

## The Role of Context in the Case of Taro

YOSHINOBU KANAZAWA<sup>a,b</sup>

<sup>a</sup> Department of Psychology, Meiji Gakuin University, Tokyo, Japan

<sup>b</sup> Correspondence regarding this article should be addressed to Yoshinobu Kanazawa, Department of Psychology, Meiji Gakuin University, 1-2-37 Shirokanedai, Minato-ku, Tokyo 108-8636, Japan  
Email: [yk@psy.meijigakuin.ac.jp](mailto:yk@psy.meijigakuin.ac.jp)

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### ABSTRACT

Muto and Mitamura (2015) are to be highly commended for publishing the case study of Taro. The article is notable for its emphasis on documenting what is behaviorally observable and reliably quantifiable. The authors' commitment to scientific rigor is laudable. Japanese psychotherapists are strongly advised to use this article as a model of evidence-based treatment in their descriptions of psychotherapy sessions. On the other hand, the reviewer would have liked to see more discussions on contextual factors around Taro, his presenting problems, and his therapy, including therapeutic relationships, Taro's emotions in therapy sessions and the therapist's responses to them, possible conflicts in Taro's family, as well as organizational issues around Taro and his symptoms in his workplace. Measurement tools are available to reliably quantify these variables. Incorporating these measures into the therapist's work with Taro would help readers better understand the therapeutic process and illuminate the mechanisms of change in the case study.

*Key words:* Acceptance and Commitment Therapy; therapeutic relationships; family systems; organizational dynamics; emotions

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The authors, Drs. Muto and Mitamura (2015), are to be highly commended for publishing the article, "Acceptance and Commitment Therapy for 'Taro,' a Japanese Client with Chronic Depression: A Replicated Treatment-Evaluation." The article is written in such meticulous detail that other researchers or therapists who are interested in conducting Acceptance and Commitment Therapy (ACT) with depressed clients and learning about its effectiveness will find this article quite informative. The detail in which it is written will greatly help researchers and therapists' attempts to replicate this study.

The article is also noted for its scientific rigor, that is, for its emphasis on documenting what is behaviorally observable and reliably quantifiable. As one example of the authors' valuing such rigor, they present the specific physical dimensions of the office in which the client was seen (p. 119). As part of this mind-set, the authors employ data from behavioral observations and from standardized quantitative measures about the process and outcome of the case. Readers are readily able to see how much change the client manifested. It is a rare article in clinical psychology in Japan to demonstrate quantitative evidence of psychotherapy process and outcome. Japanese psychotherapists are strongly advised to use Muto and Mitamura's article as a model of

evidence-based treatment in their discussions of psychotherapy sessions.

This article is a significant contribution to clinical psychology in Japan. However, as a researcher in psychotherapy process and therapist training, with a strong commitment to contextual factors in my own work, the significance of Muto and Mitamura's article might have improved even more if they paid more attention to such contextual factors and processes—like the therapeutic relationship, client emotions, family system relationships, and organizational dynamics. I assume this is deliberate on the authors' part because these variables are harder to behaviorally observe and reliably quantify, thus falling short of the high standard of scientific rigor the authors set. However, these factors are part of the therapy tradition and impressive approaches have developed to study them in a scientific way with these factors in the therapeutic environment.

## 1. THE THERAPEUTIC RELATIONSHIP

It is widely accepted in psychotherapy research that the strongest predictor of therapeutic effect is external variables (e.g., client's social support, chronicity of presenting problems) and that therapeutic relationships between therapist and client also play a major role in psychotherapy effectiveness. According to Lambert and Barley (2001), 40% of client outcome is attributable to factors outside of therapy, while so-called common factors (including therapeutic relationships) account for 30% of the variance. Placebo (expectancy) and specific techniques each account for only 15% of the outcome variance. Laska, Gurman, and Wampold (2014) find that common factors account for significant portions of outcome variance (e.g., therapeutic alliance accounts for 7.5%; empathy, 9.0%; and goal consensus/collaboration' 11.5%), whereas specific ingredients of therapeutic approaches are far less important (specific ingredients found by dismantling, 0.0%, and adherence to protocol, less than 0.1%). Although the article includes detailed accounts of therapy sessions, most of them consist of technical interventions and their outcomes. The authors do not provide details of the therapist-client relationship.

What, then, is the mechanism of change in this case? The authors seem to assume that ACT interventions do produce therapeutic change. But how much is attributable to them? Given the empirical findings reviewed above, I am skeptical about the direct relationship between intervention and outcome without a consideration of contextual factors. Let me speculate what might have influenced therapeutic outcome beyond ACT interventions.

Taro is a very compliant client. He attended every session, apparently without arriving late. He cancelled only one session due to sickness. He diligently followed the therapeutic regimen and completed the fair amount of homework assignments as well as the process measures. He seems very motivated and committed to therapy. His expectancy for ACT is extremely high.

He is not only compliant but also submissive. He tries to please others, especially those in positions of authority, even by sacrificing himself (p.125: "History of present illness"). He also describes himself as someone who will avoid unpleasant situations even if there is something he wants to accomplish (p.128). His depression and frequent leaves of absence may

be manifestations of his avoidance. His progress and compliance in therapy may be related to his submissiveness and need to please others, as well as his high expectancy for ACT. I am curious as to how his submissiveness impacted upon his therapeutic relationship and outcome.

The authors do not specifically discuss the therapeutic relationship, but I find several aspects of the therapist-client relationship to be congruent with empirically supported positive therapeutic relationships. There is a high degree of consensus on goals and procedures and the client is highly collaborative; the therapist demonstrates positive regard toward the client; the therapist collects feedback from client and discusses it in therapy. These are all empirically supported aspects of positive therapeutic relationships (Norcross & Wampold, 2011). Discussing the therapy sessions from the point of therapeutic relationship would shed another light to this article.

I would have liked to see more descriptions of emotional aspects of the therapeutic relationship and how the two parties experienced the process. This may not be part of a standard ACT paper, but it would add an important dimension to the paper and hopefully would enrich the description of the therapy.

Speaking of emotions, I would have liked to see more discussion of them in the article. For instance, Taro repeatedly talks about how afraid he is of falling behind his same age cohort (pp.126-127), which perhaps exacerbated his depression. In Session 17, Taro says he has not been assigned work of much significance. The authors use the word “workplace harassment.” Taro was probably angry and dissatisfied with the way he was being treated, but the case study description doesn't mention this and the possibility of working on his feelings in the therapy. Instead, the case study describes how the therapist asked for details of each work day. I understand ACT is a highly structured, task-oriented approach, but I would still contend that there can be a role for emotions in ACT, especially because working with emotions by enhancing emotion regulation through learning mindfulness is an important component of this therapy model. For example, Muto and Mitamura themselves cite that one of the basic principles of ACT is "to change the form and occurrence of unpleasant thoughts and emotions" (p. 123).

Writing about the therapeutic relationship and emotional aspects of the sessions would have an added value. Some of the readers unfamiliar with ACT, myself included, may find the task-oriented style of the paper rather mechanistic. No good therapy is mechanistic, and as I pointed out earlier, the sessions in this paper display characteristics of effective therapeutic relationships. Including relational and emotional aspects may help readers grasp a more comprehensive picture of the sessions as they experientially took place and foster a better understanding of the therapy.

## **2. TARO, HIS PRESENTING PROBLEMS, AND THE TREATMENT IN CONTEXT**

Community psychology (Dalton, Elias, & Wandersman, 2001; Levine, Perkins, & Perkins, 2005) and family systems approaches (Guerin, 1976; Hoffman, 1981) maintain that individuals do not exist in vacuum. People live in intertwined systems of bio-psycho-social

contexts. Therapists and researchers would benefit from such multiple perspectives. Due to the importance of context, it is recommended that psychologists who help clients in industrial settings work not only with the individual but also with the client's workplace and the organization (Caplan & Caplan, 1993; Nitta, 2002).

Taro's symptoms started at his workplace and worsened after his return to work, therefore they are better understood in that context. How does he relate to his coworkers and his superiors? How do they deal with him and his problems? Are the demands placed on him reasonable and commensurate with his abilities? How could have his coworkers and bosses been involved in his support and return to work?

In recent years Japanese corporations and the government have increasingly been attentive to employees' mental health issues, partly due to the million-dollar lawsuit against Dentsu Corporation in the 1990's. The company lost this lawsuit and had to pay nearly 1 million dollars to the parents of the young employee who had committed suicide after long days and nights of hard work. The government issued "Guidelines for Maintaining and Improving Worker's Mental Health" in March 2006, and strongly recommended employers to institute 4 types of mental health care: (1) Self-care, (2) Care by management supervisors, (3) Care by industrial health staff of workplaces, (4) Care by resources outside workplaces. Specifically, the Guidelines stipulate that the following procedures be implemented: (1) Educational training and provision of information, (2) Grasp and improvement of working environments, (3) Detection of and response to mental health disorders, (4) Support of return to work (Ministry of Health, Labour, and Welfare, 2011). The government further requires that, as of 2015, employers institute stress check systems for their employees (Ministry of Health, Labour, and Welfare, 2014). It is unfortunate that despite these concerns and government initiatives Taro's company is unresponsive to employees' mental health issues.

Muto and Mitamura compare Taro's case to another similar middle-aged, depressed man seen earlier in Japan in therapy by Muto (Muto, 2012), Muto and Mitamura point out that in contrast to Taro, the earlier client did not regress at the end of therapy, seemingly because of the differences in the work settings of each client:

The client in Muto (2012) worked for a corporation that advocated improvement of mental health conditions. Upon returning to work after a leave of absence, the in-house doctor and the client's manager periodically held interviews with the client and arranged a gradual increase in the amount of work that he took on. On the other hand, Taro, the client in this study, received no such arrangement or consideration. He was not given a computer or telephone at his desk. It is possible that acceptance was not sufficiently facilitated in this case (2015, p. 142).

To me this quote reflects the importance of work-organization variables in facilitating success. I suggest that in situations like Taro's in which the work setting is unresponsive to the mental health needs of a therapist's client, the therapist should take a more active role in considering consulting and coordinating with the work setting.

Taro's family is also an important context. He is married and the couple have a 3-year old child. According to the article, their marital relationship is good and his wife does not express dissatisfaction about Taro's frequent leaves of absence due to depression. It is not completely clear in the case study whether the therapist met with Taro alone or the couple together for the intake session or any of the subsequent sessions. However, since Muto and Mitamura do not say otherwise, it would seem that the therapist met with Taro individually and conducted individual sessions throughout the process and that the information about the family comes from Taro alone. To take one spouse's description of the marital relationship at face value often keeps the therapist from understanding the whole picture; and in fact this goes against behavioral principles of observing behavior rather than accepting an individual's description of it.

Most family therapists are aware how divergent and often conflicted family members' experiences are within the family. Just imagine, you are the wife of Taro. Your husband takes frequent leaves of absence due to a mental health problem. You, as his wife and the mother of a 3-year old child, have to take care of him and the child. Besides, you are employed full-time. I would suspect their household income is decreasing because of his frequent leaves of absence, while he needs to pay for his medical care and his psychotherapy. His wife used to work at the financial company and may still have some acquaintances there. Given the cultural tradition in Japan, she may worry about what they would think of him and her; she may even feel ashamed of having an ill husband. I would assume that Taro's symptoms, his need for medical and psychological care, and his leaves of absence from work affected their family, which may in turn have affected Taro as well.

There is also a cultural aspect that readers outside Japan may find difficult to understand. Taro is extremely concerned about falling behind his same-age colleagues (pp.126-127). Most Japanese companies hire new employees on April 1<sup>st</sup> of each year. Almost all of new employees are fresh out of school (Japanese academic year runs from April 1<sup>st</sup> to March 31<sup>st</sup>). New employees are first engaged in in-house training programs and then are assigned to different workplaces within the company. The same age cohort is thus a group where the employees belong, and in most instances the same age employees are promoted at approximately the same time. For someone to fall behind his/her same age colleagues means he is seen as a "loser."

Finally, Taro was under medical care. He was taking multiple medications. It is not clear how the therapist collaborated with Taro's physician. Further, it is unclear how much of Taro's symptomatic change is attributable to the medications and how much is to psychotherapy.

In sum, Muto and Mitamura's article is quite informative and describes ACT interventions well. Its scientific rigor is to be commended. The contribution to Japanese clinical psychology in which rigorous outcome measurement was often missing is unquestionable. I look forward to the authors' responses to the points that I have made. The intention in my commentary and the resultant dialogue with Muto and Mitamura is to enrich their case study and to help readers to better understand the therapeutic process.

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