Seeking Cultural Competence From the Ground Up
Steven C. Hayes, University of Nevada
Takashi Muto, Doshisha University
Akihiko Masuda, Georgia State University

The present article briefly reviews early evidence of the applicability of acceptance and commitment therapy and its underlying psychological flexibility model to Asians and Asian Americans. Cultural adaptation is an important goal, and we describe how it might be due within a functional contextual approach, namely, by linking cultural knowledge to processes and principles of psychopathology and behavior change. This approach in essence links cultural adaptation to functional analysis. Ideas in the target article, for example about a transcendent sense of self, are used as examples of how this can be performed.

Key words: acceptance and commitment therapy, Asian Americans, cultural competence, mindfulness.

The primary focus of the target article (Hall, Hong, Zane, & Meyer, 2011) is to explain how acceptance and mindfulness-based therapies, particularly acceptance and commitment therapy, can be made more culturally competent as applied to Asian populations. It is a good issue, but the target article shows the difficulties that are ahead of the field in accomplishing such goals.

Acceptance and commitment therapy (ACT) (Hayes, Strosahl, & Wilson, 1999) is an evidence-based form of contextual cognitive behavior therapy that emphasizes the use of acceptance and mindfulness processes, and commitment and behavioral change processes, to produce psychological flexibility. Broadly speaking, psychological flexibility is the ability to experience one’s own experience with openness and awareness and to persist or change in behavior in the service of chosen values. According to the applied theory underlying ACT, six interrelated processes foster psychological flexibility: acceptance, defusion, flexible attention to the now, a transcendent sense of self, values, and committed action. The first four of these processes are taken to constitute mindfulness skills.

Acceptance and commitment therapy emerged originally from a confluence of behavior analysis, cognitive behavior therapy, the human potential movement, and experiential psychotherapies. ACT contains terms and has sensibilities that overlap with Eastern conceptions, but it did not consciously emerge from Buddhism or other forms of Eastern thought—it seems to have arrived at a similar place rather than beginning there (Hayes, 2002).

Acceptance and commitment therapy’s link to behavior analysis is reflected in the conscious attempt to base clinically useful terms on basic behavioral processes, including those identified in an allied behavioral research program in cognition, relational frame theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001). It is also reflected in its philosophical commitment to contextualism and functionalism (Hayes, Luoma, Bond,
Masuda, & Lillis, 2006). From this perspective, issues presented by a given client need to be understood historically and in their larger context, and ACT methods and processes are defined functionally, not topographically. A de-emphasis of the model and philosophy underlying ACT leaves ACT merely as a set of techniques—we are concerned that seems to have happened at times in the target article.

In our response, we will first examine whether ACT and its underlying applied model applies to Asian populations. We will then briefly examine how we might begin to examine the cultural differences raised by the authors in a more fundamental way.

**CAN ACT BE HELPFUL TO ASIAN POPULATIONS?**

The authors state that “the effectiveness of contextual psychotherapies has not been evaluated with Asian Americans” (Hall et al., 2011, p. 219), but the evidentiary basis has become stronger recently. The data are indeed still limited, particularly given the vast diversity of Asian populations, but the available data suggest that ACT may be helpful to Asians and Asian Americans.

Takahashi, Muto, Tada, and Sugiyama (2002) conducted the first randomized study of ACT methods with an Asian population. They compared three methods of increasing pain tolerance in Japanese participants: a lecture on pain, an intervention designed to enhance a sense of control over pain, and an ACT-based acceptance intervention that consisted of an acceptance rationale and practice with two cognitive defusion exercises that are commonly used in ACT: watching thoughts as if they were leaves on a stream and giving internal experiences concrete physical form. Results showed that the acceptance intervention produced greater increases in pain tolerance.

A study by Kishita and Shimada (2011), also conducted in Japan, experimentally examined the correlational finding that psychological flexibility interacts with job control to produce higher performance (e.g., Bond, Flaxman, & Bunce, 2008). Kishita and Shimada (2011) compared a control-focused intervention consisting of a rationale, relaxation exercises, and distraction using pleasant images, to an acceptance-focused intervention using an acceptance rationale and three common ACT exercises (a “tug of war” with anxiety; using “and” instead of “but”; and noticing evaluations).

These two methods were crossed with a stressful work task that allowed high or low job control. Task performance was highest among those with ACT training and high job control.

Acceptance and commitment therapy has also been applied clinically to Asian populations in case studies. (e.g., Masuda, Muto, Hayes, & Lillis, 2008) and randomized controlled trials (RCTs). A small RCT conducted in India compared ACT and yoga for drug refractory epilepsy (Lundgren, Dahl, Yardh, & Melin, 2008). ACT produced better seizure improvement. A larger recent RCT by Muto, Hayes, and Jeffcoat (2011) examined the impact of ACT on the psychological health of Japanese international students. International students are known to experience high rates of anxiety, stress, and depression while studying in the United States (Singaravelu & Pope, 2006), but treatment is often difficult to apply as a result of stigma, language difficulties, and other factors. For example, Japanese international students see psychological difficulties as being more shameful and stigmatizing than do either European Americans students or non-Asian ethnic minority students (Masuda et al., 2009). The study by Muto et al. (2011) was based on the idea that these stigma-based barriers might be overcome by distributing an ACT self-help book to an entire population regardless of mental health status. More than half of all of the Japanese international students at a mid-sized Western university were randomized either to allow for a waitlist or to receive a Japanese translation of the first general-purpose ACT self-help book, *Get Out of Your Mind and Into Your Life* (Hayes & Smith, 2005). Although recruited without regard to health status, the sample was highly distressed, with nearly 80% exceeding clinical cutoffs on one or more measures. Students receiving the book showed significantly better general mental health during follow-up; those with mental health difficulties improved and those without initial mental health problems showed lower rates of later deterioration. Moderately depressed or stressed and severely anxious students showed improvement compared to those not receiving the book. These patterns were repeated when the waitlist participants finally received the book. Improvements in primary outcomes were related to how much was learned about an ACT
model from the book. Follow-up outcomes were statistically mediated by changes in psychological flexibility, but not vice versa, and were moderated by initial levels of psychological flexibility.

IS THE PSYCHOLOGICAL FLEXIBILITY MODEL APPLICABLE TO ASIAN AMERICANS?
Acceptance and commitment therapy researchers have also begun to consider the degree to which the psychological flexibility model is applicable to Asian Americans. One study found that the tendency to conceal emotions correlates with psychological distress equally in Asian American and European American groups (Masuda, Wendell, Chou, & Feinstein, 2010). Another study (Cook & Hayes, 2010) examined the relationship between psychological health and psychological flexibility⁄/experiential avoidance. Results confirmed other studies showing that Asian Americans used more control-oriented forms of coping (e.g., thought suppression, avoidance of felt emotion, experiential avoidance) as compared to European Americans, but these various measures of psychological flexibility related to psychological health significantly and equally in both groups. Asian Americans were more psychologically distressed, but that difference disappeared when adjusting for psychological flexibility and acceptance-based coping. Religious background did not impact these relationships. For example, self-ascribed Buddhists were not more self-accepting despite their involvement with mindfulness traditions. Acculturation also failed to modify these relationships.

MAKING PROGRESS ON CULTURAL COMPETENCE
Adjusting treatments to fit cultural groups is likely to be helpful (Sue, Zane, Hall, & Berger, 2009), but knowledge of cultural differences alone is not an adequate basis to make these adjustments. For example, the authors correctly note that “avoidant forms of coping … are relatively common among Asian Americans” (Hall et al., 2011, p. 222). To a degree, this could mean that “what may be avoidant and maladaptive in one culture may not be so in other cultures” (Hall et al., 2011, p. 222), but it is also possible that particular forms of avoidant coping could be harmful despite their cultural support, particularly if they are applied inflexibly. The data just reviewed seem broadly supportive of that possibility.

This possibility may help explain why progress has been so slow in developing culturally competent therapies that are known to be more effective than unmodified forms. As the authors of the target article note, the goal of cultural competence is more effective interventions, but meta-analyses have yet to reach agreement about the practical impact of cultural adaptation, particularly with evidence-based treatment such as cognitive behavior therapy (CBT; Griner & Smith, 2006; Huey & Polo, 2008). Brute force empiricism cannot readily succeed in this area because of the kind of studies needed. For example, the authors “hypothesize that the applicability and effectiveness of contextual psychotherapies that are culturally enhanced for Asian Americans would be moderated by acculturation” (Hall et al., 2011, p. 228). Given that the authors also believe that contextual forms of CBT are closer to Asian cultural beliefs than most other forms of therapy, however, it seems likely that the predicted effect sizes would be small even if the authors’ ideas about cultural adaptations are completely correct. Studies of moderation over small effect sizes require several hundred participants to be adequately powered. If they can be pursued, they should be, but meanwhile other ways forward need to be found.

The functional contextual development strategy underlying ACT (Vilardaga, Hayes, Levin, & Muto, 2009) suggests an alternative: link clinical concepts to basic behavioral principles. Functional analysis linked to behavioral principles has long been used by behavior therapists to modify interventions so as to fit client needs. The psychological flexibility model is in essence designed to be a kind of superset of functional analyses, which should make it contextually applicable if the model is successful in what it is designed to do. If cultural knowledge can be linked to principle-based processes, then cultural adaptations can be based on functional analyses rather than the topographical features of cultural knowledge per se (Hayes & Toarmino, 1995). There seems to be no reason why evidence-based cultural adaptation cannot be built into our models from the ground up.

The authors actually provide a very good example of how this might be carried out when discussing the
issue of self, but it is not brought to the fore because the authors are not focused on the theoretical and philosophical basis of ACT, and technological topographies provide a ready source of misdirection and resultant misunderstanding. ACT attempts to create a greater distinction between “self” in the sense of a story or narrative conceptualization on the one hand and “self” in the sense of perspective-taking skills that help establish a sense of continuity of consciousness (a transcendent sense of self) on the other. It is a hypothesis drawn from RFT that deictic verbal relations (that is, those that need to be learned by demonstration, relative to a perspective or point of view) are central to the acquisition of a transcendent sense of self. That possibility has led to a growing body of empirical work showing that deictic relations underlie perspective taking in development (e.g., McHugh, Barnes-Holmes, Barnes-Holmes, Whelan, & Stewart, 2007) and that training in deictic relations improves perspective taking and theory of mind performance (e.g., Weil, Hayes, & Capurro, 2011).

The authors make a good point when they suggest that the Japanese language itself relies more on collective language, but this does not undermine the core ACT/RFT claim—it supports it. Let us explain.

It is indeed known that differences in Asian language lead to developmental differences in perspective-taking abilities (both faster and slower depending on the specific skill) as compared to European children (e.g., Matsui, Rakoczy, Miura & Tomasello, 2009; Mitchell, Teucher, Kikuno, & Bennett, 2010; Naito & Koyama, 2006). The authors’ idea that in addition to I/you, perspective taking might develop in Asian populations more from “we/they” language (Hall et al., 2011, p. 227) seems quite possible. It fits entirely with an ACT/RFT conception because “we/they” is also a deictic verbal relation. RFT has claimed that perspective taking emerges from deictic relations, not I/you per se. Deictic relations are known to include here-/there and now/then, and others are arguably important, such as left/right, up/down, and front/back. It may indeed turn out that assessment and training of speakers of Asian languages will be easier when collective perspective-taking terms are included—that is an empirical question that is limited enough to be answered quickly. If it is correct, the cultural adaptation could be made readily. This is a concrete example of the possible utility of the development strategy being pursued by ACT researchers: cultural knowledge (e.g., of a difference in language usage) can be brought into play through principles and processes (e.g., the importance of deictic relations to the development of a transcendent sense of self) rather than through the formal or topographical properties of cultural practices per se (e.g., we need to focus on “we” not “I” because of language differences alone without knowing precisely the psychological processes these terms engage).

The focus on formal or topographical features seems to result in some misunderstanding in the target article of the role of deictic relations, including “I/you,” in a transcendent sense of self. The “I” we are speaking of is not the concept of “I” versus the concept of “you.” “I/you” truly has nothing to do with what the authors suggest, “personal possessiveness” as opposed to “an individual’s oneness with others” (Hall et al., 2011, p. 219). “I/you” refers to the perspective of I interconnected with the perspective of you. The theory argues that both emerge at the same time, and the frame does not exist until both are present and interrelated. The same applies to all deictic relations. In psychological flexibility theory, the resultant sense of self “is not a sense of self that is alone and cut off. It is inherently social, expansive, and interconnected … I begin to experience myself as a conscious human being at the precise point at which I begin to experience you as a conscious human being. I see from a perspective because I see you see from a perspective. Consciousness is shared…. Consciousness expands across time, place, and person. In a deep sense consciousness itself contains the psychological quality that we are conscious. Timelessly. Everywhere” (Hayes, Strosahl, & Wilson, in press).

There is more to this idea than flowery language. From this point of view, the sense of self we are speaking of interconnects us with others and is part of the psychological scaffolding for “we” to mean something in an experiential versus purely conceptual manner. A series of recent studies have tested this idea and have shown empirically that deictic relations are central to the ability to use empathy and to feel socially interconnected with others (e.g., Vilardaga, Estévez, Levin, & Hayes, in press; Villatte, Monestès, McHugh, Freixa i
Baqué, & Loas, 2008, 2010a, 2010b). Thus, we welcome the cultural knowledge that may help expand deictic work, but the sense of self we are speaking of is already the sense that is relevant to “an individual’s oneness with others” (Hall et al., 2011, p. 219).

The same sort of issue emerges elsewhere in the article. For example, the authors state that from a contextual CBT perspective, values work would focus on “explicating what Michelle wanted from her life, independent of what her family wanted from her, and working toward life goals that did not depend on her family to achieve them” (Hall et al., 2011, p. 225; emphasis added). Values work in ACT is undoubtedly more individualistic in a technological sense that it needs to be at the level of basic processes, merely because it emerged in a Western context, but the focus on principles and processes again allows a natural cultural adaptation that is sensitive to the individual and yet maintains contact with underlying behavioral processes. The basic science perspective on values underneath ACT is that they are freely chosen, verbally constructed consequences of patterns of action that establish intrinsic qualities of action as reinforcers in the present. Values of this kind can include collectivist values, family values, depending on one’s family, and considering one’s family. The cultural adaptations described by the authors in the area of values make rough sense, but they are cast in terms of the formal properties of cultural practices, rather than principles of behavior change. This is needlessly risky given the mixed bag, functionally and scientifically speaking, that cultural practices may or may not represent and the enormous difficulty presented in testing cultural adaptations absent their link to clear behavioral principles. An alternative, and we would argue, safer course would be to link cultural and individual differences to functional contextual principles and to attempt to build cultural competence knowledge from the ground up.

CONCLUSION
No one has yet developed an adequate model of how to modify empirically supported treatments to deal with the vast differences between human beings in areas of culture, never mind the similarly vast set of issues having to do with religion, class, age, personality, and so on. In the area of Asians and Asian Americans, there are some early indications that psychological flexibility applies and that ACT methods are helpful. It seems likely that culturally based modifications could make it more effective. The challenge is to know what modifications to make and to test them so that there is a continuous process of improvement. We are skeptical that cultural knowledge alone can provide such guidance. The connections are too varied and the tests are too cumbersome, and as a result, needed studies are delayed or simply not carried out at all. Instead, we have described the strategy being followed by the ACT development community: a bottom-up process of creating a therapy model from procedures and processes that are linked to basic behavioral principles. What that approach affords is the possibility of linking cultural knowledge to processes and principles as an extension of functional analysis. This is a specific and testable approach, and most of what the authors are proposing would have a coherent place in such a development strategy if the focus were more on functional contextual theory and less on topography. In our view, this has a greater chance of being progressive and of serving the needs of people of different cultural backgrounds.

REFERENCES


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