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FROM SHY LAMB TO ROARING LION: AN ACCEPTANCE AND COMMITMENT THERAPY (ACT) CASE STUDY

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ABSTRACT: The U.S. is becoming more culturally diverse. In order for clinicians to provide appropriate treatments for minority clients—especially immigrants—case conceptualization and treatment must both be adapted. Clinical behavior analysis, including Acceptance and Commitment Therapy (ACT), allows for individualized assessment and treatment in such cases. ACT's focus on defusion and valuing fit particularly well into issues of cross-culture problems. Thus, a case study of ACT conducted with an Asian-Indian immigrant to the U.S. is presented. Specific adaptations of clinical work are discussed, along with treatment process and outcome results. Results indicate that ACT was useful. The need for replication and controlled studies is discussed.
KEYWORDS: Acceptance and Commitment Therapy, cultural diversity

The demographic and linguistic composition of the United States of America (U.S.) is rapidly changing. It is estimated that racial and ethnic minorities will make up half of the United States population by the year 2050 (U.S. Census Bureau, 2004). Current Census Bureau estimates suggest that approximately 30% of the U.S. belongs to a racial or ethnic minority (U.S. Census Bureau, 2002). Approximately 3.7 million adults living in the U.S do not speak English in their homes, a dramatic increase from 1.7 million in 1990 (U.S. Census Bureau, 2004). The increasing diversification of the U.S. population poses a host of issues for clinicians.

The U.S. Surgeon General reported that minorities seek psychological treatment less often than individuals in the majority, and minorities who do attend

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therapy tend to drop out at high rates (U.S. Public Health Service, 1999). It is reasonable to assume that attending therapy with clinicians who speak English, rather than these clients' native languages, may hinder progress for many of these individuals. Language, however, is only one of the cultural factors that are relevant to ethnic minorities' treatment outcomes. Failing to consider a client's cultural context, clinicians are likely to overpathologize, underpathologize, or otherwise misdiagnose their clients (Kurasaki, Sue, Chun, & Gee, 2000; Sue, Zane, & Young, 1994). These issues have been attributed to communication barriers, differences in conventional interpersonal norms, differences in beliefs about treatment, and the provision of otherwise scientifically sound yet culturally inappropriate treatments (Pedersen, 2004; Sue & Sue, 2003; U.S. Public Health Service, 1999; Zane, Enomoto, & Chun, 1994).

CULTURAL DIVERSITY AND COMPETENCE

Guidelines for culturally competent clinical practice indicate that service providers must be aware of the clinical implications of differences between clients and clinicians, as well as be knowledgeable about the cultural norms of their clients' reference groups (American Psychological Association, 2003; Constantine & Sue, 2005). Culturally competent clinicians will also be skillful in the use of assessment techniques and treatment procedures, making adaptations when necessary, in ways that are culturally congruent (APA, 2003; Hays, 2001). The literature suggests a number of cultural factors for clinicians, including clinical behavior analysts, to consider in assessment and treatment planning for clients who have immigrated to the U.S.

Cultural Considerations in Treatment

The research of cultural psychologists has resulted in important guidelines to consider when treating immigrants and other minority clients. Clinicians need to educate themselves about their clients' cultural backgrounds and identities, including the relative importance of ethnicity, religion, gender, sexual orientation, disability status, and age (Hays, 2001). A client's world view, language skills, level of enculturation and acculturation, socioeconomic status, history of oppression or racism, and migration history are other cultural variables that will influence the ways and degree to which culture influences the course and outcomes of treatment (APA, 2003; Aponte & Johnson, 2000; Johnson, Bastien & Hirschel, 2009).

There are specific challenges that immigrants to the U.S. undergo; these include decline in social and economic status, separation from extended family and supports, language barriers, and isolation from one's cultural background

(Aponte & Johnson, 2000). Adjustments to such challenges depend on the process of acculturation (Berry, 1997). Acculturation refers to changes in one's values, beliefs and behaviors that occur as a result of contact with a new culture (Berry, 1997). Individuals who integrate two cultures tend to have fewer psychological difficulties, whereas individuals who completely reject the ways of the new culture or their traditional culture fare more poorly (Berry, 1990; Berry & Kim, 1988). Thus, understanding a client's beliefs, values, and behaviors related to each culture, and to the multiple cultural contexts in which they interact, is important for determining competence and/or difficulties across domains. Assessing a client's personal and social values is important. In addition, culturally responsive case formulation includes exploration of the meanings that the client has associated with problems and with treatment (Johnson et al., 2009). While the importance of cultural factors in the therapeutic environment is well attested in the literature, and several articles do address the competencies that are needed as well as ways to begin relevant conversations (e.g., Hansen, Pepitone-Arreola-Rockwell, & Greene, 2000; Cardemil & Battle, 2003), the question of how best to respond in a culturally sensitive way is less often addressed (Hays, 2001; Johnson et al., 2009).

The challenge of rapidly amassing knowledge and responding in culturally competent ways can seem daunting, even for the most experienced clinicians. Some ways of bridging the gap between clinician and client are to refer the client to a culture-specific clinic or treatment program, refer to a clinician from the same ethnic background, or to a clinician with some knowledge or experience of the client's culture (Griner & Smith, 2006). However, these options are often not available, practical, or necessarily in the client's best interest. Ideally, treatments will be built on a strong theoretical orientation and adapted as needed to meet the cultural and individual needs of the client and context (Johnson et al., 2009). There is some evidence, in fact, that staying consistent with one's theoretical orientation and approaches can be grounding when clinicians are faced with unfamiliar cultural material and behaviors (Johnson & Sandhu, in press).

Reliance on behavioral principles allows for several advantages with immigrant clients. First, many empirically supported treatments are based on these principles, thus a clinician can have confidence in their effectiveness. Second, client-specific (idiographic) tailoring of treatment may be done through functional analysis. Additionally, the clinician may be able to conceptualize and treat difficulties by referencing the extensive behavior analytic literature on culture. For example, many of B. F. Skinner's writings (e.g., Selection by Consequences, 1981) address the development of culture. The conditioning processes

that are relevant in development of culture can be taken advantage of in clinical, behavior analytic treatments.

Clinical Behavior Analysts

From a behavior analytic perspective, gaining cultural competence involves clinicians conducting functional analyses of their clients' behavior as well as examining their own behavior and developing new repertoires as necessary to predict and influence client behavior. The identification of antecedent and consequential control must address multiple levels of context – narrowly defined context may refer to a client's current private events; and, more broadly defined, context may refer to the client-clinician interaction, or even to culture.

Although a clinician cannot directly observe a client's internal behavior, it is possible to observe the extent to which a client's report of private events is related to overt behavior. For example, a clinician can make an observation that a client squirms in his chair when he says he is feeling anxious. Likewise, the clinician can create a soothing therapeutic context and assess whether the client reports changes in anxiety, or reactions to her anxious feelings. Therefore a close approximation of an A-B-C chain of events is possible, even when internal content is involved. Humans' abilities to self-report are crucial to this analysis. Thus, a treatment that addresses verbal behavior in addition to other aspects of culture is important.

Culture can be defined as the values, beliefs and overt behaviors that are learned and shared among groups of people (Kluckholm & Kroeber, 1952). Skinner (1953; 1971) outlined how operant conditioning explains the development and maintenance of culture. As a result of operant conditioning, behaviors—or group characteristics and values—which are most effective and efficient for survival are selected for a group (Skinner, 1981). This idea has been expanded with the introduction of metacontingencies (Glenn, 1986) and macrocontingencies (Glenn, 2004). Glenn asserts that there is a cumulative effect of operant behavior. One example of this effect is that most individuals state beliefs and outwardly behave in ways that correspond to the beliefs and behaviors affirmed by the majority of people in their social-verbal community; and, as such, behaviors are reinforced and culture becomes defined.

For a client who is an immigrant, there may be more than one social-verbal community in which contingencies affect in-session and out-of-session behavior. A treatment that allows for careful examination of antecedent and consequential control, including examination of verbal events, will thus be critical. A keen appreciation for the multiple cultural contexts will aid behavior analysts in assessing their client's acculturation status and competencies across domains.

Moreover, because cultural values underlie overt aspects of culture—such as language, customs, and indeed the expression of psychological symptoms—a treatment that explicitly identifies and explores values with clients may allow a clinician to be confident that this important aspect of culture has been recognized and incorporated into the treatment process (Johnson & Sandhu, in press). One such treatment is Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999).

Acceptance and Commitment Therapy

ACT is a behavior analytic treatment that encourages psychological and behavioral flexibility in the service of client values. The ACT model consists of six processes: acceptance, defusion, self-as-context, contact with the present moment, valuing, and committed action (Hayes et al., 2004). Acceptance can be thought of as a willingness to have all of one's life experiences and internal content (e.g., thoughts and feelings) without struggling against any of it. Defusion refers to the process of separating oneself from attaching literal meanings of language—for example, understanding the difference between the statements, "I am anxious" and "I am having the thought that I am anxious." The defusion process results in a distance between (verbally conditioned) setting events and problematic behaviors. Self-as-context involves being aware of and observing one's own thoughts from the perspective of a constant observer. Contact with the present moment refers to full engagement with the ongoing flow of experience (including thoughts and feelings) as it occurs in the moment. All of these processes can be viewed as attempts to loosen antecedent stimulus control that exists due to verbal conditioning. The result is that clients are able to respond to direct environmental contingencies, rather than rules or other indirectly conditioned events. The other two processes associated with the ACT model are more related to consequential control. Identifying values refers to determining the desired outcomes toward which a person can direct behaviors. This process results in identification of powerful reinforcers. Subsequently, a client builds larger and larger patterns of committed actions that are consistent with those valued directions. This behavioral activation, which is viewed as having reinforcement value based on indirect conditioning, is overtly reinforced by the clinician as well.

This paper presents a case study on the use of ACT with an adult Asian-Indian female, who had immigrated to the Southeastern U.S. several years before. The client presented with multiple difficulties in daily living. The treatment, conducted by an English speaking clinician, with little knowledge of Indian culture, required some adaptations. These adaptations and treatment outcomes will be discussed.

METHOD: CASE PRESENTATION

Clinician Information

The clinician (LJR) was a 30-year-old female, in her 1st year of graduate school. She was from a small town in the South and was culturally encapsulated. She was seeing the client to complete requirements of her first psychotherapy class. The clinician, who identified herself as "Southern" had a minimal history of interacting with someone from India. She was quite concerned about the language barrier, and expressed great doubt of her abilities to work with this client to her supervisors. The majority of supervision was conducted by a fellow graduate student (ARM), who had been conducting ACT for several years. The clinician was encouraged to conceptualize the case and presenting behaviors of the client from an ACT perspective. That is, the clinician was encouraged to stay emotionally present, be responsive but not overly reactive to her thoughts and feelings, and make a valued commitment to being useful to the client. She was also instructed to continually consider how thoughts, feelings, and overt behaviors were functionally related.

Participant Background & Presenting Problem

Jaya, a 32-year-old Asian-Indian female, presented to a training clinic in a rural southeastern town in the U.S. Originally from the Maharashtra region in Western India, she had immigrated to the U.S. with her husband nine years prior, in pursuit of his education. Her English speaking abilities were sufficient for typical daily functioning (e.g., speaking with the clerk at the grocery store), but her English vocabulary was extremely limited with respect to emotional and social content.

Jaya had two daughters, ages four and six. At the time of treatment initiation, Jaya reported that she struggled to interact with anyone outside of her immediate home environment. These difficult interactions made it "impossible," according to her report, to go outside and play with her children. Jaya expressed concern that her children were upset because of her unwillingness to participate in outside activities. She also stated that her husband did not understand her difficulties and thought she was "crazy." As a result, Jaya felt as if her husband considered her to be "weak." Jaya, after consulting with her husband about her concerns of being "crazy," agreed she should seek treatment. She had her husband call the clinic and set the appointment for the initial psychological evaluation. Jaya voluntarily entered treatment with a two-fold intent: (a) to find out if she was "crazy" and (b) to learn how to confront people who she thought were "defiling her character."

Procedure: Initial Sessions (1-3)

As is typical in many behaviorally oriented therapies, the first few sessions were spent building rapport and conducting initial assessment (See Table 1 for overview of session content). In this case, this initial assessment included an intake interview that allowed for functional analysis, emphasizing clinically relevant matters such as the variability of problem behavior as well as cultural issues such as acculturation difficulties. A standardized self-report measure of distress and therapy progress was also collected at each of these early sessions. This measure, the Outcome Questionnaire-2 (Lambert, 1996) will be described in more detail later.

General interview. Jaya's husband accompanied her to her first session, at Jaya's request. She said that he was there to provide support, to assist in treatment decisions, and also to translate. At the onset of the session, the husband reported that his wife was experiencing difficulties interacting with people outside of the immediate home environment. After the husband spoke, he asked his wife to tell the clinician about her interpersonal and psychological difficulties. Jaya expressed concerns about people in the general community "defiling her character."

Jaya reported that "everywhere [she] went people spoke about [her] behind [her] back." She stated that this was the reason she had stopped interacting with other people. At the time of the intake, Jaya's activities had become restricted to weekly trips to the grocery store, and only when accompanied by her husband and children. Jaya reported that unless her husband was outside with her, she could not play in the yard with her children for fear that her neighbors or strangers driving by would talk about her. Jaya informed the clinician that these negative experiences caused great distress for her. She reported feeling sad and crying frequently. According to her report, Jaya had requested that the FBI, police, and several previous clinicians assist her in getting people to stop talking negatively about her. However, she asserted that none of these attempts had prevented others from talking about her or had alleviated her distress.

When more detailed information was sought through clinician questioning, Jaya stated that she experienced frequent worrying, "shaky hands" (i.e., trembling), tightening of the chest, and difficulties with relaxing. Jaya explained that these symptoms occurred both in social situations and when she was at home alone. Jaya claimed that her anxiety would go away only if people would not defile her character, as it was these negative interactions with people that were ruining her life. Furthermore, Jaya reported that these negative social interactions

TABLE 1. SESSION OVERVIEW

Session Number	Assessment	Treatment
1-3	Intake interview, initial functional analysis, examination of presenting problems including but not limited to cultural issues, OQ-45.2	Rapport building
4	Ongoing functional analysis, cognitive testing, OQ-45.2, BDI-II, VLQ	Interviewing and testing
5	OQ-45.2, PAI	Testing
6	PAI, BDI-II	Reviewing assessments and treatment planning
7	Ongoing functional analysis, OQ45.2, VLQ	Only session of MAW
8	Ongoing functional analysis, OQ-45.2, VLQ, ACT Diary	First ACT session: written overview
9	Ongoing functional analysis, OQ-45.2, VLQ	Reviewing assessments, ACT emphasizing values and defusion work
10	Ongoing functional analysis, OQ-45.2, BDI-II	Reviewing assessments, ACT emphasizing values and defusion work
11	Ongoing functional analysis, OQ-45.2	Reviewing assessments, ACT emphasizing values and defusion work
12	Ongoing functional analysis, OQ-45.2, BDI-II	Reviewing assessments, ACT emphasizing values and defusion work
13	Ongoing functional analysis, OQ-45.2	Review of progress
14	Ongoing functional analysis, OQ-45.2, BDI-II	Termination

were everywhere: at the movies, in the store, and in her children's school, among other places. Jaya additionally stated that people who were across the store or in a crowded room would laugh at her and talk about her behind her back.

Jaya reported that these problems began while she was attending college in India, at the age of 21. Her first recollection of people "defiling her character" was a group of students standing outside her dorm room who were whispering that she was a "whore." She reported that these worries continually worsened over time. Despite prior aspirations, Jaya did not hold a job or have a driver's license. She also failed to complete the application process for graduate school.

Cultural interview. The clinician, guided by a treatment team, sought a cultural consultation from a local expert on Indian culture. In order to assist the clinician in understanding Jaya's beliefs about her symptoms and to generate hypotheses about their etiology, information was gathered regarding customs, beliefs about psychopathology, and acculturative distress. Despite her arrival in the U.S. nine years earlier, Jaya continued to experience major difficulties interacting with other Indians and with U.S. citizens. Jaya seemed somewhat marginalized, in that she was not integrated well into either the local community or U.S. society, more generally. She was not immune from the common problems faced during acculturation. She reported the typical feelings of loss, loneliness and isolation, discrimination and prejudice, low self-efficacy, and identity confusion. Jaya described feeling alienated from the sizeable local Indian community, believing that all Indian acquaintances were only concerned with tarnishing her image. She described feelings of loss related to her home country and culture. Additionally, Jaya had not been actively participating in her religious practice, Hinduism. She sometimes blamed the Gods for her condition and felt as if she was being punished. The result was that Jaya was feeling disconnected from her culture and faith, feeling somewhat "un-Indian" and "un-American" at the same time.

Jaya also displayed unease interacting with U.S. individuals and organizations. Despite the fact that Jaya was college educated and spoke English fairly well, she experienced great distress and difficulty accessing goods and services for herself and her family. Perceived persecution by people of both cultures had resulted in a social network that was increasingly small. Her activity was restricted and she was unable to do the things she wanted. Most distressing was the fact that she was unable to be the kind of wife and mother she desired to be.

From an acculturation perspective, Jaya's marginalized status resulted in a restricted behavioral repertoire, a lack of psychological flexibility, and little connection with U.S. culture or the local Indian community. Her inability to

behave in a way consistent with her culturally held values and expectations for herself as a mother, had begun to further erode her feelings of self-worth. While some experience of these symptoms are typical for immigrants and others undergoing acculturation, Jaya's experiences were significantly distressing to her and they interfered with her daily functioning and social relationships. Moreover, she reported a previous history of some symptoms before migration, indicating difficulties beyond mild to moderate acculturative stress.

Procedure: Ongoing Assessment and Treatment Sessions (4-14)

Treatment is best informed by ongoing assessment; the two pieces of work are, in fact, reciprocal and equally important. Therefore, the remainder of sessions with Jaya included continual functional analysis and, as it was deemed beneficial in this case, structured cognitive and personality testing. Sessions also included behaviorally oriented therapy to address concerns evident throughout the cultural and clinical assessments. Although the two are not functionally distinct, assessment and therapy will each be discussed in succession. Given that assessment results dictate treatment—and that treatment informs the need for further assessment—results are provided within the discussion of procedure.

Additional assessment. In session four, an interview assessing the possibility of Jaya having delusional thoughts was conducted. This was done by assessing setting events and contingencies associated with her report of being watched and criticized by others, as well as by analyzing her in-session and report of out-of-session overt behaviors, including refusal to leave her home. It was determined by the clinician that Jaya's problems were more consistent with social anxiety than delusion. To ensure that these problems were not exacerbated by cognitive or language difficulties, a battery of tests assessing these areas was also given during this session. Jaya was tested in English, and results indicated that Jaya's functioning was in the Average or Above Average range. Further personality assessment was also conducted in the next several sessions, at the request of the clinician's supervisory team.

The Personality Assessment Inventory (PAI; Morey, 1991), a self-administered objective measure of personality, was administered in sessions five and six. It consists of 344 items that tap into 9 clinical domains including anxiety and depression. Results suggested that the client was exhibiting a significant amount of anxiety-related depression. In addition to endorsing items that suggested Jaya had difficult social interactions, she also noted that she was experiencing physiological symptoms (e.g., tightening of chest). There was no evidence of thought disorder.

The Beck Depression Inventory–II (BDI; Beck, Steer, & Brown, 1996) is a 21-item self-report rating inventory that measures attitudes and symptoms of depression. Jaya's score at session four was 27, signifying Moderate to Severe levels of depression. Scores on the BDI were collected every two weeks during sessions 4 through 14, with the exception of no BDI being completed in session 8. A dramatic decrease in overall level of depression was reported, with a total score of two, which is at the Low range of normal, at the termination of therapy (See Figure 1 for symptoms tracked over time).

Values were assessed in sessions four, seven, eight and nine, utilizing the Valued Living Questionnaire (Wilson & Groom, 2002). The VLQ is designed to assess personal values. Individuals are asked to rate the importance of 10 potentially important life domains on a Likert-like scale from 1-10. In session four, Jaya reported valuing her family and marriage the most, each rated with a score of ten. Jaya did not report that the other domains assessed (including employment, physical well-being, and several others) were personally important to her. Thus, behavioral activation in those areas was not targeted. The VLQ also measures, via self-report, how consistently people are behaving with respect to their values. The clinician and client agree to set concrete goals that reflect behavior associated with valued living, and the client reports on progress to the clinician. The clinician also defines in-session behaviors that are monitored. At the end of the treatment, Jaya was reporting more values-consistent behavior. Her therapist observed this as well.

The OQ-45.2 is a 45-item self-report measure of patient progress in therapy. The OQ-45.2 has been found to be both a reliable and valid measure of patient progress (Lambert & Finch, 1999), and thus it was completed in all sessions except session 6 when more formal assessment was conducted. Jaya's presenting score in the subscale of symptom distress was 60, placing her in the Moderate range with respect to distress. Before the ACT intervention, Jaya's scores ranged from a score of 60 at the onset of therapy to a score of 70. After the beginning of the ACT intervention, scores ranged from a score of 54 (at session eight) to a score of 31 at the termination of therapy (See Figure 1). Scores lower than 35 are considered no longer clinically significant (Wells, Burlingame, Lambert, Hoag, & Hope, 1996).

The ACT Daily Living Questionnaire, or diary, is a self-report measure designed by researchers to use as a clinical tool (Hayes, 2004). Clients rate, on a 10- point Likert-like scale, the extent to which they have experienced difficulties and valued action each day. As ACT did not begin until session eight, this measure was not introduced until week eight. On days one and two of that week

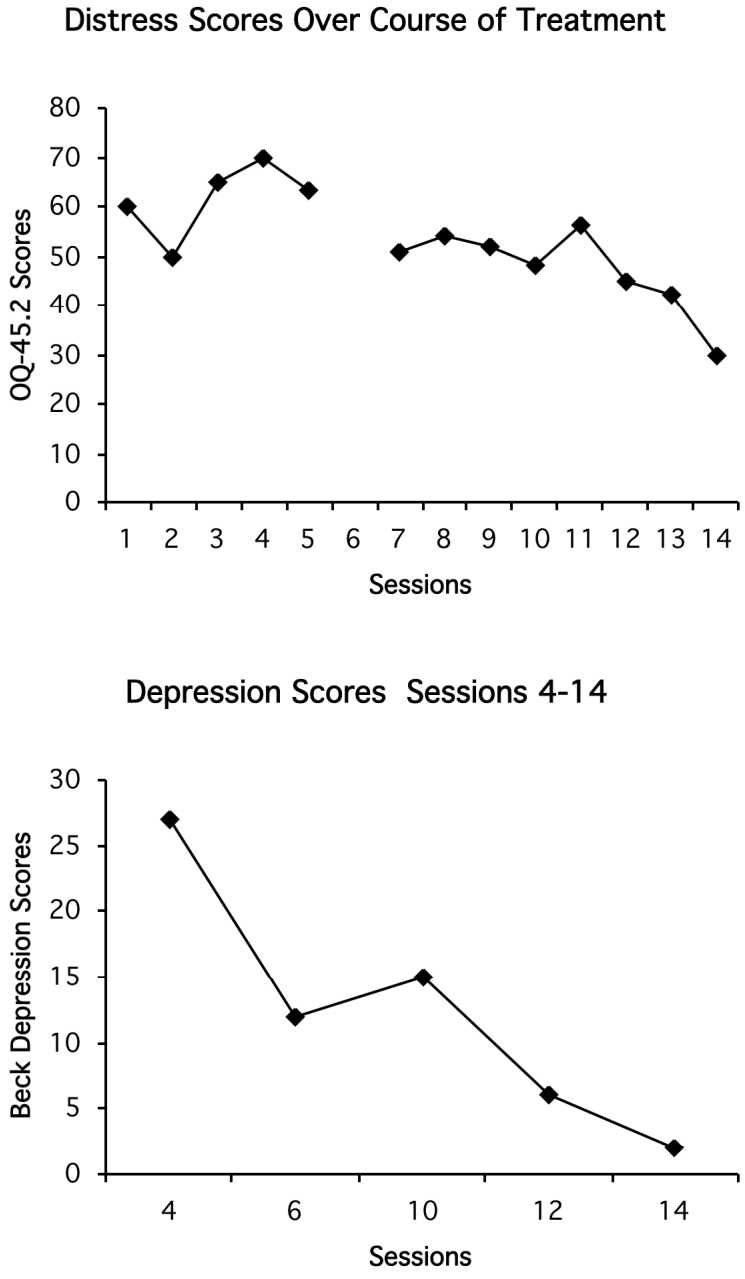

Figure 1. Symptoms Tracked Over Time. The upper graph plots distress and treatment outcomes as measured by the Outcome Questionnaire-45.2, and the lower graph tracks depression, as measured by the Beck Depression Inventory-II.

(the week between sessions 8 and 9), the client rated her struggle as a ten and valued action as a zero. On day three, the client rated her struggle as an eight and valued action as a five. On days four and five, Jaya rated her struggle as a one and valued action as a ten. This pattern was discussed at the next session, and the client attributed the change to "seeing" her behavior on paper and feeling compelled to change it.

Treatment. As previously stated, the first sessions were spent building rapport with both the client and her husband. The clinician (LJR) assured the client that her role was to "work for you [Jaya] and your family." The clinician requested that Jaya stop the clinician mid-speech and ask for clarification if she did not understand what was being said. The client (and her husband) agreed to do so.

After hearing the initial client complaints and before formal (paper-and-pencil) assessment began, the clinician presented two treatment options to Jaya and her husband: a) Acceptance and Commitment Therapy (ACT) or b) Mastering your Anxiety and Worry (Barlow, Craske, & Zinbarg, 1992). Jaya conversed with her husband, and they chose Mastering your Anxiety and Worry (Barlow et. al, 1992) to address physical symptoms of anxiety. At the request of the client, however, this treatment was discontinued after only one session. Jaya reported that she did not think the treatment was going to ameliorate her distress, or do anything to help her with the people upsetting her. It was after this session that ACT was begun.

Using an ACT model, based on functional analyses and the VLQ results, the clinician developed a treatment plan to assist the client in living a life that was consistent with her value of family. Given that Jaya's English emotion-word vocabulary was limited, some adaptations were made. For example, since Jaya could read and write English more proficiently than she could speak it, a typed draft explaining ACT principles and exercises was implemented and carried out for each of the remaining seven sessions. The typed draft included the assessment of (a) values, (b) barriers to valued action, and (c) consequences of not pursuing valued actions.

At the beginning of each session, the client and clinician reviewed the draft and discussed the content in depth. In these discussions Jaya was asked to relate these principles to her struggles and experiences in life. For example, Jaya was asked to think about the ways in which her worries got in the way of her spending time with her children. In the first ACT session, the client was also given the ACT Daily Living Questionnaire in order to monitor distress levels and the consistency of her behavior in relation to her values. The client and clinician reviewed the instructions together. Jaya wept when speaking of her struggles and how her difficulties interfered with her children living happy lives. The client and clinician

evaluated behavioral consistency in the following session. At that time, Jaya reported having experienced a pivotal realization the week prior: as she was filling out the ACT daily diary, she realized that staying at home (i.e., being safe from the outside world) was equally distressing to her as being out in public. After observing her high ratings of distress and low engagement in valued activity, she decided to go outside and play with her children. Jaya mentioned that although she still felt distressed about people who were defiling her character, she was able to make her children and husband happy. This outcome, she said, made her psychological struggles worth the cost.

The remainder of the sessions (nine through fourteen) centered on identifying barriers to committed action and facilitating defusion of anxious content. Jaya, at times, had difficulty expressing her emotional experiences in English. The clinician handled this in two ways. One way was to ask Jaya to think about and express her experiences in her native language. The clinician was able to note that Jaya would display the same behaviors (e.g., pressed speech, angry gestures) when speaking about difficulties in her native language. These overt behaviors could then be processed in session. A second way to address language barriers was present in the defusion exercises themselves. For example, regardless of whether or not the clinician and Jaya had the same word to refer to an experience, the following questions could be asked: "If this situation were an object what would it be?", or "If it had a color, what would it be?"

Defusion exercises were more specifically conducted in the following manner: Jaya was first asked to draw a representation of and verbally report experiences in which her character was "defiled." She was then asked to describe those negative experiences as an object. Jaya characterized her experience interacting with others who were against her as a rose with thorns. She reported that the rose "weighed a lot" and followed her everywhere she went. Prior to the defusion exercise, Jaya spoke about the individuals defiling her character in an urgent, pressed, angry manner. There was a shift—from when she spoke of "the man" who was defiling her character to her more relaxed posture and softened voice when describing the "thorny heavy rose."

As treatment progressed, Jaya participated more in the lives of her husband and children outside of home-based interactions. She volunteered at her children's school and attended religious services and local functions sponsored by the Asian-Indian community with her husband. Cultural identity issues were discussed as they became relevant in Jaya's growing behavioral repertoire. As Jaya participated in these events, she continued to report experiencing physiological symptoms of anxiety (i.e., tight chest, digestive problems) as well as social difficulties from believing that individuals were laughing at her and defiling her char-

acter. Although Jaya reported experiencing intense psychological and physiological difficulties, she also expressed satisfaction and happiness about being able to participate in her children's lives. Jaya told the clinician that she would rather be actively involved in her children's lives and risk feeling "bad" (both psychologically and physiologically) than remain at home not participating.

Jaya's demeanor and posture in session changed as treatment progressed. Prior to session eight, Jaya made little eye-contact and sat approximately three to four feet away from the clinician in each session. After session eight, Jaya began to not only look at the clinician but also to sit closer (one and a half to two feet). This move reflected a decline in her mistrust of others. The client noted that this shift had occurred with other people as well as the clinician. At the cessation of treatment, Jaya was engaging in a wide variety of activities outside of the home, both with and without her family. These activities included baking goods with women from the local Asian-Indian community and walking outside with her children. Jaya additionally began studying for the Graduate Record Examination (GRE), and she applied to a graduate school program at a university. On the last day of therapy, Jaya successfully walked to session without assistance from her husband. She and the clinician agreed to terminate therapy due to the significant increase in her activity levels, her behavioral flexibility with previously avoided content, and her values-consistent behavior over the course of treatment. Jaya further reported that, as a result of treatment, she had been transformed from a "weak trembling sheep to a proud roaring lion"—one who could go anywhere that was needed for herself and her family.

DISCUSSION OF CASE FINDINGS

The intended goal of Acceptance and Commitment Therapy is to increase one's willingness to interact with psychologically painful content in a flexible manner. This psychological flexibility is deemed especially important in the achievement of valuing, with the end result being that painful content no longer serves as a barrier to conducting values-consistent behavior. Given Jaya's difficulties interacting with others, and considering that these difficulties severely limited her abilities to live consistently with her values, ACT was deemed a viable treatment model for her case. In addition, ACT was deemed appropriate given that it is clinical behavior analysis that allows for idiographic assessment and treatment tailoring. Issues such as language could be specifically addressed in client-relevant ways. Treatment outcomes do indeed indicate that ACT was effective. Jaya was less anxious and depressed at the end of treatment in addition to doing more things that were important to her.

Important process variables changed over time as well. For example, Jaya became more willing to disclose to her clinician. She also, throughout the course of treatment, was less likely to avoid eye contact with the clinician. She became more responsive in treatment, responding more effectively to social cues, like head nodding, emitted by the clinician as well as following through with the therapist's suggestions in session.

ACT's success in this particular case may largely be attributed to the use of defusion techniques. Through the use of defusion techniques, Jaya was able to interact differently with previously avoided verbal content. The ACT focus on deliteralizing language enabled the clinician to focus on the aversive properties of any verbal stimuli. In fact, Jaya and the clinician were able to utilize defusion techniques on non-English words in session—without the therapist needing to understand the specific verbal content.

ACT also likely worked in this particular case because of its focus on values and behavioral activation. At the onset of therapy, and even when Jaya was speaking about her difficulties, she repeatedly mentioned caring about interacting more with her children. She was easily able to identify valued directions in which her thoughts and feelings were keeping her from going. After charting in the ACT daily diary, Jaya realized that staying home and trying to be safe were just as distressing as being out interacting with her children and others. As a result of this realization, she became more willing to accept her negative cognitions, emotions, and experiences—in order to pursue valued directions.

CONCLUSION

For Jaya, values related to parenting, traditional cultural supports, and new opportunities in the U.S., prompted psychological flexibility and action across multiple contexts. She began to live her life with an increasingly bicultural approach. For this reason, ACT's emphasis on contextual factors was a good fit. The use of written principles seemed to bolster utility. It will be important to replicate these findings—to see if ACT can be successfully used with other immigrants. This test of effectiveness will become more and more important given the increasing cultural diversity of individuals living in the United States. Idiographic, functional analyses that include assessment of verbal learning as well as direct conditioning may be essential. In fact, the clinician's greatest lesson learned from this case was how powerful functional analysis can be—despite language barriers, or clinician's self-doubt and confusion.

ACT's emphasis on deliteralizing language and its focus on client values do seem to fit well with acculturation issues. However, there is a need for controlled studies, in which direct manipulation of specific ACT processes can be observed.

More data points pre- and post-intervention would also be helpful. Moving forward, it will be important to look for the ways that cultural differences function for all involved. As the differences between client and clinician continue to grow, ACT may just be a solid link.

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