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Mitigating the Mental Health Impact of Marginalization and Discrimination

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Abstract
In honor of the life and work of Aaron T. Beck, this paper describes the application of cognitive therapy to management of marginalization stress among minoritized communities. Collaborative empiricism, cognitive restructuring, and behavioral interventions are highlighted as being particularly useful in a contemporary multicultural approach for the anxiety, depression, stress, and other sequelae of marginalization due to a stigmatized identity. Although primarily illustrated through recent work with transgender and gender diverse adults, the discussion extends to other groups including racial, ethnic, and sexual minorities and immigrants. This work illustrates the power of Dr. Beck's approach to address the presenting concerns of contemporary clinical work.

Keywords: cognitive therapy, Aaron T. Beck, marginalization stress

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As a graduate student in the clinical psychology doctoral program at the State University of New York at Albany in the 1980s, I was well acquainted with Dr. Beck's groundbreaking work on cognitive therapy for depression. All of us owned our own well-thumbed copy of *Cognitive Therapy for Depression* (Beck et al., 1979). So, we eagerly awaited publication of his 1985 book on anxiety, entitled *Anxiety Disorders and Phobias: A Cognitive Perspective* (Beck et al., 1985), as my classmates and I were fortunate enough to be part of the development and evaluation of the now standard cognitive-behavioral approaches to treating anxiety. In both those research contexts and the clinical work we did in various practica, cognitive therapy was our first-choice treatment for a wide variety of presenting problems. Even in our novice hands, we witnessed the power of collaborative empiricism as we worked side by side with our clients to address their concerns. Although our Socratic questioning sometimes ended in cul-de-sacs of logic without the sought-after rational rejoinder to our clients' automatic thoughts, just often enough we were able to guide them to a new way of thinking that reduced their distress and helped them make needed behavioral changes. We were well-trained in behavior therapy based on learning theories. However, we soon discovered that many of those behavioral approaches could be combined with Dr. Beck's new cognitive restructuring techniques to augment the learning, or, on our best days, we could use the behavioral work as information gathering expeditions that informed cognitive change.

Our most challenging cases in those days were the ones in which the client's automatic thoughts were objectively true. If cognitive therapy was about helping people challenge negative thoughts about themselves, the world, and the future, what was one to do if those negative thoughts were not irrational, but true? I remember one young man who sought treatment for social anxiety centered on self-consciousness about a physical problem that affected his gait. As a young therapist, I struggled to help him because it was not irrational that others might look at him when he walked, that he might be limited in the work he could perform, or social and sports activities he could pursue. I am sorry to say he eventually walked out of a group therapy session because the focus on cognitive restructuring on whether he was catastrophizing about his physical impairment made him understandably angry.

These days, most of the clinical work that I provide or supervise is with clients who experience anxiety, depression, and/or stress, in large part because of the stigma they face in our society. Adults who identify as transgender and gender diverse (TGD) live in a world in which their identities and basic civil rights are frequently challenged, including often by state action such as anti-TGD legislation. Even if the vote eventually leads to protection of their civil rights, there typically has been an enormous amount of hate and invalidation of their identities in the process. In their daily lives, even casual encounters can lead to misgendering, or escalate to discomfort or physical danger if the other person perceives and challenges their TGD identity. Marginalization and threat may extend even to spaces most people find safe, such as medical settings, therapists' offices, religious communities, and families. Rather than believing that our TGD clients are irrationally overestimating the danger in their lives, I have come to respect their finely tuned sensibility of the risks of a given situation and their well-earned ability to protect themselves and even thrive in a hostile society. However, this chronic marginalization stress takes a toll on their mental health and TGD clients come to our clinic for help with anxiety, depression, and stress-related problems.

A substantial literature has developed describing cultural adaptations for cognitive therapy to various communities such as older adults, people of color, and sexual minorities that can be found in special issues of *Cognitive and Behavioral Practice*. Similarly, I have found that Dr. Beck's cognitive therapy is well-suited for our work with TGD clients, but not the cognitive therapy of my days as a novice graduate student therapist. In particular, collaborative empiricism, cognitive restructuring, and the emphasis on behavioral change are especially helpful with our TGD clients.

Collaborative Empiricism

Clinical work with members of minoritized communities demands that the disempowerment and marginalization of society not extend into the therapy session. This is particularly challenging if the therapist holds more privileged identities. Dr. Beck's notion that therapy is a collaboration is well-suited to manage the power differential inherent

in the therapy setting (Padesky, 2004; Wang, 2013). A cognitive therapist brings their experience about psychological functioning and interventions but, equally important, the client brings their expertise about themselves. A course of cognitive therapy is a shared journey of discovery. Emphasizing the validity and importance of their lived experience is a key aspect of cognitive therapy for all clients, though we tend not to think of it that way for clients whose privileged identities we share. For example, a socially anxious client may believe that they are incapable of small talk because the topics they choose are too insignificant. For homework, they may agree to observe unobtrusively several casual conversations, noting the topics discussed. Those data from their own social environment, their lived experience, then informs the discussion the following week about appropriate topics for small talk.

Numerous guidelines describing a multicultural approach to therapy (e.g., Clauss-Ehlers et al., 2019) describe the importance of respecting the client's own understanding of their own identities. Certainly, being a culturally competent therapist requires general knowledge of different cultural groups and the sociopolitical context in which they live. However, each client brings their own set of intersecting identities that are uniquely their own. In our work with TGD clients, we emphasize that they define their own gender identity and any path they wish to take, or not, to affirm that identity with social, medical, or legal transition (Hope et al., 2022). We understand that they may enact gender differently depending on their other identities and context of their lives. The collaborative nature of cognitive therapy respects their lived experience and brings it into the therapeutic process.

Cognitive Restructuring

As a doctoral student reading Dr. Beck's book on anxiety, I soaked up the cognitive model that emphasized the role of perceived threat in understanding the experiences of my clients with anxiety disorders. Cognitive therapy for anxiety disorders emphasized the dysfunctional evaluation of the likelihood of the threat occurring, severity of the threat if it did occur, and/or the long and short-term consequences for

the client. These strategies are effective for anxiety where, by definition, the evaluation of the threat is dysfunctional in that most people make a different judgment. The situation is different when the client is coping with anxiety or other symptoms related to marginalization, past or anticipated experiences of bias, or discrimination (e.g., Walsh & Hope, 2010). Often people who share the client's identities would not see the evaluation of the threat as unwarranted. An immigrant client who believes they are losing opportunities at work because they are a nonnative English speaker, an African American man who becomes anxious in situations where he may encounter the police, or an elementary school teacher who is anxious about taking her same-gender partner to a work-related social event may all be making accurate judgments of the level of threat and likelihood of being rejected or even facing physical danger. In these cases, cognitive restructuring focusing on their perception of risk is usually inappropriate and may be marginalizing within the therapy session, especially by a therapist with more privileged identities (Chapman et al., 2013). However, cognitive therapy offers numerous options that affirm the client's identity and lived experience and help reduce emotional distress.

Rather than focusing on the likelihood of these bias experiences as we would with anxiety disorders, the cognitive work can focus on the meaning of the events for the person, including any internalized stigma (e.g., Steele, 2020). Another common topic for cognitive work is the client's ability to cope, even while acknowledging we all would like the world to be more fair and just. "I will lose my job if my principal finds out I am in a same-sex relationship" is a realistic concern in many school districts, notwithstanding nondiscrimination laws. Whether or not the therapist agrees with this assessment, it is crucial to trust the judgment of the client who is the expert on their own work situation. Cognitive restructuring can still be helpful, though. It may be helpful to explore other thoughts associated with that thought, which may become more apparent when exploring associated affect. Common themes include: anger and thoughts that the world should not be this way; catastrophic thoughts about the implications and meaning of a job loss; internalized negative societal message about the self and one's gay identity; or thoughts with an all-or-nothing cognitive distortion leading to a sense of helplessness that the person is unable to do anything to improve their situation (e.g., explore legal

protections, improve climate at workplace, change jobs). In our work with TGD clients, we often find that cognitive restructuring can help them cope with situations in which they face marginalization and make the changes needed to create more safe spaces in their lives.

Behavior Change

Chronic marginalization can lead to learned helplessness, characterized by automatic thoughts such as these reported by a recent client who identified as a transgender woman: "I will never be accepted or safe as a transgender woman, that's just the way people are in this state" and "I just have to learn to live with hiding my identity when I leave my house." A hallmark of Beck's cognitive therapy is the emphasis on behavior change. Cognitive restructuring should lead to changes to more functional behavior and behavioral changes can help reinforce new patterns of thinking. All of the behavioral interventions (e.g., activity scheduling, exposure) familiar to cognitive therapists who treat anxiety and depression are appropriate for clients who may be stuck due to the marginalization they experience and/or past history of trauma. The only caveat for their use with minoritized clients is to assess whether there are implications about how to deploy such interventions given the cultural context and past history (e.g., Hinton et al., 2012). For example, is the planned time and location for an *in vivo* exposure a place that is safe for this client to go? Are the planned activities for behavioral activation consistent with the client's culture and values? Does the client's past experience mean cognitive work to help with emotion regulation is essential before behavioral interventions are employed? How are other people likely to respond to the client engaging in the planned activities? An African American man who is trying to increase their physical activity by going for walks at an indoor mall will have limited benefit if they are challenged by security. A transgender man who seeks to engage in self-care by getting a haircut will not benefit if misgendered or otherwise marginalized by the barber.

One aspect of behavior change that is unique to working with clients dealing with marginalization stress is to turn to activism to change unjust situations. As noted above, it is inappropriate to use

cognitive restructuring to challenge the perception of marginalization. However, one potential response is to acknowledge that the law or conditions are unjust and take steps to change them. Whether or not they are immediately successful, clients have a number of benefits from social justice work. First, it can shift cognitions from the idea that there is something wrong with them that is causing distress to there is something wrong with the system or other people's attitudes. Second, engaging in activism often leads to increased social support from like-minded people, reducing social isolation. This social support can help buffer the negative impacts of activism if one is publicly labeled as a member of a stigmatized group through the activism. Third, the social or policy change may be enacted, improving the context for the client and many others. Such outcomes are powerful evidence to support cognitive change around one's dysfunctional beliefs about themselves, the world, or the future.

Conclusion

Dr. Beck's influence on our understanding of and intervention for the wide spectrum of mental and behavioral health concerns is enduring and profound. Cognitive therapy has had the flexibility to extend well beyond the initial application to treating depression. It adapts well to a 21st century multicultural approach to therapy for clients who are facing the mental health impacts of marginalization of their identities. Each year at the annual meeting of the Association for Behavioral and Cognitive Therapies, I looked forward to having at least a brief conversation with Dr. Beck. He always asked what is happening with cognitive therapy in Nebraska. I am pleased to say it continues to flourish and expand here and around the world.

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