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Culturally-Competent Treatments for Asian Americans: The Relevance of Mindfulness and Acceptance-Based Psychotherapies

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Abstract

The development of effective treatments for Asian Americans is important because treatment disparities continue to exist for this population. Because of their theoretical grounding in East Asian philosophies, mindfulness and acceptance-based psychotherapies appear to constitute promising ways to provide culturally responsive mental health care to Asian Americans. However, in practice these approaches often reflect conceptions of mental health that are more consistent with Western world views. We review points of intersection and divergence between Western-based mindfulness and acceptance psychotherapies and Asian American cultural values. We then propose a culturally syntonic approach that accentuates certain components of mindfulness and acceptance psychotherapies and adapts other components of these approaches to be more consistent with Asian American cultural values.

Keywords

Asian Americans; mindfulness; acceptance; self; coping

The development of effective treatments for Asian Americans is important because psychological treatment disparities persist between persons of color and European Americans. Persons of color are less likely to seek psychological services than European Americans (Snowden & Yamada, 2005). Treatment disparities are particularly acute among Asian Americans, who are proportionally the fastest growing ethnic group in the U.S. (Hwang, 2006). In the Collaborative Psychiatric Epidemiology Studies, only 9% of Asian Americans had utilized mental health services in the past year vs. 18% of the general population (Abe-Kim et al., 2007). These disparities are most pronounced for first- and second-generation Asian Americans. Although these data could be interpreted to mean that Asian Americans have lower rates of psychological disorders than other groups, help-seeking disparities also exist among those having psychological disorders. Among those likely to have DSM-IV disorders, only 28% of Asian Americans sought specialty mental

health services compared to 54% of the general population (Meyer, Zane, Cho, & Takeuchi, 2009).

These treatment disparities may be reduced when, under the appropriate circumstances, culturally-responsive adaptations are made to existing treatments (Sue, Zane, Hall, & Berger, 2009). Examples of culturally-responsive adaptations include an integration of relevant cultural considerations and factors, such as interdependence and spirituality, into treatment. Such adaptations can be difficult to accomplish, however, when applied to large, heterogeneous ethnic groups. This is particularly true for Asian Americans, with nearly two-thirds being immigrants from a range of national and cultural origins (Hwang, Wood, Lin, & Cheung, 2006).

Because of their theoretical roots in Asian philosophies, mindfulness and acceptance-based psychotherapies or contextual therapies have promise for application with Asian Americans. Examples of such therapies include Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), Dialectical Behavior Therapy (DBT; Linehan, 1993), and mindfulness-based cognitive therapy (Segal, Williams, & Teasdale, 2001). Contextual psychotherapies have been described as the third wave of behavioral and cognitive therapies, with behavior therapy as the first wave and cognitive therapy as the second (Hayes et al., 2006).

Although definitions of mindfulness and acceptance differ slightly among these third-wave therapies, there is a high degree of overlap. Mindfulness involves a heightened awareness of the here and now and full engagement in what the person is doing (Harris, 2006; Segal et al., 2001). Acceptance involves a willingness to acknowledge events, such as those that may elicit anxiety or depression, without attempting to change them and allowing one to feel unpleasant sensations, urges, and feelings without efforts to escape or struggle against them (Hayes et al., 2006). Contextual therapies emphasize the importance of recognizing (without judgment) the demands of the present context, which includes the situation and the individual's emotions and values, and they focus on responding to these demands without trying to change them. Although these therapies vary in their approaches and methods, all have components of mindfulness or acceptance or both in common.

Although Western applications of Asian principles in psychotherapy minimize their Asian religious and cultural origins (Baer, 2003; G. Hall & Eap, 2007), contextual therapies clearly feature aspects that are congruent with or reflect East Asian cultural values, norms, or world views. Most Asian Americans also have retained certain East Asian cultural tendencies despite pressure to acculturate to Western norms and values (Abe-Kim, Okazaki, & Goto, 2001). Thus, current incarnations of both Asian American cultures, and mindfulness and acceptance-based psychotherapies have their philosophical roots in East Asia, and both also involve an integration of Asian and Western cultures. The purposes of this article are to review the potential utility of contextual psychotherapy approaches in treating Asian Americans and also to highlight the ways such approaches may be culturally limited.

The applicability and effectiveness of Western mindfulness and acceptance-based approaches with groups having non-Western origins is largely unknown. We propose that reincarnations or reformulations of mindfulness and acceptance-based psychotherapies that enhance certain therapeutic elements more aligned to certain aspects of Asian American cultures may improve the effectiveness of these approaches for this clientele. Moreover, by increasing the flexibility of how well-being is defined and achieved, such cultural enhancements may strengthen the overall utility of these approaches in general.

We address the challenge of developing culturally competent treatments by first describing cultural values and beliefs that distinguish Asian Americans from their Western

counterparts. Although there are many cultural differences between Asian Americans and non-Asians in the West, we focus on differences in conceptions of the self, coping, and communication and highlight their potential role in affecting how psychotherapy is provided and received. We then review the overlapping principles of Western-based contextual psychotherapies and discuss how they overlap with and depart from identified Asian values and their original Buddhist philosophies. Based on this review, we offer hypotheses as to how specific enhancements and modifications to contextual psychotherapies may improve the effectiveness of these approaches for Asian-Americans and also broaden the scope of their effectiveness for most clients.

Asian American and European American Cultural Orientations

A broad cultural distinction between Asians and Europeans involves conceptions of the self. In most Asian cultures, the self is conceived of as interdependent with one's ingroup (e.g., family, friends, community), whereas in most Western European cultures, the self is conceived of as independent of and unique from others. As such, Asian Americans tend to be more interdependent and less independent than European Americans (Oyserman, Coon, & Kemmelmeier, 2002). Values that Asian Americans endorse more than European Americans include conformity to norms, emotional self-control, family recognition through achievement, and humility (B. Kim, Atkinson, & Yang, 1999). The goal in interdependent contexts is interpersonal harmony. Successful functioning of a group is an indication of interpersonal harmony. The interdependent self incorporates and greatly relies on feedback from others (Wirtz & Chiu, 2008).

Conversely, individual development and self-reliance tend to be endorsed more by European Americans than by Asian Americans (Wolfe, Yang, Wong, & Atkinson, 2001). The goal in independent contexts is self-reliance. Self-reliance may be expressed in individual productivity and achievement, which are generally less contingent on the abilities of others than of the self. The independent self is relatively unburdened by responsibilities to others and is also relatively uninfluenced by feedback, other than that which is self-enhancing (Wirtz & Chiu, 2008).

Psychologies of control also differ in the West and Asia. Western cultures place a much higher valence on primary control, involving active coping efforts to change the nature of the stressor. Asian cultures are characterized by secondary control strategies, which promote accepting and reframing existing realities to control their impact on functioning (Weisz, Rothbaum, & Blackburn, 1984). The terms "primary" and "secondary" could imply that primary control is more desirable. Hence, we will use the terms direct and indirect to refer to what has been labeled primary and secondary control (J. Kaplan, personal communication, March, 2009). Lam and Zane (2004) found that Asian Americans were more oriented toward indirect control than European Americans whereas the latter were more oriented toward direct control than the former. Moreover, these differences could be attributed to cultural variations in self-construals as interdependent self-construal mediated the ethnic difference in indirect control, but independent self-construal mediated the ethnic difference in direct control. Similarly, interdependent self-construals among Asian Americans have been found to be associated with a preference for indirect coping (Wong, Kim, Zane, Kim, & Huang, 2003).

High context communication in which the physical context or the internal attributes of the person are more important than the explicit message is typical in Asian cultures (E. Hall, 1976). For example, rules for communication and language used in a public setting with an authority figure (e.g., honorific) would differ from communication and language used in a private home with a family member (e.g., plain, colloquial). Thus, much of meaning often is

inferred through awareness and use of the particular context. Communication tends to be implicit, such as expressing disagreement in an ambiguous manner to preserve group harmony or suppressing emotional expression (Butler, Lee, & Gross, 2007; Park & Kim, 2008). In contrast, European American communication is characterized by low context communication in which the meaning is derived more from the explicit message and less so from the context (E. Hall, 1976). Thus, the meaning of the message may be consistent and adapted relatively little across physical or personal contexts.

Communication in Western contexts is relatively direct, emotional expression is often encouraged, and the impact of the message on group harmony is less of a priority than it is in Asian American interchanges (Butler et al., 2007; Park & Kim, 2008). Asian Americans have been found to use more implicit and less direct communication than European Americans (Park & Kim, 2008). Asian Americans typically communicate with more consideration of physical and interpersonal contexts, whereas this is less of an emphasis when European Americans express themselves.

We have delineated prototypic cultural differences between persons having Asian cultural origins and those not having such origins, but clearly there is much variability within cultural groups. Among groups having Asian and non-Asian cultural origins, there is a range of independence/interdependence, direct/indirect coping, and communication. For example, some Asian Americans are highly acculturated to Western cultural norms, whereas some European Americans are members of closely knit interdependent communities (e.g., religious communities, small towns). Thus, psychotherapy approaches that overly emphasize or rely on a single cultural frame or orientation to the self, coping, and communication may not be optimally effective for persons of Asian cultural origins, but they also may not be optimally effective for others. In the next section, we consider aspects of Asian cultural values that have been retained in the mindfulness and acceptance-based approaches.

Buddhism and Western Contextual Psychotherapies

Buddhism originated in India and was subsequently transported to East Asia. Its principles and philosophies have influenced Asian cultures for centuries, and, unlike Western contextual psychotherapies, do not primarily focus on reducing personal distress and addressing various forms of psychopathology. Mindfulness is a central component within Buddhist meditation practices, and describes the moment when an event is brought into awareness and has not been affected by labels, interpretations, and judgments. Mindfulness is the beginning step of the process of becoming aware of an event, focusing on the event, recognizing the event, labeling it, and then entering a chain of thoughts interpreting the event. Typically, the period of mindful awareness is extremely short; as soon as an event is perceived, we quickly move to identify and label the experience. Buddhist meditation practices aim to extend the period of mindfulness wherein an individual is in a place of awareness but does not segregate or distinguish perceptions from the rest of reality. In essence, mindfulness is similar to a looking glass in that both reflect reality without conception or judgment.

Buddhist descriptions of mindfulness and meditation exercises appear to differ from Western-based psychotherapy approaches. In contextual therapies, mindfulness is less narrowly defined and encompasses perception of events to the point before judgments are made about them. By engaging in purposeful attention to present reality, mindfulness helps one to view the world in a way that is not fettered by personal judgments, prejudices, or opinions. By being non-judgmental, one is further able to be harmonious with his/her environment and develop an awareness of how things are, rather than how one thinks things should be.

Western contextual therapies appear to emphasize the active role of the individual in perceiving his/her environment, and ways to actively focus on surrounding events in a nonjudgmental manner. With this emphasis, several exercises and techniques have been developed to help an individual address both mental and physical health problems. There is evidence of the efficacy of mindfulness-based cognitive therapy in preventing depression relapse, and mindfulness techniques have also demonstrated promise with anxiety and stress (Baer, 2003). Contemporary Western mindfulness interventions have included loving-kindness meditation to help develop greater compassion for others and humanity-at-large, mindfulness in relationships, and putting others first (Fredrickson et al., 2008; Hutcherson, Seppala, & Gross, 2008). Mindfulness exercises also feature prominently in ACT and DBT psychotherapy protocols, that have demonstrated strong treatment efficacy in targeting a variety of psychological problems (Kliem, Kröger, & Kosfelder, 2010; Öst, 2008). We describe later how this difference in definition of mindfulness may represent the infusion of Western-based cultural value of active, direct coping mechanisms.

The concept of acceptance as described in the contextual therapies is consistent with the Buddhist tenet that “suffering is due to attachment”. According to Buddhist philosophy, much of the reason for suffering is the desire or attachment to extending pleasure and removing pain and distress. The goal of contextual therapies is to reduce distress by increasing an individual’s willingness to accept and be less attached to the idea of ridding painful experiences. Unlike traditional cognitive-behavioral therapies, which emphasize the evaluation and change of cognitions and behaviors, contextual psychotherapies emphasize observation and acceptance of thoughts, and nonstriving (Baer, 2003). Such acceptance and nonstriving bear a closer resemblance to indirect control, characteristic of Asian cultures, than they do to direct control which seeks to actively change stressors (Lam & Zane, 2004; Weisz et al., 1984).

Contextual therapies may be intuitively appealing for application with Asian Americans in that many of their concepts are based on East Asian philosophies, such as Buddhism (Baer, 2003). Another appealing aspect of these approaches for application with Asian Americans is their ostensible emphasis on context, which is important in Asian cultures. However, similar to other evidence-based therapies (G. Hall & Eap, 2007), the effectiveness of contextual psychotherapies has not been evaluated with Asian Americans, and these psychotherapies have evolved from primarily Western-based conceptions of mental health. In view of this Western orientation, it is important to consider how Western contextual therapies may deviate somewhat from their Asian cultural base and the clinical implications of these departures for the treatment of Asian American clients.

Points of Departure among Buddhism, Asian American Cultures, and Psychotherapy

At first glance, it may appear that contextual psychotherapies incorporate Asian cultural values and that these psychotherapies can be effectively applied with Asian Americans in an unmodified manner. However, in practice, this alignment to Asian cultural values and ethnic orientations is rather limited. Differing psychologies of self, control, and communication may dictate approaches that focus on the individual rather than the group and on direct control rather than indirect control. These differences are expected since they may be necessary to reach and to work with non-Asian clientele. Yet, the adaptation of Asian principles into a primarily Western cultural therapeutic base, as creative as this may be, may result in these psychotherapies actually becoming less culturally-relevant to individuals having Asian cultural values and others who may adhere to similar values. In other words, a narrow, ethnocentric view of self, control, and communication may not only render Western psychotherapies less relevant to persons of Asian ancestry, but also to those of non-Asian

ancestry who do not completely share a Western worldview. Two aspects of contextual therapies that reflect more Western-based cultural worldviews are: (1) the marked distinction between self and others (“I” vs “You”); and (2) the importance of active coping by the self.

Self vs. Others

Western mindfulness practices tend to be self-focused with an emphasis on observing and describing (without judgment) one’s inner experience, and acting with awareness of this inner experience. The ability to observe private events (e.g, thoughts, emotions, pain) without allowing them to be self-defining (e.g., “I am stupid” vs. “I am having the thought that I am stupid”) is described by Acceptance and Commitment Therapy (ACT) as part of the “transcendent self” (Hayes, 2002). The transcendent self is defined as knowing from a locus or perspective. The transcendent self is present and knowing of all events experienced but cannot be threatened or altered by these events.

Western translations of the transcendent self for therapeutic purposes may be biased with respect to the importance of self vs. others. Contextual therapies rest on the assumption that the boundaries between the (transcendent) self and others are not only clear but also important. Given this assumption, treatment focuses on elaborating the patient’s inner experiences, values, and goals, and neglects the possibility that observation of others’ reactions may be integral to (if not more important for) guiding future behavior. Such emphasis on the individual self departs from Asian conceptions of interdependence that promote the oneness or wholeness of an individual’s identity with others.

In Western views, the transcendent self is thought to develop from deictic relations, such as here/now, I/you, or now/then (Fletcher & Hayes, 2005; Hayes, 2002). In essence, the “transcendent self” stems from an understanding of language-based concepts such as “I” as separate from but existing because of “You.” We agree with Fletcher and Hayes (2005) that human language can lead to a sense of self as a perspective and promote an understanding of how the self exists within a particular context. In Asian languages, the deictic relation of I/You is less pronounced and more fluid than in English. For example, in the Korean language, when a man introduces his wife to others (the literal translation of what) he says is “this is *our* wife” rather than “this is *my* wife”. In speech there is no clear distinction between my and our, singular or plural. When such introductions are made there is no confusion as to whom the woman is married and “this is our wife” is usually said as a signal of respect to the group the wife is being introduced. In this example there is a reduced need to clarify personal possessiveness (i.e., I vs. You) and greater importance on an individual’s oneness with others (i.e., Us). Thus, following assertions of language-based development of knowing from an individual perspective, in Asian contexts, knowing may stem from the perspective of the group rather than the individual. Moreover, for Asian clients, it may be therapeutically beneficial to develop the transcendent self by observing and describing (without judgment) others’ reactions and acting with awareness of these reactions.

ACT and other contextual therapies approach treatment primarily from a first person perspective (e.g., “what do I want given what you want?” vs. “what do we all want?”) and aims to develop an individual’s identity separate from, though inextricably tied to, one’s context. Indeed, Hayes (2002) argued that the transcendent self, an essential component of ACT, is “critical therapeutically because it means that there is at least one stable, unchangeable, immutable fact about oneself that has been experienced directly...” (p. 65). References to social norms that govern behavior in interdependent communities are largely missing from these psychotherapies. One of the principles of these approaches is for actions to become more consistent with personal values (Hayes et al., 2006). Such values, which may include one’s family, appear to be individually-determined and are not necessarily

established with reference to group or community norms. Reference to such group norms may be critically important to Asian Americans in determining their values.

Thus the primary therapeutic mission in Western acceptance-based approaches remains the affirmation of the individual self in a non-judgmental, accommodating way. This Western emphasis is not surprising given that psychotherapeutic systems inherently are value laden to fit with the cultural norms of a particular society (Lock, 1981). This emphasis contrasts with the major goal of Asian therapies, in which the pathway to positive self-regard involves establishing, maintaining, and enhancing the interdependence and interrelatedness of the self with others. In these therapies, attitudinal and behavioral processes are invoked to resocialize the person and affirm “one’s identity as an interdependent being committed to the shared values of the group” (Heine, Lehman, Markus, & Kitayama, 1999; p.771) As such, the transcendent self in Asian contexts is in a more dynamic process of change and adaptation as the person perpetually strives to align with normative expectations and relational obligations.

A case example illustrates potential difficulties with Western-based acceptance therapies for Asian-American clients. Sarah, a 29 year old single Chinese-American woman, had immigrated to the U.S. from Taiwan with her parents and older sister when she was 12 years old. Her parents spoke minimal English, and they had owned multiple small businesses in San Francisco Chinatown for the past 20 years. Although bilingual, Sarah spent most of her time with her Chinese speaking friends and family. Sarah worked in the finance department at a non-profit organization, and she lived with two Chinese roommates in the Bay Area. She sought treatment for difficulties with chronic worry and depression. Sarah spent hours lying awake in her bed pondering “what if...” scenarios and avoiding tasks that needed to be completed. As a result, she found it difficult to concentrate, fell behind at work, struggled with insomnia, and felt hopeless about the future.

During the assessment phase, Sarah struggled to articulate and elaborate on her feelings. She frequently responded to questions about her feelings and situations with “I felt bad” or “that made me feel bad”, and she was unable to specify particular emotions. She often spent most of the session sobbing but asserting repeatedly that she “didn’t know why”. In addition, Sarah showed difficulty articulating her worries and required significant prompting to do so. Her worries focused primarily on interpersonal concerns: finding a husband, disappointing her parents, being alienated by her peers and coworkers, and acting inappropriately. For example, “I worry that my parents will find out that I am still in dating Joe. Oh, they would be so angry and would definitely tell me how I am too old to be wasting my time with him. They are going to be so disappointed in me”.

Mindfulness was one of the interventions used in her treatment. Sarah was introduced to the concept of focusing on the present moment and doing so without judgment. In Western-based acceptance-based therapies, a key component to mindfulness training is to have Sarah learn to identify her different emotions and become highly attuned to her thoughts and feelings in the moment. There is a strong emphasis on the individual. This appears to contradict the Eastern emphasis on relationships with others and being attuned to one’s surroundings (B. Kim et al., 1999; Wirtz & Chiu, 2008). Consistent with this, attempts to help Sarah articulate her feelings, sit with her feelings, or notice her feelings frequently ended with Sarah expressing great frustration.

Despite these struggles in becoming more self-conscious, Sarah became highly skilled at practicing mindfulness with external cues -- noticing sounds in the room, watching tea leaves steep in hot water, smelling fragrant soaps. Therapy reinforced this external focus, and improved her ability to understand her role in different situations and the ways she could

improve her relationships. Over time, Sarah's distress decreased significantly. She began to engage in her life by becoming more observant of the reactions of others but not dwelling on the perceived reactions of others. Contrary to a more Western-based emphasis on internal self-focus, Sarah's avoidance of her internal experiences did not prevent her from succeeding in and benefitting from treatment (Butler et al., 2007). Moreover, contrary to Western contextual therapies, the mindfulness component of treatment did not emphasize noticing one's internal experiences, and observing different thoughts and emotions, but, instead, focused on increasing Sarah's ability to be attuned to her environment and others.

Active Coping

Westerners are encouraged to take an active role in reducing their distress, which includes explicit seeking of social support through the elicitation of advice, instrumental aid and/or emotional comfort (H. Kim, Sherman, & Taylor, 2008). This approach assumes that emotional and cognitive suppression or avoidance leaves one vulnerable to distress. Indeed, research indicates that for European Americans, such experiential avoidance is positively associated with psychological distress (Butler et al., 2007; Hofmann & Asmundsen, 2008). As a way to reduce experiential avoidance, Western contextual therapies encourage patients to actively acknowledge, elaborate, and embrace one's internal, private experiences (e.g., Hayes et al., 2006). The underlying assumption being acceptance (and reduced distress) can only occur once the person actively observes and elaborates on his/her internal experiences. This is consistent with Western notions of acceptance as involving aspects of an active coping approach and direct control. From this cultural frame, the "suppression" of the individual self's feelings, wants, and values are maladaptive and increase the likelihood of emotional distress.

The term suppression strongly implies that something is being prevented from expression and being actualized. Although this is clearly the case in Western cultures in which the autonomous, independent self presses for expression to be consistent with its valued attributes and emotions, such emotional expressions and displays do not appear to have the same functional value in Asian cultures. These latter cultures socialize people to be interdependent and emphasize interrelatedness with others. In this context, open displays of emotions often can threaten cherished relations with others that form the definitional anchors for the interdependent self. Emotional restraint may not be suppressive, per se, in that the interdependent self may not be stifled or repressed. On the contrary, the restriction or curbing of emotional displays often affirms or strengthens an interdependent self-construal by allowing the person to maintain or even enhance one's relations with others. Emotional restraint works as an effective means of preserving interpersonal harmony. Accordingly, emotional inhibition and control do not have the negative emotional or social consequences for persons with Asian values that they do for persons with European American values (Butler et al., 2007). Asian Americans, African Americans, and Latino/a Americans all have been found to use emotional restraint and control more than European Americans (Butler et al., 2007; Gross & John, 2003). Moreover, in some Asian cultural traditions such as Buddhism, emotional constraint and the control of overt emotional displays are often viewed and valued as signs of endurance and self-discipline (Hwang et al., 2006).

A case example illustrates how this reserved, non-cathartic approach to coping with negative emotional states in East Asian cultures may be at odds with some of the basic tenets of Western psychotherapies. John, a 63-year-old Chinese male immigrant to California, began receiving therapy for major depression as part of a treatment research study. John's depression appeared to have been triggered by his wife's recent cancer diagnosis, which prompted worries about his wife potentially dying and him being unable to cope with being alone. John's therapist, also of Chinese descent, asked John to work with her on identifying

the thoughts that arose when he felt depressed and the situations that troubled him most. John refused to engage in such exercises, repeatedly stating, “I don’t want to talk about it. It’ll make me upset.” Despite John’s refusal to identify and discuss his thoughts, John’s depression symptoms progressively improved and he reengaged in his life’s activities and responsibilities.

John’s therapist described the situation to the research clinical supervisor and expressed frustration with the protocol’s emphasis on identifying and specifying thoughts and emotions. The supervisor reminded the therapist that the rationale for the exercises is to allow John to become aware of his thoughts and feelings and be in a position to either accept the situation or take steps to change it, the underlying premise being that acceptance can only occur after observation and understanding of the phenomenon. The supervisor also warned the therapist of how cognitive and experiential avoidance could leave the patient vulnerable to future difficulties with strong negative emotions and poor emotion regulation skills.

In contrast, John’s therapist noted that, within Chinese contexts, acceptance is seen as embracing what is ambiguous and that understanding the experience or phenomenon is not necessary (Lam & Zane, 2004; Weisz et al., 1984; Wong et al., 2003). The therapist also argued that John’s depressive symptoms had improved largely because he had learned to accept his wife’s condition by “not thinking about it” and proceeding with his life on a day-to-day basis without worrying about what will happen or how he would handle it. John’s mood also appeared to improve as a result of spending more time with his children and becoming more involved in his tai chi classes.

What are referred to as avoidant forms of coping (e.g., saving face by not telling anyone about a problem, thinking about the problem myself rather than burden others to save face, focusing on others’ needs and external demands over one’s personal difficulties) are relatively common among Asian Americans (Butler et al., 2007; Gross & John, 2003). Again, what may be avoidant and maladaptive in one culture may not be so in other cultures. Similar to open, direct emotional expression, active and problem-focused coping at times can be disruptive to interpersonal relations or may cause great face loss when such coping involves the disclosure of shameful problems in the process of seeking help. Compared to their European American counterparts, Asian Americans appear to be more hesitant to explicitly seek social support due to concerns of negatively impacting their interpersonal relationships by burdening others (H. Kim et al., 2008) and, presumably, negatively impacting interpersonal group harmony.

Instead, persons of Asian ancestry commonly use implicit social support, which involves emotional support without disclosing one’s problems (H. Kim et al., 2008). Reminding oneself of significant others or being in the company of significant others without discussing one’s problems are examples of implicit social support. This type of coping does not directly address the source of stress causing the distress, but it constitutes an alternative form of control by helping combat distress through reducing self-focus and placing greater attention to one’s connection to and interrelatedness with others.

Although avoidant forms of coping may be culturally syntonetic for Asian Americans, there also is evidence that avoidant coping is associated with negative consequences for Asian Americans. These include interpersonal conflicts (Ahn, Kim, & Park, 2008) and depression (Wei et al., 2008). The Ahn et al. (2008) and Wei et al. (2008) studies were conducted in college settings, in which direct control, direct communication, and explicit social support are valued. These values may create a cultural mismatch that results in distress for those whose values differ (H. Kim et al., 2008). Thus, assessment of the relative cultural match or

mismatch of a client's coping style and their environment is necessary (Hwang et al., 2006). There is recent evidence from China that a flexible coping style consisting of a combination of direct and indirect coping is negatively associated with state anxiety (Cheng, 2009). Implicit coping skills may be viewed as passivity in independent environments, but may serve to maintain interpersonal harmony in interdependent environments. Active coping skills may be required in independent environments but may upset interpersonal harmony in interdependent environments. Insofar as some multicultural environments feature both independent and interdependent demands, implicit and active coping skills may be required in the same context.

There are these points of departure between contextual psychotherapies and Asian cultures, but the points of intersection also provide opportunities to enhance the Asian cultural elements in these psychotherapies. Our goal is to propose a culturally syntonik approach to psychotherapy that retains much of the basic structure of contextual psychotherapies while emphasizing the inherent aspects of these approaches that are consistent with Asian cultural values. In the next sections, we consider cultural enhancements to these psychotherapies and discuss specific methods that reflect such enhancements.

Cultural Adaptations of Psychotherapy

It could be argued that Asian Americans living in a Western culture where independence is valued would benefit from therapy that promotes Western cultural norms, rather than from culturally adapted forms of psychotherapy. Aside from the potential consequences of ignoring the role of cultural factors in the development, expression, and course of symptoms, the argument assumes that adjusting to Western norms in a Western culture is essential to good mental health and psychological well-being. Critics of cultural adaptation frequently point to evidence suggesting the effectiveness of standard forms of evidence-based treatments with persons of color (Huey & Polo, 2008).

Critics of the applicability of Western approaches for persons having non-Western cultural origins may contend that Western approaches are culturally encapsulated (G. Hall & Eap, 2007). The worldview differences between the West and Asia are so fundamental that those having Asian origins may not consider Western psychotherapy approaches to be relevant in addressing their problems. For example, Family Orientation and Harmony are important traits on an indigenously-derived personality measure developed in China that are not components of Western measures (Cheung, Cheung, & Leung, 2008). Moreover, interpersonal relatedness is more salient for less acculturated than for more acculturated Chinese Americans (Lin & Church, 2004). Clearly, a major therapeutic issue is that many Asian American clients (as well as others with similar psychosocial and/or cultural backgrounds) do not perceive psychotherapy as a credible means for solving their life problems (Sue & Zane, 1987). For example, Asian immigrants to the West may view traditional cultural methods of healing, such as herbal remedies and acupuncture, as the most relevant solutions to their problems. Nevertheless, many persons in the U.S. having Asian origins are bicultural (Abe-Kim et al., 2001), and they may seek solutions to their problems that incorporate Western and Asian approaches.

An alternative approach involves intentional cultural adaptation of existing treatments. Hwang (2006) has offered a viable, conceptual model for cultural adaptations to psychotherapy, with particular reference to Asian Americans. Domains of this model include: (a) dynamic issues and cultural complexities, (b) orienting clients to psychotherapy and increasing mental health awareness, (c) understanding cultural beliefs about mental illness, its causes, and what constitutes appropriate treatment, (d) improving the client-therapist relationship, (e) understanding cultural differences in the expression and

communication of distress, and (f) addressing cultural issues specific to the population. These issues can be addressed from the top-down by beginning with a Western psychotherapy framework and culturally adapting it or from the bottom-up by first generating culture-specific solutions to psychological problems and subsequently incorporating them into Western psychotherapy (Hwang, 2006). Combining top-down and bottom-up approaches may be the most comprehensive. Leong and Lee's (2006) cultural accommodation model contends that emphases on universal aspects of disorders, as espoused by evidence-based treatments, and emphases on group and individual aspects of disorders, as espoused by cultural approaches, are equally important.

An alternative to these three approaches (i.e., unmodified application of evidence-based treatments, culturally adapted treatments, and indigenous practices) is the emphasis on inherent aspects of evidence-based treatments that are consistent with cultural values. Similar to Asian American cultural contexts, Latino/a American cultural contexts emphasize interdependence. Roselló, Bernal, and Rivera-Medina (2008) have suggested that the focus on interpersonal conflicts in interpersonal therapy is consistent with Latino/a values of *familismo* and *personalismo*. Similarly, because cognitive-behavioral therapy involves guidance from the therapist, who is an authority figure, it is consistent with the Latino/a value of *respeto*. Both forms of therapy were effective in reducing depression among Latino/a adolescents. An interesting aspect of this hybrid approach is that the structure of different types of evidence-based treatments remains intact, and it can be culturally responsive even though interpersonal and cognitive-behavioral therapies stem from different clinical epistemologies.

Another approach may be to discern which aspects of a patient's problems are culturally-based and may be less responsive to standard evidence-based treatment as versus those aspects that are amenable to the interventions. The following case example illustrates this point. Michelle, a 23-year-old Korean-American woman, was pursuing a Ph.D. in computer science at a top-rated San Francisco Bay Area university. Michelle immigrated to the U.S. with her family when she was 4-years-old, and grew up in a middle-class environment in New Jersey. Michelle had an impressive academic history, including being valedictorian of her high school, graduating from an Ivy League school in the top 5% of her class, and receiving a full scholarship to attend her graduate program. During her senior year in the university, she began struggling with "really bad heart palpitations", which led her to her hospitalization and later diagnosis of panic disorder with agoraphobia.

Michelle initially sought treatment to help manage her panic symptoms but further assessment of her problems indicated that she also struggled with making decisions and asserting her wants and needs with others. For example, Michelle spoke to her parents or older sister by telephone "at least 4 or 5 times a day". During these calls, Michelle's family checked to make sure she had taken her medication, not experienced another panic attack, and/or completed all her school assignments. Michelle, in turn, asked for help with decisions that ranged from which bus to take to the grocery store to what time she should go to bed to how to approach her professor about setting up a meeting. Michelle showed similar tendencies in her therapy sessions. She rarely finished a sentence without saying "Do you think that makes sense?" or "Does that sound weird?" or "What do other people usually say?"

Diagnostically, Michelle's repeated seeking of reassurance and difficulties with indecisiveness could be viewed as a symptom of obsessive-compulsive disorder (OCD) and/or dependent personality disorder. These problems appear to be exacerbated by her family's need to check in with her and enabling of her dependency on them. Moreover, the family's continual checking of Michelle's symptom status appeared to increase her sensitivity to and

fear of somatic changes and, thus, increasing her vulnerability to future panic attacks. From a Western perspective, the goals of treatment were relatively clear: the patient should learn how to assert personal boundaries (particularly with her family), reduce or eliminate reassurance seeking behaviors, and increase tolerance of the uncertainty that comes with making decisions independently.

From an East Asian framework, however, such treatment goals might undermine the culturally valued goals of interdependence (particularly among family members) and group harmony. Moreover, Michelle was *not* seeking treatment for indecisiveness and likely would have viewed individuation from her family as irrelevant to her goal of reducing the frequency of her panic attacks. To promote such individuation would likely have reduced her willingness to stay (and her family's willingness to have her stay) in treatment.

Michelle's initial phase of treatment focused on explicitly targeting her panic disorder and agoraphobia symptoms. As treatment progressed and Michelle developed a stronger understanding of how certain behaviors (e.g., avoidance, checking for changes in bodily sensations) could exacerbate her fears, she began to question whether her interactions with her family were somehow contributing to her anxiety ("Do you think there's something wrong with always asking my family for advice?"). To address these issues, Michelle worked on articulating the reasons for feeling the need to continually seek reassurance from others and what she feared would happen if she made a decision independent of others.

Through these discussions, Michelle identified two different reasons for her indecisiveness. The first reason fit with Western conceptualizations of OCD symptom maintenance; Michelle sought reassurance to reduce her discomfort with uncertainty, which, in turn, increased her sensitivity to uncertainty and her tendency to seek reassurance to relieve her discomfort. An example of this type of indecisiveness was asking her parents whether or not she should bring an umbrella with her to class. Conceptualizing Michelle's indecisiveness as OCD symptom maintenance and then considering cultural issues is analogous to Hwang's (2006) top-down approach or the universal approach in Leong and Lee's (2006) model, both described in more detail below.

The second reason for Michelle's indecisiveness had a more culturally nuanced basis. Michelle valued the close ties she held with her family and felt that seeking their advice and opinions positioned her to make decisions that benefited not only her but also her family. For example, Michelle frequently asked her parents how she should approach different social situations and did so because, to Michelle, being socially successful would show she had been raised well and would not cause a loss of face for her family. Michelle also insisted that seeking reassurance strengthened relations with her family – from asking her sister which makeup to buy, to asking her mother to stay on the phone with her and help her decide what to make for breakfast, to asking her father to check all her financial records to make sure she balanced her checkbook appropriately.

Using the distinction made in session, the second phase of treatment focused on increasing Michelle's ability to identify urges to seek reassurance because of anxiety and practice mindfully observing urges without engaging in them. For reassurance seeking behaviors driven by the goals of interdependence and strengthening of family ties, treatment focused on helping her elaborate on these values and develop ways to supplement existing behaviors to achieving these goals. For example, Michelle began calling her mother every Saturday morning and, rather than seeking advice or reassurance, she would spend the time talking about a television program that she and her mother both watched on Friday evenings. At the end of treatment, Michelle no longer met criteria for panic disorder with agoraphobia,

showed increased ability to make decisions without seeking reassurance, and reported stronger, deeper relationships with her parents and sister.

In this case, following standard Western protocol actually may have reduced the effectiveness of treatment. Western acceptance therapy approaches work from the implicit assumption that all individuals hold values consistent with an individualistic cultural orientation, and the treatment plan is based on this premise. The treatment focus would be on explicating what Michelle wanted from her life, independent of what her family wanted from her, and working towards life goals that did not depend on her family to achieve them. *What appeared to be effective for Michelle, however, was identifying and affirming her collectivistic values and developing life goals that were interwoven with those of her family.*

A logical question is whether indigenous therapies developed in the East offer the same or greater benefits for Asian Americans compared to those developed in the West. Western mindfulness and acceptance therapies have been compared with Morita therapy, a Japanese approach (Hofmann, 2008). One of the primary principles of this approach is to accept one's feelings without attempting to change them. Another Japanese therapy, Naikan, involves resocializing clients by making them aware of their social obligations toward others (Tanaka-Matsumi, 2004). Emotions and moods are considered secondary to the consideration of reciprocity of care and benevolence. The goal of both Morita and Naikan therapies is social restoration and both emphasize integration into one's social network over individual concerns. Extended periods of social isolation in both approaches are intended to force the client to reflect on how well they fit into their social networks. Although both of these approaches are influenced by Buddhist philosophy and share some of the same principles as mindfulness and acceptance therapies, they were developed independently of Western thinking and do not address many of the issues that Asian Americans face in a Western cultural environment. Moreover, the effectiveness and mechanisms of therapeutic change of Morita and Naikan therapy have not been empirically evaluated (Tanaka-Matsumi, 2004).

Taoism is another Asian philosophy that emphasizes conformity to natural laws, freeing oneself of excessive control, and flexible development of personality (Zhang et al., 2002). A Chinese Taoist cognitive therapy has been developed, and it is similar to Morita and Naikan therapies in its emphases on the rights of others, nonstriving, restriction of selfish desires, being in harmony with others, and being humble. In a randomized clinical trial, this approach was found to reduce symptoms of general anxiety disorder, neuroticism, Type A Behavior, and substance abuse (Zhang et al., 2002). The therapeutic effects of Taoist cognitive therapy occurred more slowly than the effects of benzodiazepines, but lasted longer than the drug effects. However, the Taoist approach was not compared with non-Taoist cognitive therapy, so it is unknown if treatment effects were a function of the Taoist modifications. Although this Taoist therapy approach has not been evaluated with Asian Americans, it provides preliminary evidence that emphasis on Asian cultural elements in psychotherapy may benefit persons of Asian ancestry (Zhang et al. 2002).

An individual's level of acculturation is not absolute, fixed, or well-defined. Acculturation may be influenced during development by context. For example, beginning life in a largely non-Asian context and moving later into a primarily Asian American context may strengthen an Asian American's Asian identity. Moreover, acculturation is not a simple linear process of transitioning from one culture to another (Zane & Mak, 2003). An Asian American's Asian and American identities may develop orthogonally, and the development or loss of one does not necessitate the development or loss of the other.

Rather than viewing the benefits of cultural adaptations of psychotherapy as limited to persons of color, we propose that such adaptations may actually improve the flexibility of how treatment is delivered. The combination of Asian and Western principles may provide clients, regardless of ethnic background or level of acculturation, a rich array of coping skills and adaptive behaviors that may be superior to therapies limited to promoting Western norms and values. Social contextual demands are not uniformly individualistic, even for Westerners. For example, when one is a part of a team, such as in work or sports contexts, the success of the team often depends on cooperation and an individual's unwillingness to cooperate may compromise the team's functioning.

Cultural Reincarnations of Western Psychotherapies

Reincarnation involves the spiritual progress in one lifetime that lays the foundation for spiritual progress in the next lifetime (Kumar, 2002). A reincarnation of contextual psychotherapies with a greater emphasis on their Asian cultural roots may make these approaches more consistent with the cultural values of persons of Asian ancestry and, in turn, potentially more relevant for treating Asian Americans and non-Asians who endorse more interdependent self-views. The Buddhist Middle Path offers a model for the integration of seemingly opposing viewpoints. Applications of the Middle Path are central to concepts presented in acceptance-based therapies (e.g., Linehan, 1993). Patients are taught to understand the dialectics of seemingly opposing and conflicting states (e.g., willingness vs. willfulness) and work toward accepting and working with the pulls of each end. The Middle Path validates the need to reduce stress, but it helps the client find a way that does not have negative effects. The culturally syntonetic approach to psychotherapy similarly seeks the cultural Middle Path between Asian and the Western orientations.

Western psychotherapy approaches may, advertently or inadvertently, promote the benefit of having an independent worldview as absolute, missing the opportunity to capitalize on the potential gain of utilizing an interdependent perspective (G. Hall & Malony, 1983). Psychotherapeutic facilitation of interdependence is important because many Asian Americans are in family or community settings in which interdependence is adaptive, and because aspects of interdependence, such as indirect control, are consistent with the principles of contextual approaches. *Although mindfulness and acceptance are not specific to Buddhism or Asian cultures (Kabat-Zinn, 2003), they have great salience in Asian American cultural environments.* Thus, a therapist's understanding of interdependent cultures and the ability to facilitate a dynamic balance between interdependence and independence orientations may prove beneficial in working with bicultural clients and those from more collectivistic societies.

Culturally Syntonetic Psychotherapy Methods

In deriving a culturally syntonetic form of contextual psychotherapy we offer several recommendations to make these approaches more culturally informed and culturally nuanced so that in practice, they resonate more with Asian American cultural worldviews, norms, values, and life experiences.

Conceptions of self—Western contextual psychotherapies can be more consistent with Asian cultural norms by adopting a comprehensive conceptualization of context that extends beyond the individual self. Loving-kindness meditation is a Buddhist method of orienting oneself toward others and is already a component of some Western mindfulness psychotherapies (Fredrickson et al., 2008; Hutcherson et al., 2008). This approach involves directing compassion and wishes for well-being toward others and has been demonstrated to increase feelings of social connection and positivity toward self and others (Hutcherson et al., 2008). It also has been found to increase positive emotions and reduce depressive

symptoms (Fredrickson et al., 2008). Borrowing from Buddhism and Naikan therapy, a focus on one's obligations to others and the failures of one's compassion can serve as the motivation for engaging in loving-kindness meditation. Improved personal functioning gained from such meditation may save face for an individual and a group by allowing one to be a productive member of a group and less of a burden on others. The purpose of meditation is not solely self-fulfillment, as it often is in Western approaches, or solely out of responsibility toward others, as it often is in Asian approaches, but to benefit the self in the context of others.

The indigenous People Awakening project on the recovery from alcohol abuse for Alaska Natives exemplifies the integration of mindfulness into an interdependent cultural context (Mohatt et al., 2008). Indigenous mindfulness develops the awareness of the self in the context of the natural environment and enhances the person's appreciation and understanding of one's bond and obligations to others in the social world of kinship responsibilities. This mindfulness approach fosters a stronger sense of interdependence through affirming one's responsibilities to one's extended family and to the broader community. Awareness of these responsibilities seemed to motivate recovery from alcohol abuse, which was conceptualized as an abrogation of family and community obligations.

Interdependent transcendent self—Given the emphasis on interdependent goals and values in Asian contexts, conceptions of the transcendent self from the “I” not “You” perspective are limited and potentially less culturally relevant. What may be more viable is a transcendent self that holds a “We” not “They” perspective. To help facilitate this sense of self, the therapist would work with the patient to identify the in-groups to which s/he belongs (e.g., family, work colleagues) and collaboratively work with the patient to develop an immutable interdependent sense of self that is able to view events as separate from (not defining of) the group. Consider a patient whose family member is fired from his job and the patient reports difficulties with face loss concerns. Rather than working with the patient to observe personal reactions to the event (i.e., “how am *I* feeling?”), it may be more helpful to have the patient observe the family's reactions to the event (i.e., “how are *we* feeling?”) and distance oneself from the reactions in a non-judgmental, descriptive way (i.e., “*We* are having thoughts that this will cause others to look down on *us*” vs. “*I* am having thoughts that this will cause others to look down on *me*”).

Defining personal values—Central to ACT is living a life that is guided by personal values (Hayes et al., 2006). Several therapeutic exercises are devoted to helping an individual identify and prioritize his/her values within various life domains/relationships (e.g., spouse, parents, friends, health, children, career). Underlying these exercises is the assumption that an individual's personal values are ultimately determined by the individual and shaped by his/her own preferences, desires, and interests. For example, one common exercise is to have a patient imagine that she is attending her own funeral and list what she hopes others would say about her as an individual as a way to elicit the patient's values. From a more interdependent self perspective, the values that guide one's behavior are determined more by group needs and expectations and are often situation-specific. In therapy, a patient with a strong allocentric orientation may benefit more from exercises that help her better identify and prioritize social group norms and values and to flexibly apply these values depending on the group he is in at the moment. A potential parallel therapy exercise could be to ask the patient to imagine she is attending her own funeral and then list the ways she hopes the various groups to which she belongs had been successful as a result of her contributions. Moreover, the patient would likely benefit from exercises that help her specify the contexts in which certain values are helpful and those that are not. For example, the value of “being honest” may be important when interacting with one's close friend but may be less important when speaking with one's elders.

Coping—A culturally syntonic approach to coping would involve strengthening inherent indirect control and implicit coping among interdependent-oriented clients. Forms of indirect control among interdependent clients that appear to be avoidant may be potentially effective coping methods. For example, implicit coping may not directly address a stressor, but it still may involve coping in the form of imagined or actual social support (H. Kim et al., 2008). For example, a patient may be seeking to reduce his distress after having a negative interaction with a co-worker. An active, direct approach would likely involve working with the patient to develop strategies to effectively communicate his feelings and act in a way that would promote his goals and values. Avoidance of the co-worker and the situation would be discouraged. For more interdependent-oriented patients, it may be more helpful to accept the reactions of the coworker, practice compassion towards the co-worker, and take solace in the strength required to remain respectful, reserved, and non-reactive.

The focus on and the processing of emotions that is common in Western psychotherapies may not necessarily be appropriate for many Asian Americans. Focusing on emotions is intended to promote greater internal awareness and elaboration of individual needs and reactions, with the overall goal of facilitating direct, active coping behaviors. If an individual's goal is to engage in implicit, indirect coping, then a focus on processing the needs and demands of the context and minimizing attention to personal reactions may be more helpful and depending on the cultural context, more adaptive.

Conclusion

Western contextual psychotherapies have roots in East Asian philosophies and include many cultural elements that could be enhanced to possibly make psychotherapy more relevant and effective for Asian Americans. These psychotherapy approaches potentially offer a common ground for communication among clients, therapists, and researchers. Despite such potential, attention to non-Western cultures has been largely absent from the development and application of contextual psychotherapies (Baer, 2003; G. Hall & Eap, 2007). In our analysis, the attention to alternative cultural perspectives is used to broaden the applicability of these psychotherapies to non-Westerners. Specifically, we have offered recommendations for how alternative cultural perspectives derived from the experiences of Asian Americans, and the recommendations are more aligned with interdependent and allocentric orientations; this may enhance these approaches around issues of conceptions of self, the interdependent transcendent self, defining personal values, and coping.

Although culturally-syntonic contextual therapies are appealing, such approaches have yet to be developed or evaluated. We hypothesize that the applicability and effectiveness of contextual psychotherapies that are culturally enhanced for Asian Americans would be moderated by acculturation. Asian Americans who would optimally benefit from a culturally enhanced approach would be those who are unacculturated or bicultural. The moderating variables are cultural rather than demographic, so persons of any ethnic background who adhere to cultural values similar to those of Asian Americans may benefit from culturally enhanced psychotherapies. This hypothesis could be evaluated in research on existing vs. culturally enhanced psychotherapies with clients who vary on their levels of acculturation and/or adherence to certain Asian cultural values, coping orientations, and self-construals.

Our focus has been on Asian Americans because of the philosophical convergences between Asian cultures and the conceptual bases of contextual psychotherapies. However, there are other cultural groups in Western societies that have relatively strong interdependent orientations, and the groups are rapidly growing in the United States. Psychotherapy traditionally has served as a means to adapt culturally diverse persons to an independent culture (G. Hall & Malony, 1983). However, as culturally diverse populations continue to

increase in Western society, and Western culture itself becomes increasingly diverse, monoculturally based psychotherapy approaches may become less relevant or effective for all cultural groups including White Americans. Contextual psychotherapies have the potential to be useful and relevant treatment pathways to mental health for a culturally diverse society provided programmatic efforts begin toward implementing them in a more culturally syntonic manner.

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