CHAPTER

5

Introduction to the Manual and Understanding Cultural Complexities

Unless we know ourselves and our history, and other people and their history, there is really no way that we can really have a positive kind of interaction where there is real understanding.—***Yuri Kochiyama (Japanese American Human Rights Activist; 1921–2014)***

The goal of the subsequent chapters is to introduce the culturally adapted cognitive-behavioral therapy (CBT) for depressed Chinese Americans manual entitled, "Improving your mood: A culturally responsive and holistic approach to treating depression in Chinese Americans" (Hwang, 2008a). As previously mentioned, this manual was originally developed and funded by the National Institute of Mental Health (NIMH) grant to be the first study to culturally adapt an evidence-based treatment (EBT) for an Asian American group. Specifically, the project compared the treatment effectiveness of CBT against Culturally Adapted CBT (CA-CBT). Both treatment manuals utilized in the randomized controlled trial consisted of 12 sessions of psychotherapy (Hwang et al., 2015). The manual is intended to have flexibility in usage, and there is much more room for tailoring and adjusting the tempo of implementation when not used in a clinical trial format (eg, spending more time for each session, spending more than one meeting for each session, repeating various sessions, and utilizing select components from each session).

The 12 sessions of the manual include: session 1 (Understanding how this program can help you take control of your emotions), session 2 (Understanding how depression can negatively influence your life), session 3 (Defining and visualizing your goals), session 4 (Practicing behavioral strengthening: Effective problem-solving), session 5 (Practicing behavioral strengthening: Improving your communication skills), session 6 (Practicing cognitive strengthening: Understanding unhealthy thinking patterns), session 7 (Practicing mental strengthening: Learning effective thinking strategies), session 8 (Practicing internal strengthening: Engaging in healthy activities), session 9 (Practicing internal strengthening: Managing your stress through relaxation training), session 10 (Practicing emotional strengthening: Principles of everyday healthy living), session 11 (Strengthening family relationships), and session 12 (Reflecting upon our journey and planning the road ahead).

In addition, there were originally client and therapist versions of the manual (Hwang, 2008a, 2008b). The therapist version of the manual was a brief overview of the program including a compilation of readings related to cultural mental health and adapting psychotherapy. This book replaces the therapist manual and all of the materials in the therapist version have already been reviewed and expanded upon in this book. This book also includes recommendations based on therapist discussions during the clinical trial and recommendations from my clinical experiences. The client manual is included with the purchase of this book. The client treatment manual includes an English version and two written Chinese versions (one in simplified and the other in traditional Chinese characters).

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UTILIZING THE MANUAL FOR RESEARCH AND CLINICAL PURPOSES

This treatment manual can be used by practitioners to engage clients who are clinically depressed. It can also be used by scientist-practitioners who want to conduct treatment outcome research with Asian heritage populations. Although the manual was written primarily with Chinese heritage populations in mind, it can potentially be used and modified for other Asian heritage populations. Many of the cultural adaptation strategies that were integrated in the manual are broader issues that are relevant to many Asian heritage groups. Moreover, principles from the manual can potentially be used with non-Asian heritage populations who are from collectivistic cultural backgrounds and who might have similar therapy experiences as Asian heritage populations.

Different sections or components of the manual can also be used with White or European Americans (eg, therapy orientations, various worksheets, and therapeutic metaphors). The rationale here is that treatments developed for White populations have been applied to many ethnocultural groups and have been assumed to be generalizable. Although I am not making the same assumption, I encourage practitioners to utilize and individualize components of the manual for their clients if they feel like they might be beneficial. I have used components of the manual in my private practice with clients from various backgrounds, and they have found them useful and effective. Treatment manuals developed for various populations can have cultural-universal and culture-specific therapeutic components. Expanding our research and tailoring mental health services for various populations can help us better identify what the cultural-universal components are, as well as tailor services for specific groups. For example, many traditions and healing practices are becoming more commonplace and popular because of their therapeutic value in the West (eg, yoga, Tai Chi, acupuncture, and Traditional Chinese Medicine).

If you are using the treatment manual for a clinical trial, you may want to refrain from altering the treatment so that the results can be compared to those of other clinical trials using the same 12-session format. Specifically, in evaluating the effectiveness for research purposes, it is important to keep the treatment intact and retain core elements. However, this does not mean that sessions should be implemented in a robotic manner, and therapist individuality and clinical instincts should not be ignored and incorporated when using the manual. It is important to note that when utilizing a treatment manual, therapists do not necessarily have to lose their individuality, clinical identity, or ability to tailor or modify treatments for the patient. Although there is not enough space to provide a general review on how to effectively use treatment manuals, it is important to maintain clinical flexibility when utilizing an EBT manual. At the same time, it is also important to retain the core therapeutic and session elements.

One potential modification that may be beneficial, which we learned after completing the clinical trial, is that it may be beneficial to have multiple meetings with clients to cover sessions that contain denser material or skills that may take longer to master (eg, session 5 of the treatment manual, which focuses on improving communication). One possibility is to take a less time pressured approach to completing the 12 sessions, and complete them in 16–20 sessions. As long as all 12 sessions are covered, the treatment may still be considered intact, but extended in length. Moreover, if the investigators have another manual that is 16 or 20 sessions in length, then the adapting CBT manual can also be flexibility extended to those lengths for a more equitable comparison.

In the adapting CBT for Chinese Americans clinical trial, therapists were trained on how to use the treatment manual during a 2-day 12-h workshop, and also provided weekly ongoing group supervision. Training times were equivalent for therapists in the CA-CBT condition as well as the CBT condition. However, as mentioned in chapter "What Do We Mean by Culturally Adapting Psychotherapy?" there are some methodological biases in taking this approach because those therapists who were trained for the CBT condition are likely to have received some nonadapted therapy training for their entire clinical careers (as well as even more training in CBT if that is their primary theoretical orientation). However, therapists in the CA-CBT condition were exposed to a culturally adapted treatment (ie, CA-CBT) for the first time. This may lead to an imbalance in level of experience and training associated with adapted versus nonadapted treatments. Because of these biases, and depending on whether the therapists in your particular study have had previous experience with CBT, you may want to provide training sessions of different durations for therapists in each treatment condition as a counterbalancing strategy, especially if ongoing weekly supervision is not provided throughout the clinical trial.

If therapists are not using the treatment manual in a clinical trial situation, they are free to flexibly use the manual and tailor it to their client's needs. For example, therapists can utilize the current manual as-is, or select sessions that may be more relevant for the client. Moreover, therapists can also hand-pick which worksheets to utilize, and what metaphors, teachings, and clinical skills to use with clients. And, of course, therapists can also tailor the treatment manual and spend more time covering or repeating various sessions depending on the client's clinical needs and familiarity with therapy.

Therapists should provide the client with a physical copy of the client version of the treatment manual. This is recommended in a clinical trial setting or if you are going to be using the treatment manual intact, but can also be beneficial in a private practice setting. Having a manual in hand can provide more structure and help reduce ambiguity about the treatment process for Asian heritage clients, who may be less familiar with therapy. If therapists are only using certain components of the manual, then they are free to photocopy and use whatever sections or worksheets that they feel may be beneficial to their clients.

INTRODUCTION TO CULTURAL ADAPTATIONS

The remaining chapters in the book focus on how to use and guide clients through each session of the treatment manual. In addition, the various cultural adaptations that were implemented are also highlighted. Readers may want to read each chapter with a copy of the treatment manual in front of them to better contextualize each chapter's discussion and to visualize what is being referred to in the book. When discussing each of the cultural adaptations, I will relate the modifications back to the domains of the Psychotherapy Adaptation and Modification Framework (PAMF), highlight the therapeutic principles involved, and explain the rationale for making such adaptations. Reiterated here, the six domains of the PAMF include:

- Domain 1: Dynamic issues and cultural complexities;
- Domain 2: Treatment orientation and increasing mental health awareness;
- Domain 3: Cultural beliefs about mental illness and its treatment;
- Domain 4: Client–therapist relationship;
- Domain 5: Cultural differences in expression and communication;
- Domain 6: Culture-specific issues.

One issue to keep in mind when thinking about cultural adaptation domains is that modifications made in one area can potentially be beneficial for another area. For example, if a practitioner provides a thorough therapy orientation (Domain 1), this is also likely to help improve the client–therapist relationship (Domain 4). Therefore, targeted cultural adaptations in one domain can have multiplicative or synergistic effects with other domains, thus enhancing engagement and outcomes. For the remainder of this chapter, I will focus on introducing some basic cultural adaptations that were implemented throughout the manual. However, the major focus will be on discussing dynamic issues and cultural complexities (ie, PAMF Domain 1) involved in working with diverse clientele. Although it is impossible for any one chapter or book to comprehensively discuss these complexities, the following are some important issues to keep in mind when working with diverse populations.

BECOMING A CULTURALLY COMPETENT THERAPIST: NAVIGATING AND UNDERSTANDING CULTURAL COMPLEXITIES

The first domain of the PAMF involves understanding and addressing cultural complexities and dynamic issues. This is one of the most difficult issues to address because one's culture affects both intra- and interpersonal processes. Moreover, our brains are cognitively and genetically programmed to try to simplify and categorize the information that we encounter (Fiske, 1998). Part of this may be associated with increasing our processing speed and strategies to make sense of a complex world quickly. There are also a number of cognitive theories that suggest that when it comes to categorizing and processing information related to race our natural predisposition is to form stereotypes and generalizations (Sidanius & Pratto, 2001). Although these cognitive processes may increase our processing speed, they do not necessarily help us become more culturally competent or effective, nor do they increase the accuracy or validity of our clinical-cultural interpretations of the client or therapy interactions.

There are many types of cultural complexities that influence the therapeutic process. Specifically, providing culturally competent and effective care is a complicated task, which requires a good deal of effort, openness, and self-reflection. Sue (1998) cautioned us against the dangers associated with cultural stereotyping when working with diverse populations. He raised the cultural complexity of dynamic sizing, or the ability to know when to generalize and when to flexibly individualize treatments based on the client's individual characteristics. This is an important skill to learn if practitioners are to be culturally competent without stereotyping their clients

(Sue, 1998). Those trying to become more culturally competent may inadvertently take general recommendations to heart, apply what they have learned rigidly, and not consider the diversity and variation of people within each cultural group.

Many clients that I have worked with have had difficulty with therapists stereotyping and making them feel uncomfortable. For example, one client indicated that her therapist was generally very helpful, but made her feel uncomfortable at times because he or she stereotyped her by saying that education is really important for Asians. Sometimes, these statements originate from the therapists' desire to show the client that they are informed about the client's cultural background. However, this is driven by the therapist's own ethnocultural countertransference. The client also noted that it felt like the therapist was trying too hard and wanted to prove they knew something about Asians, and the end result was an oversimplification and ignoring of her personal needs and identity. Even if it is true that education is important to Asian culture, few people like to be stereotyped. As an alternative strategy, I would recommend evaluating and considering the relevance of cultural information, but only presenting it in the form of individualized statements such as, "It seems like education is really important for you and your family." Individualized statements can prevent clients from feeling hurt and offended. They can also help clients feel like the therapist understands and is providing a treatment that is tailored for them and their problems.

Although some clients may not be offended by stereotyped statements, some clients may, and it is better to take a more conservative approach when making group-specific statements. Therapists are not always in the position to accurately assess what the client's reactions to racial or cultural issues such as this will be. I would recommend not making any culturally laden statements about any aspect of the client's cultural background (eg, ethnic, gender, sexual orientation, or otherwise). I would say that the only exception to this rule is when you are trying to destigmatize mental illness and its treatment to help engage clients, make them feel more comfortable, and to reduce treatment failure. For example, if a particular client is struggling with stigma and being in treatment because others in their community may look down upon the client, then saying to the client, "I know there is a lot of stigma associated with mental illness and its treatment in Asian culture. I'm really glad that you came in for help. It takes a lot of strength and courage to do what's right and to effectively address the problems we face" can be beneficial.

Of course, it is also hard to write about cultural issues without making any stereotypical statements or drawing conclusions about some cultural or group differences. It is important to keep in mind that as you read this book many statements will be made about Asian heritage populations. These are not meant to be stereotyped, but rather to highlight potential cultural issues that need to be considered. This is not meant to replace our clinical-cultural skills, which help us to contextualize group information and evaluate individual differences. Readers will need to assess whether these statements apply to your particular client. In doing so, treatment providers will need to assess various individual, cultural, and clinical complexities that interact and synergize. Moreover, it is also important to keep in mind that no one book can address all of the complexities involved during the treatment process. Application of the materials presented in the treatment manual can be very beneficial, but not in the absence of good clinical skills, which in reality does require cultural competency and the ability to individualize and tailor treatments for particular clients. Effective clinical skills cannot exist without cultural competency.

CLIENTS HAVE COMPLEX CULTURAL IDENTITIES

Another important cultural complexity was highlighted by Hays (2001) in her ADDRESSING framework for understanding the multiple and interacting group memberships and identities that we hold. She highlighted that individuals hold multiple interacting group memberships and identities, not just a racial identity. She pointed out that we have multifaceted personalities, and that culture, race, and ethnicity are only one aspect of how we see ourselves. Unfortunately, sometimes we tend to overweight issues of race and ethnicity and underweight other aspects of our identity. It is important not to make assumptions about which aspects of the client's identity are most important. Other aspects of identity include:

- (A) age and generational influences;
- (D) developmental or acquired disabilities (D);
- (R) religion and spiritual orientation;
- (E) ethnicity;

- (S) socioeconomic status;
- (S) sexual orientation;
- (I) indigenous heritage;
- (N) national origin; and
- (G) gender.

This framework calls attention to dynamic cultural influences that professionals should consider when working with diverse populations. For example, a client is not just Vietnamese American. She may have multiple overlapping identities that are affecting her stress levels and problems outside of ethnic identification (eg, struggles with being a woman, sexual orientation, religious pressures, problems acculturating, and trauma associated with the refugee experience). Each of these other aspects of her identity may be the primary issue she wants to work on in therapy, not necessarily ethnic identity or issues of race.

At the same time, however, each of these other aspects of identity is also integrally tied with her ethnic identity. For example, poverty in the Vietnamese American community is very different than poverty in the White community. Being Lesbian, gay, bisexual, transgender, and queer (LGBTQ) within specific Asian heritage cultures is also very different from that of sexual orientation and identity in the White community as well. Therapists need to take all of these things into consideration when addressing the client's goals and formulating their treatment plan. This is a very important point because, although we want to take culture into account when providing effective care, we do not want to emphasize race at the expense of leaving out other important issues such as other aspects of the person's identity, clinical issues, and the client's therapeutic goals. For example, age may sometimes be the most salient issue for an elderly person coming in for treatment regarding late life issues or because of grief and loss. A young adolescent may be seeking help not only for racial identity issues but also for sexual identity issues that may be more stigmatizing and stressful, especially if their parents are homophobic. Therefore, it is important not to automatically assume that ethnic and racial issues are the most important problem that an ethnic minority client is seeking help for, and it is more effective to focus on the individual's culture.

In fact, oftentimes many ethnic minority clients come in to seek help for reasons that they see as completely irrelevant to race. For example, they may be coming in because of a break up with their partner, struggle with school, workplace conflicts, domestic violence, a physical injury problem, or financial issues. In their eyes, culture, ethnicity, and race may or may not contribute to their life difficulties. Sometimes clients are unaware of how cultural issues are playing a significant role in exacerbating their issues. For instance, an adolescent with Asian heritage may be having a lot of problems getting along with their parents, thinking that their parents are controlling and rigid; whereas, the parents feel like their child is out of control and disrespectful. Intergenerational conflict can often be influenced by the difference in degree of acculturation between parents and youth who grew up in different cultural environments. This acculturation gap difference pits parents and youth against each other because of the different cultural values that they hold. In this situation, it is the therapist's responsibility to point out how cultural issues are influencing family dynamics, something the client may be unaware of and where the youth may be blaming their parents without understanding the cultural context and forces that could drive a wedge between them—making it more difficult to communicate and understand each other's perspectives.

SHOULD I ATTEMPT TO DISAGGREGATE THE CULTURAL FROM THE CLINICAL?

This is a common question often posed by mental health training programs and supervisors who often ask the question, "What are the cultural issues involved in this case and what other clinical issues are involved?" Or, along the same lines, "How much of the issues involved in this case are clinical versus cultural?" Indeed, I was also asked these questions many times during my training. At face value, this line of thinking seems very appropriate and calls attention to the clinician to investigate the cultural and clinical factors that might be influencing the mental health of the client. However, the danger with this line of thinking is that it also traps clinicians into an artificially and overly simplistic and compartmentalized approach to problem assessment. This question artificially pressures students and practitioners to think about clinical and cultural issues independently, as if we can truly separate these issues out when conceptualizing a case. This question is inappropriate in many ways and undermines the inherently complex and unique ways that culture and clinical issues interact, which are oftentimes inseparable.

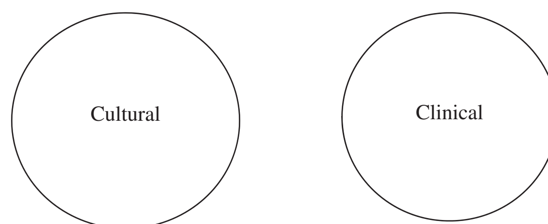
Another way to think about this is to ask ourselves the question "Why do we seldom pose this question when working with White or European American clients?" When we work with White or European Americans, we

often make an assumption that everything is clinical and do not ask or try to disaggregate the cultural from the clinical. Part of the reason for this is the inherently biased assumption that White or European culture is the norm or standard of reference. It is also associated with the broader conceptualizations of race in the US and how White Americans often do not perceive the world racially; whereas, people of color often are reminded of their racial and ethnic backgrounds. For example, when many diversity scholars teach race and ethnicity courses, White students sometimes struggle with questions about their ethnic identity because they typically have not been forced to think about these issues in their lives. Students of color in the class often typically have less of an issue answering this question. For a variety of reasons, they are more likely to have had struggles or reflected on their ethnic identity while growing up due to constant reminders. For White Americans, ethnic identity and identity oftentimes become synonymous as a human experience. However, White Americans also have a salient ethnic identity. Being White should not be synonymous with being American, which is a problem in our country—and creates the problematic assumption that people of color are not "American." This is something that has plagued Asian heritage populations who are often seen as the "perpetual foreigner." In addition, the tendency to ignore the plurality of White or European American cultural issues also impedes our ability to individualize treatment and to take into account the cultural nuances and context that may affect problem development for White populations. People of all different backgrounds deserve to have their treatment individualized to their particular needs, which need to be addressed in order to provide the most effective treatment possible.

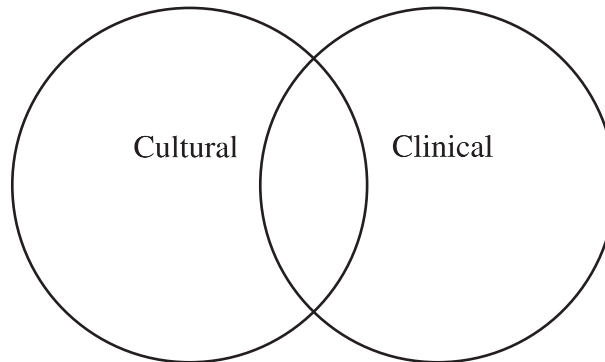
Addressing culture complexities when working with diverse populations is extremely difficult, even for those who grew up as part of an ethnic minority community. It is erroneous to assume that a therapist from an ethnic minority background will always be better at treating a client from that same background. This is because ethnic minority practitioners are trained in the Western mental health treatment system, which continues to be White- or Eurocentric. The most salient issue is whether practitioners have received cultural competency training, and learned to understand and address the complexities involved with working with diverse populations. Currently, only a small proportion of practitioner training focuses on cultural competency and working with diverse populations. Although this is improving, even the most rigorous programs may only offer a class or two on diversity issues. Therapists who want and need to be more culturally competent and effective are provided with few opportunities to enhance their cultural awareness or skills development, the latter of which is much more difficult to refine.

Moreover, we cannot rely on the clients to tell us what is cultural and what is clinical. In fact, this has been one of the biggest complaints by ethnic minorities and international students who seek help. They often complain to me that their therapists ask them this question, but state they are the ones who are coming to seek help, and they themselves do not know. Clients also complain that their therapist expects the client to teach them about their culture and how it might be affecting their problem. Again, this is something that may be outside of the client's awareness, and it is frustrating for them when they are trying to get their needs met and being asked to educate their therapist. Therefore, it is the responsibility of providers to take the initiative and learn about their clients' cultural background in order to be able to provide effective treatment.

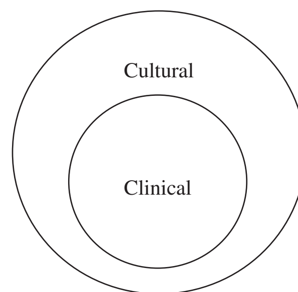
In order to best address clinical−cultural complexities, we need to shift away from thinking about whether the issues are culturally related or not related, and start to think about complex clinical−cultural interactions. Specifically, it is impossible to completely disaggregate the cultural and clinical when working with an individual. This should not be the goal when we are assessing, conceptualizing, and developing a treatment program. The cultural and the clinical are inherently intertwined. That is, clinical issues always occur within a cultural context. Let me provide you with a visual illustration of how to think about the aforementioned issues. For example, when we try to artificially separate the clinical from the cultural, this is analogous to having two separate circles representing a person's culture and clinical issues. The representation below is impossible because we cannot truly disaggregate our clinical experiences from our cultural context and selves. This is an artificial split because these issues are deeply intertwined within an individual.



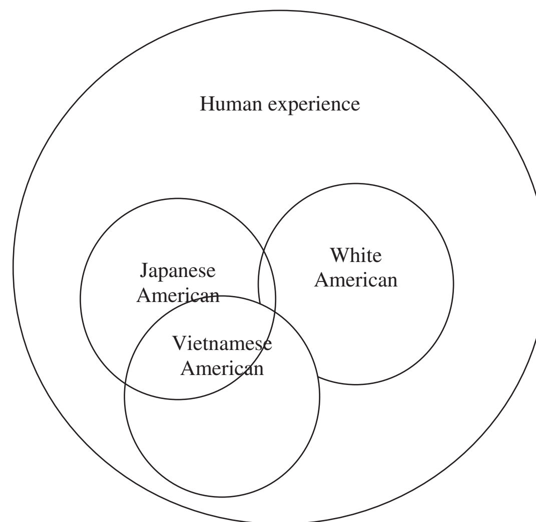
Another way to think about it is to have a cultural circle and a clinical circle overlapping, with shared and unique parts. In this situation, the therapist is asked to determine the clinical and cultural meanings of the overlapped and distinct parts. Specifically, there may be some components of the clinical that are culture-universal (etic), and some components of our cultural identity that apply to most people from the cultural background (emic), but may not apply to people from other cultural backgrounds. The overlapping portion represents the synergy between our cultural selves and the clinical problems that we face. However, even this is still somewhat inaccurate, which makes interpretation of such issues difficult.



I would recommend an embedded approach to thinking about these issues. Specifically, clinical issues always occur within a cultural context. There is no artificial separation of clinical from cultural, and everything that we experience in life is processed, interpreted, and experienced within a particular context. The visual representation of this would be a clinical circle embedded within the cultural context. The important point here is that all of a person's clinical issues are experienced from a particular cultural framework.



In addition, we also need to keep in mind that we all have a shared human experience. Some of our experiences with clinical issues may be culture-universal and some may be culture-specific. Some ethnic group experiences are similar to those of White populations or other ethnic groups, and some are unique. Therefore, in order to utilize a framework that includes both culture-specific and culture-universal experiences (eg, emic and etic), we might think of a larger circle representing the total human experience, with many different cultural groups represented and embedded within this larger circle. The different cultural groups may overlap with other groups to varying degrees. For example, there may be greater overlap between Japanese and Vietnamese experiences, compared to those of Italian and German American experiences. Moreover, this also allows for unique and shared experiences. For example, the Korean American experience with eating disorders may be both similar and different from that of White Americans. Being gay in Thai American culture may be completely different from being gay in White American culture, or there could be some similar struggles. Aging struggles for immigrant Asian populations may be similar, but also very distinct than those of nonimmigrants. Gender and dating issues may also be very similar or different between and within groups.



INTRODUCTION TO THE MANUAL AND THE USE OF CULTURAL METAPHORS

The cultural adaptation of the treatment manual began with the development of the title, "Improving your mood: A culturally responsive and holistic approach to treating depression in Chinese Americans" (Hwang, 2008a, 2008b). The traditional Chinese character title is "提升您的心「晴」指數：反映文化與綜觀整合的華裔美國人憂鬱治療." The simplified Chinese character title is "提升您的心「晴」指数：反映文化与综观整合的华裔美国人忧郁治疗." In Mandarin Chinese, the title is pronounced "Tíshēng nín de xīn 'qíng' zhǐshù: Fǎnyìng wénhuà yǐ zòngguān zhěnghé de huáyì měiguó rén yōuyù zhìliáo." Those who read Chinese characters will probably notice a set of brackets that are not typically seen in Chinese writing. These brackets are called yinhao (pronounced yǐnhào in Mandarin Chinese—引號), and are punctuation marks that are typically used to indicate a special usage of a word or accentuate its meanings. This was a complex play on words and helped bring multiple meanings to the title. In some ways, it can also be considered an ethnolinguistic cultural adaptation that brings clinical meaning to a word that traditionally was not used in a therapeutic manner. However, this type of modification is less of a Western psychotherapy meets Eastern cultural bridge, but rather a within-culture bridge of clinical meaning to a preexisting ethnic language (ie, adding clinical meaning to extant cultural and linguistic strengths).

Specifically, the character for mood, feelings, or emotions in Chinese is 心情 (pronounced xīnqíng in Mandarin Chinese). The first character (心) is pronounced xīn, and means heart. The second character pronounced qíng "情" was modified to "晴," which also has the same pronunciation. The difference between these two characters is the front part, which is called a radical or bushou (pronounced bùshǒu in Mandarin Chinese—部首). The original radical is called shuxin (pronounced shùxīn in Mandarin Chinese—豎心) and means building the heart, which helps provide the emotion and mood meaning of the two characters combined. By changing the radical and replacing it with the character rì (日), which depicts the sun, the character "晴" takes on a different meaning. Specifically, the title now possesses two different meanings. The original meaning is improving your mood, but there is also a secondary meaning of brightening your day or shining light into the darkness. This has particular meaning in Chinese culture because brightening your day with the energy of the sun is also associated with the treatment of depression in Traditional Chinese Medicine. That is, depression is associated with too much lunar energy and not enough solar energy (pronounced yángqì—阳氣), which will be discussed in further detail later in the manual. By inserting the sun character, we bridge healing concepts from Traditional Chinese Medicine to a lay phrase, which provides hope that the darkness of their depression can be brightened, and that steps can be taken to help them rebalance their lives. The balance portion comes from the Tai Chi or yinyang diagram, and the need to balance Qi or inner energy (pronounced qì in Mandarin Chinese—氣). Clients responded positively to the title, which also appropriately foreshadowed holistic and traditional concepts of energy that the treatment manual will discuss later.

In addition to promoting extant cultural strengths in the title, a Chinese saying was also employed as the motto or theme of the treatment. In Asian heritage cultures, there are thousands of philosophical sayings that have cultural, philosophical, and therapeutic value. In Mandarin Chinese, these metaphors are called idioms (pronounced chéngyǔ in Mandarin Chinese—成語). Idioms are typically four-word metaphorical sayings (but many are longer) that highlight morals and provide inspiration. They can be used to help clients find perspective and the strength they need to accomplish their goals. They are not only teachings, but also carry with them the significance of thousands of years of Chinese heritage and the cultural strengths that Asian heritage populations believe in and can relate to. Although many metaphors may not have been historically constructed for use in psychotherapy, they can be effectively integrated to bridge cultural and clinical teachings and accentuate their meanings. This is associated with Domain 3 of the PAMF, understanding and integrating cultural beliefs into the treatment. Because the Formative Method for Adapting Psychotherapy (FMAP) model highlights the use of chengyu, therapists in phase I (Generating knowledge and collaborating with stakeholders) were asked if they used them with clients and whether they could help generate a list of chengyu that might be helpful in therapy. Very few were already doing so and they were glad to help brainstorm various sayings. In addition, I also reviewed thousands of Chengyu's by going through dozens of books that specialize in these metaphorical sayings and looking for ones that might have therapeutic value in treatment.

In phase II of the FMAP (integrating generated information with theory and empirical and clinical knowledge), after careful reflection and researching of thousands of philosophical sayings, a cultural teaching was selected to be the theme and spirit of the culturally adapted treatment manual. All of the focus group therapists agreed that integrating metaphors could be effective, powerfully rich, conferring on metaphors' therapeutic benefits. The theme of the manual is "山不轉路轉；路不轉人轉；人不轉心轉" (pronounced shān bù zhuǎn lù zhuǎn, lù bù zhuǎn rén zhuǎn, rén bù zhuǎn xīn zhuǎn in Mandarin Chinese). This phrase literally means "If the mountain doesn't turn the road turns; if the road doesn't turn the person turns; if the person doesn't turn the heart/mind turns." The treatment manual provides the following more therapeutic translation, "If a mountain is blocking your path, find a road around it. If the road doesn't take you where you want to go, make your own way. If the approach you take doesn't help you reach your goal, then change your mindset and do something different."

Essentially, this helps the client develop flexibility in problem-solving. Specifically, in trying to accomplish our goals, we often encounter obstacles that sometimes seem insurmountable. Instead of trying to change something that is unmovable, sometimes we need to think of other strategies, utilize indirect methods of handling the situation, or think out of the box. When we have exhausted all possible concrete problem-solving strategies and if we cannot find a way to resolve the problem or change the stressor that we are experiencing, then we need to change the way we think and feel, and thus reframe the problem or goals to help find inner peace. Sometimes we cannot change the objective stressor, but we can change our perspective, interpretations, and focus our attention on decreasing stress and making the most of the situation. I felt this motto accurately captures the aims and goals of the culturally adapted treatment, and also accurately reflects aspects of the spirit of CBT.

When working with clients, therapists can help clients apply this theme to various situations and problems that their clients face. This can occur anytime during the treatment program. For example, the metaphorical theme of the manual can be applied to individual difficulties, couple issues, or family problems. In our experience, Asian heritage populations can be very reactive to psychotherapy and CBT if clients are pushed to cognitively reframe without first having gone through the process of actively trying to problem-solve. Asian heritage clients can become very defensive when they feel like they are being prematurely told that there is something wrong with the way they think, or that their thoughts are distorted or irrational. A process-oriented approach that takes into account timing, packaging clinical issues in a culturally meaningful manner, and the ordering of the emphasis of clinical interventions can make a significant difference in the client's acceptance and willingness to change. For example, I sometimes say to clients "I know your situation is very difficult and you have been struggling with changing things for a long time. It seems like you have already tried many different approaches to changing the situation, and although we can continue to proactively problem-solve, it may be more beneficial and effective to reframe with our hearts and mind. Sometimes the most effective approach to making the most of the situation is to change the way we think and feel so that we don't continually feel frustrated and become consumed by stress, anger, and anxiety when faced with a stressor or situation that won't change." It can be detrimental if clients continually focus their efforts on something that they cannot change, and can be very disempowering. This process should be highlighted and client efforts and focus of attention may need to be shifted to a more achievable goal.

The metaphors provided in the title and theme of the manual are just some of the examples provided in the culturally adapted treatment manual. In order for therapy to be effective, it must be clearly aligned with the

belief system of the client. The second domain of the PAMF is to understand the client's cultural beliefs about mental illness and its causes. Cultural metaphors and teachings are an essential part of effective psychotherapy and provide inherent therapy or help clients relate cultural beliefs to clinical or therapeutic concepts and principles (ie, cultural bridging). Cultural teachings and metaphors can be inspirational and provide hope and optimism toward the future and everyday problems. Cultural metaphors, teachings, and stories can be implemented in a therapeutic manner and help align clinical teachings with the client's belief system to promote healing (Bernal, Bonilla, & Bellido, 1995; Costantino, Malgady, & Rogler, 1986; Hwang, 2006). Understand how to effectively use cultural metaphors also provides therapists with cultural credibility—even if they identify or generate these metaphors together with their clients.

Other cultural sayings I have used effectively with clients in a therapeutic setting include "Shuang guan qi xia" (pronounced shuāng guǎn qí xià in Mandarin Chinese—雙管齊下), which means literally two brushes painting together, and refers to the story of a famous artist who painted using two brushes in one hand simultaneously (Hong, 1987). This story could help facilitate understanding of the simultaneous engagement of two core CBT principles, (1) challenging maladaptive cognitions and replacing them with coping thoughts and (2) engaging in behavioral strategies such as exercise and meditation to improve depressed mood. Utilizing cultural bridges and metaphors may be particularly helpful for less acculturated Asian Americans, but may also be beneficial for those who are more acculturated, as well as for clients from different cultural backgrounds. In fact, one of the drawbacks of the current literature is its focus on delineating cultural risk factors without providing an equal emphasis on identifying cultural strengths and protective factors that may shield immigrants from harm as they acculturate.

Although not specifically taught in graduate training, many mental health providers naturally integrate cultural metaphors into psychotherapy. For example, Freud's psychoanalytic theory of the conscious and unconscious mind is often explained using an iceberg metaphor. Conscious awareness is the tip of the iceberg, while the unconscious is represented by the ice hidden below the surface of the water. Similarly, the nonadapted CBT manual contains a metaphor that discusses people's different reactions to the objective fact that it is raining (Miranda et al., 2006). People can have different subjective reactions (eg, I hate the rain and traffic is going to be horrible versus it's great that it's raining because it will help clean the air and makes me feel refreshed). You cannot change the fact that it is raining, but you can change the way you think and feel about it. White clients can also benefit from cultural metaphors around the world. For example, many treatments and holistic healing books use the fishing metaphor, which is a Chinese proverb that has been integrated into Western psychotherapy (Alexander, McDaniel, & Baldwin, 2005). "Give a man a fish and you feed him for a day. Teach a man to fish and you feed him for a lifetime." I work with a lot of Caltech students in my clinical practice, and often use the metaphor of formulas (eg, if the client is struggling to reach their goals, what's the missing variable in the equation that they need to solve?).

There are even specific therapies that have been developed for ethnic populations and that are focused on metaphors. This is less of a cultural adaptation of Western psychotherapy and more accurately characterized as a treatment developed from an ethnocultural perspective. For example, cuento (metaphor) therapy was created to help facilitate therapeutic effectiveness when working with Latino heritage populations (Costantino et al., 1986). In a study of the effectiveness of cuento therapy for Puerto Ricans, high-risk children and their mothers were randomly assigned to receive either cuento therapy, traditional therapy, or no therapy. Results indicated that cuento therapy significantly reduced children's trait anxiety relative to traditional therapy and to no intervention, and that this trend was stable over 1 year (Costantino et al., 1986). In China, Taoism is also being currently integrated with cognitive therapy when treating Chinese clients with generalized anxiety disorder (Zhang et al., 2002). Using cultural metaphors and teachings as a cultural bridge to help engage clients, reduce resistance, and facilitate positive outcomes can be a very effective cultural adaptation for diverse populations (Ham, 1989; Hong, 1993; Hwang, 2006).

Besides integrating cultural teaching and metaphors, a number of other cultural adaptations were also made throughout the treatment manual. For example, we tried to reduce the amount of text that may be difficult to read or overwhelming for community mental health clients who have a lower level of education, for depressed clients who may have little energy or motivation to read dense material, and for Asian heritage clients who are less used to psychotherapy and may find readings that are too dense to fully comprehend overwhelming. This also resulted in the implementation of a layout that had more open space and that was organized in a simple and organized manner to help reduce confusion. Another cultural adaptation was providing pictures and images of Asian and/or Chinese heritage populations. Because immigrant Asian heritage populations are often marginalized in the media and have little representation, it is important to help the client identify with the treatment and to help them understand that this treatment program was specifically designed for them—a tailoring strategy that is very meaningful and emotionally reassuring for the client.

CONCLUSION

As we move ahead, we need to keep these cultural and clinical complexities in mind. We need to be careful not to stereotype, but we also need cultural information and knowledge that help us better understand the cultural context of what is occurring. We need to have cognitive flexibility and not internalize stereotypes, but at the same time use our cultural knowledge to help us ask important questions that need to be assessed and evaluated. Although cultural or group-specific information may be provided in the manual, the practitioner must remember to deconstruct stereotypes and individualize services for their clients. This requires assessing the complexities of identity, and understanding the wide variation and diversity that exist within any particular ethnic or cultural group. This may also require breaking from the norms that we have been taught during our graduate and clinical training, and engaging in behaviors that might help facilitate a stronger working relationship with our client.

For example, some therapists may feel like offering a client a cup of tea and having a drink in the therapy room may be an unwanted "object" in the therapy room and interfere with the therapeutic process. Other therapists may feel like disclosure of any kind impedes the client's ability to experience the therapist as a blank slate or neutral body. Albeit they may not be a norm for Western psychotherapy, sometimes these practices can be culturally normative and necessary. Offering tea can help reduce client discomfort and anxiety for being in such mental health treatment, and can also help facilitate a positive working relationship. Moreover, disclosing therapist cultural heritage information can also help foster closeness or serve as a cultural bridge, such that the client is able to disclose information to the therapist because they are no longer perceived as a stranger versus somebody who they are interpersonally close with. These and other complexities must be carefully evaluated for their costs and benefits. Not answering some of these questions may be perceived as rude and lead to relational distancing. However, answering them can also be a pitfall if the therapist does not understand the client's rationale for asking such questions (which can be driven by clinical and cultural issues), or if the therapist does not evaluate the impact on clinical processes or the therapeutic relationship.

In addition, just because a therapist is of the same cultural background as the client does not mean they will be more effective working with a person of the same ancestry. Although there is some research indicating the ethnic match can be important, it is the therapist's cultural competency that is the true mechanism that improves outcomes. It is also important to keep in mind that the majority of ethnic minority therapists are trained in the Western system of psychotherapy, and have had little formal training on culturally adapting therapy. A number of complexities can affect ethnic match and ethnic nonmatch therapeutic relationships, including the notion of ethnocultural transference and countertransference (Comas-Diaz & Jacobsen, 1991).

Remember that ethnic minorities and nonminorities are all in different stages of their ethnic identity development, which can affect how they interact, perceive, and interpret the therapeutic relationship and the client's problems. These issues need to be considered, especially since the notion that a therapist who doesn't know much about a client and can just refer them out to somebody else who matches the client's ethnic background, leaving many clients without accessible care. Although well-intentioned, it is important to remember that there is a shortage of ethnic minority mental healthcare providers. The "referring out" notion, when working with non-White populations, can reinforce a nonresponsibility-taking, "passing the buck" mentality by practitioners. Practitioners need to put forth effort in learning about cultural issues as they do for clinical issues. As culturally competent therapists who are continually learning and developing practical skills in cultural adaptation, we need to conscientiously evaluate and assess for these cultural–clinical complexities and be flexible when working with people who may have different worldviews.

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