The Transportability and Utility of Cognitive Therapy in South African Contexts: A Review

Charles Young
Rhodes University, South Africa

Address correspondence to Dr. Charles Young, Department of Psychology, Rhodes University, PO Box 94, Grahamstown 6140. E-mail: c.young@ru.ac.za.

Cognitive therapy could be more widely promoted in South Africa given the great disparity between the need and provision of psychological therapies. Three possible objections to the promotion of cognitive therapy are considered: uncertainty surrounding the effectiveness of cognitive therapy in South African contexts; uncertainty surrounding the applicability in multicultural contexts; and suggestions that cognitive therapy is decontextualised and therefore objectionable in a country facing major social challenges. A systematic review of the literature identified 15 outcome studies, and suggests that cognitive therapy is a viable and much-needed approach in South Africa.

Keywords: cognitive therapy; effectiveness; outcome research; South Africa; transportability

Introduction

It is surprising that cognitive therapy is not more widely promoted in South Africa given the role that South African psychologists played in the development of behaviour therapy, the forerunner to modern cognitive therapy, and that the provision of psychological therapies remains as inaccessible as it was during apartheid when the majority were denied quality health care.

An effective and accessible psychological therapy might have much to offer this developing country. This article is presents a systematic review of the relevant outcome studies on cognitive therapy, and considers its applicability and utility in South African socio-cultural contexts. Cognitive therapy refers to the family of therapies that attempt to correct maladaptive cognitive processes and structures (Gilbert, 2009a). The terms cognitive therapy and cognitive-behaviour therapy (CBT) are used interchangeably in this article.

History of cognitive and behaviour therapy in South Africa

South African clinicians at the University of the Witwatersrand (Wits), led by Joseph Wolpe, made pioneering contributions to the early development of behaviour therapy during the 1950s (Rachman, 2009). Wolpe demonstrated that the fears conditioned in cats could be de-conditioned by repeated exposure to the feared stimulus (Wolpe, 1958). He is most famous for applying these findings to humans, developing an intervention called systematic desensitisation, which involves the graded exposures to the feared situation coupled with induced relaxation (Wolpe, 1958), and is probably the most effective single psychological intervention for the treatment of anxiety (Rachman, 2009). He made other contributions to clinical psychology, not least of which was his emphasis on the importance of empirically testing therapeutic interventions (Rachman, 2000), a defining feature of cognitive therapy today.

Wolpe left South Africa and settled in the US in 1960, where his contributions were more widely acknowledged than they were in the country of his birth and where he continued his research and practice until his death in 1997.

Wolpe’s research attracted the attention of Stanley Rachman and Arnold Lazarus at Wits (Lazarus & Rachman, 1957), both of whom went on to make significant contributions to the practice of cognitive therapy. Rachman left South Africa to join Hans Eysenck at the Institute of Psychiatry in London, where he was to make a leading contribution to the treatment of obsessions at the Maudsley hospital (Salkovskis, 1999). Lazarus, credited with coining the term behaviour therapy to differentiate these new approaches from the dominant psychodynamic models (see Lazarus, 1958), followed Wolpe to the US, where he developed multimodal therapy, an integrated cognitive-behavioural approach.

Indeed Wolpe was a pioneer of behaviour therapy and Rachman and Lazarus pioneers of behaviour and then cognitive therapy. Yet despite this proud history of having featured prominently in the early evolution of behaviour therapy, South African psychologists have not embraced cognitive therapy, the offspring of this early clinical research, to the extent that it has been embraced by psychologists in the Europe and North America. A survey by Möller and van Tonder (1999) suggests that only 20% of South African clinical psychologists report having received training in cognitive therapy and only 6% claim they use the therapy as their primary therapeutic approach. The reason, perhaps, is that only two of the eight psychology departments surveyed indicated that they place a major emphasis on cognitive therapy in their clinical training programmes; this despite the growing and robust evidence demonstrating the efficacy of cognitive therapy for a range of psychological disorders (Butler, Chapman, Forman & Beck, 2006).

Cognitive therapy today

While cognitive therapy has somewhat fragmented and should rather be seen as a family of related therapies (Gilbert, 2009a), central to the practice of any cognitive therapy is the idea that people’s behaviours and cognitions are implicated in the development and maintenance of their emotional distress (Beck, Rush, Shaw & Emery, 1979). Cognitions are defined broadly to include the processes that support thinking, such as attention and memory; and the content of thinking, such as beliefs, thoughts and mental imagery (Wells, 1997). Other mental processes that are relevant include problems in shifting be-
tween different modes of processing - for example, a ruminative style of thinking is implicated in depression (Nolen-Hoeksema, 1991). The task of the cognitive therapist is to assist clients in a collaborative process to address the cognitions and behaviours implicated in their distress, a process that tends to be relatively brief, structured and problem orientated (Beck et al., 1979).

The most widely and empirically supported psychological therapy is Beck's version of cognitive therapy. A review of 16 high-quality meta-analyses suggests that cognitive therapy is highly effective for adult and adolescent unipolar depression, generalised anxiety disorder, panic disorder, social phobia, posttraumatic stress disorder, obsessive compulsive disorder, and childhood anxiety and depression as well as a host of other disorders for which the approach is at least moderately effective (Butler et al., 2006).

Recent years have seen the emergence of the so-called third-wave of behavioural and cognitive therapies, including dialectical behavior therapy (Linehan, 1993), acceptance and commitment therapy (Hayes, Strosahl & Wilson, 1999), mindfulness-based cognitive therapy (Segal, Williams & Teasdale, 2002), metacognitive therapy (Wells, 2009), and compassion focussed cognitive therapy (Gilbert, 2009b) – approaches that emphasise contextual and experiential change strategies in addition to the traditional didactic strategies often associated with Beck's approach (Hayes, 2004); though whether or not these prove to be more effective than the traditional versions remains to be seen.

Another exciting development is the increasing access to psychological therapies (IAPT) movement in the National Health Service in the United Kingdom, involving a radical departure from the traditional delivery of cognitive psychotherapy (and to a lesser extent some of the other evidence-based approaches) to address the disparity between need and provision (British Psychological Society, 2007). Based on a stepped-care model, low-intensity interventions are offered to those with mild-to-moderate disorders and delivered by graduate mental health workers, while more intensive treatment is reserved for those with moderate-to-severe disorders and are delivered by more highly trained therapists, including psychologists (Bower & Gilbody, 2005). Newer formats make use of delivery by telephone, computer, guided self-help books (available in libraries by prescription), self-help clinics, and as large as conventional therapy groups, bolstered by a growing evidence base for these flexible delivery methods (Lovell & Richards, 2000). There are obvious lessons here for how South Africa might increase access to psychological therapy and make better use of the psychological counsellors, a category of health professionals that has so far failed to become established in the public health system (Elkonin & Sandison, 2006).

So it is clear enough that cognitive therapy is an evolving, adaptive approach that is widely used in many different ways to deal with a range of psychological problems in a variety of settings. It may well be ideally suited or easily adapted to address many of the psychological disorders that are common in South Africa, and in doing so answer the call to make psychology more relevant.

The call for relevance in the practice of psychology in South Africa

As a developing country, post-apartheid South Africa faces massive social challenges of widespread poverty, crime, and illness, all exacerbated by under-resourced public services (Butler, 2004). For too long many have had little access to adequate health care. In this context, it is imperative that clinical psychology is relevant to the needs of the country and accessible to all who might benefit (Ahmed & Pillay, 2004). This could be partly achieved by promoting access to brief, effective therapies in the public health system, particularly therapies that might alleviate posttraumatic stress, a correlate of troubled social contexts and a public health concern in South Africa (Edwards, 2005a).

Given the demand for effective and accessible psychological therapies, it is surprising that South African clinical psychologists continue to pay little attention to the existing empirical evidence to guide their clinical practice (Kagee, 2006). This might be justifiable if motivated by a desire to implement indigenous psychological therapies to benefit the people of this culturally diverse country; however, there is no evidence that this is the case. It appears, instead, that many simply practice as they were taught by their lecturers, who in turn practice as they were once taught, often preferring unvalidated approaches while ignoring the move elsewhere towards evidence-based practice (Kagee, 2006). South African psychologists, therefore, should take more note of and better contribute to this growing evidence base.

Efficacy versus effectiveness

An obstacle to the more widespread use of cognitive therapy in South Africa is that although its efficacy (outcomes obtained in ideal research conditions) has been clearly demonstrated in western contexts, this does not necessarily translate to effectiveness (outcomes obtained in routine clinical settings) in African contexts. The transportability of cognitive therapy outcomes from research trials to routine clinical settings is problematic (Schoenwald & Haagwood, 2001), even within developed contexts, where less impressive outcomes in practice settings may be the result of lower levels of therapist training and experience, and increased patient comorbidity (Chambless & Hollon, 1998). The transportability to South African contexts involves an even greater inferential distance than usual: Firstly, the social contexts are very different, with South Africa carrying the burden of poverty, crime, illness and under-resourced public services; secondly, there are frequently first language differences between client and therapist (Swartz & Drennan, 2000); and thirdly, there are significant cultural differences between the participants in western research trials and those seeking assistance in African healthcare settings. Even assuming that most psychiatric diagnoses – and therefore the interventions designed to treat them – are more or less universal, which is debatable (Canino & Alegría, 2008), the beliefs implicated in the development and maintenance of these disorders, and beliefs about health and illness generally, are shaped by culture, with implications for clinical practice (Swartz, 1998). We can only begin to estimate the gap between western efficacy trials and effectiveness in South African contexts by identifying and appraising local outcome studies.

A Systematic Review of the Literature

Systematic reviews are designed to answer specific research questions, and describe the search process and inclusion and exclusion criteria in order to minimise bias in the selection of articles (Oxman, 1994). The purpose of this review is to identify published studies of the outcomes of any of the recognised, contemporary cognitive and behavioural therapies in South African contexts involving either adult or adolescent clients. The review was restricted to papers written in English and published in peer-reviewed journals between 1979 and 2009.
Articles were included in the review if they report data or describe the results obtained from outcomes studies, including case-based research, cohort studies and randomised controlled trials (RCTs). Computerised searches were undertaken on EBSCO Host, an aggregator service that included the PsycINFO, Health Source: Nursing/Academic Edition, and Medline databases. The search terms included combinations of CBT, cognitive, behaviour/behavior, behavioural/behavioral, therapy, transportability, transferability and Africa.

Only seven relevant studies were identified from the electronic literature search and another eight identified from the reference lists of the original articles or by contacting prominent authors—a total of 15 including five randomised controlled trials, seven psychotherapy case studies and three case series reports; all but two report positive cognitive therapy outcomes.

**Discussion**

The results of the systematic review reveal that few studies of the outcomes of cognitive therapy in South African contexts have been published. Nevertheless, these studies shed some light on the effectiveness and applicability of this psychological therapy, particularly those involving black African clients (white South African clients represent more closely the cultural contexts in which cognitive therapy was developed, and therefore reveal little about its cross-cultural applicability). Incidentally, there is much debate in the social sciences literature about whether or not it is appropriate to use race as a variable in research, particularly in South African contexts where race is often a proxy for class and where the research risks emphasising rather than de-emphasising racial differences (see Bowman, Seedat, Duncan & Burrows (2006) for an outline of this debate). While race may be socially constructed, it continues to shape social relations in South Africa, and the terms black, white and coloured are used in this paper to reflect the fact that race is a cultural reality for most South Africans.

**Behavioural problems.** The detailed psychotherapy case studies reported by Smith (2006), and Mashalaba and Edwards (2006) both suggest that cognitive therapy was of benefit to two black adolescent scholars, reducing the behavioural problems associated with conduct disorder. While both cases involved a number of interventions, including assisting the school to implement a consistent disciplinary regimen, both clients seem to have come to understand how their own appraisals of situations were implicated in their anger outbursts and learned to challenge their thinking, to apparently good effect. However, it is impossible to know the extent to which the correction of these cognitive distortions, as opposed to some of the other interventions, accounted for the decrease in conduct problems.

More support for the effectiveness of cognitive approaches to behavioural problems is provided by Möller and Botha (1996). The authors conducted a randomised controlled trial of rational-emotive behaviour therapy (see Dryden & David (2008) for an overview of the current status of REBT, one of the original

<table>
<thead>
<tr>
<th>Study</th>
<th>Type</th>
<th>Problem</th>
<th>Therapy</th>
<th>Clients</th>
<th>Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germond, Schomer, Meyers &amp; Weight (1993)</td>
<td>RCT</td>
<td>Rheumatoid arthritis</td>
<td>CBT</td>
<td>10 coloured and 4 white women</td>
<td>x</td>
</tr>
<tr>
<td>Möller &amp; Botha (1996)</td>
<td>RCT</td>
<td>Type A Behaviour Pattern</td>
<td>REBT</td>
<td>44 insurance salespeople</td>
<td>✓</td>
</tr>
<tr>
<td>Edwards (1997)</td>
<td>Case Series</td>
<td>Hypertension</td>
<td>CBT</td>
<td>12 black women</td>
<td>x</td>
</tr>
<tr>
<td>Rieckert &amp; Möller (2000)</td>
<td>RCT</td>
<td>Childhood sexual abuse</td>
<td>REBT</td>
<td>40 women</td>
<td>✓</td>
</tr>
<tr>
<td>Edwards, Henwood, &amp; Kannan (2003)</td>
<td>Case Study</td>
<td>Social Phobia</td>
<td>CBT</td>
<td>19 yr black man</td>
<td>✓</td>
</tr>
<tr>
<td>Karpelowsky &amp; Edwards (2005)</td>
<td>Case Study</td>
<td>PTSD</td>
<td>CBT</td>
<td>21 yr black man</td>
<td>✓</td>
</tr>
<tr>
<td>Mashalaba &amp; Edwards (2005)</td>
<td>Case Study</td>
<td>Conduct disorder</td>
<td>CBT</td>
<td>Black male adolescent</td>
<td>✓</td>
</tr>
<tr>
<td>Lundgren, Dahl, Melin &amp; Kies (2006)</td>
<td>RCT</td>
<td>Epilepsy</td>
<td>ACT</td>
<td>27 impoverished South Africans</td>
<td>✓</td>
</tr>
<tr>
<td>Smith (2006)</td>
<td>Case Study</td>
<td>Conduct disorder</td>
<td>CBT</td>
<td>Black Tswana adolescent</td>
<td>✓</td>
</tr>
<tr>
<td>Boulind &amp; Edwards (2008)</td>
<td>Case Study</td>
<td>PTSD</td>
<td>CBT</td>
<td>22 yr black Zimbabwean</td>
<td>✓</td>
</tr>
<tr>
<td>Edwards (in press)</td>
<td>Case Series</td>
<td>PTSD</td>
<td>CBT</td>
<td>5 black &amp; 1 white adolescents or adults</td>
<td>✓</td>
</tr>
<tr>
<td>Payne &amp; Edwards (in press)</td>
<td>Case Study</td>
<td>PTSD</td>
<td>CBT</td>
<td>15 yr black female</td>
<td>✓</td>
</tr>
</tbody>
</table>
cognitive therapies) and report that the interventions reduced the intensity of Type A behaviour amongst a sample of 44 insurance sales representatives.

**Social Anxiety.** Perhaps most revealing as far as the transportability of cognitive therapy is concerned are the case reports by Edwards, Henwood, and Kannan (2003), and Edwards and Kannan (2006) together reporting the outcomes of two black African students who participated in group cognitive therapy for social phobia. Treatment fidelity was assured as the therapists implemented Clark’s (1997) manualised treatment programme, which he developed in the United Kingdom based on his cognitive model of social phobia (Clark & Wells, 1995). Both clients made good progress. The cognitive model and treatment of social phobia shares some features with many of the other anxiety disorders (see Salkovskis, 1996), including the therapeutic tasks of challenging threat beliefs and appraisals, and identifying and resisting safety behaviours, so there is cause to hope that this local evidence of effectiveness for social phobia might be extended to the other anxiety disorders.

The outcomes obtained in the two social anxiety case studies are supported by the results of a South African randomised controlled trial. A comparison by Nortje, Posthumus and Möller (2008) report that their cognitive restructuring and exposure group and exposure alone group were both superior to their waiting list control group. The small sample included 36 white and eight black participants, though no comparison was made between the outcomes according to race.

**Trauma.** With the high prevalence of trauma in South Africa (Edwards, 2005a) and the call to make psychology more relevant, it is particularly useful to know whether cognitive therapy for traumatic stress is as effective in South African contexts as it appears to be elsewhere. Bouwer and Stein (1998) provide data indicating that psychopharmacology supplemented by a cognitively-orientated therapy resulted in the reduction of posttraumatic stress amongst a sample of 14 people who had been tortured by the apartheid regime. However, it is not clear to what extent these results can be attributed to the psychotherapy.

More telling are the following case studies: Karpelowsky and Edwards (2005) describe an integrated cognitive approach with a client with posttraumatic stress disorder and depressed mood. In a very moving account, the case demonstrates how guided imagery, in particular, helped the client, a 21-year-old black student, resolve his complicated grief and trauma. In another, Bould and Edwards (2008) report that outcome of cognitive therapy for a 22-year-old Zimbabwean client studying at a South African University with posttraumatic stress following a number of events including an unwanted pregnancy and subsequent termination. The case study reports clinically significant improvements as measured by the Beck anxiety and depression inventories. Payne and Edwards (in press) document the outcome of a cognitive therapy intervention based on the Ehlers and Clark (2000) model with a black adolescent who presented with PTSD after being raped. Despite being infected with HIV and being disappointed by numerous failures of the justice system, the client made good progress, again indicated by clinically significant improvements as measured by the Beck inventories and the Posttraumatic Stress Disorder Scale (PDS). Finally, a review of a series of six case studies, including the three described above and others that have not been published, supports the cultural generalisability of the Ehlers and Clark model (Edwards, in press).

Further supporting evidence comes from a randomised control trial. Rieckert and Möller (2000) investigated the effects of a rational-emotive behaviour therapy with 40 female adults who had been sexually abused as children. The participants were randomly assigned to a treatment group and delayed treatment control group, and reported significant improvements across a number of domains. A subsequent re-analysis of the data in terms of clinical significance indicates that the intervention was highly effective in reducing anxiety, and to a lesser extent depression and anger, followed by improved self esteem (Möller & Steel, 2002).

There are other studies demonstrating the effectiveness of psychotherapeutic interventions for PTSD in South Africa (Edwards, 2005b), but while these may share some of the features of cognitive therapy, they do not claim to be based on cognitive models of PTSD.

**Medical conditions.** Two studies report cognitive therapy outcomes for medical problems. In the first, Edwards (1997) offers a description of the cognitive-behavioural case conceptualisations of 12 hypertensive black women with a view to recommending how a more intensive cognitive-behavioural intervention might benefit this population. Although Edwards explains that this is not an outcome study, the results of a low-intensity intervention are reported, which had little impact. Whether or not a more-intensive cognitive-behavioural intervention is more effective remains to be seen. In the second study, Germond, Schomer, Meyers and Weight (1993) considered the effects of a cognitive-behavioural intervention for the pain associated with rheumatoid arthritis. Rather than challenge clients’ maladaptive illness representations based on individual conceptualisations, the cognitive-behavioural intervention involved a generic combination of stress and pain coping strategies, delivered in group sessions to 14 white and coloured women. The results did not corroborate other findings of the psychological benefit of cognitive behaviour therapy for rheumatoid arthritis, (though the findings of published trials tend to vary across outcome measures (Astin, Beckner, Soeken, Hochberg, & Berman, 2002)), or the benefit of cognitive therapy for pain (Morley, Eccleston, Williams, 1999). However, the results are unsurprising as neither condition is associated with strong evidence of effectiveness of cognitive therapy and neither intervention adequately implemented: The hypertension intervention was very brief, while the intervention for rheumatoid arthritis would not be considered state of the art.

Finally, Lundgren, Dahl, Melin and Kies (2006) conducted a randomised controlled trial of behavioural seizure management techniques coupled with acceptance and commitment therapy (ACT), one of the third-wave cognitive and behavioural therapies, involving 27 impoverished South Africans with epilepsy. They report remarkable reductions in seizures and improvements in quality of life for the ACT group compared to a supportive therapy group. There was a notable decrease in seizures after the start of therapy but before the seizure management techniques were implemented, and a subsequent meditational analysis (Lundgren, Dahl, & Hayes, 2008) confirms that some of the ACT components were implicated in the long-term outcomes. Both therapists were Swedish clinical psychologists, indicating that the approach was effective even with language barriers and cultural differences. These remarkable findings certainly warrant further research to determine the applicability of this third-wave therapy in South African contexts.

**Summary.** This small body of research evidence, therefore, suggests that cognitive therapies can be effective in different South African cultural contexts with a variety of psychological
problems, including two disorders (social phobia and posttraumatic stress disorder) that are typically associated with good cognitive therapy outcomes in developed contexts (Butler et al., 2006), and others (conduct disorder, type A behaviour and epilepsy) for which the evidence is less well established. The psychotherapy case studies (Boulind & Edwards, 2008; Edwards, Henwood, & Kannan, 2003; Edwards & Kannan, 2006; Karpelowsky & Edwards, 2005; Mashalaba & Edwards, 2005; Payne & Edwards, in press; Smith, 2006) are particularly revealing in that they were conducted by trainee psychologists supervised by an experienced cognitive therapist in a routine clinical setting with black clients. The evidence for the effectiveness of cognitive therapy for social phobia appears to be the most strong, consisting of two case studies that followed Clark’s (1997) manualised treatment approach and a randomised controlled trial. Furthermore, as it is major public health problem in South Africa (Edwards, 2005a), the evidence of the effectiveness of cognitive therapy for traumatic stress is encouraging. These findings offer much promise that cognitive therapy will prove to be effective in local contexts for some of the other anxiety disorders.

However, because there are only a small number of published outcomes in South African contexts involving a very limited range of the psychological disorders that are known to respond to cognitive therapy and involving a very small number of participants, far more research is needed before it can be claimed with any certainty that the effectiveness of cognitive therapy can be transported to South African cultural contexts.

Still, no psychological approach can claim unequivocal evidence of effectiveness in this African context, but cognitive therapy, at least, claims a large and robust evidence base obtained in western contexts and now this promising, even if limited, local evidence.

A note on the cross-cultural applicability of cognitive therapy

There is not much to suggest that cognitive therapists have been particularly concerned about the applicability of the approach outside of the western contexts in which it was developed. While there are studies demonstrating the effectiveness of cognitive therapy in a range of cultural contexts (including those reviewed above), these constitute only a fraction of the outcome studies that have been published (Hays, 2005), and very little has been written on how the approach should be adapted when working with clients who do not necessarily share the values and beliefs that dominate in North America and Europe.

Yet, despite the apparent lack of concern about cross-cultural issues and how these might affect practice, cognitive therapy appears to be well suited to work with diverse clients as it shares with multicultural approaches to counselling an emphasis on individual conceptualisations that determine treatment interventions (Hays, 2005). Other relevant features of cognitive therapy are that the approach is flexible, collaborative, emphasises empowerment, involves the ongoing assessment of therapy progress, and focuses on conscious processes and behaviours.

Take, for example, the concept of negative core beliefs about the self, which, according to cognitive models of emotional distress, are implicated in the development and maintenance of emotional disorders (Padesky, 1994). Core beliefs about the self illustrate how culture is relevant to the practice of cognitive psychotherapy, and also how the therapeutic approach incorporates people’s different cultural models.

These core beliefs guide attention and memory, shape our experience of events and influence our behaviour; people notice details that are congruent with their core beliefs while often missing or discounting those that are not, and the resulting information-processing biases can preserve negative beliefs despite the existence of contradictory evidence. Negative core beliefs about the self typically fall into one of three broad categories: beliefs that one is helpless, unlovable or worthless (Beck, 2005).

However, the concept of core beliefs in cognitive therapy is clearly rooted in cultural contexts where people emphasise independent definitions of themselves. Individualistic cultures value and reward personal accomplishment, autonomy, agency and self-sufficiency (Mesquita & Walker, 2003). Collectivist cultures, on the other hand, supposedly feature a non-western societies, particularly African and Asian societies, emphasise duty and relationships to others (Markus & Kitayama, 1991). Therefore, core beliefs, which are said to be the products of temperament and environment (Padesky, 1994), are at least partly cultural.

Further support is provided by Sato (2001), who suggests that those from collectivist cultures require relatedness to maintain mental health while those in individualistic cultures require autonomy. This is also supported by research suggesting that while PTSD might be a universal disorder, the cultural differences in the way the self is construed affects the way traumatic events are appraised (Jobson & O’Kearney, 2009).

The implication for the practice of cognitive therapy in multicultural contexts is that clients’ individual cultural models should be understood so that emotional experiences, behaviours and beliefs can be predicted, and cases accurately formulated and appropriately treated. In fact, this applies to all therapy clients, regardless of whether the diversity is to do with ethnicity, nationality, religion, class, age, sexual orientation, gender or disability: How people define themselves varies within cultures as it does between cultures, and a case conceptualisation integrating the best cognitive models with the client’s own experiences should guide therapy (Kuyken, Padesky & Dudley, 2008).

The question of social change versus individual psychotherapy

It has been claimed that by emphasising the role of internal cognitive processing in the development and maintenance of emotional disorders, cognitive therapy overlooks the inextricable connection between the personal and social, and attempts to repair the individual rather than society (see, for example, Lydon (1995)). Thus, clients are encouraged to cope with or adapt to the majority culture and individual psychotherapy becomes an instrument to support the status quo. This is objectionable in a country seeking social transformation.

It is true that cognitive therapy is a subjective / relational approach rather than a socioconstructive approach that emphasises the importance of cultural context (La Roche, 2005), and targets unhelpful beliefs rather than the conditions that gave rise to the beliefs in the first place. But, as argued in the previous section, this does not mean that the social context can be ignored; in fact, Bandura (1996) argues that it is misleading to portray cognitive approaches as disembodied from the environment – the difference is that cognitive approaches regard thinking as being partially rather than entirely shaped by environmental influences.

In actual fact, understanding how the client experiences his or her subjective world is a cornerstone of cognitive therapy,
drawing on phenomenological and empiricist philosophical traditions (Leahy, 1996). Core beliefs, as mentioned, are the products of the relationship between temperament and environment (Padesky, 1994), provide the structure of our experiences and are continuously shaped by our interactions with reality (Leahy, 1996). Cognitive therapists and their clients should attempt to understand how the context has shaped and continues to shape the client’s negative core beliefs, and how these beliefs influence thinking, before arranging interactions with reality that are designed to change unhelpful beliefs. An example of how context and beliefs interact is the client who comes to see herself as helpless following a violent sexual attack, and how this sense of helplessness is exacerbated by her ongoing experiences of an inefficient and unsympathetic criminal justice system.

Indeed it can also be argued that it is our troubled social context that makes effective individual psychotherapies all the more necessary. Attending to the trauma of rape is important, as is agitating for a more efficient criminal justice system and other political measures that would reduce or ameliorate the events that cause psychological harm. A move towards community psychology (de la Rey & Ipser, 2004), a positive development in South Africa, has not yet rendered individual approaches redundant; in any case, although a fairer socioeconomic system would surely alleviate much hardship, it would not eliminate entirely the misfortune that brings many to psychotherapy. Certainly while inequalities remain a seemingly entrenched feature of South African society, the disempowered and oppressed should not also have to do without individual approaches that have been shown to be effective for a range of psychological disorders.

Conclusions

There is no psychological approach that can claim unequivocal evidence of effectiveness in our particular African context. Cognitive therapy, at least, has a large and robust evidence base demonstrating efficacy in western contexts (Butler et al., 2006); and this review suggests that the few published studies reveal that it might be effective, too, in South African contexts. The approach also benefits from being relatively brief, cost-effective, versatile and accessible. Finally, cognitive therapy is both viable and applicable in this troubled, multicultural context; although social change is desirable, this has not rendered individual approaches redundant, and seems unlikely to ever do so.

Despite this, most South African psychologists prefer approaches that have little evidence of efficacy or worse (Kagee, 2006), a situation that should not continue to go unchallenged. A good starting point would be to ensure that the training of cognitive therapy should be adequately covered in South African clinical and counselling psychology training programmes, alongside a greater emphasis on evidence-based practice with all its benefits and flaws, so that psychological practice contributes to and is informed by high-quality research. The suggestion that the low status offered to cognitive therapy in South Africa might be a result of inadequate training is supported by a South African study showing that counsellor’s attitudes towards cognitive therapy for trauma were more favourable following a two-day workshop (Kagee, Suh & Naidoo, 2004).

This is not to say, though, that cognitive therapy should dominate the practice of psychological therapy as it does in other countries, a development that has caused concern, even amongst cognitive therapists (see Gilbert, 2009a); nor is it claimed that cognitive therapy suits all clients and all problems. Nevertheless, there is enough international and local evidence to suggest that the approach might have much to offer South Africa and should be more widely promoted and developed than is the case now, for the benefit of the many who have had little access to effective psychological treatments.

References


Schneier (Eds.), Social phobia diagnosis, assessment and treatment (pp. 69-93). New York: Guilford Press.


