit, Alaska Natives, Métis, Native Hawaiians, New Zealand Maori, Aboriginal Australians
National origin	U.S.-born American citizens	Immigrants, refugees, and international students
Gender	Men	Women and transgender people

*Note.* Adapted from *Addressing Cultural Complexities in Practice: Assessment, Diagnosis, and Therapy* (3rd ed., p. 8), by P. A. Hays, 2016, Washington, DC: American Psychological Association. Copyright 2016 by the American Psychological Association.

<sup>a</sup>With the increased use of the term *intellectual disability*, the term *developmental disability* is being used less often, particularly within the Disability community; however, it is included in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* and *International Classification of Diseases, Tenth Edition, Clinical Modification*.

heritage, National origin, and Gender (see Table 1; Hays, 2016). Of course, there are other cultural influences, but I focus primarily on these nine because they are the ones that have been noted by the APA (2017) and the American Counseling Association (Arredondo & Pérez, 2006) as requiring special attention because of their historical neglect.<sup>3</sup>

If you would like to begin this exercise right now, take a blank sheet of paper and write the ADDRESSING acronym vertically on the left side of the paper. Then take a few minutes to fill in the influences on you related to each of these categories. These influences might be related to a dominant cultural identity, a minority identity, or both. For example, regarding Age and

<sup>3</sup>See also the *Report of the APA Task Force on the Implementation of the Multicultural Guidelines*, which focuses primarily on implementation of the *Guidelines* with regard to ethnic and racial identity but notes the importance of these additional factors too (<http://apa.org/about/policy/multicultural-report.pdf>).

generational influences, do not just record your chronological age. Rather, think about your particular age cohort (e.g., Generation X, millennial, baby boomer) and the societal, cultural, and historical influences on people your age. Also, think about your generation-related roles. For example, are you an oldest child, adult child of aging parents, aunt, or uncle? With regard to Developmental or other Disability, write about your own experience or inexperience with disability because, with regard to the latter, a lack of experience with people of a particular identity also shapes your thoughts and behavior with others. (For more detailed questions to facilitate this self-assessment, see Hays, 2013, and Hays, 2016.)

Once you have a description of the ADDRESSING influences on yourself, put a star next to each category in which you hold a dominant cultural identity. For example, if you are a young or middle-aged adult (i.e., you are not a child or older adult), put a star next to Age and generational influences; if you do not have any disability, put a star next to Developmental or other Disability; if you are of Christian or secular heritage, put a star next to Religion and spiritual orientation; if you are of European American heritage, put a star next to Ethnic and racial identity; if you grew up middle class or are currently middle class, put a star next to Socioeconomic status; if you are heterosexual, put a star next to Sexual orientation; if you do not have any Indigenous heritage, put a star next to Indigenous heritage; if you are a U.S.-born American citizen, put a star next to National origin; and if you identify as male, put a star next to Gender. Now, look at your list. I call this starred list your *constellation of privileges*, and everyone's constellation is unique.

Identity is complex, and it can shift with context and over time (Ferguson, Nguyen, & Iturbide, 2017). For example, it is possible to hold both a minority and a dominant cultural identity simultaneously (e.g., if you have a White parent and an African American parent). There is no right or wrong identity with this exercise. The point is to recognize the influences on you and the privileges you hold in relation to your dominant-culture identities. This recognition can be extremely difficult because, as the saying goes, privilege is like oxygen; you don't notice it unless it's not there. The reason it is important to recognize privilege is that the areas in which we hold privilege are usually the areas in which our knowledge and experience regarding minority groups are most limited. And as therapists, the less we know about and understand our clients' experiences, the less effective we are.

There are a number of things you can do to stay engaged in the process of recognizing your cultural influences and privileges. These include obtaining cultural information from culture-specific sources (e.g., news published by ethnic and other minority communities), attending cultural celebrations and other public events, obtaining supervision from a person who belongs to and is knowledgeable about a minority culture, consulting with a culturally

diverse professional group, reading from the wealth of multicultural counseling research now available, and developing relationships with people of diverse cultures. Clients should not be expected to educate you about the broader social and cultural meanings of their identities. However, you will have to obtain information from clients regarding their unique personal experience of their culture. Engagement with these forms of learning facilitates the development of the cognitive schema or template into which client-specific information can be considered and incorporated. The development of this cultural schema is the responsibility of you, the therapist.

### **Cognitive Behavioral Assessment**

One of the first steps in a cognitive behavioral assessment involves conceptualization of the problem. CBT divides problems into two general categories. The first category consists of problems in the client's environment (e.g., a difficult task, a conflict, a stressful situation) that imply an environmental solution (e.g., changing the task, obtaining help, decreasing stressors in the situation). The second category consists of problems that are more internal—namely, those involving dysfunctional cognitions and undesirable overwhelming emotions. Difficulties in this second category are commonly referred to as *cognitive problems*. Many problems involve both environmental and cognitive elements, but distinguishing between the two is important in developing the most effective intervention.

#### *Environmental Problems*

One would think that cultural influences would be included in the definition of any environment, but this has not been the case with CBT. Cultural aspects of clients' environments have often been overlooked or framed in negative terms.

A *culturally responsive* assessment takes into account both positive and negative aspects of clients' cultural environments. Culturally related *stressors* can include acculturation; discrimination; living in an unsafe neighborhood, in inadequate housing, or extreme poverty; receiving insufficient welfare support; inadequate health care or social services; legal problems; and exposure to disasters or war (American Psychiatric Association, 2000).

Even if clients do not perceive cultural stressors such as racism and other forms of oppression, it is important that therapists be aware of them. In their work with transgender clients, Austin and Craig (2015) used an inverted pyramid (upside-down triangle) to illustrate the effects of societal oppression on mental health—an illustration that could be helpful with clients experiencing various forms of societal oppression. The top and widest level of the inverted pyramid represents oppressive dominant cultural

beliefs and messages regarding the minority group; the second level down, institutional levels of discrimination such as laws, business practices, the media, and religions; the third level down, direct interpersonal interactions that are hurtful; and the bottom tip of the inverted pyramid represents the individual, including internalized beliefs and feelings. This illustration can be helpful in validating clients' struggles because it affirms the individual is "doing their best to cope with complex and often hostile environmental circumstances" (p. 24).

Positive aspects of a person's cultural environment have received much less attention. These positive aspects can be considered in two categories: environmental conditions and interpersonal supports (Hays, 2016). The first category, *environmental conditions*, may be natural or constructed. Examples of *natural conditions* include rivers, beaches, and land available for subsistence and recreational fishing, hunting, gardening, and farming. *Constructed environmental conditions* may be an altar in one's home or room to honor deceased family members, a space for prayer and meditation, availability of culturally preferred foods, the presence of culture-specific art and music, a place for animals, and communities that facilitate social interaction (e.g., villages in which homes are within walking distance of one another).

*Interpersonal supports* include extended families (blood related and non-blood related), religious communities, traditional celebrations and rituals, recreational activities, storytelling activities that pass on the history of a group, and involvement in political and social action groups. Having a child who is successful in school can also be an important source of pride and strength for parents and extended family.

The explicit consideration of these positive aspects of cultural environments is important for a number of reasons. For one, helping clients to recognize culturally related supports communicates respect for a client's cultural heritage. Respect is a central concept among many people of minority cultures, and as such, it is important for the purposes of establishing a good working relationship (Boyd-Franklin, 2003; El-Islam, 1982; Kim, 1985; Matheson, 1986; Morales, 1992; Swinomish Tribal Community, 1991).

In addition, cognitive behavioral research encourages the incorporation of strengths and supports in the development of effective therapeutic interventions. The use of naturally occurring supports works precisely because the supports are naturally occurring and thus easier to implement and maintain. The explicit consideration of culturally related environmental conditions and supports opens up an array of interventions that might otherwise be overlooked from a dominant cultural perspective.

When investigating cultural supports, it is important to consider the client's orientation to their culture of origin and the dominant culture. LaFromboise, Coleman, and Gerton (1993) proposed a model of *bicultural*

*competence* that emphasizes the reciprocal relationship between the person and the environment or, in this case, two environments (the culture of origin and the second culture). They suggested that competence in each of these cultures can be observed in the individual's (a) knowledge of cultural beliefs and values, (b) positive attitudes toward both majority and minority groups, (c) bicultural efficacy, (d) communication ability, (e) role repertoire, and (f) sense of groundedness in a social support system.

This model may be helpful in one's exploration and choice of supports. For example, consider the situation of a middle-aged, urban American Indian woman. If the woman grew up in an American Indian family and cultural context, identifies strongly with her specific Native culture and functions well in the dominant cultural setting in which she works and lives, and currently is well grounded in a social support system that includes Native and non-Native people, the range and types of environmental supports that would be appropriate for her would be quite different from those of another middle-aged, urban American Indian woman who grew up in an adopted European American family with little connection to her cultural heritage. Whereas the first woman might be open to traditional rituals, supports, or healing practices in addition to some dominant cultural approaches, the second woman could interpret the suggestion of traditional rituals, supports, or healing practices as presumptive and thus involving racist assumptions.

### *Cognitive Problems*

This brings us to the second category of problems—namely, those that can be thought of as internal to the client. These include overwhelming emotions, disturbing thoughts, frightening physical sensations, and maladaptive behavior. CBT refers to these problems as *cognitive* because the disturbance is seen as emanating from dysfunctional cognitions and cognitive processes. As noted earlier, CBT proposes that we can increase our control over disturbing physiological sensations, overwhelming emotions, and self-defeating behaviors if we recognize our unhelpful cognitions and change them to more helpful, realistic, and positive ones.

Attention to cultural influences within this second category of problems is important for several reasons. Culture plays a role in the creation, shaping, and maintenance of cognitions and cognitive processes (Dowd, 2003). Cultural influences can be seen in one's definitions of rationality and in one's view of what constitutes adaptive and maladaptive behavior. Cultural influences are interwoven with beliefs regarding acceptable coping behaviors and forms of emotional expression and with religious and social values that affect clients' perceived choices.

Because minority cultural influences are often framed as negative by the dominant culture, therapists will give deliberate attention to the positive aspects of cultural influences on internal processes. These can be conceptualized as *personal strengths* and include pride in one's culture and identity; a religious faith or spirituality; musical and artistic abilities; bilingual and multilingual skills; a sense of humor; culturally related knowledge and practical living skills regarding fishing, hunting, farming, cooking, and the use of medicinal plants; culture-specific beliefs that help one cope with prejudice and discrimination; and commitment to helping one's group—for example, through social action.

Here again, the client's connection to and competence in their culture of origin and the dominant culture are important. For example, consider the situation of a young Vietnamese man in his early 20s who lives in the United States with his parents and younger siblings and who presents with anxiety related to family and work conflicts. From a dominant cultural perspective, the therapist might conceptualize the client's problem as one of individuation and encourage him to question the authority of his parents and find his own place to live. Such an approach could involve challenging culturally based beliefs regarding interdependence of family members, responsibility to others, and respect for elders. If the client and his family are open to alternative cultural perspectives, considering these different views could be helpful. However, if they are not, such an approach would probably diminish the therapist's credibility and lead the young man to terminate therapy. More helpful approaches might involve teaching the client (and possibly the family) skills for problem solving, conflict resolution, and frustration tolerance that do not involve challenging core cultural beliefs.

### **Addressing the Complexity of Problems**

Of course, environmental and cognitive aspects of problems often overlap. An ever-present danger with CBT lies in the inaccurate conceptualization of a client's problem (i.e., distress) as due to dysfunctional cognitions when it is a consequence of unacceptable environmental conditions (e.g., an abusive relationship, a racist workplace, physical and social barriers to a person who has a disability). As therapists, we do not want to be in the position of encouraging a client to adapt to an environment that is dangerous or harmful. Attempts to change a client's thinking about such conditions without trying to change the conditions may give the message that the conditions are acceptable and that the client is to blame for them.

Returning to the example of Shelby, let us say that her coworkers and supervisor resent her and that their feelings emanate from racial prejudice. In response to this environmentally based problem, the therapist would explore



with Shelby the possibility of taking action aimed at changing her work environment (e.g., proactively talking with her supervisor to respond to the complaints, talking to someone above her supervisor, filing a complaint, looking for a new job, consulting an attorney). However, if Shelby's anxiety is so great that it prevents her from engaging in this type of problem solving, it may be necessary to take a more internal (cognitive) focus to managing the anxiety. This internal focus would involve helping Shelby change her self-defeating thoughts to more helpful ones that decrease her anxiety. Such cognitive restructuring might be conducted first or in combination with the problem solving aimed at changing Shelby's work environment.

Building on the existing literature in the domains of CBT and multicultural therapy, this book provides clinicians and counselors with practitioner-oriented suggestions, guidelines, and examples illustrating the use of CBT with people of diverse cultural identities. The book is intended for psychologists, counselors, family therapists, social workers, and psychiatrists who are interested in using cognitive behavioral approaches to assessment, therapy, and supervision with clients and students of diverse identities. It should appeal to those who already hold multicultural expertise and want to learn specific skills and interventions, as well as to cognitive behavior therapists who wish to expand their approaches to more diverse populations. An underlying premise of the book is that culture influences us all, and the consideration of culture is an essential component of assessment and therapy with everyone. By focusing on the application of CBT with people of minority identities, we hope to call attention to how cultural considerations can enhance and facilitate CBT with people of minority, dominant, bicultural, and multicultural identities.

## OVERVIEW OF THE BOOK

This Introduction is followed by eight chapters focusing on the use of CBT with specific ethnic groups—namely, American Indian, Alaska Native, Latinx, African American, Asian American, South Asian, Arab, and Orthodox Jewish cultures—followed by chapters on CBT with people of nonethnic minority groups: older adults, people with disabilities, and sexual and gender minorities. Ethnic groups are included first because ethnicity and race were the initial focus and have continued to be the primary focus in the field of multicultural psychology. In this initial section on ethnic and racial minority groups, we place American Indian and Alaska Native people first because Indigenous people literally are the First Peoples. In keeping with the conceptualization of identity as complex and multidimensional, these chapters do not assume a European American norm but rather include people of

multidimensional identities (e.g., people of color who are older, have a disability, or are gay, lesbian, bisexual, or transgender).

This second edition builds on the first with the following changes: All chapters have been updated to include relevant demographic information and studies since 2006, culture-specific assessment information is now embedded in each chapter rather than in one separate general chapter, and a chapter has been added regarding CBT with South Asian clients, particularly people of Asian Indian heritage.

Each of Chapters 1 through 11 offers an overview of the respective cultural group, including sociodemographics and information regarding within-group diversity, followed by a discussion of the advantages of using CBT with each group, potential limitations, and suggested adaptations for assessment and therapy. Case examples illustrate the practical application of these adaptations. Chapter 12 addresses cultural considerations in supervision and training.

One final note: Although we have done our best to include a diverse range of cultural influences and minority groups, there is still a long way to go. We recognize the need for more empirically based research involving minority cultures. In the meantime, we hope that the clinically based suggestions and modifications provided in this book will contribute to the search for and consideration of evidence-based practices. We look forward to future research involving an even greater number of cultural groups from a variety of countries.

## REFERENCES

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- American Psychological Association. (2017). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality*. Retrieved from <http://www.apa.org/about/policy/multicultural-guidelines.pdf>
- American Psychological Association, Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, *61*, 271–285. <http://dx.doi.org/10.1037/0003-066X.61.4.271>
- Arredondo, P., & Pérez, P. (2006). Historical perspectives on the Multicultural Guidelines and contemporary applications. *Professional Psychology: Research and Practice*, *37*, 1–5. <http://dx.doi.org/10.1037/0735-7028.37.1.1>
- Austin, A., & Craig, S. L. (2015). Transgender affirmative cognitive behavioral therapy: Clinical considerations and applications. *Professional Psychology: Research and Practice*, *46*, 21–29. <http://dx.doi.org/10.1037/a0038642>
- Barker, C. H., Cook, K. L., & Borrego, J., Jr. (2010). Addressing cultural variables in parent training programs with Latino families. *Cognitive and Behavioral Practice*, *17*, 157–166. <http://dx.doi.org/10.1016/j.cbpra.2010.01.002>

- Beck, J. S. (2011). *Cognitive therapy: Basics and beyond* (2nd ed.). New York, NY: Guilford Press.
- Beck, J. S., & Beck, A. (2011). *Cognitive therapy for challenging problems: What to do when the basics don't work*. New York, NY: Guilford Press.
- Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counseling Psychology, 58*, 279–289. <http://dx.doi.org/10.1037/a0023626>
- Bennett, S. T., Flett, R. A., & Babbage, D. R. (2014). Culturally adapted cognitive behaviour therapy for Maori with major depression. *The Cognitive Behaviour Therapist, 7*, 1–16. <http://dx.doi.org/10.1017/S1754470X14000233>
- Bernal, G., & Domenech Rodriguez, M. M. (Eds.). (2012). *Cultural adaptations: Tools for evidence-based practice with diverse populations*. Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/13752-000>
- Boyd-Franklin, N. (2003). *Black families in therapy*. New York, NY: Guilford Press.
- Casas, J. M. (1988). Cognitive-behavioral approaches: A minority perspective. *The Counseling Psychologist, 16*, 106–110. <http://dx.doi.org/10.1177/0011000088161009>
- Chang, D. F., Hung, T., Ng, N., Ling, A., Chen, T., Cao, Y., & Zhang, Y. (2016). Taoist cognitive therapy: Treatment of generalized anxiety disorder in a Chinese immigrant woman. *Asian American Journal of Psychology, 7*, 205–216.
- Chang, E. C., Downey, C. A., Hirsch, J. K., & Yu, E. A. (Eds.). (2018). *Treating depression, anxiety, and stress in ethnic and racial groups: Cognitive behavioral approaches*. Washington, DC: American Psychological Association.
- Chu, J., & Leino, A. (2017). Advancement in the maturing science of cultural adaptations of evidence-based interventions. *Journal of Consulting and Clinical Psychology, 85*, 45–57. <http://dx.doi.org/10.1037/ccp0000145>
- Craig, S. L., McInroy, L. B., Alaggia, R., & McCreedy, L. T. (2014). Like picking up a seed, but you haven't planted it: Queer youth analyze the It Gets Better Project. *International Journal of Child, Youth & Family Studies, 5*, 204–219. <http://dx.doi.org/10.18357/ijcyfs.craigsl.512014>
- Davidson, R. J., & Kaszniak, A. W. (2015). Conceptual and methodological issues in research on mindfulness and meditation. *American Psychologist, 70*, 581–592. <http://dx.doi.org/10.1037/a0039512>
- Dobson, K. (Ed.). (2001). *Handbook of cognitive-behavioral therapies*. New York, NY: Guilford Press.
- Dowd, E. T. (2003). Cultural differences in cognitive therapy. *The Behavior Therapist, 26*, 247–249.
- El-Islam, F. (1982). Arabic cultural psychiatry. *Transcultural Psychiatric Research Review, 19*, 5–24. <http://dx.doi.org/10.1177/136346158201900101>
- Ferguson, G. M., Nguyen, J., & Iturbide, M. I. (2017). Playing up and playing down cultural identity: Introducing cultural influence and cultural variability. *Cultural*

- Diversity & Ethnic Minority Psychology*, 23, 109–124. <http://dx.doi.org/10.1037/cdp0000110>
- Friedman, S., Braunstein, J. W., & Halpern, B. (2006). Cognitive behavioral treatment of panic disorder and agoraphobia in a multiethnic urban outpatient clinic: Initial presentation and treatment outcome. *Cognitive and Behavioral Practice*, 13, 282–292. <http://dx.doi.org/10.1016/j.cbpra.2006.04.009>
- Fuchs, C. H., West, L. M., Graham, J. R., Kalill, K. S., Morgan, L. P. K., Hayes-Skelton, S. A., . . . Roemer, L. (2016). Reactions to an acceptance-based behavior therapy for GAD: Giving voice to the experiences of clients from marginalized backgrounds. *Cognitive and Behavioral Practice*, 23, 473–484. <http://dx.doi.org/10.1016/j.cbpra.2015.09.004>
- Glickman, N. S. (2009). Adapting best practices in CBT for deaf and hearing persons with language and learning challenges. *Journal of Psychotherapy Integration*, 19, 354–384. <http://dx.doi.org/10.1037/a0017969>
- Graves, S. L., & Blake, J. J. (Eds.). (2016). *Psychoeducational assessment and intervention for ethnic minority children: Evidence-based approaches*. Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/14855-000>
- Greenberger, D., & Padesky, C. (2015). *Mind over mood: Change how you feel by changing the way you think*. New York, NY: Guilford Press.
- Hall, G. C. N., Yip, T., & Zárate, M. A. (2016). On becoming multicultural in a monocultural research world: A conceptual approach to studying ethnocultural diversity. *American Psychologist*, 71, 40–51. <http://dx.doi.org/10.1037/a0039734>
- Hamp, A., Stamm, K., Lin, L., & Christidis, P. (2016). *2015 APA survey of psychology health service providers*. Retrieved from <http://www.apa.org/workforce/publications/15-health-service-providers/index.aspx>
- Hays, P. A. (2013). *Connecting across cultures: The helper's toolkit*. Thousand Oaks, CA: Sage.
- Hays, P. A. (2014). *Creating well-being: Four steps to a happier healthier life*. Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/14317-000>
- Hays, P. A. (2016). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (3rd ed.). Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/14801-000>
- Hinton, D. E., & Jalal, B. (2014). Parameters for creating culturally sensitive CBT: Implementing CBT in global settings. *Cognitive and Behavioral Practice*, 21, 139–144. <http://dx.doi.org/10.1016/j.cbpra.2014.01.009>
- Hinton, D. E., Pich, V., Hofmann, S. G., & Otto, M. W. (2013). Acceptance and mindfulness techniques as applied to refugee and ethnic minority populations with PTSD: Examples from “culturally adapted CBT.” *Cognitive and Behavioral Practice*, 20, 33–46. <http://dx.doi.org/10.1016/j.cbpra.2011.09.001>
- Huey, S. J., Jr., Tilley, J. L., Jones, E. O., & Smith, C. A. (2014). The contribution of cultural competence to evidence-based care for ethnically diverse populations.

- Annual Review of Clinical Psychology*, 10, 305–338. <http://dx.doi.org/10.1146/annurev-clinpsy-032813-153729>
- Iwamasa, G., & Smith, S. K. (1996). Ethnic diversity and behavioral psychology: A review of the literature. *Behavior Modification*, 20, 45–59. <http://dx.doi.org/10.1177/01454455960201002>
- Kantrowitz, R. E., & Ballou, M. (1992). A feminist critique of cognitive-behavioral therapy. In L. S. Brown & M. Ballou (Eds.), *Personality and psychopathology: Feminist appraisals* (pp. 70–87). New York, NY: Guilford Press.
- Kim, S. C. (1985). Family therapy for Asian Americans: A strategic-structural framework. *Psychotherapy: Theory, Research, Practice, Training*, 22, 342–348. <http://dx.doi.org/10.1037/h0085513>
- Kohout, J. L., Pate, W. E., & Maton, K. I. (2014). An updated profile of ethnic minority psychology: A pipeline perspective. In F. T. L. Leong (Ed.), *APA handbook of multicultural psychology: Vol. 1. Theory and research* (pp. 19–42). Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/14189-002>
- LaFromboise, T., Coleman, H. L. K., & Gerton, J. (1993). Psychological impact of biculturalism: Evidence and theory. *Psychological Bulletin*, 114, 395–412. <http://dx.doi.org/10.1037/0033-2909.114.3.395>
- La Roche, M. J., D'Angelo, E., Gualdron, L., & Leavell, J. (2006). Culturally sensitive guided imagery for allocentric Latinos: A pilot study. *Psychotherapy: Theory, Research, Practice, Training*, 43, 555–560. <http://dx.doi.org/10.1037/0033-3204.43.4.555>
- Lucassen, M. F. G., Merry, S. N., Hatcher, S., & Frampton, C. M. A. (2015). Rainbow SPARX: A novel approach to addressing depression in sexual minority youth. *Cognitive and Behavioral Practice*, 22, 203–216. <http://dx.doi.org/10.1016/j.cbpra.2013.12.008>
- Malchiodi, C. A., & Rozum, A. L. (2012). Cognitive-behavioral and mind-body approaches. In C. Malchiodi (Ed.), *Handbook of art therapy* (2nd ed., pp. 89–102). New York, NY: Guilford Press.
- Matheson, L. (1986). If you are not an Indian, how do you treat an Indian? In H. P. Lefley & P. Pedersen (Eds.), *Cross-cultural training for mental health professionals* (pp. 115–130). Springfield, IL: Charles C Thomas.
- Morales, E. S. (1992). Counseling Latino gays and Latina lesbians. In S. H. Dworkin & F. J. Gutierrez (Eds.), *Counseling gay men and lesbians: Journey to the end of the rainbow* (pp. 125–140). Alexandria, VA: American Counseling Association.
- Naeem, F., & Kingdon, D. (Eds.). (2011). *Cognitive behaviour therapy in non-Western cultures*. New York, NY: ANOVA Science.
- Neblett, E. W., Jr., Bernard, D. L., & Hudson Banks, K. (2016). The moderating roles of gender and socioeconomic status in the association between racial discrimination and psychological adjustment. *Cognitive and Behavioral Practice*, 23, 385–397. <http://dx.doi.org/10.1016/j.cbpra.2016.05.002>

- Pedersen, P. (1987). Ten frequent assumptions of cultural bias in counseling. *Journal of Multicultural Counseling and Development*, 15, 16–24. <http://dx.doi.org/10.1002/j.2161-1912.1987.tb00374.x>
- Shealy, K. M., Davidson, T. M., Jones, A. M., Lopez, C. M., & de Arellano, M. A. (2015). Delivering an evidence-based mental health treatment to underserved populations using telemedicine: The case of a trauma-affected adolescent in a rural setting. *Cognitive and Behavioral Practice*, 22, 331–344. <http://dx.doi.org/10.1016/j.cbpra.2014.04.007>
- Smith, T. B., Domenech Rodríguez, M., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology*, 67, 166–175. <http://dx.doi.org/10.1002/jclp.20757>
- Swinomish Tribal Community. (1991). *A gathering of wisdoms, tribal mental health: A cultural perspective*. La Conner, WA: Author.
- Tropp, L. R., & Mallett, R. (Eds.). (2011). *Moving beyond prejudice reduction: Pathways to positive intergroup relations*. Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/12319-000>
- Washington, B. (2012, May 31). Coyote thoughts: A Native explains mental health. *Indian Country Today*. Retrieved from <https://newsmaven.io/indiancountrytoday/archive/coyote-thoughts-a-native-explains-mental-health-PMJLkx4xUGMPdkvNgBB6Q/>
- Wenzel, A., Dobson, K. S., & Hays, P. A. (2016). *Cognitive behavioral therapy techniques and strategies*. Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/14936-000>
- Wood, P. S., & Mallinckrodt, B. (1990). Culturally sensitive assertiveness training for ethnic minority clients. *Professional Psychology: Research and Practice*, 21, 5–11. <http://dx.doi.org/10.1037/0735-7028.21.1.5>
- Zane, N., Bernal, G., & Leong, F. T. L. (2016). *Evidence-based psychological practice with ethnic minorities*. Washington, DC: American Psychological Association.