COGNITIVE-BEHAVIOURAL THERAPY AND ETHNIC MINORITY GROUPS:
A REVIEW OF OUTCOME RESEARCH

BY

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The undersigned certifies that she or he has read and recommends to the Faculty of Graduate Studies and Research for acceptance, a final project entitled COGNITIVE-BEHAVIOURAL THERAPY AND ETHNIC MINORITY GROUPS: A REVIEW OF OUTCOME RESEARCH submitted by RHONDA WOODCOCK in partial fulfillment of the requirements for the degree of Master of Counselling.

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Abstract

Cognitive-behavioural therapy (CBT) has become an accepted and empirically validated therapeutic approach in psychotherapy for a number of different presenting concerns. However, it is unclear whether there is empirical evidence to illustrate the efficacy of CBT with individuals from visible ethnic minority populations. Therefore, the aim of this project was to conduct a literature review to assess the degree to which CBT has received both quantitative and qualitative support for the treatment of individuals from visible ethnic minority populations. After an overview of CBT and issues related to efficacy research, 22 quantitative and qualitative outcome studies published between 1999 and 2005 were described and the methodologies were analyzed to determine the efficacy of CBT with visible ethnic minority participants. The findings from the review and analysis illustrate that CBT has not been proven to be efficacious in the treatment of visible ethnic minority clients.
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CHAPTER I

Introduction

Over the last decade, Canada’s population rate has been on the rise. However, according to Statistics Canada (2005) the visible minority population is growing much faster than the total population. Visible minority populations are defined by the employment equity act as “persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in color” (Statistics Canada, 2005). Between 1996 and 2001, the total Canadian population increased 6%, while the visible minority population rose 27% because of increased immigration (Statistics Canada, 2005). More recently, in a report for the period between July 1, 2004 and July 1, 2005, Statistics Canada (2005) highlighted that the yearly immigration rate is maintaining an upward trend with Canada receiving 244,600 immigrants. This is 5,500 more than in the previous year. The increased immigration over the years has made Canada home to almost 4 million individuals who identified themselves, according to a national survey conducted by Statistics Canada (2005), as members of visible minority groups in 2001, accounting for 13.4% of the total population. For the purpose of this paper, the focus will be on visible ethnic minorities from non-European origins.

As Western society is becoming increasingly diverse, the challenge of meeting psychological health needs requires attention. Yet, despite the increases in people from visible ethnic minority groups in Canada, cognitive-behavioural therapy (CBT) has remained one of the most accepted and commonly applied treatments in the field of psychotherapy, presumably because it has been supported by empirical evidence in many efficacy studies for specific disorders (Chambless et al., 1996). Since the publication of the American Psychological Association Division 12’s report for the Task Force on Promotion and
Dissemination of Psychological Procedures (1995), that constructed a list of empirically supported treatments (ESTs) including 16 empirically supported treatments and 56 treatments that are possibly efficacious (awaiting replication), there has been a real motivation to move the field of counselling and psychotherapy toward the application of treatments that are supported by empirical evidence (Chambless et al.). CBT possesses the most empirical evidence for its efficacy than any other therapeutic intervention to date. Although, Bernal and Scharrón-Del-Rio (2001) reported that a closer look at the efficacy research conducted from 1966-1997 and included in the EST list established by the American Psychological Association revealed that most of the studies contain few (if any) formal consideration for cultural, population, or construct validity; thereby decreasing the external validity or generalizability of the findings and highlighting that it is unclear if CBT is suitable for all clients.

It has also been noted that Chambless et al. (1996) were careful to point out that if ESTs had not been established for an individual from a particular ethnic minority group that the treatments established as efficacious for other populations included in the ESTs list should be applied (Bernal & Scharrón-Del-Rio, 2001). The problem with this statement is it contradicts the main purpose of initially creating the list of ESTs, which was to standardize empirically supported counselling treatments across clients. However, in the absence of evidence regarding the generalizability of treatments across populations, Chambless et al. make the suggestion to apply the ESTs with the unsupported faith that these treatments will be as therapeutic for ethnic minority populations as they are for the participants included in the EST research studies. Therefore, the lack of consideration for and inclusion of ethnic minority populations in the research deemed as ESTs, including CBT, needs to be addressed.
CBT originated from philosophies of middle-class, mainstream, European/American cultures with “agentic and individualistic” (Hays, 1995) values. The words “agentic” and “individualistic” were used to characterize the Western values inherent in CBT (Hays). Agentic or human agency refers to the capacity for humans to make choices and to impose those choices on the world (Wikipedia, 2005). This Western value or spiritual confidence occurs in contrast to the spiritual belief or value regarding the forces of nature and/or one’s spiritual understanding of the will of God in determining one’s life course. The latter two values or spiritual confidences can often be found to exist in the worldviews of minority populations. Dana (1998) defined worldview as “a cultural construction of reality that has developed as a basis for sanctioned actions to permit survival and adaptation under particular shared living conditions, geographic circumstances, and catastrophic events” (p. 16). Therefore, Dana concludes that an individual’s worldview is comprised of one’s philosophical understandings of the world, including one’s values, spiritual beliefs and understandings of the human race.

The other significant divergence in values and worldviews between many visible ethnic minority groups and the Western world is the importance that European Americans’ and Canadians’ place on individualism and independence. This autonomous, self-determining ideal contrasts drastically with the common collectivist or interdependent value that is maintained by many visible ethnic minority groups (Hall, 2001). African American, Asian American, and Latino American cultures, which are the primary ethnicities included in this review, all emphasize the importance of interpersonal relationships and a group identity (Broderick & Blewitt, 2006; Hall, 2001). These human differences could substantially impede the counselling process if not recognized and acknowledged within the application of
CBT. Although the visible ethnic minority participants included in this review are based predominantly in the American cultural context, it is presumed by the author that the findings from this review are relevant to Canadian culture due to the similarities of these North American countries.

One recent and vivid example that illustrates the discrepancy found between minority and non-minority spiritual worldviews was the devastation in 2001, when the Western world was subjected to the fanatically diverse and conflicting underlying values and spiritual beliefs guiding the actions of the peoples responsible for the September 11, 2001 catastrophe (the 9/11 event) in the United States. There has been an emphasis on increasing awareness to and respecting the discrepancies between the underlying values and worldviews of people from visible ethnic minority groups for several decades (Casas, 1988; Pedersen, 1995); though after the 9/11 event, the significance of the variations between groups were illuminated, and the reality that differences existed between worldviews, such as the value and meaning of life, were difficult to ignore.

It has been argued that just as the philosophies or worldviews that guide some of the visible ethnic minority populations’ thoughts, emotions, and behaviours may be unfamiliar and foreign to people from the Western world, so may be the European/American/Canadian philosophies and worldviews that underlie and guide CBT to people from visible ethnic minority populations. Therefore, the change in the overall structure of the population and the discrepancies found between the worldviews of different cultural groups suggests the need for a thorough investigation of the philosophies that guide CBT as well as a literature review to determine whether the efficacy of CBT has been researched for the treatment of visible ethnic minority populations. Therefore, the purpose of this project is to review current and
relevant literature to examine the extent to which CBT has received support for the treatment of peoples from visible ethnic minority groups and to discuss the implications of the findings of this review for counselling practice and future research.

This project consists of a number of sections starting with a description of CBT that includes a brief illustration of the history of CBT, the assumptions and techniques that guide CBT, as well as an analysis of the strengths and limitations of the different processes of CBT in reference to the treatment of peoples from visible ethnic minority groups. Further, a brief illustration of the etic and emic perspectives that have influenced psychotherapy is provided, followed by an overview of efficacy research and the application and implications of its use with visible ethnic minority clients. A detailed description of the methods used to assess the recent and relevant quantitative and qualitative outcome studies that were conducted between 1999 and 2005 is included, followed by a thorough description and methodological analysis of the chosen research studies. The project concludes with a synthesis and discussion of the findings from the 22 efficacy studies and provides suggestions and implications for professional practice and future research.
CHAPTER II
Theoretical Foundations

Cognitive-behavioural therapy is a well-established and extensive therapeutic approach in the field of psychotherapy. Therefore, a comprehensive overview of CBT is beyond the scope of this project. I will however include: a brief illustration of the history of CBT; an overview of the fundamental characteristics and assumptions of CBT, including CBT’s view of human nature and CBT’s view of emotional disturbance; as well as a brief overview of the implications of a few of the techniques used in CBT for the treatment of visible ethnic minority clients.

The History of Cognitive-Behavioural Therapy

The basic assumptions that guide CBT were derived from a collection of different European-American theorists over the years. The most prominent influences include cognitive therapy, rational emotive behavioural therapy, behavioural therapy, and the social learning theory. Brief illustrations of the different schools of psychotherapy are provided to demonstrate the influence of the different theorists and to illustrate how CBT emerged and evolved over the years.

Cognitive-therapy began in the early 1960s as the result of Aaron T. Beck’s research on depression (Beck, 1967). Beck’s cognitive therapy interventions are designed to help clients distinguish, reality test, and correct distorted cognitions and the dysfunctional schemata that trigger and inspire these distortions through cognitive and behavioural exploration. Albert Ellis’s (1962) rational emotive behaviour therapy (REBT) also influenced the development of CBT. REBT is very similar to Beck’s cognitive therapy (CT), though one fundamental difference between REBT and CT will be addressed here. In CT, the
relationship between client and counsellor is based upon “collaborative empiricism” (Corsini & Wedding, 2000), where the client and counsellor work as co-investigators, examining evidence to support or reject the client’s cognitions. In REBT however, the relationship is not as collaborative and the therapist employs a fairly “rapid-fire active-directive-persuasive-philosophic methodology” (Corsini & Wedding) to actively dispute the client’s irrational cognitions. CBT maintains more of Beck’s cognitive therapy than Ellis’s REBT (Corsini & Wedding).

Behaviour therapy also played an important role in initiating some of the early theoretical developments of CBT. However, behaviour therapy began to evolve in the zeitgeist in the late 1960s and 1970s when the importance of the subjective including cognitive and emotional processes in altering behaviours began to elicit increased consideration among researchers and clinicians (Corey, 1996). This brought about an amplified emphasis on cognitive processes and procedures in behaviour therapy.

The introduction of Bandura’s (1969) social learning theory in the late 1960’s also influenced the progression of behavioural therapy. The social learning theory introduced the concept of observational learning or the modeling of others in the environment. This concept invoked the notion that cognitive explanations, including an individual’s perceptions and interpretations of external stimuli, were necessary to explain the influence that observation and modeling had on one’s learning and behaviours. Thus, behaviour therapy and the unique impressions of the other influential schools of psychotherapy were ultimately united with cognitive therapy to make it cognitive-behavioural therapy.

More recently however, Leslie Greenberg (2002) highlighted that there is a need for a shift in the dual focus of CBT to an even more integrated or constructivist approach that
acknowledges that personal meaning is not solely constructed from cognitions and
behaviours, but also includes affect and motivation. Greenberg argued that emotional change
processes have long been neglected in the cognitive-behavioural field of psychotherapy.
Greenberg recently introduced a significant addition to CBT that stresses the importance of
acknowledging and attending to both affective and cognitive sources of experience and
multiple levels of processing. Greenberg referred to the affective units as “emotion schemas”
(p. 164).

With the historical changes and the recent trend towards the constructivist approach
that embraces “cognitive schemas” (Beck, 1967) as well as “emotion schemas” (Greenberg,
2002), comes the introduction of a broad therapeutic approach to counselling. Therefore, as is
outlined above, CBT consists of an assorted set of interconnected theoretical orientations and
clinical practices that have been applied in the counselling field for many years as well as the
new innovative approach outlined by Greenberg which will hopefully be accepted by
counsellors and psychotherapists throughout the professional field today.

Characteristics and Assumptions of CBT

View of human nature. In the early 1900s there was a shift in the focus of psychology,
led by J. B. Watson, from mentalism to the study of objective behaviour (Bankart, 1997).
Watson’s emphasis that behaviour could be understood as a result of learning became the
recognized foundation of behaviorism (Corsini & Wedding, 2000). Pavlov’s (1927) classical
conditioning and Skinner’s (1953) operant conditioning became predominant in psychology
at this time and intervention strategies were directed at associative learning and influencing
behaviour through positive and negative reinforcement. Therefore, early behaviour therapies
asserted a firm mechanistic and deterministic view of human nature, whereby all behaviours
were based on a stimulus-response model of learning (Vera, Vila, & Alegria, 2002). This passive view of human nature posited the notion that humans were mechanically directed and influenced by their environments, which encouraged a sense of submission or learned helplessness (Catania, 1998).

However, with the influence of Bandura’s (1969) social learning theory, which included observational learning, and the evolving acceptance of cognitive processes, the notion that humans were passive recipients of their environment began to shift (Vera et al., 2002). In the late 1960s, cognitive-behavioural theorists began to view humans as active participants or authors of their own experiences and environments. Active cognitive processes are at the forefront of the change process in this view of human nature, which has been guiding the cognitive-behavioural approach for decades.

However, more recently Greenberg’s (2002) constructivist or integrative focus has started to shift the CBT view of human nature one step further to include the dynamic influences of both cognitions and emotions. Theorists are beginning to agree that emotion plays an autonomous role in functioning and affect shape cognitions just as cognitions influence emotions (Greenberg). Therefore, although cognitions and client responsibility for altering dysfunctional cognitions remain at the forefront of CBT’s active view of human nature, a shift that includes the emotional reflexes of human nature is emerging.

*View of human nature for use with ethnic minorities.* The traditional, active view of human nature encourages a real sense of personal control (Sarafino, 2002). However, increased personal control also elicits increased responsibility for the chosen paths of one’s life and for one’s feelings, emotions, and behaviours. CBT’s traditional view of human nature may encourage a real sense of empowerment for many clients, but may not be as
empowering for those visible ethnic minority clients who have suffered oppression, discrimination, sexism, and/or racism. Each one of these social elements is out of the individual’s control and can have lasting, damaging effects on one’s being. Therefore, CBT’s traditional view of human nature that espouses personal control and responsibility may be more harmful than beneficial for some visible ethnic minority clients because of its emphasis on personal control and responsibility.

Kernes and McWhirter (2001) suggested that Greenberg’s (2002) introduction of emotion schemas and the reflexive and therefore, less controllable influences of affect are starting to elicit a new view of human nature which encompasses more of a compensatory model. This model consists of the belief that people are not responsible for problems, but that they are responsible for solutions. From this model of human nature, the client and counsellor conduct a thorough exploration of the clients’ emotions, all the while focusing on client strengths to facilitate client empowerment. The client’s emotions, in this evolving view of human nature, are validated instead of ignored as in the more traditional CBT view of human nature. This evolving CBT focus allows for the reflection of the reciprocal process of cognitions and affect, thereby taking historical and societal oppression, discrimination, and racism into consideration. A full integration of Greenberg’s view of human nature may help to increase the usefulness of CBT for the treatment of visible ethnic minority clients, unless the culture believes that the expression of emotion is a sign of weakness.

View of Emotional Disturbance. The main goal of CBT is to provide symptomatic relief for a variety of presenting concerns by helping clients identify automatic thoughts and challenge and correct distorted cognitions and the dysfunctional schemata that trigger and inspire these distortions through vigorous cognitive and behavioural explorations (Robins &
Automatic thoughts are defined by Robins and Hayes as “a surface level of cognition that can be brought into awareness fairly readily by the patient and clinician” (p. 205). The automatic thoughts characteristically held by depressed clients are “negative thoughts about themselves, their world, and their future (the depressive triad) that embody themes of worthlessness, guilt, incompetence, defeat, deprivation, loneliness, and hopelessness” (Robins & Hayes, p. 205).

Automatic thoughts are embedded in an individual’s cognitive schema, which develops throughout the life span and contains the individual’s fundamental beliefs and assumptions that guide him or her throughout life (Corsini & Wedding, 2000). Schemas start to develop early in life and are reinforced through socialization processes that influence the construction and stability of one’s worldview. Cognitive schemas can therefore be both functional and healthy, initiating positive cognitions, or dysfunctional and damaging, producing mental distress.

Cognitive distortions are the links between dysfunctional schemata and automatic thoughts (Robins & Hayes, 1993, p. 205) and are the result of “systematic errors in reasoning” (Beck, 1967). When an individual perceives an event or when recollections are processed, the novel information is often distorted or biased to fit into the individual’s existing appropriate schemata. The end result of this distorted process is that the individual’s automatic thoughts are triggered by, and become comprised of, detrimental cognitive distortions, which can lead to emotional disturbances.

*View of emotional disturbance for use with visible ethnic minorities.* The main limitation of CBT’s view of emotional disturbance that must be addressed for the treatment of peoples from visible ethnic minority populations is the constructivist belief that a
permanent reality does not exist (Vera et al., 2002). As outlined above, cognitive schemas begin to develop early in life and include conceptual elements of cognitive functioning, which are constructed through one’s life experiences and exist in one’s long-term memory. Therefore, an individual’s cognitive schema constructs one’s reality and thus, one’s worldview. Visible ethnic minority clients’ cognitive schemas, which may possess unique cultural and familial traditions and values in comparison to those more commonly found with peoples of the Western world, may therefore not coincide with the Western beliefs about what constitutes a healthy cognitive schema. In fact, because each individual experiences unique life events and holds distinctive perceptions of his/her life experiences, regardless of race, ethnicity, colour, etc., it can be difficult to ascertain agreement or harmony between client and therapist schemas and worldviews of CBT therapists. Therefore, the traditional CBT expectation that clients must reconstruct their subjective experience of reality to fit in with, or adapt to, their existing environment may be detrimental and oppressing for any client, but may be especially damaging for visible ethnic minority clients who may possess diverse cognitive schemas (Vera et al.).

The more recent inclusion of the role of affect and emotion schemes (Greenberg, 2002) however, added another element to the view of emotional disturbance in CBT. Greenberg illustrated that just as cognitive schemas are developed early in life and continue to develop throughout the lifespan, so do emotion schemes, which influence expectancies, beliefs, emotions, desires, and goals. Therefore, Greenberg highlights the reciprocal process of cognition schemas and emotion schemes as leading to emotional disturbance.

This evolving hypothesis that includes the role of affect in CBT’s view of emotional disturbance possesses several strengths for the treatment of peoples from visible ethnic
minority groups, which emphasizes the rationale for the inclusion of Greenberg’s work for this project. First, increasing awareness to one’s emotions caused by different events helps people to make sense of their experience (Greenberg, 2002). Secondly, “awareness of emotion also involves overcoming avoidance and the promotion of emotional processing” (Greenberg, p. 169). Third, increasing awareness to emotion, which helps to externalize the emotion, promotes reflection on experience to create new meaning for their experiences, thereby illustrating the interplay between cognitive schemas and emotion schemes (Greenberg). Therefore, although the researchers did not report the an emphasis on affect in the 22 studies reviewed below, more emphasis on the influence of affect along with cognition on individual well-being may help to increase the efficacy of CBT for the treatment of visible ethnic minority clients.

**Basic CBT Techniques**

One of the strengths of CBT as an intervention for clients from visible ethnic minority groups is that therapists can choose from a wide range of tools and techniques that can be adapted to meet the unique needs of the individual (Corey, 1996). Beck, Rush, Shaw, & Emery (1979) offered several CBT techniques that have a common underlying assumption regarding the view of emotional disturbance. A few of the basic cognitive techniques used in CBT will be examined to illustrate how the assumptions that guide these techniques can affect visible ethnic minority clients. The techniques that will be explored include, “examining and reality testing automatic thoughts and images”, “reattrIBUTion techniques”, and “the search for alternative solutions.” The impact of some of the behavioural techniques applied in CBT is also explored in more detail below.
Examination and reality testing automatic thoughts and images. The main goal in reality testing automatic thoughts and images is to “encourage a more accurate description and analysis of the way things are” (Beck et al., 1979). In this technique, the individual’s thoughts are subjected to the close examination of reality testing, where the counsellor uses the method of “Socratic Dialogue” (Corsini & Wedding, 2000, p. 256) to ask the client a series of carefully designed questions to elicit a different interpretation and new understanding of the event.

The strength of this technique when used with members from visible ethnic minority groups is that CBT counsellors do not claim to know what is right and wrong for clients from any cultural group. Instead the relationship between client and counsellor is one based on collaboration. Therefore, if this technique is used appropriately, the client, not the counsellor, determines which thoughts are detrimental.

However, Cormier and Nurius (2003) highlight that although the client is the one who is determining what cognitions are detrimental to one’s well-being, the counsellor’s values may still emerge through the types of questions asked which may subtly devalue the client’s worldview. Racism is often very subtle, but the results are just as damaging as overt racism (Pedersen, 1995). Therefore, although the CBT counsellor may be well-intentioned as mentioned above, minority worldviews’ may possess cognitive schemas and structures that are very unfamiliar to the Western counsellor. The counsellor’s bias or lack of knowledge and understanding of the minority client’s worldview could therefore lead to further oppression.

Another possible strength or limitation (depending on the client) of the CBT technique of examining and reality testing automatic thoughts and images for its use with
clients from visible ethnic minority populations is that the direct nature of challenging cognitions through reality testing exercises may or may not fit with some culture and gender socialization patterns (Cormier & Nurius, 2003). Finally, another drawback of the technique of reality testing and restructuring client cognitions has been noted by current models of feminist therapy and multicultural therapy. These disciplines do not agree with the CBT assumption that maintains that if counsellors can change an oppressed person’s way of thinking, the presenting problem will automatically be resolved (Cormier & Nurius).

Reattribution techniques. A cognitive pattern that people suffering from depression tend to possess consists of inaccurately assigning blame or responsibility for unpleasant, uncontrollable events to themselves (Beck et al., 1979). The CBT technique of reattribution is applied when this cognitive pattern is established. The reattribution technique consists of a collaborative examination of the relevant events leading up to the self-assignment of blame or responsibility using reason and logic. The objective of this CBT technique is to reveal the event in its totality by recognizing the multitude of extraneous factors that may have contributed to the negative experience.

This CBT technique is particularly useful in its application with members from visible ethnic minority groups because it alleviates responsibility from the individual and places it back on to society or the events that are out of the client’s control. This is a particularly relevant technique for clients who have endured oppression or discrimination because it helps to alleviate self-reproach and facilitates in the expansion of one’s sense of self-efficacy.

The limitation of this technique in its application with peoples from ethnic minorities, or for any cultural group, is that it may lead to resentment and hostility towards society as a
whole if the focus for client problems repeatedly remains outside of themselves. Therefore, this technique needs to be applied with caution and balance, so as not to encourage learned helplessness (Catania, 1998).

*The search for alternative solutions.* Once clients are able to distance themselves from their cognitions and begin to be able to recognize and identify rigid patterns and themes that guide their automatic thoughts, problems that were previously viewed as insolvable may be transformed in the clients’ minds (Beck et al., 1979). It is at this point in the therapeutic journey that the search for alternatives may prove to be a useful CBT tool. Searching for alternatives involves the active investigation of other possible interpretations, explanations, or understandings of the client’s professed concerns. From this perspective, individuals are dysfunctional to the degree that their experience is troubling to them or is incompatible with social experience (Vera et al., 2002). The focus of this CBT technique is to alter the client’s cognitive schema that is contributing to negative thinking by searching for alternative solutions to, and interpretations of, one’s experience.

A major limitation of this technique when used with members from visible ethnic minority groups is that it discounts or belittles the client’s subjective experience by contending that “a permanent, external reality does not exist” (Vera et al., 2002, p. 6). This notion maintains Greenberg’s (2002) view of human nature that purports that reality is constructed by the individual and is the result of the interaction between subjective and social experience. Individuals, who have suffered oppression, racial discrimination, and/or inequity, etc., may not believe or accept that the harmful attitudes and behaviours of discrimination are their own subjective constructions or that they can alter their beliefs and emotions to these events by searching for alternative solutions or interpretations. Some acts of discrimination
and the effects of historical oppression may be too entrenched in the visible ethnic minority’s identity to be able to identify or accept alternative solutions for their experiences (Vera et al.). Therefore, this CBT technique may produce more harm than good for clients of visible ethnic minority groups because of unintentional racism (Pedersen, 1995) by the counsellor.

**Behavioural techniques in CBT.** Other CBT techniques consist of behavioural techniques, such as “assertiveness training, behavioural rehearsal, graded task assignments, relaxation methods, social skills training, shame-attacking exercises, homework, and bibliotherapy” (Corey, 1996, p. 342). Behavioural techniques used in CBT also help to empower clients and are particularly useful with members from visible ethnic minority groups. Hays (1995) stated that CBT “views clients as being in control of their thoughts and emotions and thus able to make changes themselves” (p. 312). Behavioural techniques thereby empower the client to apply these learned skills independently, outside of the counselling situation. These empowering techniques could be very beneficial for clients from visible ethnic minority groups.

However, counsellors must ensure that these CBT techniques are not in conflict with the clients’ or the clients’ families’ worldviews. Grieger and Ponterotto (1995) highlight that “a worldview assessment should be a key aspect of any client assessment and problem/goal conceptualization” (p. 371). This assessment is necessary to ensure that the techniques learned from CBT do not produce “intergenerational conflict” (Prendes-Lintel, 2001) or produce more damages than benefits for the client. Client safety is of the utmost importance and if the psychoeducational methods of CBT go against the clients’ or the clients’ families’ level of, or attitude towards, acculturation and/or psychological mindedness then the benefits and the use of CBT must be reassessed (Grieger & Ponterotto).
Summary of CBT Assumptions and Characteristics

The exploration of the history and some of the basic assumptions and characteristics of CBT displays that this therapeutic approach possesses some strengths, but also some major limitations for the treatment of visible ethnic minority clients. Because CBT was founded by European-American, middle-class, university-educated, White, men (Hays, 1995), the inherent values of the paternal Western world and the here-and-now focus were incorporated into this therapy. However, just as the world had evolved since the historical beginnings of CBT, the inclusion of Greenberg’s (2002) work in the analysis above displays that so is the therapeutic intervention of CBT. Although many potential issues have been identified, therapists and counsellors may continue employing traditional CBT assumptions and techniques with no, little, or inappropriate attention placed on cultural differences, all of which could lead to unintentional racism (Pedersen, 1995) and elicit more harm than benefit for the client. This notion of universal versus cultural-specific counselling approaches brings us to an exploration of the emic and etic perspectives.

Etic and Emic Perspectives

There has been tension in psychotherapy for the past 20 years, since the multicultural movement, over whether it is more appropriate and beneficial for counsellors to assume a culture-specific position, which has been coined the emic perspective, or a universal perspective, which has been termed the etic position (Daya, 2001; MacDougall & Arthur, 2001; Pedersen, 2001). I will first provide definitions for the above terminology to provide significance to the debate as there is controversy even over the definitions of terms. Pedersen (1991) defined multiculturalism as “a wide range of multiple groups without grading, comparing, or ranking them as better or worse than one another and without denying
the very distinct and complementary or even contradictory perspectives that each group
brings with it” (p. 4). From this view, the multicultural movement thus leads to the inclusion
of a large number of variables, such as sex, race, socioeconomic factors, nationality,
ethnicity, language, and religion, etc., making multiculturalism broad and generic to all.

From this etic perspective all counselling and psychotherapy is multicultural because
“no two individuals, even if they are from the same cultural group, share the same
worldview” (Ho, 1995, p. 6). Because all counselling is multicultural from this perspective, it
is important for counsellors and therapists to look beyond culture and instead focus on the
clients’ internalized culture, which consists of “the cultural influences operating within the
individual that shape (not determine) personality formation and various aspects of
psychological functioning” (Ho). It has been argued that the etic perspective is concerned
primarily with the therapeutic relationship between client and counsellor (Daya, 2001).
Professionals working from the etic perspective maintain that “the problem with emphasizing
culturally specific techniques in professional practice with diverse clients is the risk that the
cultural characteristics of the client may be overemphasized” (Daya, p. 51). Therefore, the
etic perspective encourages counsellors and psychotherapists to apply the traditional
therapeutic approaches and techniques, such as CBT, with all clients regardless of culture.
This universalistic perspective has been leading psychotherapy and counselling for some
time.

However, another more limited definition of multiculturalism is provided by Locke
(1990), who focuses on racial/ethnic minority groups within a culture. This definition
highlights the emic or culture-specific perspective. The emic perspective maintains that
counsellors must have knowledge specific to the client’s culture to be effective in counselling
This viewpoint holds the assumption that visible ethnic minority clients receive inadequate and/or ineffective treatment(s) because of the counsellors’ lack of cultural knowledge and therefore, the counsellors’ inability to employ therapeutic treatments to meet the needs of the cultural client.

The above review of the theory and techniques that underlie and guide CBT illustrates that the CBT assumptions and interventions have some value for visible ethnic minority clients, but also illustrates that this therapeutic approach poses some disadvantages as well.

My objective in the following review, is to examine whether the etic perspective, which has been guiding therapeutic treatment of peoples from all cultures and which encourages the wide application of CBT has received empirical support from efficacy research.

**Efficacy Research**

There has been much debate over the years about what constitutes efficacious treatments in counselling and psychotherapy and even more controversy over how treatment outcomes can be evaluated accurately and impartially. The question and appeal to identify which treatments work for which patients under what conditions has been looming for about 30 years (CPA, 2005). The Division 12 Task Force initiative was established to address these concerns and to identify and establish an inventory of empirically supported treatments that would be used by professionals to help them choose which therapeutic approaches and/or interventions would best suit the particular needs and presenting concerns of the client. To date, 16 empirically supported treatments and 56 treatments that are probably efficacious have been identified (CPA). The subjective nature and the recent controversy over evaluation methods for determining efficacious treatments caused the Task Force, headed by Dr. Diane
Chambless, to identify two categories: treatments classified as well-established or efficacious and those that are probably efficacious (see Appendix for the criteria used by the Task Force to establish empirically-validated treatments).

Chambless and Hollon (1998) established the principles that are employed by the Task Force to determine and identify efficacious or empirically supported psychological treatments. It was determined that treatment efficacy must be demonstrated in controlled research where it is logical to conclude that the positive changes observed and recorded in the dependent variable (the subjects) are due to the independent variable (the treatment) and cannot be attributed to chance or other confounding variables. Mertens (1998) defined the dependent variable as “the variable that the researcher is interested in measuring to determine how it is different for groups with different experiences” (p. 4). The independent variable is defined as the variables on which the groups in the research differ because they have been exposed to different treatments (Mertens, 1998). Chambless and Hollon (1998) proclaimed that efficacy is best demonstrated in controlled, randomized, clinical trials, and that replication of the study, carried out by trained professionals other than the original researchers, is critical. Two research methodologies utilized in efficacy research (quantitative and qualitative) will be described below.

*Quantitative Research Design*

Quantitative research has been the research design of choice in psychotherapy because it is the only method of research that can truly test hypotheses concerning cause-and-effect relationships (Mertens, 1998). An important component that guides quantitative research is the researchers’ effort to maximize a study’s internal validity meaning that the changes in the dependent variable are due to the affect of the independent variable.
Mertens suggests that internal validity can be maximized by implementing the following controls into quantitative research to protect against extraneous variables:

1. The randomization of subjects to either a control group (which receives either no treatment or an alternative treatment) or an experimental group (which receives the treatment, which in this case is CBT).
2. Treatments are manualized.
3. Participants are seen for a fixed number of sessions.
4. Target outcomes are well operationalized, meaning that data collection is focused on a particular attribute or quality of the person or setting and is often collected through standardized assessments and questionnaires.
5. Raters and diagnosticians are blind to which group the patient comes from.
6. Participants meet criteria for a single diagnosed disorder and patients with multiple disorders are typically excluded.
7. There is an adequate sample size for the study based on a relevant percentage of the total population to which the results can be generalized.
8. A follow-up is conducted after a fixed duration.

External validity is also important in research studies. External validity refers to the extent to which the research findings in one study can be applied or generalized to other populations and settings (Cozby, 1997). Mertens (1998) highlights that there is a strain that is always present between internal and external validity. This tension exists because to achieve perfect internal validity and control for all extraneous variables, the laboratory or controlled environment used in quantitative research is the perfect setting; whereas, external validity is best achieved in natural environments with the inclusion of wide-spread and diverse
populations (Mertens). The particular methods used to evaluate internal and external validity are explored in more detail in the methods section of this project.

Qualitative Research Design

Qualitative research differs significantly from quantitative research in that the focus is on providing a comprehensive description of the subjective effects of the specific treatment in its natural setting (Mertens, 1998). Qualitative methods encompass three kinds of data collection: “(1) in-depth, open-ended interviews; (2) direct observation; and (3) written documents, including such sources as open-ended written items on questionnaires, personal diaries, and program records” (Patton, 1987, p. 7). Qualitative data provide depth and detail through direct quotation of narratives and careful description of experiences (Patton).

Qualitative designs take the form of naturalistic research to the extent that observations and date collection occur in the participants’ natural setting without rigorous planning or manipulation, as is the case of quantitative research. This natural, in-depth, narrative method allows for the unique nature of the participants’ worldviews and therefore, individual differences to emerge regarding the affects of the intervention (Patton, 1987). It must be noted however, that qualitative designs can be very time consuming, and that complications in detecting valuable emerging patterns among the subjective reports may arise (Patton).

The advantage of using qualitative methods that elicit detailed descriptions of the participants’ contextual information, worldviews, and intervention experiences is that the methods help to improve the transferability of the research outcomes, which is the qualitative parallel to external validity or generalizability in quantitative...
research (Mertens, 1998). An example of how qualitative methods are utilized in efficacy research is offered by Seligman (1995).

Efficacy Research and Visible Ethnic Minority Clients

Ethnic minority researchers are recognizing that the quantitative methods for evaluating and determining efficacy research, as illustrated by Chambless and Hollon (1998), may be appropriate for White, middle-class, educated populations but may not be suitable or generalizable to clients from various visible ethnic minority groups (Bernal & Scharrón-Del-Rio, 2001) because of the exclusion of diverse voices, subjective narratives, and natural environments. There is an emphasis in efficacy research on maintaining internal validity over external validity (Bernal & Scharrón-Del-Rio). The problem with this research preference is that it does not acknowledge the fact that cultural difference may affect the treatment outcomes (Atkinson, Kim, & Caldwell, 1998; Fischer, Jome, & Atkinson, 1998; Frank & Frank, 1991; Kim, Ng, & Ahn, 2005; Sue & Sue, 1999; Sue & Sue, 2003; Torrey, 1986). Bernal and Scharron-Del-Rio recommend that efficacy research combine both quantitative and qualitative research designs.

Summary

There is a need to assess the efficacy of CBT with visible ethnic minority clients because the review of CBT above indicates that some of the theoretical assumptions and techniques that guide CBT may not be suitable for ethnic minority populations. Further, as noted above, the majority of efficacy research to date has not been conducted with visible ethnic minority clients and therefore possesses limited generalizability across populations.
CHAPTER III

Methods

I decided to review all of the recent and available outcome studies that applied CBT for the therapeutic treatment of all visible ethnic minority groups appearing in the English literature from 1999-2005 to determine the extent to which CBT has received both quantitative and qualitative support with ethnic minority populations. The dual paradigms included in this review allowed for the inclusion of client outcomes that illustrated objective client change as well as subjective client satisfaction reports.

This review was commenced by searching for potential outcome studies through PsycInfo, EBSCOhost, and OVID, and was augmented with findings from World Wide Web selecting studies that utilized the terms “cognitive behavioural therapy”, “cognitive therapy”, and “behaviour therapy” in conjunction with “ethnic”, “culture”, “multicultural” and “minority”. Further, the search terms “efficacy research”, “ethnic minority research”, and “empirically supported psychotherapies” were applied to the search engines noted above to enhance the richness of this review. The bibliographies of each of the outcome studies that were deemed appropriate for the review as well as the references included in the efficacy research articles were also consulted. Outcome studies were deemed appropriate for the review if the intervention applied within the study was identified by the researchers as CBT and the research included and focused on visible ethnic minority participants. Due to the small number of studies on this topic, research that included participants from visible ethnic minority groups that would be seen in Canada was chosen for this review. However, it must be noted that the 22 studies explored within this project were conducted with participants who were citizens of other countries. Although this is not the preferred approach, these
studies can inform our knowledge of the use of CBT with members of these visible ethnic groups.

This search located 22 outcome studies that employed CBT in the treatment of people from visible ethnic minority populations. Nineteen of these outcome studies included quantitative research methods and three outcome studies applied qualitative methods. I was guided in my analysis of the quantitative studies by the evaluation guidelines described by Mertens (1998), which are outlined below. Although this review includes both quantitative and qualitative research, the studies were analyzed and assessed in accordance to the guidelines appropriate for the particular paradigm. Therefore, to assess the three qualitative outcome studies included in the review, I have combined the guidelines offered by both Mertens (1998) and Patton (1987) to ensure a thorough assessment and have illustrated the guidelines below.

**Quantitative Research Methods**

The 19 quantitative research studies were assessed according to the eight controls outlined above and re-established below, which Mertens (1998) highlighted could be used to maximize internal validity: (1) use of a randomized group design; (2) use of manualization; (3) applying a fixed number of sessions; (4) Target outcomes are well operationalized; (5) blind assessors; (6) focus on a single well-defined disorder; (7) use of a sample large enough to detect group differences reliably; and (8) follow-up after a fixed duration.

**Internal validity.** Further, the research was assessed for the level of control applied to guard against the following eight extraneous variables that Campbell and Stanley (1963; as cited in Mertens, 1998) identified could threaten internal validity:
1. **History.** Could events (other than the independent variable) have influenced the results?

2. **Maturation.** Could biological or psychological changes in study participants (other than those associated with the independent variable) have influenced the results?

3. **Testing.** Could the participants have become ‘test wise’ because of the pre- and posttests?

4. **Differential selection.** Did the experimental and control groups differ in ways other than exposure to the independent variable?

5. **Experimental mortality.** Did participants drop out during the study?

6. **Selection-maturation.** Was differential selection a problem based on the biological or psychological characteristics of the sample?

7. **Experimental treatment diffusion.** Were the treatment and control groups close enough to share ideas?

8. **Compensatory equalization of treatments.** Were extra resources given to the control group?

**External Validity.** The following questions, adapted from Mertens (1998) and criteria offered by Bernal and Scharrón-Del-Rio (2001) were used to assess the level of external validity operating within each of the following quantitative outcome studies:

1. **Was the experimental treatment described in sufficient detail?** The independent variable must be sufficiently described so that the reader could reproduce it if desired.

2. **Were multiple treatments used? Did they interfere with each other?** If subjects receive more than one treatment, it is impossible to conclude which of the treatments, or combination of the treatments, is necessary to bring about the desired result.
3. *Was the Hawthorne effect operating?* The idea of being singled out to participate in a research study and provided with special attention can result in increased motivation to act in a way that subjects perceive as desired by the researchers.

4. *What was the influence of the individual experimenter?* The effectiveness of a treatment may depend on the individual who administered the treatment. Therefore, the effect of the researcher would not generalize outside of the particular study.

5. *Were the participants sensitized by taking a pretest or posttest?* Participants may be more sensitized to the treatment than those who experience the treatment without a pretest or posttest. Pretests and posttests can influence the participants’ response to treatments and thus results, particularly if the pretest or posttest alludes to the content and/or subject of the study.

6. *Was there an interaction of history and treatment effects?* Research is conducted at a particular time with contextual factors that cannot be exactly duplicated for another research study. Therefore, if specific historical influences are present in a situation (i.e. unusual depression or anxiety because of a flu epidemic, a tornado disaster, or budget cuts), the treatment may not be generalized to another situation or another population.

7. *What was the influence of the type of measurement used for the dependent variable?* The assessment of treatment outcomes depends on the type of measurement. For example, because the following research studies are conducted with visible ethnic minority participants, translations, language, and cultural considerations may be necessary to ensure that the measurements are valid.
The above criteria are used for the evaluation of external validity in quantitative research. However, Bernal and Scharrón-Del-Río (2001) offer additional methodological suggestions for to increase external validity in quantitative research that involves ethnic minority clients. Therefore, along with the evaluation questions above (Mertens, 1998), the following criteria will be used to assess the efficacy research included in this review:

8. Providing a clear description of inclusion criteria.
10. Utilizing treatment models that have been tested with a particular cultural group.
11. Ensuring the treatments are delivered by culturally trained and competent practitioners.

Qualitative Research Methods

To evaluate the following qualitative outcome studies included in the review, I have combined the guidelines for evaluating qualitative research offered by both Mertens (1998) and Patton (1987) to ensure a thorough assessment and included the following:

1. *Did the researchers maintain sufficient involvement at the site to understand the culture and overcome distortions?* This guideline implies that the qualitative researchers go into the field so that they have the opportunity to develop direct and personal relationships with the participants of study to increase the researchers’ knowledge and awareness of the participants’ worldviews and to decrease researcher bias (Patton).

2. *Did the researchers provide a sufficient thick description?* “Extensive and careful description of the time, place, context, and culture is known as a ‘thick description’” (Mertens, p. 183).
3. **Did the researchers use triangulation?** Triangulation entails assessing information that has been collected from different sources or methods for consistency and reliability of evidence across sources of data (Mertens). For example, qualitative researchers may apply observation techniques for data collection along with the interview guide or open-ended interview (Patton).

4. **Did the researchers apply an inductive analysis?** Inductive analysis means that researcher bias is not occurring and that the patterns, themes, and categories of analysis emerge out of the data rather than being decided prior to data collection and analysis (Patton).

5. **Did the researchers use member checking?** Member checking is used by researchers to ensure that the information that was synthesized from the study about the participants was accurate and reflected the participants’ perceptions (Mertens, 1998). The suggestions offered by Bernal and Scharrón-Del-Río (2001) regarding the evaluation of research that includes ethnic minority clients has also been included and used to evaluate the transferability of the qualitative research studies included in this review.

6. Providing a clear description of inclusion criteria.

7. Using a large sample size.

8. Utilizing treatment models that have been tested with a particular cultural group.

9. Ensuring the treatments are delivered by culturally trained and competent practitioners.

**Analysis of Methods**

Based upon the standards outlined above, the studies were critiqued and then divided into three groups according to the degree of experimental control applied by the researchers.
The 22 research studies, consisting of 19 quantitative studies and 3 qualitative studies, included in this review were categorized into well-controlled, moderately-controlled, and poorly-controlled classifications based upon the author’s analysis of the level of internal validity and external validity maintained in each study. It must be noted that the analysis is limited to the extent to which the researchers included relevant and pertinent information from which to conduct this analysis.
Well-Controlled Studies

Alcohol abuse, CBT, and Hispanic clients. Arroyo, Miller, and Tonigan (2003) conducted a study on the prediction that the 12-step facilitation (TSF) treatment for alcohol abuse, when applied with Hispanic clients, would be less effective than CBT or motivational enhancement therapy (MET). Outcomes for non-Hispanic white (n = 105; 70% male) and Hispanic (n = 100; 80% male) clients were analyzed to determine the efficacy of the three differential treatments. Clients were randomly assigned to one of three manualized treatments and were followed for 12 months after completion of treatment.

The researchers used a battery of assessment measures including a detailed reconstruction of alcohol use via the Form 90 interview (Miller, 1996; as cited in Arroyo et al, 2003), quantification of AA attendance and involvement, and the Acculturation Rating Scale for Mexican Americans, which helped to determine whether the participants associated more with one culture or another. The results of the study indicated that non-Hispanics fared significantly better than Hispanics when assigned to TSF, but that Hispanics and non-Hispanics showed similarly favorable outcomes in the CBT and MET groups. Overall, the results of this study indicated that CBT is as beneficial for Hispanics as non-Hispanics in the treatment of alcohol abuse.

This research study was considered to maintain high internal control because of its application of the following criteria for quantitative studies: the participants were randomly assigned into three different experimental groups where comparisons of the effectiveness of the interventions could be concluded, the treatments were manualized, the focus was on one
well-defined disorder (alcohol abuse), the outcome measures were reliable, the sample size was adequate for detecting group differences, and the researchers conducted follow-up after one year. Therefore, the study maintained high internal validity.

As well, although the researchers provided detailed descriptions of the treatments used and applied one treatment per group, which increases the ability of research replication, the inclusion of mainly males, the rigorous controls, the small sample size, and the unnatural context used to maintain internal validity creates a deficit for the generalization of the research findings to other male Hispanics. Therefore, this study maintained high internal validity but lacks external validity, suggesting that CBT in this treatment program may be as effective for the treatment of Hispanic males as non-Hispanic males, but it is unknown whether other Hispanics in other settings would benefit from this treatment approach for alcohol abuse.

Phobic and anxiety disorders, CBT, and Hispanic/Latino youth. Pina, Silverman, Fuentes, Kurtines, and Weems (2003) compared two clinical trials conducted by Silverman et al. (1999a, b) for phobic and anxiety disorders to examine treatment response and maintenance to exposure-based cognitive-behavioural therapy (CBT) for Hispanic/Latino relative to European-American youths with phobic and anxiety disorders. The sample was comprised of 131 Hispanic/Latino and European-American youths (46% girls), aged 6-16 years of age and their parents (one parent for each youth participant; 90% mothers). Across the trials, 79 (60%) were European-American and 52 (40%) were Hispanic/Latino. Pina, et al. reported that there were no significant differences between European-American and Hispanic/Latino participants with respect to the sociodemographic characteristics. The diagnostic tool that was used to assess participants and parents for phobias and anxiety was
The Anxiety Disorders Interview Schedules for Children (ADIS-C and ADIS-P). Youth-completed measures included The Revised Children’s Manifest Anxiety Scale (RCMAS) and the Fear Survey Schedule for Children-Revised (FSSC-R). Parent-completed measures included the RCMAS Parent (RCMAS/P) as well as the FSSC-R where parents were asked to rate their children’s fears. All participants were randomly assigned to one of two time-limited (10-12 sessions), exposure-based, manualized, CBT sessions. It was reported that trained competent multicultural therapists delivered the intervention. The treatment sessions were mainly delivered in English, although the researchers also delivered the treatment to 4% of the participants in Spanish. After treatment completion, participants were reassessed at post-treatment and 3-, 6-, and 12-month follow-up. 73% of the Hispanics/Latinos completed treatment and 78% of the European-Americans completed treatment.

Findings illustrated that Hispanic/Latino youths responded favorably to the CBT intervention in this research. In fact, the results displayed that outcomes were similar to European-American youths, in treatment gains. This was evident by a remarkably consistent pattern of findings across a variety of outcome indices: diagnostic recovery rates, clinically significant improvement, child- and parent-completed questionnaires, including effect sizes, as well as, diagnostic recovery rates. Overall, the study’s findings showed that exposure-based CBT for use with anxiety disorders in youths works as well with this specific population of Hispanic/Latino youths as with European-Americans.

This research study was considered a well-controlled study because of its application of the following criteria for quantitative studies: the participants were randomly assigned to one of two time-limited trials where comparisons of the effectiveness of the interventions could be concluded, the treatments were manualized, the outcome measures were valid and
reliable, and the researchers took language effects into consideration for the delivery of the intervention. As well, a detailed description of the participants’ contextual information was included, with 45% of the participants reporting Cuba as their country of origin and 18% reporting other Central and South American countries of origin. Therefore, the study maintained high internal validity.

There were, however, some limitations to this research study such as the fact that the focus included two well-defined disorders (anxiety and/or phobic) instead of a sole focus on one disorder, and there was a short follow-up applied in this study. As well, although the researchers described the experimental treatment in detail, ensured the treatments were delivered by culturally sensitive practitioners, and provided a clear description of the inclusion criteria, the research was classified as maintaining a low level of external validity because of the small sample size. Therefore, this study maintained high internal validity but lacks external validity, suggesting that CBT in this treatment program may be as effective for the treatment of Hispanic/Latino youth as it is for European-American youth, but it is unknown whether other Hispanic/Latino adolescents in other settings would benefit from this treatment approach for phobic and anxiety disorders.

*Depression, CBT, and low-income, minority women.* Miranda et al. (2003a) conducted a randomized, longitudinal, controlled study to determine the impact of CBT for depression compared with referral to community care with low-income and minority women. The study was conducted with 267 women with current major depression, who attended Women, Infants, and Children (WIC) food subsidy programs and family planning clinics from March 1997 through May 2002. Participants were assessed with the application of The Hamilton Depression Rating Scale measured monthly from baseline through 6 months, the
Social Adjustment Scale, and the social functioning (Short Form 36-Item Health Survey) measured at baseline and 3 and 6 months. Participants were randomly assigned to an antidepressant medication intervention (trial of paroxetine switched to bupropion, if lack of response) \( n = 88 \), a psychotherapy intervention (8 weeks of manual-guided (CBT) \( n = 90 \), or referral to community mental health services \( n = 89 \). Both the medication intervention and the CBT intervention reduced depressive symptoms more than the community referral did. The medication intervention also resulted in improved instrumental role and social functioning. The CBT psychotherapy intervention resulted in improved social functioning. Therefore, the outcome gains were more extensive and robust for the medication intervention. Though, the CBT group displayed modest outcome gains.

This research study was considered to be a well-controlled study because of its application of the following criteria for quantitative studies: the participants were randomly assigned to a psychotropic medication group, to a manualized CBT treatment group, or to community mental health services; the outcome measures were valid and reliable; the sample size was adequate for detecting group differences; and the researchers took language and reading ability effects into consideration. Miranda et al. (2003a) also took cultural differences into consideration and recruited three distinct cultural groups, including black women born in the United States, Latinas born in Latin America, and white women born in the United States to increase the generalizability of the findings. The participants were also screened for major depressive disorder and were excluded if they had other identified issues. The rigorous controls, longitudinal study method, careful selection of participants, and extensive consideration of cultural issues helped to balance out the tension often found between maintaining internal and external validity. Therefore, this study has been categorized as
maintaining high internal control, and moderate external control. A larger sample size used in this research would have helped to improve the generalizability of this research to other people from the three distinct populations included in this review. One other factor that could have been addressed by the researchers that may have affected the external validity of this research was whether there was a Hawthorne effect that influenced the results. This research, which attempted to provide high levels of internal and external validity, displayed that CBT had only modest affects for depression with this low-income Hispanic, female group.

Depression, CBT, and Puerto Rican adolescents. Rossello and Bernal (1999) conducted a study to evaluate the efficacy of CBT and interpersonal psychotherapy (IPT) with depressed adolescents in Puerto Rico. Participants were assessed for depression according to the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., revised). Seventy-one adolescents met the criteria for a diagnosis of depression and were randomly assigned to one of three treatment groups: CBT, IPT, and wait list. The two treatment conditions consisted of 12 one-hour individual therapy sessions held once a week over a 12-week period. Detailed manuals were prepared for both therapy conditions to ensure that both groups received the same treatment and to aid in replication. The Children’s Depression Inventory, the Piers-Harris Children’s Self-Concept Scale, the Social Adjustment Scale for Children and Adolescents, and the Family Emotional involvement and Criticism Scale were used to assess treatment outcomes. Results illustrated that both IPT and CBT are efficacious treatments for depressed Puerto Rican adolescents. However, it was found that 82% of the participants in the IPT and only 59% of those in CBT were in a functional range at the end of treatment; thereby displaying that IPT may be a more efficacious treatment for Puerto Rican adolescents.
This research study was deemed as well-controlled, maintaining high internal validity according to the criteria for evaluating quantitative research for several reasons. First, the researchers randomly assigned participants to one of three treatment groups: CBT, IPT, and wait list control group. Secondly, the researchers used detailed manuals to guide the application of both interventions and provided detailed descriptions of both of the interventions, which increases replication ability. Thirdly, the researchers applied reliable and valid assessment measures and employed trained assessors for data collection. And fourth, focus was on one well-defined disorder, depression. However, although the researchers took cultural issues into consideration by including family members in the assessment, by translating and adapting the assessments to meet the needs of the participants, and by ensuring that the treatments were delivered by culturally trained and competent practitioners, the small sample size significantly decreases the generalizability of this research. Therefore, the findings of this study, which illustrated only moderate outcomes for the CBT treatment could only be generalized to other Puerto-Rican adolescents presenting with depression, but could not be generalized outside of this cultural group.

_Depression, CBT, and HIV-positive patients._ Markowitz, Spielman, Sullivan, and Fishman (2000) conducted a 16-week controlled clinical trial for HIV-positive patients with depressive symptoms. The researchers applied the Hamilton Rating Scale for Depression (Ham-D) to assess mood disorders and all participants were clinically judged to have significant unipolar depression. Participants also completed the Beck Depression Inventory (BDI) weekly. Participants (N=101; 58 white, 21 Hispanic, 18 African American, and 4 Asian American or other; 91% were women) were randomized to participate in 16 weeks of treatment with interpersonal psychotherapy, cognitive-behavioural therapy (CBT), supportive
psychotherapy, or imipramine plus supportive psychotherapy. Raters were blind to the ethnicity of the participants.

Ethnic groups were then dispersed into very small numbers among the four treatment cells. The researchers found that ethnicity did not influence outcome for most of the treatments. However, analyses revealed that African-American subjects (N=4) assigned to CBT had poorer outcomes than did subjects from other ethnic backgrounds or in other treatments. Whereas other subjects improved over time, African-American CBT patients markedly worsened. African Americans who received other psychotherapy or pharmacotherapy had outcomes that did not differ from those of other ethnic groups.

This research was deemed to be a well-controlled study for several reasons. First, the researchers randomly assigned participants to four, time-limited treatment groups. Secondly, the focus of this research was on one well-defined disorder, being unipolar depression. Third, the researchers applied reliable and valid assessment measures and employed independent raters to assess outcomes. Fourth, although the researchers did not claim that the interventions were manualized, they did report that the sessions were audiotaped and that high levels of adherence to treatments were followed. Therefore, the research was deemed to maintain high internal validity. However, although the researchers provided a clear description of the inclusion criteria there was no mention that the treatments were delivered by culturally trained and competent practitioners. As well, the small number of ethnic participants in each treatment severely limits the generalizability of results. More research with a larger sample is necessary to determine the efficacy of CBT with in HIV-positive ethnic minority patients with depression.
Depression, CBT, and post myocardial infarction patients. Schneiderman et al. (2004) conducted a study to assess whether a psychosocial intervention to decrease depression and increase social support would reduce mortality and nonfatal myocardial infarction (MI) in acute post-MI patients. The 2481 (973 white men, 424 minority men, 674 white women, 410 minority women) patients with myocardial infarction (MI) who had major or minor depression and/or low perceived social support were randomly assigned to usual medical care or CBT. The representation of minorities was 19% black, 10% Hispanic, 3% Asian, and 2% American Indians. The researchers applied the Beck Depression Inventory, the Depression Interview and Structured Hamilton, and the Hamilton Rating Scale for Depression to yield level of severity. Criteria for low perceived social support were based on the ENRICHED Social Support instrument. “Follow-up assessments were performed 6 months after randomization and annually thereafter, for a mean of 2.4 and a maximum of 4.5 years” (Schneiderman et al., p. 478). Results displayed that white men may have benefited from the cognitive-behavioural intervention, but that the other subgroups did not.

This research study was categorized as being well-controlled for several reasons. First, the researchers used random assignment methods to allocate the participants to either a CBT treatment group or to a regular medical care group. Second, the researchers applied valid and reliable assessment measures. Third, follow-up assessors were blind to the treatment assignment. Fourth, the sample size was large enough to detect group differences. Fifth, the focus was on one well-defined disorder, depression. And finally, long-term follow-up was included to assess the enduring effects of the studies.

This research, however, also possessed limitations that decreased the value of this study. These limitations include the fact that because the objective of the study was to assess
the participants’ level of depression, including level of social support, the Hawthorne effect, as well as the fact that 30% of the participants received group-based CBT, could have greatly influenced the results. As well, it was reported that the participants and the interventionists were aware of the participants’ treatment assignment; therefore, experimenter effects could have influenced the results. The large sample size would have increased the generalizability of this research, although the external validity cannot be determined in this study because of a lack of information for evaluation purposes supplied by the researchers. Further research is necessary to determine the basis for these findings.

Post Traumatic Stress Disorder (PTSD), CBT, and Iranian sexual abuse victims.
Jaberghaderi, Greenwald, Rubin, Oliaee Zand, and Dolatabadi (2004) conducted a study in Iran to compare the efficacy of CBT and EMDR on PTSD with 14 Iranian sexual abuse victims (girls aged 12-13). The participants were randomly assigned to either CBT or EMDR treatments and received up to 12 45-minute sessions. Assessment of post-traumatic stress symptoms and problem behaviours was completed at pre-treatment and two weeks post-treatment. Measures included the Child Report of Post-traumatic Symptoms (CROPS), the Parent Report of Post-traumatic Symptoms (PROPS), The Rutter Teacher Scale, and the Subjective Units of Distress Scale (SUDS). Each treatment was manualized, and the CBT procedure was based on Deblinger and Heflin’s (1996) CBT work. In the CBT condition, the focus was on skill development (i.e. symptom management) exposure and homework tasks.

Pre-treatment measures suggested that the groups did not differ significantly on age, socio-economic status, type, severity, amount of sexual abuse, or extent of other trauma/loss history. Outcome measures suggested that both treatments showed large effect sizes on the posttraumatic symptom outcomes, and a medium effect size on the behaviour outcome, all
statistically significant. A non-significant trend on self-reported post-traumatic stress symptoms favored EMDR over CBT. Treatment efficiency was calculated by dividing change scores by number of sessions. It was found that EMDR was significantly more efficient, with large effect sizes on each outcome. Therefore, the findings of this study suggest that both CBT and EMDR can help young Iranian girls to cope with and/or recover from the effects of sexual abuse, but it must be noted that it was found that EMDR elicited more beneficial results.

This research was considered to be well-controlled for several reasons. First, the researchers randomly assigned participants to one of two time-limited interventions, CBT or EMDR. Second, both of the treatments were manualized and conducted by trained clinicians. Third, the focus of the research was on one well-defined disorder, PTSD with one well-defined cause, sexual assault. And fourth, the assessment measures used were reported to be reliable and valid across several settings and languages. Measures were translated in Persian and treatments were delivered by culturally trained and competent practitioners. Therefore, the rigorous controls implemented in this study deem this study to be well-controlled, maintaining high internal validity.

However, treatment effects could not be accounted for because no wait-list control group was utilized in the study. As well, Hawthorne effects and experimenter effects could have influenced the results. Finally, the small number of ethnic participants included in this research severely limits the generalizability of results. Therefore, although this study maintained a high level of internal validity, the results of this study, which displays that CBT is less beneficial than EMDR, are limited in terms of determining the effectiveness of CBT with this ethnic group.
Moderately-Controlled Studies

Panic disorder, CBT, and African-American women. Carter, Sbrocco, Gore, Watt Marin, and Lewis (2003) conducted a study to examine the efficacy of group Panic Control Therapy (PCT; based on CBT) for 25 African-American women. The participants were randomly assigned to either a treatment or wait-list control group. Treatment included 11 group sessions. All participants were screened for the presence of any DSM-IV Axis I diagnosis. Interviewers also assigned an overall Clinical Severity Rating (CSR) from 0 to 8 based on level of distress and interference in functioning. Frequency of panic was also assessed with an open-ended question format during. All interviews were conducted by people who did not know group assignment at pre- and posttest. Before treatment, participants were assessed and were found to be moderately anxious and depressed. After treatment, the intervention group experienced a significant reduction in panic frequency, avoidance behaviour, state and trait anxiety, and anxiety sensitivity. “On average, 54% of the treated group was classified as recovered, 17% as improved but not recovered, and 27% as unimproved. As many as 95% of the Wait list Control group were unimproved” (Carter et al., 2003, p. 516). The authors concluded that the results illustrated the participants developed moderate benefits from the CBT intervention.

Although the researchers randomly assigned the participants to either a time-limited treatment group or a wait-list control group, focused on a single well-defined disorder, and included blind interview assessors for data collection, the small sample size, the omission of a detailed description of the treatments used, and the exclusion of discussions regarding experimenter effects, effects of sensitization to pretest, and Hawthorne effects deemed this research as maintaining moderate control with moderate internal validity and low external
validity. As well, the intervention applied in this study was not manualized and did not consist of pure CBT which makes the replication of this study difficult. Further, there was no mention of language effects and no mention that the treatments were delivered by culturally trained and competent practitioners. Therefore, the generalizability of this research is severely limited. Further research is necessary to determine the efficacy of CBT with African-American women with panic disorder.

*Alcohol and drug use, CBT, and Hispanic and African American juvenile offenders*

Gil, Wagner, and Tubman (2004) conducted an experimental study to examine the effects of an alcohol and other drug use (AOD) intervention with Hispanic and African American juvenile offenders. Participants were 213 juvenile offenders referred for treatment (mean age = 15.7 years), 97 of whom had completed treatment. Data were collected through structured face-to-face interviews. Alcohol and marijuana use measures were collected using the Time-line Follow-back interview (TLFB). ATTAIN is a controlled clinical trial that evaluates the effectiveness of a brief motivational, cognitive-behavioural intervention, termed guided self change (GSC), with multi-ethnic adolescents who have some juvenile justice system involvement and who are experiencing problems with AOD use. Participants were randomly assigned to the individual format of guided self-change (I-GSC), the family involved format of guided self-Change (F-GSC), or a waiting list control condition. The results of this study indicated that there were significant reductions in alcohol and marijuana use for all ethnic groups from baseline to post-intervention in both the I-GSC and the F-GSC.

This research study was deemed as being moderately-controlled for several reasons. First the researchers applied the random assignment method allocating participants to an individual format of guided self-change (I-GSC), the family involved format of guided self-
Change (F-GSC), or a waiting list control condition. Second, the researchers focused on a well-defined disorder, being alcohol and drug abuse. Third, treatment manuals for the GSC were followed. However, this study also lacks in internal validity, according to the criteria established by Mertens (1998) for evaluating quantitative research in that the outcome measures relied solely on self-report measures and therefore, did not include measures that have demonstrated reliability and validity.

It must also be mentioned however, that this study also lacks in external validity as multiple treatments were applied, instead of pure CBT, making it difficult to determine which of the treatments, or combination of treatments, brought about the reported results. As well, the Hawthorne effect could have influenced results, there was no mention of language effects within this study, and the inadequate sample size make the findings of this research impossible to generalize outside of the population included in this study. Therefore, this study has been deemed to maintain a moderate level of internal validity and a low level of external validity. A more specific, pure treatment of CBT, which applies standardized measures and includes a large sample size is necessary to determine the efficacy of CBT with Hispanic and African-American juvenile offenders in the treatment of alcohol and drug use.

*Psychological distress, CBT, and HIV-infected Chinese men.* Chan et al. (2005) conducted a study to examine the efficacy of a cognitive-behavioural program (CBP) with 16 Chinese heterosexual HIV-infected men in Hong Kong. The aim of treatment was to improve the quality of life and to reduce psychological distress. Prior to intervention, baseline measures showed that the sample had a lower quality of life in comparison with the local general population. The participants also experienced a significant level of psychological
distress. Measures included the Health-Related Quality of Life (HRQOL) and the Center for Epidemiologic Studies-Depression Scale (CES-D).

The participants were randomized to the CBP or to a wait list control (WLC) group. To ensure a satisfactory randomization, the 16 participants were grouped into eight matched pairs based on their demographic background including age, education level, employment status, marital status and the time since diagnosis. Participants within each matched pairs were randomized to either the CBP group or the WLC group respectively. However, two participants in the CBP group and one from the WLC group dropped out due to practical employment reasons. Thus, the final sample that entered statistical analyses consisted of 13 participants. Six participants belonged to the CBP group and seven belonged to the WLC group. The CBP group consisted of seven weekly sessions, with each session lasting for two hours. Immediately after the CBP was completed, post-treatment data were collected and comparison data were obtained from the WLC group. The results of the study indicated that following intervention, men in the CBP group demonstrated significant improvement in the mental health dimension of quality of life and a significant reduction in depressed mood.

This research study was categorized as being moderately controlled for several reasons. First, the researchers did apply careful random assignment to a time-limited treatment group or a wait-list group. As well, the researchers employed outcome measures that were deemed reliable and valid. However, several limitations must be considered that decrease the internal validity of this study. First, the sample size was very small, making it difficult to detect group differences reliability. Secondly, the focus on the research was on two presenting concerns, including depression and quality of life. Third, it was not reported whether the CBT treatment was manualized. Fourth, it was not reported whether language
effects could have influenced the assessments and thus the findings. Further, history and maturation could have influenced the reported results of this study.

Limitations of the external validity of the study must also be considered. First, the experimental treatment was not described in sufficient detail making it difficult to know whether a pure form of CBT was applied as well as making replication of the research impossible. Second, experimenter effects, the Hawthorne effect, and history (especially considering the group format) could have influenced results. Factors such as group support, attention from therapist, catharsis, and sharing may have all had an impact on the findings of this study. And finally, the small number of ethnic participants included in this study severely limits the generalizability of results. Therefore, this study is deemed to possess moderate internal validity and low external validity. Further research is necessary to determine the efficacy of CBT for psychological distress with HIV-infected Chinese men.

**PTSD, CBT, and Cambodian refugees.** Otto et al. (2003) conducted an experimental study to provide evidence for the efficacy of sertraline compared to sertraline plus CBT for the treatment of PTSD in a sample of Cambodian refugees. Participants included ten Khmer-speaking women (mean age = 47.2) who met the criteria for current PTSD determined by the Structural Clinical Interview for DSM-IV. Five participants were randomly assigned to sertraline treatment and five to sertraline plus ten sessions of CBT. Outcome measures included the Clinician-Administered PTSD Scale and the Anxiety Sensitivity Index. Results of this study indicated that the participants in the CBT group plus sertraline group were provided with substantial additional benefit relative to the sertraline treatment alone group. Otto et al. (2003) reported that benefits ranged from “medium to large effect sizes for PTSD and associated symptoms” (p. 1271). The findings of this study illustrated that the culture-
specific (interpreted for Khmer-speaking women) version of CBT can be effective for the
treatment of PTSD with Cambodian women.

This research study was classified as being moderately-controlled for several reasons.
First, the researchers applied a randomized group design, allocating the participants to either
a sertraline treatment group or a group consisting of sertraline plus ten sessions of CBT,
which allowed for a comparison between groups. Second, the focus of the research was on a
well-defined disorder, which in this study was PTSD. Third, the outcome measures applied in
the study were reliable and valid and were translated into Khmer to control for language
effects. However, there are also several limitations that need to be addressed in this study that
decrease the level of research’s level of external validity. The two main limitations of this
study are the small sample size and the inclusion of multiple treatments. Both of these
research characteristics make it very difficult to generalize the findings of this study to
populations other than the one included in the research. The small sample size has led me to
classify this study as moderately-controlled with a low external validity. More research is
necessary with this population to determine the efficacy of CBT with Khmer-speaking
women.

PTSD, CBT, ethnic women. Kubany et al. (2004) conducted a study on cognitive
trauma therapy (CTT) for battered women with posttraumatic stress disorder (PTSD). The
intervention included in this research consisted of trauma history exploration; PTSD
education; stress management; exposure to abuse and abuser reminders; self-monitoring of
negative self-talk; cognitive therapy for guilt (two to four sessions are usually devoted to
cognitive therapy for trauma-related guilt); and modules on self-advocacy, assertiveness, and
how to identify perpetrators. Participants included 125 formerly battered women, ranging in
age from 18 to 70, with a mean age of 42.2 years. Participants' ethnic backgrounds were diverse and included White (n = 66), Native Hawaiian (n = 11), Filipino (n = 9), Japanese (n = 8), Black (n = 6), Samoan (n = 6), American Indian (n = 2), and other or mixed ethnicity (n = 17). All participants had been physically, sexually, and/or psychologically abused (e.g., threatened, stalked, badgered, humiliated) by an intimate or romantic partner. Participants were randomly assigned to immediate or delayed CTT. The researchers applied a number of assessment scales including the Clinician-Administered PTSD Scale (CAPS), the Distressing Event Questionnaire (DEQ), the Beck Depression Inventory (BDI), the Rosenberg Self-Esteem Scale (RSES), the 32-item TRGI, which assesses guilt and cognitive and emotional aspects of guilt associated with specific traumatic events, the Sources of Trauma-Related Guilt Survey—Partner Abuse Version (STRGS-PA), the Personal Feelings Questionnaire (PFQ), the Client Satisfaction Questionnaire (CSQ-8), and the TLEQ, which assesses exposure to a broad spectrum of 21 potentially traumatic events. PTSD remitted in 87% of women who completed the CTT treatment, with large reductions in depression and guilt and substantial increases in self-esteem. White and ethnic minority women benefited equally from the treatment. Gains were maintained at 3- and 6-month follow-ups.

This research study was considered a moderately-controlled study because of its application of the following criteria for quantitative studies: the participants were randomly assigned to a treatment group and a wait-list control group where comparisons of the impact of the interventions could be assessed, the focus was on one well-defined disorder (PTSD), the outcome measures were reliable, and the researchers conducted two follow-ups at 3- and 6-months. Although, history and maturation could have also influenced the findings of the results, since participants were included in the study only if they had been out of an abusive
relationship for at least a month, with no intention to reconcile. Time and healing could therefore have had a significant influence on the results of this study. Therefore, the level of internal validity maintained in this study has been deemed as moderate.

Several limitations for the studies external validity must also be considered. First, although the researchers included a number of different ethnicities in the study, once the subjects were randomized to the treatment group and the control group, the small number of visible ethnic minority participants included in each group severely limits the generalizability of this research. As well, multiple-treatment interference makes it difficult to determine which treatment(s) brought about the reported results. Therefore, it is difficult to generalize the results of this study to other members of the ethnic minority groups, due to these limitations.

Community violence, CBT, and Latino immigrants. Kataoka et al. (2003) conducted a quasi-experimental study to determine the efficacy of CBT for Latino immigrant students who have been exposed to community violence. The participants consisted of 198 students in third through eighth grade with trauma-related depression and/or post-traumatic stress disorder. Only a portion of the participants were randomized. The participants were given a battery of assessment measures including the Life Events Scale, the Child PTSD Symptom Scale (CPSS), and the Children’s Depression Inventory (CDI) to determine levels of trauma. All measures were translated from English to Spanish and translations were reviewed by multiple bilingual/bicultural clinicians to verify accuracy and appropriateness of the translation. Almost all children in the program had clinical levels of PTSD symptoms (90%), one-third of youths had co-morbid PTSD and depressive symptoms in the clinical range (32%), and 10% of students had clinical levels of depression only. The intervention was an
eight-session CBT group-based intervention for trauma in schools. Out of the 198 participants (50% female), 67 youths received the treatment immediately and 46 students were randomized to the waitlist group. The results of the study illustrated that the school-based, trauma-focused, CBT intervention for Latino immigrant students is associated with modest reduction in symptoms of PTSD and depression.

This research study was considered a moderately-controlled study because of its application of the following criteria for quantitative studies: a portion of the students were randomly assigned to a treatment group and a wait-list control group where comparisons of the impact of the interventions could be assessed, the trained clinicians followed a treatment manual for the time-limited application of CBT, the researchers took language effects into consideration and delivered the intervention in Spanish, the assessments used were valid and reliable, and the researchers conducted a follow-up at 3 months. Because of the lack of full randomization, the dual focus on both PTSD and depression, the variation in participants’ ages, and their differing levels of cognitive development this study was considered to maintain a moderate level of internal validity.

The level of external validity was negatively affected by the history and treatment effects of study. The degree and context of community violence that this group had been exposed to may not be able to be replicated in other studies. As well, the Hawthorne effect could have been operating, as the special attention from the study may have influenced the students’ reports. And finally, the small sample size used in this research decreases the generalizability of the findings of this research outside of the young, Hispanic population group included in the study. Therefore, although this study found modest benefits from CBT, further research is necessary to determine the efficacy of CBT in the treatment of trauma-
related depression and/or post-traumatic stress disorder with young, Latino Hispanic populations.

*Depression, CBT, and Spanish-speaking and African-American clients.* Miranda, Azocar, Organista, Dwyer, and Areane (2003b) conducted a study to determine whether supplementing traditional CBT for depression with clinical case management (i.e. telephone outreach, home visits, assessment of self-reports of problems in housing, employment, recreation, and relationships, and setting goals) would reduce the rate of dropout from care as well as improve outcomes for ethnically diverse, impoverished medical outpatients in comparison to the use of CBT alone. One hundred and ninety nine ethnically diverse participants were chosen to participate in the study because of high levels of depression and poor functioning assessed by the Structured Clinical interview for DSM-III-R36 (SCID) and the Beck Depression Inventory (BDI). Of this sample, 77 participants were Spanish-speaking (33% from El Salvador; 22% from Nicaragua; 17% from Mexico; 9% from South America; 6% from Puerto Rico; 5% from Cuba; and 2% from Guatemala). Of the 122 participants for whom English was the first language, 38% were African American; 47% were white; and 15% were Asian or American Indian. Miranda et al. (2003b) ensured that bilingual and multicultural staff were available to participants throughout the study and adapted the language of the intervention and the treatment manual to meet the linguistic and reading levels of the participants. The participants were randomized into a CBT group (n = 103) and a CBT, in conjunction with case management, group (n = 96).

In regards to outcome, the results indicated that the enhanced intervention of clinical case management along with CBT was more effective than CBT alone in reducing depressive symptoms and improving functioning among Spanish-speaking patients, but not among
English speaking patients. In fact, it was found that the African-American participants did more poorly than any of the other English-speaking participants. The authors suggested that these results indicate that the supplemental (CBT) case management intervention is effective for some ethnicities, but not others, and that CBT in conjunction with another treatment was more effective than CBT alone.

This research study was considered to be moderately-controlled study because of its application of the following criteria for quantitative studies: the researchers randomly assigned participants to either a CBT alone group or a CBT in conjunction with case management group where comparisons of the impact of the interventions could be assessed; the sample size was adequate for detecting group differences; the researchers took language effects into consideration and delivered the intervention in both Spanish and English; the assessments used were valid and reliable; and a follow-up was conducted at 6 months.

However, the findings from this study must be perceived with extreme caution because researchers reported that the Latino participants received more home visits. Therefore, the case management group may have been influenced by compensatory equalization of treatments (Mertens, 1998), meaning that extra resources were provided to some of the participants in the control group and history because events other than the independent variable could have affected the results. These limitations have reduced the categorization of the study from a well-controlled study to a moderately controlled study with a moderate level of internal validity.

The external validity of the study however, was also rated as being moderate. Several strengths must be noted such as the adequate sample size, the diverse population and the inclusion criteria reported in the study, the researchers’ responsiveness for delivering the
treatment in two languages by culturally trained and competent practitioners, interpreting the treatment manuals, and adapting the language to meet the linguistics and reading levels of the participants. However, several limitations to the external validity of the study must also be noted such as Hawthorne effects, experimenter effects, and the fact that multiple treatments were used, one of which was not manualized or consistent for each ethnic group, making generalizability of this research impossible. Further research is necessary with Spanish-speaking and African-American clients to determine the efficacy of CBT for the treatment of depression.

*Depression, CBT, and elderly Chinese.* Dai et al. (1999) conducted a study to determine the efficacy of psychoeducation classes (including CBT) on the depressive symptoms of elderly Chinese Americans. Twenty Chinese speaking subjects were recruited from a church to participate in the experimental group which involved eight psychoeducational CBT classes once a week. Twenty subjects were selected and randomly assigned to each of the experimental and control groups. The researchers reported that 7 subjects dropped out prematurely for relevant reasons. The researchers provide detailed information that occurred throughout each session, which were all is based on CBT, relaxation techniques, and the sharing of feelings with group members. Measures, pre- and post-treatment, included the Hamilton Depression Scale and the sub-section of the Hamilton Anxiety Scale. The authors concluded that the results indicated there was significant improvement in depressive symptoms and anxiety symptoms in the experimental group, but that there was no improvement in the control group.

This research was classified as being moderately-controlled for several reasons. First, the researchers randomly assigned participants to a treatment group delivering CBT and a
wait-list control group. Therefore, comparisons of the impact of the interventions could be assessed. Secondly, the researchers took language effects into consideration and delivered the intervention in Mandarin Chinese. Third, the assessments used were valid and reliable. However, the study also had limitations to internal validity that must be addressed. First, the participants could have become test wise because the same assessments were applied at pre-treatment and post-treatment. As well, history must be taken into consideration, as other events such as the group format, where the subjects were “encouraged to share their feelings and thoughts” (Dai et al, 1999, p. 539) about the interventions could have impacted the results making it difficult to determine whether the reported changes were the result of the CBT intervention or whether the results could have been impacted by participants’ feelings of increased social support and the therapeutic effects of catharsis.

The external validity of the research study was deemed as low because of lack of reports of experimenter effects and Hawthorne effects. As well, the small sample size makes the generalizability of the findings of this research impossible. More research is necessary to determine whether CBT is effective with elderly, Chinese Americans with symptoms of depression.

Poorly-Controlled Studies

Mental health, CBT, and Chinese participants: Fu Keung Wong, Yu Kit Sun, Tse, and Wong (2002) conducted a quasi-experimental study to investigate the efficacy of a cognitive-behavioural group intervention in helping Chinese clients deal with maladaptive physiological, cognitive, behavioural, and emotional responses to stressful life circumstances. Participants were recruited in Hong Kong on a voluntary basis through flyers and newspaper advertisements. The General Health Questionnaire-12 was used to choose
participants by determining levels of mental health. Those at risk (n = 32; 25 female and 7 male) of developing poor mental health were further assessed on measures of mental health, rational thinking, coping skills, and negative and positive emotions at pretest and posttest. The CBT intervention was based on the one developed by Beck (1995) and was applied for eight sessions with the each session lasting two hours. The results suggested that participants made a significant clinical improvement in mental health by the end of treatment. 70% of the participants changed from an at-risk group to a mentally healthy group.

This research study was considered to be poorly-controlled for several reasons. First, there was no randomization of participants and no control group. Therefore, a comparison between groups was nonexistent. Further, the focus was not on one well-defined disorder. Instead the researchers focused on overall mental health functioning including depression, anxiety, and inadequate coping skills for life stressors. As well, although the researchers reported that all four of the groups included in the study were subjected to the same intervention format, the CBT treatment was not manualized. The researchers did however utilize and translate assessment measures that had shown to be effective for the local Chinese population in previous research. According to the criteria outlined by Mertens (1998), all of the methods used within this study illustrate a lack of internal control.

However, the external control of the study must also be considered. The participants were all administered a pretest before commencing the CBT intervention and were given the same assessment at the end of the treatment. Therefore, testing effects may have impacted the findings as participants may have been sensitized to the treatment by taking the pretest. As well, treatments were delivered in all four of the groups by four different clinicians causing experimenter effects to come into question. As well, one must consider the influence of
Hawthorne effects in this study. Participants were recruited through flyers and newspapers advertisements and were therefore voluntary to the program. As well, a total of 43 participants were offered pretreatment interviews and only 35 members were recruited. Therefore, being singled out and chosen to participate in the study could have significantly influenced the results of this study. And finally, the small sample size included in this study makes the generalizability of this research impossible. Further research that includes a large sample size is needed to determine the efficacy of CBT with this Chinese population.

**PTSD, CBT, and Armenian children.** Goenjian et al. (1997) conducted a quasi-experimental study with 64 sixth and seventh graders who exhibited PTSD symptoms one and half years after experiencing an earthquake from four schools in Armenia. Students from two schools received treatment and students in the remaining schools served as assessment-only controls. Treatment consisted of four 30-min group sessions and an average of two individual sessions conducted over 3 weeks in a school setting. The intervention included reprocessing the trauma, clarification of cognitive distortions, coping strategies, grief resolution, problem solving, aggression management, and relaxation techniques. Participants were encouraged to discuss the traumatic event, draw pictures of the event, and identify how the most traumatic moments were associated with current trauma-related distress. Severity of depression and PTSD were assessed with self-report measures prior to treatment and again 18 months later. Participants who received treatment reported decreases in overall PTSD symptoms and across the three PTSD clusters, whereas those who did not receive treatment did not show such reduction. The authors reported that 60% of participants in the treatment group and 52% in the control group exhibited PTSD at pretreatment. At the 18-month follow-up, rates were 28% of the treatment group participants and 69% of the control group
participants exhibited PTSD, suggesting that the CBT intervention had a significant impact with Armenian children in the treatment of PTSD.

Although the Armenian students experienced reductions in PTSD following treatment, methodological drawbacks must be acknowledged in this study. This research has been deemed as poorly-controlled research for several reasons. Although, the researchers did report that this was quasi-experimental research, I will note that participants were not randomly assigned to a treatment group or to a non-treatment control group. As well, it was not reported that the CBT treatment was manualized and outcome measures were based exclusively on self-report measures; thereby decreasing the study’s level of internal control.

The research is also lacking in external control. Although the experimental treatments were described in sufficient detail, multiple treatment interference makes it impossible to determine which intervention elicited the found results. For instances, reprocessing of traumatic material may better fit into an EMDR intervention than CBT. As well, the fact that the research included a small sample size and the notion that there could have been an interaction between history (the earthquake) and treatment effects severely decreases the generalizability of the findings of this research. Therefore, although it was reported that the CBT intervention had a significant impact with Armenian children in the treatment of PTSD more research is needed with this population because of the lack of internal and external control.

*Depression, CBT, and minority, medical outpatients.* Organista, Muñoz, and Goñzalez (1994) conducted a quasi-experimental study to determine the effectiveness of CBT on the treatment of depression in low-income, minority (Spanish) medical outpatients. Subjects consisted of 175 depressed, low-income, minority medical outpatients treated with
CBT (75% were female; 3% Asian, 18% African American, 44.4% Latino, 34.6% White). Measures included a pre- and post-application of the Spanish language version of the Beck Depression Inventory (BDI), a Structured Clinical Interview for DSM-III-R – Patient Edition (SCID-P), and a Demographic Questionnaire. Subjects were offered 12 sessions of standardized CBT for their depression. Treatment focused on the role of thoughts, behaviours, and interpersonal interactions on mood. Most of the subjects who completed therapy (n = 74) received group therapy (n = 39), but some received individual therapy (n = 22), or a combination of both (n = 13). Group treatment consisted of three four-session CBT modules, the total sessions being 12. Groups met weekly for 2-hour sessions for 12 weeks, and individual treatment was conducted weekly in 50-minute sessions ranging from 12 to 20 weeks.

Findings suggested that CBT was effective in reducing symptoms of depression in a diverse clinical patient population but to a degree in need of examination and enhancement. Organista et al. (1994) stated that “symptom reduction in the current sample was a little better than reductions reported for untreated control subjects in published outcome studies” (p. 253). Patients who benefited the least from CBT were those who entered treatment with the most severe symptoms of depression and who were not married or living with partners.

This research was classified as being poorly-controlled because of several methodological limitations. The limitations of this study included lack of randomization, lack of a control group to compare the effects of the intervention, and lack of manualized treatments, as it was reported that some participants received individualized treatment, some received group format, and some received both the individualized and the group format. As well, testing may have influenced the results as participants completed the same assessment.
measures pre- and post-treatment. As well, the researchers reported that there were high drop out rates (58%).

The external validity of the study was however rated as moderate for several reasons. First, the researchers had the participants complete a demographic questionnaire that illustrated ethnicity, marital status, employment, and education making generalizability to other populations a possibility. Second, the researchers described the treatment in sufficient detail. Third, the authors provided a clear description of inclusion criteria, and ensured that the treatments delivered were culturally sensitive. However, it must be noted that although the researchers include a fairly adequate sample size for this research, the number of ethnic minority clients within each minority group were small. Therefore, although this study maintained a poor level of internal validity, it possesses a moderate level of external validity and displayed a low level of effectiveness for CBT in the treatment of depression with Hispanic and African-American clients. Future research that includes a larger number of visible ethnic minority groups is necessary to increase the generalizability of this research.

PTSD, SUD, CBT, and Incarcerated Women. Zlotnick, Najavits, Rohsenow, and Johnson (2003) conducted an uncontrolled pilot study to determine the efficacy of Seeking Safety, which is a manual-based treatment that draws upon the tradition of CBT of substance abuse, with 18 underprivileged, incarcerated women suffering from PTSD and substance abuse disorder (SUD). All participants were recruited from a voluntary, residential substance abuse treatment program in a minimum-security woman’s prison facility. All participants met DSM-IV criteria for PTSD and met criteria for a current substance dependence disorder determined by the Structured Clinical Interview for DSM-IV-Patient version. Some of the participants could not speak English well enough to understand the consent form so it was excluded from the study. Treatment sessions
were 90 minutes long and were held in group format twice a week for just over 12 weeks. There were 3-5 women per group. Assessments were conducted at pre- and post-treatment (during incarceration) and 6 to 12 weeks post-release. A trained research assistant administered all measures. Measures included the Clinical-Administration Posttraumatic Stress Disorder Scale-I (CAPS-I), providing a diagnosis of length and degree of PTSD, the Addiction Severity index, and the Structured Clinical Interview for DSM-IV-Patient version (SCID), to assess alcohol or drug use and/or dependence. At post-treatment, participants’ opinions about treatment were assessed on the Helping alliance Questionnaire-II and the Client Satisfaction Questionnaire. The researchers reported that the participants’ ethnicity’s included 12 white, 2 African-American, 1 Hispanic, and 3 other. Findings illustrated that nine of the participants no longer met criteria for PTSD at the end of the treatment and that at a follow-up 3 months later, seven still no longer met the criteria for PTSD.

This research study was categorized as a poorly-controlled research study, lacking internal validity for several reasons. First, the researchers did not include a control group in the study; therefore, there was no randomization of the participants. Second, the focus in this study was not on one single well-defined disorder; all of the participants held dual diagnoses with PTSD and substance abuse disorder. Third, because the same assessments were delivered pre- and post-treatment, the participants could have become test wise, which could have affected the results. Fourth, it must be noted that the participants were paid $50 to complete the pre- and post-assessments. Therefore, monetary rewards could have influenced the participants to make favourable reports of change. Finally, language effects could have significantly influenced the results of the study. The researchers reported that some of the participants could not speak English well enough to understand the consent form, but
there was no mention of translations or adaptations to the treatment or to the assessment measures included in the review. Therefore, this study has been categorized as possessing low internal validity.

There are also several limitations that cause the external validity of this study to be considered as being low. First, a small sample size was used for the research which severely decreases the generalizability of the findings of this research. As well, the researchers did not provide a sufficient detailed description of the treatment procedures, making replication of the study impossible to conduct. As well, experimenter effects and the Hawthorne effect could have greatly influenced the results, particularly because the relationship between the participants and the researcher could have been based on monetary gains rather than trust and mutuality. Finally, there was also no indication as to which ethnic groups gained from the CBT-based treatment. Therefore, the findings of this study need to be taken with extreme caution and highlights the lack of support in determining the efficacy of CBT with incarcerated, female, minority clients.

Analysis of Qualitative Research

*Well Conducted Research*

*CBT, values, Indian Hindus, and Thai Buddhists.* Scorzelli and Reinke-Scorzelli (2001) conducted two qualitative studies (one in India and one in Thailand) to examine cognitive approaches to mental health counselling to broaden the worldview of mental health counsellors and to enhance their sensitivity to clients of diverse cultural backgrounds. Participants in the India study included 62 graduate students with 80% identifying their religion as Hinduism. The second qualitative study was conducted with 58 program directors in Thailand, where 54 of the participants identified their religion as Buddhism. The procedure consisted of a workshop, taught by the principle researcher, where the participants
were educated on a cognitive approach to therapy. The principle components covered through several methods including an overview of the philosophy of rehabilitation and psycho-social implications of disability and five hours of training, including handouts, booklets, specific techniques, and case presentations in reality therapy and rational emotive behavioral therapy. The major elements covered included, “the role of emotions in behavior, the identification of irrational thoughts, and methods of changing automatic thoughts” (Scorzelli & Reinke-Scorzelli, p. 86). In order to control for language effects, three translators were provided throughout the sessions. Data collection involved a survey method for determining whether the participants believed that the cognitive theories were consistent with their religious beliefs and cultural values. The survey involved “yes” or “no” responses and also included having the participants to provide subjective rationales for their responses.

These researchers found that the participants in the India study felt that the cognitive approach to counselling conflicted with their values and beliefs, although it was reported that “no common trend was identified” (Scorzelli & Reinke-Scorzelli, 2001, p. 86). Instead the researchers found that the reasons provided by the participants “varied and seemed based more on the students’ interpretation of religious or cultural values than any group norm” (Scorzelli & Reinke-Scorzelli, p. 86). The Thai Buddhist group however, reported that cognitive therapy was consistent with their religious and cultural beliefs.

These research studies were categorized as “well-conducted” qualitative research studies for several reasons. First, the researchers went into the field so that they had the opportunity to develop direct, personal relationships with the participants, which allowed the researchers to develop knowledge and understanding of the culture and to overcome distortions (Patton, 1987). Second, the researchers provided a “thick description” (Mertens,
1998) of the context and the culture, which allows for transferability of the findings. Third, the researchers used inductive analysis, which implies that the data emerged out of the data rather than being decided by the researchers prior to data collection (Patton). Finally, the researchers applied a standardized open-ended method of data collection, which consisted of a set of carefully worded and arranged questions that were answered by each respondent and followed with the participants’ written subjective rationales to provide a more comprehensive and subjective motivation for the responses. For these reasons, the research was deemed to possess high external validity because the results will be meaningful when counselling other members of the two populations included in this research. Therefore, this qualitative research study illustrates that the basic assumptions and techniques guiding CBT seem to conflict with the worldviews of Indian Hindus, but that CBT may be favorable for Thai Buddhist clients.

**CBT and an East Indian family.** Dattilio and Bahadur (2005) conducted a qualitative single-case study to determine the effectiveness of CBT in the treatment of the daughter of an East Indian Family. The researchers reported that the daughter was 15 years of age was highly acculturated into the American style of life. Her family on the other hand maintained a lower level of acculturation. The conflicting worldviews within the family unit and the requests of a physician brought this family into counselling where a cognitive-behavioural therapeutic approach was applied.

The CBT therapist, who was also the author and researcher of this study, reported that she was very aware of how important it is to consider the worldviews of the daughter and her parents before commencing therapy. The therapist also reported that she did not assume a position of favoring the value of independence (which is often pronounced in CBT) for the daughter of this family and instead respected the family’s interdependent cultural values. The
counsellor also reported that she orientated the family to the assumptions and techniques of CBT and adapted it to meet their therapeutic and cultural needs.

Cognitive-behavioural therapy was then employed with this family. The researchers reported that the family members identified their own cognitive distortions, recognized how these distortions were affecting their emotions and behaviours, and worked on developing alternative responses or interpretations of the events. Thus, the goal of this study was to eventually restructure the family members’ cognitive schemas to decrease the amount of conflict found within the family. The researchers reported that the “key to working with cultures such as the Indian culture is to remain mindful of the larger cultural beliefs as well as the specific family’s context, and adapt the approach accordingly” (Dattilio & Bahadur, 2005, p. 380). The researchers reported that the collaborative approach used in CBT that allowed for the family’s cultural beliefs to inform the treatment goals and process facilitated the positive outcome results.

This qualitative study was categorized as a “well-conducted” qualitative, case-study research for several reasons. I will highlight the strengths of this study initially. First, the researcher maintained sufficient involvement with the family to develop an extensive understanding of each family member’s internalized culture, to build relationships based on trust with each of the family members, and to overcome any biases that the researcher may have had regarding the cultural group. Second, the researchers provided a sufficiently “thick description” (Mertens, 1998) of the research, including a description of the time, place, context, and culture. Third, the researchers applied triangulation by utilizing several methods of data collection and assessment, which in this case were observations, subjective homework assignments, and subjective reports of change and satisfaction.
The findings of this study may be useful when counselling other East Indian families because of the detailed description of the participants’ culture and worldview, the inclusion of the participants’ subjective experiences of the treatment, and the inclusion of a detailed description of the process of the intervention. Therefore, this study was deemed as a well-conducted study.

Summary of Analysis

Table 1, 2, and 3 synthesize the lengthy data gathered from the analysis of the quantitative and the qualitative research studies. The tables note the researchers who conducted the efficacy research, the population and the disorder treated, the level of internal and external validity maintained in the research, and the reported outcomes of all the above outcome studies. A more detailed investigation and discussion of the findings from the research analysis is provided in the following section.
<table>
<thead>
<tr>
<th>Reference</th>
<th>Study Sample</th>
<th>Condition Treated</th>
<th>Internal validity</th>
<th>External validity</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arroyo et al. (2003)</td>
<td>Hispanic</td>
<td>Alcohol Abuse</td>
<td>High</td>
<td>Low</td>
<td>Good</td>
</tr>
<tr>
<td>Jaberghaderi et al. (2004)</td>
<td>Iranian girls</td>
<td>Sexually Abuse</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Markowitz et al. (2000)</td>
<td>White (58)</td>
<td>HIV-positive and depression</td>
<td>High</td>
<td>cannot assess –</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>Hispanic</td>
<td>Depression</td>
<td>High</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Miranda et al. (2003a)</td>
<td>Hispanic</td>
<td>Depression</td>
<td>High</td>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Rosello and Bernal (1999)</td>
<td>Puerto-Rican Adolescents</td>
<td>Depression</td>
<td>High</td>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Schneiderman et al. (2004)</td>
<td>N = 2481</td>
<td>Depression</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Silverman et al. (1999a, b,)</td>
<td>Across the trials</td>
<td>Phobic and Anxiety Disorders</td>
<td>High</td>
<td>Low</td>
<td>Good</td>
</tr>
<tr>
<td>Reference</td>
<td>Study Sample</td>
<td>Condition Treated</td>
<td>Internal validity</td>
<td>External validity</td>
<td>Outcome</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Carter et al. (2003)</td>
<td>African-American</td>
<td>Panic Disorder</td>
<td>Moderate</td>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Chan et al. (2005)</td>
<td>Chinese</td>
<td>Psychologic al Distress</td>
<td>Moderate</td>
<td>Low</td>
<td>Good</td>
</tr>
<tr>
<td>Dai et al. (1999)</td>
<td>Chinese</td>
<td>Minor Depression</td>
<td>Moderate</td>
<td>Low</td>
<td>Good</td>
</tr>
<tr>
<td>Gil et al. (2004)</td>
<td>Hispanic and African American adolescents</td>
<td>Substance Abuse</td>
<td>Moderate</td>
<td>Low</td>
<td>Good</td>
</tr>
<tr>
<td>Kataoka et al. (2003)</td>
<td>Latino Children</td>
<td>Exposure to Community Violence</td>
<td>Moderate</td>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Kubany et al. (2004)</td>
<td>White (66), Native Hawaiian (11), Filipino (9), Japanese (8), Black (6), Samoan (6), American Indian (2),</td>
<td>PTSD</td>
<td>Moderate</td>
<td>Low</td>
<td>Good</td>
</tr>
<tr>
<td>Miranda, Azocar et al. (2003b)</td>
<td>Hispanic (77) English first language (122) 38% African American 47% white 15% Asian or Amer. Indian.</td>
<td>Depression</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Low</td>
</tr>
<tr>
<td>Otto et al. (2003)</td>
<td>Cambodian Refugees</td>
<td>PTSD</td>
<td>Moderate</td>
<td>Low</td>
<td>Good</td>
</tr>
</tbody>
</table>
Table 3
Poorly-Controlled Quantitative Research and Well-Conducted Qualitative Research

<table>
<thead>
<tr>
<th>Reference</th>
<th>Study Sample</th>
<th>Condition Treated</th>
<th>Internal Validity</th>
<th>External Validity</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantitative Research</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fu Keung Wong et al. (2002)</td>
<td>Chinese</td>
<td>Mental Health due to life stressors</td>
<td>Low</td>
<td>Low</td>
<td>Good</td>
</tr>
<tr>
<td>Goenjian et al. (1997)</td>
<td>Armenian children</td>
<td>PTSD</td>
<td>Low</td>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Organista et al. (1994)</td>
<td>Hispanic African American</td>
<td>Depression</td>
<td>Low</td>
<td>Moderate</td>
<td>Low</td>
</tr>
<tr>
<td>Zlotnick et al. (2003)</td>
<td>White (12) African-American (2) Hispanic (3)</td>
<td>Substance Abuse and PTSD</td>
<td>Low</td>
<td>Low</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

| Qualitative Research           |                             |                                            |                   |                   |          |
| Dattilio and Bahadur (2005)    | East Indian                 | Family Conflict                           | High              | Good              |          |
| Scorzelli and Reinke-Scorzelli (2001a) | Thai Buddhism               | Examining the values of CBT               | High              | Good              |          |
| Scorzelli and Reinke-Scorzelli (2001b) | Indian 80% Hinduism          | Examining the values of CBT               | High              | Low               |          |
CHAPTER V

Synthesis and Implications

The results of this analysis will be discussed in terms of the following topics. First, the methodological limitations of the efficacy research will be considered. Next, the results of the efficacy research will be considered with regard to the implications for the use of CBT with the particular visible ethnic minority groups included in the review and with visible ethnic minority clients in general. The discussion section will follow with a discussion of the limitations of this literature review and will conclude with recommendations for future research.

Methodological Limitations

Twenty-two research studies that applied CBT to the treatment of peoples from visible ethnic minority groups were included in this review. Although it must be noted that one or two of the studies utilized for this review included visible ethnic groups that were not minorities in their countries limiting the results of the review. For example, Rossello and Bernal (1999) conducted research in Puerto Rico with Puerto Ricans participants. The small number of studies on this topic illustrates the lack of attention that has been given to determining the efficacy of the well-known and prevalent CBT approach in the field of psychotherapy for the treatment of visible ethnic minority populations. Further, the incredibly small number of qualitative research studies that were found for this review illustrates the past and present preference for experimental, quantitative research. Mertens (1998) also highlights that “there is a greater tendency for research with statistically
significant results to be published” (p. 53). Therefore, as illustrated by this literature review, publication bias may have decreased the number of available research studies on this topic.

According to Chambless and Hollon’s (1998) criteria for establishing efficacious treatments, not one of these studies illustrated that CBT was “efficacious” in the treatment of the specific visible ethnic minority clients because the research has not been replicated. In fact, only seven out of the 22 examined studies were deemed by the researcher to be well-controlled studies, obtaining this rating for displaying high internal validity and excluding the external validity of which the majority were deemed as being low. These seven studies may be deemed by Chambless and Hollon as being possibly efficacious, awaiting replication even though they maintain low external validity and therefore cannot be generalized outside of the specific participants or populations included in the research. This discrepancy, is beyond the scope of this paper, but is an area that requires further attention.

Although this analysis displayed a wide-range of results for determining the efficacy of CBT with members of visible ethnic minority populations, two general observations can be made. First, the tension between internal and external control within research studies became abundantly apparent as not one of research studies maintained high internal as well as high external control. This provides support for the similar observation made by Bernal and Scharrón-Del-Rio (2001) in an earlier review of efficacy research conducted with ethnic participants. There does not seem to be an improvement in the design of efficacy studies since this original review was undertaken.

The second interesting finding from this analysis of the research illustrated that some visible ethnic minority groups as a whole seemed to experience greater gains from CBT than other visible ethnic minority groups. These findings support the notion that different cultural
groups may have unique reactions to the application of CBT. A more detailed analysis follows that explores the differences that were found between the visible ethnic minority populations included in this review.

**Summary of CBT and Hispanic/Latino/Puerto Rican Participants**

Although, the different cultural groups who speak Spanish are referred to, or refer to themselves, as Hispanic, Latino, Chicano, Mexican, Cuban, Spanish, Puerto Rican, etc., for the purpose of this paper, I have brought the various Spanish-speaking minority groups into one categorization and will refer to this diverse group as Hispanic, in light of the terminology used in many of the research studies and to avoid confusion.

The overall findings of the outcome studies illustrated that Hispanic participants gained better therapeutic outcomes from CBT in the treatment of depression and alcohol and substance abuse than any of the other visible ethnic minority participants. Nine out of the 19 quantitative outcome studies included in this literature review applied CBT with Hispanic clients. I will however only address six of the studies that included a majority of Hispanic participants. Four out of the six well-controlled studies found that CBT was effective with Hispanic clients. Silverman (1999a, b; outlined by Pina, et al., 2003), Arroyo et al. (2003), Markowitz et al. (2000), and Rossello and Bernal (1999) conducted well-controlled studies, that maintained high internal validity and found that Hispanic participants obtained substantial outcome gains from the CBT treatment. However, it must be noted that Rossello and Bernal (1999) found that IPT was even more effective with Puerto Rican participants. It must also be noted that Miranda et al. (2003a) conducted a well-controlled study and found only moderate outcome effects for the Hispanic participants. As well, out of 2481 post-MI
patients, Schneiderman et al. (2004), who also conducted a well-controlled study, found that the Hispanic participants (10%) did not gain substantially from the CBT treatment.

Although the findings presented displayed a variety of outcome findings, the evidence illustrates that Hispanic participants had a higher rate of outcome gains as a whole than any other visible ethnic minority group included in this review. This is an interesting finding as it was also reported by researchers and recognized from the review that the methodology for this cultural group seems somewhat more favorable than what is offered for other cultural groups. For example, after a thorough examination of the research studies illustrated above, it was found that treatments and assessment tools were reported to be translated and adapted for the Hispanic culture more often than for other cultures (Kataoka et al., 2003; Miranda et al., 2003a, b; Organista et al., 1994; Rossello & Bernal, 1999; Silverman et al., 1999a, b). This finding illustrates the significant impact that language and special attention to cultural differences has on the therapeutic process and might also be a consequence of the fact that the Hispanic culture may be more acculturated to the United States and the high number of Hispanics in the U.S. accounts for the volume and methodology utilized in these efficacy studies.

The findings that the Hispanic population fared better than other cultural groups also coincides with other literature, which describes Latinos as being more amenable to advice and counsel rather than insight-oriented therapy (Lozano-Vranich & Petit, 2003; Ponce & Atkinson, 1989). Thus, CBT, which provides specific and direct therapeutic instructions, may be better suited than insight-oriented psychotherapy for the Hispanic population as a whole. Further efficacy research is required to substantiate this possibility.
Summary of CBT and African-American Participants

Seemann, Buboltz, Jenkins, Soper, and Woller (2004) conducted survey research to determine psychological reactance rates in 2347 undergraduate students attending three universities in the United States. Participants included 1749 Caucasians and 598 African-Americans. Seemann et al. defined psychological reactance as “the tendency of a person to act in a way to protect personal freedoms from actual or perceived threats” (p. 167). The rationale underlying the research was the hypothesis that psychological reactance can play a factor in the process and outcome of therapy, and therefore may be an important variable in counselling visible ethnic minority clients (Seemann et al.). The findings illustrated by the survey demonstrated that African-Americans were more likely to produce higher reactance scores than Caucasians and that males produced higher reactance scores than females. These findings are significant to this literature review and are outlined in more detail below.

Four out of the 19 quantitative outcome studies illustrated above included, and paid particular attention to, the impact of CBT in the treatment of depression (one study focused on depression and anxiety) with African-American participants. Three of the studies found that African-American participants obtained poor outcome gains or could actually be harmed from the CBT treatment (Miranda et al., 2003b; Markowitz et al., 2000; Schneiderman et al., 2004). Although, it must also be noted that in a moderately-controlled study conducted by Carter et al. (2003) to determine the efficacy of CBT in the treatment of anxiety and depression with African-American women outcome findings were slightly higher with “54% of the treated group classified as recovered, 17% as improved but not recovered, and 27% as unimproved” (Carter et al., p. 516).
These findings cannot be taken lightheartedly, as it not only supports Seemann’s et al. (2004) findings regarding psychological reactance, but also suggests that African-American clients, particularly male clients, may actually be disadvantaged or even harmed by the CBT treatment. Further, in a study conducted by Folensbee, Draguns, and Danish (1986) to determine counselling preference with African-American participants, it was found that affective responses were preferred by this group over a closed question format of research. This research is significant to this review because of the high level of internal control and therefore lack of subjective assessment methods applied throughout these research studies. Therefore, an integrated analysis of all of these studies that include African-American participants illustrates that qualitative research that encourages subjective responses may better suit this population. There is an urgent need for further research to determine the efficacy of CBT with the African American population.

Summary of CBT and Asian Participants

Three out of the 19 quantitative outcome studies illustrated above included Chinese participants and one study’s focus was applied with Cambodian participants. For the purposes of general comparison, I have grouped these two ethnic groups into one category, termed Asian participants. All four of these studies found that the participants treated with CBT obtained significant benefits. These beneficial findings, however, must be taken with caution because of three of the studies were found to have only moderate levels of internal validity and all of the studies had low levels of external validity making the generalizability of the findings difficult. However, the significance of the positive benefits found with this population illustrates the need for further research to substantiate the efficacy of CBT with Asian and Cambodian participants.
The Efficacy of CBT for use with Visible Ethnic Minority Clients

Many of the outcome studies illustrated above, such as the studies conducted by Gil et al. (2004), Goenjian et al. (1997), Dai et al. (1999), and Kubany et al. (2004), found that minority populations may benefit from CBT treatment when it is paired with other interventions that include intensive outreach and encouragement to support the CBT intervention. The combined treatment approach used in these studies are significant as they illustrate that a new level of awareness or concern, stemming from more of a Feminist approach that addresses and validates cultural oppression and/or racial issues, in combination with the therapeutic approach of CBT may elicit more beneficial results for many visible ethnic minority groups. In fact, this research highlights Greenberg’s (2002) hypothesis that the inclusion of affect and emotion may increase the benefits of the cognitive-behavioural treatment for all cultural groups.

This combined or eclectic approach emphasizes the fact that it is possible to alter the therapeutic approach and techniques used in CBT to meet the unique, cultural needs of client. Therefore, a more eclectic approach with the empowering qualities of Feminist therapy to educate participants on the effects of oppression and discrimination may be more beneficial with many of the visible ethnic minority groups included in the studies above. Qualitative efficacy research with visible ethnic minority populations to determine the efficacy of CBT in combination with other treatment methods may provide valuable information about what helps or does not help clients from diverse backgrounds. Qualitative efficacy research also is needed to better understand the complexity of variables involved in successful treatments with different clients and issues.

Limitations of Literature Review
A limitation of this literature review is that reports about the participants’ level of acculturation were not included in many of the research studies and thus not included in the literature review. Grieger and Ponterotto (1995) illustrated that results of past research demonstrates the relationship between the level of acculturation and measures of mental health. In fact, a participant’s level of acculturation can affect his/her “psychological mindedness” (Grieger & Ponterotto) as well as his/her attitude toward Western-type mental health services. Therefore, the participants’ level of acculturation could have significantly affected the findings of each of the studies and could therefore, have influenced the results of this literature review. Participants also were not assessed regarding their level of acculturation before assigning them to ethnic minority groups in the research studies.

In addition, it is difficult to understand how other variables such as gender, age, and religion influence the efficacy of CBT with these clients. There may be other cultural factors that are relevant to therapeutic outcomes for visible ethnic minority groups.

Further, it must be noted that the analysis of the research included in this review was difficult because many of the studies did not define or apply terminology in similar ways. This was especially found to be true when working with efficacy research. There seems to be an assumption in the field of psychotherapy that efficacy research consists solely of quantitative research and excludes qualitative research. As can be seen from this literature review, this assumption could be detrimental for clients from visible ethnic minority populations. As well, many of the studies included brief descriptions of the CBT interventions that were used in the studies or applied combined treatments making it difficult to compare the interventions across studies. Further, there was no mention within any of the studies regarding whether the interventions applied were the participants’ initial treatments or
whether the participants had participated in psychotherapy in the past. Future research could learn from the limitations of these studies.

**Recommendations for Future Research**

The focus of much of today’s visible ethnic minority research occurs with the Hispanic population because of this ethnic minority groups’ increased immigration into the United States. However, what is needed in Canada is more research to determine the efficacy of CBT with other visible ethnic minority populations not included in this literature review, such as the East Indian population, the First Nations populations, the Japanese population, and more of the Arab populations. Therefore, this literature review was lacking in providing a broad exploration of the visible ethnic minority groups that inhabit Canada because of the lack of research.

**Conclusions**

Treatments that are empirically supported and considered to be efficacious for one population may not be efficacious for another population. The critical elements of cultural oppression, individual worldviews (Ho, 1995), treatment preference (Kim et al., 2005) and level of acculturation (Grieger & Ponterotto, 1995) must be taken into consideration when counselling members of visible ethnic minority groups to ensure that the chosen approach and techniques elicit more benefit than harm.

There has been an increased effort to emphasize the importance of training competent multicultural counsellors over the last decade (Arthur & Stewart, 2001; Sue, Arredondo, & McDavis, 1992; Sue, Ivey, & Pedersen, 1996; Toporek & Reza, 2001). However, these efforts have turned the focus away from perceiving people as an integrated part of one’s culture to perceiving each client as unique in his or her own way, regardless of ethnic
orientation. This perspective refers to the etic approach outlined above, which Daya (2001) described as a universalistic position that “emphasizes the internalized culture by asserting that each person, not just those individuals belonging to ethnic minority groups, holds a unique culture” (51). From this perspective, all counselling is multicultural; and it is alleged that each individual has unique and distinct counselling needs (Daya).

However, in light of the culturally-specific findings elicited from this review, a shift to the inclusion of the emic or culture-specific approach described above may be necessary to meet the needs of the many people from visible ethnic minority populations. The concern with the culture-specific, emic perspective that may have caused such an enormous shift away from it, is the fear that counsellors working from this position may fall into the trap of “unintentional racism” (Pedersen, 1995) by stereotyping clients according to their cultural ethnicity and disregarding the client’s unique, individual experiences. Another limitation of the emic or culture-specific perspective is that the counsellors and therapists working from this perspective would have to possess a high level of knowledge about the cultural characteristics of each minority group, which would place specific limitations on the professionals’ scope of cultural expertise (Vera et al., 2002).

Therefore, the questions that must be asked, in light of the findings from this literature is, “How can counselling professionals find a balance or extension between or beyond these two opposing views that will meet the needs of our ever-changing population?” There have been on-going debates between practitioners and researchers who support either the emic or the etic position within the multicultural counselling field for years (Dana, 1998; Daya, 2001; Pedersen, 1991). Though, we must ask ourselves, “Do counselling professionals have to encompass an and/or attitude with regards to multicultural counselling and the etic
and emic perspectives?” The etic perspective may provide a more straightforward approach for therapists and counsellors in the field of psychotherapy, but with the findings that visible ethnic minority clients may not utilize psychotherapy services as much as their counterparts because of a deficit in meeting their mental health needs (Garland et al., 2005; Sue, 1988) and with the finding of this literature review that illustrates that CBT has not been proven to be effective with visible ethnic minority clients, more emphasis needs to be placed on making services culturally sensitive with the amalgamation of the etic and emic perspectives; thereby applying counselling approaches and interventions that are flexible and adapted to the unique individual, yet also placing a greater emphasis on cultural similarities and differences.

This review highlights the need for increased efficacy research regarding the value of CBT for the treatment of visible ethnic minority persons that uses both well designed quantitative and qualitative methodologies.
References


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Folensbee, R. W. Jr., Draguns, J. G., & Danish, S. J. (1986). Impact of two types of


Consulting and Clinical Psychology, 61, 205-214.


Appendix: Task Force Criteria for Empirically-Validated Treatments

Criteria for Well-Established Treatments

I  At least two good between group design experiments demonstrating efficacy in one or more of the following ways:

A. Superior to pill or psychological placebo or to another treatment.
B. Equivalent to an already established treatment in experiments with adequate statistical power

II  A large series of single case design experiments (n > 9) demonstrating efficacy. These experiments must have:

A. Used good experimental designs and
B. Compared the intervention to another treatment as in I.A.

FURTHER CRITERIA FOR BOTH I AND II:

III Experiments must be conducted with treatment manuals.
IV Characteristics of the client samples must be clearly specified.
V Effects must have been demonstrated by at least two different investigators or investigatory

Criteria for Probably Efficacious Treatments

I  Two experiments showing the treatment is more effective than a wait-list control group.

II  One or more experiments meeting the Well-Established Criteria I, III, and IV, but not V.

III A small series of single case design experiments (n > 3) otherwise meeting Well-Established Treatment Criteria II, III, and IV.
