CHAPTER

1

Why Is It Important to Culturally Adapt Therapy for Asian Heritage Populations?

You cannot change any society unless you take responsibility for it, unless you see yourself as belonging to it and responsible for changing it.—**Grace Lee Boggs (Social activist, 1915–Present)**

WHY WRITE THIS BOOK FOR ASIAN HERITAGE POPULATIONS?

This chapter focuses on helping the reader understand why cultural adaptations may be beneficial for Asian heritage populations. In doing so, it describes what groups are included under the Asian heritage rubric, and provides numeric information about population sizes across the world and within the United States (US). Moreover, the chapter discusses how and why the mind–body split diverged between the East and West. Finally, the chapter includes some basic information about the development of psychotherapy and provides an overview of the options that we have for providing culturally competent and adapted care for diverse populations.

Asian heritage groups are the most populous people in the world and are rapidly increasing in numbers. Meeting the mental health needs of such a large group that has little exposure and understanding of mental illness and its treatment can be quite challenging, but is sorely needed. Asian heritage populations are culturally more distinct from European Americans than are many other minority groups, which have historically had much European influence. Asia was the only continent that was not colonized to a large degree by Europeans. As a result, Asian values, languages, religions, and beliefs tend to be more distinct from the West. Because these differences are more likely to impact treatment, using this population to provide a deeper understanding of cultural adaptations and to illustrate what modifications look like may be more informative.

Although quite distinct, Asian heritage populations and immigrants also share many similarities when it comes to understanding and exposure to mental illness and its treatment. Individual and community stigma are deleterious and misconceptions related to mental illness lead many to believe that those with psychological problems are crazy, dangerous, or weak. This leads many to hide their problems for fear of embarrassment and loss of face, which also influences cultural differences in communication and expression of distress (ie, the tendency to report more somatic symptoms and the tendency not to deny having problems or hold things in until they become intolerably worse). These cultural differences have traditionally led to underreporting of mental illness and psychiatric symptoms, as well as underutilization of mental health services (Chun, Enomoto, & Sue, 1996; Corrigan, 2004; Hwang, 2006). Moreover, mental health services in Asia are not only heavily stigmatized, but practically nonexistent—which also compounds the reluctance in seeking Western mental health care. There is currently no licensure system for mental health practitioners (eg, psychologists, social workers, marital family therapists) and few training programs are available. There is also very little mental health education in Asia or in Asian American communities.

Although mental health services have not yet been well established in Asian heritage countries, we know that in the US, effectively treating Asian Americans is problematic and underresearched. Asian Americans are not only less likely to seek treatment (Bui & Takeuchi, 1992; Hu, Snowden, Jerrell, & Nguyen, 1991; Snowden & Cheung, 1990; Sue, 1977; Sue, Fujino, Hu, Takeuchi, & Zane, 1991), but also more likely to evidence more severe

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psychiatric impairment when they finally do seek help (Sue, 1977; Sue & Sue, 1987). Overall, Asian Americans are less satisfied with mental health treatment, evidence worse treatment outcomes, and dropout more prematurely and at higher rates than White Americans (Sue, 1977; Zane, Enomoto, & Chun, 1994). More recent studies have also found that Asian Americans are less likely than White Americans to seek psychiatric help and take the appropriate medications (Escobar et al., 2010; González, Tarraf, Whitfield, & Vega, 2010; Masuda et al., 2009).

Because of all of these complex issues and the vast diversity between different Asian heritage populations, addressing their unique needs is not only a unique challenge, but also an important endeavor. Given the dearth of clinical outcome research for this population, developing culturally responsive and effective interventions to address these distinct cultural issues are of the utmost importance. Moreover, the lack of research offers little scientifically supported insight on how mental health services can be adapted or tailored to be more effective for this heterogeneous group. This lack of research is problematic because it can lead to an automatic assumption that Western psychotherapies will be just as effective for Asian Americans as other groups, without having put this to an empirical test. With the rapidly changing demographics of the US, these critical lacunae in our knowledge along with our underpreparedness to effectively treat ethnic minorities and Asian heritage populations suffering from mental illnesses will become more apparent.

WHO DO WE MEAN BY ASIAN HERITAGE POPULATIONS?

There are many differences in how people conceptualize and utilize terms to describe racial and ethnic issues. In this book, I will use the term White or Western to represent those from European ancestry. For example, Asian Indians and people from the Middle East are considered racially White according to anthropological definitions. According to the US census, Latinos are considered to be Hispanic Whites. In discussing ethnocultural issues in this book, only people of European ancestry are considered White. In addition, the terms "ethnic" groups or populations will be used to describe the rest of the world population. The term ethnic minority will be used to describe ethnic groups within countries where people who are White or from a European ancestry are the majority or hold the most socioeconomic and social power.

I specifically chose not to use the term "non-White" because White people have historically been used as a frame of reference for which people of color across the world have been compared. White as a standard of comparison also indicates that as a whole they possess higher social status and power. The utilization of White people as the central frame of reference in psychology is so pervasive and ubiquitous, that oftentimes when people think of psychological principles and theories, studies conducted on White populations become synonymous with universal truths. Acknowledging this ethnocentric and Eurocentric bias is important in advancing and equalizing psychology as the science of human behavior for all people across the world. Unfortunately, the pervasiveness of this biased modus operandi is so omnipresent and has become so synonymous with the field of psychology that it has even led some scholars to write books such as *Even the Rat Was White: A Historical View of Psychology* (Guthrie, 1976). The approach utilized in this book is an ethnic studies' perspective, rather than a cross-cultural framework that compares diverse populations to Whites.

Not until recently has a shift been made to become more inclusive of people of color in the study of psychological science. With this shift comes the idea that we need to culturally adapt, test, and modify Western psychotherapy for ethnic populations, and to learn more about extant indigenous medicines, develop new ethnic-focused treatments, and research cultural strengths in the hopes of integrating them into psychotherapy. This book has a primary focus on culturally adapting psychotherapy for Asian heritage populations. Although the models and frameworks as well as the complex ways of thinking about culture and mental health can be generalized and applied to other groups, a central and deeper focus on Asian heritage populations will help people go beyond superficial understanding of cultural competence and develop more concrete skills that they can apply in the therapeutic setting.

Asian heritage populations are the largest group in the world. People of Asian descent currently account for approximately 3.84 billion (54.2%) of the world's population (United Nations Department of Economic and Social Affairs, 2012). In addition, Asian heritage populations are the fastest growing in the world and are projected to increase to 5.16 billion (54%) by 2050 (United Nations Department of Economic and Social Affairs, 2012). Who is included under this Asian heritage label? The continent of Asia is the largest in the world, spanning across vast geographic regions, and including people of many different national origins. For example, East Asians include people from China, Taiwan, Hong Kong, Macau, Japan, and Korea. Southeast Asians include people from Brunei,

Burma, Cambodia, East Timor, Indonesia, Laos, Malaysia, Philippines, Singapore, Thailand, and Vietnam. South Asians include people from Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka. Although some South Asians (eg, Asian Indians) are considered to be racially White according to the original anthropological definitions of race (Koshy, 1998), many would consider themselves culturally Asian. According to the US Census they are considered Asian. In addition, despite being culturally distinct and considered a separate racial group from Asians under the US Census, Hawaiians and Pacific Islanders are frequently and incorrectly grouped together with Asians in general reports.

When we examine specific Asian heritage regions, we find that there is considerable variation in population sizes (United Nations Department of Economic and Social Affairs, 2012). South Asia, which is the most populous region in the world, currently has 1.75 billion people (24.4% of the global population). Among the nations in this region, India is by far the largest with a population of 1.25 billion (17.5% of the world population), Pakistan at 182.14 million (2.5%), and Bangladesh at 156.60 million (2.2%). East Asia is the next largest region, with a current population of 1.62 billion (22.6%). The most populous countries include China (1.39 billion; 19.4% of the world population) and Japan (127.14 million; 1.8%), followed by the two Korean republics that have a combined population of 74.2 million (1.0%). Southeast Asia has a total population of 618.79 million (8.6% of the world population) and contains five nations with populations greater than 50 million. They include Indonesia (249.87 million; 3.5% of the world population), Philippines (98.39 million; 1.4%) and Vietnam (91.68 million, 1.3%), Thailand with population of 67.01 million (0.9%), and Myanmar with a population of 53.26 million (0.7%).

By 2050, the total Asian population is projected to increase to over 5 billion. South Asia is projected to have a population of 2.31 billion (24.2%). India is projected to increase to 1.62 billion (17.0%), Pakistan is projected to increase to 271.08 million (2.8%), and Bangladesh is projected to increase to 201.95 million (2.1%). East Asia is projected to slightly shrink in population to 1.61 billion (16.9%). China will continue to be the largest nation at 1.38 billion (14.5%). Japan is projected to decrease to 108.33 million (1.1%), and the Korean republics will increase to a combined 78.11 million (0.8%). Southeast Asia is expected to increase to 787.54 million (8.2%). Indonesia is projected to remain the largest country in the region with a population of 321.38 million (3.4%), followed by the Philippines (157.12 million; 1.6%), Vietnam (103.70 million; 1.1%), and Myanmar (58.65 million; 0.6%). Thailand is expected to shrink slightly to 61.74 million (0.6%).

In addition to being the largest population in the world, Asia heritage populations also make up the largest migrant population worldwide. Specifically, there is an ongoing diaspora of Asian heritage populations totaling 70.8 million (30.6% of the total 231.5 million worldwide migrant populations). Intra-Asian immigrants (migration between Asian countries) total 54.0 million and are the single largest migration corridor in the world (United Nations Department of Economic and Social Affairs, 2013). In regards to migration to the West, 15.7 million Asians have immigrated to North America and 18.7 million have immigrated to Europe. Among the European-bound immigrants, there is a significant spread throughout the different countries, but most have immigrated to the UK and France (The Economist Online, 2011). Approximately 11.6 million of the Asian immigrants to North America end up in the United States, where they tend to settle in either California or New York (Hoeffel, Rastogi, Kim, & Shahid, 2012; Migration Policy Institute, 2012). Comparatively few migrate to Oceania (eg, Australia, New Zealand, and the Polynesian islands; 2.9 million), Africa (1.1 million), or Latin America (0.3 million).

UNDERSTANDING ASIAN HERITAGE POPULATIONS IN THE UNITED STATES

Although Asians have immigrated to countries all around the world, the US continues to be the most popular destination and houses the largest number of Asians outside of Asia. It is important to note that the US is a rapidly diversifying country built by immigrants. The face of America today is multiethnic, consisting of people from all different colors, backgrounds, and national origins. The original melting pot metaphor, which hypothesized that the US would become a blend of people from all different cultural backgrounds (including nonsegregated neighborhoods, mixed-race children, and a color-blind society), has not come to fruition. Instead, the tossed salad metaphor has become more of the reality (eg, largely segregated neighborhoods, differences in social status, White privilege, and continued experiences with discrimination and racism among people of color). Specifically, White Americans have become the lettuce of the salad and the minorities have been likened to the different vegetables helping to give the salad its flavor.

Today, people in the US are growing up with increased exposure and contact with people of different racial backgrounds. A multicultural and ethnically diverse US has become the reality. Results from the 2010 census indicate of the 309 million people in this country, 196.8 million (63.8%) are White Americans, 37.7 million (12.2%) are African American, 47.4 million (15.4%) are Latino Americans, 14.5 million (4.7%) are Asian Americans, 2.2 million (0.7%) are American Indian, 9.0 million (2.9%) are of mixed race, and 1.8 million (0.6%) reported being "other" (Humes, Jones, & Ramirez, 2011). These demographic figures indicate that we are not only a very diverse country, but perhaps the most ethnically and racially diverse country in the world.

Moreover, diversity in the US is also on the rise. By the year 2060, the US population will have grown from 309 million to 420 million—a 36.1% increase. White Americans are projected to increase to 179 million (42.6% of the US population), African American to 55 million (13.1%), Latino Americans to 122 million (29.1%), Asian Americans to 33 million (7.9%), American Indians to 2.9 million (0.7%), and mixed-race individuals to 26 million (6.6%) (United States Census Bureau, 2012a). Although many neighborhoods are racially diverse, we know that the majority of urban neighborhoods remain quite segregated. For example, the 2010 mixed-race numbers, as well as the 2060 projections, indicate that there is very little racial blending and intermarriage. Moreover, if we examine children under the age of one, the 2010 census reports that only 4.9% were of two or more races (Frey, 2011).

Historically, Asian heritage populations in the US (ie, Asian Americans) have been the fastest-growing group proportionately; whereas, Latino Americans have been the fastest growing numerically. Recently, Latinos became the fastest growing numerically and proportionately—with Asian Americans coming in second. Census projections indicate that Asian Americans will continue to have the second fastest proportional growth rate of all the racial groups and are projected to increase by 127.6% by 2060. Latinos are projected to increase by 157.4%.

Although Asian heritage populations in the US are only the third largest ethnic minority group, their numbers should not be mistaken to be small. To put this in perspective, the state of Utah has a population of 2.8 million people according to the 2010 census and is projected to grow to 6.0 million by the year 2060 (Governor's Office of Management and Budget, 2012). On the other hand, Asian Americans in the US account for 14.5 million and are projected to grow to 33 million by the year 2060. The numbers of Asian Americans in the US could therefore be considered equivalent to the population of five states of Utah, and given population projections, by 2050 will be six times that of the state of Utah.

The diversity of Asian heritage populations across the world is reflected in Asian Americans in the US. Despite many similarities across Asian Americans, there are over 43 different ethnic groups encapsulated under this label, and they vary in experiences, beliefs, values, histories, migration patterns, religions, and languages (Lee, 1998). Utilizing census data, the Asian American and Pacific Islander Health Forum report (APIAHF, 2011) indicates that approximately 9 out of 10 (85.1%) Asian Americans come from six major groups, including Chinese (22.8%), Asian Indian (19.4%), Filipino (17.4%), Vietnamese (10.6%), Korean (9.7%), and Japanese (5.2%). Asian Indians surpassed Filipinos for the first time in the 2010 census, indicating the increase of migration from South Asia over the last 10 years.

Even among Asian American groups encapsulated under the same ethnic label, there is great linguistic and cultural diversity. For example, among Chinese Americans, there is great geographic diversity in immigration origins and histories, including sojourners from mainland China, Hong Kong, Taiwan, Singapore, Vietnam, and other places. Chinese Americans speak a variety of languages, a small sampling of which includes Mandarin, Cantonese, Taiwanese, Toishanese, Hakka, Shanghainese, and Sichuanese, which are all mutually incomprehensible.

The diversity among Asian Americans is compounded by differences in acculturative status and immigration cohorts. Throughout history, Asians Americans have faced racist immigration laws that have impeded their migration to the US, and which limited their numbers. For example, the Chinese Exclusion Act of 1882 was created following the influx of Chinese workers who, among other accomplishments, helped build the transcontinental railroad (National Archives and Records Administration, n.d.). Believing that this was driving unemployment and decreasing wages, President Arthur stopped Chinese immigration for two decades and prevented the existing immigrants from gaining citizenship. The 1924 Immigration Act expanded this restriction to Japanese immigrants as a result of similar economic concerns (Solomon, 2012). In 1929, the National Origins Act set quotas for immigrants and entirely barred immigration from the Asian-Pacific triangle region.

Not until the Hart-Celler Immigration Bill in 1965 were these restrictions dropped, though priority immigration was given to family members of current resident aliens, refugees, and to highly educated individuals (Center for Immigration Studies, 1995). This created the Asian brain drain phenomenon where highly educated individuals left their country of origin en masse, and came to the US. Because of these premigration factors, after 1965, Asians came to the US with higher social, economic, and educational status—thus fueling the creation of

the model minority stereotype. Those who immigrated prior to the immigration acts, on the other hand, predominantly came as poor migrant and blue-collar workers, and thus were more likely to have a lower socioeconomic status than that of more recent generations of immigrants. Due to these institutionalized racist immigration laws and the restriction on Asians coming into the US, the number of Asians in the country dramatically decreased, resulting in them becoming the third largest ethnic minority group.

For the majority of the population, issues of race and ethnicity are often intertwined with social economic status and wealth. Although there has been a reduction of overt racism over the past several decades (especially after the civil rights movement of the 1960s), we know that racism and prejudice are still widespread, and that covert prejudice, racial microaggressions, and internalized racism have taken its place (Dovidio, Glick, & Rudman, 2005). Meeting the mental health care needs for all Americans is an important endeavor which has yet to be effectively addressed. Decades of research indicate that poor and disadvantaged clients who want and need appropriate clinical services do not receive quality mental health treatment due to classist and racial biases (Smith, 2005).

Because ethnic minorities are overrepresented among the impoverished, figuring out how to properly address class as well as racial issues will be of utmost importance (Hwang, 2006; Kliman, 1998; Lott & Saxon, 2002). Recent data highlight the disproportional representation of poverty among each of the major groups in the US. For example, the poverty rates for various groups are as follows: 15.4 million White Americans are below the poverty level (8.1%), 8.1 million African Americans (24.9%), 1.3 million Asian Americans (12.6%), 7.8 million Hispanic Americans (22.6%), and 0.6 million American Indians (25.7%) (Bishaw & Iceland, 2003; National Congress of American Indians, 2000). These numbers indicate that it is difficult to disaggregate race from poverty in the US. Cultural adaptations will, to some extent, need to take into account issues of social economic status, education and literacy, single-parent homes, and neighborhood context and its associated risk factors (eg, crime, gangs, and drugs). For Asian heritage populations, poverty issues are more salient among Southeast Asian and refugee groups, such as Vietnamese, Cambodian, and Hmong Americans. The Asian American poverty rate needs to be disaggregated in order to provide a more accurate picture.

MIND–BODY DIVERGENCE BETWEEN THE EAST AND THE WEST

The philosophical and cultural conceptualization of the mind and body varies greatly across the world. A central difference between the West and the rest of the world occurred thousands of years ago when Plato (429–347 BCE) began theorizing about the soul and arguing its distinctness from the body. This had a significant impact on the development of Western medicine and the idea of a separate mind and body, which became more ingrained over thousands of years. However, it wasn't until Descartes (1596–1650) that the legacy of mind–body dualism (also known as Cartesian dualism or substance dualism) become more ingrained in Western thought at a practical and systematic level. This duality, currently known as the mind–body split, has played a significant role in shaping the development of Western medicine and the treatment of mental illness.

With this mind–body split came the division of Western medicine into separate physical and mental health treatment systems. The term psychiatry comes from the Greek words psyche (soul) and iatreia (medical treatment). The term psychology has a similar etymology, psyche (soul) and logos (study of). Modern-day usage of the term psyche, which is often synonymous with the term psychology, refers to the totality of the human mind and what Sigmund Freud (1856–1939) later popularized as both the conscious and unconscious mind. This splitting of the mind from the rest of the body reinforced the divergence of mental and physical health care.

The field of psychiatry and psychology began reinforcing an artificial separation between the mind and the body. The reason I call this separation artificial is because the vast majority of psychiatric disorders possess both mental and physical symptoms. For example, out of the nine symptoms included in the diagnosis for major depression diagnosis, four of them are physical in nature (eg, changes in appetite/weight, difficulty sleeping, psychomotor agitation or retardation, and fatigue or loss of energy). In fact, if one were to systematically review the symptoms of various mental illnesses, approximately half of the symptoms are physical in nature. This artificial separation of the mind and body creates a lot of stigma toward mental illness for those who come from cultural backgrounds that tend to be more holistic and mind–body integrative. Some of the major cultural adaptations discussed later in this book address this mind–body separation and destigmatizing mental illness.

In the East, traditional and indigenous medicines were developing centuries before the time of Plato. The oldest Ayurvedic text, the Rigveda, was written approximately 3000 years ago in India (Rigveda, 2014). Ayurvedic

medicine emphasized the balance of so-called life forces (called *Dosha*), each individual's constitution (*Prakriti*), and the energy of the universe. All aspects of life, from spirituality to personal hygiene, are considered part of the holistic scope of Ayurvedic medicine. At approximately the same time in China, Traditional Chinese Medicine (TCM) was also developing in a holistic and integrative manner. As with Ayurvedic medicine, the Chinese believed that life energy (called *Qi*) flowed throughout the universe and within a person's individual body (United States Department of Health and Human Services, National Center for Complementary and Alternative Medicine, 2013). Therapeutic practices (eg, *TaiChi* and *Qigong*) and physical exercises (eg, Kungfu) were designed to increase physical health, dexterity of mind, and increase centeredness and balance. The twin concepts of Yin and Yang Qi were central to balancing energy and promoting physical and mental health.

In traditional Asian therapies, the mind–body split promulgated by Plato and Descartes in the West is seen as artificial (Walsh, 1989). For example, the Rigveda advises, "The first form of happiness is sound health. . .So it is essential to maintain the health of the mind and body simultaneously." Similarly, the ancient Chinese physician known as Sun Simiao, in his book *Essential Prescriptions*, claimed that "A person who is good at preserving life constantly reduces thoughts, ideas, desires, business affairs, speaking, laughter, worrying, joy, happiness, anger, likes and dislikes. . . If you fail to eliminate these twelve excesses, construction and defense will lose their measure, and qi and blood will flow frenetically" (Wilms, 2010). In both of these texts, Asian therapies require an integrative approach to treating the mind and body. The status of one affects and is integrally tied with the other.

This divergence between Eastern and Western medical treatment systems can be especially problematic when treating those from Eastern backgrounds with Western psychotherapy. Not only does this mind–body split socially stigmatize those with mental illness as "crazy," but it also increases the discomfort of those suffering when they finally do seek help. Furthermore, it also causes people to have less faith in psychotherapy and its treatment techniques, as well as to have a stereotyped or misinformed understanding of how it works.

As more evidence supports the benefits of traditional medicines, its integration into mainstream and primary care treatment systems will become more apparent. A 2007 report indicated that 19.2% of adults in the US used mind–body therapies, and 3.4% used alternative medicine in the past 12-month period (Barnes, Bloom, & Nahin, 2008). Deep breathing, meditation, and yoga were the most popular mind–body therapies. Deep breathing exercises were used by more than 27 million people, meditation by more than 20 million, and yoga by more than 13 million people. While less popular, Tai Chi was still being used by more than 2 million people. Among the alternative medical systems, acupuncture and homeopathic treatment were the two most popular, with usage by more than 3 million people. Though Western medicine has always been based on a mind–body split, there is an ongoing movement to increase the presence of mind–body therapies and scientifically explore their therapeutic effects.

Today, there is also an increasing trend of including Asian meditation and mindfulness techniques in treating both physical and mental health problems. Mindfulness has been used to treat physical health and mental illness as a specific practice. For example, Davidson et al. (2003) found that an 8-week program in mindfulness meditation increased both brain function associated with positive emotions and vaccine-response antibody production. In addition, it has also been integrated into different therapeutic modalities (eg, mindfulness-based cognitive therapy and dialectical behavioral therapy). Because there is no distinct and separate mental health treatment system in traditional Asian medicines, many Asian heritage populations may not know where to go for Western mental health providers. This integration of Eastern and Western traditions also calls into question the expression versus repression of emotion, as well as the improvement of one's mental health by talking about one's problems versus trying to empty one's mind of excess thought.

The spread of Western medicine across the world was no coincidence. With imperialism and colonization of the world, Europeans spread across Africa, South America, and North America promoted European culture, ideas, values, religions, and medicines. At the same time, many populations from around the world were looked down upon, enslaved, or discriminated against. A particularly interesting book entitled, *Guns, Germs and Steel: The Fates of Human Societies* (Diamond, 1997) discusses how Europe was able to colonize and conquer much of the world. This book was both a Pulitzer Prize winner and an Aventis Prize winner for nonfiction and best science book. It was later turned into a documentary by PBS in 2005 (Horth, Lambert, & Harrison, 2005). Although one may wonder why understanding historical context is important to culturally competent and adapted therapy, the impact of historical and modern-day racism and discrimination has significantly affected people of color. Understanding the influence of prejudice and discrimination on interracial experiences and perceptions is a necessary part of cultural understanding and competence. Therapists need to be nonreactive and responsive to the needs, experiences, and feelings of people of color.

Because of the aforementioned issues, Western medicine spread and the evolution of traditional and indigenous medicines stymied. Given the decimation and taking of wealth from many countries around the world, few

resources were invested in the scientific study of traditional medicines, which were believed to be nonevidence-based. Financial resources were invested into empirically supporting Western medicine, whereas few resources were available to research the efficacy and mechanisms of traditional medicines.

Meanwhile, Asia was the only major populated continent that was not completely taken over by the Europeans. Because of British influence in India, Western medicine rapidly took hold in India and Ayurvedic medicine quickly lost favor. It did not receive the attention or funding it needed to develop and advance as a modern day science. Because China was able to resist colonization and fought off the British during the Opium Wars, TCM remained intact. It was not until the modern era that Western medicine quickly took hold of the rest of Asia. China invested a lot of financial and human resources and was eventually able to thwart European colonization, leading to the preservation of Chinese culture and sovereignty.

However, China continued to struggle economically and focused on developing primary and basic infrastructures, such as education, transportation, finances, and physical health treatment. Unfortunately, the mental health treatment system fell far behind when it came to effectively treating those suffering from mental illness. Western medicine flourished in China and operated in a largely separate system from TCM—which was deemphasized and received less empirical funding, but still remained popular among Chinese people given its historical and cultural roots. Consequently, it is important for those working with populations who believe in traditional and indigenous medicines to understand these issues because they are integrally tied with people's beliefs and cultural systems. Culturally competent mental health care providers need to be able to work effectively with people who hold different beliefs and values. Even if the goal is to indoctrinate clients toward Western psychoeducation and methods of mental health care, this is not an easy task and requires familiarity with cultural beliefs, intra- and interpersonal understanding, a strong working alliance, and some understanding of traditional medicines and religions.

THE DEVELOPMENT OF WESTERN PSYCHOTHERAPY

Western psychotherapy's ancestry and deep historical roots come from European and US history. Given its origins, it is culturally laden with Western values and could be considered a treatment that has been developed and tailored for those from European and White American ancestry. It is important to note that 84.2% (5.97 billion) of the world's population consists of people from non-European ancestry (United States Census Bureau, 2013). Therefore, it is important to understand whether Western psychotherapy works well with people from diverse backgrounds and whether cultural adaptations and modifications can increase therapeutic effectiveness. Given that mental health treatment is significantly underdeveloped in countries of non-European ancestry, figuring out how to meet the mental health needs of the world's diverse population is of utmost importance.

The emphasis on a separate mind and body in the West reinforced the development of separate nosological classification, diagnostic, and treatment systems for physical and mental health. This differentiation also led to specialized research programs, evidence-based initiatives, as well as targeted funding priorities. Psychiatry eventually developed into the practice of prescribing drugs for mental illness, and psychology focused on talk therapy as a means to improve mental well-being. Eventually, the development of different theories and methods for treating mental illness led to the evolution of different schools of psychological thought.

Specifically, there have been four major waves or schools of psychotherapy (Dryden & Mytton, 1999; Enns & Sinacore, 2005). Starting with psychoanalysis in the late 1800s, Freud popularized the idea of the psyche as being composed of both the conscious and unconscious. Moreover, with the evolution of psychoanalysis came the coining of classic terms such as free association, transference, countertransference, repression, and the "talking cure." Additionally, other terms and concepts such as the Oedipal complex, the Electra complex, penis envy, and the classic id, ego, superego were also heavily popularized—but found to be culturally biased and lacking scientific support. Over time, psychoanalysis evolved into different schools of psychodynamic thought, eventually decreasing the emphasis on psychosexual development. A stronger emphasis was placed on attachment theory and interpersonal relations, which have a stronger research foundation and may be more universally accepted.

Since the development of psychoanalytic and psychodynamic therapies, many different schools of thought developed and psychotherapy branched out into different theoretical orientations and modalities. The second wave of psychotherapy was behaviorism and emphasized learning and reinforcement through behavioral modification. The third wave consisted of humanistic and experiential therapies, focusing more on self-actualization, empathy and shared emotional experiences, and the healing power of therapists' unconditional positive regard

toward the client. The fourth wave consisted of cognitive therapy, with a strong emphasis on irrational thinking or cognitive errors, the cognitive triad (negative thoughts about the self, world, and future), and cognitive reframing. Counseling psychologists have conceptualized major schools of psychotherapeutic thought, not as waves, but as forces in counseling (Ivey, D'Andrea, & Ivey, 2011). These forces include psychoanalytic/psychodynamic, cognitive and behavioral therapies, and existential-humanistic therapies.

Recently, a fifth wave was proposed—specifically, integrative psychotherapy which combines elements from different major theoretical orientations, with an emphasis on retaining empirically supported therapeutic mechanisms (Norcross & Goldfried, 2005). If a fifth wave were to become widely established and to become fully accepted, then this integrationist approach may benefit from incorporating multicultural issues. In fact, this is a prime opportunity to integrate culturally competent therapy and cultural adaptations into mental health care—especially since the vast majority of practicing therapists utilize an integrated therapeutic approach; albeit, not necessarily including the same mechanisms stressed by Norcross.

It is important to note that Western psychotherapies are already culturally individualized for White Americans. Specifically, they were developed for and continually adapted to the needs of White or European American populations. In order to provide equitable treatment, we need to be able to individualize and tailor treatments for people of color as well. By studying culture, we come closer to understanding universal truths about human behavior and the treatment of mental disorders, as well as gaining a better understanding of the diversity of culture-specific issues. Furthermore, we begin to identify culture-universal healing mechanisms of psychotherapy that can be generalized to all groups. Certain fields of psychology have begun to strongly prioritize the role of culture in mental health. For example, the field of counseling psychology has noted that the fourth force of counseling psychology is the incorporation of multicultural issues—specifically, culturally effective therapies that incorporate multicultural and feminist perspectives (Ivey et al., 2011).

Whether the next major wave or force of psychotherapy and counseling is integrationist or multicultural, there is no doubt that psychology is heavily laden culturally. The vast majority of psychological research has primarily focused on White Americans or those of European ancestry, and whether treatments will work as effectively with non-White populations is an empirical question that needs to be further explored. However, whether cultural adaptations can increase the effectiveness of psychotherapy, not only in terms of symptom change, but also in terms of client engagement, treatment satisfaction, stronger working alliances, increased feelings of comfort, and reduction of premature dropout is also an important area to explore.

Much more work needs to be done in studying cultural issues in mental health for ethnic minorities, international populations of color, as well as immigrants and refugees. It is important to study culture and broaden the populations whom we study in mental health because the study of culture informs psychological science. Just as the study of psychological science (eg, social psychology, cognitive psychology, development of psychology) informs clinical science, the incorporation and study of culture are integral to understanding human behavior. The study of culture can help inform both the psychological science and the clinical science of defining and treating mental illness.

WHAT ARE OUR OPTIONS FOR PROVIDING CULTURALLY COMPETENT AND EFFECTIVE CARE?

In recent years, there have been multiple initiatives brought forth to establish, define, and validate empirically supported treatments (ESTs) and evidence-based psychological practices (EBPPs) in the US (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006; American Psychological Association Task Force on Psychological Intervention Guidelines, 1995; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Unfortunately, ethnic minorities and diverse populations have, for the most part, been left behind in these initiatives. For example, a comprehensive review of randomized clinical trials (RCTs) funded by the National Institutes of Health (NIH) between the years 1994 and 2004 found that less than 50% of the studies reported descriptive information on patient cultural backgrounds (Mak, Law, Alvidrez, & Perez-Stable, 2007). Moreover, with the exception of European Americans or White Americans, all other ethnic minority groups were underrepresented in the trials that did report ethnic backgrounds, and only 2.3% of all trials were focused solely on ethnic minorities.

In addition, a recent paper published in the annual review of psychology (Hartmann et al., 2013) indicated that there has not been much progress in publishing cross-cultural and ethnic minority research in leading

psychology journals. According to this review, only 2% of peer-reviewed publications addressed cross-cultural issues, and 4% addressed ethnic minority issues. These numbers did not change much from the prior article that assessed publication rates in ethnic minority psychology and cross-cultural psychology. Specifically, from 1993 to 1999, only 1% of publications focused on cross-cultural issues and 3% focused on ethnic minority issues (Hall & Maramba, 2001). This lack of research is problematic because it can lead to an automatic assumption that Western psychotherapies will be just as effective for other groups, without having put this important question to an empirical test. Moreover, this lack of research offers little scientifically supported insight into how mental health services can and may need to be modified to make them more effective for diverse groups.

Regarding the small but growing body of extant research available, summary reports indicate that ethnic minorities are less likely to receive quality health services and evidence worse treatment outcomes than White Americans (Institute of Medicine, 1999; United States Department of Health and Human Services, 2001). Despite the enormity of this public health burden, few published studies have examined or demonstrated the efficacy of psychological treatments for ethnic minorities, especially regarding the efficacy of EBPPs for ethnic minorities and immigrants. For White Americans and people of Western European descent, there has been considerable progress in establishing and defining effective and possibly efficacious treatment (Bernal & Scharrón-del-Río, 2001; Nagayama-Hall, 2001; United States Department of Health and Human Services, 2001).

Furthermore, relatively little is known about the efficacy of ESTs for ethnic minorities and immigrants. According to the Surgeon General's report entitled "Mental Health: Culture, Race and Ethnicity," out of the 9266 participants involved in the efficacy studies forming the major treatment guidelines for bipolar disorder, schizophrenia, depression, and ADHD, only 561 were African American, 99 were Latino, 11 were Asian American/Pacific Islanders, and none were American Indians/Alaskan Natives (United States Department of Health and Human Services, 2001). Because of these small numbers, few of these studies had the statistical power needed to examine the impact of care for specific ethnic groups. As the demographics of the US changes rapidly, this critical lacuna in our knowledge along with our underpreparedness to effectively treat ethnic minorities suffering from mental illnesses will become more apparent.

As we strive to meet the mental health care needs of diverse populations, a number of questions will need to be answered for both the US as well as other countries around the world. Currently, mental health providers are faced with the dilemma of whether to (1) implement an "as-is approach" to disseminating evidence-based treatments (EBTs) to culturally diverse ethnic groups, (2) develop new, culture-specific EBTs for each ethnic group, or (3) adapt EBTs to be more culturally congruent in order to better fit the needs of ethnic clients (Hwang, 2006). Recent reviews underscore the limitations of EBT literature, stating that few studies have been conducted confirming whether EBTs are efficacious when treating ethnic minorities and provided several recommendations for moving beyond this impasse (Hwang, 2006; Miranda et al., 2005; Nagayama-Hall, 2001).

Although some may debate that an "as-is" approach to implementing EBTs is sufficient for treating ethnic minorities, it would be difficult to argue that culturally modifying and individualizing treatments for diverse clients would not confer additional benefits and improve therapeutic outcomes. After all, the goal of therapy is to individualize and tailor treatments for specific clients. For White Americans and Western European consumers, the tailoring of psychotherapy is already embedded into the core of psychotherapy itself—cultural adaptation and individualization of treatments has been historically integrated into psychotherapy as it was developed for Europeans and White Americans. Psychotherapy was developed within a cultural context by and for European and White Americans, with little consideration of ethnic minorities and other groups around the world. As a result, psychotherapy is heavily laden with Western cultural values and beliefs, and therefore is culturally tailored toward Europeans and White Americans. An "as-is" approach to psychotherapy with people from other backgrounds imposes Western values and concepts onto groups for which they were not originally developed.

Although an "as-is approach" in disseminating EBTs to ethnic minority clients is better than no treatment at all, this may not be the best approach in terms of meeting the needs of diverse populations and engaging them in mental health care that has traditionally been heavily stigmatized. Moreover, we now know that many ethnic minorities receive substandard treatment when it comes to mental health care and psychiatric prescription practices (ie, being prescribed older medications that may be less effective and associated with more side effects) (Institute of Medicine, 1999). However, this is not to say that an "as-is" approach to psychotherapy will not work with some ethnic minority groups, especially for those who are more White-identified. Specifically, we can postulate that "as-is approaches" will work better for ethnic minorities who are more culturally similar to White or European Americans.

Fewer modifications would need to be made for those who are more assimilated into White mainstream culture or perhaps even for diverse populations who have been in the US for multiple generations. Nevertheless,

even those who have been here for quite a while may have distinct cultural differences and may benefit from individualization or personalization of care to match their cultural value systems and beliefs (eg, African Americans and American Indians). Therefore, an "as-is" approach to implementing EBTs is likely to generalize to some groups and provide some therapeutic benefit, but may not be a sufficient model for optimal care and may also lead to problems with patient engagement and premature treatment failure.

Many clinical scholars who focus on reducing domestic and international mental health disparities, as well as many practitioners who treat people from different backgrounds, believe that improving the mental health care of diverse populations and learning how to best culturally adapt and individualize mental services is an important endeavor. It is certainly possible, if not probable, that targeted cultural adaptations can further improve treatment outcomes, increase client engagement, and reduce premature treatment failure (Hwang, 2006). Moreover, if diverse populations received culturally adapted, individualized, and tailored care like White populations do, could therapeutic benefits be maximized?

A number of clinical researchers have already begun culturally adapting Western psychotherapy to better meet the needs of diverse communities and testing its efficacy (Bernal, & Domenech Rodríguez, 2012), leading to a small but growing body of literature that indicates cultural adaptations can indeed be therapeutically beneficial (Griner & Smith, 2006). Because cultural adaptations involve individualization of care to include and respond to cultural values and beliefs, adaptations of EBTs may be the optimal solution for effectively addressing mental health disparities and improving treatments for diverse populations. Moreover, the study of culturally adapting therapy may also lead to additional scientific benefits that would help advance the field of psychology and the study of all human behavior—namely, the establishment of empirically validated and EBTs that are clinically effective and that focus on culture-universal elements.

For Asian heritage populations where cultural differences are more likely to be greater and more distinct, the cultural adaptation of therapy may be even more important than for groups that have greater Western influence and exposure (eg, African Americans who have been here for generations and for whom there is not a linguistic issue, or for Latinos who been heavily influenced by European and Spanish influence and colonization in Central and South America). Because there are more African Americans and Latinos in the US, and because there are fewer linguistic difficulties involved in researching these populations, more cultural adaptation work has been conducted with those communities than with Asian heritage populations. Even though Hispanic and Latino immigrants are likely to face linguistic issues when seeking mental health care, learning Spanish is much easier for the majority of Americans because Spanish originates from Europe and contains many similarities to English. In contrast, many Asian heritage languages are linguistically distinct and are based on complex character systems making them difficult to learn.

Specifically, trying to conduct clinical research on Asian heritage populations in the US is also much more complicated. Asian heritage groups are very diverse in terms of national origin and languages spoken. Finding linguistically fluent staff who are also capable of reading and writing an Asian heritage language is also challenging. Because Spanish utilizes a phonetic writing system, those who can speak can typically read and write. However, because many Asian languages are based on a character system, just because someone can speak one of the Asian heritage languages does not mean that they can read and write. Reading and writing require specialized education and the memorization of the meaning of pictographic characters that have no pronunciation system. In fact, most Asian Americans who did not grow up in Asia, but who can speak some of their Asian heritage languages, are illiterate in terms of reading and writing ability (Kim & Chao, 2009). The linguistics of emotions are also more similar between Spanish and English, than between English and Asian heritage languages, which are more linguistically and culturally distinct.

Finally, Asian Americans are also stereotyped as being the "model minority" who are not supposed to have problems and are "supposed" to be successful and high achieving. We know that this stereotype is not true for a variety of reasons. Debunking the model minority stereotype is not a central focus of this book. However, some basic issues that have led to the development of this stereotype include the historically discriminatory immigration laws that were previously discussed.

With the equalization of immigration in 1965 came an influx of Asian immigration to the US. However, priorities were given for family reunification, refugees, and those who were more highly educated. These laws led to a diverse group of Asian Americans with different educational backgrounds. For example, some groups such as Asian Indians and Chinese Americans are overall more highly educated because they utilized the third criteria for entry. However, other groups such as Hmong and Vietnamese came as refugees and evidence much greater poverty and lower educational achievement compared to White Americans (Pew Research Center, 2013). In fact, of the 15 largest Asian ethnic groups in the US, 11 of them have evidence poverty rates higher than the national average.

In regards to income, because Asian heritage populations tend to have larger and multigenerational households, household income research that does not account for the number of multiple earners in the family presents a distorted picture of socioeconomic status. For example, Asian Americans have the highest rate of multiple earners per household than any other group in the US—approximately half of all Asian American households have two or more wage earners (United States Census Bureau, 2012b). Stereotypes of Asian heritage populations as being the model minority may also influence funding priorities and attention to mental health care needs and services that are available. This, combined with the lack of exposure and education about psychological problems, as well as high stigma toward mental illness and its treatment, further exacerbates the problems of those from Asian heritage backgrounds not seeking help and hiding their problems due to shame and fear of others finding out about their problems.

Earlier, I cited the numbers of participants from each of the major racial groups that were included in the efficacy studies forming the major treatment guidelines for writing of psychiatric disorders in the US. Out of the 9266 participants treated in these trials, only 11 were Asian American or Pacific Islander (United States Department of Health and Human Services, 2001). Collapsing Asian heritage populations with Pacific Islanders is problematic because they are distinct cultural groups with different histories and value systems. Moreover, even if we include these combined numbers, when we examine representation by disorder, we see that Asian American or Pacific Islander participants were severely underrepresented when forming the treatment guidelines for various disorders.

Specifically, for bipolar disorder, none of the 921 patients included were Asian American. When forming the guidelines for treating schizophrenia, only 5 out of 2813 were Asian Americans. Regarding depression treatment, only 2 out of 3860 were from an Asian heritage. In addition, only 4 out of 1672 patients were Asian Americans when forming the treatment guidelines for ADHD. These numbers further highlight the fact that Asian heritage populations were left behind when major treatment guidelines for psychiatric disorders were developed, and that mental health treatments have not been specifically developed with Asian heritage populations in mind (United States Department of Health and Human Services, 2001).

In regards to randomized controlled trials (the "gold standard" in the field for determining treatment outcomes), a recent review indicated that Asian Americans were practically nonexistent (Miranda, et al., 2005), with only a handful of small sample trials having been conducted since then. The underrepresentation of Asian Americans in randomized controlled trials extends to children as well (University of California, 2011; Williams, Powers, Yun, & Foa, 2010). Although we can make assumptions that Western psychotherapies will generalize to Asian Americans, there is little empirical evidence to confirm this. As a result, we know very little about whether Western psychotherapies will generalize to Asian Americans and whether they will remain effective. Moreover, it is possible that culturally adapted therapies will help to improve client engagement and clinical outcomes; however, once again, there have been few resources committed to studying this issue. For immigrant Asians and Asian heritage populations internationally, where cultural differences are more likely to be larger and more distinct, culturally adapting EBTs to better address their needs may be a better and more cost-effective culturally responsive approach to improving care.

The final of the three aforementioned options is to develop novel and indigenous mental health treatments for each cultural group domestically and internationally. Although this may be an aspirational idea, it may not be a very practical option for a number of reasons, including the fact that it will be prohibitively costly and time-consuming, which would further delay implementation of culturally effective care. Furthermore, developing novel treatments that are systematically different would also lead to extensive training difficulties. Specifically, it would be difficult to train therapists to implement treatments that are based on different theoretical paradigms and treatment models.

For the US, developing novel treatments that vary too far from the established psychotherapy treatments available may not be a practical solution. For countries outside the US which are struggling to meet the mental health needs of their people, developing novel and ethnic-specific treatments may be an aspirational ideal. Most non-Western countries have poorly developed treatment systems, and very little funding to pursue costly developmental research, which would also further delay implementation. As a result, most non-Western countries outside of the US (especially developing countries), have adopted Western mental health models and methods. For example, if you travel to an Asian heritage country, most of the psychology textbooks and books concerning mental illness and its treatment are direct translations of books written in English from the US.

The US is the foremost producer of mental health information and publishes the highest amount of psychological and psychiatric research (Arnett, 2008; United States National Institutes of Health, 2014). It has conducted the most clinical trials and has played a leading role in shaping and developing evidence-based practices.

The models and frameworks that the US develops have an international impact and therefore it is imperative that we serve as a role model to other countries. At a practical level, developing countries have fewer resources to commit and are focused on meeting other basic needs (eg, economics, education, pollution, medical care, crime, and poverty). Many countries have adopted the mental health models and frameworks of the West, with little to no modification. Therefore, what we do in the US has a significant effect on international mental health care. Prioritizing and developing culturally adapted and effective interventions may not only help outcomes for ethnic minorities in the US, but may also improve global mental health care for diverse populations.

Given that the majority of the world comes from a non-Western background, culturally adapting mental health services to better meet the needs of the world's population makes intuitive sense. In order to provide effective treatments for people of diverse backgrounds, we need to individualize treatments for clients, which cannot happen unless we have a deep structural understanding of cultural issues and how they impact mental health processes and their treatment. Because mental illness is a worldwide health problem that affects people from all cultural and socioeconomic backgrounds, addressing worldwide mental health issues should be a priority. Graduate programs need to train therapists to understand the complex interplay between cultural and clinical issues. This requires a therapist to learn about clients from diverse backgrounds, to become more linguistically proficient in other languages, to understand cultural beliefs about mental illness, and to become proficient in therapeutic techniques that can be aligned with the client's cultural background. Specifically, adapted treatments have the potential to improve clinical outcomes and increase client engagement. Many clinical researchers have already begun culturally adapting psychotherapy, but much more work needs to be done to improve mental services and ensure that all groups receive quality mental health care.

An "as-is approach" to psychotherapy may be insufficient to meet the needs of the community, and developing evidence-based and culturally adapted treatments will be critical to improving mental health care for diverse populations who have unique struggles and needs. Improving the effectiveness of mental health treatments for people of non-European backgrounds is especially important given that three-fourths of the world is collectivistic and possesses belief systems that are distinctly different than those in the Western world. It is important to note that determining what to modify and what not to modify is not easy. We do not want to implement cultural adaptations that are not evidence-based or scientifically sound, nor do we want to leave out specific mechanisms and aspects of psychotherapy that have been empirically validated and been shown to be beneficial for multiple groups. More effort needs to be placed on identifying mechanisms that may be culturally universal and generalizable to all humans, as well as identify culture-specific healing mechanisms. Therefore, an evidence-based approach to cultural adaptations is needed to retain the healing aspects of extant therapies and to implement modifications that are empirically sound and that will be therapeutically effective.

Because great diversity exists internationally as well as within the US, finding a way to effectively meet the mental health needs of diverse clients, as well as engaging treatment-resistant populations into psychotherapy and improving outcomes, is of critical importance (Hwang, 2006). Just as the study of psychological science informs clinical science, the scientific study of culture can also improve our understanding of universal- and culture-specific aspects of human behavior. The study of culture advances the development of psychological and clinical science, which affords and increases our ability to improve mental health treatment for all groups.

The goal of this book is to address the aforementioned issues by (1) discussing the needs for culturally adapting psychotherapy, (2) differentiating the more general notion of cultural competency from the more specific skill set of culturally adapting treatments, (3) helping mental health practitioners and clinical researchers understand the differences between surface structure adaptations and deep structure adaptations, (4) understanding how culture influences various aspects of mental health, (5) providing a detailed example of how a culturally adapted EBT can be developed through theoretical and community-participatory frameworks, and (6) providing readers with a first-time look at an evidence-based, culturally adapted treatment manual that provides concrete examples and illustrations of what culture adaptations actually look like.

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