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CHAPTER

30 Cultural Adaptations of Acceptance and Commitment Therapy

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Abstract

ACT is best understood functionally and contextually as the purposeful behavior of a clinician in a therapeutic context that is both principle-informed and experientially guided. From a functional and contextual account, every ACT case is subject to cultural adaptation because no two individuals have identical learning histories and situational contexts. If ACT is practiced functionally and contextually, no additional guidelines for cultural adaptation are needed. What is extremely difficult, however, is to practice and embody ACT *functionally and contextually*. The article offers some insights into how a clinician stays connected with the therapeutic context with a given client functionally and contextually.

Keywords: cultural adaptation, acceptance and commitment therapy, cultural humility, cultural competence, functional contextualism

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Overview

Formally called comprehensive distancing, acceptance and commitment therapy (ACT) originated from a Western cultural worldview in the early 1980s (Hayes, 1987; Zettle & Hayes, 1986). Since then, ACT has been shaped into diverse forms (e.g., individual psychotherapy, group therapy, bibliotherapy, e-therapy) and adapted for use in various applied and clinical settings. These settings include independent practice, managed care, inpatient care, counseling and outreach, and, most recently, telehealth. For the past two decades, ACT has also been studied and practiced across the globe, including Africa, Asia, Central America, Oceania, and South America (Masuda, 2020). This global-level dissemination effort has been prompted in part by a large body of evidence pointing to ACT as a unified evidence-based procedure of behavior change (Twohig, Levin, & Ong, 2020).

The cultural adaptation of evidence-based procedures, such as those found in ACT, is not straightforward, however. In fact, scholars in diversity psychology have argued that a hasty adaptation of ACT may fall short of its intended clinical effects or may even cause harm to clients (Hall, Hong, Zane, & Meyer, 2011; Masuda, 2020). Some of the key questions raised in this context include (1) whether ACT is practiced effectively in *its original forms* with clients from diverse sociocultural backgrounds (e.g., racial/ethnic minority individuals); (2) whether key ACT concepts and methods are biased toward the social norms of a particular group of individuals, such as those of the Western, educated, industrialized, rich, and democratic (WEIRD; Henrich, Heine, & Norenzayan, 2010); (3) under what circumstances cultural adaptation of ACT is recommended; (4)
p. 663 when recommended, how the cultural adaptation ↳ of ACT should be implemented; and (5) what would be a guiding model for such adaptation efforts (Masuda, 2020).

It is also important to note that some cultural adaptation efforts that have been made in ACT seem to deviate from the philosophical assumptions of *functional contextualism*, the essential standpoint of ACT (Drossel, McCausland, Schneider, & Cattivelli, 2014; Pasillas & Masuda, 2014). As discussed elsewhere (Masuda, 2020, 2014b), carefully examining the aforementioned questions may help clarify the fundamental understanding of what ACT is (for) and how the "cultural adaptation of ACT" can be carried out effectively in a culturally humble and competent manner.

In this assessment of the cultural adaptations of ACT, we briefly present an overview of cultural competency, cultural humility, and cultural adaptation to orient readers to the present topic of interest. Subsequently, in comparison to a content-oriented approach to cultural adaptation, we present a functional contextual account of cultural adaptation and its application to ACT. Finally, we offer some examples of how the cultural adaptation of ACT can be done *functionally and contextually* (Drossel et al., 2014; Pasillas & Masuda, 2014), followed by an empirical review of ACT in the areas of diversity and cultural considerations.

Cultural Competence, Cultural Humility, and Cultural Adaptation

A given evidence-based procedure found to be effective in a specific sociocultural context cannot be assumed to be effective in other sociocultural contexts (Cheng & Sue, 2014). Despite its unified nature in theory and practice (Hayes, Pistorello, & Levin, 2012; Hayes, Strosahl, & Wilson, 2012), ACT is no exception. In behavioral health literature, *cultural competence, cultural humility,* and *cultural adaptation* are three major constructs that address the importance of implementing and disseminating evidence-based practice equally across individuals from various sociocultural backgrounds. As such, it may be worthwhile to touch on these concepts and on how ACT can be understood through these conceptual lenses.

The concept of *cultural competence* has been discussed at multiple levels, including individual, organizational, and systemic ones (S. Sue, 1998). At an individual and psychological level, it generally refers to a *clinician's skill sets,* or ongoing behavioral *processes,* that are aimed at effectively working with diverse groups of individuals (S. Sue, Zane, Hall, & Berger, 2009; Whaley & Davis, 2007). More specifically, Whaley and Davis (2007) operationalize cultural competence as "a set of problem-solving skills that include: (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's 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, Stanley Sue and colleagues conceptualize cultural competence as a multidimensional process of "*scientific mindedness* (i.e., forming and testing hypotheses), *dynamic sizing* (i.e., flexibility in generalization and individuation), and *culture-specific resources* (i.e., having knowledge and skills to work with other cultures) in response to different kinds of clients" (S. Sue et al., 2009, p. 529; italics added).

C*ultural humility* can be viewed as a clinician's fundamental attitude in the pursuit of cultural and clinical competence. Based on the principles of social justice, the perspective of cultural humility emphasizes the
p. 664 importance of a clinician's lifelong motivation to learn from ↳ others; critical self-examination of cultural awareness; interpersonal respect; development of mutual partnerships that address power imbalances; and an other-oriented stance open to new cultural information in theory and practice (e.g., Fisher, 2020; Hook, Davis, Owen, Worthington, & Utsey, 2013; Mosher et al., 2017). In the context of ACT, the concept of cultural humility offers insights into how clinicians and clinical researchers can work with a given individual client or group in an interpersonally genuine and humble way. This concept may be particularly relevant to ACT researchers and clinicians, as cultural considerations in ACT are examined predominantly from the perspective of WEIRD individuals. In fact, the fundamental framework of cultural consideration that many ACT researchers and clinicians follow in cultural adaptation work is predicated on the extent to which a given culturally adapted ACT deviates from the WEIRD-based, "original" and "pure," version of ACT. The concept of cultural humility invites us to make a fundamental shift in perspective from which cultural considerations of ACT are scrutinized (e.g., considering cultural adaptation of ACT from a perspective of racial and ethnic minority client or that of a foreign scholar, such as the first and last authors of this article).

Finally, *cultural adaptation* refers to "the systematic modification of existing evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way as that it is compatible with the client's cultural patterns, meanings, and values" (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009, p. 362). To date, the final product of cultural adaptation efforts in *content* and *form* are often emphasized, *more so than the guiding framework from which these adaptations are made.* This may be in part due to the assumption that a given treatment is best understood as a set of applied tools (e.g., specific procedures and therapeutic interactions) that are also defined in content and form. For example, culturally adapting an English-written ACT protocol for a Japanese client may include literally translating the protocol into the Japanese language, selecting and modifying therapeutic exercises in content for that client (e.g., using metaphors that will be intuitive to a particular Japanese client), and explicating treatment goals that are tailored to the sociocultural contingencies in that client's life context (Masuda, 2016, 2020; Masuda, Muto, Hayes, & Lillis, 2008). Once again, when the cultural adaptation of ACT is typically presented in extant literature, the topographical features of such efforts (*outcome*) are often highlighted, but not the very *context* that is taken into account for such topographical change (*process*) and the guiding framework of how to do so (Drossel et al., 2014).

Functional and Contextual Adaptation of ACT

From a functional and contextual perspective, not all accounts of cultural competence, cultural humility, and cultural adaptation are equally adequate (Masuda, 2014b). More specifically, from this perspective, these terms are best understood and practiced *functionally and contextually* through the framework of the "act-in-context." Similarly, from the clinician's perspective, a given ACT intervention is best viewed as the behavior of the whole clinician who serves as the therapeutic context for a given client's behavior change (Zettle & Hayes, 1986). For this very reason, the term *cultural adaptation* of ACT may be misleading, as it implies that ACT possesses an ontologically based *original form*.

Once again, if ACT is treated topographically (i.e., as a therapeutic tool to be fine-tuned in form), and not as the dynamic "act of a whole person in a given context," the focus on examining cultural adaptation will be fixed at the *content* level (Masuda, 2014a). This content-focused and ontological way of understanding ACT in the context of cultural adaptation efforts diverges from the very functional and contextual framework on which ACT is predicated. For this reason, one of the first peer-reviewed papers on ACT deliberately defined
p. 665 it as ↳ a set of contextually situated behavioral *processes of change* (Hayes & Wilson, 1994), not as a manualized protocol or set of topographically defined techniques.

Workability and Shortcomings of Content-focused Cultural Adaptation

From a functional and contextual perspective, *workability* is a key criterion of effective cultural adaptation of ACT. Workability requires us to ask, will this metaphor, activity, or therapeutic angle work for achieving a particular end? In ACT, or in any other functional and contextual therapy, the workability of a technique is determined not by its *form,* but by the contextually situated interaction between the behavior of the client and that of the therapist where the technique unfolds (Masuda, 2016, 2020). Take, for example, the Tug of War with a Monster metaphor (Hayes, Strosahl, et al., 2012, p. 276), whereby the clients are asked to see their distressing private event as a monster with whom they are engaging in a tug of war. This metaphor works only if the client is able to intuitively and experientially relate the narrative within the metaphor (e.g., pulling a rope against a powerful monster) to their own struggles with difficult private events, and then draw some wisdom from it (e.g., the awareness that they can respond to private events differently by letting go of the control agenda).

For some clients, the Tug of War with a Monster metaphor evokes such insight immediately; but for others, having such insight with this metaphor is extremely challenging. The latter may be the case if individuals do not have sufficient sociocultural learning history to make effective use of this metaphor. In other words, if a client has never played tug of war before, they will hardly know what the therapist is talking about—it may not be a *workable* metaphor for evoking the awareness that this metaphor intends to evoke. As discussed elsewhere (Drossel et al., 2014; Masuda, 2020), ACT's functional and contextual framework allows clinicians to attend to a given client's unique socioculturally shaped learning history and the workability of therapeutic work unfolding in a given moment in session, and to make adjustments to the therapeutic work accordingly. What follows is part of a metaphor that can be presented as an alternative to the Tug of War with a Monster metaphor when working with people in Hawai‘i, especially Native Hawaiian-identified clients.

This alternative metaphor is tentatively called the Taro (Kalo) Plant in Nature metaphor, which was originally developed by the second author (L.M.) in the context of working with many Native Hawaiian-identified clients (see Figure 30.1). Functionally and contextually, this metaphor is presented with some of the clients in Hawai‘i in order to help them become intuitively and experientially connected with (1) the transient nature of private events, including difficult emotions; (2) the futility of experiential avoidance; and (3) psychological openness (e.g., acceptance) as an alternative by highlighting the way a taro plant coexists and thrives with nebulous and dynamic conditions of nature.

Hawaiian culture has deeply intimate relationships with nature (i.e., dynamic natural forces) and offers notable cultural wisdom of how to coexist and thrive optimally in a dynamic tropical climate. For example, winds and rains of different types, textures, intensities, seasonality, and localities are honored and given different names and connotations (Akana, 2015). Many people in Hawai‘i recognize that some rains are ominous, violent, and powerful, that some are soft and gentle, and that others are associated with the flourishing or blooming of particular plants. In this metaphor, emotions that clients experience are first reframed as forces in the body as if they are various natural forces in nature, such as rains and wind of the valley. Reframing emotions as if they are these naturally experienced forces allows clients to derive their emotions as *fundamentally natural*, allowing them to change the way they relate to their emotions, even difficult ones. The parallel with the Tug of War with a Monster metaphor in this case is the intuitive
p. 666 understanding that emotion, like weather, is something transient that ↳ comes and goes. In addition, it is obvious to most clients that no one is powerful enough to stop or change the weather, and that, for example, trying to stop the experience of a rainstorm will only cause undue struggle, in addition to getting one soaked. In this metaphor, the client and clinician connect emotions to rain and wind, all of which are temporary and will pass, all of which are potential sources of meaning and significance, and all of which will be felt differently the less one struggles to fight against them. In the words of this metaphor, sometimes hunkering down and waiting for a storm to pass over is the most advantageous course of action to take.

Figure 30.1.

Taro (Kalo) Plant

This part of the Taro (Kalo) Plant in Nature metaphor highlights the forceful, and yet transient, nature of difficult private events, including difficult emotions, as well as the futility of attempting to control them. This metaphor is particularly effective for many people in Hawai‘i, especially Native Hawaiian-identified clients, who embrace the forceful, and yet transient, nature of the tropical climate they are in, as well as the cultural wisdom that highlights the futility of attempting to keep nature under control. By simply framing "private events" with "natural forces" (e.g., "emotions and thoughts that we have are like rains and winds in nature"), clients intuitively derive alternative, and more *natural* ways of relating to their private events. For this very reason, the Taro (Kalo) Plant in Nature metaphor or similar variants may also be particularly intuitive and experiential for clients from other cultures who have lived closely with this cultural wisdom. Later in this article, we will present the rest of this metaphor, which teaches clients the whole repertoire of psychological flexibility.

p. 667

ACT as Contextually and Pragmatically Situated Acts of Clinicians

Because no two individuals have identical learning histories and situational contexts, cultural adaptation should occur in every clinical case, including the one that unfolds between client and therapist with a similar sociocultural background. In other words, every ACT case is subject to cultural adaptation, and for ACT, cultural adaptation is not a matter of whether or not it is necessary, but rather *to what extent* it occurs (Masuda, 2020). Theoretical and applied implications drawn from the perspective of functional contextualism highlight this very nature of cultural adaptation in ACT (Hayes, Barnes-Holmes, & Wilson, 2012; Hayes, Long, Levin, & Follette, 2013).

From the standpoint of the therapist, ACT can be viewed as a *contextually situated, purposeful act of a clinician* in a therapeutic context that is *principle-informed* and *experientially guided* (Masuda, 2020). ACT is said to be contextually situated, as the act of a clinician in a given therapeutic encounter represents the therapist's and client's contextually shaped learning histories unfolding in that very moment. ACT is said to be *purposeful* in that the clinician's actions are intentionally directed toward the promotion of the client's psychological flexibility. ACT is thus considered to be *principle-informed*, as the clinician's behavior is always guided by the psychological flexibility model (PFM) of well-being and behavior change. The following clinical implications are derived from the PFM (Hayes, Strosahl, et al., 2012; Masuda, 2016, 2020, 2014b).

1. From a larger functional and contextual perspective, many of a given client's presenting concerns (e.g., chronic worries, anxieties, trauma, negative self-appraisal, relationship conflicts, hopelessness, shame) are cognitively and socioculturally developed and maintained.

2. Within this sociocultural framework, client efforts to solve these concerns (e.g., experiential avoidance), which are often futile, are also cognitively and socioculturally regulated (e.g., rule-governed behavior).

3. An ACT case conceptualization is formulated in terms of the extent to which a client engages in meaningful and purposeful living. as well as the extent to which experiential avoidance dominates.

4. It is important to identify contextual factors that maintain the behavioral repertoires described in (3), especially the ones that can be systematically manipulated by the client, clinician, or both.

5. A client's sociocultural factors (e.g., cultural norms, cultural values, upbringing, learning history, verbal antecedents and consequences, and community) are functionally understood and are translated into the *contextually situated* target behavioral processes identified in (3).

6. The promotion of greater behavioral adaptation and flexibility does not necessarily require the elimination of presenting concerns in their form or frequency.

7. Practicing meaningful and purposeful living with psychological openness represents greater behavioral adaptation and flexibility.

8. In practice, the client and clinician identify and examine ways to move the above-mentioned behavioral processes in (7), while taking into account information gathered in (4).

These clinical implications may appear to be too general for many ACT researchers and clinicians, and not specific enough to the cultural adaptation of ACT. However, these are the very implications that we feel are
p. 668 necessary and useful to follow for the effective cultural adaptation ↳ of ACT (Masuda, 2020). These implications become especially salient when we consider that every ACT case is subject to cultural adaptation to some degree. In fact, we believe that no additional psychological principles or guidelines are required for the effective cultural adaption of ACT (Pasillas & Masuda, 2014). What many often overlook is how difficult it is to follow these clinical implications, especially for those from WEIRD sociocultural backgrounds. In other words, for effective clinical work to take place, it is imperative to understand and follow these clinical implications *functionally and contextually for each clinical case*.

Finally, *when understood functionally and contextually*, the PFM is theorized to be universally applicable. However, as discussed previously, the practice of PFM-informed ACT is extremely idiographic (Hayes et al., 2019; Hayes, Strosahl, et al., 2012). That is, the behavior of an ACT clinician is shaped and adjusted functionally and contextually through the *ongoing* interaction with a given client. This is the ongoing and *experientially guided* aspect of ACT that was mentioned earlier.

Cultural Adaptation of ACT

Given its functional and contextual foci, ideally the cultural adaptations of ACT should align with the conceptual and applied foundations of clinical behavior analysis (Dougher & Hayes, 2000; Vilardaga, Hayes, Levin, & Muto, 2009). More specifically, unlike a content-focused intervention approach, intervention work in ACT does not begin in earnest until the client's presenting concerns, general functioning, and treatment goals are understood functionally and contextually using the PFM conceptual framework (Masuda, 2020).

Psychological Flexibility as a Socioculturally Situated Overarching Behavioral Repertoire

The promotion of psychological flexibility (e.g., engaging in meaningful and purposeful living with psychological openness) in clients is the overarching treatment goal of ACT (Hayes, Strosahl, et al., 2012). It is important to emphasize that the way in which the behavioral repertoire of psychological flexibility is manifested topographically can vary significantly across clients (Masuda, 2020). This variability is theorized to occur because of different sociocultural contingencies, both historical and situational, that operate for different individuals within their unique sociocultural environments.

For example, social contingencies that are aligned with an *individualistic* world view are likely to shape psychological flexibility in particular forms (Markus & Kitayama, 1991; Weisz, Rothbaum, & Blackburn, 1984). More specifically, any behaviors under the contingencies that reflect values of individuality, justice, and autonomy, such as self-assertiveness, may be promoted as part of psychological flexibility. For clients who draw their values from a *collective and interdependent* culture, sociocultural contingencies that promote and maintain interpersonal harmony and conformity to the collective whole are likely to shape their psychological flexibility into collectivistic forms (Markus & Kitayama, 2010). In a collective culture, behavioral pursuits of self-efficacy and self-worth may not be a culturally situated form of psychological flexibility unless they reflect the self as part of a communal whole (Kaholokula, 2017; Odom, Jackson, Derauf, Inada, & Aoki, 2019). Once again, as discussed extensively elsewhere (Drossel et al., 2014; Masuda, 2020), it is crucial for ACT clinicians to be mindful of the situational and context-dependent nature of psychological flexibility *for each client*.

Awareness of One's Own Assumptions

Clinicians are also historical beings who are influenced by their previous and current learning history (Masuda, 2020). This means that a therapist's standards and views of adaptive and maladaptive behavior
p. 669 are also functionally and contextually shaped within a given sociocultural ↳ context (e.g., verbal community). As such, it is imperative that the clinician not make assumptions regarding which client's behaviors are adaptive or not adaptive without carefully assessing their functions in the context in which they occur. Here we will focus on potential biases in the domain of actual practice, using values and commitment work as an example.

As discussed elsewhere (Markus & Kitayama, 1991, 2010; Masuda, 2020), striving for personal achievement in the domains of occupation and education is often viewed as a value-consistent action in Western cultural contexts. This focus is also the case for many clients in non-Western cultural contexts (e.g., those in collectivistic cultures). However, while the pursuit of personal growth tends to be individualistic in mainstream Western cultures, such pursuits are more collectivistic and interpersonal in collectivistic cultures (e.g., the collectivist view may be, "I will pursue education *as a member of my family for the prosperity of my family*"). For therapists with a Western world view, this collectivistic quality may come across as being passive or an indication of arrested development. However, within these collectivistic

cultural views, such relational and collective qualities are the very essence of adaptive and intrinsically rewarding personal values.

Assertiveness is another example that has been discussed in the domains of values and committed action. Speaking up for one's own thoughts, beliefs, and "wants" is often valued in many Western cultural contexts, including those in the United States (Duckworth, 2008; Markus & Kitayama, 2010; Weisz et al., 1984). For example, ACT therapists often encourage clients to be assertive to their partners in their intimate relationships. As the proverb "the squeaky wheel gets the grease" goes, the act of assertiveness is often followed by favorable outcomes, and this is in part because Western sociocultural contexts tend to encourage such interpersonal communication styles (Masuda, 2020). However, in other cultural contexts, such as those of many racial and ethnic minority individuals in the United States, directly expressing assertiveness can be viewed as a sign of hostility, self-centeredness, and disruption of interpersonal harmony (D. W. Sue, Sue, Neville, & Smith, 2019). It is important to clarify that we do not contend that directly communicated assertiveness should be discouraged for all non-Western clients from non-Western cultures. Instead, what we attempt to clarify here is that the *form* of assertiveness that is adaptive in Western cultural contexts (e.g., "I want … ", or even, "I need … ") may not be so in other sociocultural contexts. As the Japanese proverb "a nail that stands will be hammered down" goes, directly communicated assertiveness may actually result in unintended negative outcomes, especially when it emerges from a sense of self as a unique being that is separated from others. Once again, it is important for the therapist to become cognizant of the *function* of the target behavior, which depends on the context in which it occurs. To do so, it is important for the therapist to become aware of their own socioculturally situated assumptions and biases.

Therapeutic Relationship and Stance of the Therapist

In ACT, a therapeutic relationship is the *contextually situated*, ongoing, and dynamic interplay between the client and the therapist as *historical and situational beings* (Hayes, Strosahl, et al., 2012, see pp. 141–149). For clients, the therapeutic relationship is a context where they can learn a new set of behaviors or insights through interacting with a clinician as a crucial contextual factor (Robins, Schmidt, & Linehan, 2004). For clinicians, the therapeutic relationship is also an interpersonal context that requires them to be flexible in response to ongoing changes in each therapeutic moment with the client (Kohlenberg & Tsai, 1991).

As reflected in the work of many celebrated ACT clinicians and trainers (e.g., Wilson & Dufrene, 2008), extant ACT manuals (e.g., Hayes, Strosahl, et al., 2012, pp. 141–142) often encourage a therapeutic relationship to be horizontal with a powerful interpersonal connection between client and therapist. However, from a functional and contextual perspective, one cannot assume that this particular *form* of
p. 670 interpersonal style will be universally effective for ↳ all clients (Masuda, 2020). In fact, a therapeutic interaction that is vertical, prescriptive, and directive may be more effective for some clients from certain sociocultural backgrounds. For example, when A.M. worked with Black and Latinx clients in Atlanta, Georgia, he tended to present himself politely as an expert, at least initially, and he interacted with them in a humble, and yet directive, manner more so than when he was working with White American clients in the same city. Once again, A.M. chose this style of therapeutic interaction based on its *workability* (i.e., function), not simply because a given client identified as Black and Latinx (i.e., content). Similarly, many Latinx and Black clients, regardless of their ages, also preferred to call him "Dr. Masuda" or "Dr. Aki," rather than calling him "Aki," which was more common among White American clients. A.M. then called them, "Mr.… " or "Mrs.… " in return to express his respect and humility to them, especially when they were older than he was. In sum, A.M.'s therapeutic relationship is not always horizontal in form, as is often suggested by ACT manuals. However, this vertical and more polite *form* of therapeutic relationship is still ACT-consistent if it *functions* to promote greater psychological flexibility (Drossel et al., 2014; Pasillas & Masuda, 2014). The key takeaway here is that effective styles of therapeutic relationships can vary widely in form or content across

different client-therapist dyads. As such, it is crucial for the therapist to cultivate this careful discernment of function, such that they may finetune the form of therapeutic relationship with a given client in each moment based on its workability, in service of promoting the psychological flexibility of that client.

Another important topic to discuss here is therapist self-disclosure. A therapist's self-disclosure in session is a central topic in ACT therapist training (Hayes, Strosahl, et al., 2012). It is also discussed extensively in cultural adaptations of ACT (Masuda, 2020; Pasillas & Masuda, 2014). For example, ACT therapists are often encouraged to share their personal struggles with their clients in session to highlight the ubiquitous nature of human suffering (e.g., a clinician saying "we are in the same stew, and the truth is I've also been struggling with chronic depression for years"). One major purpose of therapist self-disclosure in session is to help clients to relate to and experience their own internalized struggles openly as they are without attempting to change them.

Note, however, that the therapist's self-disclosure of their own psychological struggles may not always be therapeutic for all clients, especially during the initial phase of the therapeutic relationship. This is because, for some clients, mental health issues are cultural taboos, and self-disclosure of one's own mental health issues is not part of their sociocultural norms and contingencies in interpersonal contexts (Komiya, Good, & Sherrod, 2000; D. W. Sue et al., 2019). Once again, when A.M. worked with racial and ethnic minority (REM) clients in Atlanta, Georgia, he learned to avoid sharing his personal psychological struggles with them until they perceived him as a behavioral health expert whom they could trust. A.M. also found that his strategic self-disclosure of his own psychological issues with REM clients was effective when it was presented with them genuinely, but more descriptively and calmly as a matter of fact, rather than emotionally or intimately, as it is often done in experiential ACT workshops for professionals. Once again, given the potential pitfalls of a therapist's self-disclosure, clinicians must be mindful of the timing and content of self-disclosure. Similar to that of the therapeutic relationship, the general consensus here is to self-disclose only if it is considered to be therapeutic for the client.

Case Example: ACT Case Conceptualization and Cultural Considerations

ACT is not suitable for every client. For this very reason, it is imperative that an ACT clinician first examine (1) whether the PFM can adequately conceptualize a given client and their presenting concerns and (2) if so,
p. 671 whether a tentative treatment goal(s) derived from ↳ the PFM-informed case conceptualization is *socioculturally* sound for that client. Once again, while ACT offers a generic case formulation framework (e.g., Bach & Moran, 2008), understanding a given client must be extremely idiographic (Hayes, Strosahl, et al., 2012; Masuda, 2020). Next, we discuss how a culturally and idiographically informed ACT case can be formulated by using one of our previously published ACT case studies as an example (e.g., Masuda et al., 2008).

"Yoko" was a 23-year-old Japanese international student who endorsed fatigue, body dissatisfaction, and restrictive eating as her presenting concerns (Masuda et al., 2008). This was an outpatient individual ACT case completed by the first author of this chapter (A.M.) when he worked as a predoctoral psychotherapist in a university counseling center. A.M. was assigned as Yoko's therapist after she completed the intake assessment with another predoctoral therapist, who was a White woman. He was assigned to this case primarily because he was the only Japanese-speaking therapist in the counseling center at the time, and also because he was familiar with Japanese culture as well as challenges that Japanese international college students often experience in the United States. Yoko was a senior student, and she attended a total of 26 individual sessions from July 200x to May 200x + 1.

Besides the presenting concerns mentioned previously, one other notable concern that A.M. noticed in Yoko was her strong entanglement with internalized shame, which can be understood in part through an Asian

cultural practice of *saving face* (or saving honor). As discussed elsewhere (e.g., S. Sue, Cheng, Saad, & Chu, 2012), *saving face* is an Asian and Asian American cultural practice that signifies a desire or behavioral effort to avoid humiliation or embarrassment, maintain dignity, and preserve the reputation of oneself and one's family. For many Asians and Asian Americans, this cultural practice is pervasive across various life domains, including work, education, family, and interpersonal relationships. Furthermore, relevant to the topic of the present article, many Asians and Asian Americans view personally having mental health issues as a major threat to their *face*.

This seemed to be the case for Yoko as well. Later during ACT sessions, Yoko disclosed to A.M. that a significant portion of her suffering came from internalized shame related to the implication of having mental health issues and that, because of the shame, she had kept her "mental health issues" to herself for years. As a result, for Yoko, the ACT therapy was her first behavioral health service experience. The following section presents the PFM-informed case formulation where Yoko's presenting concerns were understood in part through the cultural framework of *saving face*.

Yoko's entanglement with internalized shame was theorized to have been maintained for years in part under the sociocultural contingencies of saving face. These contingencies of saving face and resultant internalized shame were also theorized to serve as the context for perpetuating her presenting concerns of body dissatisfaction and restrictive eating, which began 2 years prior. More specifically, under the influence of these sociocultural practices, Yoko seemed to have begun to evaluate her body shape and weight to be unacceptable and her experience of body dissatisfaction to be shameful. To downregulate her body dissatisfaction and internalized shame, she began engaging in restrictive eating and other compensatory behaviors (e.g., running and walking), and she did so *secretively* to save her *face*. However, as her body dissatisfaction continued to grow over time despite her continuing efforts to keep it under control, so did her restrictive eating and other compensatory behaviors (see Hayes, Wilson, Gifford, Follette, & Strosahl, 1996 for the paradoxical effects of experiential avoidance). Furthermore, to conceal restrictive eating and other compensatory behaviors, she began to isolate herself from others more and more. At the beginning phase of ACT therapy, Yoko appeared to be preoccupied with her body dissatisfaction and internalized
p. 672 shame, although she initially denied ↳ them as her primary concerns (see below). She also did not seem to allocate much of her time and effort to activities that were purposeful and meaningful to her. The often secretive nature of disordered eating concerns was theorized to be particularly salient for Yoko, as her behavior was influenced by the contingencies of *saving face* and other Asian and Asian American cultural practices that she used to maintain face.

Cultural Considerations and Treatment Plan and Delivery

As discussed previously, sociocultural contingencies operating in a client's life context must be taken into consideration in an ACT treatment plan and delivery. To highlight this importance, we continue to present the ACT case with Yoko (Masuda et al., 2008).

At the time of ACT with A.M., Yoko mainly socialized with other Japanese international students. She also told A.M. that she planned to go back to Japan after graduation. For this reason, Yoko was expected to continue to remain under contingencies of *saving face* (i.e., "世間体、面子、見栄" in Japanese) and other Japanese cultural practices, and therefore the present ACT work with Yoko was done while taking these cultural considerations into account. For example, when working on normalization and validation of her psychological suffering (悩み; "having mental health issues"), Yoko and A.M. conceptualized her sociocultural environment as invalidating and dismissive of her experience of psychological distress. More specifically, A.M. encouraged Yoko to openly acknowledge and experience psychological suffering as common human experiences *within the skin*, while adhering to the cultural practice of saving face *outside the skin*. This context-specific encouragement of psychological acceptance may be in sharp contrast with how

ACT is typically conducted with clients from WEIRD backgrounds in the United States, where psychological acceptance is encouraged indiscriminately across all contexts, both inside and outside the skin. What follows is the vignette between Yoko and A.M., which highlights the context-specific encouragement of psychological acceptance:

> **Therapist (A.M.):** (*gently and kindly*) Maybe everyone has a story kept from others … like the story that you had shared with me that was kept to yourself for years …. What if I say we're all struggled within, and yet we just don't show that to others? What if I say I also have a shameful secret about myself that had been kept to me for years?
> **Yoko:** (nodding quietly and listening to A.M. thoughtfully)
> **Therapist:** What if I say because we don't see it in others when we are with them or when we see them, each of us comes to believe, "It must be just me who has this shameful secret … and to fit in or to be accepted, I must keep it to myself, and it can't spill out from me."
> **Yoko:** (nodding quietly and looking the therapist in the eyes)
> **Therapist:** … and then we all get tired, and what's worse is that we feel disconnected from others and we even feel disconnected from ourselves …. like I don't know myself. It's ironic isn't it?
> **Yoko:** (nodding and looking at the therapist thoughtfully)
> **Therapist:** … What if I say, although we are expected not to show these to others, whatever these are … and although we're not expected to express our feelings on these secrets … it is *okay* for us to have them and have them with us inside. What if I say it's okay to give us permission to have them with us, *within*?

Therapist's Awareness of Own Stimulus Function for a Given Client

It is imperative for clinicians to become cognizant of their own *stimulus function* for a given client. A clinician may ask themselves, "how might I be serving as a stimulus (i.e., antecedent) of client behaviors?"
p. 673 This question is critical, as clinicians evoke certain forms of behavior from ↳ their clients more regularly than other forms of behavior in their therapeutic relationships (e.g., Zane & Ku, 2014). Consider the therapeutic work between Yoko and A.M. as an example. As noted above, Yoko completed an intake assessment with another predoctoral therapist prior to seeing A.M. As noted earlier, the intake clinician was a White American woman, and she informed A.M. that Yoko's primary concerns were likely to be her body dissatisfaction and restrictive eating, as they discussed these concerns extensively during the intake assessment. For this reason, during his first session with Yoko, A.M. asked her to confirm that these were the concerns that she wanted to work on in psychotherapy. However, Yoko denied that these were her presenting concerns and told A.M. that instead she wanted to work on improving her English communication skills, which was much less stigmatizing. As discussed briefly above, A.M. viewed this as Yoko's "possible guardedness" driven in part by internalized shame that was evoked by her cultural adherence to *saving face*.

In hindsight, this case formulation was not inaccurate, but it was incomplete. What should also have been taken into consideration was A.M.'s stimulus function for Yoko. More specifically, one might, speculate that A.M. being a *Japanese male*, might have evoked certain cultural and power dynamics, perhaps making her extremely hesitant to discuss her body dissatisfaction and restrictive eating concerns in therapy with him, which she openly disclosed to her intake therapist. We can also speculate that for Yoko, A.M. might have served as part of the sociocultural contingencies of saving face and other Japanese cultural practices during the earlier phase of therapy (Zane & Ku, 2014). As discussed elsewhere (Masuda et al., 2008), Yoko and A.M. spent the next two sessions primarily on improving her communication skills. Then after a gentle prompt from A.M at the end of that second session, she finally disclosed to A.M., with hesitation, her struggles with internalized shame and body dissatisfaction. If A.M. was cognizant of the cultural dynamic that he unknowingly brought to the therapeutic dynamics between Yoko and him back then, he could have moved

forward in these sessions differently. Since this experience, A.M. has intentionally discussed with clients potential cultural issues both at the outset and throughout the course of therapy, which may show up during therapeutic work (e.g., see Masuda, Ng, Moore, Felix, & Drake, 2016).

Modification of Therapeutic Techniques

As described previously, from a functional contextualist perspective, modifications of treatment in form (e.g., cultural adaptation) are always expected (Masuda, 2016, 2020). In ACT, these content modifications can take place within therapeutic procedures/techniques used (e.g., experiential exercises, metaphors, and activities), their length, session format, or across other relevant domains, such as client-therapist match in gender and inclusion of "key brokers" (see Pasillas & Masuda, 2014).

Once again, consider ACT values and committed action work with Yoko as an example (Masuda et al., 2008). Unlike a content-focused adaptation, a *functional and contextual* adaptation of ACT started with identifying behavioral processes that might increase or undermine greater psychological flexibility for Yoko. Here, primary behavioral processes identified as supportive of psychological flexibility were (1) the construction of freely chosen meaningfulness and purposefulness as a guiding direction in her life (i.e., values); (2) identification of actions that reflected these values; and (3) continuous engagement in these values-directed actions.

The next step in this cultural adaptation of ACT was to identify potential strategies to move these behavioral processes forward. ACT manuals often suggest the use of the Skiing metaphor (Hayes, Strosahl, & Wilson, 1999, pp. 220–221), the Path Up the Mountain metaphor (Hayes et al., 1999, pp. 221–222), or the Passengers on the Bus metaphor (Hayes et al., 1999, pp. 157–158) to promote these behavioral processes. If the use of
p. 674 these recommended ↳ metaphors were judged to be effective for Yoko, there would be no reason not to use them and see if they in fact yielded the intended functional effects (e.g., Yoko became more willing to pursue values-directed action). If not, it would be important to identify other potential strategies that could be valuable to her. For Yoko, the latter was the case.

More specifically, A.M. incorporated proverbs and common personal mottos that were familiar to many Japanese people, including Yoko, and that adequately captured the behavioral processes of values-directed action and purposeful and meaningful living. These included "思い立ったが吉日 (Never put off until tomorrow what you can do today)," "七転び八起き (Fall seven times, stand up eight)," "継続は力なり (Perseverance is power)," and similar others. Yoko appeared to relate well to these proverbs at both a personal and an experiential level. If the use of these proverbs did not yield the intended effects, A.M. reviewed why that was the case and explored potential alternatives (i.e., functional analysis). In sum, the modification of ACT must be done functionally and individually with a given client in the service of promoting greater behavioral adaptation and psychological flexibility.

Another example of modification in therapeutic technique is use of the Taro (Kalo) Plant in Nature metaphor. As noted previously, traditional Native Hawaiian culture and world views have a rich, complex relationship with elements and forces of nature, such as winds, water, rains, and waves, and with spiritual significance associated with different types of animals and plants (Abbot, 1992; Akana, 2015). As such, metaphors involving such forces or aspects of nature may be particularly salient to Native Hawaiian clients who identify more strongly with traditional Hawaiian culture and world views. We presented the earlier part of the Taro (Kalo) Plant in Nature metaphor in a previous section; following is the rest of this metaphor that is used to enhance psychological flexibility, with particular salience to many Native Hawaiian-identified clients.

This metaphor aims to promote client psychological flexibility by using the image of a kalo (taro) plant in a blowing wind as a parallel with the client's relationship to their emotional and physiological challenges.

Kalo (also known as taro and *Colocasia esculaenta*) is one of the most important plants in Hawaiian culture. It is not only the source of poi, a staple food in the Hawaiian Islands prior to the devastating impacts of colonization and colonialism, but also is symbolized as the older sibling of the first Hawaiian in the traditional story of creation (Handy & Handy, 1972). Because it remains an important plant, food, and symbol of Hawaiian culture and identity in Hawaiʻi today, many Native Hawaiian clients are readily familiar with the image of kalo plants growing in kalo patches or loʻi. As such, it was deemed a potentially apt symbol to include in a metaphor about one's relationship to their thoughts and feelings and therefore useful in therapy to increase psychological flexibility and value-based actions.

As shown in Figure 30.1, kalo are plants with large heart-shaped leaves at the ends of tall slender stalks. These stalks, called hā in the Hawaiian language, connect to the edible corm and roots in the soil. If one has seen kalo growing in loʻi, they will notice that when the wind blows, the leaves of the kalo twist and turn, a motion that can be called "lau kapalili" or quivering, throbbing, or palpitating leaf (Pukui & Elbert, 1986). The rest of Taro Plant in Nature metaphor goes as follows:

> **Therapist (L.M.):** What if I say that we are like kalo plants? When a wind blows, the leaf may quiver and shake, but the roots are still connected firmly in the ground .... As we have discussed together before, the winds can symbolize strong and uncontrollable feelings we experience. The wind's/emotions then cause our body and mind to flutter and quiver, which can manifest as distressing thoughts and memories, rumination, heart palpitations, body tension, restlessness,
p. 675 and other psychosomatic experiences. ↳
> **Client:** (nodding quietly and listening to L.M. thoroughly)
> **Therapist:** We recognize that we cannot control the wind and that doing so would only cause us to struggle harder and in vain. Like the kalo, we can remember that although our mind and body are quivering or trembling in different ways, we are always connected to our breath (hā), just as the leaf is connected to the hā (stem). When we remember and reconnect with the breath, while allowing the wind to continue blowing as it is and allowing the leaf to quake as it is, we follow the long slender stalk down to the solidity of the roots down in the earth, and in doing so we bring our awareness down with our breath into our body, our center, where we remember we are rooted, no matter how strong the wind is blowing.

In Hawaiian language, the belly, guts, or intestines are called "naʻau," which can refer to one's "heart/mind/feelings/intuition" and is also connected to the concept of "naʻauao," meaning wisdom and knowledge, literally "daylight (enlightened) mind".

> **Therapist (L.M.):** What if I say the wisdom from your culture and your ancestors that is particularly relevant here is that we live and breathe like a kalo plant? If we reconnect with our hā (breath), which is connected with the "naʻau," and if we remember to reconnect with the awareness of "naʻauao," a deeper wisdom that is underneath the vicissitudes of thoughts and feelings perhaps, we may stop trying to fight the winds and the kapalili inside (representing anxiety, worrying mind, etc.) ....
> **Client:** (nodding quietly and listening to L.M. thoroughly)
> **Therapist:** Also see if you can notice that as a kalo, we are rooted into our land, or perhaps we can say, we are connected to our land as if there are no separations between us and the land. From this perspective, perhaps, you are more than who you feel you are ... perhaps you are truly part of nature, part of the past and future, and of the wisdom of interconnectedness handed down from your ancestors ... From this standpoint, how would you like to live your life?

Once again, this part of the Taro Plant in Nature metaphor is intended to help a client develop a more defused and flexible relationship to distressing thoughts and feelings for the purpose of pursuing values-

directed living. At the same time, this part of the metaphor also serves as an easy-to-remember mindfulness of breath practice, which is often included in the second author's (L.M.) therapeutic work. L.M. often presents this metaphor to his clients in Hawai'i because it could intuitively teach them the perspective of psychological flexibility. For many of his clients, it has been helpful to generalize their repertoires of psychological flexibility from their intuitive relationship with nature to the context of their often-unwanted private events and internal experiences.

Research Support

The synthesis of knowledge and evidence regarding the *cultural adaptation* of ACT is still in its infancy (Masuda, 2020). To date, the importance of effective cultural adaptation of ACT has been discussed conceptually in the context of multicultural competencies and mindfulness- and acceptance-based cognitive behavioral therapies (Masuda, 2014b), treatment development (Hayes et al., 2013), and the inclusion of underrepresented groups in ACT research (Woidneck, Pratt, Gundy, Nelson, & Twohig, 2012). Similarly, ACT scholars have begun to examine the *cross-cultural utility and validity* of ACT and the psychological flexibility model to various cultural and anthropological contexts (e.g., Fung, 2015; Pasillas & Masuda, ↳ 2014; Perry, Gardener, Oliver, Taş, & Özenç, 2019; Sabucedo, 2017; Stewart et al., 2016; White, Gregg, Batten, Hayes, & Kasujja, 2017).

p. 676

For example, Masuda (2014a) has argued that ACT can be a highly pragmatic, experiential, and collaborative therapeutic approach across diverse clients through connecting them to their *contextually situated values* and using this information to guide the therapeutic process and promote flexible and purposeful living. Similarly, Perry et al. (2019), in their examination of the cultural flexibility of the ACT model, assert that the emphasis on values and context, two central tenets of the ACT model, offers potential for its cultural adaptability for underserved populations, such as Turkish-speaking communalities in East London, while taking into account their collectivistic structure, religious beliefs, and many experiences of distress due to collective experiences of loss, displacement, and existence as a refugee. Thus, it is crucial to reiterate that ACT is culturally adaptative only when it is idiographically tailored for a given client(s) in a functional and contextual manner (White et al., 2017).

Despite the dearth of empirical research on key questions regarding the cultural adaptation of ACT, some understanding can be gained through examining the methods and processes of cultural adaptation that have been described briefly in previously published ACT outcome studies in socioculturally diverse contexts. For example, in designing an ACT therapist training program in Sierra Leone, Stewart et al. (2016) met with key local stakeholders about how to best tailor core ACT processes to local customs for therapist training as well as the resources available in the training setting (e.g., intervention delivery without the use of electricity). Additionally, Hassinen and Lappalainen (2018) adapted ACT for deaf Finnish individuals through the creation of videos of ACT metaphors and exercises translated into Finnish sign language. A professional Finnish translator and extant Finnish ACT protocols were also used to further enhance the development of this video-augmented ACT intervention through Finnish sign language. Unfortunately, space limitations in journal articles often preclude detailed descriptions of *how* the cultural adaption of ACTs were implemented in many research studies examining ACT in diverse cultural contexts. As such, more research will be needed to bridge the gap between conceptual and empirical work in the cultural adaptation of ACT to attain a better understanding of key functional processes necessitated in this context.

Finally, it has been historically challenging to include individuals from underrepresented populations across the globe in ACT studies, despite the fact that the cultural adaption of ACT is most relevant to these groups. At the time of writing, there remains a disproportionately small number of studies examining ACT outcomes and processes with a range of hard-to-access minority groups, though the trend is certainly on

the rise. Similarly, there are disproportionately smaller numbers of ACT researchers and clinicians from these underrepresented groups, resulting in slower progress in cultural adaptation of ACT. These underrepresented groups include ethnic minorities; sexual minorities (e.g., lesbian, gay, bisexual, pansexual, and queer folx); gender minorities (e.g., transgender and gender nonconforming or gender fluid folx); the differently abled; and elderly populations. These groups of individuals may benefit most from further empirical exploration into their psychological health and well-being. While this inequity in representation is generally paralleled in social science research writ large (e.g., Henrich et al., 2010), leaders in ACT research call for greater conscientiousness from the community in filling these gaps in knowledge and, ultimately, service delivery (Hayes et al., 2013; Masuda, 2014b; Skinta & Curtin, 2016).

Conclusions and Final Notes

ACT is best understood as the purposeful behavior of a clinician in a therapeutic context that is both
p. 677 principle-informed and experientially guided. Every ACT case is subject to cultural ↳ adaptation because no two individuals have identical learning histories and situational contexts, including the one that unfolds between client and therapist of a similar sociocultural background. With respect to the very topic of this article, it is extremely difficult to practice and embody ACT *functionally and contextually*. If followed functionally and contextually, an ACT framework allows a clinician to adapt and finetune their clinical work with a given client while staying connected to the promotion of psychological flexibility as the ultimate treatment goal. If the PFM is followed functionally and contextually, therefore idiographically to a given client, no additional guidelines for cultural adaptation are needed. The very fact that the present article is placed as a standalone entry toward the end of this volume suggests the importance of explicating functional contextualism as the standpoint of learning and practicing ACT further, so that we do not fall prey to the same pitfalls of symptom-oriented, content-based treatment development approaches (Hayes & Hofmann, 2020) in our cultural adaptation efforts (e.g., ACT for Japanese, ACT for multiracial clients, ACT for Muslim, ACT for the democrat). At last, given its importance, we hope that the same level of careful investigation will continue to be implemented for the cultural adaptation of ACT, as our field has done for a wide variety of behavioral health issues (e.g., depression, anxiety, chronic pain) in service of our clients' well-being. As ACT has shifted from a symptom-focused paradigm to a unified and process-based one in recent years (Hayes & Hofmann, 2018), we hope that our cultural adaptation efforts also shift from content-focused cultural adaptation of ACT to a more process-based, principle-informed cultural adaptation of this therapy.

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