CHAPTER

4

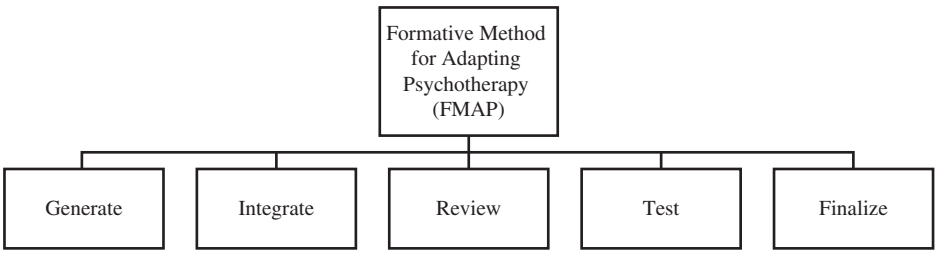
The Formative Method for Adapting Psychotherapy

You should never let your fears prevent you from doing what you know is right.—***Aung San Suu Kyi (Burmese Politician, Political Prisoner, Nobel Peace Prize Winner; 1945–Present)***

The purpose of this chapter is to introduce an empirically supported and flexible approach for culturally adapting mental health services. In addition, an initial introduction to the culturally adapted treatment manual is provided. The cultural adaptation framework utilized is called the Formative Method for Adapting Psychotherapy (FMAP) (Hwang, 2006, 2009, 2011; Hwang et al., 2015). The FMAP is a community-participatory framework that integrates a bottom-up approach to generate knowledge from the ground up. Moreover, it utilizes a top-down approach to further inform cultural adaptations by incorporating theory and maximizing the usage of our extant knowledge base. Although theoretically driven approaches to cultural adaptation provide a strong foundation for tailoring interventions, an integration of bottom- or ground-up community-based approaches can also provide invaluable information by confirming theory-related adaptations, generating ideas or by providing more specificity in the adaptations or examples offered.

Community-based formative approaches to therapy adaptation can also serve as a powerful tool for cultural understanding because they involve consumers (eg, therapist and clients), as well as community stakeholders. Furthermore, this collaborative approach helps clinical researchers because it is beneficial not only for research purposes, but also for helping spark ideas and generating information that is useful for community stakeholders. For example, by participating in focus group discussions, therapists and administrators may develop new ideas and learn from the process, which has the inevitable potential for improving treatment for clients. The FMAP can be used by community service agencies to generate ideas for developing new programming and culturally modifying extant programs as well.

The FMAP consists of five phases: (1) generating knowledge and collaborating with stakeholders, (2) integrating generated information with theory and empirical and clinical knowledge, (3) reviewing the initial culturally adapted clinical intervention with stakeholders and revising the culturally adapted intervention, (4) testing the culturally adapted intervention, and (5) synthesizing knowledge produced by the earlier phases and finalizing the culturally adapted intervention. This iterative approach provides the opportunity to revise and adjust to feedback provided by consumers.



Culturally Adapting Psychotherapy for Asian Heritage Populations.
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This integrative framework builds upon the cultural competency movement by offering specific and practical advice for culturally adapting therapy. It utilizes a multiphase approach to developing adapted interventions. The FMAP can be used not only to generate ideas for therapy adaptation, but also to provide additional support for theoretically identified modifications. It can also help provide therapists with more specific and refined recommendations for increasing therapeutic responsiveness. The FMAP also highlights the importance of providing rationales and justifying why adaptations are being made. It uses an evidence-based approach to confirm the therapeutic benefits of modifications. Information utilized includes extant research and clinical knowledge and insight established in working with community collaborators, stakeholders, and experts in the field. This framework can be used to culturally modify evidence-based practices (EBPs), evidence-based psychological practices (EBPPs), or empirically supported treatments, such as cognitive-behavioral therapy (CBT). Although originally developed with mental health services in mind, the FMAP can also be used to culturally adapt physical health services.

The FMAP was originally developed to help clinical researchers and practitioners generate ideas for systematically adapting treatments. The FMAP was used to develop the culturally adapted treatment manual for depressed Chinese Americans (*Improving Your Mood: A Culturally Responsive and Holistic Approach to Treating Depression in Chinese Americans*) that will be presented later in the book. This treatment manual is a culturally adapted cognitive-behavioral therapy (CA-CBT) treatment for depressed Chinese Americans, a project funded by a National Institutes of Mental Health (NIMH) R34 treatment development and clinical trial grant (Adapting CBT for Chinese Americans, Principal Investigator (PI): Hwang) entitled the "Adapting CBT for Chinese Americans" project.

The treatment manual created by the FMAP was tested against a nonculturally adapted CBT manual in a NIMH-funded clinical trial on empirically supported adapted interventions. It was implemented at two Asian-American-focused community mental health clinics, Asian Pacific Family Center (APFC) in Los Angeles and Richmond Area Multi-Services (RAMS) in San Francisco. Fifty Chinese Americans who met criteria for major depression participated in the randomized controlled trial (RCT) and were randomly assigned to 12 sessions of CBT or CA-CBT (Hwang et al., 2015). The RCT did not influence procedures for prescribing antidepressants and utilized a stratified randomization procedure for patients who were on and not on antidepressants when they first came to the clinic.

The results indicated that clients in the CA-CBT evidenced a greater overall decrease in depressive symptoms than those in CBT (10 Hamilton depression rating scale (HDRS) points compared to 5 HDRS points, respectively). Moreover, participants in CA-CBT evidenced a dropout rate of 7.4% ($n = 2$); whereas, those in CBT evidenced a dropout rate of 26% ($n = 6$). These findings provide initial evidence that cultural adaptations that individualize and tailor treatments for a person's cultural background can confer additional treatment benefits. Please see Hwang et al. (2015) for a more detailed discussion of the research study, methodology, and limitations. Although much more research needs to be conducted in this area, these initial findings also indicate that culturally adapting therapy may be a promising strategy that can help address the needs of diverse populations.

The remainder of this chapter focuses on introducing the different phases of this framework and providing a concrete example of how it was used to develop an evidence-based culturally adapted intervention. By reading about how this intervention was used to inform the adaptation of services for one particular group (ie, Chinese Americans) with major depression, the reader will gain an in-depth understanding of the cultural adaptation process so that they will be better equipped to utilize this framework when adapting treatment for other groups and problems. Therapists who already utilize the CBT theoretical orientation should be able to quickly understand the CBT part of the treatment, and only need to learn how to culturally adapt services. Those who are unfamiliar with CBT may benefit from reviewing a nonadapted manual before reading this book, which will help them better understand what modifications were made. Although the treatment manual provided as part of this book is of a cultural adaptation of CBT, the principles and ways of thinking about cultural adaptations are broad and specific enough to provide the reader with the necessary knowledge to culturally adapt treatment for other theoretical orientations.

Moreover, although this is a culturally adapted CBT manual, the adaptations provided are broader in scope and integrate healing principles from Asian culture, philosophy, and religions that go beyond CBT. The treatment manual is much more holistic than traditional therapies, and many of the cultural adaptations can be applied to other theoretical orientations. In addition, although the treatment was developed for individual psychotherapy for depression, the framework used to develop this culturally adapted treatment should also be able to be applied to other clinical disorders as well as couples, family, or group treatments. Subsequent chapters in this book will teach readers how to use the manual, highlight where cultural adaptations are made, provide rationales for modifications, and discuss how such adaptations can be beneficial across different therapeutic modalities.

PHASE 1: GENERATING KNOWLEDGE AND COLLABORATING WITH STAKEHOLDERS

The first phase of the FMAP focuses on generating knowledge and ideas for cultural adaptation that promote work effectively with diverse clientele. Information is generated by collaborations with consumers and community stakeholders (eg, clients, therapists, administrators, and community representatives). The first step of implementing the FMAP is to decide which stakeholders to involve and when to involve them. The FMAP identifies six main categories of stakeholders, including (1) health and mental healthcare agencies, (2) health and mental healthcare providers, (3) community-based organizations (CBOs) and community leaders, (4) traditional and indigenous healers, (5) spiritual and religious organizations, and (6) current or past clients or patients. The number and type of stakeholders involved may vary depending on funding, the type of services being modified, the timeline allotted for developing the adapted intervention, and the specific characteristics and context of the community you are working with.

In the Adapting CBT for Chinese Americans project, four types of stakeholders were chosen for involvement: (1) ethnic-specific community health service agencies that were Asian-focused (ie, clinics that self-designate as specializing in providing culturally responsive and effective services for Asian Americans), (2) mental health providers (psychologists, social workers, marital family therapists, and psychiatrists), (3) Traditional Chinese Medicine (TCM) practitioners, and (4) spiritual and/or religious Taoist masters and Buddhist monks and nuns. Collaborating with community experts in the field, as well as indigenous healers, can provide valuable feedback for culturally adapting treatment, improving client engagement, and enhancing outcomes.

Because the goal of the Adapting CBT for Chinese Americans project was to create a culturally adapted treatment manual that could be used by community health agencies and their treatment providers, it was essential to involve community clinics that specialize in working with Asian Americans with mental illness. Like many clinical researchers, I had the urge to just sit down and write a culturally adapted treatment manual based on my clinical experiences. Instead, I used the FMAP phase 1 process, which utilizes a community participatory approach, to generate additional insight and information and to reaffirm the validity of those adaptations.

Specifically, I believed a practical and consumer-driven approach to help practitioners who want and need cultural competency to make the shift between cultural awareness and clinical application was needed. Since there are dozens of clinics and therapists that have been working with Asian heritage populations for years, taking advantage of their insider knowledge and experiences would certainly be informative and beneficial. Questions include asking them about how they work with Asian heritage populations, what adaptations they learn to make while on the job, and what they wish they would have learned during their graduate training. Moreover, a community-participatory approach increases the likelihood that the treatment developed would be more likely to be utilized by community clinics and patients. Overall, community-generated programs may have greater credibility because they are seen as being informed by community experts, rather than only by the academic ivory tower perspective. This also helps establish university–community relationships, linkages, trust, faith, involvement, support, and mutual understanding.

COMMUNITY MENTAL HEALTH CLINICS AND TREATMENT PROVIDERS

Collaborations were made with mental health clinics to ensure that the intervention developed would be ecologically valid and could be feasibly implemented in real-world settings (eg, the frequency of sessions, staffing and assignment of caseloads, hours of operation, billing, and financial limitations). Depending on the type of treatment program that you are developing, an important aspect of collaborating with clinics is to ensure that the treatment program is not only effective, but also sustainable within that particular clinic context. For the purposes of our project, we collaborated with seven Asian-focused clinics, two of which served as primary clinical trial sites and five as focus-group collaborators.

Five agencies participated in the focus groups, including Asian Americans for Community Involvement (AACI) in San Jose, Asian Community Mental Health Services (ACMHS) in Oakland, Asian Pacific Counseling and Treatment Center (APCTC) in Los Angeles, Asian Pacific Mental Health Services in Gardena, and Chinatown North Beach Service Center in San Francisco. Several clinics were involved to help ensure that there was a breadth of viewpoints and perspectives, and that agency-specific beliefs, biases, or preferences were not overrepresented. Focus groups were not conducted at clinical trial sites (APFC in Los Angeles and RAMS in San Francisco) to ensure that treatment conditions would not be contaminated and that therapists in both conditions

would not be systematically adapting therapy. Specifically, we needed to randomize the therapists from those sites into CBT and CA-CBT. If the therapists participated in focus group discussions about cultural adaptations, then our ability to disaggregate the effects of the two treatments would be affected and we would run the risk of both interventions being culturally adapted.

We were successful in eliciting the participation of all clinics we approached to collaborate in these focus groups. This was not an easy task given that community clinics sometimes do not want to collaborate with academic institutions since there is a long-standing history of researchers coming into community settings and taking information without giving anything back to the community. However, in our study, we tried to help engage the clinic directors and the therapists and pointed out the direct benefits of the study to the clinic. Specifically, having several hours of focus groups on culturally adapting therapy not only informed the development of a new treatment, but also provided therapists with important training on EBPs and tailoring services for Asian heritage clientele. Moreover, it provided a forum for therapists to connect with each other and share their experiences and strategies when working with Asian heritage populations.

Moreover, I emphasized that I would personally run these focus groups (eg, rather than having postdoctoral fellows or graduate students facilitate them). This also gave me more credibility in the eyes of the community agencies because the PI/Professor would be directly involved in every aspect of the program, which culturally is the most respectful strategy in developing positive collaborations. Moreover, I emphasized that they would be contributing to the first culturally adapted and evidence-based treatment manual for Asian heritage populations, and that I wanted to involve the community in developing this manual because it would be a manual created for them to use—and therefore would benefit from their feedback and involvement.

I conducted 14 focus groups with therapists at these community mental health clinics that were located throughout California. Multiple groups of therapists participated in separate focus groups of the larger clinics. Two sets of 4-h focus group meetings were conducted. Each focus group consisted of two parts. The initial 4 h helped generate ideas for cultural adaptation and the review of a nonadapted CBT manual (phase 1 of the FMAP, generating information) (Miranda et al., 2006). Therapists were asked what they felt about their general impressions using CBT with Asian heritage populations, whether there were particular aspects of CBT that would be most effective or should be retained, and what cultural adaptations or modifications might help improve client engagement and outcomes. In addition to the CBT framework, therapists were also asked about adaptations that could be implemented with other therapeutic orientations, as well as modifications not specific to a particular orientation. The second part of the focus groups involved reviewing the culturally adapted treatment manual and providing feedback (phase 3 of the FMAP, reviewing and revising the culturally adapted intervention).

Focus group therapists were of various Asian heritage backgrounds and were asked for feedback concerning the treatment of Asian heritage populations, as well as Chinese heritage populations. Inclusion of therapists from multiple Asian heritage backgrounds when discussing adaptations helped provide breadth of modification ideas that could potentially generalize to multiple Asian heritage groups. This strategy was utilized because it is unlikely that funding agencies will commit resources to culturally adapting treatments for every single Asian American group. In designing an evidence-based method for adapting services for Chinese Americans, we wanted to identify cultural modifications that would also be beneficial for other groups. Since this was the first RCT conducted comparing an adapted versus nonadapted treatment for an Asian heritage group, utilizing broader strokes for adaptation is more flexible and practical. In the future, more resources should be committed to individualizing and adapting therapy for the unique characteristics of different Asian heritage populations.

Although focus groups can generally be conducted effectively with up to 10 participants, focus groups consisted of 4–6 mental health practitioners. This helped set the stage for richer breadth and depth of discussions. Having fewer therapists gave each participant more time and opportunity to talk about their experiences. This strategy helped facilitate more productive group dialogs about cultural adaptations, which ones they used in their clinical practice, and identify what they wish they would have learned in their graduate training program that they learned on-the-job or through subsequent cultural competency trainings.

TRADITIONAL AND INDIGENOUS MEDICINES, SPIRITUAL LEADERS, AND HEALING METHODS

Since indigenous medicines (eg, TCM) and religions have strongly influenced Chinese and other Asian heritage cultures for thousands of years, interviews were also conducted with several TCM doctors, Buddhist monks, nuns,

and spiritual and religious Taoist masters. Collaborating with traditional healers helped incorporate extant cultural beliefs and strengths that are grounded in client belief systems. These traditional healers also helped the program generate ideas of how Western mental health treatment and traditional medicines can work together to optimize outcomes. It was important to involve cultural healers because these traditions have strongly influenced Asian culture for thousands of years, and have influenced Asian notions of self, health, and well-being. This also provided an opportunity to exchange ideas, build a sense of community, and strengthen referral networks. Knowledge generated from these interviews provided rich insight and knowledge that helped maximize understanding of extant healing practices, and how they interface with Asian cultural customs, traditions, beliefs, and values.

Before conducting the interviews, I did a great deal of research, reading dozens of books and articles about TCM, Buddhism, and Taoism. I was also an Asian studies double major in college, which gave me some background perspective on this topic. Studying these traditions helped with the formulation of salient questions that were greater in depth and complexity. This was more beneficial than trying to interview people without having done the requisite background preparation. This is important because it is a sign of respect to show people that you have done basic preparatory work before meeting them. Otherwise, time is used less efficiently covering simplistic issues and fundamentals that can be gleaned from background readings.

In discussing TCM, we discussed mind–body balance, integrative treatments, holistic strategies, and notions of energy (pronounced qì in Mandarin Chinese—氣). We also discussed the notion of depression in TCM, and how it is seen as a mind–body illness. This parallels the research literature that has examined the culture-bound syndrome known as neurasthenia (pronounced shénjīngshuāiruò in Mandarin Chinese—神經衰弱), which is included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) appendix and the Chinese Classification of Mental Disorders (Chen, 2002). In the remainder of this book, you will notice that when I discuss various cultural concepts, I also provide the Chinese characters. This is important because many Asian heritage languages have a basic root in Chinese characters. By providing these characters, those from other Asian heritage cultures who also utilize or relate to these characters can to some extent understand and read these concepts in their own languages.

We also discussed how Chinese medicine takes a different approach to conceptualizing and treating depression. For example, prescription of medication typically involves multiple pills that target various symptoms. Moreover, meditation and breathing exercises are often implemented and vary depending on the type of depression a person is experiencing. When somebody is suffering from an angry depression, they often have an abundance of fire energy (pronounced huǒqì in Mandarin Chinese—火氣). An overabundance of fire energy can be the result of mistreatment, social turmoil and conflict, or dissatisfaction with relationships. When clients come to the doctor with an angry form of depression, doing more assertive and forceful breathing exercises that involve the entire body should be recommended. These exercises are very similar to more aggressive and bolder styles of kung fu (eg, Tiger style), where the client would be asked to get into a horse stance (similar to a squat), and use their palms to engage their upper body strength and push out their anger while flexing their arm muscles. Clients are told to release their anger and fire Qi, as they expel toxic energy in a cathartic manner and breathe in more relaxing energy.

Clients with more sad, grieving, and low-energy types of depression are told to breathe in a more relaxed, centered, and balanced fashion that helps cultivate energy. Softer movements, similar to those of Tai Chi (pronounced tàijí in Mandarin Chinese—太極) are utilized to help cultivate inner strength and flexibility of thought and action. Tai Chi is a Chinese martial art based on a principle that helps regulate the body, breath, and mind. It is both a physical and meditative exercise. Some TCM doctors who believe in Western psychiatric medications will also refer clients to psychiatric services if the herbal medications and meditational breathing exercises they prescribe are ineffective. Others TCM doctors are unlikely to refer clients to Western mental health treatment because they believe that Chinese medicine in the form of acupuncture, herbs, and mindfully breathing is more effective than Western medication.

Interviews were also conducted with Buddhist monks and nuns to help understand how faith and spirituality intersect with mental illness and its treatment. Buddhism is a polytheistic and nontheistic religion that has influenced Asia since the 5th century BC. Nontheistic religions are traditions of thoughts within religions that serve as guiding philosophical principles that significantly influence cultures. The philosophies underlying these religions often have nonreligious connotations and play a guiding role in influencing cultural values and mores, shaping social behavior, and cultivating principles of living. Other significant components of Buddhism include reaching enlightenment and ending the cycle of suffering and rebirth (Encyclopedia of Buddhism, 2003). Interview discussions also focused on a number of significant topics including karma, the principle of causality where one's intent and actions affect one's future. Karma is associated with the idea of rebirth, with one's positive and negative actions influencing reincarnation, suffering, and enlightenment.

When asked about depression, monks and nuns mentioned how prayer and chanting meditations could help clients relieve stress and feel more centered and balanced. They recommended that people come to the temple to meditate and cultivate mindfulness to help relieve stress, anxiety, and worrisome thoughts. For the more severely mentally ill, they recommended attending retreats or living in the temple for a period of time to have a vacation from modern-day societal stressors, emotional triggers, and to rebalance their focus and energy. People can practice mindfulness by reengaging with life's simple tasks such as sweeping the floor, participating in daily meditation and prayer, and eating simple less processed foods that are low in sugar and oil. Letting go of negative feelings, accepting oneself and one's feelings, as well as accepting the feelings of others are emphasized. They also discussed the importance of understanding how transient life is, and how we must make the most of life and take an active role in problem-solving.

Another significant teachings of Buddhism is the principle of the four noble truths, which include (1) the notion that life contains dukkha or suffering, (2) understanding what causes suffering, (3) that the cessation of suffering is possible, and (4) the path or means to suffering's cessation (Encyclopedia of Buddhism, 2003). Some Asian heritage clients will come to therapy feeling like there is little they can do to end their problems or suffering. They take a very fatalistic attitude and twist Buddhist principles into a form of passive pessimism. For example, they may become hyperfocused on the first noble truth (life is suffering) and feel like there is nothing they can do about it. What I often say to them is that even though Buddha said life is suffering, he did not say to suffer needlessly and take on a helpless and hopeless role. I actively remind them of the three other noble truths, that we must take an active role in understanding why we are suffering, have hope and believe that we have the power to influence and end suffering, and that we can work together in therapy to develop strategies to reduce suffering and solve life's problems. This is also another example of culturally adapting treatment and integrating extant cultural strengths.

Another significant teaching from Buddhism is The Noble Eightfold Path, which is intended to help people cultivate good karma and act wisely and righteously (Bohdi, 1999). Specifically, the paths of (1) right view and (2) right intention are meant to cultivate wisdom. The paths of (3) right speech, (4) right action, and (5) right livelihood are meant to foster morality. And, the paths of (6) right effort, (7) right mindfulness, and (8) right concentration are meant to help increase mental fortitude and concentration. The noble eightfold path is very similar to many principles of psychotherapy. A cultural bridge can be utilized to link philosophical and religious principles to healing mechanisms of therapy, which can be a very effective cultural adaptation.

As part of phase 1 (generating knowledge and information), I also interviewed Taoist Masters to find out more about how they conceptualize and treat mental illness. Taoism has influenced Chinese and other Asian cultures for more than 1500 years. Taoism is also a polytheistic and nontheistic religion that has not only a religious influence, but also a significant impact on Asian culture, philosophy, and beliefs. The Tao, literally meaning "the way," is integrally related to TCM and notions of Qi, or energy. Interviews were conducted with both spiritual and religious Taoist Masters. Spiritual Taoism is associated with principles that guide human behaviors and actions, understanding the world, and having connections with nature. Religious Spiritual Taoism, on the other hand, is associated with ancestor worship, animism, alchemy, and spirits and demons.

The philosophical Taoist leaders discussed the importance of the Tai Chi diagram (pronounced tàijítú in Mandarin Chinese—太極圖), which is symbolic of the balance between male and female energies, light and dark, good and evil, sun and moon, and a healthy lifestyle. They talked about the deeper meanings behind the Tai Chi diagram that people from Asian heritage backgrounds are less familiar with, but may benefit from understanding. Specifically, they discussed that the Tai Chi diagram is a cultural and religious symbol that can help heal mental illness and cultivate inner peace, balance, and awareness. The Masters told me that they oftentimes help people understand the ups and downs of life by teaching about why the line is curvy rather than straight. They also discussed how no matter how good life is something bad will likely happen. Moreover, no matter how bad life is something good can always happen. This symbol can be used to represent balance, promote strength and resilience, understand the transient nature of stress, and help people normalize and accept the ups and downs of life. These are important principles that can be culturally bridged with psychotherapy.

When talking to religious Taoist Masters, I learned about how mental illnesses are associated with spirits and demons. The Taoist master told me that according to Taoism, mental illnesses are caused by a spirit haunting an individual. The master said that some spirits are supposed to be there because of karma and what somebody did in their past life. In those situations she is unable to help remove those spirits. However she said that some people have mental illness that is caused by rogue spirits. Those are cases where she can help heal them by exorcising the spirit. It is important to note that even if therapists do not believe in spirits and karma, many clients from Asian heritage may. Therefore, we have to keep an open mind and be attentive, engaged, ask questions,

and listen in order to facilitate and maintain a positive working alliance. This is an important component of cultural competency, and is one of the domains of the Psychotherapy Adaptation Modification Framework (PAMF) (ie, improve the client–therapist relationship).

PATIENT OR CLIENT FEEDBACK

In addition to treatment providers, patients and/or clients are the primary consumers and main stakeholders. Their involvement in the process can be extremely important because they are the actual recipients of the intervention and can give you experiential feedback and recommendations for improvement. Nevertheless, choosing whether or not to involve clients in the focus groups and development of the culturally religious-adapted CBT treatment was a complicated decision. There are many different advantages and disadvantages of doing so that individual clinicians and investigators need to consider for themselves. In this program, we chose to not include clients in the initial phases of development, and to query their feedback after going through the clinical trial. This decision was influenced by our grant timeline and limitations for developing and testing a treatment within 3 years.

The choice to involve patients for culturally adapting physical health services may be more straightforward and pragmatic than when adapting mental health services. For physical health services, patients are often able to provide very concrete and practical feedback on engagement, satisfaction, improvements, and benefits. However, mental health services can be more complicated, especially for Asian heritage populations where understanding of mental health treatment is typically low, stigma is often high, and previous experience with services is low.

In addition, involving clients in mental health services has some potential disadvantages, especially for Asian heritage populations where issues such as privacy and confidentiality, knowledge about mental illness, and understanding of appropriate and effective treatment may be more limited. Since many depressed Asian heritage clients have little to no exposure to mental health services, they may have minimal ability to differentiate types of treatments offered, nor have a well-informed perspective to discuss how to culturally adapt psychotherapy. In addition, because Asian heritage populations tend to delay help-seeking, they may be more clinically severe and may not be in a good emotional place to provide feedback. Asking clients who are seeking help for the first time to participate in focus groups could also create discomfort, and make clients question or lose confidence in the staff's credibility to help them if staff are asking clients for advice. Even if we let them know that we are trying to improve mental services, this may be seen as a loss of credibility and increases worry about whether the program can help them.

After reflecting upon these issues and talking it over with directors and therapists, we decided not to run focus groups with clients because of concerns regarding confidentiality. We made an active choice not to involve clients in phase 1 of the FMAP. Instead, we preferred to elicit client feedback later in the process, specifically in phases 4 and 5 (eg, understanding and documenting their reactions during the treatment process and conducting exit interviews to help revise and improve the culturally adapted intervention after the clinical trial is over). Conducting individual interviews affords more privacy and helped address confidentiality and HIPAA (Health Insurance Portability and Accountability Act) concerns, but tends to be more time-consuming and may provide less information than group discussions, which can be used to generate insights and build upon ideas.

CBOs AND COMMUNITY LEADERS

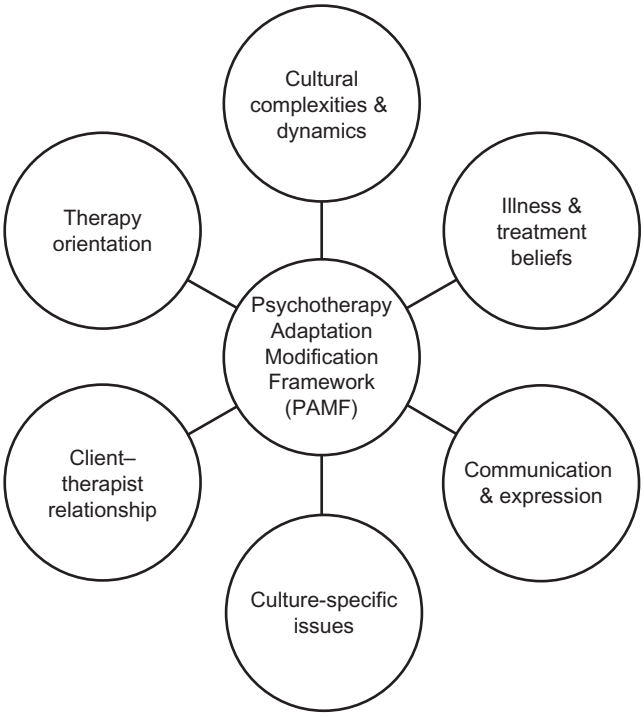
Collaborating with community leaders and CBOs can also be beneficial in developing community-informed treatments. CBOs are local nonprofit organizations that serve as a resource and provide services to the community (Sweeney & Knudsen, 2014). These services include health and mental health education, social welfare, and services for those who are disadvantaged. CBOs typically involve the community and its citizens in developing programs and services.

In this study, the community health agencies that we worked with were community-based mental health organizations (Sweeney & Knudsen, 2014). We also worked with the directors of these agencies in implementing the programs, but chose not to run focus groups with nonagency community leaders because of time constraints. Nevertheless, it may be advantageous to work with a variety of nonclinic community leaders in developing culturally adapted programs. This may be less beneficial for the actual treatment development, but especially beneficial for issues such as community engagement, help-seeking, prevention efforts, and reducing barriers to

care. In developing programs that are likely to be disseminated nationwide, running focus groups with national experts and leaders in the field may be especially beneficial. This would help address systematic issues and barriers that cut across multiple communities, which could help facilitate implementation.

PHASE 2: INTEGRATING GENERATED INFORMATION WITH THEORY AND EMPIRICAL AND CLINICAL KNOWLEDGE

The second phase of the FMAP focuses on combining the information generated in phase 1 with extant empirical and clinical knowledge (eg, reviewing the current research base, as well as knowledge generated from clinical experience and case studies). For the Adapting CBT for Chinese Americans project, this involved integrating what we learned from the focus groups with theory and published research. It is important to note that I developed a top-down and theoretically driven approach to culturally adapting therapy prior to developing the community participatory and bottom-up FMAP. This theoretically driven framework called the PAMF was the first framework that I developed for understanding and conceptualizing how to think about cultural adaptations (Hwang, 2006). The FMAP was developed later and named by reversing the acronym of the PAMF to accentuate the integration of top-down and bottom-up approaches. Published in 2006 in the *American Psychologist* (the flagship journal of the American Psychological Association (APA)), the PAMF was one of the first comprehensive and practical frameworks for culturally adapting therapy (see the figure below).



The PAMF is a three-tiered approach to therapy adaptations (ie, domains, principles, and rationales) and was developed to help identify areas that can be targeted for adaptation, while providing rationales for increasing the credibility of said modifications. It was developed to help practitioners make the shift from the more abstract notion of being culturally competent to more concrete and specific skills in order to effectively work with diverse clientele. This three-tiered approach to cultural adaptations was developed in order to make the PAMF more accessible, user-friendly, and adaptable for use with other diverse populations. Existing research and clinical knowledge are used to drive adaptations.

The first-tier "domains" of the PAMF include: (1) understanding dynamic issues and cultural complexities, (2) orienting clients to psychotherapy and increasing mental health awareness, (3) understanding cultural beliefs about mental illness, its causes, and what constitutes appropriate treatment, (4) improving the client–therapist

relationship, (5) understanding cultural differences in communication as well as the expression and experience of distress, and (6) addressing cultural issues specific to the population, addressing culture-specific issues such as acculturative-family distancing (Hwang, Wood, & Fujimoto, 2010), problems in parent–child relationships influenced by intergenerational communication difficulties and discrepancies in cultural values that are exacerbated by growing up in different countries. Broader domains identify general areas that practitioners should think about when modifying their approach for treating their clients.

The second-tier "principles" are more detailed recommendations for culturally adapting therapy that offer more concrete and specific advice. "Corresponding rationales" are the third tier and consist of explanations for why these adaptations may be effective, helping the practitioner understand why some of these modifications can be beneficial, and should be based on research and clinical evidence (Hwang, 2006, 2009; Hwang, Wood, Lin, & Cheung, 2006). During the initial conceptualization of the PAMF, 25 therapeutic principles were offered as practical ways to culturally adapt therapy for Asian heritage populations (Hwang, 2006). After the development of the FMAP, and as we continued to expand upon our knowledge after the clinical trial started, a number of additional therapeutic principles and corresponding rationales were offered (ie, an expansion from the original 25 principles to 48 principles) (Hwang, 2009).

The NIMH R34 grant is an intervention and treatment development grant, and therefore was the ideal funding mechanism for the Adapting CBT for Chinese Americans project. The PAMF was written into the NIMH R34 grant to help show the grant reviewers that we had an evidence-based, conceptual, and theoretically driven framework that would guide cultural adaptations. Because pilot data are often important for getting funding, projects that do not have pilot data really need to have a strong theoretical foundation and plan put in place to demonstrate scientific feasibility and validity.

The PAMF was created to help support the EBPPs movement, and also serves as an important step in helping to develop evidence-based therapies (EBTs) and manualized treatments. It was created to help support the cultural competency movement, as well as help push the field ahead by improving the science of developing culturally adapted EBTs. Adapting treatments to address issues broadly and deeply is especially important because it will help increase the ecological validity of Western psychotherapies when used to treat culturally diverse clientele. It is top-down in the sense that it is theory-driven and utilizes information about the culture of interest to inform and generate ideas for therapy adaptation, provide additional support for theoretically identified modifications, as well as to help flush out and provide more specific and refined recommendations for increasing therapeutic responsiveness.

When working with different populations, practitioners make individual adjustments and modifications to work best with their clients (Hwang, 2006; Hwang et al., 2006). Although the application of the PAMF was first published by using Asian heritage populations as an illustrative example, this framework can be applied to other heritage groups and serve as a guideline to inform adaptations. The PAMF can also be modified and expanded across the three tiers. For example, if you want to use a framework to modify therapy for another group, you can increase the number of domains and expand upon the principles, as well as justify the adaptations with an evidence-based and clinically sound rationale. When adapting therapy, a top-down theoretically driven approach that utilizes the PAMF can be beneficial to provide structure and meaning to adaptations.

The PAMF was explicitly integrated into phases 2 and 5 of the FMAP to generate and integrate extant knowledge with information generated from bottom-up processes. During phase 2, information was integrated with knowledge generated by focus group discussions and to facilitate the development of the culturally adapted intervention. Information generated from our community-therapist focus groups was synthesized with the PAMF framework, extant theories, empirically supported therapy literature, my previous experience conducting therapy in a variety of community-based settings, and my ongoing private practice experience.

The goal of a top-down and guided framework is to integrate the collective knowledge of practitioners and researchers to target areas where adaptations may be most beneficial and effective. In addition, it was developed to help practitioners thoroughly think through the reasons why they were making specific adaptations and to support these modifications with previous knowledge and cultural reasoning. It is important to note that many practitioners in the field have tremendous knowledge and experience in working with different cultural groups. Therapists are encouraged to use this collective knowledge in conjunction with their clinical style to individualize treatments for their clients. For beginning clinicians, the PAMF can support skill development in working with ethnically diverse clients.

As a theoretically driven framework, the PAMF can also be integrated in phase 5, which focuses on synthesizing insight generated by the earlier phases and finalizing the culturally adapted intervention. Specifically, after the clinical trial is over, the number of cultural adaptation principles can be further expanded and this

information can be utilized to revise and create a new edition of the treatment manual. It is important to note that using the knowledge gained through the top-down and bottom-up processes can be very informative in revising and improving culture-adapted treatments in an iterative fashion. The information generated as part of the FMAP approach can also be used to strengthen the original knowledge base, thus creating a dynamic feedback loop and interplay between new and existing knowledge. The PAMF and FMAP are unique adaptation frameworks that can guide adaptations, provide an evidence-base for modifications, and offer clinical heuristics on how to work with Asian heritage populations. Although a therapeutic framework, such as the PAMF, may aid in identifying salient issues and providing initial suggestions, it only serves as a starting point and utilizing the entire FMAP process can help develop additional ideas and validate adaptations generated.

Outside of research, the PAMF can be used by educators as an overview for introducing students and clinicians to areas that are important to address in the clinical setting. Educators and practitioners alike could then move toward more in-depth training, discuss any possibilities for further improvements, and focus on implementing what they have discussed (eg, how to do a therapy orientation, brainstorm suggestions for cultural bridging, how best to integrate indigenous beliefs about healing with treatment, and how to improve the client–therapist relationship).

PHASE 3: REVIEWING THE INITIAL CULTURALLY ADAPTED CLINICAL INTERVENTION WITH STAKEHOLDERS AND REVISING THE CULTURALLY ADAPTED INTERVENTION

The third phase of the FMAP involves having consumers and/or stakeholders review the culturally adapted intervention, make suggestions for improvements, and affirm whether cultural modifications are beneficial and sound. In the Adapting CBT for Chinese Americans project, another 4-h focus group that focused on reviewing the culturally adapted intervention was solicited from the same therapists who participated in phase 1 focus groups. The culturally adapted treatment manual was titled *Improving Your Mood: A Culturally Responsive and Holistic Approach to Treating Depression in Chinese Americans* (Hwang, 2008a, 2008b), and is a 12-session evidence-based and manualized treatment.

Therapists were very enthusiastic about the project and excited to help in the development of the first culturally adapted Asian heritage intervention. After careful review and discussion, therapists unanimously agreed that the culturally adapted intervention would be effective in treating depressed Chinese Americans and was an improvement over nonadapted CBT. Discussions during the focus group were largely confirmatory and the therapists agreed that the cultural modifications aligned well with Chinese American beliefs, as well as Asian heritage cultural values. Due to time constraints, TCM doctors, Buddhist monks and nuns, and spiritual and religious Taoist Masters were not reinterviewed, nor provided the culturally adapted intervention for review. However, projects that have longer timeframes and larger budgets may benefit from taking more time and seeing what additional feedback traditional healers can provide. Since they are less likely to have experience with psychological treatments, if one were to have them review the adapted intervention, then the best strategy would be to provide both the adapted and nonadapted intervention so that they can compare and contrast.

Because of time restrictions, the Chinese language version was not provided to therapists during the second set of focus groups. Nevertheless, the therapists discussed linguistic issues to help ensure that the phrasing of ideas, words, and concepts would translate properly into different Chinese languages. Although the initial version of the treatment manual was written in English, the manual was written with translations in Chinese in mind (the primary author was trilingual in English, Mandarin, and Taiwanese). This helped strengthen language equivalence across different language versions. In addition, the manual was eventually written in both simplified and complex characters, which are utilized in different Chinese-speaking countries (eg, complex characters in Hong Kong and Taiwan and simplified characters in mainland China).

The intervention was translated and back-translated by a team of four master's level therapists, one postdoctoral fellow and the primary author to help ensure semantic, linguistic, and conceptual equivalence. In addition, feedback from 15 bilingual undergraduate students, 3 master's level therapists, 1 postdoctoral fellow, and 4 graduate students was elicited. Because there are regional differences in how Chinese is written and spoken, the large number of people involved in the translation process and review helped ensure cross-region comprehensibility from different Chinese heritage countries and regions (eg, Mainland China, Taiwan, and Hong Kong). Although we did not create different Chinese language versions for the numerous Chinese languages

and dialects, the written Chinese character version that we created was comprehensible by the over two dozen people involved in the translation process. Both the CA-CBT manual and the CBT manual were translated by the research team.

Regarding Chinese languages, over 15% of the world speaks a Chinese heritage language (Lewis, Simons, & Fennig, 2014). Mandarin Chinese unifies the country under one formal language. Almost every province and major city in China has its own Chinese dialect/language, resulting in dozens of mutually incomprehensible spoken languages. There are 34 regions in China, which are divided into 22 provinces, 4 municipalities, 5 autonomous regions, and 2 special administrative regions, as well as the claim to province or country of Taiwan (The Central People's Government of the People's Republic of China, 2013). Depending on the linguistic classification system, there are 7–17 main Chinese root language lineages or groupings, with each of these root languages containing a few to several additional dialects.

The root languages tend to be mutually incomprehensible; whereas, the dialects within their root languages tend to sound similar and are more mutually comprehensible. Mandarin Chinese is the youngest of the Chinese languages. In fact, if you read historical Chinese stories and poems, they are typically written using one of China's older languages (one of the other 7–17 root languages). The Chinese languages are linked to some extent by the written meaning of the Chinese character system. Chinese characters are categorized into the historical complex characters (used by Hong Kong and Taiwan) and the newer simplified characters (used by mainland China). The only difference between complex and simplified characters is the number of strokes and intricacies of the characters. Mainland China's version of Mandarin is the only language in the Chinese language family written in the simplified character system. The Chinese character system links all of these different languages. However, the character order and representations may differ.

PHASE 4: TESTING THE CULTURALLY ADAPTED INTERVENTION

The fourth phase of the FMAP involves testing the culturally adapted intervention to determine whether it is ecologically valid, engages clients, and improves clinical outcomes. A RCT was conducted at two ethnic-specific service agencies, the APFC in Los Angeles and the RAMS in San Francisco. These are the two largest ethnic-specific service agencies in the US that focus on Asian heritage populations, and also the only two that are APA-accredited predoctoral internship sites. These are also the two sites where focus groups were not conducted so that the clinical trial treatment conditions would not be contaminated.

Because the clinical trial was conducted in the community mental health setting, it is a hybrid between an efficacy study and an effectiveness study, with a greater focus on effectiveness. This is critical since the efficacy–effectiveness debate has shown that most efficacy trials conducted at universities and research hospitals (ie, the laboratory setting) are not as effective when tested in real-world clinics (Lambert & Ogles, 1994; Weisz, Donenberg, Han, & Kauneckis, 1995). Efficacy trials typically constrain the type of people who can be enrolled in the trial (eg, screening for individuals who have no comorbid disorders) and utilize staff who have smaller caseloads and more supervision than what is typically provided in the community. Moreover, efficacy trials are often located in wealthier neighborhoods, and the social economic status of the participants tends to be higher than those who seek help in the community. Community clinics tend to have more variability among their patients, both in terms of psychiatric symptomatology, comorbid disorders and social economic status. As a result, effectiveness trials are much more difficult to implement.

Because the focus of the Culturally Adapting Therapy for Chinese Americans project is on developing an ecologically valid and effective intervention, we did not run the clinical trial at a university or research hospital. By directly working with ethnic-specific community mental health clinics and practitioners, this study circumvented many aspects of the efficacy–effectiveness debate. The clinical trial accepted patients with comorbid conditions, as long as those conditions would not be better addressed by an evidence-based treatment manual that targets those specific problems. Specifically, we excluded clients who had psychotic disorder, bipolar, or a primary substance abuse problem.

A RCT methodology was used to test the trial's effectiveness (Hwang et al., 2015). The assessments were conducted at baseline and sessions 4, 8, and 12 of treatment, as well as 3 months posttreatment. In addition, a variety of clinical outcome measures from clients, therapists, and independent assessors were used to assess symptom reduction, treatment satisfaction, premature dropout, working alliance formation, and attitudes toward psychotherapy. Therapy sessions were recorded so that they could be coded for treatment fidelity (adherence,

receipt, and enactment of treatment), and therapists and clients were also asked to self-report on treatment adherence. Therapists in both conditions received 12 h of training on either CBT or CA-CBT, followed by weekly group supervision by the author of the culturally adapted intervention.

Because the NIMH R34 grant is a treatment development grant, having one supervisor supervise both treatment conditions was deemed the best option. This process allowed the author of the treatment manual to gain invaluable knowledge from supervising therapists in both conditions. This allowed the author to compare and contrast the therapist experiences and difficulties in supervising adapted compared to nonadapted interventions, understand what struggles therapists experience while trying to implement each intervention, and also gain insight on how to further refine the culturally adapted intervention. Although having one supervisor for both conditions could potentially lead to allegiance biases, the use of different supervisors could also lead to a supervisor effect that would be impossible to disaggregate (ie, if a differential effect was found, this could be a result of supervisor differences such as age, gender, experience, and effectiveness).

The author of the culturally adapted intervention was well-trained in the CBT manual that served as the comparison treatment in the clinical trial. He was previously trained and supervised on how to use the nonadapted CBT manual by its author (ie, Miranda, J.), who offered high-quality training since she wrote the nonadapted manual. The nonadapted CBT manual, "Cognitive behavioral therapy for depression—Thoughts, actions, people and your mood" is a widely used 12-session manualized treatment for depression (Miranda et al., 2006). Various versions of this manual has been shown to be effective for treating depression in African Americans, Latinos, and White clients in a variety of clinical settings (Miranda, Azocar, Organista, Dwyer, & Areane, 2003; Miranda, Chung et al., 2003; Miranda, Duan, et al., 2003; Munoz & Mendelson, 2005; Sherbourne et al., 2001).

Although strictures were put in place to not systematically adapt the CBT condition (eg, therapists were not allowed to participate in the focus groups or look at the CA-CBT manual), the therapists, as well as the supervisor, may have inherently made some cultural modifications to CBT (eg, they had experience working in ethnic-specific clinics that are known for providing culturally sensitive or competent care). In addition, the supervisor also implemented the strictures upon himself not to volunteer information on how to culturally adapt therapy or utilize culture-adapted interventions from the treatment manual.

As mentioned in prior chapters, the testing of a culturally adapted intervention with a nonadapted intervention is not really a true test of modified versus nonmodified treatments. This is because even nonadapted interventions include some cultural adaptations. The more accurate framing of the comparison is really between systematic and unsystematic adaptations, or surface structure versus deep structural adaptations. Therapists cannot truly prevent themselves from making no adaptations because the goal of psychotherapy is to individualize therapy for clients. Telling therapists not to make any modifications is putting them in an ethically precarious place and perhaps even violating their professional responsibilities (American Psychological Association, 2010; American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006; Bernal & Domenech Rodríguez, 2012). Specifically, all therapy to some extent is culturally adapted and individualized to meet the needs of clients.

PHASE 5: SYNTHESIZING KNOWLEDGE PRODUCED BY THE EARLIER PHASES AND FINALIZING THE CULTURALLY ADAPTED INTERVENTION

Phase 5 of the FMAP involves synthesizing all of the information generated throughout the different phases of the project and utilizing the insight and knowledge gained to further refine and modify treatment. It is important to note that an evidence-based approach to culturally adapting interventions should be iterative in nature, involving multiple rounds of revision and further revision to maximize the cultural effectiveness of the intervention. The culmination of knowledge and information gathered from conducting the clinical trial are both vital to developing an ecologically valid and effective treatment.

In the Culturally Adapting CBT for Chinese Americans project, therapists and clients participated in exit interviews and filled out questionnaires regarding their experiences while in the program. Therapists discussed and gave feedback on both the adapted intervention and standard CBT. Therapists were asked both individually and as a group about the difficulties in implementing their respective interventions, client reactions to various aspects of treatment, and areas for improvement. Clients also talked about their experiences of being in psychotherapy and were queried on their experiences with the respective treatment manuals. Specifically, clients who finished the treatment were asked about their experiences, what they found useful, what they did not like, and their recommendations for improving the treatment.

Clients were also asked to discuss whether the program helped them feel less depressed and more effective in dealing with their life problems. Therapists were asked whether they felt the program helped their client's feel less depressed and deal with their life problems. Moreover, both groups were asked to provide feedback on what aspects of the program are most beneficial and also asked for recommendations for improving the program.

Much of this information is still being processed and analyzed for potential areas of further modification. Moreover, we audio-recorded all of the therapy sessions for clients treated with both CBT and CA-CBT. Hundreds of hours of therapy are currently being transcribed and translated into English for further analysis. Because it is incredibly difficult to staff and find research assistants who are able to type in Chinese characters, this has become a lengthy endeavor. Nevertheless, we hope the insight provided by coding and reviewing the therapy process from both interventions will provide further insight on how to culturally modify and adapt psychotherapy.

This information is likely to be richer and more detailed, and provide different insight then self-reported feedback from clients and therapists, which is more likely to be influenced by each particular person's level of awareness, the amount of thought they put into it, and what they were willing to tell the clinical assessors or the PI while filling out exit interviews and participating in exit discussions. Eventually, the PI will consolidate all of this information along with his experiences supervising both treatment conditions to further revise and finalize the treatment manual. Rationales and sources for adaptations will be made explicit (eg, whether the modifications are supported by theory, research, prior clinical knowledge, or information generated from the FMAP clinical trial).

As the field of culture-adapted therapy moves forward, we need to ensure that these movements are clinically informed, theoretically grounded, systematic, and empirically driven. Although researchers complain that clinicians are too slow to adopt EBTs, some clinicians argue that narrow diagnosis-specific treatments tested in rigorously controlled laboratory conditions have limited clinical utility when used with real-world complexities and comorbid conditions (Goodheart, 2006). More work needs to be done to ensure that our treatments are clinically informed, scientifically grounded, and sufficiently capture the cultural complexities involved with treating America's diversifying population (Comas-Diaz, 2006).

It is important to underscore that there is no shortcut to becoming culturally competent and that learning to work effectively with diverse clientele is a complex process that takes time, commitment, and hard work. Moreover, learning how to use group knowledge to effectively inform and individualize treatment requires the therapist to have sufficient knowledge of that group, cognitive flexibility, introspection, clinical experience, and willingness to consult with supervisors or colleagues. Because it is difficult for practitioners to know whether they are responding to a client in a culturally sensitive manner or whether they are influenced by their own biases, ongoing training, consultation, and hypothesis-testing are essential in the search for cultural competence.

Additionally, we also need to think about how to empirically validate which changes lead to better outcomes, and how to measure these changes. Researchers will need to think critically about how to disaggregate the effects of traditional (eg, working alliance, prior treatments, current medications) and cultural (eg, introduction of cultural bridges, cultural metaphors, more direct therapy orientations, improved cultural competence of the clinician) intervention mechanisms. In addition, widely used definitions of outcome may have to be expanded to include not only symptom reduction, but also different aspects of treatment engagement and other outcomes such as premature dropout, functional disability, client satisfaction, treatment adherence, knowledge, attitude, and belief in the treatment. Since modifications along all of the cultural adaptation domains may not be equally beneficial, dismantling studies could be used to determine which adaptations are most important in facilitating change.

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