Cognitive-Behavioral Therapy and Social Work Values: A Critical Analysis

A. Antonio González-Prendes, Ph.D.
Wayne State University
aa3232@wayne.edu

Kimberly Brisebois
Wayne State University

Journal of Social Work Values and Ethics, Volume 9, Number 2 (2012)

Abstract

Increasing numbers of clinical social workers use cognitive-behavioral therapy (CBT) in their practice. This article analyzes how CBT fits with social work values and in particular with social justice. We propose that CBT is a good fit with the values of the profession and make suggestions for areas of improvement.

Keywords: cognitive-behavioral therapy, social work values, social justice, social work practice

1. Introduction

In a day when evidence-based practice has become so important to the social work profession, cognitive-behavioral therapy (CBT) has become one of the most frequently used forms of psychotherapeutic intervention. Extensive research supports the effectiveness of CBT approaches for a wide range of psychosocial issues (Dobson & Dobson, 2009; Granvold, 2011). It is one of the most widely researched and published models of therapy, with more than 325 published outcome studies that validate its efficacy (Butler, Chapman, Forman, & A. Beck, 2006). This empirical validation has made CBT a popular choice for social work practitioners seeking evidence-based treatments. For the purpose of this paper we use CBT as a generic term that encompasses theoretical and practice approaches that emphasize that a person's thinking is the prime determinant of emotional and behavioral responses to life events (A. Beck, 1976; Ellis, 1994; Meichenbaum, 1993). Although there may be subtle differences among the various CBT approaches, Dobson and Dobson (2009) identify three basic assumptions that underscore most CBT approaches: (1) cognitive processes and content are accessible and can be known; (2) our thoughts and beliefs mediate the way we process information and consequently affect our emotional and behavioral responses; and (3) maladaptive cognitions can be intentionally targeted and changed in a more rational and realistic direction, thus relieving symptoms and increasing functionality. In CBT individuals are seen not as passive entities simply reacting to environmental cues or past experiences, but rather as human beings with the potential to actively shape the course of their lives. CBT methods are particularly popular in the fields of substance abuse and mental health. "Cognitive-behavioral treatment models are among the most extensively evaluated interventions for alcohol and illicit drug use" (Magill & Ray, 2008, p. 256), and several studies have demonstrated the effectiveness of CBT methods with this population (Rose, 2004; Van Wormer & Davis, 2008). CBT is also

recognized as an effective short-term treatment suitable for individuals with various mental health concerns (Butler et al., 2006; Leishsenring & Leibing, 2003; Pilling et al., 2002).

According to the National Association of Social Workers (NASW, 2005), clinical social workers constitute the largest group of behavioral health providers in the United States. Along these lines, NASW (2006) points out that more than 60% of mental health treatment is delivered by social workers. Social work involvement in the fields of substance abuse and mental health is prevalent and expected to rise. According to projections in the Occupational Outlook Handbook, 2010–11 edition, the Bureau of Labor Statistics (BLS, 2010) indicates that employment for social workers is expected to grow by 16% between 2008 and 2018. The greatest increases are projected in areas associated with clinical social work: medical and public health (22%), and mental health and substance abuse (20%). According to BLS (2010), the total number of social workers practicing in these domains in 2008 was 206,700. Over time, the social work profession has shifted from a focus on psychoanalytic models of practice to more practical approaches (Ronen, 2007).

The past three decades have shown the distinct influence of CBT on social work theory and practice evident by the steady increase in the number of social workers who use CBT as their preferred model of practice (Granvold, 2011; Thyer & Meyers, 2011). A study by Strom (as cited in Thyer & Meyers) surveyed clinical social workers and found out that 67% used a CBT orientation and 32% used a behavioral orientation. In 2009, Bike, Norcross, and Schatz replicated an earlier study by Norcross and colleagues and found that while only 10% of social workers practiced from a cognitive-behavioral perspective in 1987, that percentage more than tripled by 2007. Similarly, in a review of 16 major systems of psychotherapy Prochaska and Norcross (2010) found that among social workers, clinical and counseling psychologists, and counselors, cognitive-behavioral orientations comprised the second-largest approach, just behind integrative models. When they examined the social work profession in particular, Prochaska and Norcross found that 30% of social workers in the United States practice from a behavioral or cognitive orientation. In another survey of licensed clinical social workers across 34 states, Pignotti and Thyer (2009) asked about interventions used in practice and found that 43% of respondents used cognitive-behavioral therapy, 18% indicated cognitive therapy/restructuring, and 12% used behavior modification. Other approaches included solution-focused therapy (23%) and psychodynamic therapy (21%). Furthermore, when Prochaska and Norcross polled a panel of experts to forecast the future of psychotherapy, the results indicated that cognitive therapies were projected to be the most popular—with the more generic approach "cognitive-behavioral therapy" ranked number one and Aaron Beck's cognitive therapy ranked number three. Since most cognitive therapists integrate behavioral experiments and interventions in their work with clients, the differences between cognitive-behavioral and cognitive therapy are most likely a matter of semantics and style rather than differences in core philosophies. What these studies indicate is the increasing use of CBT among social workers. Yet, at this point no one has really asked this question: How does CBT fit with the values of the social work profession and its mission of social justice?

"Social work is among the most value-based of all professions" (Reamer, 1995, p. 3) and for good reason. Social workers often hold considerable power in their work as they regularly work with the most vulnerable, powerless, and oppressed populations (Compton, Galaway, & Cournoyer, 2005). The NASW outlines strict regulations and ethical obligations that hold its members accountable for their actions. These standards encourage clients and the general public to trust and be confident in the integrity of the profession (Beckett & Maynard, 2005). A comprehensive code of ethical standards and guidelines provides an element of validation to the profession. Randall and Kindiak (2008) suggest that the "ultimate

evidence of an occupation achieving professional status is professional self-regulation..." (p. 346). When social workers do not abide by these ethical principles, that self-regulation is undermined. For this reason, the importance of ethical practice in social work is clearly essential. Values and ethics have been integral to the profession since its inception and are critical in shaping social work's fundamental aims and mission (Reamer, 1995). Ethical principles must be implicit in the practice of social work. As Sheafor and Horejsi (2006) suggest, "practice principles should reflect a combination of values and knowledge that underlay all practice activities" (p. 81).

Rooted in the preceding discussion, the purpose of this article is to analyze critically the compatibility of CBT and social work values. This analysis we believe is long overdue. In this article we specifically evaluate how CBT fits with social work values outlined in the NASW Code of Ethics (1996), such as valuing the importance of human relationships, respecting the dignity and worth of individuals, exhibiting competence in practice, and focusing on social justice. While our discussion focuses on the micro-practice approach of CBT, we will also address the role of CBT within the concept of the social environment and its fit with social justice.

2. Methodology

To explore available material that would allows us to evaluate the compatibility of CBT with social work values, we conducted an extensive review of the literature. For this purpose we conducted searches in the databases Social Work Abstracts (EBSCO), PsycINFO, PubMed, Proquest Library, Wilson Select, and Google Scholar. For the searches we used keywords: cognitive-behavioral therapy, cognitive therapy, rational-emotive behavior therapy, clinical social work, social work practice, social problems, social work values, social justice, worth of the person, importance of human relationships, and competence. In addition we also reviewed the literature on the effectiveness of CBT with various disorders as well as with various populations.

3. CBT and the Importance of Human Relationships

NASW (1996) suggests that an appreciation and respect for the value of the importance of human relationships compels social workers to engage their clients as partners in the helping process. From the early evolution of cognitive-behavioral therapy (A. Beck, 1976; Ellis, 1962, 1994), the nature of the therapeutic relationship has been defined as a collaborative endeavor between the client and the social worker, one that underscores not only the importance of that collaborative relationship but also the importance of the active role of the client in that process. This collaboration is defined by the client's right to self-determination and his or her ability to make choices relative to the treatment process (A. Beck, Shaw, Rush, & Emery, 1979; J. Beck, 1995). This collaboration is also underscored by a focus on clients' strengths and client empowerment. Both of these concepts, strength and empowerment, are cornerstones of social work practice (Ashford, Le Croy, & Lortie, 2006; Cormier, Nurius, and Osborn, 2009; Van Wormer & Davis, 2008; Zastrow and Kirst-Ashman, 2007). As Van Wormer and Davis assert, choice is a key aspect of a strength-based approach, and the justice-conscious social worker must ensure that clients are actively involved in making choices relative to the goals, contexts, and methods of treatment. In CBT the strength and empowerment perspective is embodied in the concept of "collaborative empiricism" (J. Beck, 1995), whereby clients and social workers work in tandem to uncover evidence that will help clients to assess the validity and functionality of maladaptive cognitions and to develop healthier and more rational, realistic perspectives of self, the world, and others.

According to Bordin (1994), "a therapeutic alliance grows out of the experience of association in a shared activity" (p. 16). In CBT the collaboration between the client and social worker reinforces the importance of human relationships and is continually reinforced in all phases of treatment. Therefore in CBT, clients decide what problems to address and what goals to pursue. Furthermore

in CBT, this client-centered focus is deemed to be essential for therapy to be successful (Gilbert & Leahy, 2007; Hardy, Cahill, & Barkham, 2007). Clients' choices and contributions extend to the formulation of the therapeutic agenda for each individual session (see J. Beck, 1995) as well as the formulation of homework assignments and behavioral experiments that allow clients to test out new behaviors and hypotheses in their natural environments.

In the CBT model clients are seen as possessing the abilities and strengths to become active agents in their own change process. According to J. Beck, a key principle of CBT is to empower clients to "become their own therapist" (p. 7) and thus learn to problem-solve independent of the therapist. CBT is an empowering approach (Dobson & Dobson, 2009; Hays, 1995). Client empowerment in CBT takes place in various forms, from socializing the client to the cognitive-behavioral model; to sharing information about the nature of the problem that afflicts the client; to providing a detailed rationale behind proposed interventions. Having that knowledge allows clients to make choices about the context and course of treatment. Empowerment is rooted in the idea of helping clients acquire knowledge and skills to increase their sense of self-efficacy and power, both personal and interpersonal, in order to take action that will improve the conditions of their lives (Cormier et al., 2009; Gutierrez, 2001). In CBT, client empowerment is also underscored by these points: (1) Recognition of the expertise that clients have about themselves is important. Although the social worker may have expertise about cognitive-behavioral methods and other change strategies, clients are the ultimate experts on themselves, and as such their input and participation are actively sought out. (2) The notion that clients can change their thoughts and beliefs and in doing so can engender healthier emotional and behavioral responses to life situations has value. Clients are not deemed to be merely reacting to environmental cues or as slaves to their past. Rather, they are seen as having the strengths and abilities to rewrite the script of maladaptive or irrational messages into more realistic, rational, and balanced perspectives. (3) The focus placed on helping clients develop cognitive and behavioral skills allows clients eventually to apply those skills to various life events independent of the social worker.

Traditionally, a criticism of CBT approaches has been that CBT practitioners tend to focus more on the practical and technical interventions of therapy and not on the therapeutic relationship. Although it is true that in CBT models the primary means of emotional and behavioral change is the change in cognition, this does not imply a lack of appreciation for the value of the therapeutic relationship. In the more recent past there has been a more concerted effort to illuminate the value and importance of positive client/therapist relationship in CBT (J. Beck, 1995; Leahy, 2006). True to the premise that practice should be grounded in research, CBT recognizes the numerous studies that have underscored the importance of empathy and a caring therapeutic relationship in successful therapy (e.g., Berg, Raminani, Greer, Harwood, & Safren, 2008; Green & Christensen, 2006). Studies on CBT demonstrate that therapists practicing from this perspective work to maintain good relationships with their clients (Llewelyn & Hume, 1979; Murphy, Cramer, & Lillie, 1984) and that they provide encouragement, reassurance, praise, and empathy (Brunick & Schroeder, 1979). According to Keijsers, Schaap, & Hoogduin (2000), "The therapeutic relationship in CBT is characterized by an active, directive stance by the therapist, high levels of emotional support, high levels of empathy and unconditional positive regard" (p. 268). The emotional experiences that result from this relationship can be integral to client progress and lead to changes in cognition and client insight (Hardy et al., 2007).

4. CBT and Dignity and Worth of the Person

Respect for the inherent dignity and worth of the person implies that social workers treat individuals with care and value, and that they promote

socially responsible client self-determination (NASW, 1996). Similarly, respect for the worth of the person is a primary tenet of CBT. CBT therapists accept their clients regardless of their faults or failings and see value in the person no matter what the feeling, behavior, or condition (Ellis, 2005). In Rational-Emotive Behavior Therapy (REBT), a CBT model, "...therapists fully accept their clients no matter how poor their behavior and they practice and teach tolerance and unconditional positive regard" (Ellis, 1979, p. 3). CBT avoids labeling people or making value judgments on individuals; instead it values open-mindedness and does not view people as "good" or "bad" (Ellis, Gordon, Neenan, & Palmer, 1997). In fact, judgmental attitudes and stereotypical labels that frame self or others in absolute and general derogatory terms are seen as maladaptive and irrational. J. Beck (1995) points out that in cognitive therapy such pejorative labels, placed on the self or others, are considered as cognitive distortions or errors in thinking that need to be corrected. Instead, cognitive therapists are encouraged to focus on and judge behaviors for their adaptability and functionality, or lack thereof, while working to accept their clients fully and unconditionally and to convey such acceptance openly. A behavior may be judged according to how it affects the individual's quest to attain his or her life's goals. However, "bad" behaviors do not define an individual as a "bad person" any more than "good" behaviors define individuals as "good persons." CBT therapists actively teach their clients to accept themselves fully and unconditionally, regardless of their failings, mistakes, or fallibilities and independent of the approval or respect that they may or may not get from others (Dryden, 1990). CBT views the estimation of self-worth as exceptionally important in repairing client functioning (Ellis, 2005) and thus stresses the need for client self-acceptance and the therapist's strong persistence in reinforcing it (Ellis, 1985).

Additionally, the problem-solving approach of CBT emphasizes client self-determination (i.e., the client chooses what problems to address and what goals to pursue) and self-efficacy by facilitating a process that is based on client perspective of those issues that are most critical to healthy functioning (Pantalone, Iwamasa, & Martell, 2010). Even though the CBT-practicing social worker may possess the knowledge and skills of therapeutic strategies that facilitate change in the client, therapy is client-centered. The goal is to pass on to the client the knowledge and skills (i.e., cognitive and behavioral) that clients will ultimately use to face and resolve life's challenges. Given that the fundamental philosophy of CBT (A. Beck, 1976; Ellis, 1962, 1994) embraces the belief that clients have the strengths and ability to change how they feel or act by changing how they think, and that the client has an active role in determining the course of treatment, we suggest that this approach is congruent with social work's notion of self-determination. Therefore, by respecting and appreciating the inherent worth of the human being, by promoting an attitude of unconditional acceptance of self and others, and by encouraging the development of client self-determination in every step of the therapeutic relationship, CBT and social work go well together in this respect.

5. CBT and Competence

Competence in social work practice implies that social workers practice within their areas of knowledge and expertise and that they strive to increase their skills and understanding while contributing to the knowledge base of the profession (NASW, 1996). We suggest that competent practice should be based on two factors: (1) the use of evidence-supported interventions to address clients' problems, and (2) the effective and efficient use of time, not only to fit with today's demands of the managed care system but also to help reduce the cost of treatment for those who can least afford it. This becomes more important for social workers, who are the most likely practitioners to deliver mental health services to the poor and other underprivileged individuals. CBT by nature is a brief and time-limited approach that promotes research for the identification of evidence-based practices.

No discussion of CBT is complete without recognizing the vast number of empirical studies that support its effectiveness across a broad range of personal, interpersonal, and social problems (Butler et al., 2005; Dobson & Dobson, 2009; Granvold, 2011). With the growing demand for social workers to rely on the use of evidence-based and time-efficient interventions, CBT offers a value-laden approach, rich in research evidence and empirical validation. Strom-Gottfried (2008) suggests that "competence refers to the belief that social workers must be equipped with the knowledge, skills and values needed for practice" (p. 24). Evidence-based practice must rely on results of critically appraised research and determines if interventions do more good than harm, and that "emphasizes the ethical obligations of professionals in making decisions" (Gambrill, 2007, p. 74) by involving clients in the decision-making and ensuring that they are informed throughout the helping process.

CBT approaches promote professional competence through the pursuit of evidence-based models of treatment and ongoing research to validate its use with various disorders and populations. Treatment formats have been developed to include individual, group, couples, and family practice (Dobson & Dobson, 2009; Granvold, 2011). Despite the abundance of research supporting the use of CBT across various problems and populations, some criticism exists. Some have suggested that the need still exists to promote further research and evidence with at-risk populations and particularly with racial and ethnic minorities (Bryant & Harder; Granvold, 2011), while others have found mixed results regarding the efficacy of some methods (Carroll & Onken, 2005). Unfortunately, CBT's popularity and common sense approach may lead some, who do not possess knowledge, training or expertise in CBT, to falsely believe that they can effectively engage in the practice of CBT. Therefore when assessing the empirical literature on CBT, social workers must be cognizant of the fact that the way such methods are implemented may be the key to individual success and that the level of professional knowledge and training and expertise with CBT techniques could influence therapeutic efficacy. On the other hand, the popularity of CBT has given rise to the dissemination of treatment procedures through workshops and courses that provide social workers with opportunities to raise their level of competence as CBT practitioners, as well as giving them access to treatment guidelines and manuals (Shafron et al., 2009). In order to disseminate information and promote competence, organizations such as the Beck Institute in Philadelphia and the Albert Ellis Institute in New York City provide training and certification. Training is aimed at individuals at various levels of CBT expertise and development who wish to acquire or enhance their knowledge and skills, and, if desired, pursue certification. The end result is to increase the level of competence among CBT practitioners. Through its focus on promoting research, developing evidence-based practices, and providing opportunities for continuing education and development, CBT provides social workers with the opportunities to develop their level of competence as social work practitioners.

6. CBT and Social Justice

In a series of seminal articles describing the relationship between social justice and social work, Wakefield (1988a, 1988b) suggests that "justice," and specifically what he refers to as "minimal distributive justice," is the organizing value and defining function of social work. NASW (1996) suggests that social justice implies that social workers should ensure that clients have access to needed information, resources, and services, as well as equality of opportunities and participation in decision making. Although social justice has traditionally been linked with macro-level practice such as policy making and social reform, and issues such as poverty, discrimination and economic deprivation, Wakefield (1988a) argues that economic goods are not the only goods associated with social justice and that clinical social work is a natural part of a justice-oriented profession. Wakefield (1998a) suggests that "minimal distributive

justice" in social work ensures not only that individuals receive at least a minimal level of socially produced goods to allow for effective rational action but also that "anyone falling below the social minimum in any of the social primary goods is brought above that level in as many respects as possible" (p. 295). Following Wakefield's argument, one would ask what might be the socially produced good that clinical social workers help their clients to obtain. And, more specifically, for the purpose of our discussion, we would ask how the practice of cognitive-behavioral therapy might be compatible with the notion of social justice and how it might facilitate access to such socially produced goods.

For this part of the discussion we refer to Rawls (1999), who defines social primary goods as goods that a rational person may want to pursue in order to improve the quality of his or her life. Rawls identifies such primary goods as liberty, opportunity, income, wealth, and self-respect. Building on Rawls' ideas, Wakefield (1988b) argues that a major purpose of clinical social work is to aim at psychological justice, and that a key function of psychological justice is the establishment of self-respect, a social primary good, essential for pursuing a rational course of action, a good that is acquired out of one's interaction with one's social environment. Therefore, clinical interventions aimed at promoting self-respect and other psychological goods would be congruent with a social justice perspective (Swenson, 1998; Wakefield, 1988a, 1988b). Consequently, the pursuit of "distributive justice" can occur at either the macro level of practice, through seeking and advocating for policy and social reform, or at the micro level, through direct clinical social work practice. When it comes to the pursuit of justice, the NASW Code of Ethics does not differentiate between macro- and micro-practice. Furthermore, it seems logical, as Salas, Sen, and Segal (2010) suggest, that "social work is most effective when the false dichotomy between working with individuals and working towards social change is reconciled and when social justice is addressed at all levels of practice" (p. 95). But how specifically, we might ask, can social workers ascertain that their micro-level practice—and more specifically, clinical social work practice from a CBT perspective—meets the social justice mission of social work? To answer this we look at Swenson's (1988) discussion of the contributions of clinical social work to a social justice perspective. Swenson identifies various factors of clinical social work that promote social justice, factors that include having a focus on client strengths and empowerment, developing an appreciation for resources and context that define the client's social reality, planning and advocating for services, and addressing social action to change social institutions so that social justice becomes available to all. Other authors have suggested that social justice at the micro level is served when such practice addresses issues of power, privilege, and oppression (Jacobson, 2009; Parker, 2003). We argue that CBT—grounded in a nonjudgmental, strength-based, and empowering philosophy, and placing its focus on promoting unconditional acceptance and respect of self and others—is a good fit with the social justice mission of social work. Furthermore, we propose that CBT promotes equality within the therapeutic relationship, aims to understand the context that has shaped the client's reality, and promotes a healthy level of social interest where it is rational to want to protect the rights of others and address unfair and unjust treatment (e.g., oppression, discrimination) that diminishes the quality of one's social environment. A discussion of the focus of CBT on clients' strengths and clients' empowerment has been made elsewhere in this article.

How does CBT demonstrate an appreciation for the contexts that define clients' realities? For this we look at the CBT concept of "core beliefs" or "schemas." These entail the most central, fundamental, and absolute views that an individual has about the self, about the world-at-large, and about other people (Dobson & Dobson, 2009; Granvold, 2011; J. Beck, 1995). Core beliefs can be conceptualized as forming a "filter" through which a person looks at life, affecting the way new

information is processed and assimilated, how reality is interpreted, and how one defines his or her self and world views. According to J. Beck, core beliefs begin to develop in childhood out of the early context of the child's life. In other words, out of the early experiences with significant others (e.g., parents, caretakers, teachers) and the social environment at large, the child begins to formulate and internalize fundamental views about the self, others, and the world. In this manner individuals who from an early age have been subjected to systematic abuse, emotional and physical neglect, degradation, etc., may be at risk of internalizing negative core beliefs about the self (e.g., "I am not good enough"; "I am unlovable"; "I am defective"), about the world (e.g., "The world is a dangerous place"), and about others (e.g., "Others are cruel"; "People cannot be trusted"). The existence of such beliefs increases the chances that the person will face difficulties in adaptation that interfere with his or her capacity to pursue a rational course of action, to function effectively within the social environment, and to establish healthy relationships. Since core beliefs develop out of the early interactions of the individual with his or her social environment, CBT aims to understand not only the content of the beliefs but also the social context that contributed to the formation of such beliefs. CBT encourages practitioners to understand the full impact of those experiences on the client's thinking.

Responding to past criticism that CBT ignores the contributions of environmental factors to clients' problems, Dobson and Dobson (2009) argue that by definition CBT promotes a collaborative relationship with clients that allows for the identification and exploration of socio-economic factors such as poverty, violence, and various forms of discrimination. Furthermore, social workers working from a CBT perspective recognize the impact of internalized biases, stigmas, and other oppressive messages associated with societal attitudes such as racism, homophobia, heterosexism, and the stigma that society attaches to issues of mental illness and substance abuse. Equally important is to recognize how these oppressive messages, often formulated in the form of internalized self-deprecatory statements, underscore problems such as depression, anxiety, and internalized homophobia, among others (Balsam, Martell, & Safren, 2006).

Rawls (as cited in Wakefield, 1988b) suggests that supportive interaction is the preeminent factor in the formation of self-respect. We agree with Rawls' notion that a supportive, loving, nurturing, and healthy social environment, particularly during childhood, contributes to the development of a healthy sense of self-respect. Unfortunately, not all individuals are privileged to have a supportive and healthy environment. Instead, some individuals early on in life receive pervasive negative messages, implicitly or explicitly, from family, caretakers, and society—messages that devalue their respect and worth as human beings. For example, some individuals may devalue their worth and respect because they struggle with a particular disorder (e.g., alcohol and/or drug use disorders, depression, schizophrenia, etc.). In such cases, individuals could have internalized societal biases and pejorative labels attached to terms such as "addict" or "mental illness." A function of CBT is to help the individual restore a healthy level of self-respect by promoting unconditional self-acceptance regardless of the condition afflicting the person, while at the same time helping the person acknowledge and accept both his or her strengths and the deficits (A. Beck, 1976; A. Beck et al., 1979; Ellis, McInerney, DiGiuseppe, & Yeager, 1988; Ellis, 1998). CBT, for example, may help the individual reframe oppressive messages (e.g., "I have schizophrenia; therefore I am defective") into more rational, realistic, and balanced self-views (e.g., "Even though I have schizophrenia, it does not diminish my worth as a human being"). Therefore, we suggest that for social workers practicing from a CBT perspective, in order to have a full appreciation of the client's reality and beliefs about the self, the world, and others, they must consider both the specific content of such beliefs and the contexts that might have influenced the development of those beliefs.

7. CBT and the Social Environment

Even though CBT is a micro-theory of clinical practice, we have argued that an appreciation of the context of the individual's social environment is essential to gain a full appreciation of factors that influenced the formation of a person's core beliefs and schemas. Nonetheless, the focus of CBT is to help individuals regain a healthy level of functioning by helping them to engender cognitive and behavioral changes that lead to more rational action as well as to higher levels of self-acceptance and respect of self and others. While the cognitive aspect of CBT focuses on the development of more rational and balanced views of the self, the world, and others, the behavioral aspect addresses social and behavioral skills deficits in order to enhance the individual's effective pursuit of his or her life goals. With this in mind, an objective of CBT is to help individuals develop a healthy sense of self-interest. That is, individuals are helped to identify and pursue their own life goals and ambitions, attend to their physical and emotional well-being, and assume a greater sense of responsibility for the direction of their lives (Ellis & Dryden, 1997; DiGiuseppe, 2010). However when discussing self-interest, it is important to underscore the distinction between a healthy sense of self-interest, as described above, and selfishness. The latter is defined as being "concerned chiefly or only with oneself, without regard to the well-being of others" (Morris, 1980, p. 1171). At the heart of a healthy sense of self-interest is social interest. Ellis and Dryden (1997) and DiGiuseppe (2010) suggest that because most people choose to live within social groups and communities, it is rational and self-helping to act morally toward other members of the community and protect their rights, demonstrating concern for the well-being of the larger society and working to ensure the survival of one's community. This is a rational course of action. Social workers who help their clients engender a healthy sense of self-respect and self-acceptance are also helping those same clients develop a healthy sense of self-interest. Those individuals who develop a healthy appreciation and respect of themselves will be more likely to attend not only to their own needs and desires but also to the needs and well-being of the community and society in which they live. Therefore, as Wakefield suggests (1988b), self-respect is a necessary attribute for the pursuit of a rational course of action that eventually leads one to address the unfair and unjust treatment that undermines and diminishes the quality of life in one's community and society.

8. Conclusion

We have argued that CBT, as a theory of clinical practice, is congruent with social work values and the social justice perspective. CBT does this by promoting self-respect through the development of unconditional self-acceptance; adopting a strength perspective that recognizes clients' abilities to change and the expertise that they have about themselves; promoting a collaborative therapeutic relationship that respects and seeks out clients' input and participation in every step of the process; empowering clients to become active agents in the resolution of their problems; and acknowledging the impact of one's social context on core beliefs and schemas, as well as the oppressive nature of internalized biases and stigmas. Although the overall practice of CBT focuses on interpersonal or micro-level practice, it recognizes that part of a rational person's sense of self-respect and self-interest is a healthy sense of social interest. This sense of social interest compels the individual to protect the rights of others and to work toward the well-being of one's community. A number of authors have argued that the social justice mission of social work can be carried out at the micro or clinical level of practice (Jacobson, 2009; Parker; 2003; Salas et al., 2010; Swenson, 1998; Wakefield, 1988a, 1988b). Here we have argued that CBT, a micro-level theory of practice, with its focus of helping individuals engender self-acceptance and self-respect, is a good fit with social work values and with the Rawlsian view of justice as postulated by Wakefield (1988a, 1988b).

Nonetheless there are areas of improvement where social workers can play a key role. The

NASW Code of Ethics (1996) advises that social workers must be mindful of cultural and ethnic differences when working with their clients. Furthermore, Sheppard (2002), in a discussion on mental health and social justice, emphasizes the need to appreciate and not take for granted cultural differences when diagnosing and treating mental illness. Not attending to or taking for granted cultural differences in beliefs and behaviors could lead social work practitioners to erroneously pathologize behaviors that do not conform to the dominant culture. An area of attention in the field of CBT is the need for more inclusion of cultural diversity in intervention research. Hays (2006) argued that research on CBT has been primarily of a Eurocentric nature and that therefore there is a need to generate more research with cultural minorities, particularly at a time when the population of the United States is becoming more racially, ethnically, and culturally diverse. Although the criticism of the lack of cultural diversity in intervention research is valid, it would be unfair to single out CBT for such criticism. More than 10 years ago the Surgeon General of the United States in his report on mental health and culture (United States Department of Health and Human Services, USDHHS, 2001) challenged the mental health community and researchers to generate more intervention research exclusively targeting minorities. Pantalone et al. (2010) suggests that the field of CBT has increasingly recognized the need to generate competent cross-cultural approaches to work with diverse populations, but more needs to be done.

We suggest that since social workers constitute not only the largest group of mental health providers in the United States but also, quite likely, the largest group of providers of mental health services to minorities that are underrepresented in intervention research, we are uniquely positioned to promote and conduct clinical intervention research with these populations. This would allow for the development of more effective culture-sensitive treatment interventions and further strengthen the fit of CBT with social work values and the profession's mission of social justice.

References

Ashford, J. B., Le Croy, C. W., & Lortie, K. L. (2006). *Human behavior in the social environment: A multidimensional perspective* (3rd ed.). Belmont, CA: Thompson/Brooks-Cole.

Balsam, K. F., Martell, C. R., & Safren, S. A. (2006). Affirmative cognitive-behavior therapy with lesbian, gay, and bisexual people. In P. A. Hays & G. Y. Iwamasa (Eds.). *Culturally responsive cognitive-behavioral therapy: Assessment, supervision, and practice* (pp. 223–244). Washington, DC: American Psychological Association.

Beck, A. T. (1976). *Cognitive therapy of the emotional disorders*. New York: Penguin Books.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford.

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford.

Beckett, C., & Maynard, A. (2005). *Values & ethics in social work: An introduction*. London: Sage Publications.

Berg, D., Raminani, S., Greer, J., Harwood, M., & Safren, S. (2008). Participants' perspectives on cognitive-behavioral therapy for adherence and depression in HIV. *Psychotherapy Research, 18*, 271–280.

Bike, D. H., Norcross, J. C., & Schatz, D. M. (2009). Processes and outcomes of psychotherapists' personal therapy: Replication and extension 20 years later. *American Psychological Association*, *46*(1), 19–31. doi: 10.1037/a0015139.

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (Eds.). *The working alliance: Theory, research, and practice* (pp. 13–37). New York: John Wiley & Sons.

Brunick, S. A., & Schroeder, H. E. (1979). Verbal therapeutic behavior of expert psychoanalytically oriented, gestalt, and behavior therapists. *Journal of consulting and clinical psychology*, *47*, 567–574.

Bryant, C. E., & Harder, J. (2008). Treating

suicidality in African American adolescents with cognitive-behavioral therapy. *Child & Adolescent Social Work Journal*, *25*, 1–9. doi: 10.1007/s.

Bureau of Labor Statistics, *U.S. Department of Labor, Occupational Outlook Handbook, 2010–11 Edition*, *Social Workers,* on the Internet at http://www.bls.gov/oco/ocos060.htm (visited February 22, 2011).

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, *26*, 17–31. doi: 10.1016/j.cpr.2005.07.003.

Carroll, K. M., & Onken, L. S. (2005). Behavioral therapies for drug abuse. *American Journal of Psychiatry, 168*, 1452–1460.

Cormier, S., Nurius, P., & Osborn, C. J. (2008). *Interviewing and change strategies for helpers: Fundamental skills and cognitive-behavioral interventions (*6th ed*.)*. Pacific Grove, CA: Brooks/Cole.

Compton, B. R., Galaway, B., & Cournoyer, B. R. (2005). *Social work processes* (7th ed.). Belmont, CA: Brooks/Cole-Thomson Learning.

DiGiuseppe, R. A. (2010). Rational-emotive behavior therapy. In N. Kazantzis, M. A. Reinecke, & A. Freeman (Eds.). *Cognitive and behavioral theories in clinical practice* (pp. 115–147). Washington, DC: American Psychological Association.

Dobson, D., & Dobson, K. S. (2009). *Evidenced-based practice of cognitive-behavioral therapy*. New York: Guilford.

Dryden, W. (1990). *The essential Albert Ellis: Seminal writings on psychotherapy*. New York: Springer Publishing Company.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. New York: Citadel Press.

Ellis, A. (1979). Rational-emotive therapy. In A. Ellis & J. M. Whitley (Eds.), *Theoretical and empirical foundations of rational-emotive-therapy* (pp. 1–60). Monterey, CA: Brooks/Cole Publishing Company.

Ellis A. (1985). *Overcoming resistance: Rational-emotive therapy with difficult clients*. New York: Springer Publishing Company.

Ellis, A. (1994). *Reason and emotion in psychotherapy: A comprehensive method of treating human disturbances: Revised and updated*. New York: Citadel Press.

Ellis, A. (1998). *How to control your anxiety before it controls you*. Secaucus, NJ: Birch Lane Press.

Ellis, A. (2005). *The myth of self-esteem: How rational-emotive behavior therapy can change your life forever*. Amherst, NY: Prometheus Books.

Ellis, A., McInerney, J. F., DiGiuseppe, R., & Yeager, R. J. (1988). *Rational-emotive therapy with alcoholics and substance abusers*. Needham, MA: Allyn & Bacon.

Ellis, A., & Dryden W. (1997). *The practice of rational emotive behavior therapy* (2nd ed.). New York: Springer.

Ellis, A., Gordon, J., Neenan, M., & Palmer, S. (1997). *Stress counselling: A rational emotive behavior approach*. New York: Springer Publishing Company.

Gambrill, E. (2007). Critical thinking, evidence-based practice, and cognitive behavior therapy. In T. Ronen & A. Freeman (Eds.), *Cognitive behavior therapy in clinical social work practice* (pp. 67–87). New York: Springer Publishing Company.

Gilbert, P., & Leahy, R. L. (2007). Introduction and overview: Basic issues in the therapeutic relationship. In P. Gilbert and R. L. Leahy (Eds.). *The therapeutic relationship in the cognitive-behavioral psychotherapies* (pp. 3–23). New York: Routledge.

Granvold, D. K. (2011). Cognitive-behavioral therapy with adults. In J. R. Brandell (Ed.). *Theory and practice in clinical social work* (2nd ed., pp. 179–212). Thousand Oaks, CA: SAGE Publications.

Green, E. J., & Christensen, T. M. (2006). Elementary school children's perceptions of play therapy in school settings. *International journal of play therapy*, *15*(1), 65–85.

Gutierrez, L. M. (2001). Working with women of color: An empowerment perspective. In

J. Rothman, J. L. Erlich, & J. E. Tropman (Eds.), *Strategies of community intervention* (6th ed., pp. 209–217). Itasca, IL: Peacock.

Hardy, G., Cahill, J., & Barkham, M. (2007). Active ingredients of the therapeutic relationship that promote client change: A research perspective. In P. Gilbert and R. L. Leahy (Eds.). *The therapeutic relationship in the cognitive-behavioral psychotherapies* (pp. 24–42). New York: Routledge.

Hays, P. A. (1995). Multicultural applications of cognitive-behavior therapy. *Professional Psychology: Research and Practice, 26*, 309–315.

Hays, P. A. (2006). Introduction: Developing culturally responsive cognitive-behavioral therapies. In P. A. Hays & G. Y. Iwamasa (Eds.). *Culturally responsive cognitive-behavioral therapy: Assessment, supervision, and practice* (pp. 3–19). Washington, DC: American Psychological Association.

Jacobson, M. (2009). The faculty meeting: Practicing justice-oriented group work. *Social Work with Groups, 32*, 177–192.

Keijsers, G. P., Schaap, C. D., & Hoogduin, C. A. (2000). The impact of interpersonal patient and therapist behavior on outcome in cognitive-behavioral therapy: A review of empirical studies. *Behavior Modification, 24*, 264–297.

Leishsenring, F., & Leibing, E. (2003, July). The effectiveness of psychodynamic therapy and cognitive behavioral therapy in the treatment of personality disorders: A meta-analysis. *American Journal of Psychiatry*, *160*, 1223-1232.

Llewelyn, S. P., & Hume, W. I. (1979). The patient's view of therapy. *British Journal of Medical Psychology*, *52*, 29–35.

Magill M., & Ray, L. (2009). Cognitive-behavioral treatment with adult alcohol and illicit drug users: A meta-analysis of randomized controlled trials. *Journal of Studies on Alcohol and Drugs, 70*, 516–527.

Meichenbaum, D. H. (1993). Stress inoculation training: A 20-year update. In P. M. Lehrer & R. L. Woolfolk (Eds.), *Principles and practice of stress management* (2nd ed., pp. 373–406). New York: Guilford Press.

Morris, W., et al. (1980). *The American heritage dictionary of the English language*. Boston, MA: Houghton Mifflin.

Murphy, P. M., Cramer, D., & Lillie, F. J. (1984). The relationship between curative factors perceived by patients in their psychotherapy and treatment outcome: An exploratory study. *British Journal of Medical Psychology*, *57*, 187–192.

National Association of Social Workers. (1996). *Code of ethics*. Retrieved from http:// www.naswdc.org/ pubs/code/code.asp.

National Association of Social Workers. (2005). *NASW standards for clinical social work in social work practice*. Washington, DC: NASW.

National Association of Social Workers. (2006). *Life's journey: Help starts here*. Retrieved from http://www.socialworkers.org/pressroom/swm2006/swmToolKit2006.pdf.

Pantalone, D. W., Iwamasa, G. Y., & Martell, C. R. (2010). Cognitive-behavioral therapy with diverse populations. In K. Dobson (Ed.). *Handbook of cognitive-behavioral therapies* (pp. 445–462). New York: Guilford Press.

Parker, L. (2003). A social justice model for clinical social work practice. *Affilia, 18*, 272–288.

Pignotti, M., & Thyer, B. A. (2009). Use of novel unsupported and empirically supported therapies by licensed clinical social workers: An exploratory study. *Social Work Research, 33*, 5–17.

Pilling, S., Bebbington, P., Ruipers, E., Garety, P., Geddes, J., Orbach, G., & Morgon, C. (2002). Psychological treatments in schizophrenia: Meta-analyses of family intervention and cognitive behavioral therapy. *Psychological Medicine*, *32*, 763-782.

Prochaska, J. O., & Norcross, J. C. (2010). *Systems of psychotherapy* (7th ed.). Belmont, CA: Cengage.

Randall, G. E., & Kindiak, D. H. (2008). Deprofessionalization or postprofessionalization? Reflections on the state of social work as a profession. *Social Work in Health Care*, *47*(4), 341–354.

Rawls, J. (1999). *A theory of justice*. Cambridge, MA: Harvard University Press.

Reamer, F. G. (1995). *Social work values & ethics*. New York: Columbia University Press.

Ronen, T. (2007). Clinical social work and its commonalities with cognitive behavior therapy. In T. Ronen & A. Freeman (Eds.), *Cognitive behavior therapy in clinical social work practice* (pp. 3–24). New York: Springer Publishing Company.

Rose. S. (2004). Cognitive-behavioral group work. In C. Garvin, L. Gutierrez, & M. Galinsky (Eds.). *Handbook of social work with groups* (pp. 111–135). New York: Guilford Press.

Salas, L. M., Sen, S., & Segal, E. A. (2010). Critical theory: A pathway from dichotomous to integrated social work practice. Families in society: *The Journal of Contemporary Social Services, 91*, 91–96.

Shafron, R., Clark, D. M., Fairburn, C. G., Arntz, A., Barlow, D. H., Ehlers, A. ... Wilson, G. T. (2009). Mind the gap: Improving the dissemination of CBT. *Behavior Research and Therapy*, *47*, 902–909. doi: 10.1016/j.brat.2009.07.003

Sheafor, B. W., & Horejsi, C. R. (2006). *Techniques and guidelines for social work practice* (7th ed.). Boston: Pearson Education Inc.

Sheppard, M. (2002). Mental health and social justice: Gender, race and psychological consequences of unfairness. *British Journal of Social Work, 32*, 779–797.

Strom-Gottfried, K. (2008). *The ethics of practice with minors: High stakes, hard choices*. Chicago: Lyceum Books Inc.

Swenson, C. R. (1998). Clinical social work contribution to a social justice perspective. *Social Work, 43*, 527–537.

Thyer, B. A., & Myers, L. (2011). Behavioral and cognitive therapies. In J. R. Brandell (Ed.). *Theory and practice in clinical social work* (2nd ed., pp. 21–40). Thousand Oaks, CA: SAGE Publications.

U. S. Department of Health and Human Services (2001). *Mental health: Culture, race, and ethnicity, a supplement to Mental Health: A report of the Surgeon General.* Rockville, MD: Author

Van Wormer, K., & Davis, D. R. (2008). *Addiction treatment: A strength perspective* (2nd ed.). Belmont, CA: Thompson/Brooks-Cole.

Wakefield, J. C. (1988a). Psychotherapy, distributive justice and social work: Part 1: Distributive justice as a conceptual framework for social work. *The Social Services Review, 62*, 187–210.

Wakefield, J. C. (1988b). Psychotherapy, distributive justice and social work: Part 2: Psychotherapy and the pursuit of justice. *The Social Services Review, 62*, 353–382.

Zastrow, C., & Kirst-Ashman, K. K. (2007). *Understanding human behavior and the social environment* (7th ed.). Belmont, CA: Thompson/Brooks-Cole.