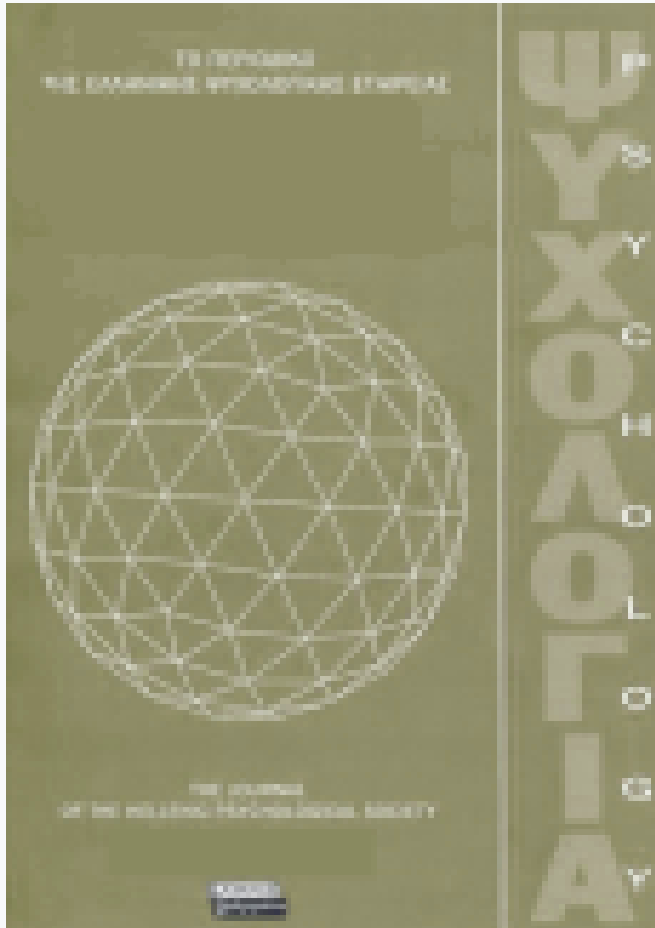


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Linking African and Western models through integration of trickster folktales in the application of Cognitive Behavior Therapy for depression

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ABSTRACT

The unique re-entry challenges of African psychologists trained in western universities is evolving strategies for applying general clinical theories and therapeutic techniques in ways that are clinically effective and culturally sensitive. This case study presents the cross-cultural application of Cognitive Behavioral Theory (CBT) for the treatment of Major Depressive Disorder (MDD) with a 12-year-old Nigerian adolescent. Cultural relevance is enhanced by the integration of culture-based trickster folktales in the cross-cultural application of CBT. The strategies for identifying major themes, contents, contexts, the characteristics of the villains and victims, nature of interpersonal relationships, emotions, behavior and consequences in trickster folktales are described. The case study further demonstrates how these components of trickster folktales are used for the implementation of core therapeutic techniques of Cognitive Behavioral Therapy (CBT). The outcomes are discussed in terms of the benefits of the therapeutic application of CBT, efficacy of modified CBT in non-western countries, and client's characteristics important in the treatment of Major Depressive Disorder with culturally modified CBT in adolescents.

Key words: Cognitive Behavioral Theory, African trickster folktales, Major Depressive Disorder.

1. Introduction

With independence in the 1950's and 60's, the number of African students in European and American universities increased significantly. At least 9.1% of all international students in the United States were Africans (Zikopoulos, 1997). Major re-entry challenges for Africans are how to

effectively address the differences between western psychological theories and techniques and the African belief systems, ideas about causation, illness behavior and therapeutic expectations (Nzewi, 1989,1992). This is the central question in the dialectical discourse on cultural relativism and universalism. If there is primacy of the human universals (the biological

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over cultural influences and experiences) then it can be argued that psychological epistemologies, theories and methodologies could be effectively applied across cultures regardless of their cultures of origin (universalism). The alternative perspective is the extent to which human behavior and psychopathology are so defined and shaped by culture that they could only be best understood in the cultural contexts in which they occur (relativism) (Boas, 1911; Linton, 1945; Pike, 1954; Whiting & Child, 1953). Limitations of wholesale application of western diagnostic and therapeutic models in non-western cultures have been identified in the literature. These include the context dependence of manifestations of psychological disorders (Littlewood, 1990; Patel et al., 2001; Patel & Winston, 1994; Tseng & Streltzer, 2001); the application of pathogenicity/pathoplasticity models in the diagnosis and treatment of culture bound syndromes (Kleinman & Good, 1985; Kleinman, 1988); higher rates in non-western societies of somatic symptoms associated with psychological disorders (Escobar, 1996; Myers, 2008; Okulate et al., 2004).

However, extreme universalism and radical relativism have been abandoned in favor of a more integrationist approach in cross-cultural application of western theoretical and therapeutic models (Berry & Kim, 1993; Devereux, 1978; Kleinman, 1995; Lonmer & Malpass, 1994). Central to the effectiveness of the integrationist approach are cultural competence, sensitivity and cross-cultural relevance of the treatment modalities (APA, 2003; Atkinson, Bui, & Mori 2001; Bennett, 1986; Dowdy, 2003; Sue, 2001) and the need to adapt, develop and test western therapeutic approaches that show empirical soundness and a promise of therapeutic efficacy for non-western clients (Rossello & Bernal, 1999; Soltani, Moayyeri, & Raza, 2004; Wilkes & Rusch, 1988). A great deal of interest has been generated in the efficacy of cognitive-behavior therapy for the treatment of depression in non-western cultures.

Cognitive behavioral therapy (CBT) has been modified and adapted for treatment of Hispanics

with depression (Bernal, Bonilla, & Bellido, 1995; Interian & Diaz-Martinez, 2007; Interian et al., 2008; Organista & Munoz, 1996); with adolescents in Puerto Rico (Rossello & Bernal, 1999), with the Chinese (Cheng & Davenport, 2005; Liu, 2007; Williams, Foo, & Haarhoff, 2006); with Iranian patients (Khodayarifard, Rehm, & Khodayarifard, 2007); with Cambodian refugees (Hinton & Otto, 2006) and with Vietnamese refugee women (Tran, 2006). A review of literature produced no published article on the application of CBT in Nigeria. The goals of this paper are to describe the cross-cultural adaptation of CBT through integrating Nigerian trickster folktales in the application of CBT and to report the outcomes of a modified CBT model in the treatment of a Nigerian adolescent with major depression.

Diagnosis and Treatment of Depression in Africa

Early research on the prevalence of depression in Africa between the 1930's and 60's indicated very low incidences of depression and suicide in West Africa (Asuni, 1962; Aubin, 1939; Carothers, 1947; Laubscher, 1938). But more recent literature have raised questions about this assumption and report prevalence rates of depression ranging from 3% to as high as 12% in Africa (Patel et al., 2001; Marsella, 1980; Marsella et al., 1985; Kleinman, 1978; 1982). Depression also contributes significantly to morbidity and disability in Africa (Patel et al., 1997). No data exists on the prevalence and rates of depression in adolescents in Africa. The discrepancies in findings on rates of depression in Africa have been attributed to inability of standard diagnostic instruments (DSM & ICD) to effectively screen for culture-specific expressions of depression (Beiser, 1985). Differences in diagnostic criteria in Western and African countries for depression, low rates of hospitalization in Africa, low prevalence of hospitalized depressives for countries in sub-Saharan Africa (Weinberg, 1965), and vegetative symptoms such as loss of enjoyment, sleep and

appetite being more characteristic of cross-cultural experience of depression have resulted in the discrepancies on rates of depression in Africa (Keitner et al., 1991). Other factors include presentations of depression in Africa that are more likely to include somatic symptoms (Ilechukwu, 1991; Kirmayer, 1984; Kirmayer et al., 1993; Kleinman, 1988; Makanjuola, 1987; Prince, 1968;); cultural definitions of emotional states (Leff, 1973, 1977); dimensions of individualism and collectivism with characteristic dominant symptoms of feelings of loneliness and alienation in individualistic societies and symptomatic patterns of somatization in collective cultures (Kleinman, 1988).

Cross-cultural application of Cognitive Behavioral Therapy (CBT)

Cognitive behavioral therapy has been found to be effective in its cross-cultural applications. Major contributory factors to the cross-cultural efficacy of CBT are that it is evidence based and outcomes are easily assessed as well as the cross-cultural adaptability of the CBT model. Additionally, benefits of CBT reported in the literature include being short-term and problem focused (Williams, Foo & Maarhoff, 2006), improved treatment retention rates (Interian et al., 2008; Penley, Wiebe, & Nwosu, 2003); the potential to reformulate CBT to reflect culturally congruent core beliefs (Bernal, Bonilla, & Bellido, 1995; Busch, 2006; Listug-Lunde, 2005); immediacy and magnitude of symptom relief (Lazarus, 1963; Pearsons, Davidson, & Tompkins, 2002) and room for continuous assessment (Beck & Weishaar, 1989).

The case study

N was a 12 year old Nigerian girl who was diagnosed with trauma induced depression following sexual assaults by a 30 year old man. N was a student in the last year of primary school and had no history of behavioral problems or psychological disorder. N was a good student

and got along with her siblings and peers. She received treatment for physical injuries. N's parents became alarmed when her behavior changed. N became sullen, withdrawn, tearful most of the time and was not doing well in school. N's parents took her back to the physician who referred her for psychotherapy with a diagnosis of depression. The referring physician did not prescribe anti-depressant medication due to concerns of about side effects.

2. Method

Tools and Diagnosis

Clinical interviews were conducted to determine if N met the DSM-IV criteria for the diagnosis of depression. The Beck Depression Inventory (BDI) was also used to measure the severity of N's depression. BDI is a 21 item self report inventory that is most widely used to measure the severity of depressive symptoms in adults and adolescents (Beck, Steer, & Brown, 1996). The 21 items of the BDI offer 4 choices keyed from 0-3 in the direction of increasing severity. Total scores on the BDI range from 0-63 with suggested cut-off scores range for the diagnosis of major depression of 0-13 (minimal); 14-19 (mild); 20-28 (moderate); and 29-63 (severe). A reliability coefficient of .92 for outpatients has been reported (Beck, Steer, & Brown, 1996). The BDI has been adopted and translated for application with Spanish speaking populations (Bonilla et al., 2004; Beck, Steer, & Brown, 1996); with Mexican Americans (Penley et al., 2003); with Chinese (Chinese Beck Depression Inventory) (Yeung et al., 2002; Zheng & Lin, 1991); with Korean Americans (Busch, 2006); and with Hmong refugees (Mouanoutoua et al., 1991). The use of BDI to assess depression in N was consistent with cross-cultural application of BDI and was supported by research findings of the accuracy of diagnosis derived from BDI. N had no difficulty with the items and had a level of competency in the English language that enabled her to understand the

meanings of all items. However, N was visibly uncomfortable with item 9 (suicidal thoughts or wishes) and item 21 (Loss of interest in sex). No clinical significance was attached to her discomfort with these items because N had recently been sexually assaulted and also, there is a strong cultural taboo against taking one's life. N endorsed zero for each of the two items and for each of the four times she took the BDI.

N's BDI score was 54 (severe). N's psychological symptoms included sadness, social withdrawal, tearfulness, sense of hopelessness, self-criticism, lack of enjoyment, withdrawal from social and interpersonal interaction at home and school, avoidance behavior in communal settings, loss of interest in everyday normal activities, feelings of worthlessness, excessive feelings of shame and guilt, perception of the self as impure and damaged and views about her future as bleak.

N's physiological symptoms included sleepiness at home and at school, weight loss, loss of energy, loss of appetite, diminished participation in recreational activities with her siblings and peers.

School related symptoms included poor academic performance, lack of concentration and tardiness with homework assignments.

It is of importance that, as revealed from the assessment procedure, physical trauma resulted from sexual assault.

Diagnosis-Based on the Diagnostic statistical manual of mental disorders (Fourth edition) DSM-IV TR (American psychiatric association, 1994, pp 339-344), N's symptoms and a score in the range of "severe" on the BDI, the following diagnoses were made:

Axis1: 296.23 ICD F32.2 Major Depressive Disorder (MDD), single episode. Severity: 3 severe without psychotic features

Axis 2: 799.9 No diagnosis on Axis II

Axis 3: 995.5, Vb1.21 Sexual abuse. Severity: Moderate

Axis 4: Problems related to cultural and social environment. Severity: Moderate

Axis 5: Current global assessment of functioning

"GAF" =55 "(current)" Highest GAF = 80 at termination of treatment.

Case Conceptualization:

N's Major Depressive Disorder (MDD) was triggered by sexual assault that resulted in physical injury and psychological distress.

Negative Automated thoughts:

The assault is her fault. She is impure, defective, worthless and permanently damaged. Her future was bleak and she had no hopes for marriage.

Beliefs and assumptions:

Her parents, siblings and the entire community were ashamed of her for bringing shame to herself and the family. Her family was angry with her and didn't want to talk to her. Her sexual assault was her destiny.

Affective- Feelings of rejection and low mood.

Behavioral- Social withdrawal, isolation and passivity.

Strengths and Asserts

N had no history of psychological disorder or behavioral problems. She was intelligent, a good student and had stable life circumstances with social and psychological support from her family. N was articulate and seemed open to new life experiences.

Therapeutic Goals and Tools

The goals of therapy were to obtain symptom relief from depression; to use folktales generated by N to explore her negative thoughts and challenge her beliefs about personal responsibility for her sexual assault, her destiny, irreversible loss and feelings of guilt and shame. Other goals included reactivating her interest in school and re-establishing normal social interpersonal relationships with her family, her peers and members of her community.

The conceptual framework used in my work with N was consistent with the major paradigms of cognitive theories of change of the CBT model (Beck, 1976; Beck, 1995; Beck, 2005). The underlying assumption of the cognitive theories of depression are that a core etiology of depression is cognitive bias, that is, fundamental impairment in normal cognitive processes and the activation of dysfunctional attitudes and beliefs by stressful life events (Beck, 1976). Three major components of the emotional and psychological symptoms central to the CBT model are negative automatic thought processes, cognitive distortions or systematic logical error and depressogenic schema (Beck, 1991, 1995; Pearsons, Davidson, & Tompkins 2002; Williams, 1997). Thoughts are believed to mediate maladaptive emotional and behavioral responses. Treatment is aimed at changing dysfunctional cognitions by substituting more adaptive thoughts and engaging behavioral and emotional responses. The work with N was aimed at achieving these goals.

Trickster Folktales and Cognitive Behavioral Therapy

The efficacy of stories, metaphors, anecdotes, analogies and proverbs generated by the therapist in CBT

Stories and metaphors in CBT enhance information processing in sessions and facilitate the development of problem solving skills (Otto, 2000); stories and metaphors emphasize key issues (Rose, 2003); are tools for communication, providing clarity and teaching specific skills (Blenkiron, 2005), provide means to assess and change cognitive representation (Goncalves & Craine, 1990) and using the client's own insights to stimulate growth and change (Burns, 2004; Dowd, 2003). In the application of CBT with N, her self-generated trickster folktales rather than stories, analogies or metaphors generated by the therapist were used. It was expected that this would provide similar therapeutic benefits reported for stories, metaphors, analogies and proverbs generated by therapist. Folktales have

been used in the application of other therapeutic techniques such as symbolism in psychoanalysis (Freud, 1965) and as archetypes in Jungian analysis (Jung, 1983).

The trickster folktales generated by N were incorporated into her cognitive behavioral treatment for major Depressive Disorder. It was expected that N's trickster folktales would reflect her thoughts, feelings and reactions to the precipitating event and cultural meanings in ways that did not violate cultural restrictions on discussions of sexual matters. It was also expected, based on the cultural relevance of trickster folktales and the demonstrated efficacy of stories, metaphors, analogies and proverbs in CBT, that N's self-generated trickster folktales would facilitate the identification, exploration and modification of her cognition and beliefs related to the activating event. The use of CBT with N was also expected to enhance rapport, provide the initial distance necessary for the discussion of the sensitive topic of her sexual assault. Additionally, trickster folktales would provide the basis for challenging negative thinking and because they are her stories, N would feel comfortable explaining, analyzing and identifying beliefs, emotions and conflicts in the folktales.

Trickster Folktales in Nigeria

Nigeria has a rich oral tradition and story telling (folktales) provide entertainment for children, a method of expressing ideas, inculcating values, beliefs and moral codes of the society. Encouraging children to repeat and create trickster stories is a means of reinforcing cultural beliefs and values and developing creativity. By far the most popular folktales and the ones most frequently presented to children are stories about "mbe", tortoise, the trickster. The trickster in the Igbo cultural folktales epitomizes the duality of good and evil, the constant pull of opposites, the desirable and the undesirable dimensions of human characteristics. The tortoise represents the negative dimensions of humanity, the

culturally unacceptable human behavior traits and those self-gratifying, antisocial behaviors that people are so often drawn toward. The tortoise is physically weak, slow, powerless and encased in a shell, though protective none the less, restrictive. These limitations notwithstanding, positive human qualities of intelligence, resourcefulness, wit, creativity, insight, resilience, and success are attributed to the tortoise. But the tortoise often succumbs to the dark side of his personality and uses his abilities to exploit the vulnerabilities of its adversaries and to defeat and humiliate others. The tortoise is envied for his multitude of abilities but at the same time despised for his greed, disloyalty, selfishness and dishonesty. The duality of good and evil in the tortoise makes tortoise folktales and stories ideal for cross-cultural therapeutic work with children who have to deal with personal experiences related to the dark side of human personality.

Because the tortoise is endowed with such great gifts, he has no need to resort to trickery and deceit. To do so, becomes a question of choice and therefore condemnable.

There are three parts to trickster folktales. The first is the context, usually a difficult situation, or a challenge. Second, the cognitive components, that is, the tricks or cunning, such as deceit, exploitation, skills and strategies used by the trickster to achieve self-gratification, satisfy personal greed at the expense of others. The third part is the consequence of the trickster's behavior to the victim, the trickster and the community. Predictably, the nature of the trickster's behaviors invariably evokes condemnation, resentment and retaliatory responses from others. All trickster folktales therefore provide underlying lessons and morals about human relationships and interactions. Trickster folktales therefore seemed to provide valuable therapeutic tools for addressing N's personal, interpersonal and psychological responses to sexual assault. N was most likely to draw upon her personal experiences, feelings, ideas and perceptions about the precipitating event, the cultural

meanings and implications of the event and the resultant cognitive distortions to create a tortoise, trickster folktale that addressed all three components of her problems, the cognitive, emotional and behavioral. How the experiences of the victim of the trickster are constructed, the meanings assigned to the experiences, the nature of the interaction among the characters and consequences associated with each character's behavior would provide information that would be useful in the application of Cognitive Behavior Therapy (CBT).

Culturally, the folktales would provide insight into elements of cultural beliefs and values that may have generated additional symptoms. Additionally, working directly on the traumatic event with N was likely to result in re-experiencing of the event at the time N was ill prepared to deal with the trauma directly. Using trickster folktales created by N as conduits to the event provided N some needed distance from the trauma. The folktales also provided the means for rapid assessment of her problems, clarification and selection of major target goals for treatment. Use of trickster folktales would provide opportunities to focus on her sexual assault in ways that did not violate the cultural restriction on the discussion of sexual matters with minors.

The cultural model for analyzing and exploring trickster folktales was adopted in the CBT application. Trickster folktales are culturally explored for major themes and contents, characteristics and behaviors of victims and villains, nature of relationship and interaction among main characters, their intents and feelings, attributions as well as the consequences of the character's behaviors to themselves, others and the community. Finally, the lessons and morals of the trickster folktales are identified.

The techniques for the integration of trickster folktales in CBT application consisted of three steps. First using the cultural model for exploring and analyzing trickster folktales, N was invited to explain and describe the characters and their roles in her trickster folktales. Next, N's negative

thoughts and beliefs, negative emotions expressed by the characters particularly the victims, her attributions of responsibility were identified by the therapist. Thirdly, content areas related to N's negative thoughts, emotions, self-perception, shame and guilt were identified for challenging and modifying her assumptions.

Also, homework in CBT enhances therapeutic relationships, motivation and skills for managing negative symptoms (Rector, 2007); provides significant increase in quantity and quality of coping skills (Carroll, Nich, & Ball 2005), reinforce therapeutic gains, increase motivation for change, client's involvement (Thase & Callan, 2006) and cultural relevance of CBT (Foo & Kazantzis, 2007). One of N's homework assignments was creating and writing trickster stories. A total of four stories were created by N.

Moreover, specific behaviors targeted for interventions were N's social isolation and withdrawal. These were the easiest to change yet had the potential to quickly produce a positive outcome that would maximize her positive experience at home and school. N was instructed at the first session to increase the rate of self-initiated interaction and to keep records of the interactions. The number of her self-initiated social interactions at home and school by the first session was noted. These were established as the baseline against which to measure improvement.

3. Treatment

Session 1

In the initial session, explanations of cognitive behavioral therapy (CBT) were provided. This was followed by a clinical interview and the administration of the Beck Depression Inventory (BDI). Components of the trickster folktales were reviewed with N and how they would be used in CBT was explained to her. A popular trickster story was reviewed with N to ensure that N would be able to create and write trickster stories that

would be useful in therapy. The next two sessions were devoted to establishing rapport, setting therapeutic goals and doing some work on her feelings of shame and beliefs about family rejection. N was instructed to reduce avoidance behavior, focus on the nature and quality of her interactions with others and identify and evaluate the accuracy of her thoughts and reactions. It was evident by the third session that increased interaction with her family and peers resulted in a reduction in social discomfort. N reported that she no longer hid from people.

N's First Trickster Folktale-Session 5

First Trickster Folktale: N brought in a story about a famine in a village that necessitated the decision by all adult animals to travel to a distant village in search of food and water. The trickster did not want to go with them, but he nevertheless wanted to receive some of the food and water the animals might bring back. So the trickster pretended to be seriously ill. He stopped several times even before they got to the outskirts of the village to cough and rest. Not wishing to be delayed, the animals told the trickster to return home to the children and the old animals. The trickster returned home only after it exacted a promise from all the animals that they would share their food and water with him. In the absence of the adults, the trickster exploited the children by forcing them to work for him. Every morning, the trickster rounded up all the children in the village and took them to his house. He assigned the children to wash, sweep, clean, repair his walls, roof and floors and prepare his farm for planting crops. On the return of adults and parents of the children several weeks later they learned of trickster's exploitation of their children, and were very unhappy. They were angry when they realized that the trickster was not ill and that they had been fooled. And even more furious when the trickster forced each and every animal to keep their promise, which was to share everything they brought back with the trickster.

Thus, the trickster, after collecting a portion of every animal's food and water, ended up with more food and water than any other animal in spite of the fact the trickster never ventured out in search of food and water. This made the animals even more furious and they held a meeting and decided to take all the food and water from the trickster and ostracize him.

Major Themes of N's stories

The major themes of N's trickster story were dishonesty, exploitation, greed, betrayal of trust and the resultant justified parental anger. Also implicit in this folktale was the trickster's ability to manipulate even the adults in N's story. These themes provided the bases in sessions five and six for therapeutic focus on the adult's perception of the young animals as victims, the trickster as the perpetrator, and the logic of parental attribution of responsibility and shame to the trickster and not the children. The children, (victims') experiences in N's story were used to reevaluate N's perception of her experience of sexual assault. Parental reactions were used to enable N reevaluate her perceptions about rejection by her parents, and shaming her family and the community. The children's position of helplessness in their exploitation by the trickster provided the contexts for cognitive restructuring of her ideas about her destiny and personal responsibility for her sexual assault. The absence in N's expressed cognition and affect of justified feelings of anger about her assault, provided the contexts for a systematic focus on anger and grief. First using the folktale and secondly N's reference to her mother crying in session two and N's difficulty with expressing grief. Because the themes of N's story were relevant to the therapeutic goals, they became the major focus of our work rather than direct reference to her sexual assault. N felt less threatened about exploring the implications of the experiences of the characters in her story, the children and the trickster.

Evaluation of the nature and appropriateness of her mother's emotional response to the incident triggered intense emotional reaction by N. N cried and expressed her sadness over the event. In spite of her grief, she was able to remain engaged with the evaluation and understanding of her feelings. She was able to perceive the man as solely responsible for the assault and her grief as justified. Also of importance was the fact that the story was her story. Therefore, challenging N to come up with logical explanations, morals and cultural perspectives about all the components of her story was normal and consistent with cultural expectations about exploring the values, morals and beliefs inherent in every trickster story. This provided reinforcement of more logical cognition and clarification of distortions in the perception of her experience. Homework assignment included monitoring situations that triggered emotional reactions, determining ease in responding appropriately and identifying blocks if she felt uncomfortable doing so. (Table 1)

This first trickster folktale channeled the focus in sessions 5 and 6 on N's feelings of guilt and shame and her sense of personal responsibility for her sexual assault. Parental perception of children as victims, the trickster as the perpetrator, attribution of shame and responsibility towards the trickster rather than the children provided the basis for intervention around N's cognitions about shaming her family and her conclusions regarding parental rejection. The children's helplessness in the absence of their parents or anyone else who could defend them, provided opportunities for cognitive restructuring of N's ideas about destiny and personal responsibility for the assault. The parents' anger was a means for recognizing N's difficulty with acknowledging and expressing anger towards her assailant and the possible link to her depressed mood and feelings of shame and guilt.

Session 9: Second Trickster Story

The second trickster story was written for the ninth session. In this second story, the trickster

Table 1
CBT with N's First Trickster Folktale

Major themes: Formulations for CBT

The deception and extraction of a promise to receive food established the character as a trickster, other themes were exploitation of children and parental anger. Justification consequence-ostracism.

Major Characters	Context
Parents – Entrusted care of children to trickster and elders of village	Famine – Parents travel to distant village for food and water.
Children – Left behind in the village by their parents	
Trickster – Villain	Deception, exploitation, self-serving behavior (far reaching consequences in a collectivist society).
Intervention: Enable N to begin to re-asses her cognitions about her assailant and his culpability for the crime.	

Nature of the relationships among characters:

Character	Context
Trickster	Exploitation, disregard for the welfare of the children, betrayal of trust
Children	Powerless, defenseless, implied sense of failure in their collective inability to resist the trickster's demands, by implication they were partially responsible for their exploitation
Intervention: Negative cognition-related to N's responsibility for the sexual assault, sense of shame and guilt.	

Consequences:

Character	Context
Trickster	Parental anger and punishment
Intervention: Condemnation of the assault-Justified outrage by parents, none directed at children.	
Self - Children	Protection and support by parents. No attribution of blame, no expression of negative emotions. Perceived as victims and no match for the trickster who conned even the parents.
Intervention: Challenge-Feelings of shame and guilt and sense of responsibility for the assault. Parental rejection as a result of being angry with her for the sexual assault.	

repeatedly teased a young female cat about her inability to climb up his neighbor's roof. After the cat climbed up the roof to prove that she could do so, the trickster told her that she could not bring down to the trickster some food items spread out on his neighbor's roof to dry without falling off the roof. The cat did so several times to prove the trickster wrong. When the neighbor suddenly came home, the trickster quickly realized that the cat's presence in his house would raise suspicion about his involvement in the theft of the neighbor's food. Otherwise, no one would suspect a tortoise of climbing up his neighbor's roof. To hide the cat and prevent her from divulging their activity, the trickster covered her with a cloth and sat on her. The cat was in so much pain that she thought she would die. The important themes in the second story were the facts that the cat was young, female and conned by the older trickster. Physical pain and difficulty breathing were reminiscent of N's experience of sexual assault.

Clinically, the themes of the second story and the symbolism of the cat's experiences permitted detailed analysis of the major sequences of the event. N identified deceit, greed, evil intent, selfishness and exploitation of the cat's naivete as the major themes of this story. Also of clinical and therapeutic importance were the facts that the cat was female and the trickster male. Of note was the lack of punishment in this story for the trickster's crime. That was atypical of cultural trickster stories and perhaps exemplified N's ambiguity about her role in the assault. Nevertheless, the story provided the focus for therapeutic intervention around arbitrary inferences, self-blame, and conflicts about her status as a victim.

THERAPIST: What do you think about the cat's experience in your story?

N: I think that the cat is stupid and unintelligent. I say that because the trickster fooled her.

THERAPIST: Apart from being unintelligent, can you think of other reasons why the cat may have been unaware of the trickster's intentions?

N: Maybe because she was young and was not as experienced as the trickster.

THERAPIST: Good, can you think of anything else?

N: Maybe because she trusted the trickster. Maybe because she believed that adults are good and are supposed to be kind to children.

THERAPIST: The reasons you have given seem quite accurate in the context of your story and cultural expectations of adults. Given these reasons, do you still think that the cat was stupid?

N: Maybe not.

THERAPIST: It seems that you're not quite sure in spite of the reasons you have provided.

N: I think that she should have known that the trickster is evil.

THERAPIST: You seem to have very high expectations of her and to hold her to a higher level of responsibility than the trickster. How would you judge the trickster's behavior based on cultural norms?

N: The trickster should not have sat on her.

THERAPIST: Can you think of some reasons why the trickster should not have sat on her.

N: The cat did everything the trickster asked her to do. He could have hidden her in his backyard and kept the neighbor in the front of the house.

THERAPIST: Can you think of anything else?

N: He should have realized that he was causing her pain. She could have died.

THERAPIST: Given all of these facts related to the situation, should the cat blame herself for what happened?

N: No. Although she was stupid.

THERAPIST: Can you describe the cat's physical and emotional experience of being sat on?

N: She could not breathe and was in pain. N cried and remained silent for sometime. Then she told me she did not want to talk about the cat anymore.

THERAPIST: Okay. Would you like to explore how members of the cat's community was likely to respond to the trickster?

N: They would be very angry with him and punish him and chase him out of their village.

THERAPIST: Would they also be angry at the cat and punish her?

N: I don't think so. I think that they would feel sorry for her and take care of her.

THERAPIST: Should the cat that was sat on by the trickster also be very angry with him?

N: Yes. I think so. He did a very bad thing.

Major therapeutic outcomes of this session included N's willingness and ability to begin confronting her fears about the assault, express her sorrow over the event, acknowledge the self as the victim and exploring the assault in relation to cultural meanings of shame and blame. However, there were still some indications of lingering negative self-perception, self-blame, pessimism and shame. These remain blocks to sufficient discharge of justified anger and grief necessary to achieve some relief from the burden of fear and shame and restoration to her premorbid level of functioning.

N's Subsequent Trickster Folktale

Subsequent trickster folktales contained themes, contexts and interpersonal relationships that allowed for direct exploitation and modification of her thoughts and fears around the assault, expression of anger and grief, recognition of the self as a victim and the understanding that the assault need not continue to have detrimental effects on her current and future life. The third trickster folktale presented in session 11 mirrored N's fears about impurity & eligibility for marriage and her future. Significant therapeutic milestones in her story included condemnation of the perpetrator and by implication, exonerated the victim, important in addressing feeling of guilt and worthlessness. The resultant focus on the link between her dysfunctional schemata and her

depressive affect enhanced training for development of skills in monitoring the effect of depressive schemata in these areas.

Session 14: Fourth Trickster Folktale

The fourth trickster story was written for session 14. The fourth trickster story was a continuation of her third story. The young girl's "chi" (personal god), outraged by the trickster's behavior intervened on her behalf. Her chi communicated to the village medium in her trance that the trickster was to be publicly flogged in the Village Square for his crime. Her chi also stipulated that only the girl had the power to halt the flogging. No one listened to the trickster's cries for mercy. They were all accustomed to the trickster's intrigue and deceit. But the trickster was genuinely in pain because his skin was broken in spite of his shell and was bleeding. The trickster was repentant and appealed for mercy and forgiveness. The girl was asked to make a decision about the trickster's fate. Because the trickster was weak, pitiful, powerless, and close to death, the girl did not feel comfortable about letting the trickster die. She stopped the punishment. The trickster survived and lived in seclusion but lost his status and power. The therapeutic implications of N's story indicated that she had made some progress on feelings of shame and blame and perceived herself as the victim. The dispensation of deserved punishment to the trickster, though through magical thinking, her chi, was clinically significant. The young girl's ultimate exoneration by her personal god eliminates all reasons for shame. Having been exonerated by her personal god, poised to avenge any injustice, no one was likely to blame her for the trickster's behavior. The incorporation of the protective intervention of the chi in the fourth story signaled a shift from blaming the chi for failing to prevent the attack, a distortion of cultural beliefs, to reassignment of a positive role to the chi, a more accurate attribution. It was also an assertion of the girl's self-worth and value.

While the trickster was disempowered and reduced to begging for mercy, the girl was empowered by her magical possession of life and death decision over the trickster, a clinically significant reversal of roles. Equally of clinical and personal significance was the element of forgiveness in her story. This was consistent with cultural beliefs about deferring punishment for injustices to the chi of the parties involved rather than seek revenge.

Therapeutic use of the fourth trickster story focused on N's capacity to positively influence her life in the absence of intervention by her chi, the meaning of forgiveness in the contexts of her experience, focus on residual distortions and illogical inferences as well as preparation for termination. The two last sessions were used to reevaluate N's level of depressive symptoms and to help N to analyze and summarize her gains in therapy and the discovery of the roles of her misperceptions and beliefs in her depression. N was encouraged to continue to use cognitive techniques to test her misinterpretations and the logical or illogical bases of her thinking and beliefs and develop a pattern of evaluating all possible factors before reaching conclusions. N's negative reactions to termination and the meanings of termination were used to further demonstrate methods for assessing the functionality of cognitive perceptions and inferences.

In N's fourth and final trickster folktale, the victim is protected by her "Chi," personal god

who avenges an injustice. This was clinically significant and signaled a shift towards an assertion of her self-worth and value. Having been exonerated by her personal god from all responsibility for her experience, no one was likely to blame her for the trickster's behavior, not even herself. Equally significant in the fourth folktale was the element of forgiveness that was consistent with cultural beliefs that people ultimately pay for their misdeeds.

The last two sessions were used to re-evaluate N's level of depressive symptoms and help N to identify and summarize her therapeutic gains. N was encouraged to continue to use cognitive skills gained in therapy, to continue to test her thoughts and beliefs and to develop a pattern of generating possible alternatives that would enable her to arrive at logical conclusions.

4. Evaluation of Therapeutic Outcomes:

Beck Depression Inventory (BDI) baseline score obtained in the first session was 54, indicating severe levels of depressive symptoms. N's score on the BDI decreased markedly at termination and continued to decrease after follow-ups two months and six months after cognitive behavior therapy. (Table 2)

Regarding social isolation and school, N's baseline data for social interactions were low (0-2) at home and (0-6) at school and were mostly non-

Table 2
N's BDI Scores at Pre, Post and Follow-ups
 BDI Scores (With a maximum score of 63)

	Pre	Post	2 months	6 months
Total Score	54	8	5	2
Percent (%)	86 %	13 %	8 %	3 %
Score Range	29-63	0-13	0-13	0-13
Clinical Indication	Severe	Minimal	Minimal	Minimal

self initiated. By the fifth session, N had almost returned to her normal level and at the end of therapy, N no longer exhibited symptoms of social withdrawal. Her grade improved and she was excited about preparing for secondary school. Overall, N achieved full relief of core symptoms of depression, regained interest in interpersonal relationships and changed dysfunctional thoughts and beliefs about her future. Follow-up evaluations indicated no relapse. N seemed to have maintained the gains made in psychotherapy. Full termination of relationship with N was not achieved. As a result of our therapeutic work together, N perceived me as an “auntie” and periodically came to see me on a more or less social basis. This was attributed to cultural factors rather than to N’s dependence. Her parents also encouraged her to keep in touch with me. N continued to create trickster folktales.

5. Discussion

This case presents and describes the processes for enhancing cultural relevance of CBT in clinical work with a Nigerian adolescent with MDD through integration of trickster folktales. In N’s case, the combination of trickster folktales and CBT was successful in eliminating symptoms of Major Depressive Disorder and culture related symptoms of shame, guilt and negative self-perception. The severe levels of depressive symptoms at the beginning of CBT and the marked decrease of N’s scores on the Beck Depression Inventory (BDI) at termination and follow-ups was attributed to treatment rather than spontaneous remission or maturation, two conditions that have been shown to be important in determining therapeutic outcomes (Kazdin, 1993; Lazarus, 1963; Pearsons, Davidson, & Tompkins, 2002). The outcomes of this case are consistent with literature on the efficacy of cross-cultural adaptation and the modification of CBT (Interian et al., 2008; Cheng & Davenport, 2005; Comas-Diaz, 1981; Khodayarifard, Rehm, & Khodayarifard, 2007; Rosello & Bernal, 1999; Williams et al., 2006).

Trickster folktales enhanced the efficacy of CBT. Their effects on therapeutic relationships, client’s motivational level, development of problem solving, skills, clarification of therapeutic goals and client engagement in the therapeutic process through story generation are similar to the benefits documented in literature, concerning the use of metaphors, stories, and analogies in CBT (Burns, 2004; Goncalves & Craine, 1990; Otto, 2000). Trickster folktales allowed direct intervention on symptoms embedded in cultural beliefs such as feelings of shame and impurity that would otherwise have been difficult to address in ways that were culturally meaningful. There were also specific features of CBT that made it particularly suitable for modification. These included clear achievable goals, a structured therapeutic process, more active and direct involvement by the therapist (Hayes & Iwamasa, 2006); targeting specific problems for symptom relief and incorporation of education and training in the therapeutic process (Rosello & Bernal, 1999; Interian et al., 2008). These factors have been shown to reduce attrition rates and enhance positive outcomes (Sue & Sue, 2007). In the Nigerian cultural setting in which people have little experience with psychotherapy or are outright skeptical about the efficacy of talk therapy, these features of CBT provided face validity and quantitative measures of therapeutic outcomes.

Of major importance in the efficacy of combined CBT and trickster folktales, were N’s characteristics and asserts. N was young, had no prior history of psychological disorders or behavior problems. She was intelligent, a good student and could engage in a level of cognitive discourse necessary for cognitive restructuring and completion of homework. The precipitating event for N’s Major Depressive Disorder was particularly related to the ontological and existential questions inherent in trickster folktales. It is likely that trickster folktales could produce similar results with other adolescents in Nigeria. Although somatic symptoms were not part of N’s clinical picture and were not addressed in CBT applications with N,

somatic symptoms do tend to occur often in clients with depression in Africa. Somatic symptoms could be treated with CBT with particular reference to their cultural meanings and significance.

This application of modified CBT with N and the successful reduction of her depressive symptoms demonstrated that CBT, a western theoretical and therapeutic model, could be modified and applied in non-western cultures, such as Nigeria, in ways that maximized positive outcomes.

References

- Atkinson, D. R., Bui, U., & Mori, S. (2001). Multi-cultural sensitive, empirically supported treatment- an oxymoron. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 542-574). Thousand Oaks, CA: Sage.
- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders*. (4th ed.) [DSM-IV]. Washington DC: Author.
- Asuni, T. (1962). *Suicide in Western Nigeria*. *British Medical Journal*, 109, 1-6.
- Aubin, H. (1939). Introduction al'etude de la psychiatrie chez les noirs. *Annals of Medical Psychology*, 97, 1, 1-27.
- Beiser, M. (1985). A study of depression among traditional Africans, urban North Americans, and Southeast Asian refugees. In A. Kleinman & B. Good (Eds), *Culture & depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder*, pp. 272-298. Berkeley, California: University of California Press.
- Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. New York: Harper & Row.
- Beck, A. T. (1976). *Cognitive theory and the emotional disorders*. New York: International University Press.
- Beck, A. T. (1991). Cognitive therapy: A 30 year retrospective. *American Psychologist*, 46, 368-375.
- Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press.
- Beck, J. S. (2005). *Cognitive therapy for challenging problems*. New York: Guilford Press.
- Beck, A., Steer, R., & Brown, G. K. (1996). *BDI-II Manual*. San Antonio: The Psychological Corporation – Harcourt Brace & Company.
- Beck, A. T. & Weishaar, M. E. (1989). Cognitive therapy. In R. J. Corsini & D. Wedding (Eds), *Current therapies* (pp. 285-320). Illinois: P. E. Peacock.
- Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and sensitivity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychological treatments with Hispanics. *Journal of Abnormal Child Psychology*, 23, 67-82.
- Bennett, M. J. (1986). A developmental approach to training for multicultural sensitivity. *International Journal of Intercultural Relations*, 10, 179-196.
- Berry, J. W. & Kim, U. (1993). The way ahead: From indigenous psychology to a universal psychology. In U. Kim. & J. W. Berry (Eds), *Indigenous psychology: Research and experience in cultural contexts* (pp. 277-280). London: Sage Publications.
- Blenkiron, P. (2005). Stories and analogies in cognitive behavior therapy: A clinical review. *Behavioral and Cognitive Psychotherapy*, 33, 45-59.
- Boas, F. (1911). *The mind of primitive man*. New York: McMillan.
- Bonilla, J., Bernal, G., Santos, A., & Santos, D. (2004). A revised Spanish version of the Beck Depression Inventory: Psychometric properties with a Puerto Rican sample of college students. *Journal of Clinical Psychology*, 60, 119-130.
- Burns, G.W. (2004). *101 Healing stories for kids and teens: Using metaphors in therapy* New York: Wiley.
- Busch, E. (2006). Culturally authentic CBT with Korean Americans. *Dissertation Abstract International: Section B: The Science and Engineering*, 66, 11-B, p. 6264.
- Carroll, K. M., Nich, C., & Ball, S. A. (2005). Practice makes progress? Homework assignment and outcome in treatment of cocaine dependence. *Journal of Consulting and Clinical Psychology*, 73, 4, 749-755.
- Carothers, J. C. (1947). A study of mental derangement in Africans and attempts to explain its peculiarities more especially in relation to the

- African's attitude to life. *Journal of Mental Science*, 93, 5, 48-59.
- Cheng, S. W. H. & Davenport, D. S. (2005). Cognitive-behavior therapy with Chinese American clients: Cautions and modifications. *Psychotherapy, Theory, Research, Practice, Training*, 42, 101-110.
- Comas-Diaz, L. (1981). Effects of cognitive and behavior group treatment on the depressive symptomatology of Puerto Rican women. *Journal of Consulting and Clinical Psychology*, 49, 627-632.
- Devereux, G. (1978). *Ethnopsychanalysis: Psychoanalysis and anthropology as complementary frames of reference*. Berkeley, CA: University of California Press.
- Dowdy, K. G. (2000). The culturally sensitive medical interview. *Journal of American Ass-JAAPA*, 13, 91-104.
- Dowd, E. T. (2003). Cultural differences in cognitive therapy. *The Behavior Therapist*, 26, 247-249.
- Emsline, G. J., Rush, A. J., Wineberg, W. A., Kowatch, R. A., Hughs, G. W., Carmody, T., et al. (1997). A double-blind, randomized, placebo-controlled trial of fluoxetine in children and adolescents with depression. *Archives of General Psychiatry*, 54, 1031-1037.
- Escobar, J. I. (1996). Overview of somatization: diagnosis, epidemiology, and management. *Psychopharmacological Bulletin*, 32, 589-596.
- Foo, K. H. & Kazantzis, N. (2007). Integration of homework assignment based on culture: Working with Chinese patients. *Cognitive and Behavioral practice*, 14, 3, 333-340.
- Freud, S. (1965). *The interpretation of dreams*. New York: Avon Books.
- Goncalves, O. F. & Craine, M. H. (1990). Use of metaphors in cognitive therapy. *Journal of Cognitive Psychotherapy*, 4, 2, 135-149.
- Hays, P. A. & Iwamasa, G. Y. (2006). *Culturally responsive cognitive-behavior therapy: Assessment, practice and supervision*. Washington, DC: American Psychological Association.
- Hinton, D. E. & Otto, M. W. (2006). Symptom presentation and symptom meaning among traumatized Cambodian refugees: Relevance to a somatically focused cognitive behavior therapy. *Cognitive and Behavioral Practice*, 13, 4, 249-260.
- Ilechukwu, S. T. C. (1991). Psychiatry in Africa: Special problems and unique features. *Transcultural Psychiatric Research Review*, 28, 169-218.
- Interian, A. & Diaz-Martinez, A. M. (2007). Consideration for culturally competent Cognitive Behavior Therapy for depression with Hispanic patients. *Cognitive and Behavioral Practice*, 14, 87-97.
- Interian, A., Allen, L. A., Gara, M. A., & Escobar, J. I. (2008). A pilot study of culturally adapted cognitive behavior therapy for Hispanics with major depression. *Cognitive and Behavioral Practice*, 15, 67-75.
- Jung, C. G. (1983). *The essential Jung*. New York: MJF Books.
- Kazdin, A. E. (1993). Drawing valid inferences from case studies. In A. E. Kazdin (Ed.), *Methodological issues and strategies in clinical research* (pp. 475-490). Washington, DC: American Psychological Association.
- Keitner, G. I., Fodor, J., Ryan, C. E., Miller, I. W., Epstein, N. B., & Bishop, D. S. (1991). A cross-cultural study of major depression and family functioning. *Canadian Journal of Psychiatry*, 36, 4, 254-258.
- Khodayarifard, M., Rehm, L. P., & Khodayarifard, S. (2007). Psychotherapy in Iran: A case study of cognitive behavior family therapy for Mrs. A. *Journal of Clinical Psychology*, 63, 8, 745-753.
- Kirmayer, L. (1984). Culture, affect and somatization II. *Transcultural Psychiatric Research Review*, 21, 237-262.
- Kirmayer, L. J., Robinson, J. M., Dworkind, M. et al. (1993). Somatization and the recognition of depression and anxiety in primary care. *American Journal of Psychiatry*, 150, 734-741.
- Kleinman, A. (1978). Culture and depression. *Culture and Medical Psychiatry*, 2, 295-296.
- Kleinman, A. (1982). Neurasthenia and depression: A study of somatization and culture in China. *Culture, Medicine and Psychiatry*, 6, 2, 117-189.
- Kleinman, A. (1988). *Rethinking psychiatry: From cultural categories to personal experiences*. New York: Free Press.
- Kleinman, A. (1995). Do psychiatric disorders differ

- in different countries? The methodological questions. In N. R. Goldberger and J. B. Veroff (Eds), *The culture and psychology* (pp. 631-651). New York: University Press.
- Kleinman, A. & Good, B. (Eds). (1985). *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder*. CA: University of California Press.
- Laubscher, B. F. J. (1938). *Sex, custom and psychopathology*. New York: McBride.
- Lazarus, A. A. (1963). The results of Behavior therapy in 126 cases of severe neurosis. *Behavior Research and Therapy*, 1, 69-79.
- Leff, J. (1973). Culture and the differentiation of emotional states. *British Journal of Psychiatry*, 123, 299-306.
- Leff, J. (1977). International variations in the diagnosis of psychiatric illnesses. *British Journal of Psychiatry*, 131, 329-338.
- Linton, R. (1945). *The cultural background of personality*. New York: Appleton-Century-Crofts.
- Listug-Lunde, L. B. (2005). Cognitive behavior treatment for depression in Native American middle-school students. *Dissertation Abstract International: Section-B: The Science and Engineering*, 66, 2-B, p. 1176
- Littlewood, R. (1990). From categories to contexts: A decade of the new cross-cultural psychiatry. *British Journal of Psychiatry*, 156, 308-327.
- Littlewood, R., & Lipsedge, M. (1987). The butterfly and the serpent: Culture, psychopathology and biomedicine. *Culture, Medicine and Psychiatry*, 11, 289-336.
- Liu, E. T. (2007). Integrating cognitive behavioral and cognitive-interpersonal case formulations: A case study of Chinese American male. *Psychometric Case Studies in Psychotherapy*, 3, 3, 1-33.
- Lonner, W. J. & Malpass, R. (Eds). (1994). *Psychology and culture*. Boston: Allyn & Bacon.
- Makanjuola, R. O. A. (1987). "Ode Ode-ore" a culture-bound disorder with prominent somatic features in Yoruba Nigerian patients. *Acta Psychiatrica Scandinavica*, 75, 231-236.
- Marsella, A. J. (1979). Cross-cultural studies of mental disorders. In A. J. Marsella, G. DeVos, & F. L. K. Hsu (Eds), *Perspectives on cross-cultural psychology* (pp. 233-262). New York: Academic Press.
- Marsella, A. J. (1980). Depressive experience and disorder across cultures. In H. C. Triandis & J. Draguns (Eds), *Handbook of Cross-Cultural Psychology* (pp. 237-289). Boston: Allyn & Bacon.
- Marsella, A. J., Sartorius, N., Jabensky, A., & Fenton, F. R. (1985). Cross-cultural studies of depressive disorders. In A. Kleinman & B. Good (Eds), *Culture and depression* (pp. 299-234). Berkeley: University of California Press.
- Mouanoutoua, V. L., Brown, L. G., Cappelletty, G. G., & Levine, R. V. (1991). A Hmong adaptation of the Beck Depression Inventory. *Journal of Personality Assessment*, 57, 309-322.
- Myers, D. (2008). *Exploring psychology*. New York: Worth Publishers.
- Nzewi, E. N. (1989). Nigerian traditional concepts of psychopathology. In K. Peltzer & P. Ebigbo (Eds), *Clinical psychology in Africa* (pp. 208-216). Nigeria: Chuka Press.
- Nzewi, E. N. (1992). Diagnostic psychological assessment of psychopathology in transcultural settings. *African Journal of Consulting Psychology*, 1, 42-68.
- Okulate, G. T. & Jones, O. B. (2002). Two depression rating instruments in Nigerian patients. *Nigerian Postgraduate Medical Journal*, 9, 2, 74-78.
- Organista, K. C. & Munoz, R. F. (1996). Cognitive Behavior Therapy with Latinos. *Cognitive and Behavioral Practice*, 3, 255-270.
- Otto, M. W. (2000). Stories and metaphors in Cognitive-Behavior Therapy. *Cognitive and Behavioral Practice*, 7, 2, 166-172.
- Patel, V. (1996). Recognizing common mental disorders in primary care in African countries: Should "mental" be dropped? *Lancet*, 347, 742-744.
- Patel, V., Abas, M., Broadhead, J., Todd, C., & Reeler, A. (2001). Education and debate, depression in developing countries: Lessons from Zimbabwe. *British Medical Journal*, 322, 482-484.
- Patel, V., Todd, C. H., Winston, M., Gwanzura, F., Simunyu, E., Acuda, W. et al. (1997). Common mental disorders in primary care in Harare,

- Zimbabwe: Associations and risk factors. *British Journal of Psychology*, 171, 60-64.
- Patel, V. & Winston, M. (1994). The universality of mental disorder revisited: Assumptions, artifacts and new directions. *British Journal of Psychiatry*, 165, 437-440.
- Pearsons, J. B., Davidson, J., & Tompkins, M. A. (2002). *Essential components of cognitive behavior therapy for depression*. Washington, DC: American Psychological Association.
- Penley, J. A., Wiebe, J. S., & Nwosu, A. (2003). Psychometric properties of the Spanish Beck Depression Inventory-II in a medical sample. *Psychological Assessment*, 15, 569-577.
- Pike, K. L. (1954). Emic and etic standpoints for the description of behavior. In K. L. Pike (Eds), *Language in relation to a unified theory of the structure of human behavior*, Part 1 (pp. 8-28). Glendale, CA: Summer Institute of Linguistics.
- Prince, R. H. (1968). The changing picture of depressive syndromes in Africa: Is it fact or diagnostic fashion? *Canadian Journal of African Studies*, 1, 177-192.
- Rector, N. A. (2007). Homework use in cognitive therapy for psychosis: A case formulation approach. *Cognitive and Behavioral Practice*, 14, 3, 303-316.
- Rose, D. J. R. (2003). *Analogies in medicine: A personal view*. *British Medical Journal*, 326, 111.
- Rossello, J. & Bernal, G. (1999). The efficacy of cognitive behavioral and interpersonal treatments for depression in Puerto Rican adolescents. *Journal of Consulting and Clinical Psychology*, 67, 5, 734-745.
- Soltani, A., Moayyeri, A., & Raza, M. (2004). Impediments to implementing evidence-based mental health in developing countries. *Evidence Based Mental Health*, 7, 64-66.
- Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist*, 29, 790-821.
- Sue, D. W. & Sue, D. (2007). *Counseling the culturally diverse: Theory and practice*. New York: Wiley & Sons.
- Thase, M. E. & Callan, J. A. (2006). The role of homework in cognitive behavior therapy of depression. *Journal of Psychotherapy Integration*, 16, 2, 162-177.
- Tran, S. N. (2006). Short-term, time-limited behavior therapy for major depression with Vietnamese refugee women: An analysis of three cases. *Dissertation Abstract International: Section B: The Science & Engineering*, 66, 7-B, p. 3961.
- Tsang, Wen-Shing & Streltzer, J. (Eds), (2001). *Culture and psychopathology: A guide to clinical assessment*. Washington, DC: American Psychiatric Press.
- Yeung, A., Howarth, S., Chan, R., Sonawalla, S., Nierenberg, A. A., & Fava, M. (2002). Use of Chinese version of Beck Depression Inventory for screening depression in primary care. *Journal of Nervous and Mental Disease*, 190, 94-99.
- Weinberg, S. K. (1965). Cultural aspects of manic-depression in West Africa. JSTOR: *Journal of Health and Human Behavior*, 6, 4, 247-253.
- Wilkes, T. C. & Rush, A. J. (1988). Adaptations of cognitive therapy for depressed adolescents. *Journal of the American Academy of Adolescent Psychiatry*, 27, 381-386.
- Williams, J. M. C. (1997). Depression. In D. M. Clark, C. G. Fairburn (Eds), *Science and practice of cognitive behavior therapy* (pp. 259-283). Oxford: Oxford University Press.
- Williams, M. W., Foo, K. H., & Haarhoff, B. (2006). Cultural considerations in using cognitive behavior therapy with Chinese people: A case study of an elderly Chinese woman with generalized anxiety disorder. *New Zealand Journal of Psychology*, 35, 3, 153-162.
- Whiting, J. W. M. & Child, I. L. (1953). *Child training and personality*. New Haven, Conn.: Yale University Press.
- Zheng, Y. & Lin, K. M. (1991). Comparison of the Chinese Depression Inventory and the Chinese version of the Beck Depression Inventory. *Acta Psychiatrica Scandinavica*, 84, 531-536.
- Zikopoulos, M. (1997). *Open doors: 1987-1988 report on international exchange*. New York: Institute of International Education.

Συνδέοντας αφρικανικές και δυτικές θεραπευτικές μεθόδους μέσω της αξιοποίησης λαϊκών ιστοριών στην εφαρμογή της Γνωσιακής Συμπεριφοριστικής Θεραπείας της κατάθλιψης

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ΠΕΡΙΛΗΨΗ

Οι μοναδικές προκλήσεις που αντιμετωπίζουν οι Αφρικανοί ψυχολόγοι που έχουν εκπαιδευτεί σε δυτικές χώρες είναι να χρησιμοποιούν γενικές θεωρίες στο κλινικό χώρο παρέμβασης και θεραπευτικές τεχνικές με τέτοιο τρόπο που να είναι κλινικά αποτελεσματικές και «πολιτισμικά ευαίσθητες». Η παρούσα μελέτη περίπτωσης περιλαμβάνει τη δια-πολιτισμική εφαρμογή της Γνωσιακής Συμπεριφοριστικής Θεραπείας (CBT) για τη θεραπευτική αντιμετώπιση της Μείζονος Καταθλιπτικής Διαταραχής (MDD) σε μια 12χρονη Νιγηριανή. Η πολιτισμική σχετικότητα αναβαθμίζεται μέσω της εναρμόνισης αφρικανικών λαϊκών, φανταστικών ιστοριών με «πονηρούς» χαρακτήρες και της διαπολιτισμικής εφαρμογής της Γνωσιακής Συμπεριφοριστικής Θεραπείας. Οι στρατηγικές που περιγράφονται αφορούν την ανάπτυξη των κεντρικών θεμάτων, την περιγραφή των πλαισίων, τα χαρακτηριστικά των κακοποιών και των θυμάτων, τη φύση των διαπροσωπικών σχέσεων, τα συναισθήματα, τη συμπεριφορά και τις συνέπειές της στις ιστορίες με πονηρούς ήρωες. Οι αφρικανικές ιστορίες χρησιμοποιούνται για την εφαρμογή κεντρικών θεραπευτικών τεχνικών της Γνωσιακής Συμπεριφοριστικής Θεραπείας. Τα αποτελέσματα συζητούνται σε σχέση με τα οφέλη της θεραπευτικής παρέμβασης, την αποτελεσματικότητα της τροποποιημένης Γνωσιακής Συμπεριφοριστικής Θεραπείας σε μη-δυτικού τύπου κοινωνίες, καθώς και σε σχέση με τα χαρακτηριστικά του πελάτη που είναι σημαντικά, προκειμένου να επιλέξει κανείς τον τρόπο που θα αναδιαμορφώσει τη θεραπεία της Μείζονος Καταθλιπτικής Διαταραχής με πολιτισμικά ευαίσθητη Γνωσιακή Συμπεριφοριστική Θεραπευτική προσέγγιση στην εφηβεία.

Λέξεις-κλειδιά: Γνωσιακή Συμπεριφοριστική Θεωρία, Αφρικανικές λαϊκές φανταστικές ιστορίες, Μείζων καταθλιπτική διαταραχή.

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