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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.

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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 curriculum 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, & Artz, 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

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