

ADDRESSING INTERNALIZED OPRESSION IN  
COGNITIVE-BEHAVIOURAL THERAPY:  
TOWARDS A LIBERATING AND INCLUSIVE CLINICAL PRACTICE.

by

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## Abstract

This document consists of five chapters that attempt to integrate liberating and anti-oppressive concepts and Cognitive-Behavioural principles in psychotherapy. Its purpose is to develop guidelines for cognitive-behavioural practitioners to *critically think* and *deliver* Cognitive-Behavioural Therapy (CBT) by addressing oppression, its internalization, and adapting their clinical practice to increase its inclusiveness and facilitate liberating processes with their clients. Theoretical conceptualizations of oppression in cognitive behavioural terminology and language are reviewed. Cognitive-behavioural *assumptions* and *underpinnings* are described, followed by the definition of the construct of oppression, and the process of its internalization. Research and different models of clinical practice found in literature are described. The common guidelines in these models are identified and examined to determine concrete strategies for practitioners to deliver a liberating, anti-oppressive cognitive behavioural therapy; and address internalized oppression when it is maintaining pervasive symptoms in clients' lives. *Key word(s): oppression, CBT, internalization, internalized oppression, cognitive therapy, social learning theory, cognitive restructuring, emotional reprocessing.*

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## Chapter 1

### **Cognitive Behavioural Theory & Oppression**

#### **Introduction**

This chapter describes cognitive-behavioural procedures and foundations, and identifies the socio-cultural context in which this approach of psychological practice developed. Further, some cultural limitations of these foundations are reviewed, as well as the adaptive and transformative properties of CBT. The construct of oppression is also described, providing a cognitive-behavioural framework and rationale that will guide the rest following chapters.

#### **Cognitive-Behavioural Therapy**

Cognitive-Behavioural therapists work with clients in order to help them change detrimental cognitions (distortions, automatic negative thoughts, dysfunctional beliefs, and others) as well as maladaptive behaviours, which, according to the cognitive behavioural model, are the maintaining factors of distress and suffering (Beck, 1979; Young, 2003; Beck, 2011; Persons, 2008). The hypothesis that guides cognitive therapy is that if we help our clients to change their cognitive distortions, automatic negative thoughts, dysfunctional beliefs, and maladaptive behaviours, they will no longer present the problematic symptomatology or difficulties (Beck, 2015). Where do these ideas come from?

#### **The importance of the socio-cultural context in cognitive-behaviourism.**

According to Aaron Beck, one of the most recognized authors in cognitive-behavioural therapy, cognitions influence mood, behaviour, and physiological responses of individuals (Beck, 1995). The reason why cognitive material is essential for CBT is that, according to this model, it

mediates the way we perceive and assimilate the world, a concept that known as cognitive mediation. As part of a cognitive-behavioural conceptualization (which will provide the framework for understanding a client's situation), Beck (2011) points out that cognitive factors are constructed upon the individual's environmental context (culture, community, religion, etc.). Hence, cognitive behavioural theory acknowledges the influence of the socio-cultural context in the development of cognitive phenomena.

In order to initiate a process of case formulation based on cognitive behavioural theory, clinicians assess the dysfunctional thoughts and beliefs associated with clients' presenting problems; and the reactions (emotional, physiological, and behavioural) associated with this thinking. After doing so, they will "hypothesize how the patient developed this particular psychological disorder" (Beck, 2011, p. 29), in a process of analysis that will allows them to identify and describe the causal relations, maintenance factors, and contingencies that perpetuate distress in their clients. Through the content of cognitive material, clinicians can identify how clients view themselves, others, the world and the future; and their underlying beliefs (attitudes, expectations and rules) and thoughts. Further, clinicians hypothesize how the identified 'dysfunctional' cognitions contribute in the maintenance of the presenting difficulties. Further, they will propose interventions that, according to the cognitive-behavioural model, would help their clients to question the dysfunctional thoughts and beliefs, and "seek in a variety of ways to produce cognitive change—modification in the patient's thinking and belief system—to bring about enduring emotional and behavioural change" (Beck, 2011, p. 2).

### **Context, foundations, values of CBT and its limitations.**

According to Hays (1995), one of the limitations of CBT is that, even if it is presented as a value-neutral approach to psychotherapy, "the fact is that there are no value-neutral

psychotherapies; any intervention represents at the least a valuing of change” (p. 311). Such values are based on the socio-cultural momentum of the theoretical model. In the case of cognitive-behavioural movement, the fact is that its originators have been primarily individuals of socially dominant groups (i.e., university-educated, Euro-American men) (Hays, 1995). Even if this does not mean that CBT is not applicable in contexts other than the West, Hays suggests that it is important to acknowledge that, in psychology, cognitive behaviourism, and the world, the dominant social group's values are often assumed to be universal, either because the values of marginalized groups are not as well-known, or they are actively suppressed through systematic oppression from the dominant culture.

For these reasons, it may be important to acknowledge the origin of prevailing theories of psychotherapy, and the worldviews those are based on, to examine whether non-dominant (or so called minority) populations' worldviews are being “mislabelled as dysfunctional or pathological (American Psychological Association [APA], 2003; Sue, Arredondo & McDavis, 1992)” (p. 27, in Arthur & Collins, 2010). Arthur and Collins precisely suggest that the dominant theories need to be deconstructed to unveil their embedded values, assumptions about clients, role of therapists, and their implications in their clinical practice. For example, acknowledging that such values are not representative of the experiences of all clients; and tend to emphasize individualism and the development of a separate sense of self (Arthur & Collins, 2010), may help clinicians identify what is ‘getting in the way’ of having an inclusive and integral cognitive-behavioural practice. These authors’ recommendation to clinicians is to think critically about the values and assumptions that drive their practice.

### **Critically Reviewing CBT foundations**

Critically thinking about the assumptions and worldviews of their practice is one way in which cognitive-behavioural therapists can evaluate their degree of cultural awareness (Arthur & Collins, 2010). Loewenthal and House (2010) explored the ontological assumptions and worldviews behind CBT theory and praxis. In one of their chapters, Paul (2010) identified that even if empirical data shows that CBT and Evidence-Based Treatments have high levels of effectiveness (average of approximately 70%), an average of 30% of patients do not respond to them, suggesting that there are some issues in such treatments that need to be addressed, supporting the idea of non-universality (Hays, 1995). As Arthur and Collins (2010) indicate, many patients who belong to non-dominant cultural groups do not respond to traditional psychological practices, as such practices don't seem to reflect their experiences nor consider their worldviews or values.

### **Transformation of CBT**

The flexibility and maturation of CBT has allowed clinicians to incorporate other theoretical perspectives into CBT, in order to respond to gaps found in the practice, such as Motivational Interviewing (Millner and Rollnick, 1991), Acceptance and Commitment Therapy (Hayes et al., 1999), Dialectical-Behavioural Therapy (Linehan et al., 2001), or mindfulness-based CBT adapted models. This shows the transformation that cognitive behavioural researches and practitioners have incorporated to best address the needs of diverse clients. Then, it is possible to see that CBT is going through a process of transformation from radical behaviourism to integrative worldviews, incorporating Eastern-based values and practices like mindfulness and acceptance. One example of this is the shift from the over-value attributed to change, which is the tendency of orthodox cognitive-behaviourism (Hays, 1995), to its relativeness and consideration of acceptance. This means that, progressively, more CBT theorists

and practitioners are incorporating knowledge that brings new perspectives to the approach, adapting it and changing it, and integrating new concepts, which would be considered almost antithetical to the medical model and more orthodox perspectives.

The influence of the incorporation of philosophies that had been historically discarded by the Western sciences (e.g. mysticism, spirituality) in the transformation of traditional CBT, allows clinicians and theorists to unveil new mechanisms of change and enhance the efficacy of their practice, without giving up the principles of the approach. Young, Klosko and Weis (2003) suggest that core CBT strategies such as empirical analysis, logical discourse, experimentation, gradual steps, and repetition “are often insufficient to alter the distorted thoughts and self-defeating behaviours of individuals with certain characterological challenges” (Paul, 2010, p. 132). These strategies rely on empiricism, logic, individualism, and scientific method, which do not respond integrally to the complexity and diversity of the human experience, as they tend to ignore or lessen the importance to spirituality, collectivism, mysticism, and so on. As can be seen, part of the transformation of CBT is the integration and incorporation of philosophies from different socio cultural backgrounds with diverse values and underpinnings. Additionally, it is possible to say that a model of practice that relies exclusively on Western worldviews and discards others would be less effective, ethical, and integral; and that determining that some clients have ‘characterological challenges’ when they belong to non-dominant cultures in the Western society would be unethical and oppressive.

### **CBT plasticity.**

Hays (1995) points out four main strengths of CBT that facilitate its adaptation towards cultural awareness, which are: 1) CBT must be adapted to meet the needs of the individuals; 2) it focuses on client empowerment, 3) it is specific (identification of behaviours, conscious

processes); and 4) it is subject to verification by the parts involved as an on-going assessment process. According to the author, such strengths facilitate cultural awareness and remind CBT practitioners of the importance of the socio cultural context in their practice. Acknowledging the importance of the context then would include some form of socio cultural context assessment (as the source of the underlying values, worldviews and beliefs); and the design of strategies in such a context to empower clients who seek for clinical services.

Hence, critically thinking about the theoretical underpinnings of our approach is a way to help us explore our clinical practice and identify the assumptions and worldviews we pursue when following a theoretical model; as it will allow us to identify possible ways to address cultural issues, and sensibly adapt to the diversity of clients and the human complexity. Engaging in such a process may actually be essential as, ultimately, the theoretical approach used will dictate case formulations, assessment and intervention strategies. Critical thinking about the theoretical approach can also help us realize which belief system is guiding our practice, and how we can engage in a liberating or an oppressive process, in terms of oppression and systemic issues (Arthur & Collins, 2010). Additionally, it is a chance to question our own methodologies, beliefs, thinking patterns, and assumptions, just as we help our clients do with their presenting problems. We can gain awareness on our assumptions and beliefs, identify if we are following them as absolute truths, assuming their universality; and if we are critically reviewing how functional or relative they might be depending on the context. We can become aware of the power dynamics embedded in the clinical practice as well: if we are playing the 'expert role' and replicating detrimental patterns that perpetuate victimization or suffering of our clients; or if we are being accepting, inclusive, and compassionate. In this document I address these matters in terms of oppression, and propose some guidelines for clinicians to be able to transform their

Cognitive-Behavioural clinical work into a more liberating, inclusive, and anti-oppressive practice.

### **Oppression & CBT conceptualizations**

Many sociological theories can be incorporated to understand and eventually transform a practice in terms of oppression and liberation, starting from feminism to colonialism or social justice. However, few authors have attempted to frame these issues in cognitive-behavioural terms (David, 2014), which may be related to the lack of awareness on oppression and systemic issues in cognitive-behavioural theory and practices. On the other hand, there has been some attention for the validation and adaptation of cognitive-behavioural treatments in individuals whose belief system differs from the Western belief systems (see Arthur & Collins, 2010; Lowenthal & House, 2010; Young et al. 2003; Hays, 1995). Critically thinking about CBT and exploring its foundations may be a way in which clinicians can, not only identify where their practice and theories come from, but to whom are they designed for. Additionally, bringing awareness on systemic issues that limit and constrict the lives of our clients and, perhaps, ourselves, may help us to increase our competence and enhance the effectiveness of our cognitive behavioural practice following the multicultural guidelines of the APA (2006) for the ethical practice of psychotherapy.

Some of these issues have been addressed and can be found in cultural diversity clinical research, and data show the benefits (and ethical duty) of culturally-competent clinical practice (Arthur & Collins, 2010). Okazaki and Tanaka-Matsumi (2006) assert in their chapter on cultural considerations for cognitive-behavioural assessment that there is a large body of research that demonstrates advances of evidence-based psychological assessment and interventions for ethnic minority populations (Miranda et al., 2005), for example. However, they also found that cultural

influences in the assessment of psychopathology still pose a challenge for cognitive-behavioural therapists given the legitimate critique that cognitive-behavioural assessment measures (as well as treatments) have not been adequately validated to address socio-cultural issues.

These findings are consistent with the experience of culturally diverse clients who seek for psychotherapy as some of them find that their experiences—lived realities—are not reflected and captured by Western psychological work (theory, research, and services) (David & Derthick, 2014). The experience of being unheard and marginalized then becomes a gap between peoples who experience oppression and their access and adherence to mental health services under the “dominant White, Western, patriarchal, and heterosexual worldview that permeates our world” (David & Derthick, 2014, p. xx). This supports the idea that the process of adaptation of CBT into a more culturally sensitive practice is a need rather than an option if we also follow the APA guidelines on multicultural education, training, research, practice, and organizational change for psychologists (APA, 2002), and the effectiveness guidelines policy statement on evidence-based practice in psychology on the relevance of patients' characteristics, values, and context (APA, 2006). It also gives us an idea of the perspective and experiences that culturally diverse clients may have, the effect that living in a Western culture where the distribution of power, access to services, and privilege is given to certain group memberships; and where their identities and inter-sectionalities may play a crucial role.

### **Historic Context & Oppression**

David and Derthick (2014) highlight the importance of evaluation and assessment of the impact of historical and cultural context on individuals and groups. According to these authors, such assessment would provide clinicians with higher insight on the historic context and its

effects, like historic trauma resulting from genocide, slavery, colonization, racism, sexism and other violent acts to which minority groups have been historically subjected to has on both members of the marginalized and non-marginalized groups, for example. The authors point out that individuals are not only affected by the systemic oppressive dynamics of the past, but by the systemic oppressive dynamics of current historic momentum as well, because once violence is generated, individuals tend to perpetuate the oppressive intra and interpersonal relational patterns they have learned from the historic and current system (David & Derthick, 2014).

In terms of exposure to violence, for example, David and Derthick (2014) point out that, as oppressive violence is “internalized so quickly” (p. xv), some victims and witnesses of trauma and violence develop similar responses and can even become perpetrators as well as an act of survival. This means that violence can generate more violence, unleashing an ongoing behavioural cycle that can be maintained through generations (David & Derthick, 2014). These dynamics can set a path of perpetuation of violence, as they will tend to be replicated (either from the victim or aggressor places), subtly or out of awareness. The authors also specify that, even if they are in privileged positions in society, members of dominant groups may not be immune to the detrimental effects of oppression, as even those who benefit from oppression are also exposed to the violence (Williams, 2012), as oppression is a violent dynamic. The effects of this exposure include high levels of psychological distress when faced by dissonance of learned maladaptive beliefs (i.e. beliefs on group membership superiority/inferiority), and other dysfunctional self-schemas with the potential of mental health repercussions (high anxiety, stress, rumination, worry, etc.).

For these reasons, understanding the historical context of the background, the practice, and the clients is essential for CBT therapists, because it increases the awareness of the ways in which the historic and current socio-cultural context may not only be a source (Beck, 2011), but a set of environmental contingencies that maintain or perpetuate our clients' detrimental cognitions and maladaptive behaviours (negative automatic thoughts, beliefs, schemata, etc.). According to David and Derthick (2014), incorporating a comprehensive description of the historical and current contexts of clients offers an overture for the possibility of change by creating new meanings and narratives. This possibility is an opportunity for liberation, and can help clients gain higher awareness of the impact of the historical context on their lives, and "change their ending, by starting their story at the time before being pathologized by Western medical model ideas of how dysfunctional they are" (David & Derthick, 2014, p. xv).

In cognitive-behavioural terms, the liberating experiences that David and Derthick (2014) describe can be framed as cognitive restructuring or emotional reprocessing experiences (Beck, 1995; Foa & Kozak, 1986), which are, ultimately, the main strategies and focus of CBT procedures. In addition, clinicians can increase awareness on the historic moment of psychotherapy, cognitive-behaviourism, and the influence of the socio-cultural dynamics on their practice and themselves as well, which would provide them with much more cultural sensitivity. Hence, this would help clinicians elaborating more comprehensive assessments and interventions, and counteract the tendency to pathologize or perpetuate oppressive dynamics with clients, recognizing the systemic and environmental contingencies and systems present.

### **Context and identification of the source of psychological problems**

Locating psychological problems within individuals and ignoring their socio-cultural context (as reviewed before, the main source of cognitive phenomena), makes us prone to pathologizing and invalidating our clients' experiences through blame. This issue is addressed by David and Derthick (2014), who assert that, in the field of psychology and most other scientific disciplines, "there has been a long-standing bias to look for factors within individuals to explain psychological phenomena (e.g., biological or physiological factors; Keller, 2005)" (p. 2), following a Western, medicalization model of understanding human psychological experiences that do not adhere to the norm expectations. For this reason, it is of critical importance to consider the factors outside individuals (communities, organizations, institutions) that strongly influence the psychological phenomena as well, and open the possibility for exploring them (which may be historical, contemporary, socio-political) (David & Derthick, 2014) as valid factors that contribute in the maintenance of suffering and pervasive internal experiences in individuals. This can be done by cognitive-behavioural therapeutic procedures in the frame of cognitive restructuring in a form of re-attribution, where problems can be reframed from *intrapsychic* to *societal/political* (Arthur & Collins, 2010).

David and Derthick (2014) also assert that pathologizing and locating the problems within individuals is problematic and limiting because it does not acknowledge or address the systemic issues that maintain psychological difficulties; neither does it provide opportunity for questioning the assumptions clinicians and their practices have that are not 'obvious to the eye', such as micro-aggressions (Sue, Capodilupo, Torino, Bucceri, Aisha, Holder, Nadal & Esquilin, 2007) or other implicit communications or behaviours that convey oppression and violence and usually happen out of awareness. Enhancing the effectiveness and competence of the cognitive

behavioural clinical practice then needs to acknowledge the systemic issues that permeate our lives (making them visible, externalize, verbalize them) and facilitate dialog that allows their critical thinking and questioning. To do so, we can identify and describe concrete philosophies and belief systems which may directly permeate the praxis and experience of psychotherapy; and analyse the influence of power dynamics and identities present in the participants of the clinical practice and their therapeutic relationship.

David and Derthick (2014) also consider that locating the problem within individuals and lessening the importance of contextual contingencies leads to a simplified solution to a complex problem, particularly when the aim becomes eliminating a behaviour instead of understanding the client as a whole person in relationship with others and the environment. Hence, locating the problems in the context and systemic issues, provides us with an opportunity to understand the contextual issues, refrain from seeing our clients in a simplistic fashion, and reframe the scope of the practice. Supporting clients, helping them feel empowered (Thomas & Velthouse, 1990), and strengthening their sense of self-efficacy (Bandura, 1977) may begin by a case conceptualization that is sensitive to the historical momentum, cultural context, oppressive dynamics (racism, ageism, machismo, sexism, etc.), and design interventions that can help them break down their pervasive effects on our clients.

### **Conclusions**

Cognitive Behaviourism was developed in a socio-cultural background and historic momentum that has deeply influenced its values, assumptions and worldviews. Through its transformation process, CBT has shown increased effectiveness, transcending some limitations of its original historic momentum, which is evident in the incorporation of conceptualizations from

other socio-cultural contexts and worldviews. However, some authors have identified gaps in the degree of cultural sensitivity of CBT practice, which affect its effectiveness, ethical consistency, and translate into potential replication of oppressive dynamics. These gaps include the assumption of universality and lack of critically reviewing its embedded values and socio-cultural influences. Fortunately, its plasticity has shown that it can be progressively transformed into a more culturally aware, liberating practice, which would align with the social responsibility to deliver a more ethical and effective psychotherapy.

## Chapter 2

### **Internalized Oppression & Cognitive-Behavioural Therapy:**

#### **How does oppression affect people and what can CBT practitioners do about it?**

### **Introduction**

Cognitive Behavioural Therapy (CBT) has become one of the most influential forms of psychotherapy in several countries throughout the world. However, there is limited empirical data that shows its appropriateness, efficacy or effectiveness with members of non-dominant groups (Iwamasa, Pai, Sorocco, 2006). According to David (2009), the main components of this popular empirically supported treatment may effectively be applied to conceptualize and address the cognitive phenomena resulting from experiencing oppression, which can be encompassed in the concept of internalized oppression. Following this idea, cognitive-behavioural components, like cognition, mood, physiological reactions, behaviours, and environment can be used to understand internalized oppression and its related operation processes.

### **Description of Internalized Oppression**

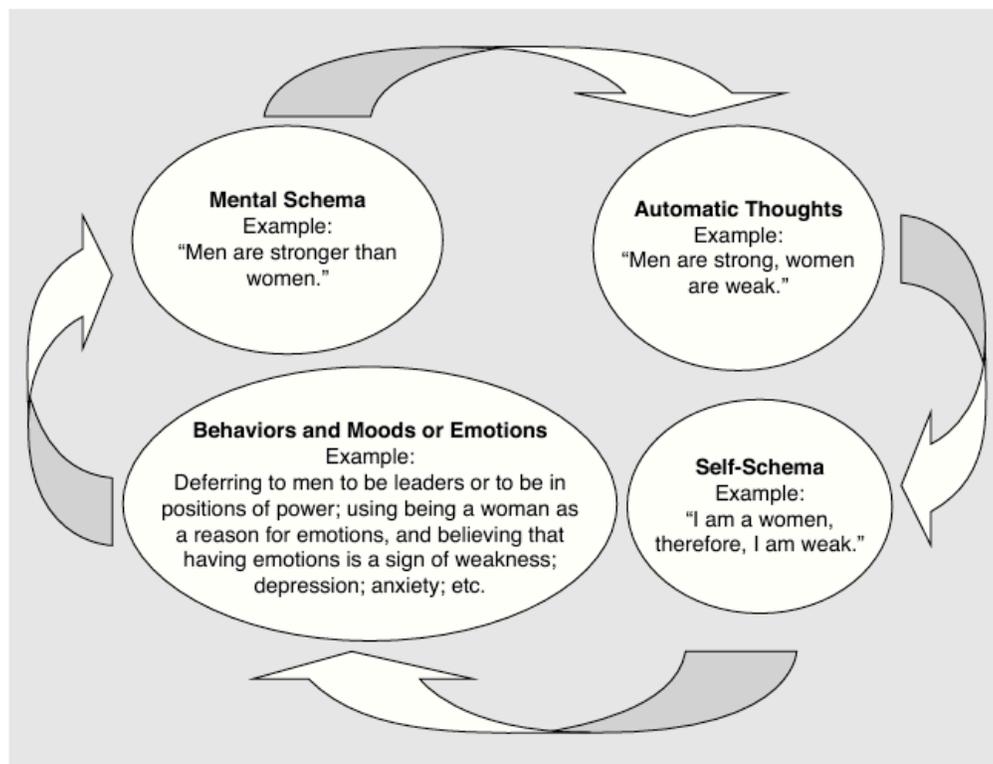
Various authors (Taylor, 2014; David & Derthick, 2014; Bailey, 2008; David & Okazaki, 2006; Duran & Duran, 1995) assert that the process of internalization of oppression occurs when members of a non-dominant group accept, consciously or unconsciously, the domination and alleged superiority of a dominant group and the subjugation and alleged inferiority of their own group membership. This process is based on distorted beliefs that affect the way individuals think, feel, and behave in society (cognitive, emotional, behavioural phenomena). Additionally,

some authors agree that both members of dominant and non-dominant groups are impacted and shaped by the experience of oppression, as its effects also negatively affect privileged individuals by the mere experience of such a violent dynamic (Williams, 2012). According to Taylor (2014), internalized oppression can be considered a form of hate or self-hate, and there is emerging empirical literature that suggests that it is negatively related to various mental health markers, especially self-esteem; and positively to distress and depression.

**Description of the process of internalization of oppression and the context in which it occurs.**

According to Williams (2012), internalized oppression (IO) is an effect or by-product of living within an oppressive context and/or a condition necessary for the maintenance and perpetuation of oppression. David (2009) describes the internal phenomenon of IO as a set of self-defeating cognitions, attitudes, and behaviours “that have been developed over time as one consistently experiences an unjust and oppressive environment” (p. 85). The consequences of IO include distorted views of one’s self and of others (as consequence of how one experiences his/her environment); and automatic negative thoughts and negative core schemas (i.e. automatic negative cognitions and perceptions of one’s heritage group) as a result of historic oppression that different groups have been enmeshed in, “both in subtle and overt ways, consistently receiving the message that they are inferior to the dominant group” (p. 85). Internalized oppression remains a largely under-theorized concept (Williams, 2012). Hence, the need for describing and defining it is imperative. David (2013) proposed a model of IO using cognitive-behavioural terminology and processes, which is displayed in Figure 1.

Figure 1. David's (2013) Model of conceptualization of internalized oppression using cognitive behavioural concepts.



On David's (2013) model, IO manifests as a set of detrimental cognitions (schemas, automatic thoughts) and maladaptive behaviours that are related to emotions that support the oppressive beliefs, which, in turn, maintain the internal oppressive cycle. In this way, it is possible to visualize how IO can be directly related to maintenance factors of psychological problems in adjustment and mental health symptomatology, playing a critical role in the development of the detrimental cognitions, which are, according to cognitive-behavioural principles, constructed upon the individual's environmental context (culture, community, religion, etc.) (Beck, 2011) and generate the maladaptive behaviours.

### **IO according to group membership and power dynamics.**

David and Derthick (2014) define oppression in terms of *group membership*. According to this conceptualization, individuals' differentiation of power and access to resources is given according to their group membership: dominant/dominated; powerful/powerless; superior/inferior, where oppressors (the ones in dominant power), "use their access to power and privilege to impose their worldviews on the oppressed, and justify and enforce the social, political, systematic denial of resources of the oppressed" (p. 3), in an imposition-depravation dynamic. This dynamic can be observed in behavioural, cognitive, and emotional processes. As an example, the authors refer to dynamics that can occur in a heteronormative culture (such as Western culture), where heterosexuals hold power and privilege over non-heterosexuals (heterosexism) (David and Derthick, 2014).

The authors point out that privileged individuals, who are more likely to be in positions of power, can impose a certain belief (cognitive) about 'acceptable expressions of love and partnership' (affective/emotional), playing a significant role in perpetuating the macro-level heterosexism (societal) in the micro-level (individual). A known and fairly common example of such a dynamic is the 'preference' of homosexuals who "pass for" heterosexuals (Perez, 2005) in our society. Heterosexism is also perpetuated when heterosexual individuals refuse "to support anti-discrimination policies and laws which would make it more likely for non-heterosexuals to make themselves visible and attempt to secure positions of power... denying access to resources based on non-heterosexual as abnormal, deviant, pathological, abominable" (p. 4), and other inferiorizing labels. There have been various attempts to conceptualize IO, in which the construct has shown consistency and reliability.

## **Construct validity of IO and its assessment**

### **Available Scales.**

There are various scales for assessing internalized oppression. These scales assess different oppression sub-categories, like racism and heterosexism, or different dimensions such as to which degree someone has been affected by its experience; while others examine the degree of awareness an individual may have of oppression. Some examples are the Internalized Racial Oppression Scale (IROS; Bailey et al., 2006), the Awareness of Privilege and Oppression Scale (APOS; Montross, 2003), the Resistance/Internalization Oppression Scale (RIOS; Jones-Howard, 1999), the Diversity and Oppression Scale (DOS), the Appropriated Racial Oppression Scale (AROS; Campón, 2015), or the Nadanolitization Scale (NAD; Taylor, Dobbins, & Wilson, 1972; Taylor & Grundy, 1996). Of these scales, there is information on statistical validity and significance, as well as construct validity for the internalized oppression construct.

### **Research with the identified scales.**

Bailey (2008) conducted a study to examine the construct validity on the Internalized Racial Oppression Scale (IROS; Bailey et al., 2006) through the use of confirmatory factor analysis and social desirability. The results supported the factorial structure of the IROS (internalization of negative stereotypes, self-destructive behaviours, devaluation of own worldview, belief in biased historical facts, alteration of physical appearance) after latent variable path analysis and confirmatory factor analysis. The scale was found to be a predictor of

psychological distress, psychological well-being, collective self-esteem, and satisfaction with life (Bailey, 2008).

Campón (2015) conducted a study to validate the Appropriated Racial Oppression Scale (AROS) that examined internalized racial oppression in a sample of 656 people of colour. Through exploratory factor analysis for this construct, a 32-item, four-factor structure was revealed, and with confirmatory analysis, a four-factor, 24-item model for appropriated racial oppression resulted. According to Campón, path analysis results indicated both predictive and criterion-related validity for the Appropriated Racial Oppression Scale (AROS). The results suggest that the construct ‘appropriated racial oppression’ and its specific dimensions were directly related to the anxiety and depression subscale scores from the Mental Health Inventory (MHI-18; Veit & Ware, 1983). In this study, participants with higher levels of appropriated racial oppression also had higher levels of anxiety and depression.

Other scales like the Resistance/Internalization Oppression Scale (RIOS; Jones-Howard, 1999) have demonstrated adequate construct and criterion validity with measures of African-American identity, coping skills, and ego resiliency and acceptable internal reliability estimates. Research and studies on construct validity of IO are of paramount importance because they help to describe the phenomenon, break it down into its different cognitive, behavioural, and emotional characteristics; intra and interpersonal dynamics, and demonstrate its impact on mental health. They also inform clinicians with evidence-based practices in psychology (EBPP), which can translate into the promotion of effective psychological practices among clinicians (empirically supported principles of psychological assessment, case formulation and interventions) as set by the APA (2006); and raise awareness on IO as a public health concern.

## **Environmental contingencies & Perpetuation of psychological distress:**

### **From individuality to collectiveness and vice-versa**

#### **Intrapersonal dynamics.**

According to Williams (2012), members of non-dominant groups in an oppressive system “internalize messages of subordination, through which they learn to think, behave, and understand the world in ways that maintain and perpetuate oppression” (p. 21). This is one way in which members of non-dominant groups may engage in perpetuating oppression in the intra-personal or micro-level with repercussions on the societal or macro-level with or without awareness. Additionally, the author asserts that it is vital to recognize that “oppression has structured and mutually reinforcing ways of reproducing inequality through the daily functioning of society and societal institutions” (p. 21). Those internalized messages then create an internal setting of perpetual oppression, as “thoughts that occur most frequently and are most easily accessible in memory are the ones we tend to believe” (p. 96, David, 2009). As IO operates in form of beliefs, its informative power for the individual can become higher, and directly related to the amount of detrimental automatic and distorted thoughts.

#### **Interpersonal & Collective dynamics.**

Other authors like Tappan (2006) or Arthur and Collins (2010) assert that behaviours resulting from internalized oppression from both members of dominant and non-dominant groups perpetuate oppressive systems and maintain a set of behavioural contingencies and responses to anti-oppressive behaviours in the social environment (family, community, society, etc.). These responses guarantee an understated agreement on the censorship of behaviours that attempt to

challenge the status quo (the current oppressive system), where such behaviours are castigated by the very same individuals (both oppressed and privileged). When individuals respond aversively to behaviours that challenge or change that status quo, a reinforcement-punishment contingency environment (see Social Learning theory, Bandura, 1977) provides them with valuable information which conditions individuals' behaviours to perpetuate the oppressive system and maintain the status quo. This is how the behavioural responses of the individuals in oppressive systems are enmeshed in a *set of societal responses* (aversive or rewarding) that provide them with the contingencies that inform them how to "behave" in a pro-oppressive fashion.

**Behavioural examples of internalized oppression in both dominant and non-dominant groups.**

Various authors have identified and described behavioural examples that evidence the operation of IO in people. One of them is micro-aggressions (Sue et al., 2007), which are hostile, derogatory, or negative slights and insults towards people of a non-dominant group (i.e. non-whites, non-heterosexual, non-male) and which are made in ordinary and daily environmental settings, intentionally or unintentionally without awareness. According to these authors, we are in a societal setting where we are constantly exposed to micro-assaults, explicit racial derogations (either verbal or nonverbal attacks like name-calling, avoidant behaviours, or purposeful discriminatory actions like denying access to a service); micro-insults, which convey rudeness and insensitivity and demean a person's racial heritage or identity (subtle and frequently unknown to the perpetrator, but conveying a hidden insulting message to the recipient); and micro-invalidations, which are communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a persons from non-dominant groups. As an example,

the authors describe micro-aggressions to which Asian-Americans (who were born and raised in the US) face, like being constantly asked by strangers where are they from, where “the effect is to negate their U.S. American heritage and to convey that they are perpetual foreigners” (p. 274).

David and Okazaki (2006) conducted a study with Filipino Americans to see if they could find empirical evidence to support the existence of explicit IO in cognitions of members of a non-dominant group (Filipino-Americans), such as undesirable, unpleasant, and negative thoughts regarding their Filipino culture and, on the other hand, desirable, pleasant, and positive thoughts regarding the American culture. According to the authors, the results confirmed their hypotheses, and suggest that “oppression has been internalized deeply enough by members of this group for a distorted cognitive system to be developed and automatically operate” (p. 86). David (2009) suggests that, consistently with cognitive-behavioural theory, the underlying set of automatic negative thoughts, attitudes, and behaviours are based on maladaptive general beliefs that contribute to the creation of dysfunctional self-schemas, which may lead to psychological distress and psychopathology.

### **The effects of internalized oppression & its sub-categories**

David and Derthick (2014) identify different effects of IO and colonialism on individuals of non-dominant groups, which include self-doubt, identity confusion, feelings of inferiority, and self-fulfilling prophecies/confirmation biases related to behaviours motivated by the internalized detrimental beliefs. They also identify that other effects of IO include violence sublimated or redirected to members of one’s group, self-destructive behaviours and violence towards the self (substance abuse, suicide), self-denigration, and incorporation of negative stereotypes into cultural values and traditions. For example, IO in the form of homophobia and heterosexism has

been identified in both heterosexuals, and some LGBT individuals are explicit in the preference of homosexuals who “pass for” heterosexuals (Perez, 2005), showing a clear example of the internalized oppressive dynamics described before.

Internalized racism is another form of internalized oppression that has been linked to impairment of psychological well-being. For example, emerging research suggests that racism has a detrimental effect on numerous aspects of mental and physical health (Liu, 2013; David, 2014), and specifically, that constructs relevant to minorities (e.g., enculturation, ethnic identity, collective self-esteem) are important contributors to their mental health and levels of depression. According to these authors, research also suggests that these constructs may be influenced by IO (e.g., David & Okazaki, 2006; David, 2010 ; Walker et al., 2008).

Studies also suggest that internalized oppression may be related to depression (David, 2014), and that addressing IO in therapy may offer significant beneficial results to LGBT individuals, as research has demonstrated that rates of depression are elevated among lesbian, gay, bisexual and transsexual (LGBT) people as a result of social stigmatization (Ross, et al., 2007). These authors conducted a study in the Centre for Addiction and Mental Health in Toronto where they tested a CBT-based group intervention for LGBT people living with depression, which was delivered incorporating anti-oppression principles, and included sessions on coming out and internalized homophobia. The results indicate that participants demonstrated statistically significant reductions in symptoms of depression (BDI-II scores and other validated mental health indicators), and statistically significant increases in self-esteem constructs following the intervention. The authors conclude that such an adapted, integrative group CBT intervention, presented from within an anti-oppressive framework in LGBT clients was effective in decreasing depression severity and increasing self-esteem among the participants in this sample.

## **Addressing internalized oppression in psychotherapy**

The reverse process of internalization of oppressive beliefs is externalization, which allows the individual to question such beliefs and critically engage in changing them (Ryan, O'Dwyer & Leahy, 2015). Externalization is a process that involves the separation of the problem from the person, which becomes the initial step in the re-authoring of the persons' narrative. This process is congruent with David's (2014) process of giving clients the chance to 're-write' their story instead of being defined by the oppressive story they learned about themselves. For these reasons, externalizing the systemic issues from the individual is a great opportunity for the client to step away from the self-blame and the shame of their pathologization, as well as taking, willingly, responsibility on the building of their own liberation.

### **Conclusions**

Research indicates that oppression can be internalized and have debilitating and detrimental effects on the individuals' mental health and psychological well-being, specially in peoples who belong to non-dominant groups. IO is characterized by a series of detrimental beliefs and negative self-schemas that have distressing cognitive, emotional, and behavioural implications. The construct of internalized oppression has been evaluated and found to have construct validity in the development and testing of different scales. The detrimental cognitive, emotional, and behavioural phenomena produced by IO in the micro-level (individual) also contribute to the perpetuation of a set of environmental contingencies in macro-level (collective)

and maintain the *status quo*. Addressing IO in clinical CBT practice is plausible, possible, and significantly beneficial for clients.

### Chapter 3

#### **Cognitive-Behavioural Conceptualization and Guidelines to address Internalized Oppression.**

Research has shown that CBT is culturally modifiable and can be effective for various non-dominant populations (David, 2009; Hays & Iwamasa, 2006). The flexibility of CBT is based on its principles, which emphasize 1) tailored interventions to meet the needs of individuals in their unique contexts; 2) work towards empowerment of clients by recognizing them as the experts regarding their experiences; and 3) the acknowledgement and use of the client's strengths and support systems (David, 2009). Additionally, as has been identified before (see chapter 2), CBT foundations are compatible with the construct of internalized oppression (IO), and can be used to assess and develop strategies to address it.

Assessment and intervention strategies to address IO may focus on the set of self-defeating cognitions, attitudes, and behaviours (David, 2009) developed over time in our culturization process (hence, the mere exposure to oppression). David (2009) addresses and describes the consistency of cognitive behavioural conceptualizations and self-defeating cognitions, attitudes and behaviours in the following paragraph:

Consistent with cognitive behavioural theories on psychopathology (e.g., Beck, Ruch, Rush, Emery, & Shaw, 1979), underlying such automatic thoughts, attitudes, (e.g.,

"Lighter skin is more attractive or desirable") or behaviours (e.g., discriminating against less-Westernized members of the same racial group) are maladaptive general beliefs (e.g., "Being White or American is better than being Black/Asian/Hispanic/Latino/a/Native") that have been developed from previous experiences (e.g., colonialism, slavery, boarding schools, contemporary oppression). Such thoughts and beliefs contribute to the creation of dysfunctional self-schemas (e.g., "I'm Black/Asian/Hispanic/Latino/a/Native, therefore I am not attractive and I am inferior to Whites") that may lead to psychological distress and various psychopathology. (p. 86)

According to the author, such cognitions, consistent with the cognitive-behavioural model, can be addressed in psychotherapy through assessment and intervention, and can be subject to identification, description, and restructuring.

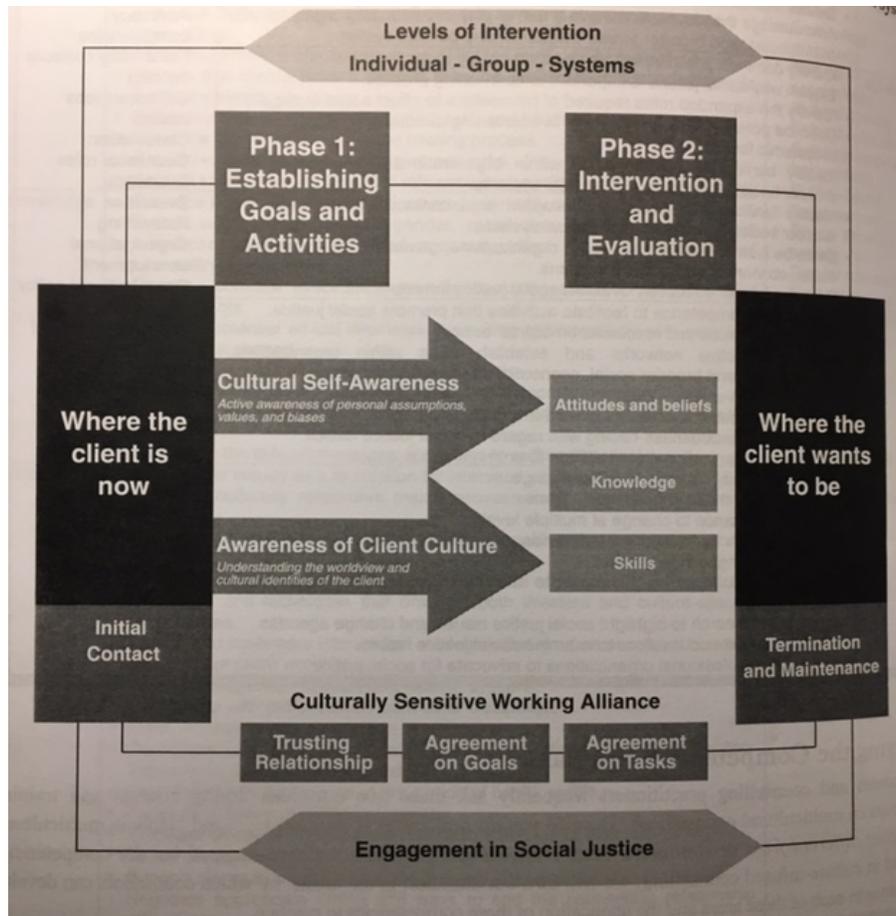
### **Guidelines and models of strategies to address oppression**

According to David (2009), IO can influence the development of psychopathology among individuals, especially members of non-dominant groups. David offers suggestions for clinicians to culturally modify CBT to conceptualize and address IO. In his article, he proposes three main goals in the process, which are: (1) increase awareness of minority groups' historical and contemporary experiences of oppression; (2) inspire greater awareness of how internalized oppression may influence psychopathology; and (3) generally articulate how CBT may be applied to address internalized oppression within racial and ethnic minority communities. These three goals can be guidelines for clinicians to formulate cases, plan treatments, and propose interventions that help them to address internalized oppression with their clients, as well as within themselves.

## **Culturally Sensitive Therapy: Competencies and Procedures**

Various authors have identified the need and benefits of having a culturally sensitive practice as a way to adapt therapies and EBPPs to address oppression (Hall, 2000; David, 2009; Okasaki & Tanaka-Matsumi, 2006; Arthur & Collins, 2010; David & Derthick, 2014;). Arthur and Collins (2010) propose a framework of culture-infused clinical competencies based on empirically supported studies and research in the multi-culturally field in counselling psychology. These competencies include three domains: 1) cultural self-awareness, 2) awareness of the clients' cultural identities, and 3) culturally sensitive working alliance/therapeutic relationship, which lead the clinician to incorporate anti-oppressive and liberating principles to their clinical work, as “a foundation for effective and ethical professional practice” (p. 45). These competencies help clinicians to pursue cultural consciousness by addressing oppression, power dynamics, identity (sexual, gender, individualistic, sexual orientation), systemic issues, attitudes and beliefs, privilege, discrimination (racism, sexism, heterosexism, classism, ableism, ageism, elitism, etc.) and its effects on individuals in the therapeutic process.

*Figure 2: Arthur and Collins' (2010) Model Of Engagement In Social Justice (p. 64).*



**Other successfully implemented models addressing internalization of oppression:  
Gay Affirmative Practice.**

Craig, Austin, and Alessi (2012) presented a study with a clearly defined adaptation of CBT for Sexually Minority Youth (SMY), which is sensible to the unique struggles of this population. Such adaptation considers the particularities of coming out, stigma, and discrimination of sexually diverse people in today's society, and the role of social support and community based on Marshal et al.'s (2011) Minority Stress Theory, and Gay-Affirmative Practice (Davies, 1996). According to the Minority Stress Theory, many individuals who belong to minorities (or non-dominant groups, like LGBT peoples) experience additional chronic stress than members of the dominant or privileged groups as a result of experiences of prejudice and

discrimination. Gay-Affirmative Practice is a tailored model of practice used to adapt a clinician's existing treatment model (Craig, Austin & Alessi, 2012) to focus on the celebration and advocacy for the validity of LGBTQ individuals and relationships, acknowledging the "impact of macro-level forces, particularly heterosexism and homophobia, on the well-being of sexual minorities (Lebolt 1999; Langdridge 2007). Practicing affirmatively includes "deprogramming" feelings of difference, which are perpetuated by stigma and marginalization (Davies, 1996)" (p. 261).

The model presented by Craig et al. (2012) is based on existing literature and includes the following 10 guidelines:

- 1) Affirm identities of SMY during the assessment process.
- 2) Foster collaboration by clearly explaining the treatment process.
- 3) Identify the SMY's Personal Strengths and Support Networks.
- 4) Distinguish between problems that are environmental and those that stem from dysfunctional thoughts.
- 5) For environmentally based problems, help clients make changes that decrease stress, increase personal strengths and supports, and to build their skills for interacting with the social environment.
- 6) Validate clients' self-reported experiences of discrimination.
- 7) Emphasize collaboration over confrontation, with attention to client-therapist differences.
- 8) With Cognitive Restructuring, question the helpfulness (rather than the validity) of the thought or belief.

9) Use client-identified strengths and supports to help SMY develop a list of helpful thoughts.

10) Ensure that homework assignments emphasize congruence with LGBTQ culture as well as the client's stage in the coming out process.

According to the authors, this approach is very useful for clinicians working with LGBTQ youth in order to help them find more plausible ways of thinking and behaving, while simultaneously validating their unique struggles (e.g., experiencing homophobia and coming out). As homophobia and heterosexism are forms of oppression, the gay affirmative practice model that targets internalized homophobia can be incorporated in the adaptation of CBT to address internalized oppression (including other sub-categories, like racism).

### **Ideas from Social Work**

Lee and Brotman (2013) wrote an article on anti-oppressive practice that aims to contribute to social work scholarship about LGBTQ migrants, featuring four main interrelated spheres. The first sphere is a reflexive anti-oppressive praxis, which includes developing critical analysis to bring to light hidden practices of marginalization and exclusion; and understanding of the historical, social, political, and structural dimensions that shape the complex ways in which multiple oppressions operate in clients' lives. Second, a set of micro-skills, which is based on being transparent about the social power we hold based on our social location, and the limitations we have to make decisions and/or distribute resources due to our position within an organization or institution, in order to strengthen trust with clients. An emphasis on thinking structurally is

made, as a means to identify the present systemic issues; and finally, a piece on policy advocacy and community organizing, which are more pertaining to social work.

### **Commonalities through the models**

The models reviewed propose competencies and guidelines for anti-oppressive practices in psychotherapy and CBT. The main commonalities are: 1) All models stress the importance of awareness on group identities for both the clinician and the client (David, 2009; Arthur & Collins, 2010; Craig, Austin & Alessi, 2012; Lee and Brotman, 2013). 2) There is a strong emphasis on acknowledging and understanding the historical, social, political, and structural dimensions of oppression, as referred on Gay Affirmative practice as the ‘macro-level forces’ and which interact with micro-level or intrapersonal forces (thoughts, beliefs, schemas, behaviours).

It is also possible to identify an emphasis on collaboration regarding the construction of treatment goals and planning in a culturally sensitive working alliance (Arthur & Collins, 2010; Craig, Austin & Alessi, 2012). Finally, the models of multicultural competence and social work highlight the importance of addressing power dynamics with clients and have an open conversation of their role in the interaction between a practitioner and a client. The models of Craig et al. (2012) and Lee and Brotman (2013) have an additional focus on building coping strategies or skills to cope with both internalized oppression and systemic oppression.

### **Guidelines for CBT assessment and intervention of internalized oppression**

Assessment in CBT involves the evaluation of clients' cognitions and behaviours (Okazaki & Tanaka-Matsumi, 2006). The assessment of thought content and cognitive (verbal)

information is common through the identified guidelines and models found. According to David (2009), the elements through which Internalized Oppression can be identified are the following:

- *Automatic Negative Thoughts*
- *Attitudes*
- *Behaviours*
- *Maladaptive General Beliefs*
- *Dysfunctional Negative Self-Schemas*

Following the guidelines identified in the different models, we can explore the cognitive material through its content to identify where Internalized Oppression is manifesting (see Chapter 2, definition of I.O.).

### **Bringing awareness on clients' and own cultural identities.**

The initial demographic information that clients provide when they seek for psychotherapy (i.e. sex, age, ethnicity, etc.) is a starting point, as it provides an idea of the client's perception on their group membership and social location. Their experience of these identities can be explored with questions like "What does it mean for you to be a woman?", which may provide us with access to thoughts, attitudes, and beliefs regarding gender, for example. Certain cognitive distortions (arbitrary inference, selective abstraction, and overgeneralization, stylistic (exaggeration), or semantic (inexact labelling) (Beck & Alford, 2014), maladaptive general beliefs, or negative self-schemas, can be identified with a focus on oppressive worldviews, where the beliefs resulting from IO make the oppressive beliefs, realities. It is important to clarify that, when identifying cognitive distortions, the validity of oppressive experiences is not to be argued; what is to be argued is the detrimental beliefs that experiencing

oppression leads people to think. An example could be: “I’m a woman therefore, I am weak” (self-schema). This detrimental belief would lead to behaviours like deferring to men to be leaders or to be in positions of power (behaviours), and support the mental schema (‘Men are stronger than women’), as described on David and Detrick’s (2014) model (view Figure 1). Clinicians may also do the same in a self-reflective process, identifying their own identities, and the subsequent attitudes and beliefs (Arthur & Collins, 2010).

*The Culturally Informed Functional Assessment (CIFA) interview (Tanaka-Matsumi, Seiden, & Lam (1996).*

Tanaka-Matsumi, Seiden, and Lam (1996) designed a culturally-informed functional assessment interview to facilitate the integration of cultural observations into cognitive-behavioural assessment and treatment planning (Okazaki & Tanaka-Matsumi, 2006) with the aim to increase the cultural relevance of a case formulation “by generating detailed, culturally relevant information regarding observable events that are potentially connected to the client's presenting problem” (p. 256). This interview involves eight successive stages, and starts with an assessment of the client's cultural identity and level of acculturation, followed by an elicitation of the client's conceptualization of the problems and possible solutions, involving the clients in the assessment process and treatment planning, and engaging them in the therapeutic process (working alliance/therapeutic relationship).

### **Acknowledgement of historical, social, political, and structural dimensions of oppression.**

This guideline is directed to help clinicians understand the macro dynamics involved in the process of internalization of oppression (acquisition and learning of the oppressive ideas), and

guides them to formulate questions with the potential to open dialog on the external nature of an oppressive belief. This may foster the reverse process of internalization: externalization, which can then become an opportunity for emotional reprocessing (Ryan, O'Dwyer & Leahy, 2015; David, 2014; Foa & Kozak 1986), giving the clients the opportunity to consider that they are not to blame for having oppressive, detrimental ideas, as they have been learned from culture and society.

Rossenwasser (2002) wrote in her article about the use of collaborative inquiry to heal from internalized anti-Semitism in a therapeutic group of Jewish women, that the results of such an intervention were understanding that “shared pain resulted from systemic oppression, which was not our fault, emboldened us to become more visible as Jews and to confront anti-Semitism” (p. 53), showing how the process of acknowledgement of systemic oppression helped this group of women to take the blame of oppression away and engage in behaviours that allowed them to become more empowered (e.g. confronting oppression).

Various cognitive-behavioural interventions can specifically target internalized oppression by helping clients develop realistic and accurate perceptions of themselves, others, and the world they live in (David, 2009). David points out that a realistic perception of society would involve identification of oppression still being present in today's world; where an accompanying goal for the client could be to develop a:

more adaptive perception of reality (i.e., they must learn that, although oppression is real and powerful, it is not an insurmountable obstacle), and clinicians may work with their clients to develop strategies to cope with the oppression they experience (e.g., the client

learns how to directly confront micro-aggressions in a way that feels empowering, the client learns about legal options if they experience work discrimination, etc.). (p. xx)

This also includes acknowledging that the IO experience may vary among individuals (intersectionality), and that goals and techniques of interventions should be personalized or tailored to the individual needs of each client (David, 2009).

### **Conclusions**

Common guidelines to address oppression in clinical practices were identified through the reviewed models: 1) increased awareness on identity and inter-sectionalities; 2) acknowledgement of historical, social, political and structural dimensions of oppression; 3) collaboration; and 4) coping strategies/skill building. Through an evaluation of cognitive material and behavioural performance, CBT practitioners can design strategies and interventions that respond to these guidelines in order to transform their practice into a more liberating, culturally aware and anti-oppressive one.

## Chapter 4

### **Therapeutic Strategies to address Internalized Oppression in CBT**

Internalization of oppression has been addressed by psychology in various sub-categories including racism, homophobia, and stigma (see Gay Affirmative Practice Guidelines to address internalized homophobia, (Davies, 1996) and Narrative Enhancement and Cognitive Therapy for Internalized Stigma (Yanos, Roe, Lysaker, 2011), for example. According to Hays (1995), addressing internalized oppression as a general concept instead of compartmentalizing it in different types (only racism or homophobia, for example) could facilitate the identification and comprehension of its various manifestations in a client's life. This would allow practitioners to elucidate and integrate the complexity of inter-sectionality of the various identities clients have. This information supports the proposal of addressing oppression as a matter of clinical attention on this paper.

To address oppression in CBT, different authors have identified series of intervention strategies directed to clients, therapists, and treatments that influence the outcome of the clinical practice (David, 2009). Intervention outcome research has typically focused on three major sources that contribute to observed variance in treatment outcomes: (1) client characteristics and behaviour (e.g., values, acculturation, fatuity characteristics and dynamics); (2) therapist characteristics and behaviour (e.g., values, preference for certain treatments); and (3) treatment features and procedures (David, 2009). This chapter will focus on the two first foci of intervention outcome to develop specific strategies to address internalized oppression and enhance treatment outcomes based on the guidelines identified in the models described in previous chapter (David, 2009; Arthur & Collins, 2010; Craig, Austin & Alessi, 2012; Lee and Brotman, 2013).

**Strategies directed to clients: client's values, acculturation, fatuity characteristics and cognitive dynamics.**

**Increased awareness on identity**

Identifying the clients' identities and the historical and their current experiences of oppression is the first guideline identified across the models reviewed (David, 2009; Arthur & Collins, 2010; Craig, Austin & Alessi, 2012; Lee and Brotman, 2013). The perception of one's identity in relationship with internalized oppression can be determined by group membership (Taylor, 2014; David and Derthick, 2014; Bailey, 2008; David & Okazaki, 2006; Duran & Duran, 1995). To describe their identities, clients can be inquired to identify their group memberships in the realms of gender, ethnicity/race, or cultural identity (e.g. being a woman, a man; gay, transsexual; black, Asian; Canadian); and verbalize the experience of being part of those groups (e.g., How does it feel like to be a white, lesbian woman in this society for you?). Following David's (2009) first guideline, minority groups' historical and contemporary experiences of oppression can also be verbalized in dialogue with the client (e.g. What struggles can you imagine women had a hundred years ago? / Which ones they have now?).

The ADRESSING framework (Hays, 2001), is a tool that facilitates therapists' cross-cultural competence to increase their awareness on identity issues. The acronym summarizes the multiple dimensions of culture that have been neglected in psychological work and practice (Okazaki & Tanaka-Matsumi, 2006), which includes: 1) Age and generational influences, 2) Developmental and acquired disabilities, 3) Religion and spirituality, 4) Ethnicity, 5) Socioeconomic status, 6) Sexual orientation, 7) Indigenous heritage, 8) National origin; and 9) Gender. The ADRESSING framework provides clinicians with information about their clients' identities and their cultural environment in terms of power, privilege, and access to resources,

consistently with David and Derthick's (2014) conceptualization of oppression in terms of group membership.

In the process of bringing awareness on identity, clinicians need to be attentive to their clients' reports of cognitions in various forms and behavioural performances (Okazaki & Tanaka-Matsumi, 2006; David, 2009), through which internalized oppression can be manifesting (automatic negative thoughts, attitudes, behaviours, maladaptive general belief, dysfunctional negative self-schemas); and encourage them to challenge the ones they report as distressing. For example, a therapist may hear a maladaptive general belief like "Women are weaker than men" and help the client verbalize the behavioural impact of such a belief; and determine where this idea may come from. Such an intervention may foster cognitive restructuring (Beck, 1995; David, 2009; Ross et al. 2012, David & Derthick, 2014) and the process of creating new meaning (Ryan, O'Dwyer & Leahy, 2015) (e.g. How does a person who thinks they are weak act? / How does a person who thinks they are strong act?; How do you think women can become stronger and gain power? / What can women tell themselves when they feel disempowered? / How would that look in their life?).

### **Acknowledgement of historical, social, political and structural dimensions of oppression**

The second guideline identified from the reviewed models (David, 2009; Arthur & Collins, 2010; Craig, Austin & Alessi, 2012; Lee & Brotman, 2013) suggests that therapists need to foster the acknowledgement of the systemic nature of oppression, in a process where clients' feelings and experiences can be validated, and the causes of the problems can be located outside the individual instead of attributing them to intrapersonal variables (David & Derthick, 2014). This can be done by selecting maladaptive (oppressive) cognitions like "I am gay, therefore

there's something wrong with me" (dysfunctional self-schema); and asking the client questions like "Who told you so?", "Where do you think this idea comes from?", or "Who benefits from that idea?", in an attempt to frame the problem from intra-psychic to societal/political, and encourage the client to think critically and question the oppressive beliefs (Arthur & Collins, 2010). Additionally, therapists can help clients externalize the effects of living in an oppressive context (e.g. "How has living in a racist/homophobic society impacted you?").

The second guideline of David's (2009) model indicates that increased awareness on how internalized oppression may influence psychopathology is of vital importance. This process can begin with psycho-education on the construct of oppression and sharing information like research that has shown how internalized oppression affects people's lives and mental health (g.e. oppression and its relation to depression, for example). Cognitive restructuring can be fostered by questions like "How do you think oppression could affect your choices, your thoughts and your mood?" As suggested by Okazaki and Tanaka-Matsumi (2006), these type of questions may inspire greater awareness in the client on how oppression influences their behaviours, cognitions and emotions.

### **Collaboration**

Craig et al. (2012) suggest in their guidelines that collaboration can initiate by explaining clearly the treatment process to the client and providing a rationale for the assessment and intervention strategies. This idea is not contrary to CBT, as Aaron Beck even referred to clinicians as collaborative empiricists (Beck, 1995). Arthur and Collins (2010) specify that the working alliance needed for developing culture-infused competencies includes three components: 1) co-construction of the goals to be accomplished through the relationship, 2) co-construction of the tasks to be fulfilled by each partner in the relationship, and 3) mutual trust and respect that

provides a solid foundation for facilitating the identification of culturally appropriate goals and tasks (p. 50). Incorporating these components allows the clinician to facilitate collaboration and strengthen the therapeutic relationship.

Additionally, a collaborative approach could also increase the sense of empowerment in the therapeutic relationship by increasing intrinsic task motivation, as incorporating the components proposed by Arthur and Collins (2010) would give to the clients a sense of impact, competence, meaningfulness, and choice (Thomas & Velthouse, 1990); as well as increase their perception of power in response to the power dynamics present in the therapeutic relationship (therapists' position as professional, figure of authority and other identities that may influence the interaction). By the end of the sessions, clients can be asked for feedback through questions like "How is this therapeutic process going for you?" / "How do you think we can make it work best for you?"

### **Identification of client strengths**

There are various ways in which clients' strengths and identities can be identified and validated. Craig et al. (2012) propose, in the case of therapy with gender diverse youth, for example, that "Practitioners should ask clients to list positive feelings about identifying as lesbian, gay, or bisexual" (p. 261), and discuss their favourite lesbian and gay cultural icons or identify positive traits about other lesbian, gay, or bisexual people they know. This can also be done with ethnicities and the different group memberships of the clients, where positive feelings towards one's identities can foster cognitive restructuring by challenging negative thoughts or beliefs against one's own group (Beck, 1993; Craig et al., 2012) that characterize IO.

According to Craig et al. (2012) as well, an effective assessment of interpersonal and environmental supports should include questions about the client's family of origin as well as

family of choice (e.g., boyfriend/girlfriend's family or best friend's family), informal supports (e.g., friends, partners), and formal peer supports (e.g., gay-straight alliances in school), community groups (e.g., SMY support group or a social action group), and participation in events or rituals that help celebrate sexual minority identities, such as gay pride parades" (Craig et al, 2012). This can be done in addition to the initial assessment of the clients' current repertoire of coping skills, through questions like: "Who usually supports you when you face discrimination? What do you do when you face discrimination? / What do you do when you feel oppressed?", as a way to do a behavioural assessment in the form functional analysis (Okasaki & Tanaka-Matsumi, 2006; Persons, 2008), from which a list of the clients' strengths and coping strategies can be done in collaboration.

### **Coping strategies/skill building**

Craig et al. (2012) suggest that practitioners need to validate their client's concerns and frustrations "as well teach them skills for coping with situations that are beyond their control" (p. 262), like encountering oppression in their daily living. These authors focus on cognitive skills fostered by the practice of cognitive restructuring in session to help clients develop the ability to recognize dysfunctional thoughts that work against their long-term goals, evaluate their utility and take action (either cognitive or behavioural), which would decrease feelings of hopelessness (Craig et al., 2012; Beck 1993). To address automatic negative thoughts (e.g., "I will always be unhappy") by cognitive restructuring, the clinician and the client can identify some of the most distressing thoughts; and think of ways in which they can be challenged. The therapist can elicit questions like "does having this thought makes it a reality?", which can help the client to learn to gain awareness on their thinking processes, identifying the detrimental thoughts (oppressive thoughts) as such, in an externalizing process where the client learns to arrive to conclusions like

“I can have a thought like this; and it does not define my faith or me as a person” (Craig et al., 2012).

Craig et al. (2012) also suggest that therapists can help clients materialize cognitive coping strategies by building a list to generate new thoughts to replace the less helpful ones. According to the authors, doing such an exercise of awareness on “specific strengths and supports generated during an initial assessment, can be a concrete reminder of past successes” (p. 263), where less helpful thoughts can be re-formulated into positive self-statements. Craig et al. (2012) suggest that the re-formulations acknowledge the issues and the adversities, the client’s successful attempts to cope with them, and the conclusions they can draw from them, in a format like:

“... adversity I have coped with in the past has made me stronger; if I got through last year, I can get through anything; my differences are what make me unique and special; or my best friend’s family is my new family, and they appreciate me for who I am. These new thoughts and beliefs can be listed on a sheet of paper for the youth to take with him/her” (p. 263).

**Strategies directed to therapists: Addressing therapist’s values, acculturation, fatuity characteristics, and cognitive dynamics.**

Therapists need to be aware of their own identities, values, acculturation, and cognitions in order to be able to provide a liberating and anti-oppressive clinical practice, as they may have subtle biases toward values supported by the status quo (Hays, 1995). One of the most useful resources available for therapists to ameliorate the dearth of culturally competent practice is supervision (Iwamasa, Pai & Sorocco, 2006). For these reasons, this section on therapists

suggests both intrapersonal and interpersonal strategies (through supervision relationship) as the vehicles to address oppression in their clinical practice.

### **Awareness on identity**

As with clients, therapists can raise awareness on their identities by identifying their own group memberships in the realms of gender, ethnicity/race, or cultural identity (Taylor, 2014; David and Derthick, 2014; Bailey, 2008; David & Okazaki, 2006; Duran & Duran, 1995). They can identify their views on their different group memberships and the feelings or emotions related to their group memberships in terms of gender, ethnicity/race and cultural identity; as well as their position of power and privilege as therapists (g.e. being a man, a woman; bisexual, heterosexual; White, Latino; a professional, a therapist, a client) (Arthur & Collins, 2010).

Iwamasa, Pai, and Sorocco (2006) describe various guidelines to foster cultural competency for therapists through supervision, like the heuristic model of non-oppressive interpersonal development presented by Ancis and Ladany (2001), which is a stages model that involves active exploration of the supervision participants' own group memberships (socially oppressed or socially privileged), and aims for multicultural integrity, awareness, and proficiency in interacting with and understanding oppression and socially oppressed groups. In the latter stages of cultural competence, supervisees are expected to be able to recognize oppression when it happens and accurately empathize with feelings of oppression in clients. Additionally, they “may advocate against oppression and willingly use their privilege to promote equality” (p. 273, Iwamasa, Pai & Sorocco, 2006).

These authors also describe four main steps that professionals need to accomplish to begin the process of becoming multiculturally competent within the multicultural counselling field suggested by Lee (1997), which include: (a) become aware of one's own cultural background, (b)

be aware of and understand cultural biases that may interfere with helping effectiveness, (c) learn about the history and culture of diverse groups, and (d) develop new skills.

Okazaki and Tanaka-Matsumi (2006) suggest that the ADDRESSING framework (Hays, 2001) greatly helps therapists to increase their cross-cultural competence for bringing awareness on their own identity. Following the model dimensions, therapists can identify their own identities and positions of power and privilege by identifying and describing their identities, which would allow them and their supervisors to contemplate their degrees of privilege and power and its possible influences on their practice. Vikki Reynolds (2010) illustrated an approach to therapeutic supervision called *Supervision of Solidarity* to help therapists to practice in oppressive contexts based on six principles. One of the principles of such supervision is called Power Addressing, which invites the supervisee (and supervisor) to increase ‘collective accountability’, a process that requires the analysis of the “multiplicity and intersection of sites of both power and oppression” (Reynolds, 2010, p. 249), which allows the supervision participants not only to identify their identities, but to analyse their relational impact in the clinical practice.

A supervisor can ask a supervisee: “After describing the dimensions of your identity, how do you think they may influence your clinical practice? / How can you determine the power balance in the therapeutic relationships of your practice and how can you address imbalance? / How can you relate to experiences of clients with different identities from yours?”. A supervisor can also ask a therapist questions like “How could oppression be operating in your clinical practice?” “How do you think your clients could perceive it?” and “What can you do to address it?”, in order to foster recognition of oppression when it happens in the therapeutic room and relationship, and accurately empathize with feelings of oppression in clients (Iwamasa, Pai & Sorocco, 2006). The

analysis of these power and oppression dynamics may be done from this type of questions, responding to the Power Addressing principle and the collective accountability process (Reynolds, 2010).

### **Acknowledgement of historical, social, political and structural dimensions of oppression**

According to Iwamasa, Pai, and Sorocco (2006), in order to begin this conversation, a supervisor may discuss with the therapist the fact that traditional therapies have been developed from a Eurocentric point of view, and many of their components do not adhere to the realities of cultural minority populations, which would translate in an imposture of the Eurocentric values, attitudes, and beliefs worldviews on clients who do not belong to this group. Such issues can be discussed with questions like “Which could be the benefits of the influence of Eurocentric worldviews in CBT?”, as well as “Which could be the issues, considering that there are clients who don’t adhere to them?” In this way, supervisors can help practitioners to think of some of the main assumptions in CBT, and acknowledge historical dimensions of oppression in the theoretical approach that guides their practice. Social and political dimensions can be addressed with questions that elicit the experience of oppressed groups, like “How do you think CBT could impose Eurocentric views on a First Nations client?” and “What attitudes do you think a client from African descent with a family history of slavery could have if they perceive the Eurocentric nature of CBT?” “How could you address it?”.

In order to foster the acknowledgement of the systemic nature of oppression, therapists need to think of strategies to unveil the systemic issues that may affect their professional practice, instead of blaming themselves or attributing their difficulties to intrapersonal variables of them or their clients (David & Derthick, 2014). This can be done by identifying oppressive thinking like

“I am the therapist, so I always know how to solve my patient’s problem”; and asking themselves questions like “Where does this idea comes from?”, “What are the exceptions to this idea?”, “Are there alternatives to this idea?” or “Who benefits from that idea?”, in an attempt to frame the problem as societal/political and encourage the therapist to think critically and question the oppressive dynamics inherent to the professionalization process, the practice of psychotherapy and the medical model in their beliefs and attitudes (Arthur & Collins, 2010). Additionally, supervisors can help therapists externalize the effects of living in an oppressive context in their clinical practice by asking questions like “How can the power given to you by your position as a professional in mental health may affect your practice? / What can you do to address those influences?”), which would allow them to identify cultural biases that may interfere with helping effectiveness (Lee, 1997), consider the potential risks in which their practice could be doing harm by replicating oppression (Reynolds, 2010), and think of ways to cope with such issues.

### **Collaboration**

In order to foster collaboration in their clinical practices, therapists need to clearly explain the treatment process and provide comprehensive rationale for the assessment and the intervention strategies to their clients (Craig et al., 2012). As part of a culturally sensitive working alliance (Arthur & Collins, 2010), therapists must give all the information their clients ask for and guarantee that their feedback and ideas are incorporated in the treatment process. Therapists can ask themselves if they are giving their clients this information and if they are giving them chances to give feedback on the process. Guidelines can be developed by practitioners to make sure they are guaranteeing collaboration. Supervisors can help encourage their supervisees to establish such guidelines and formulate questions like “How are you guaranteeing that you get your client’s feedback and thoughts on the therapeutic process?” or

“Which questions can you ask to your clients to encourage them to share their feedback and thoughts on the therapy with you?”.

According to Okasaki and Tanaka-Matsumi (2006), supervisors can also help therapists to have clarity on their proposals for assessment and intervention through a culturally sensitive case formulation. Such a process aims to generate detailed, culturally relevant information regarding observable events that are potentially connected to the client's presenting problem. One example of a culturally sensitive case formulation is the Culturally Informed Functional Assessment (CIFA) interview (Tanaka-Matsumi, Seiden, & Lam, 1996). Through such an assessment, the therapist and the supervisor can build a case formulation identifying: 1) the therapist's and the client's cultural identity and level of acculturation; 2) the presenting problems; the client's and the therapist's explanations or conceptualizations of the problems and their possible solutions; 3) the functional analysis of the antecedent-target-consequence sequence; 4) the negotiation of similarities and differences between the functional analysis (therapist's proposal) and the client's causal explanation of the problems; 5) the development of a treatment plan that is acceptable to all parties involved, including culturally different individuals and reference groups, and data gathering that facilitates ongoing assessment of the client's progress; and 6) the discussion of treatment duration, course, and expected outcome (Tanaka-Matsumi, Seiden, & Lam, 1996).

### **Conclusions**

It is possible to exemplify and describe concrete therapeutic assessment strategies and interventions directed to clients' and therapists' characteristics and behaviours in cognitive-behavioural practice following the guidelines identified in the anti-oppressive models reviewed. Various models and frameworks that align with the guidelines proposed can provide clinicians

with concrete steps to adapt their clinical practice. These assessment and intervention strategies adhere to specific cognitive-behavioural methodologies, such as the ADDRESSING framework (Hays, 2001), the Heuristic Model of Non-Oppressive Interpersonal Development (Ancis and Ladany, 2001), or Davie's (1996) Gay Affirmative Practice Guidelines. These strategies incorporate cultural awareness, liberation, and validation of clients' diverse experiences based on anti-oppressive principles.

## Chapter 5

### **Treatment features and Procedures to address Internalized Oppression in CBT**

CBT focuses on the change of maladaptive behaviours by changing detrimental ways to think (Craig et al., 2012; Beck, 2011). The change of such behaviours and thinking starts by identifying (evaluating) “the clients' cognitions in various forms and behavioural performance” (p. 248, Okasaki & Tanaka-Matsumi, 2006). This chapter will provide a description of the main procedures of cognitive-behavioural treatment, including assessment and intervention methodologies that encompass the fundamental mechanisms of change of the theoretical model to address internalized oppression.

#### **Assessment, Case Formulation & Functional Analysis**

According to Okasaki and Tanaka-Matsumi (2006), in a culturally aware practice, practitioners initially need to be aware of cross-cultural differences in self-reported affect, behaviour, and well-being. Afterwards, cognitive-behavioural scales and instruments can be used for assessing specific disorders, cognitive styles, and behaviours. When the cognitive-behavioural assessment is done, the cognitive-behavioural therapist would use functional analysis and design a case formulation where the interventions will target maintenance factors of the problematic cognitions and behaviours found in such an analysis.

#### **Assessment.**

Practitioners can identify culturally relevant information in the form of cognitive styles and behaviours potentially connected to clients' presenting problems through various scales and instruments. The results from the utilization of those scales can be incorporated in the assessment, so the treatment can be informed on levels of acculturation, internalized oppression,

or its sub-categories (racism, homophobia, etc.). Some of the strategies to conduct such a culturally-sensitive assessment include the Culturally Informed Functional Assessment (CIFA) interview (Tanaka-Matsumi, Seiden, & Lam, 1996) or the ADRESSING framework (Hays, 2001). Implementing these assessment strategies can be of vital help in connecting the cultural factors influencing detrimental cognitive styles and maladaptive behaviours informed by oppression and its internalization. For example, using the ADRESSING framework (Hays, 2001) can help practitioners identify whether clients belong to non-dominant groups and are more likely to be affected by the self-detrimental effects of internalized oppression (e.g., negative self-schemata based on their identities) (David, 2009).

As part of a collaborative practice, practitioners can offer a detailed assessment on oppression or internalized oppression to their clients with the use of different scales, for example the previously reviewed Internalized Racial Oppression Scale (IROS; Bailey et al., 2006), the Awareness of Privilege and Oppression Scale (APOS; Montross, 2003), the Resistance/Internalization Oppression Scale (RIOS; Jones-Howard, 1999), the Diversity and Oppression Scale (DOS), the Appropriated Racial Oppression Scale (AROS; Campón, 2015), or the Nadanolitization Scale (NAD; Taylor, Dobbins, & Wilson, 1972; Taylor & Grundy, 1996). These scales provide the practitioner and the client with detailed information on the configuration of oppression and its sub-categories, and dimensions; degree of pervasiveness, or the level of awareness of its internalization in clients' lives.

### **Case Formulation.**

Okasaki and Tanaka-Matsumi (2006), suggest that therapists must “evaluate the client's presenting problems using functional analysis, and, second... assess the larger context of the client's social network with attention to cultural influences” (p. 245). Persons (2008) asserts that

case formulation is vital to CBT, as it guides decision making in the therapeutic process and helps to work with the client to collect data to monitor the progress of therapy as well as make adjustments as needed in the context of a collaborative therapeutic relationship. According to this author, case formulation also offers a systematic method to determine if a particular behaviour is adaptive or maladaptive, according to the client's particular circumstances. The particularities and unique characteristics of the situations the client face would be covered in a functional analysis. Additionally, the information on a culturally sensitive assessment like the ADRESSING framework (Hays, 2001), where the client's age and generational influences, developmental or acquired disabilities, religion and spirituality, ethnicity, socioeconomic status, sexual orientation, origin heritage, national origin, and gender can help practitioners identify their clients' degree of privilege, vulnerability or access to power; which would facilitate the determination of behaviours that are adaptive or maladaptive in the clients' particular circumstances.

### **Functional Analysis.**

A case formulation with functional analysis helps describe the clients' symptoms and problems, propose hypotheses about the mechanisms causing them, identify its precipitants, as well as the origins of the development of its mechanisms (Persons, 2008). Considering the clients' identities and cultural factors in specific situations can help therapists understand the functionality of their responses in contexts where they experience oppression. For example, a client who belongs to a non-dominant ethnic group may face racism with confrontation in certain circumstances; and avoidance in others, which may or may not be adaptive depending on the situations the client is describing and the clients' emotional experience. The context in which the behavioural responses to oppression are happening may inform both the client and clinician on the micro and macro-level contingencies present when engaging in those responses. In this way,

functional analysis combined with a culturally sensitive assessment like the Culturally Informed Functional Assessment (CIFA) interview (Tanaka-Matsumi, Seiden, & Lam, 1996) can strengthen collaboration in the therapeutic process, by identification of cultural identities, presenting problems, and both the client's and the therapist's explanations or conceptualizations of them. This may open the possibility to identify alternative behavioural solutions in specific situations in a collaborative and informed process; as well as engaging the client in the development of a treatment plan that is comprehensive and acceptable, made by culturally different individuals. Reference groups and data gathering can be agreed upon, which would facilitate ongoing assessment of the client's progress, and the discussion of treatment duration, course, and expected outcome (Tanaka-Matsumi, Seiden, & Lam, 1996).

### **Intervention fundamentals**

Cognitive behavioural interventions target the detrimental cognitions and maladaptive behaviours as the maintenance factors of the presenting problems, and may take as reference Beck's cognitive theory (where treatment targets are schemas, automatic thoughts, and maladaptive behaviours that the cognitive model views as mechanisms causing and maintaining clients' symptoms) (Persons, 2008). According to David (2009), internalized oppression can be identified in automatic negative thoughts, attitudes, behaviours, maladaptive general beliefs, and dysfunctional negative self-schemas regarding a person's identities (resulting in self-doubt, identity confusion, feelings of inferiority, and self-fulfilling prophecies/confirmation biases related to behaviours motivated by the internalized detrimental beliefs); as well as behaviours and linked emotions that perpetuate oppression, like the emotional activation produced by avoidance

and violence sublimated or redirected to members of one's group, self-destructive behaviours and violence towards the self (substance abuse, suicide), self-denigration, and incorporation of negative stereotypes into cultural values and traditions (David & Derthick, 2014). Cognitive-behavioural treatment features intervention procedures to address the maintenance factors of the symptoms caused by internalized oppression, which are identified and described in the assessment process and functional analyses of the problematic behaviours.

### **Cognitive Restructuring**

Cognitive restructuring is considered an essential element in the effectiveness of CBT (Clark, 2014), and one of the main intervention strategies of cognitive behavioural therapy. It consists of structured, goal-directed, and collaborative intervention strategies that focus on the exploration, evaluation, and substitution of the maladaptive thoughts, appraisals, and beliefs that maintain psychological disturbance (Clark, 2014), and was developed by Aaron Beck in cognitive and schema therapy (Beck, 1995). Cognitive restructuring has three central elements, which are: 1) Collaborative empiricism (therapeutic relationship involving the client and therapist in sharing their respective expertise in order to describe, explain, and help resolve the problems), 2) Verbal interventions (evidence gathering, cost/benefit analysis, identifying cognitive errors, and generating alternative explanations), and 3) Empirical hypothesis-testing (planned experiential activities, based on experimentation or observation, undertaken by patients in or between cognitive therapy sessions) (Clark, 2014). Functional analysis of the problematic behaviours facilitates cognitive restructuring, as it informs the clinician with clients' cognitions related to the presenting symptoms; and helps building hypotheses about the causal mechanisms, and identifying its precipitants and origins (Persons, 2008). Hence, a culturally aware cognitive

behavioural treatment would consider these three central elements when implementing cognitive restructuring with an affirmative and liberating focus.

### **Collaborative Empiricism.**

In terms of collaborative empiricism, the cognitive behavioural and culturally aware treatment would encourage the clients and therapists in sharing their expertise (professional, experiential) to describe, explain, and help resolve the presenting problems (Clark, 2014), as Craig et al. (2012) suggest in their collaboration guidelines described previously. Such an exercise of collaborative empiricism would be a constant in treatment and clients' feedback, knowledge, and ideas are to be incorporated (Arthur & Collins, 2010) in the cognitive restructuring interventions. In this process, the therapists' professional knowledge can be addressed as a perspective, and the client's knowledge as another, *equally valid* perspective. Both parts can have dialog on the relativeness of the perspectives and, perhaps, their utility instead of arguing their validity (Davies, 1996) in different settings, especially when talking about oppression.

### **Verbal Interventions.**

Verbal interventions focus on evidence gathering, cost/benefit analysis, identification of cognitive errors, and generating alternative explanations in a solution-focused manner, where the experience of oppression is validated, and the effectiveness of the clients' behaviours is subjected to the cognitive analysis. In this process, clients and therapists may have the chance to think of more helpful behaviours or thoughts for the client to cope with oppression in daily life and micro-aggressions. Craig et al. (2012) suggest that the cognitive interventions need to facilitate the clients' process of re-formulation of self-detrimental cognitions into positive self-statements. Such re-formulations would acknowledge the issues and the adversities that oppression poses, the

client's successful attempts to cope with them, and the constructive conclusions they can draw from them.

### **Empirical Hypothesis-Testing.**

The cognitive restructuring interventions of the treatment must incorporate planned experiential activities, based on experimentation or observation, done by clients in sessions or in between them (Clark, 2014). The main focus of such experiential activities is not to test the reality of oppression or the validity of the clients' oppressive experiences, but rather to focus on the usefulness, utility, desire, and effectiveness of the clients' behaviours and cognitive strategies to cope with such experiences in different settings. For example, experiential activities may include exercises to confront micro-aggressions, racism, or homophobia (David, 2009; Taylor, 2014; Sue et al., 2007), where the aim is to help clients make changes that decrease stress, increase personal strengths and supports, and build skills to interact with others and their environment (Craig et al., 2012). The situations when these experiential activities can be carried out can be defined from the functional analyses of problematic behaviours identified on the assessment process.

### **Emotional Processing**

Emotional processing is a theory developed by Foa and Kozak (1986), and describes the mechanism of change in psychotherapy (and particularly, cognitive-behavioural therapies) in terms of learning principles and behaviourism. Emotional processing theory is basic to CBT because it strategically guides its interventions to change the memory structures directly related to the maintenance factors of problematic symptoms (detrimental cognitions, maladaptive behaviours and distressing emotions) (Foa & Kozak, 1986). A concrete step towards addressing the detrimental psychological consequences of oppression and internalized oppression is the

verbalization and externalization of oppression present in cognitions; as well as the emotional activation such a process provokes in clients with targeted interventions and strategies to facilitate such a process with cognitive restructuring.

According to Foa and Kozak (1986), clinical interventions centred in exposure aim to give the client the opportunity to get in contact with the triggers of emotions, resulting in the modification of the underlying memory structures. This translates into the modification of emotional responses in presence of the triggers, following the learning principles of conditioning. Emotional reprocessing may be fostered in the frame of internalized oppression and liberation through the externalization (Ryan, O'Dwyer & Leahy, 2015; David, 2014) and verbalization of the individual's experience of oppression, violence, its systemic issues; its consequences at the individual level, and related emotions. Hence, externalizing the core self-schemas, thoughts, and beliefs rooted in internalized oppression gives clients opportunity to get in contact with the emotions resulting from the self-defeating oppressive cognitions; and increase the potential of modification of the related underlying memory structures from the safe environment of the therapeutic relationship. This needs to be done with appropriate clinical interventions (Foa & Kozak, 1986) that take the self-blame and the shame away from the client (David, 2014).

### **Self-efficacy**

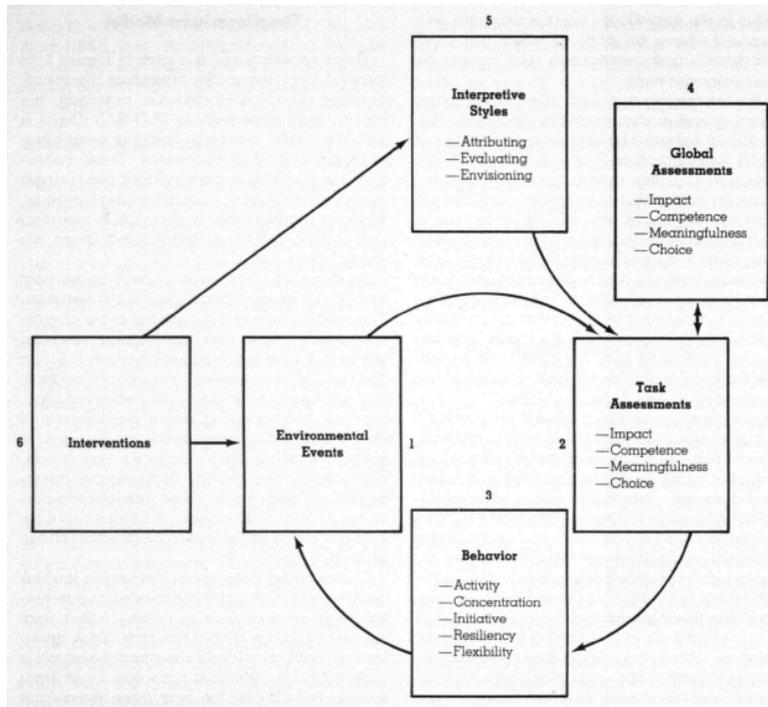
Albert Bandura (1977) developed an integrative theoretical framework to describe how psychological changes can be predicted and explained in different modes of treatment. According to Bandura, psychological procedures, in whatever their form, alter the level and strength of self-efficacy in clients. This means that clients feel that they have some degree of control on power over their environment or their responses to them. According to Bandura, performance-based procedures have proved to be most powerful for achieving psychological changes, and

“unsuccessful performance is replacing symbolically based experiences as the principle vehicle of change” (Bandura, 1997, p. 191). This consideration is important because it shows the impact of the concept of self-efficacy in the outcome of strategies used in the clinical practice, in terms of oppression and internalized oppression, where the intervention strategies (cognitive restructuring, emotional reprocessing) can be designed to help clients gain power on their lives using the principles of learning and conditioning, which play a fundamental role in cognitive-behavioural case formulation and conceptualization. The cognitive-behavioural treatment for people experiencing internalized oppression encourages clients to gain power and resources and actively pursue liberation engaging in behaviours and cognitive strategies that help them challenge oppression and cope with the systemic issues that affect them, which is congruent with the second guideline of culturally sensitive practices reviewed in the previous chapter (David, 2009; Okazaki & Tanaka-Matsumi, 2006).

### **Empowerment**

Consistently with Bandura’s self-efficacy theory, Thomas and Velthouse (1990) propose a cognitive model of empowerment that consists of increasing intrinsic task motivation, sense of impact, competence, meaningfulness, and choice as a motivating component of change. Consistent with the idea that clients who have internalized oppression can benefit from gaining back the power that they has been taken from them by oppression (David, 2009), applying this model of empowerment in treatment can be of help in designing interventions that are meaningful for the clients and have the potential of create new meaning from the externalizing process (David & Derthick, 2014). As represented in Figure 3, this cognitive model consists of a core cycle of environmental events, task assessments, and behaviour; and two intrapersonal related elements (4 and 5), and empowering interventions (element 6).

Figure 3: Thomas and Velthouse's (1990) cognitive model of empowerment.



Following Thomas and Velthouse's (1990) cognitive model, ways to influence the variables in the model to "increase an individual's task assessments (as well as producing gradual increases in global assessments)" (p. 671) can be identified, and this can be implemented by two general intervention strategies, which are: 1) changing the environmental events on which individuals base their task assessments; and 2) changing the individual's styles of interpreting those events. The guidelines identified in the previous chapters can help in identifying the environmental events operating (macro-level systemic oppression); functional analysis in assessing behavioural tasks performed (or to be performed); and cognitive restructuring in changing interpreting styles. Hence, following this model, the implementation of these strategies

would strengthen the interventions in the treatment, identifying behaviours that produce high levels of empowerment and sense of self-efficacy in clients.

### **Other relevant treatment strategies**

#### **Validation**

Marsha Linehan developed Dialectical-Behavioural Therapy (DBT), where, as its name suggests, is a treatment “firmly anchored in behaviour therapy; the change strategies at its centre are standard cognitive and behavioural treatment approaches” (p 354, Linehan, 1997). Linehan incorporated validation as an essential component of DBT practice as she observed that if the treatment was solely focus on client change (of motivation or by enhancing capabilities), it is usually experienced as invalidating by clients who are in intense emotional pain; and that a treatment focused on exploration and understanding, in the absence of clear focus on efforts to help the client change, is often experienced as invalidating as well, as it does not recognize the necessity for immediate change of the distressing experience.

According to Linehan (1997), validation occurs when the therapist communicates to the client that their responses “make sense and are understandable within her current life context or situation” (p. 356). Validation allows therapists to actively accept their clients and communicate acceptance, taking their responses seriously without discounting or trivializing them (Linehan, 1997). Hence, validation strategies could be very helpful to implement in treatments with clients struggling with internalized oppression, as it would allow clinicians to develop interventions (g.e. cognitive restructuring, emotional processing) that acknowledge oppression and its experiences (David, 2009), instead of questioning its validity; which, in turn, could help to focus on the

clients' resources, coping strategies and skills to cope with it (Craig et al., 2012). Implementation of validation requires the therapist to search for, recognize, and reflect to the client the validity inherent in their response to events (Linehan, 1997), being mindful that many of those responses are responses to oppression and internalized oppression, and in such a context of constant oppressive contingencies (Williams, 2012; David, 2009; Tappan, 2006; Arthur & Collins, 2010), make sense. Validation can be implemented in treatment dialogs and interactions, which can transform the treatment into an accepting, understanding, and supportive therapeutic environment and strengthen the vehicle of change (therapeutic relationship).

### **Consciousness & awareness facilitation**

Facilitating the awareness and consciousness on different dimensions of our clients' experiences, like internalized oppression, has the potential to promote freedom from its detrimental consequences. Bankart (1997) conceptualizes the notion of the consciousness of the self as "using all the powers of being (love and will, biology and intellect, solitude and passion) to experience the world and the self truly, free from distortion and repression" (p. 373). Hence, providing clients with possibilities to gain awareness and consciousness may be essential for a liberating practice and the building of freedom, resulting in an increase of their sense of self. This focus on awareness and consciousness is consistent with the guidelines identified through all the models reviewed on this work, and supports the idea that human beings benefit from freedom, liberty, and awareness.

### **Conclusions**

Culturally sensitive and tailored features and procedures can be used to adapt cognitive behavioural treatments to address internalized oppression. A comprehensive identity and cultural

assessment process with functional analysis may allow clinicians to design intervention strategies to address oppression, incorporating the principles of cognitive-behavioural therapy and based on liberation and anti-oppressive foundations. Cognitive restructuring, emotional processing, and behavioural interventions need to focus on clients' experiences of oppression, on useful thoughts, coping skills, and identification and incorporation of adaptive behaviours that work for the client—not for an oppressive system. This is facilitated by a strong, collaborative therapeutic relationship, characterized by empowerment and validation strategies that help clients have a liberating, anti-oppressive psychotherapeutic experience.

### **Overview of limitations and future research**

Tappan (2006) asserts that there are serious limitations to an overemphasis on the personal, individual, and psychological dimensions of both internalized oppression and domination, which go far beyond the individual psychological level. According to this author, “it is easy, particularly from a dominant point of view, to see the oppressed as “victims” and to see their reaction to oppression as reflecting a set of “psychological problems,” thereby obscuring the role that systemic, structural, and institutionalized forces play in the production and reproduction of oppression” (Tappan, 2016, p. 2117). Hence, even if cognitive-behavioural therapy may be beneficial for individuals suffering the consequences of internalized oppression, the change of systemic, structural and institutional levels are not addressed in detail in this paper. Perhaps, as an Evidence Based Practice (APA, 2006), more adapted Cognitive Behavioural research and practice can make oppression more visible; demonstrate its pervasiveness in human life, and the urgent need to address it in a systemic, structural level in society. Research on oppression and its internalization can increase the interest in the phenomenon of internalized oppression, catalyse its

acknowledgement and contribute in the development of public health policies that can have a wider impact on the systemic, structural, and institutionalized forces that produce and reproduce the oppression.

This paper is written in a Western socio-cultural context, and it is made to bring awareness to CBT practitioners in the Western world who may not have had much contact with the concepts of oppression, internalized oppression or social justice in their education or professional practice. Even if this document may be of help to non-Western practitioners, there may be assumptions that are not evident or explicit, either from lack of awareness or themes that are out of scope of the paper, and may not speak to the realities and experiences of CBT practitioners from non-Western socio-cultural backgrounds, where the dominant groups, values, and worldviews are different.

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