

# Integrating Evidence-Based Practice, Cognitive–Behavior Therapy, and Multicultural Therapy: Ten Steps for Culturally Competent Practice

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During the past decade, 3 major developments in psychotherapy have been converging: the establishment of evidence-based practices in psychology (EBPP); enormous growth in cognitive–behavior therapy and research (CBT); and increasing recognition of the impact of multicultural influences, as highlighted in the field of multicultural therapy (MCT). Cognitive–behavioral research has produced many empirically supported treatments used in the establishment of the scientific research base of EBPP, and MCT research has provided a wealth of qualitative information that balances this scientific emphasis with recognition of the importance of culturally competent clinical judgment, expertise, and experience. This article describes the advantages and potential limitations involved in the integration of CBT and multicultural considerations, with limitations reframed as opportunities to improve the relevance and effectiveness of psychotherapy. Ten suggestions are provided for integrating multicultural considerations into the clinical practice of cognitive–behavior therapy.

*Keywords:* multicultural, cultural competence, cognitive–behavior therapy, evidence-based practice

During the past decade, three major developments in psychology have been converging. The first development consists of the establishment of evidence-based practices in psychology (EBPP). Initially, the EBPP movement focused on the development of empirically supported or evidence-based *treatments*, with an emphasis on treatments tested in randomized controlled trials (Kazdin, 2008). However, in response to many psychologists' concerns regarding the exclusive focus on brief manualized treatments, the American Psychological Association Presidential Task Force on EBPP (2006) agreed to define *evidence-based practice* as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 271). Although controversy continues regarding the adoption of EBPP, as Messer (2004) notes:

The issue need not be framed so starkly as science versus humanism or the use of evidence versus clinicians' subjective and clinical judgment. ESTs [empirically supported treatments], for example, provide one kind of relevant data on which clinicians can rely, but they are not and cannot be the sole source of evidence-based practice. (p. 586)

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The second major development in psychology has been the enormous increase in cognitive–behavior therapy (CBT) practice and research. A survey of more than 2,000 counselors, social workers, and psychologists found that approximately 69% reported using CBT (Psychotherapy Networker, 2007). Another poll of practicing psychologists found that 89% of the 470 respondents used CBT (Meyers, 2006). The number of publications on CBT is too exhaustive to list here, but includes more than 200 manuals (Chambless, Hayes, Craighead, & Azrin, 2006, cited in Kot, 2007) and numerous books on a wide range of problems (see Antony, Ledley, & Heimberg, 2005, and Hays, 2006b, for summaries). Given CBT's emphasis on scientific analysis and quantifiable outcomes, it is not surprising that CBT has also become the most widely researched evidence-based psychotherapy (see Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Hwang, 2009; and Nicolas, Arntz, Hirsch, & Schmiedigen, 2009, for additional reviews of the cognitive–behavioral literature and evidence-based cultural adaptation models with Chinese Americans and Haitian American adolescents).

The third major development in psychology is multiculturalism, and with regard to psychotherapy in particular, the field of multicultural therapy (MCT). Since 2000, more than 40 multicultural counseling and clinical books and a plethora of articles have been published on diverse ethnic, religious, national, sexual, and other cultural minority groups (see Hays, 2008, for a summary of books). The relatively recent and strong influence of multiculturalism has led to its conceptualization as a "fourth force" in the development of psychology, building on the first three forces of psychoanalysis, behaviorism, and humanism (Pedersen, Draguns, Lonner, & Trimble, 2002). However, although MCT research has been extremely valuable in calling attention to the importance of cultural competence in the application of all forms of therapeutic practice and research, the need remains for more

empirically supported interventions with diverse minority populations (Whaley & Davis, 2007).<sup>1</sup>

### A Convergence

At this point, the three developments of EBPP, CBT, and MCT are converging, complementing, and contributing to the relatively rapid expansion of one another. Cognitive-behavioral research has produced many empirically supported treatments (ESTs) used in the establishment of the scientific research base of evidence-based practices, and MCT research has provided a balance to this scientific emphasis via a wealth of qualitative data regarding the importance of culturally competent clinical judgment, expertise, and experience. MCT researchers have also pushed CBT to expand its empirical approach to include more diverse populations (Suinn, 2003).

The process of integrating multicultural considerations throughout every aspect of CBT is still in the beginning stages, but already includes at least one book (Hays & Iwamasa, 2006), a special section of the journal *Cognitive and Behavioral Practice* (2006, Vol. 13), and a growing number of empirically based studies, qualitative studies documenting clinical evidence, and review articles of ESTs with minority populations (e.g., regarding the latter, see Horrell, 2008, and Miranda et al., 2005). This special section includes two articles (Hwang, 2009; Nicolas, Arntz, Hirsch, & Schmiedigen, 2009) that contribute to the growing body of literature in this particular area. In summary, it appears that CBT holds great promise for the development of culturally competent evidence-based practices. In the following sections, I draw from and build on this work via 10 clinician-oriented suggestions and a case example for integrating multicultural considerations into CBT.

For the purpose of this integration, I define culture broadly on the basis of the influences and minority groups that the American Psychological Association has called attention to in its multicultural guidelines (American Psychological Association, 2002). These influences can be summarized via an acronym that reminds psychologists of the influences that are important to be considering and ADDRESSING: Age and generational influences, Developmental Disabilities and disabilities acquired later in life, Religion and spiritual orientation, Ethnic and racial identity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and Gender (Hays, 2008; see Table 1). The ADDRESSING framework includes a comprehensive approach to multicultural work that extends beyond the simplistic use of this acronym to the ongoing, lifelong process of increasing one's multicultural competence. The following suggestions are offered with the hope that psychologists are committed to and involved in this process.

### CBT and MCT: A Perfect Fit, Almost

CBT and MCT share a remarkable number of assumptions that facilitate their integration (Hays, 1995). One, both emphasize the need to tailor interventions to the unique needs and strengths of the individual; MCT particularly emphasizes cultural influences that contribute to this uniqueness. Two, both emphasize empowerment: CBT via an educational approach that teaches specific skills that clients can take with them; MCT through its attention to cultural identity as a source of strength. Three, CBT focuses on conscious

Table 1  
*The ADDRESSING Framework: Summary of Cultural Influences and Related Minority Groups*

Cultural influence	Minority group
Age/generational	Children, elders
Developmental disabilities	People with developmental disabilities
Disabilities acquired later in life	People with disabilities acquired later in life
Religion and spiritual orientation	Religious minority cultures
Ethnic and racial identity	Ethnic and racial minority cultures
Socioeconomic status	People of lower status by class, education, occupation, income, or rural/urban habitat
Sexual orientation	Gay, lesbian, and bisexual people
Indigenous heritage	Indigenous/Aboriginal/Native people
National origin	Refugees, immigrants, international students
Gender	Women, transgender people

*Note.* From Hays, P. A. (2008). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (2nd ed.). Washington, DC: American Psychological Association.

processes that can be easily articulated and assessed—an approach that is well suited to people who speak English as a second language or who do not share the same cultural assumptions that underlie the European American concept of the unconscious. Four, CBT integrates assessment throughout therapy, an action that communicates respect for clients' viewpoints regarding their progress; such demonstrations of respect are considered a core part of culturally responsive practice (Boyd-Franklin, 2003). Five, both CBT and MCT call attention to naturally occurring strengths and supports that can be used to facilitate change. Finally, CBT's behavioral roots emphasize the influence of environment on behavior, which fits well with MCT's emphasis on cultural influences.

### Potential Limitations

All of these similarities would suggest that CBT and MCT are made for each other; however, there are also a number of potential limitations to multicultural applications of CBT. Because it emphasizes conscious processes, overt behavior, and language, CBT has traditionally been conceptualized as a relatively value-neutral approach (Kantrowitz & Ballou, 1992). However, CBT and the

<sup>1</sup> There is some question as to whether MCT is a therapy per se, or rather, an approach that can be used to rethink and expand other therapies. My own position leans toward the latter, that MCT is more accurately conceptualized as a type of *technical eclecticism* (to borrow a term used by Lazarus & Beutler, 1993, in reference to CBT). Although MCT can be distinguished by a particular set of theoretical premises (e.g., that culture influences the therapeutic relationship), multicultural therapists typically draw from a wide range of interventions and procedures according to the particular needs of their clients and the evidence supporting those interventions and procedures. However, I believe it is helpful to conceptualize MCT as a field (rather than simply referring to the process of multiculturalism) because the field provides a centering point for research that might otherwise be overlooked or marginalized.

other major practice theories are and always have been embedded with many of the values supported by the dominant culture. Consider the value that CBT and the field in general place on assertiveness, personal independence, verbal ability, rationality, cognition, and behavioral change. In contrast, many cultures value subtle communication over assertiveness, interdependence over personal independence, listening and observing over talking, acceptance over behavioral change, a less linear cognitive style, and a more spiritually oriented worldview (Jackson, Schmutzer, Wenzel, & Tyler, 2006).

A second limitation of CBT is its focus on the present, which can easily lead to a neglect of the past. Obviously, cognitive-behavioral assessment involves the investigation of each client's *personal* history. However, if therapists are unaware of the history of a client's *culture*, they may have difficulty interpreting the client's personal experiences and behaviors. This limitation is more related to the knowledge base of the therapist, but the here-and-now orientation of CBT lends itself to errors in this direction.

A third limitation of CBT involves its individualistic orientation. CBT grew out of behaviorism, which strongly emphasizes the influence of physical and social environments, including cultural influences on behavior. However, CBT's emphasis on the individual may lead a less experienced therapist to overemphasize cognitive restructuring to the neglect of environmental interventions (e.g., focusing on the need for a client with a disability to change his or her thinking regarding environmental obstacles without addressing ways in which the environment could be changed first).

In summary, recognition of these potential limitations does not preclude the integration of CBT and MCT. Rather, such awareness presents opportunities for rethinking, refining, adapting and increasing the relevance and effectiveness of psychotherapy.

### *Culturally Responsive CBT*

CBT as commonly practiced often begins with the task of making changes in the client's situation or environment, toward the goal of alleviating or solving the presenting problem. However, at times, a client may experience an event that cannot be solved or changed (e.g., a family member's chronic illness) or that the client chooses not to change (e.g., the choice to stay in a job with a difficult new boss because retirement is only 6 months away). When this is the case or all possible environmental changes have been addressed, the therapist may teach the client *cognitive restructuring*. Via cognitive restructuring, clients learn to recognize common cognitive errors, automatic dysfunctional thoughts, and cognitive tendencies that work against their long-term goals. By considering a broader range of possible interpretations and beliefs, clients learn to see themselves, the world, and the future more fully and realistically (J. S. Beck, 2005). Building on this mainstream approach to CBT, the following suggestions are intended to facilitate the integration of diverse cultural considerations into cognitive-behavioral assessment and therapy.

1. *Assess the person's and family's needs with an emphasis on culturally respectful behavior.* Whereas rapport has been the focus of research on building relationships among European Americans, the concept of *respect* tends to be more highly valued among many people of Asian, Native, African, African American, Latino, and Middle Eastern cultures, particularly with regard to

authority-laden relationships such as psychotherapy (Abudabbeh & Hays, 2006; Boyd-Franklin, 2003; Iwamasa, Hsia, & Hinton, 2006; Matheson, 1986; Organista, 2007). Because respectful behaviors differ across cultures, it can be helpful to use a hypothesis-testing approach when one is beginning cross-cultural work. Keeping the ADDRESSING list in mind can facilitate this approach by reminding the therapist of influences on the client, the therapist, and their interactions. Specifically, when trying to figure out why an initial assessment is not going well in the moment, it can be helpful to ask oneself, "Could the discomfort I am sensing right now have anything to do with my or the client's expectations regarding respectful behaviors connected to any of the ADDRESSING influences (e.g., the person's age, ethnic, or racial identity, etc.)?"

For example, cognitive-behavioral assessment is a relatively directive process, and repeated questioning is considered disrespectful in some cultures, particularly among many Native people and elders of diverse cultures, including European American (Weisman et al., 2005). In such cases, the therapist may need to slow down the questioning process, allow for silences, or give the individual more control in the flow and content of information provided (Hays, 2006a). (Of course, cognitively impaired individuals will usually need more structure.) Allowing for some "small talk that includes judicious self-disclosure" at the beginning of an assessment can help, particularly with clients for whom a warm personal approach is valued even in professional relationships (Organista, 2006, p. 81). It may also be necessary to initially avoid questions that reflect negatively on the person's family or culture (Paradis, Cukor, & Friedman, 2006). Clients of minority identities may be especially reluctant to share such information with a therapist of a dominant cultural identity, fearing that the information may reinforce dominant cultural prejudices in the therapist.

2. *Identify culturally related strengths and supports.* Although cognitive-behavioral assessment usually involves seeking information regarding clients' strengths and supports, a *culturally responsive* cognitive-behavioral assessment draws attention to strengths and supports that have a cultural connection. The explicit consideration of culturally related strengths and supports is important to draw attention to culture as a resource (Cross, 2003). In addition, culturally reinforced supports may be more easily incorporated into interventions and thus increase the likelihood of treatment success.

Culturally related *personal strengths* include pride in one's culture and identity; religious faith or spirituality; musical and artistic appreciation and abilities such as weaving, beading, and sewing; bilingual and multilingual skills; culturally related knowledge and practical living skills such as fishing, hunting, farming, and the use of medicinal plants; and culture-specific beliefs that help one cope with prejudice and discrimination. *Interpersonal supports* include extended families, traditional celebrations and rituals that involve an entire religious culture, storytelling activities that pass on the history of the group, involvement in political or social action groups, and having a child who is successful in school as a source of pride for the family. *Environmental supports* include space for prayer and meditation; available food, cooking, and eating of preferred foods; access to nature for gardening, fishing, hunting, and farming, all of which have a spiritual connection for many rural and Indigenous people; the presence of culture-specific art, music, and home furnishings; a place for animals; and com-

munities that facilitate social interaction such as villages where homes are within walking distance of one another (Hays, 2007).

Because in many Asian and Native cultures, reciting one's strengths is often considered immodest, asking a client directly about their strengths may elicit a shrug or "I don't know." In such cases, it can be helpful to ask the person, "What would your mother, friend (or other significant person) say are your strengths?" In addition, the ADDRESSING list can be helpful in calling therapists' attention to cultural strengths and resources related to each of the influences.

3. *Clarify what part of the problem is primarily environmental (i.e., external to the client) and what part is cognitive (internal), with attention to cultural influences.* Culturally responsive CBT emphasizes the distinction between external and internal contributing factors for the same reason that mainstream CBT does: to provide direction in choosing the most effective type of intervention. However, with culturally responsive CBT, the distinction is even more important because it facilitates the therapist's consideration of cultural influences that may affect the client's situation and options. Focusing too quickly on internal cognitive explanations of a client's problem may lead the therapist into cognitive restructuring when the situation requires change first. Furthermore, an exclusive focus on the individual to the neglect of cultural context risks pathologizing the individual when the situation is the problem, for example, in the case of a workplace that is racist, heterosexist, or hostile to people with disabilities.

Of course, there is often overlap between the internal and external components of a problem. For example, Mona, Romesser-Scehnet, Cameron, and Cardenas (2006) emphasize the need for therapists to recognize the limiting aspects of physical and social (i.e., external) barriers experienced by people with disabilities, as well as the ways in which these barriers may contribute to the development of particular internal cognitive distortions. For example, in countering the belief that one must appear as nondisabled as possible to be attractive, the authors advise therapists to recognize the pervasiveness of such beliefs and real obstacles in the dominant culture and help the client to develop realistic and not simply more positive thoughts.

4. *For environmentally based problems, focus on helping the client to make changes that minimize stressors, increase personal strengths and supports, and build skills for interacting more effectively with the social and physical environment.* Culturally responsive examples include the following:

(a) Group therapy and skills training in a format that is culturally acceptable to the client. For example, Organista (2006) found that the use of CBT manuals, homework assignments, and chalkboard work helped his Latino clients to think of group therapy as a classroom experience ("la clase de depression"), thus decreasing the stigma attached to psychotherapy. However, with Orthodox Jewish clients, Paradis et al. (2006) noted that individual therapy is usually preferable to group therapy because of the shame attached to mental health problems. These authors added that when groups are used, they should be single gender, and in vivo practice exercises should be arranged outside the client's neighborhood to minimize the possibility of embarrassment from neighbors viewing.

(b) Communication skills training that acknowledges cultural differences in communication preferences. For instance, LaFromboise and Rowe (1983) taught dominant culture assertiveness

skills to American Indian leaders to help them in their interactions with European Americans, while simultaneously emphasizing the value of retaining American Indian skills (i.e., bicultural competence).

(c) Increasing culturally congruent self-care activities, and for low-income clients, activities that cost little or nothing. For example, for many Alaska Native people (and some non-Native people in Alaska), berry picking is a fun activity that costs nothing, connects one to nature, and may even have a spiritual feeling (Minton & Soule, 1990).

5. *Validate clients' self-reported experiences of oppression.* When a client reports an incident of discrimination or oppression, therapists are cautioned to avoid automatically minimizing or looking for alternative explanations (e.g., "Could it be that he meant something else by that?" or "Maybe she was angry about something when she said that?"). Although CBT emphasizes the exploration of alternative hypotheses, such attempts may be perceived as evidence of the therapist's own racist attitudes or naiveté. In working with African Americans, Kelly (2006) advised beginning with the supposition that the incident has occurred. Once the client feels believed and validated, the therapist may then assess the relevance of the incident to the client's presenting problem.

6. *Emphasize collaboration over confrontation, with attention to client-therapist differences.* The assumption that cognitive restructuring is confrontational probably derives from Ellis' emphasis on "the use of vigor and force in counteracting irrational philosophies and behaviors" (Dryden & Ellis, 2001, p. 314). However, Beck and associates have consistently emphasized the importance of a *collaborative* alignment with the client (A. T. Beck, Rush, Shaw, & Emery, 1979; J. S. Beck, 2005). A sense of alignment is especially important when the client belongs to a minority group (Vasquez, 2007), and involves communication of the therapist's understanding of the system of privilege and oppression in which the client lives. For example, in working with an Alaska Native man, a European American therapist wrote the stressors he described on an erasable board attached to the side of her file cabinet. She then said, "Let's take a look at these," and moved her chair next to his so that as they talked about each stressor, they were literally (physically) facing his problems together (Bethany Thornton, personal communication, January 28, 2009).

The idea of alignment is also helpful with couples. For example, Boyd-Franklin and Franklin (1998) described the example of a professional African American couple who experienced the impact of racism on a day-to-day basis in their work in a major law firm. The therapist observed that the couple were engaging in a great deal of angry blaming of one another, and told them that she believed they were both victims of racism, but instead of uniting to fight against it, they were "tearing each other apart and letting racism win" (p. 275). In reframing the problem in this way, she encouraged them to recognize their mutual oppression and look for ways to work together and support one another.

7. *With cognitive restructuring, question the helpfulness (rather than the validity) of the thought or belief.* When clients and therapists come from different cultures, questioning the validity or rationality of a behavior or belief may be seen as naïve or uncaring. For instance, toward illustrating the illogic of a client's fears that her son might be wrongfully arrested, asking, "So what if that

happens?" could backfire if those fears are grounded in a reality that the therapist does not understand.

A more culturally responsive approach (and one often used in the cognitive therapy of Beck and associates) is to help the client consider the helpfulness (i.e., utility) of the belief or thought. Specifically, the therapist may ask the client, "Is it *helpful* for you to say this to yourself, to hold onto this belief, or to repeat this thought or image to yourself?" The therapist may also help the client to consider the advantages and disadvantages of the belief, as a way of determining how well a belief or thought is working for the person (J. S. Beck, 2005). This form of questioning avoids the problem of determining what is rational or functional in a client's culture, and recognizes that the client is ultimately the best judge regarding the helpfulness of beliefs and behaviors in their particular context (Wood & Mallinckrodt, 1990).

To illustrate the subtleties of questioning the helpfulness versus validity of a belief or behavior, consider the case of a 52-year-old Alaska Native woman I will call Anna, who is Christian and a single parent to her three grandchildren. She lives in a rural area with limited social services, and believes that the local law enforcement officials do not like Native people. She worries that her daughter and son-in-law who are chronically drug addicted may return at any time and take their children back, which they can legally do. Anna's worries include the belief that her son-in-law might kill the children either deliberately by abuse or indirectly by neglect.

Clearly in this situation, the first step would be to assist Anna in making a safety plan for her grandchildren and herself. Once a plan is in place, the culturally responsive therapist might then engage Anna in problem solving to address environmental sources of her distress (e.g., poverty, the demands of single parenting). This "external" work would include looking for culturally related strengths and supports upon which she could build, for example, enlisting the help of extended family members or church friends, joining a drumming or dance group, or engaging in outdoor activities that decrease feelings of stress. It could also involve exploring the possibility of obtaining legal custody of the grandchildren. Once these externally oriented strategies have been started, or in tandem with them, the therapist might then begin to address the internal aspects of Anna's distress via cognitive restructuring.

With cognitive restructuring, the therapist would need to proceed cautiously because challenging Anna's beliefs could alienate her. The therapist would want to first demonstrate respect for Anna's perspective by listening carefully and using silence to indicate thoughtfulness regarding her concerns (Hays, 2006a). Even if the therapist believes that Anna could be catastrophizing about her daughter and son-in-law or overgeneralizing regarding the authorities, the best course would be to validate the possibility that the son-in-law could harm his children and that the local authorities are prejudiced against Native people, recognizing that Anna may see the therapist as an authority too. Without directly challenging these beliefs, the therapist could help Anna to recognize repetitive thoughts and images that increase her distress (e.g., the "What ifs," as in "What if my daughter and son-in-law return high on drugs? What if they insist on taking the children? What if no one will help me?" and other self-talk such as "No one really cares; this is hopeless"). The therapist could then help Anna to develop more reassuring ways to talk to herself (e.g., "I am a strong Native woman. I have faced many hard things in my life and

gotten through them. I know my sister, best friend, and my pastor care about me. I can draw strength from nature, my traditions, and God. Remember the Serenity Prayer").

Only after a very strong trust has been developed (and if it seems relevant) might the therapist consider exploring with Anna alternative ways to think about the authorities (e.g., Could there be some Native or open-minded non-Native authorities in the next town who might be helpful? Could there be an authority who is not a law enforcement official that could be helpful, for example, her pastor?).

*8. Do not challenge core cultural beliefs.* In general, therapists are advised to avoid challenging *core* cultural beliefs unless the client is clearly open to this, as such challenges may be perceived as disrespectful or naïve. For example, a therapist with an individualistic, dominant cultural orientation might be inclined to encourage Anna to disconnect from her daughter. However, such an approach would likely fail because it runs counter to core Native beliefs about the importance of family relationships.

*9. Use the client's list of culturally related strengths and supports to develop a list of helpful cognitions to replace the unhelpful ones.* When a client has difficulty creating new helpful thoughts, the list of personal strengths can provide a reminder of internal coping resources and past successes. The list of interpersonal supports offers evidence that the client is valued by others. And for spiritually oriented clients, the list of natural environmental supports may be a reminder that a Higher Power cares for the client. These strengths and supports can be phrased as self-statements that the client repeats to herself (as in Anna's helpful self-talk above).

*10. Develop weekly homework assignments with an emphasis on cultural congruence and client direction.* The importance of cultural congruence and client direction was described by Lau and Kinoshita (2006) in the example of an older Chinese man who initially failed to complete a homework assignment despite the fact that he and the therapist chose it from an older adults inventory of enjoyable activities (that did not attend to cultural differences). The therapist subsequently encouraged the client to develop a list himself, which then included tai chi, Chinese calligraphy, reading the Chinese newspaper, and visiting Chinatown, and led to a homework completion of 100%.

A question that I frequently use to help clients create their own homework is, "What is the smallest possible step you could take that would feel like you are making progress?" For clients who are religious or spiritually oriented, I slightly rephrase the question as, "What is the smallest possible healing step you could take this week?" (adaptations of questions by Dolan, 1991, p. 133). I explain why the step needs to be small: to increase one's experience of success and because making changes step-by-step is the most likely way to ensure long-term maintenance. (See Foo & Kazantzis, 2007, for more on cultural considerations with CBT homework assignments.)

## Conclusion

By definition, EBPP require cultural competence, and cultural competence requires that psychologists consider the influence of culture throughout every aspect of their work. With CBT, this includes consideration of the influence of culture on the therapist, on the client, on the therapeutic relationship, and on the specific components of CBT. CBT is not the only theory with potential for

culturally competent practice. However, the strong beginning research base of CBT with minority populations suggests that it holds great promise for expanding the relevance and effectiveness of psychotherapy.

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