COMMENTARY

Being Mindful About the Assessment of Culture: A Cultural Analysis of Culturally Adapted Acceptance-Based Behavior Therapy Approaches

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In this article we review a wide range of cultural adaptations of acceptance-based behavior therapies (ABBT) from a cultural perspective. Consistent with the cultural match model, we argue that psychotherapeutic cultural adaptations are more effective as the cultural characteristics of patients are matched to the cultural characteristics of the intervention. Cultural match model is then used to examine ABBT cultural adaptations. Overall we conclude that the studies herein included are a promising first step to develop culturally competent ABBTs.

This special series reviews a wide range of cultural adaptations of acceptance-based behavior therapies (ABBTs), including Acceptance and Commitment Therapy (ACT; Petkus & Wetherell, 2013–this issue), Mindfulness-Based Stress-Reduction (MBSR; Dutton, Bermudez, Matas, Majid, & Myers, 2013–this issue), Culturally Adapted Cognitive Behavioral Therapy (CA-CBT; Hinton, Pich, Hofmann, & Otto, 2013–this issue), and an article describing some clinical challenges faced by ABBT practitioners working with culturally diverse groups (Rucker Sobczak & West, 2013–this issue). Although these articles stem from diverse psychotherapeutic approaches, they all share an emphasis on altering clients’ relationships to unwanted internal experiences by cultivating acceptance through the practice of mindfulness (Fuchs, Lee, Roemer, & Orsillo, 2013–this issue). These articles are an important contribution to the psychotherapeutic literature as they adapt ABBTs to the rapidly growing population of culturally diverse individuals in the United States (Humes, Jones, & Ramirez, 2011). Given empirical evidence indicating that ABBTs are effective in ameliorating human suffering (Roemer & Orsillo, 2009), especially among ethnic minorities (Fuchs et al., 2013–this issue; Lee & Fuchs, 2009), the need for cultural adaptations is pressing.

A central assumption underlying much of the cultural competence literature is that it is necessary to match the cultural characteristics of the treatment with those of clients (Bernal, Jimenez-Chafey, & Domenech Rodriguez, 2009; La Roche & Christopher, 2009; Sue, Ivey, & Pedersen, 2007). As the match between the cultural characteristics of an intervention and those of clients increases, so does the effectiveness of the cultural adaptation. This cultural match model entails two conditions: first, that researchers are cognizant of the cultural assumptions of an intervention, and second, that they assess and compare these cultural characteristics with those of their clients. Discrepancies between the cultural characteristics in clients and interventions then guide the way in which the intervention is culturally adapted (La Roche, 2012; La Roche & Lustig, 2010). However, in contrast to this approach, researchers often make the assumption that individuals of specific groups (or sometimes whole groups) possess certain cultural characteristics, which makes it unnecessary to assess their characteristics. In this article, we examine the ABBT adaptations presented in this special issue from the cultural match model perspective. We analyze each of the treatment models and interventions through this model and suggest how ABBT researchers may use this model in order to further adapt treatments to other cultural groups.

In the first article, Petkus and Wetherell (2013–this issue) adapt ACT strategies to the characteristics of older adults. An important contribution of this article is that it broadens the concept of diversity by not solely defining it as ethnicity or race, but by including underrepresented cultural groups, such as older populations, within the
definition. In this article, Petkus and colleagues argue for the suitability of ABBTs for older adults based on a series of unique developmental characteristics. For example, many are facing health challenges that are difficult to eliminate, are better able to regulate emotions (e.g., ability to dissociate past feelings from current feelings), or have experienced life transitions that have distanced them from their values. Examples of adaptations of ABBT for older adults include those that consider cognitive, functional, and sensory impairments experienced by older adults (e.g., allow for additional sessions to cover content) and those that consider the likely significance of values work among older adults (e.g., addressing values work during the first sessions, including discussion of religion and end-of-life issues). The authors underline the importance of assessing the very characteristics they are proposing to affect via the applicability of ABBTs for adult adults, such as health conditions and cognitive fusion, when utilizing ABBTs in therapy with an older patient. The emphasis placed on assessing characteristics is also clear in their case example. This emphasis underscores the variability in older adults’ experiences and the dangers of making assumptions based on age group.

Overall, the rationale for their adaptations seems promising, and points to the need for research assessing the accuracy and utility of these ideas. That said, it would be interesting if the authors had extended this discussion to explore ways in which researchers and clinicians can assess the claims about the importance and content of older adults’ values. For example, consideration of how to assess the extent to which older adults endorse the importance of symptom reduction versus values work would seemingly be an important part of adapting ABBTs among older adults. Furthermore, we would add that not only should future researchers not assume the presence of these developmental characteristics and instead assess these characteristics (e.g., increased affect regulation or ability to defuse from thoughts), but also that it would be helpful if future researchers examined these characteristics’ influence on each of the treatment modules. The actual assessment of these characteristics along with the implementation of the proposed adaptation would provide valuable information for how ABBTs can be adapted for a variety of individuals, young and old.

In the next article, Dutton and colleagues (2013—this issue) develop an MBSR for low-income, predominantly African American women with intimate partner violence and PTSD. Their adaptations are based on the challenges posed by chronic trauma and to the everyday realities of low-income participants rather than race or ethnicity. Their adaptations are informed by focus groups and interviews with the residents and directors of domestic violence and homeless shelters. These interviews revealed concerns about the length and organization of the curricula and challenges related to child care, as well as some of the interventions themselves (e.g., closing one’s eyes during meditation). Many of the adaptations of the intervention were based on these interviews. For example, the length of session was shortened, the sequence of sessions was changed, the secular nature of mindfulness was emphasized, and child care was provided. These adaptations are reflective of the population for which the intervention was developed. These interviews and focus groups were, in effect, ways to measure the characteristics of the population and then to adapt the treatment accordingly.

However, some cultural characteristics were not measured. For example, it was not required that treatment be delivered by a mental health professional or in a mental health treatment setting as means to reduce the perceived mental health stigma. These adaptations were based on past studies indicating that stigma is a barrier to mental health care, especially among African American populations (Snowden & Cheung, 1993). Although this is an important consideration and likely made a difference in reducing stigma for some of the women, it may have been more effective to assess perceived stigma and then assess the impact of the adaptation on clients’ levels of acceptability. Moreover, the main goal of Dutton and colleagues’ (2013—this issue) article is to assess if their intervention is feasible and acceptable. They suggest that it is feasible given the high percentage of participants who concluded the intervention. Alternatively, however, statistics suggesting feasibility should be viewed with caution given the low percentage of participants who actually completed all sessions and the low proportion of women who agreed to participate in this study.

Consistent with an increasing number of studies indicating that minority populations tolerate repeated exposure therapies less well than some other populations (e.g., Lester, Resick, Young-Xu, & Arzt, 2010; Markowitz, 2010), Hinton and colleagues developed CA-CBT in order to address their sample of traumatized refugee (mainly Southeast Asians) and Latino individuals. In the development of their treatment, Hinton and colleagues considered evidence that ethnic minorities and refugee clients present with more somatic complaints, that psychological flexibility is an important skill for ethnic and refugee populations to utilize in order to adjust to new contexts, and that ethnic and minority populations may experience more worry as a result of experienced stressors based on living in a poor urban context. As a result of these considerations, acceptance and sensorial mindfulness techniques are used in CA-CBT. Other modifications based on Southeast Asian, Buddhist, and Latino cultures are made in the manner in which therapists talk about mindfulness and acceptance. This is evidenced, for example, in the use of loving-kindness imagery, culturally appropriate metaphors to illustrate concepts, and the use...
of culturally consistent values in their clinical examples (e.g., performing mindfulness and loving-kindness is merit making not only for the client but also her deceased husband in the next life). These modifications are extremely important and capture how Hinton and colleagues are considering and assessing cultural characteristics and then responding with adaptations of the treatment.

Hinton and colleagues (2013–this issue) include many cultural adaptations in their CA-CBT protocol. It may have been useful, however, if explanations of how the cultural characteristics of a cultural group were considered in the CA-CBT protocol, and if explanations of how this adaptation differs from standard CBT interventions were included. This information could then be used in the development of similar adaptations for different cultural groups. In line with this suggestion, Hinton, Kredlow, Bui, Pollack, and Hofmann (2012) have developed culturally sensitive measures to examine cultural syndromes that are then used to tailor treatments for each client. The Cambodian Somatic Syndrome Inventory (SSI; Hinton et al., 2012), for example, not only assesses key symptoms measured in the DSM-IV, but also specific Cambodian cultural syndromes. As these inventories are incorporated into their CA-CBT protocol, it is likely that clinicians will be able to design more culturally sensitive and effective treatments for their clients. Given Hinton and colleagues’ ability to incorporate and assess these cultural characteristics, it is not surprising that several pilot randomized control trials are finding that CA-CBT is an effective treatment modality for ethnic refugees and Latinos (e.g., Hinton, Chhean, Pich, Safren, & Pollack, 2005).

In the final article of this series, rather than focusing on a particular group as the previous authors do, Rucker Sobczak and West (2013–this issue) attempt to clarify some ABBT strategies that may be particularly useful with culturally diverse groups given their common experiences of discrimination, powerlessness, and marginalization. These strategies include consideration of the acceptability of mindfulness, attending to differences in the client and therapist’s perspective, and promoting acceptance and pursuit of values in the face of adversity. In clarifying these strategies, Rucker Sobczak and West highlight the importance of assessment of the cultural characteristic that underlies the cultural adaptations. In the case example of Angie, they clearly examine the function of avoidance in her life and how it may interfere with valued action, rather than making assumptions about it. Then, in discussing the acceptability of mindfulness, they underline the importance of discussing the meaning of mindfulness to individual clients before taking the next step of making a case for why and how mindfulness may be useful. And again, in discussing how therapists can negotiate differing values with their clients, they again take a client-centered approach where the focus is on the client’s experiences, rather than making assumptions about differences or similarities. In these examples, there is implicit emphasis upon not making assumptions about clients based on their contexts. Instead, focus is directed upon exploration as an assessment of these factors prior to making cultural adaptations to treatment. It would be interesting to test Rucker Sobczak and West’s hypotheses within a clinical trial and to devise ways to quantitatively assess the cultural characteristics they purport to affect the effectiveness of their adaptations to treatment.

Thus, ABBTs have the potential to encourage more mindful reactions to oppression and avoidance. However, to do so, it would first be necessary to develop clinical strategies to assess reactions to oppression. For example, there is a growing literature about racial identity development and the impact of racism that considers the way in which oppression is internalized and results in different identities and actions (Helms, 2007). For example, measures of perceived racism (e.g., Landrine & Klonoff, 1996), racism-related stress (e.g., Harrell, 2000), emotional and behavioral reactions to racism (e.g., Vines et al., 2001), or ethnic or racial identity development (e.g., Helms, 2007) may be useful in this respect. If this research were incorporated, it would allow researchers to not only examine how these variables affect the level of avoidance of distress and ability to control the factors that cause the distress, but also the extent to which someone feels they have the ability and control over their lives to do valued actions (in those treatments for which valued action is a piece).

Rucker Sobczak and West (2013–this issue) also discuss the need to understand if clients endorse a collectivistic (understanding oneself as part of others with permeable boundaries) or individualistic (understanding oneself in isolation from others and with firm self boundaries) self-orientation, as this will have important clinical implications. Similarly, it may be useful to further explore the impact that the underlying ABBT conception of the self may have and whether it has varied applicability to different groups. ABBT approaches highlight distinctions between internal and external experiences. Much importance is given to the need to cultivate acceptance of our inner experiences. However, having internal experiences assumes an individualistic self in which there is a clear boundary between what is experienced as inside and as outside. However, for individuals from many collectivistic groups, these internal/external demarcations are permeable and “others” are parts of themselves (Triandis, 1994). Clinicians and researchers who are not aware of these distinctions may dismiss the presence of these relationships when in fact they are a fundamental and core aspect of their self. Thus, it is important to underscore Rucker Sobczak and West’s ideas and to clarify the meaning of these self-orientations because conceptualizations of internal and external experiences may vary among some cultural groups.
Conclusion

This special series is a first step in assessing the acceptability and clinical usefulness of ABBT in culturally diverse groups. Overall, the results of current studies suggest that ABBT is a useful approach with culturally diverse groups. Nevertheless, significantly more studies are required to assess ABBT’s efficacy and effectiveness with different groups. Most of the articles reviewed herein present clinical considerations based on clinical and research experiences that would require significantly more methodological rigor to be suggestive of efficacy. It is, however, promising that in such an early stage of development, ABBT researchers and clinicians have invested a significant amount of effort in considering the usefulness of their ideas with culturally diverse groups.

Furthermore, it is laudable that all authors largely included clear rationale for why their cultural adaptations are conducted and explained changes in their interventions according to the characteristics of the target group. Nevertheless, we believe that, in the future, it will be useful to assess the cultural characteristics of each participant and contrast these with the characteristics of the intervention. This will allow authors to have a better idea of the degree of cultural match between participants and the intervention, which in turn will allow them to determine which changes are more effective with which individuals. Furthermore, by clearly identifying the rationale for adaptations based on cultural characteristics and in assessing these characteristics, researchers and clinicians are then better able to utilize this research in work with a larger variety of individuals. For example, research that provides clear conceptualization and evidence for an adaptation for Latino individuals with more collectivistic orientations can tentatively apply these adaptations to White or African American individuals who endorse a more collectivistic orientation. ABBT is becoming one of the most promising set of strategies to ameliorate psychological pain. It is commendable that the first steps to assess its applicability with different cultural groups have been taken.

References


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