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Cultural Considerations in Applying Cognitive Behavioral Therapy to Racial/Ethnic Minority Groups with Serious Mental Illness

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The Issue

Over 100 million people in the US identify as belonging to a racial/ethnic minority group. Individuals with a serious mental illness who also identify as a racial/ethnic minority tend to receive poorer quality of care, have less access to services, and experience higher dropout rates and poorer outcomes when compared to their White counterparts[1]. These differences have spurred initiatives to integrate cultural perspectives into evidence-based treatments.

The Audience

This practice brief is intended to help clinicians — particularly those who administer Cognitive Behavioral Therapy for individuals with serious mental illness—to enhance their cultural awareness and incorporate culturally-relevant practices into their formulation and treatment approach.

Key Points:

- Culture directly influences many aspects of the CBT model.
- Adapting evidence-based interventions like CBT to better consider culture may help to reduce mental health disparities among racial/ethnic minorities.
- The goal is to understand the patient's cultural background and to make appropriate changes to how therapy is delivered without altering the theoretical underpinnings of CBT.
- Though specific adaptations can be helpful, the most important components of cultural sensitivity include awareness, openness, and genuine curiosity to diverse values, perspectives, and experiences.

The Approach

Scholars have developed an evidence-based framework for adapting CBT for individuals from non-Western cultures that may also be applicable to cultural minority groups in the United States[2]. Culture refers to, "the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and […] it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs"[3]. Thus, culture can impact an individual's life experiences, core values, belief systems, patterns of thinking, attributional styles, as well as beliefs about mental illness and appropriate treatment approaches. These factors are all important components of the CBT model (see Figure 1) and highlight the importance of considering cultural concepts in case formulation and treatment.

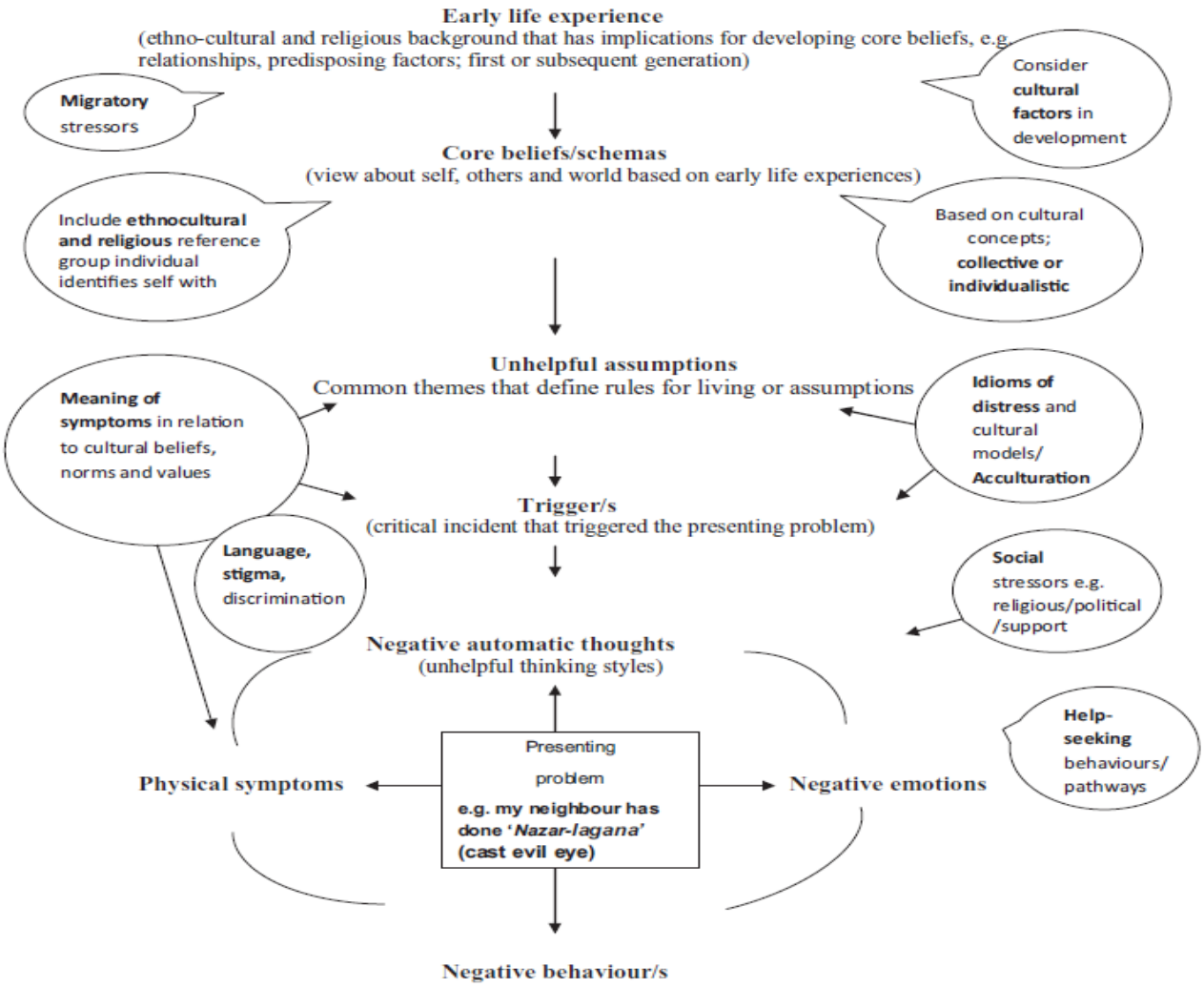

Figure 1. Role of culture in CBT model. Reprinted with permission from Rathod *et al*. (2015).

This brief will describe several techniques that may assist clinicians in integrating culture into their CBTp practice.

The Techniques

Therapeutic Style and Practices:

- **Authority:** Within some non-Western cultures, therapists may be expected to take on an authoritative role. Consider beginning with a directive style, easing into collaborative approaches as therapy proceeds. This may include providing:
  - Direct feedback
  - A clear summary of the discussions
  - A statement of new insights or therapeutic gains.
- **Language:** Language should be *adapted*, not simply *translated*. For example, certain forms of assertiveness may be inappropriate or offensive in some cultures. Instead:
  - Explore culturally appropriate expressions
    - For example: *Describe a person you think of as assertive; how would they handle this situation?*
  - Teach skills in a culturally sensitive manner and adapt CBT terminology using culturally relevant words and phrases
    - For example, when reviewing cognitive errors, explain the concept (e.g., black and white thinking) and ask the client if there is a label/idiom of distress that is more relevant to them.
  - Use culturally appropriate stories and metaphors in conveying messages and activating change.
- **Supports:** Look for opportunities to include, share materials with, and maintain regular contact with relevant cultural supports. Cultural support teams may include:
  - Family members
  - Religious/spiritual leaders.
- **Religion and Spirituality:** When religious/spiritual belief systems are endorsed by the person, it can be useful to incorporate positive aspects of religious/spiritual coping into treatment. Suggested strategies:
  - Involve significant religious/spiritual supports in treatment
  - Collaborate with mentors and/or healers in discussing/delivering information
  - Provide services in non-clinical settings (e.g., churches or community centers).[4]
- **Case Formulation:** Development should incorporate:
  - Cultural identity/ies of the individual
  - Cultural conceptualizations of symptoms or experiences
  - Psychosocial predisposing, precipitating, and perpetuating factors
  - Cultural stressors
  - The relevance of religion/spirituality
  - Competencies and resources.
- **Stigma:** Stigma can play a significant role in acceptance of mental illness and willingness to seek treatment[1] and can be addressed by:

- Exploring preferences surrounding the setting of therapy (e.g., home visits, clinic visits, and community settings) to help minimize perceptions of stigma and feelings of shame and guilt
- Working with clients to explore the impact of belonging to two cultural minority groups (i.e., individuals with mental illness and a racial/ethnic minority group) on wellbeing and belief systems.

Techniques for Engagement:

- **Collaboration:** At the onset of therapy, utilize a collaborative information-seeking approach. This acknowledges that clients are the expert in their own experiences and promotes an open and curious therapeutic stance.
  - For example, one can set the stage for therapy with a statement such as, "*While I am the expert in delivering the therapy, you are an expert in your own culture. I understand and respect the impact of cultural beliefs and hope that we can work together so that I can learn some things about your culture from you.*"[2]
- **Psychoeducation:** While providing psychoeducation, explore the relevance of a bio-psycho-social-spiritual model of illness, which incorporates consideration of how spirituality may relate to:
  - Perceptions of cause and effect (e.g., "mental illness is a punishment from God for a prior wrongdoing")
  - Coping styles (e.g., prayer, reading spiritual texts, attending services)
  - Preferences for traditional help-seeking pathways (e.g., healers, spiritual supports)
  - Ways in which stress and symptoms can be expressed differently across cultures, as well as the significance of culturally specific protective factors (e.g., family, faith) and stressors (e.g., migration stress, discrimination).
- **Normalization and Validation:** Other important components of the engagement stage include normalization and validation. Suggested strategies:
  - Consider presenting clients with examples of cultural icons who have disclosed mental illness
  - Among racial/ethnic minority populations, experiences of discrimination and marginalization may trigger fears and expectations of similar treatment from one's therapist -- it is critical to acknowledge that clients are the experts in their life experiences, cultural influences, and symptoms
  - Validate a client's initial framing of their presenting problem -- this can be critical for fostering the willingness to consider alternate explanatory models later in treatment.[4]

Symptom-Specific Approaches:

- **Positive Symptoms:** Assess the cultural relevance of hallucinations and delusions (e.g., paranoia versus institutional mistrust). This can be integrated into a case formulation and assist in generating alternative perspectives that are culturally consistent.

    - Develop alternative explanations to delusional thought content that is in line with the client's cultural belief system and identify culturallly-consistent coping strategies to address distressing symptoms.
- **Negative Symptoms**: In work managing negative symptoms (e.g., diminished affect, reduced social drive, loss of motivation) the therapist should empower the client using cultural strengths such as:
    - Faith and community supports
    - Culturally relevant pleasurable activities that would be both culturally acceptable and personally activating.
- **Substance Use:** When substance use is culturally sanctioned, focusing on harm reduction may be more appropriate than abstinence. In these instances, it can also be helpful to involve family members in education of the impact of drugs/alcohol on symptoms and overall functioning.

Wellness Planning:

- **Treatment Termination:** When preparing for treatment termination, normalize the concept of relapse in a way that is meaningful to the client (e.g., "*how many times a year on average do you catch a cold? How do you deal with it – do you take vitamins, rest, go to the doctor– what measures do you take?"*).
- **Challenges:** Wellness planning sessions also provide opportunities to discuss anticipated challenges (e.g., racism) and ways to overcome them, in addition to exploring concerns about therapy ending.
- **Final Session:** Consider cultural variations in expressing goodbye (e.g., gifts, food).
- **Transition:** At treatment termination, it may be appropriate to transition clients to other community supports or spiritual counseling.

Why this Matters

While the racial/ethnic diversity of the US is ever-expanding, significant mental health disparities continue to be observed among racial/ethnic minority groups with a serious mental illness. Consideration and inclusion of culturally relevant practices may help to reduce these disparities and enhance the relevance and acceptability of evidence-based interventions among these populations.

References:
1. Maura, J., & Weisman de Mamani, A. (2017). Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: A review. Journal of Clinical Psychology in Medical Settings, 24(3–4), 187–210. https://doi.org/10.1007/s10880-017-9510-2
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