CHAPTER 2

Psychotherapy in Cultural Context: An Overview

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Acceptance, mindfulness, and values are recent "hot topics" in the field of psychotherapy and applied psychology (Baer, 2006; Hayes, Follette, & Linehan, 2004). A number of new cognitive and behavioral therapies have emerged that integrate mindfulness, acceptance, and values into their models and practice (Hayes, Villatte, Levin, & Hildebrandt, 2011). Examples of such interventions include acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999), dialectical behavior therapy (DBT; Linehan, 1993), mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002), and many others. These interventions have been applied in a wide range of health service settings for diverse individuals with a broad array of psychological and physical health issues (Hayes, Villatte et al., 2011).

Given their rapid expansion in recent years, it is quite natural for many to wonder about the cultural competency of acceptance- and mindfulness-based psychotherapies. For example, experts in diversity psychology (Hall, Hong, Zane, & Meyer, 2011) have raised concerns, such as whether cultural adaptation is necessary for these interventions when applied to ethnic minority individuals and whether their essential concepts and processes, such as acceptance, are culturally biased. As discussed elsewhere (Sue & Zane, 1987), we cannot fully grasp the heart of psychotherapy without considering the cultural context in which it occurs. Nevertheless, understanding the intricate interplay between psychotherapy and cultural context is extremely challenging. Despite extensive triumphs and progress in this area (Sue, 2009), we still have a long way to go.

To overcome this challenge, Sue and his colleagues (Sue, Zane, Hall, & Berger, 2009) suggest the adaptation of a bottom-up, pragmatic theoretical framework to systematically organize our knowledge and strategies. As such, the present chapter provides an empirically based conceptual framework, upon which some of the recent acceptance- and mindfulness-oriented psychotherapies are based. Because every conceptual model is developed from a particular worldview, we first present our essential philosophical assumptions and analytic goals. Subsequently, I will explicate a conceptual account of complex

human behavior and discuss *culture* and *psychotherapy* within this conceptual framework. Finally, we will discuss whether acceptance, mindfulness, and values are culturally biased and delineate the potential contributions of the acceptance- and mindfulness-based approach to the issues of cultural diversity and competence.

Our Essential Perspective

There are almost infinite ways of viewing culture, psychotherapy and culture, and relevant topics (e.g., cultural competence; Sue et al., 2009). Although having diverse ideas can be viewed as a strength, it may also hinder advancement in the welfare and betterment of individuals (Sue et al., 2009). According to Hayes and his colleagues, this somewhat chaotic phenomenon in the topic of culture and psychotherapy is partially attributable to (a) different levels of analysis (e.g., biological, psychological, and social levels of analysis) used to understand culture and psychotherapy and the tension between these different levels of analysis (Hayes & Toarmino, 1995), (b) different worldviews (Hayes, Hayes, & Reese, 1988), and (c) the lack of a coherent theoretical framework for systematizing and refining our knowledge and skills (Hayes et al., 1999). As such, one way to clearly elucidate our position is to present our worldview, conceptual model, and the level of analysis at the outset.

Levels of Analysis

As the "biopsychosocial model" has flourished in the field of behavioral science, the link between culture and psychotherapy has been discussed at multiple levels (Chiao et al., 2010; Sue et al., 2009; Wang & Sue, 2005; Whaley & Davis, 2007). Different levels of analysis have distinct units of understanding (biological, psychological, and social), each with particular analytic goals. We consider no particular level of understanding (e.g., biological) to be superior to others (e.g., psychological; Hayes & Toarmino, 1995).

Psychological accounts of human behavior are conducted at the level of the individual. This level of analysis focuses on the *act of a whole individual*. The psychological level of analysis is relevant to, but different from, a biological or intraorganism level of understanding; biological levels focus on a part of an individual (e.g., brain or particular trait) as the fundamental unit of understanding. For example, at a psychological level of analysis, it is the entire person who thinks, not the brain or a particular cognitive schema, and it is the whole person who speaks, not the mouth or the language centers of the brain. Similarly, the psychological level of understanding is pertinent to, but distinct from, a group, social, or cultural level of analysis, because these levels focus on the practices of a *group* of individuals or a system, rather than the act of each individual member that composes that group.

These distinctions may be confusing because all cultural practices are also psychological events, but not vice versa, just as all psychological events are also biological events, but not vice versa (Hayes & Toarmino, 1995). This allows cultural phenomena to be discussed at a group/cultural level, at a psychological level, and at a biological level. Because such a reductionist approach is possible, however, knowledge applicable to a group may be incorporated into a psychological level of understanding without sensitivity to the idiographic nature of a given person. As Hall and his colleagues (2011) point out, a piece of information at the group level (e.g., "Asians are hardworking people") is not necessarily applicable to a given individual member of that group.

Functional Contextualism

Whether it is explicitly recognized or not, all people are bound to their worldview (i.e., philosophical perspective; Hayes et al., 1988). A worldview provides ways of making sense of the world, including personal experience. The author of the present chapter takes the perspective of functional contextualism (Biglan & Hayes, 1996). This fundamental worldview underlies a number of acceptance- and mindfulness-based psychotherapies that have been developed in recent

years (Hayes, Villatte et al., 2011), as well as in many spiritual traditions, such as Buddhism (Hayes, 2002).

An essential aspect of functional contextualism is the view of an "act-in-context" as an ongoing process (Hayes et al., 1988). In this chapter, the terms "act" and "behavior" are used interchangeably, and at a psychological level of analysis, these terms refer to everything a person does and says as a whole organism, including feeling, thinking, and overtly behaving. As such, the terms "behavior" and "action" capture a wide range of activities and psychological processes (e.g., friendship, love, anxiety, compassion, culture, mindfulness, acceptance, values, and cultural competence), which are viewed in terms of "the behavior of a whole person in a historical and situational context."

The behavior of a given person cannot be separated from the context in which it occurs. This is because its very nature (e.g., function, purpose, and meaning) is found only within its intricate interaction with the context. Take the example of the present author speaking Japanese. He is bilingual and speaks Japanese and English. When he talks to his sister, he speaks Japanese. When he talks to his wife, he speaks English. From a functional and contextual perspective, simply viewing his behavior as speaking a particular language is incomplete because the behavior is essentially situational and historical. In any given moment, a behavior is the manifestation of his learning history intricately interacting with a current situational context, and it serves a particular purpose (e.g., communicating with his sister). A functional and contextual way of viewing a behavior is said to be *holistic* and *idiographic* since a given person has his or her own unique experience.

The goal of functional contextualism is the prediction-and-influence of the behavioral phenomenon of interest (Biglan & Hayes, 1996). An analysis is said to be "true" or "valid" to the extent that it leads to the achievement of this goal. Prediction-and-influence is one goal, not two separate ones. Prediction is used in a restricted sense that is bound to influence (Biglan & Hayes, 1996). For example, if the focus of analysis is the therapist's behavior of cultural competency, a functional contextualist asks not only "What is cultural competency?"

From a functional-contextual perspective, the first question cannot fully be answered without answers to the latter question. Additionally, we can identify an infinite number of cultural factors in analysis of cultural competence. And yet, functional contextualism takes only particular kinds of cultural factors into consideration. Once identifying the target behavior, we look for cultural factors that contribute to the occurrence of that behavior, and, at the same time, that can be influenced by the client or therapist or both. Finally, functional contextualism focuses on the "act-in-context" for this pragmatic purpose. From this perspective, it is the context that maintains the behavior of a whole person, and we can only influence the behavior through acting on the context where it occurs.

Functional and Contextual Theory of Complex Human Behavior

Relational frame theory (RFT) is a theory of complex human behavior that is based on functional contextualism (Hayes, Barnes-Holmes, & Roche, 2001). RFT postulates that almost all of our behaviors are learned, shaped, and maintained verbally. This conceptual position overlaps with conventional *behavioral principles* (Ramnerö & Törneke, 2008). RFT expands conventional accounts by highlighting the predominantly verbal nature of our behavior while also taking into consideration the context in which the behavior occurs for the purpose of behavior change (Hayes et al., 2001).

Verbal behavior (e.g., cognitive process, mental activity) is roughly defined as a process of describing, relating, and evaluating an event in terms of other events (Hayes et al., 2001). For example, the word "tree" is a symbolic representation of the actual experience of seeing, touching, and smelling a tree. We can think about a tree, describe a tree, and relate a tree to other objects because we can relate a symbolic, verbal representation (i.e., the word "tree") to actual experience. We can see the complexity of this symbolic relating when we think, ruminate, wonder, rationalize, believe, try to make sense of

something, and so on. As humans are social beings, verbal processing becomes a central part of living. It occurs in almost every facet of our lives (Hayes et al., 2001).

Additionally, verbal processing has become a dominant source of regulating behaviors at both psychological and group levels (Hayes et al., 2001). This regulatory function of language occurs indiscriminately, whether a behavior is adaptive or not. For example, many clinically relevant behaviors, such as staying in bed when depressed, are regulated and maintained by verbal processes such as self-talk (e.g., "I'm too exhausted," "What's the point of getting up, anyway?"). At a group level, many cultural practices are often verbally transmitted from generation to generation.

There are several reasons we should emphasize verbal processes in psychotherapy and culture. First, in many clinical and applied contexts, behavior change involves verbal processes. In psychotherapy, client behavior change is navigated by the verbal exchange between the client and the therapist (Hayes et al., 1999). In cultural competency trainings, a therapist's behavior is shaped through his or her insight as well as through feedback from others (e.g., client, colleagues). Even in a high-context *less-verbal* communication culture, behavior change involves verbal processes.

Second, the products of verbal processing, such as particular beliefs or stereotypes (e.g., "I can't move on unless I keep all of my painful memories under control"), are difficult to eliminate once formed. We may develop new attitudes (e.g., "I can move on with pain"), but we cannot replace old ones with new ones (Wilson, Lindsey, & Schooler, 2000). Furthermore, attempts to eliminate and suppress unwanted thoughts and attitudes are futile and often counterproductive (Wegner, Schneider, Carter, & White, 1987). As mentioned in the following paragraphs, the rigidity of verbal ideas is particularly relevant to psychotherapy and cultural competency training.

Third, verbal processing can change the functions of other behavioral processes (Hayes et al., 2001). For example, suppose a person occasionally takes medicine for a physical or emotional ailment. Once hearing "medicine is toxic," she begins to avoid taking all medications

without actually experiencing negative effects. As noted elsewhere (Hayes, Niccolls, Masuda, & Rye, 2002), this indirect learning is quite efficient and economical in many contexts, but it could be quite debilitating in other contexts.

One of the most debilitating features of verbal processing is that it can obscure here-and-now experience (Hayes et al., 1999). This is in part because, through verbal processing, we respond to a particular event (or person) in terms of its relation to other events. A salient example is stereotyping behavior. Because verbal processing is stereotype-generating by nature (Hayes et al., 2002), attempts to eliminate stereotypes and preconceptions are perhaps futile. Given the rigidity of verbal ideas, acceptance- and mindfulness-based psychotherapies, such as ACT, teach the client to coexist wisely with verbal processing, rather than trying to get rid of it.

A Functional and Contextual Account of Culture

What is culture from a functional and contextual point of view, and how is a functional and contextual account of culture different from extant views? In a recent article, Whaley and Davis (2007) define culture as "a dynamic process involving worldviews and ways of living in a physical and social environment shared by the groups, which are passed from generation to generation and may be modified by contacts between cultures in a particular social, historical, and political context" (p. 564). Whaley and Davis's account of culture, like those of many others, is based on a group level of analysis, whereby the focus is placed on the process of a group.

A functional and contextual account of culture varies, depending on the level of analysis and its analytic goal. At a group level, the definition of culture is translated into "the practice of a group in context." For example, cultural practices are thought to be behavioral events considered in terms of their prevalence in a population and analyzed in terms of contextual features that affect the social propagation and

maintenance of these behaviors. As such, a culture is viewed as a set of functionally interrelated cultural practices (Hayes & Toarmino, 1995).

Contextual features that maintain a strong cultural practice may be entirely different from those that promote psychological adjustment of a given individual (Hayes, Muto, & Masuda, 2011). For example, staying married can be a cultural practice supported in diverse social communities. In these contexts, many people are often prohibited from getting a divorce even if staying in a marriage is extremely detrimental. Many cultural practices are maintained by contextual features that only emerge at the level of the group.

Psychotherapy is often viewed at the psychological level, where the focus is placed on a *given individual* interacting with another individual (Hall et al., 2011; Hwang, 2011). At this level of analysis, "culture" and "cultural factors" are translated into the framework of "behaviors of a *given person* in a historical and situational context." In this analysis, cultural factors are translated into the target behavior or contextual factors. As stated earlier, not all cultural factors are included in the analysis. Only the cultural factors that are relevant to the target behavior and that are systematically arranged by the client or the therapist are included in the analysis. For example, imagine that you are about to work with a 21-year-old Asian American male who wants to improve his communication skills with his family members, particularly with his parents. From a functional and contextual perspective, understanding the verbal and social contexts in which his communication with family members occurs is relevant. However, from a pragmatic point of view, if the verbal context cannot be arranged systematically, the analysis remains incomplete.

Acceptance, Mindfulness, and Values

The conceptualizations of acceptance, mindfulness, and values vary across researchers and practitioners (Hayes & Wilson, 2003). A functional and contextual perspective views acceptance, mindfulness, and values as ongoing *processes* of "behavior in a

Hayes, 1996); these processes are particular *ways of relating* to our verbal processes.

Acceptance, Mindfulness, and Values as Behavioral Processes

In acceptance- and mindfulness-based psychotherapies, such as ACT, the focus is on the promotion of vital living. Vital living is marked by consciously being in contact with the present moment without needless defenses while persisting with and changing behavior in the service of chosen values (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hayes, Villatte et al., 2011). As discussed elsewhere, verbal processes often keep us from contacting here-and-now experiences and amplify excessive defenses. Vital living is the presence of openness to one's experience, not necessarily the replacement of defenses with openness, in addition to the behavioral commitment to a life that is worth living.

Acceptance, mindfulness, and values reflect flexible and vital living through allowing us to coexist with our verbal behavior. Acceptance is a behavioral process of a whole person in a given context consciously allowing difficult psychological events (e.g., a negatively evaluated verbal event, such as anxiety) to be present and felt so as to be able to move in a valued direction. Mindfulness is characterized by purposeful awareness of the present moment in a way that is nonjudgmental and accepting of one's internal and external experience. Being nonjudgmental does not mean the absence of verbal judgment. Rather, it is the awareness of such verbal processes and the ability to choose a course of action freely, whether judgment is present or not. Finally, values are verbal processes that increase the likelihood of intrinsically reinforcing activity (see Hayes et al., 1999).

Acceptance, mindfulness, values, and vital living are behavioral processes with particular qualities (i.e., flexibility, openness, sensitivity, and vitality), and they are not bound to specific forms of attitudes or actions. For example, socializing with someone is a sign of acceptance to some individuals in particular contexts, and it can be an

escape from reality for others. Similarly, experiencing anxiety as it is and acting inconsistently with it by continuing to talk may be a sign of vitality and flexibility. Experiencing anxiety as it is and not acting on it when almost being hit by a moving bus may not be so vital. We cannot see if a given behavior is flexible, open, sensitive, and vital merely in its form. To do so, we have to view it functionally and contextually.

Acceptance, Mindfulness, and Values as Therapeutic Techniques

The terms "acceptance," "mindfulness," and "values" are also used to describe a set of particular techniques and therapeutic styles (Hayes & Wilson, 2003). When viewed as techniques and styles, they are often viewed exclusively in their form (i.e., as topographical features). While topographical features can be the proxy of effective treatment and cultural competency, an exclusive emphasis on form obscures their principle-based nature. Acceptance, mindfulness, and value-based techniques are called such because they target the *processes* of acceptance, mindfulness, and values. From a functional and contextual perspective, topographical adherence to a treatment protocol does not necessarily affect the target processes (Ramnerö & Törneke, 2008). What is crucial in acceptance- and mindfulness-based psychotherapies is the functional and contextual adherence (Hayes, Muto et al., 2011).

Are Acceptance, Mindfulness, and Values Culturally Biased?

Experts in diversity psychology have recently argued that acceptance- and mindfulness-based therapies are culturally biased (Hall et al., 2011). We agree and disagree with this position, depending on how we conceptualize acceptance- and mindfulness-based psychotherapies,

either topographically (i.e., as a set of techniques) or functionally and contextually (i.e., as a conceptual model). Specifically, a topographically defined psychotherapy is likely to be culturally biased because not all techniques will serve the same functions in different sociocultural contexts.

At the conceptual level, however, we believe that acceptance- and mindfulness-based psychotherapies are less culturally biased. This is in part because their conceptual models, especially the one presented in this chapter, are contextual and process based. As Whaley and Davis (2007) stated, a process-oriented account is less prone to cultural stereotypes than a topography- and content-oriented model. Furthermore, a growing body of evidence points to a broad applicability of acceptance- and mindfulness-based conceptual accounts (Hayes et al., 2006; Hayes, Muto et al., 2011; Hayes, Villatte et al., 2011). For example, diminished openness to one's difficult experience seems to be more or less applicable to emotional struggles experienced by a 21-year-old African American male as well as to those experienced by a 61-year-old Caucasian American female. Diminished value-directed living is likely to be related to a lower quality of life in a 41-year-old Asian American male who is physically disabled as well as in a 31-year-old Mexican American female who self-identifies as a "queer." In all cases, strategies that promote acceptance, mindfulness, and values seem to improve quality of life. That said, evidence is still limited, and we need to continue to investigate this assertion further.

Although the conceptual account does not change, topographical adaptation is inevitable for acceptance- and mindfulness-based psychotherapies when applied to a given individual. As mentioned earlier, what defines acceptance- and mindfulness-based psychotherapies are their functions in a given context, not necessarily their topographical presentations. For example, ACT is called ACT because it is designed to promote vital living through improving acceptance, mindfulness, values, and relevant processes (Hayes et al., 2006). As such, "cultural adaptation" or "individually tailored treatment" in form is assumed and expected when applied to a given individual (or group of individuals).

Cultural Competence: From an Acceptance and Mindfulness Perspective

Cultural competence is multifaceted, and the problems giving rise to cultural competency can be argued at multiple levels (e.g., treatment level, agency level, and systems level; Sue et al., 2009). That being said, this section focuses on the behaviors of a therapist in the context of psychotherapy as well as in the context of competency training.

At the level of therapist behavior (e.g., psychological level of analysis), Whaley and Davis (2007) view cultural competence as "a set of problem-solving skills that includes (a) the ability to recognize and understand the dynamic interplay between the heritage and adaptation dimensions of culture in shaping human behavior; (b) the ability to use the knowledge acquired about an individual heritage and adaptation challenges to maximize the effectiveness of assessment, diagnosis, and treatment; and (c) internalization (i.e., incorporation into one's clinical problem-solving repertoire) of this process of recognition, acquisition, and use of cultural dynamics so that it can be routinely applied to diverse groups" (p. 565). Similarly, Sue and colleagues (Sue et al., 2009) view cultural competence as a multidimensional process of "scientific mindedness (i.e., forming and testing hypotheses), dynamic sizing (i.e., flexibility in generalizing and individualizing), and culture-specific resources (i.e., having knowledge and skills to work with other cultures) in response to different kinds of clients" (p. 529). Concurring with Whaley and Davis (2007) as well as Sue et al. (2009), we believe that these behavioral processes are crucial for embodying an effective psychotherapy with a client in a given treatment as well as for working effectively with a diverse group of individuals. In this final section, we introduce several suggestions regarding cultural competence and cultural competency training. We especially focus on the impact of verbal processes and how they could promote and hinder our competency.

First, we cannot stress enough that no degree of knowledge about group memberships and the characteristics of those groups, no matter how detailed, can substitute for the individual level of knowledge when working with a given person (Hayes & Toarmino, 1995; Hwang, 2011). When the goal of analysis and intervention is behavior change of a given client (e.g., improvement in quality of life of *this* person), the case conceptualization and intervention should focus on the idiographic nature of that person. Only the individual level of understanding allows a therapeutic strategy specific to *this* person.

Second, choosing the cultural factors that should be taken into consideration depends on the goal of analysis/intervention as well as whether these factors can be systematically arranged in order to influence the behavioral phenomena of interest. For example, the goal of case conceptualization is not to gather an exhaustive number of cultural factors relevant to a given client, but to achieve its identified treatment goal.

Third, once becoming aware of one's own biases and stereotypes toward the client, the therapist does not have to make efforts to dispute the occurrence of these events. Verbal processing by nature is stereotype generating, and efforts to control the occurrence of stereotypes can disable us with fear. The problem is not having these events, but the impact that verbal processing may have on our actions. We can experience stereotyping views toward a particular individual and still connect with him or her genuinely and effectively. Acceptance- and mindfulness-based psychotherapies focus on learning to notice biases and stereotypes as they occur without acting on them. This stance can allow the therapist to choose and focus on his or her value-directed action in therapy without needlessly struggling with verbal content.

Fourth, acceptance- and mindfulness-based psychotherapies may provide balance in cultural competency training. They direct our focus to the promotion of what to do to be culturally competent (e.g., perspective taking, art of psychotherapy) in addition to what not to do. In cultural competency trainings, the focus is often placed on problem solving of culturally incompetent behaviors (e.g., biased

thoughts, automatic behaviors). Nevertheless, the absence of culturally incompetent behaviors does not necessarily mean the prosperity of culturally competent behaviors.

Fifth, it is important to be mindful of one's own sense of self-righteousness. An attachment to the perceived sense of being right can be more harmful than useful even when we are doing the "right" thing. This is also the case for cultural competency trainings. Pointing out or correcting others' cultural incompetency from the sense of righteousness can even represent an act of stigmatization. Embracing the conflicts between the pursuit of cultural competency and the inevitability of posing stereotypes on self and others will provide a human level of cultural competency training.

Finally, it is important that those of us who highly value cultural competency consider whether specific training in group-level cultural competence is necessarily relevant or important for psychologists. We must first consider the function of cultural competency training in therapy and research settings. If our job is to promote cultural diversity and competency and to find common goals to promote the betterment of human beings and the world, then idiographic approaches, which consider the context of the individual, may be enough for adequate cultural competence.

Conclusion

Given the recent expansion of acceptance- and mindfulness-based psychotherapies in a wide range of clinical and applied areas, many wonder about the cultural competence of these psychotherapies and the extent to which cultural adaptation is necessary. Nevertheless, "culture and psychotherapy" is an extremely challenging topic. The present chapter provides a conceptual framework for organizing our knowledge to promote cultural competency and treatment effectiveness particularly at an individual level. I hope that this chapter initiates dialogue and efforts for further advancing diversity and cultural competency in the field of psychotherapy and applied psychology.

References

Baer, R. A. (2006). *Mindfulness-based treatment approaches: Clinician's guide to evidence base and applications*. San Diego, CA: Elsevier Academic Press.

Biglan, A., & Hayes, S. C. (1996). Should the behavioral sciences become more pragmatic? The case for functional contextualism in research on human behavior. *Applied & Preventive Psychology, 5*(1), 47–57. doi: 10.1016/s0962-1849(96)80026-6.

Chiao, J. Y., Hariri, A. R., Harada, T., Mano, Y., Sadato, N., Parrish, T. B. et al. (2010). Theory and methods in cultural neuroscience. *Social Cognitive and Affective Neuroscience, 5*(2–3), 356–361. doi: 10.1093/scan/nsq063.

Hall, G. C. N., Hong, J. J., Zane, N. W. S., & Meyer, O. L. (2011). Culturally competent treatments for Asian Americans: The relevance of mindfulness- and acceptance-based psychotherapies. *Clinical Psychology: Science and Practice, 18*(3), 215–231. doi: 10.1111/j.1468-2850.2011.01253.x.

Hayes, S. C. (2002). Buddhism and acceptance and commitment therapy. *Cognitive and Behavioral Practice, 9*(1), 58–66. doi: 10.1016/s1077-7229(02)80041-4.

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). *Relational frame theory: A post-Skinnerian account of human language and cognition*. New York: Kluwer Academic/Plenum Publishers.

Hayes, S. C., Follette, V. M., & Linehan, M. M. (2004). *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition*. New York: Guilford Press.

Hayes, S. C., Hayes, L. J., & Reese, H. W. (1988). Finding the philosophical core: A review of Stephen C. Pepper's world hypotheses: A study in evidence. *Journal of the Experimental Analysis of Behavior, 50*, 97–111.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy, 44*(1), 1–25. doi: 10.1016/j.brat.2005.06.006.

Hayes, S. C., Muto, T., & Masuda, A. (2011). Seeking cultural competence from the ground up. [Article]. *Clinical Psychology: Science & Practice, 18*(3), 232–237. doi: 10.1111/j.1468-2850.2011.01254.x.

Hayes, S. C., Niccolls, R., Masuda, A., & Rye, A. K. (2002). Prejudice, terrorism and behavior therapy. *Cognitive and Behavioral Practice, 9*(4), 296–301. doi: 10.1016/s1077-7229(02)80023-2.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford Press.

Hayes, S. C., & Toarmino, D. (1995). If behavioral principles are generally applicable, why is it necessary to understand cultural diversity? *The Behavior Therapist, 18*, 21–23.

Hayes, S. C., Villatte, M., Levin, M., & Hildebrandt, M. (2011). Open, aware, and active: Contextual approaches as an emerging trend in the behavioral and cognitive therapies. *Annual Review of Clinical Psychology, 7*, 141–168. doi: 10.1146/annurev-clinpsy-032210-104449.

Hayes, S. C., & Wilson, K. G. (2003). Mindfulness: Method and process. *Clinical Psychology: Science and Practice, 10*(2), 161–165. doi: 10.1093/clipsy/bpg018.

Hwang, W.-C. (2011). Cultural adaptations: A complex interplay between clinical and cultural issues. *Clinical Psychology: Science and Practice, 18*(3), 238–241. doi: 10.1111/j.1468-2850.2011.01255.x.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Ramnerö, J., & Törneke, N. (2008). *The ABCs of human behavior: Behavioral principles for the practicing clinician*. Oakland, CA: New Harbinger Publications.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford Press.

Sue, S. (2009). Ethnic minority psychology: Struggles and triumphs. *Cultural Diversity and Ethnic Minority Psychology, 15*(4), 409–415. doi: 10.1037/a0017559.

Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42*(1), 37–45. doi: 10.1037/0003-066x.42.1.37.

Sue, S., Zane, N., Hall, G. C. N., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525–548. doi: 10.1146/annurev.psych.60.110707.163651.

Wang, V. O., & Sue, S. (2005). In the eye of the storm: Race and genomics in research and practice. *American Psychologist, 60*(1), 37–45. doi: 10.1037/0003-066x.60.1.37.

Wegner, D. M., Schneider, D. J., Carter, S. R., & White, T. L. (1987). Paradoxical effects of thought suppression. *Journal of Personality and Social Psychology, 53*(1), 5–13. doi: 10.1037/0022-3514.53.1.5.

Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services: A complementary perspective. *American Psychologist, 62*(6), 563–574. doi: 10.1037/0003-066x.62.6.563.

Wilson, T. D., Lindsey, S., & Schooler, T. Y. (2000). A model of dual attitudes. *Psychological Review, 107*(1), 101–126. doi: 10.1037/0033-295x.107.1.101.