Principle-Based Cultural Adaptation of Cognitive Behavior Therapies: A Functional and Contextual Perspective as an Example

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Abstract

Cognitive behavior therapy (CBT), a family of psychotherapies, is well recognized across the globe as an effective approach for promoting greater behavioral adaptation. Whereas the dissemination of CBT at a global level is encouraging, many experts raise concerns about the suitability of the application of CBT across a variety of sociocultural groups. The present article contends that the cultural competence of CBT is diminished when CBT is understood merely as techniques with a set topography. Using a contextual and functional framework, the article highlights the importance of principle-based practice to promote culturally competent and ideographically sensitive clinical work.

Key Words: Cognitive Behavior Therapy (CBT), context, principle-based CBT practice

Cognitive behavior therapy (CBT) is often viewed as a family of psychotherapy approaches designed to promote greater behavioral adaptation via cognitive and behavioral change (Herbert, Gaudiano, & Forman, 2013; Mennin et al., 2013). In recent years, CBT, which originated in Western culture, has been disseminated to regions across the globe, including Japan and other Asian countries (Ono et al., 2011). This extensive dissemination is supported by substantial body of evidence demonstrating the clinical effectiveness of CBT across diverse psychosocial issues.

Researchers and practitioners have expressed cautions about the dissemination of CBT, especially when it is transferred to non-Western sociocultural contexts (Hall, 2001; Hays, 2009; Hofmann, 2006; Sue, 1999), however. Their concerns include whether CBT can be practiced effectively in its original form with clients from diverse sociocultural backgrounds, whether key concepts and strategies of CBT are biased toward Western values (e.g., individualism, autonomy), and whether cultural adaptation of CBT is necessary and, if so, under what circumstances (Cardemil, 2010; Hall, 2001; Hall et al., 2011; Hays, 2009).

Although investigating the cultural competence of CBT is a pressing concern, it is important first to revisit what CBT is. That is necessary because critiques of CBT’s cultural competence depend on which of several possible viewpoints one takes on CBT (e.g., viewing

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CBT as a set of techniques vs. viewing it as the principle-informed behavior of clinicians. Furthermore, being explicit about the fundamental viewpoint will help us examine how we can best conceptualize CBT in order to promote its cultural sensitivity and competence (Hayes et al., 2013; Sue et al., 2009).

The purpose of the present article is to describe the importance of conceptualizing and practicing CBT as the principle-guided behavior of clinicians in a therapeutic context. The principle(s) used in CBT must be pragmatic, precise and broadly applicable. To achieve this, CBT principles must be more or less functional, contextual, and process-based (A. Masuda, 2014).

**Major Themes in Cultural Competency and Cultural Adaptation**

Hall (2001) states that culturally sensitive and culturally competent treatment involves "the tailoring of psychotherapy to specific cultural contexts" (p. 502). Issues of cultural competence and cultural adaptation of psychosocial treatments have emerged mainly because of the evidence that a given psychotherapy that has been found to be effective for a particular group of clients (e.g., Europeans and Americans) is not necessarily effective for other groups of individuals (e.g., Asian Americans; Hall, 2001; Sue, 1998, 1999). At an individual level of analysis, cultural competence is often defined as the clinician's skill in forming and testing hypotheses, flexibility in generalization and individualization in assessment, case conceptualization, and treatment, as well as knowledge and skills in working with diverse clients from other cultures for the purpose of working effectively with them (Sue et al., 2009; Whaley & Davis, 2007).

Whereas cultural competence refers to clinicians' skill sets for working effectively with diverse groups of individuals (Sue et al., 2009; Whaley & Davis, 2007), the construct of cultural adaptation seems to refer to a strategic adjustment of existing treatment protocols (Cardemil, 2010). For example, Bernal et al. (2009) define cultural adaptation as "the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way as that it is compatible with the client's cultural patterns, meanings, and values" (p. 362). When adapting an CBT protocol written in English for Japanese-clients, the processes of cultural adaptation may include translating the protocol into Japanese, modifying therapeutic exercises in the protocol to suit a given Japanese client, or setting up a treatment goal that reflects sociocultural contingencies operating in the Japanese culture. To date, following these guidelines (Hinton & Jalal, 2014; Hofmann, 2006), CBT has been adapted to a range of underserved groups in the U.S. and other countries, including traumatized Cambodian refugees (Hinton & Otto, 2006) and Vietnamese refugees with post-traumatic stress disorder and comorbid panic attacks (Hinton et al., 2006).

**Pitfalls of Viewing CBT Topographically as a Set of Techniques**

Despite the heterogeneity within CBT (Herbert & Forman, 2013; Mennin et al., 2013), CBT is more than just a set of treatment techniques (Lazarus & Rego, 2013). In particular, with the goal of promoting behavioral adaptation (Mennin et al., 2013), CBT as a whole has embraced its roots in empirically verified theories (i.e., CBT accounts of psychopathology and behavior change) that inform the delivery and adjustment of clinical work tailored to a given individual client (Herbert et al., 2013). Historically, CBT practitioners and theorists have made great
efforts to develop and refine the underlying theory so as to be pragmatic (informing how to influence the phenomena of interest), precise to a given clinical case, and broadly applicable to diverse clinical cases at the same time (Hayes, Barnes-Holmes, & Wilson, 2012). In other words, the fundamental and historical stance of CBT is congruent with the values and goals advocated by the proponents of cultural competence and the cultural adaptation of therapy.

However, CBT’s commitment to principle-informed practice has been weakened in recent years (Herbert et al., 2013; Hofmann et al., 2013; Rosen & Davison, 2003), as it is viewed more and more as a mere set of techniques (Hayes et al., 2013; Hayes, Muto, & Masuda, 2011; Lazarus & Rego, 2013). This trend is partially due to the proliferation of an atheoretical understanding of CBT, as well as content-focused treatment adherence (Hayes et al., 2013; Rosen & Davison, 2003). CBT can be said to be atheoretical or too content-focused when treatment protocols are followed as a step-by-step “cook book” approach, without carefully considering the intended aims of the therapy or the client’s progress. For example, suppose that a clinician decides to use a CBT treatment manual for a new adult client with severe anxiety, and that the manual tells the clinician to teach a coping skill in the first session using instruction, role-play, modeling, and feedback, and then conduct an in vivo exposure in the next session. At a principle level, the manual seems to recommend this sequence so that the client can use the new coping skill during the exposure exercise. If so, it is extremely crucial for the clinician to ensure that the client gains the coping skill prior to the exposure exercise. However, if the clinician is merely focusing on delivering the treatment components by following the manual’s instructions exactly, the clinician may fail to attend to ongoing functional relations between the treatment and the client’s behavior.

Similarly, the cross-cultural adaptation of CBT may fall short when it is too content-focused. Consider one of my previous clinical experiences. When I was a therapist trainee in a university counseling center in the U.S., I was assigned as therapist for a Japanese student. This was mainly because I was the only Japanese-speaking therapist in that facility. At that time, I had never used Japanese in therapy, although I had dealt with many clients using English, following acceptance and commitment therapy protocols (ACT; Hayes, Strosahl, & Wilson, 2012). Not knowing what to do, I decided to work with the client by translating literally into Japanese what I usually said to English-speaking clients. This correspondence-based literal translation is not uncommon, but from a functional standpoint, it is problematic, as it tends to overlook the intended, compared to the actual effects of the translated phrases (Drossel et al., 2014).

Introducing a stance of psychological acceptance to English-speaking clients, I often used the phrase, “See if you can make room inside for that difficult thought,” which usually promotes clients’ willingness to become open to difficult thoughts and feelings in service of pursing a fulfilling life (psychological acceptance). Literally translating that English phrase, I said to the Japanese client, ‘‘その難しい思いに対して自分の中に部屋を設けますか’’.” I noticed that she looked puzzled with what I had said. My question in Japanese was a correct literal translation. However, to a native speaker of Japanese, it is obvious that the expression was quite awkward, and was not likely to yield the same intended effect of psychological acceptance. Looking back, I realize that I could have said to
her something like, "(人ってなるべくつらい思いを忘れようとするけど) 自分にそう感じてしまうところがあってもいいのかもしれませんね。"

The limitations of content-based understanding and practice are also highlighted in the debate regarding cultural competence in and of itself (Sue et al., 2009; Whaley & Davis, 2007). For example, Whaley and Davis (2007) note that a content-based account is more prone to cultural stereotypes and biases (for example, "When working with a Japanese client, be direct and authoritative by saying this and that, whereas when working with an American client, be friendly and collaborative by saying this and that"), given within-group variability. Whaley and Davis (2007) also advocate a process-based account for promoting therapists' cultural competence, and conceptualize therapists' diverse repertoires of problem-solving skills as the heart of sociocultural competence.

In sum, a major shortcoming of content-focused treatment and correspondence-based literal translation of treatment protocols is that the topographical presentation (content) of therapeutic work does not necessarily determine its effects. A given form of a treatment technique (e.g., relaxation exercise, metaphor) may work for some clients but not for others, and a given form of a treatment technique may work for a particular client in this session, but not in a later session. Whether a given behavior is adaptive or not is contextually and functionally determined.

Viewing CBT merely as a set of techniques limits the scope of CBT work. As the proponents of common-factors approaches emphasize, clinical work involves what are typically referred to as non-specific factors, such as hope through the therapeutic relationship, a working alliance, clinician characteristics, client characteristics, and insight (Messer & Wampold, 2002). If CBT is viewed merely as a set of tools (Rosen & Davison, 2003), that obscures the complex and multidimensional nature of CBT work between the client and the clinician (Laska et al., 2013). As Paul (1967) famously noted, CBT, which is viewed more and more as a set of techniques, has historically integrated all of these factors into clinical work, while employing a pragmatically coherent model of cognitive and behavioral change.

CBT as a Contextually and Pragmatically Situated Act of a Clinician

The alternative account of CBT proposed in the present article is not novel. The present article simply advocates for the reestablishment of principle-informed CBT for the purpose of promoting culturally competent CBT practice. More specifically, from a pragmatic and functional standpoint (Anderson et al., 1997; Follette et al., 1996; Hayes & Wilson, 1995; Kohlenberg et al., 1993), CBT should be viewed as a series of purposeful acts of a clinician in therapeutic contexts that are both principle-informed and experientially guided. The clinician's work is principle-based in that clinician's behavior throughout the course of therapy (e.g., therapeutic interaction, assessment, case-formulation, and the implementation and adjustment of intervention) is informed by an empirically verified conceptual model of psychological health and behavior change (Goldfried & Davison, 1994; Hayes et al., 2007). Simultaneously, the clinician's work is said to be experientially guided as the clinician's behavior is adjusted based on the ongoing therapeutic interaction with the client.

Critiques of CBT regarding its cultural competence can be made largely on two related but distinct levels: the theoretical level and the
technical level. At the level of theory, the clinician and researcher examine whether a given CBT theory is adequately applicable to this particular client, as well as to many other clients, for influencing greater behavioral adaptation. A potential candidate for such a guiding theory is the contemporary behavioral account of behavioral health and change proposed by Hayes and colleagues (Hayes et al., 2001; Hayes et al., 2007; Hayes, Villatte, et al., 2011; Hayes et al., 1996).

A detailed explanation of Hayes et al.'s model is beyond the scope of this paper. However, the model states that, although varying greatly in contents, clinical concerns experienced by various clients from diverse sociocultural backgrounds can be characterized by the behavioral excess of negatively reinforced ineffective problem-solving strategies, behavioral deficits in intrinsically reinforcing or socially adaptive activities, or both. Similarly, greater behavioral adaption, although varying greatly across individuals, is characterized by the process of contacting the present external and internal environments openly and fully, based on what the situation affords, and changing and persisting in behavior in the service of chosen values, as opposed to avoidance of private experiences (Hayes et al., 2006). As many CBT theories have suggested (Hofmann et al., 2013; Mennin et al., 2013), some major clinical implications from this behavioral account are:

1) The adaptiveness (or maladaptiveness) of a given behavioral and cognitive pattern is contextually determined, and dependent on the functional relation between the client's behavior and the historical and situational context in which it occurs. This statement is not surprising for Japanese individuals, who tend to endorse a holistic and contextual perspective (Markus & Kitayama, 1991; T. Masuda & Nisbett, 2001). For example, a given interpersonal behavior, such as the assertiveness associated with saying "No," is adapted in some contexts, such as when talking to a "pushy" store clerk. The same form of behavior may not be appropriate in other contexts, such as when involved in group decision making.

2) Clients' clinical concerns and ineffective problem-solving strategies inevitably involve verbal processes. This does not mean that the client's presenting concerns are mainly negative cognitions (e.g., depressive thoughts), or that a particular cognition or verbal rule always regulates problematic behavioral strategies. Rather, this statement simply postulates that a client's cognitive/verbal processes should be taken into account, because human beings are social beings, and verbal behavior is the quintessential form of social behavior (Hayes et al., 2001; Hayes & Toarmino, 1995). Behaviorally speaking, the majority of human behaviors, whether adaptive or maladaptive, are conceptualized as rule-governed (Hayes, 1989; Hayes et al., 2001).

3) Dysfunctional verbal phenomena may not have to be changed in form or frequency when greater behavioral adaptation is being promoted. This postulate is also consistent with a holistic perspective that people in Eastern cultural contexts tend to endorse (Hofmann, 2006; Markus & Kitayama, 1991; Singelis, 1994). The dysfunctional verbal phenomena referred to here may be any event (including thoughts, feelings, patterns, beliefs, and actions) that is considered problematic within a contextualized framework. In Western cultural contexts, individuals are often encouraged to make direct efforts to eliminate dysfunctional verbal phenomena, in order to achieve greater well-being (Weisz et al., 1984). However, along with a holistic view, the present behavioral account states that it may not be
necessary to eliminate problems in order to have a fulfilling life (Hayes, Villatte, et al., 2011). Learning to be open to the problems (e.g., psychological acceptance) may be more constructive in some contexts, rather than attempting to eliminate them (Hayes, Villatte, et al., 2011; Mennin et al., 2013).

(4) These suggested behavioral changes are made through verbal and experiential interactions between the clinician and the client. The goals of the clinician are to undermine the behavior regulatory function of verbal events that maintain detrimental problem-solving strategies, and to promote the behavior regulatory function of cognitions that increase adaptive and intrinsically reinforcing behavior (Hayes et al., 2006; Mennin et al., 2013). In a psychotherapy setting, this is usually done through verbal and interpersonal interaction between the client and the therapist (Dougher & Hayes, 2000). As such, it is important for a clinician to be interpersonally and verbally skilled so as to be able to promote the client's greater adaptation (Follette et al., 1996; Kohlenberg et al., 1993).

Principle-Based CBT

From the standpoint of principle-based CBT practice, intervention cannot be done until a tentative conceptualization of the case and treatment plan have been formed. In addition to forming a conceptualization of the case, the clinician must examine whether the model that is followed adequately accounts for the client's concerns, and if so how. Forming and revising the conceptualization of the case is an ongoing process throughout the course of therapy. Although there is a generic case-conceptualization framework presented in a given CBT approach, it is important to understand that every client is idiosyncratic (Hayes & Toarmino, 1995; Hays, 2009). Furthermore, the purpose of case conceptualization is not only to understand the client, the presenting concerns, and the treatment goals, but also to elucidate plans for effective cognitive and behavior change.

It is important for a CBT clinician to take sociocultural factors into consideration in case conceptualization and intervention. In essence, many CBT theories view a given client and the client's clinical concerns in terms of the "act of a whole person in historical and situational context" (Hayes, Strosahl, & Wilson, 2012). Based on this worldview, sociocultural factors are translated and integrated into a given CBT model if doing so is relevant to the promotion of greater behavioral adaptation. For example, in an acceptance and commitment therapy (ACT) case conceptualization, sociocultural factors, such as the practice of religion and spirituality, interdependence, and social discrimination, are understood in terms of behavior patterns (e.g., relations among particular emotions, cognitions, behavior, and the short-term and long-term consequences) in given contexts. For example, if interdependence is viewed as being clinically relevant, it can be translated into the behavioral excess or deficit in particular behavioral patterns of the client in interpersonal settings. Together with that client, the clinician then identifies how these patterns are maintained and how they can be intervened.

Awareness of One's Own Biases

Similar to clients, clinicians are also historical beings who are influenced by their previous and current learning history. As such, it is crucial for the clinician to be careful not to make assumptions regarding which behaviors are adaptive or not adaptive without carefully assessing the context in which they occur. Whether a given behavior is problematic or
Adaptive is not determined by its form or by the clinician's values. Rather, it is determined by the historical and situational context in which the client's behavior occurs.

Modification of Therapeutic Techniques

Structural modifications of treatment are always expected in CBT, and effective forms of therapeutic interaction between the client and the clinician depend on the client's learning history, the clinician's learning history, and the interaction of the two. As such, the clinician must be cognizant of the actual function of the ongoing therapeutic interaction with a given client. Modifications may include altering the content of mindfulness exercises, metaphors, and activities; changing the length of metaphors, exercises, and session activities; or revising the session format. These modifications should always be in the service of promoting greater behavioral adaptation and ideographically tailored to a given client. What is crucial here is that while the structures of therapeutic work vary between and within clients, such changes remain theory-consistent in terms of the processes to be targeted and overall treatment goals. A pragmatic theory with precision and broad applicability informs the clinician about the direction of therapy, the treatment goals, the progress of therapy, and the therapeutic processes on the path to reaching the goals.

Conclusion

Many forms of CBT are well recognized as effective for promoting greater behavioral adaptation in clients across the globe. Although the dissemination of CBT is encouraging, CBT is increasingly viewed as a set of techniques packaged in a treatment protocol, which hinders the effectiveness and sensitivity of CBT. Given this concern, the present article emphasizes the importance of principle-informed CBT practice. Framing CBT as the behavior of a clinician in therapeutic contexts that are both principle-informed and experientially guided, this article highlights the importance of employing a CBT model that is pragmatic, precise, and broadly applicable, in order to craft the most effective individually tailored treatments.

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