

***Commentary on Acceptance and Commitment Therapy for "Taro,"*
a Japanese Client with Chronic Depression: A Replicated Treatment-Evaluation**

Examining the ACT Model in the Case Study of Taro

STEVEN C. HAYES ^{a,b}

^a University of Nevada

^b Correspondence regarding this article should be addressed to Steven C. Hayes, Department of Psychology, University of Nevada, Reno, NV 89557-0062
Email: stevenchayes@gmail.com

ABSTRACT

ACT is a functional contextual form of behavioral and cognitive therapy. It shares commonalities with other contextualistic approaches such as constructivist or narrative therapies, but it differs in its scientific goals. Because of these differences, it is oriented toward manipulable processes linked to basic principles. In this commentary I describe these characteristics and link them to the target article (Muto & Mitamura, 2015). I discuss how a major value of case studies of this kind is the exploration in an intensive way of the links between a model and treatment decisions, processes of change, and outcomes. This recasts somewhat the use of case studies and time series designs in the empirical investigations of ACT, and provides special opportunities for the examination of cultural factors in the application of an evidence-based model. Finally, I note how ACT may help bring together some of the wings of clinical work in Japan.

Key words: acceptance and commitment therapy; philosophy of science; functional contextualism; flexibility; culture

The case of Taro by Muto and Mitamura (2015) reflects the process of thinking behind Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2012) and its theoretical and strategic tradition, Contextual Behavioral Science (CBS; Zettle, Hayes, Biglan, & Barnes-Holmes, in press). In my commentary I want to focus on a handful of things: the philosophy of science behind ACT; what can be learned from case studies of this sort about psychological flexibility theory; and the importance of fitting ACT to specific cultures. Finally, I will have some brief comments about psychotherapy in Japan.

PHILOSOPHY OF SCIENCE

In the introduction to this series, Dr. Iwakabe (2015) describes the difference between the more narrative and integrative approach taken by Dr. Murase (2015) and the behavioral approach taken by Drs. Muto and Mitamura (2015), as one between extremes. If so, it is like two extreme ends of a line that have been bent back to form a circle.

The philosophy that underlies both a narrative approach and the particular behavioral approach represented by ACT is contextualism. With a few edits I've added, much of the clinical essence of the philosophy of science underlying ACT is well captured by Iwakabe's description of Murase's approach: the importance of understanding a client and his or her behavior in living context, assessing the realistic constraints as well as opportunities and sources of support, and building a growth-facilitating therapeutic relationship while igniting or tapping into the client's strengths. Contextualists of all varieties see action "in living context." For a contextualist, an act separated from history, setting, and purpose, is not a psychological act at all. Just as the purposes of clients need to be included to understand a client, the clinician's exploration of the interplay between context and action is limited and channeled by the purpose of the clinical analyst, and "truth" is taken to be the accomplishment of such purpose.

Thus, a contextualistic frame of reference needs to be applied also to the clinician or the clinical scientist, and as that occurs the analytic and practical purpose of intervention and understanding itself comes to the fore.

You can see these attributes, which Iwakabe originally used to describe Murase's approach, in the Mutu and Mitamura case. There is little interest in labeling the client. From the beginning the goal is to understand the client's situation and history, to build a trusting therapeutic relationship, and to enhance positive skills of awareness, acceptance, embrace of purpose, and practical action. The focus is on how the therapeutic relationship – the context of clinical work – can be used to foster the accomplishment of the client's goals by fostering the deployment and development of positive skills.

What, then, is the difference between these approaches?

A CBS approach is constrained by two additional purposes. It seeks (1) the prediction and influence of acts-in-context, and (2) generating scientific principles that afford the accomplishment of prediction and influence with precision, scope, and depth. These purposes are not justified, nor can they be since they are pre-analytic—rather they are merely declared and owned. They are an undefended starting point for this tradition; they are declared naked and in the wind, so to speak. In a deep sense, these goals define the game being played.

The brand of contextualism defined by these goals is called "functional contextualism" (Hayes, 1993; Biglan & Hayes, in press). It is distinguished from the more descriptive forms of contextualism that are commonly represented by narrative and constructivist approaches by these additional purposes.

I confess I am not steeped in Murase's work, but the more informed reader can see if my a priori expectations I am about to state are met. Narrative approaches like Murase's tend to seek an appreciation of the participants in the whole event. The details matter—but only with reference to the whole. The experiences of client and therapist alike intertwine with and penetrate the unfolding story of a life being lived. The reader is invited into that experience of appreciation—it is part of the very nature and purpose of understanding. In some ways work of this sort feels more like a living act of constructing a meaningful history, and not like an analytic process of prediction, change, and evaluation.

This is quite different from a functional contextualistic approach. In descriptive forms of contextualism appreciation can be done in direct and more common sense language, as the story of change in a human life is told. For the functional contextualist, the goal is prediction and influence, with precision, scope, and depth, and that requires abstract but applicable terminology. “Prediction and influence” as a unified goal means that analysis must always ultimately focus on manipulable events—things the clinician can change directly. If the analyst stays entirely inside the world of experience, prediction is possible but not influence because the analyst himself or herself is in the context of clients’ action. The language of influence and change thus must start there. And by declaration (that is, for no other reason than this is the game being played) for a functional contextualist the ways of speaking that support prediction and influence must have precision (a limited number of things can be said about a given event), scope (these ways of speaking must apply to a wide range of events) and depth (the account at a psychological level of analysis must cohere with accounts at other levels of analysis, such as the cultural level, or the biological level). Terms matter, and those in the CBS tradition are constantly seeking to ground their clinical terminology in basic behavioral and evolutionary principles, because common sense terms alone cannot meet the goals of the analysis.

Functional contextualists and descriptive contextualists are like members of the same family playing different games. Imagine that a large family went on a vacation and some of the children decided to go sailing, while others decided to play golf. You could easily recognize the family resemblance among the children regardless of what they were doing—the children may look and sound and think somewhat similarly while golfing or sailing. At the same time, sailing is not golfing. If the children who were sailing tried to hit a golf ball with the mast they would not succeed. If someone asked “which is better, sailing or golf,” we would need to know “better defined how?”

In the same way, the CBS game needs to be evaluated against its own stated goals. CBS is trying to build a progressive scientific tradition that integrates basic behavioral science, evolution science, and clinical science so as to create a psychology more adequate to the challenge of the human condition. It has a resonance with deep clinical traditions, and with spiritual traditions, but it is a modern offshoot of behavioral thinking.

I wanted to cover this material because there is a tendency to miss the family resemblance and to see only what is unique. The two “extremes” in this series are not really extremes. They are just family members playing different games.

LEARNING ABOUT FLEXIBILITY PROCESSES FROM CASE STUDIES

Less formal case studies and single case designs are distinguished primarily by the use of systematic data and methodological tools designed to limit the sources extraneous variability and measurement error so that treatment-related variability can be detected (Hayes, Barlow, Nelson-Grey, 1999). For example, in Muto and Mitamura’s case study, the addition of a baseline phase with regular systematic measurement provides some protection against changes due to maturation, coincidental extraneous factors, or underlying time-based processes. These features makes it much more likely that improvement seen was due to the intervention.

The efficacy of interventions in populations can only be established with large numbers of people, but the nature of the information from time series studies and from traditional group comparison studies differs. A series of case studies, if systematically done, allow treatment responders to be identified at the level of the individual. That is hugely important in being about to arrive at nomothetic generalizations about treatment responsivity that apply at the level of the individual, and it is quite different from generalizations that only apply to populations. Group comparison studies tend to be lean in their longitudinal information about individuals and rich at the level of identifying variability between people within conditions. That limits generalization to the level of the group. A systematic series of case studies and single case designs allow nomothetic generalizations to be built in another way: from the bottom up, one case at a time. Such generalization cannot be made on the basis of small numbers of people, however. People differ. Cultures differ. The generation of findings that apply across many individuals needs to be based on findings across many individuals—but ideally with intensive information at the individual level. That is part of what makes case studies and single case or time series designs useful

There is an equally important feature that fits with the underlying philosophical assumptions of ACT and CBS. The precision and scope of theoretical concepts are tested in the relationship of putatively pathogenic or prosperity-promoting processes on the one hand, and clinical intervention decisions and clinical outcomes on the other. The Muto and Mitamura case study includes rich information on the level of psychological flexibility in the case, the changes seen week-to-week as linked to intervention, and the resulting outcomes. Processes change when they are targeted (Figure 3), and changes in outcome closely track changes in processes. The latter relationships were not as fully explored at they might have been in the target article (e.g., statistically speaking, we could examine whether lagged correlations suggest that processes predicted subsequent outcomes more so than outcomes predicted processes); but even a cursory examination of the Figure shows that these processes and outcomes were indeed strongly related over time.

This pattern of results is a test of the precision and scope of psychological flexibility processes. The theory that underlies ACT suggests that human growth and prosperity is the result of a small set of interrelated processes involving openness, awareness, and active engagement.

The usual way that process → outcome relationships are tested is flawed in psychological science because it is almost entirely focused on the group level of analysis, with cross sectional rather than longitudinal analyses dominating. Experience sampling (e.g., Vilardaga, Hayes, Atkins, Bresee, & Kambiz, 2013) and other more contextually sensible methods are emerging to check and correct this domination, but working from the bottom up with case studies is prophylactic as well because it makes it impossible to comfortably throw longitudinal trends and variation within those trends into the garbage pail of group “statistical error.”

In my humble opinion it is the process → outcome link that is the most important contribution of this case study and of similar ACT case studies. Efficacy can better be addressed in large group studies that are careful to baselines and add rich longitudinal information, but process → outcome relations are not population questions. There may be nomothetic generalizations that are possible but they have to be built from the bottom up. If in this case, for

example, ACT produced wonderful outcomes but there was no rough relationship between processes and outcomes, then the theory is incorrect, or the measures are unreliable, or the relationship is inconsistent. Even a handful of such cases would question the model unless there were many, many more positive case examples.

FITTING ACT TO CULTURES

One benefit of a model that is based on basic principles is that cultural adaptations can occur with more direct theoretical guidance. For example, suppose it is argued that a transcendent sense of self emerges in part from deictic (i.e., context-based) cognitive relations: those that require a perspective or point of view to disambiguate. In individualistic cultures the distinction between self and non-self may be close to the relation of I and you. In collectivistic cultures, it may be much closer to the distinction between we and they (Hayes, Muto, & Masuda, 2011). These differences can readily be tested in assessment and intervention, and cultural adaptations can be made in a way that is theoretically informed and theoretically consistent.

The present case of Taro shows this sensitivity. For example, a mindfulness exercise was selected (tea tasting) that deliberately tapped into cultural traditions, and the therapist linked the exercise to that cultural wisdom: “During the exercise the therapist explained the close connection between mindfulness and Zen practice, and how Zen monks had codified the tea ceremony.” When the client questioned certain ACT ideas, the therapist was sensitive to the linkage between theory and the language community:

The therapist then said, “This is the Chinese character that represents the concept of mindfulness,” and he wrote the character down on a piece of paper (The character 念 meaning ‘sense’ or ‘feeling’, is written by combining the character 今 for ‘now’ above the character 心, for ‘heart/mind’). Taro asked, “Is this 念 ‘nen’?” The therapist responded, “If you pronounce it as ‘nen’, it can be misinterpreted as having a certain nuance of ‘resentfulness’ in Japanese” (p. 130-131).

Notice also that at several points the therapist introduced entirely new exercises and metaphors, always explaining them in common sense ways that fit with the clients’ experience:

Even along familiar streets there are all sorts of fascinating things and occurrences to be discovered amidst all that we frequently overlook. When you find something like this that catches your attention, take a photograph and send it to me. I’m looking forward to seeing the interesting things you discover (p. 131).

These details should not be waived away as unimportant. Evidence-based treatment has a bad name in its impact on clinical creativity and freedom when it is taken to mean the rigid following of manuals and protocols. That, however, is not the only model of evidence-based treatment. An alternative model is the use of principles that have been shown to apply to the clinical goal at hand. This was always the vision of behavior analysis, but clinical behavior analysis stumbled on the topic of human language and cognition. ACT has overcome this barrier to a degree, and there are many points in the case study where evidence of technological flexibility co-exists with evidence of theoretical coherence.

This line of thinking suggests that cultural adaptations in ACT will best be made by clinicians in the actual language of their cultural community, yet by clinicians who are nevertheless sophisticated in their understanding of psychological flexibility processes and their basis in behavioral principles, Relational frame Theory (RFT), evolution science, and functional contextualism. The authors of the target case fit that description precisely.

As a result it is hard to pigeonhole this case study as a behavior therapy case that treated the client as a collection of problems that a pile of techniques can correct. Yes, it is rigorous and theoretically driven. Yes, it involved extensive assessment and theoretical analysis. But at the same time it genuinely feels as though it is driven by clinical need, and by the experiences of the therapist in the room with the client. When new things emerge, new directions are taken. The therapist meets the client where he is. The high ratings given by the client and his wife a year later seem to fit that view.

PSYCHOTHERAPY IN JAPAN

Psychotherapy in Japan has a rich tradition, but it also has divisions that have emerged. These include the time worn differences between theoretical orientations, but they also include divisions between more spiritual and more empirical traditions. The slower professionalization of psychotherapy in Japan may actually provide benefits because psychotherapy is becoming more professional only now, after the near collapse of the traditional psychiatric nosology, or the excessive and passé tendency to equate clinical science with randomized controlled trials alone.

We need a new model of evidence-based and culturally adapted intervention: one that is transdiagnostic, flexible, process-focused and adaptable. In that world, case studies and systematic time series analyses have an important role to play, not as a substitute to randomized controlled trials, but as an important supplement and augmentation. ACT can prosper in such a world, and in Japan it will help build bridges between traditions without losing the best of an empirical focus. That is perhaps the most exciting implication of this series and it is a foundation that Japanese psychotherapists can build on if they set aside attachment to narrow schools and focus on connection and cooperation in the interests of the long term good of the clients they serve.

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