CHAPTER

6

Understanding How This Program Can Help You Take Control of Your Emotions (Session 1 of the Treatment Manual)

Hope cannot be said to exist, nor can it be said not to exist. It is just like roads across the earth. For actually the earth had no roads to begin with, but when many men pass one way, a road is made.—***Lu Xun (Influential Chinese Writer; 1881–1936)***

As mentioned in the previous chapters, when the term Asian heritage population or Asian American is stated in this book, it is not meant to be a stereotypical statement that applies to people of all Asian backgrounds. This book recognizes that there is great diversity within and between different Asian groups, and also targets people who are less acculturated. Nevertheless, the cultural adaptations presented in this book focus on issues that are likely to cut across many different Asian groups. Individual practitioners will need to carefully evaluate and make informed decisions when deciding which adaptations may potentially be suitable for their clients. This requires asking clinical and culture-related questions, conducting additional research, and engaging in experiences that will help them better understand and feel comfortable when working with clients from different backgrounds. These are important points and are highlighted here, rather than at every juncture in the book where a statement about Asian heritage is made.

The goals for the remaining chapters are to (1) introduce each of the sessions of the treatment manual and to train practitioners on its usage, (2) highlight where cultural adaptations were made and provide concrete examples of therapeutic modifications, and (3) provide rationales for clinical modifications and illustrate how cultural adaptations can be beneficial to clients. Rationales for cultural adaptations presented in this book are supported and justified by theory, empirical research, and clinical experience (vis-à-vis my own clinical expertise, reaffirmation of modifications by therapists who utilized the treatment manual with clients, and support from the therapists who participated in focus groups that informed the creation of the manual). Cultural adaptations are meant to increase client engagement, reduce premature treatment failure, facilitate the buy-in into therapy, bridge therapeutic concepts with cultural values and understanding, strengthen the core and active ingredients of therapeutic change within various treatment modalities, and highlight extant cultural strengths that can also be used as active mechanisms for clinical change.

At times, it may be difficult to understand why a particular cultural adaptation is labeled as such, and how it is different from regular clinical practice. This gets back to the issue that we sometimes can't separate the clinical from the cultural, and that we are focusing on effective clinical interventions that work well with diverse populations. Nevertheless, what is emphasized and the degree of emphasis, how certain concepts are introduced, how certain cultural-universal phenomena (etic) are experienced in a culture-specific way (emic), the specific manner in which the adapted clinical intervention is delivered, and the qualitative nuances in expression, communication, and client–therapist interactions may be somewhat different.

It is important to note that most manualized treatments, regardless of theoretical orientation, utilize a more proactive psychoeducational approach than their nonmanualized counterparts (eg, manualized cognitive-behavioral therapy (CBT) vs nonmanualized CBT or manualized interpersonal therapy vs nonmanualized

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psychodynamic therapy). This active learning educational approach aligns with orienting clients to mental illness and its treatment domain of the psychotherapy adaptation and modification framework (PAMF). This is one of the most important modifications that can be utilized when working with Asian heritage populations. Consequently, the culturally adapted CBT manual that is presented in this book also implements a semistructured and psychoeducational approach, the importance of which will be further explicated later in this chapter.

Similar to many manualized treatments, each session begins by highlighting the session goals. The first session of "Improving Your Mood: A Culturally Responsive and Holistic Approach to Treating Depression in Chinese Americans" is entitled, "Understanding how this program can help you take control of your emotions." There are a number of specific session goals, which provide a much more comprehensive therapy orientation for clients than other treatments. The session goals for the client are to:

- Understand the purpose of this program and why it was developed;
- Understand confidentiality and privacy;
- Understand the facts and fallacies about psychotherapy;
- Understand the client and therapist roles and responsibilities;
- Understand the course of psychotherapy;
- Understand why dropping out of therapy is problematic;
- Understand you and your problems;
- Address emergency issues and understand depression and suicide;
- Develop goals and identify signs of treatment progress.

Similar to the client's goals located at the beginning of each session of the manual, each of the remaining chapters in this book will also have specific chapter goals for practitioners. Some of these chapter goals are the same as the treatment manual stated client goals, but some are different. In order to increase ease of understanding, each of the client's session goals is embedded and will be discussed within the overarching chapter goals. When the session goal and the chapter goal are the same, then the content will be presented as a single chapter goal. Similar to what is presented below, additional chapter goals will also be presented as bullet points as a primary topic or subtopic. The chapter goals for Session 1 are to:

- Understand the importance of psychoeducation when working with Asian heritage populations
- Understand the power of having a treatment specifically developed for the client
  - Understand the purpose of this program and why it was developed
- Understand the importance of reducing stigma
- Understand the importance of therapy orientation in increasing client engagement, lowering stigma, and reducing premature treatment failure
- Learn how to provide a comprehensive therapy orientation
  - Understand confidentiality and privacy
  - Understand the facts and fallacies about psychotherapy
  - Understand the client and therapist roles and responsibilities
  - Understand the course of psychotherapy
  - Understand why dropping out of therapy is problematic
  - Understand you and your problems
- Understand why it is important to address clinical emergencies and crisis issues when working with Asian heritage population
  - Address emergency issues and understand depression and suicide
- Emphasize the importance of goal setting when working with clients in unfamiliar with psychotherapy
  - Develop goals and identify signs of treatment progress.

CHAPTER GOAL #1: UNDERSTANDING THE IMPORTANCE OF PSYCHOEDUCATION WHEN WORKING WITH ASIAN HERITAGE POPULATIONS

Psychoeducation about mental illness and its treatment is one of the most important cultural adaptations that can be utilized when working with groups that are less familiar with psychotherapy, such as Asian heritage populations. In addition, psychoeducation also aligns with the cultural value and importance placed on

education. Historical and contemporary Asian cultural values have typically emphasized education as the most important aspect of social mobility and success. In contemporary society, education is also seen as a way for immigrant Asians to become successful. Specifically, education is seen as a key factor in family prestige, social mobility, creation of opportunities, and financial stability (Chang & Sue, 2003). Education is seen as a means to an end, and is a mark of social status and increases family honor and reputation. The importance of education has been deeply ingrained in Chinese and other Asian cultures for thousands of years. Confucius (551–479 BC) believed that education was a necessary characteristic of a proper person who contributes to both society and government. He argued that in order to attain self-mastery one must do so through scholarship and study (Whaley, 2013).

Along with a number of other factors, the cultural values placed on education have reinforced the "model minority" stereotype. This became largely apparent in the 1980s and was exemplified by the 1987 cover of Time magazine, "Those Asian-American Whiz Kids" (Brand, 1987), which depicted Asian Americans as super achievers and even the "New Jew." This stereotype is problematic and has created additional problems for Asian heritage communities. However, an in-depth discussion of this issue is beyond the scope of this book. Nevertheless, it is important that for many people of Asian backgrounds, there is familial pressure to pursue certain careers (eg, science, math, medicine, pharmacy, law, engineering, business, and accounting) that are deemed to be more financially stable or practical. This value has emphasized maximizing achievement and success for social mobility, but it also creates problems within Asian families. For example, many Asian heritage clients come to treatment with parent–child relationship problems and conflict. Some of these stem from family pressures to choose certain careers that focus on pragmatic living. Academic pressures to succeed in college and graduate schools can also be daunting for those who are struggling with their studies and having difficulty meeting the model minority stereotype.

Nevertheless, understanding the importance of education in Asian heritage populations provides some clinically useful information. First, it tells us that an educational approach to psychotherapy can be beneficial and may be one of the most important ways to engage Asian heritage populations and increase acceptance of treatment. Moreover, understanding that education is important for Asian heritage populations can also shift the therapy dynamic, at least initially, into more of a teacher–student dynamic. Associated with this shift is respect and reverence for teachers (and similarly to therapists) as authority figures. An educational focus can facilitate openness to learning, highlight the potential benefits of "homework," and create willingness to try different educational approaches (eg, active learning, multisensory approaches to learning) that have been shown to be effective by educational and psychological research (Freeman et al., 2014).

In addition to understanding the importance of education in Asian heritage populations, it is also important to understand that Asian educational systems are very different from Western educational approaches. Specifically, the top-down unidirectional emphasis and flow of information from teacher to student in the East versus the collaborative and discussion-oriented approach in the West. Knowing this is important because it provides clinically useful information that helps therapists frame client's therapy participation and interactions. Specifically, there is some literature to suggest that therapists may misinterpret the quietness, reservation, and lack of proactive engagement as a sign of disinterest, not taking therapy seriously, or not taking responsibility for their own treatment progress (Hwang, 2006).

It can be clinically unsound to analyze the verbal and nonverbal communications of clients without fully understanding the culture of how clients might respond to authority figures and behave in therapy sessions. Clients with less exposure and familiarity with mental illness and its treatment may be silent or act awkward for a variety of reasons. Therapists need to be careful in their interpretations, and not automatically think that the client is sitting there and not saying anything because they are disinterested, dissociating, disrespecting the therapist, or too clinically severe to talk. It is possible that there are cultural reasons for confusion and discomfort. Moreover, Asian heritage populations who are unfamiliar with therapy may also be trying to figure out whether therapy will be beneficial, afraid of interrupting the therapist, fearful that asking questions may be interpreted as being disrespectful, and contemplating whether they want to continue treatment or not because they are unsure whether therapy works.

In addition, it is important to remember that Western mental health treatments (eg, psychotherapy and psychiatric medications) are not widely available in most Asian countries. As a result, Asian heritage populations are less educated about mental health services. This can lead to greater reservation when seeking help and while talking in therapy. Clients may feel uncomfortable or not know what is customarily normal to say and do while in treatment (Hwang, 2006). This also has implications for when people seek help, and how severe there problems and symptoms are when they finally do go for treatment. This lack of familiarity can also increase the

likelihood of premature treatment dropout when clients come in with the expectation that the "doctor" will tell them what to do, and when they come in with expectations that they will see immediate benefits.

Consequently, one important aspect of culturally adapting therapy is to enculturate clients to the culture of psychotherapy and mental health services. This can be difficult because there may not only be a lack of understanding of how therapy works, but also misconceptions while at the same time feelings of stigma. Nevertheless, orienting clients so that they understand that psychotherapy is most effective when a collaborative approach is utilized (as opposed to a unidirectional relationship where the doctor tells the client what to do) is an important adaptation and point of discussion. This also involves helping clients feel comfortable in treatment, and normalizing the educational and learning aspects of psychotherapy to help decrease stigma. These cultural adaptations are very important for Asian heritage clients who come in to treatment expecting fast and concrete results.

The culturally adapted treatment manual utilizes the strategies noted above, and implements both active learning and multisensory approaches (Shamas & Seitz, 2008). This cultural modification can be seen throughout the manual. For example, check boxes were placed next to various issues so that clients can endorse whether they were struggling with these problems (eg, checking off the symptoms they are struggling with and denoting the types of communication problems that they are having). Self-identification of problem areas also helps increase personal involvement, facility ownership, and decrease defensiveness. It is important for clients to be actively engaged, collaborate with the therapist, and learn how to self-diagnose their own symptoms, triggers, and problems.

The treatment manual also helps clients to not only think about what they learn about in their heads, but also to read, visualize, discuss, and write about the issues they are facing. This multisensory learning approach helps consolidate learning and memories and facilitates skill acquisition. For clients who are clinically depressed, it also helps prevent them from getting lost in their own internal dialog and worry thoughts. Clients can better recall discussions to address specific challenges, and utilize their visual memories from various chapters and worksheets.

CHAPTER GOAL #2: UNDERSTAND THE POWER OF HAVING A TREATMENT SPECIFICALLY DEVELOPED FOR THE CLIENT

We often take it for granted that psychotherapy was created for and by people from European descent. Consequently, therapy is deeply embedded within a White–European cultural context. When White or European Americans seek mental health treatment, they intrinsically understand that this treatment was created by and for them, thus resulting in a strong cultural congruency and fit. This helps facilitate acceptance and belief in the treatment. It is very important not to forget that "Whiteness" is not cultureless or a-cultural, which often occurs when people grow up not having to think about ethnocultural issues or how they are different. Because of the cultural norms, pervasiveness, and dominance of White culture in the United States, being White oftentimes mistakenly becomes synonymous with being human.

Conversely, Western psychotherapy was not created for and by non-White groups. The major pioneers and leaders of therapy, regardless of theoretical orientation or modality, have all been White American or European. During the time that psychotherapy was created, importance was not placed on addressing diversity issues. During those historical movements when psychotherapy was being developed, racism and marginalization of minority groups was rampant. Civil rights of people of color had yet to be adequately addressed. Therefore, the development and evolution of psychotherapy occurred in a singular cultural context (eg, White culture). The issues and stressors that non-White populations were struggling with were not a major topic of focus for psychotherapy. The topics, needs, and goals of people of color were not systematically targeted or integrated into the development of theoretical frameworks and strategies.

When diverse populations seek mental health treatment, there is an inherent level of cultural incongruence between the culture of the client and the culture of the treatment. At some level, whether consciously or unconsciously, diverse populations experience this incongruency. Although some may argue that the culture of psychotherapy is universal and generalizes to all human beings, very little empirical evidence and testing of mental health services have been conducted with non-White populations. This is something that is often taken for granted when White people seek help, and also taken for granted by mental practitioners who assume that they do not have to make any cultural modifications or adaptations to individualize psychotherapy for their clients, which is an inherent goal in all treatment.

Understand the Purpose of This Program and Why It Was Developed

The session goal *Understand the purpose of this program and why it was developed* is a very important part of the therapeutic process. One of our first cultural adaptations was to let our clients know that this program was developed specifically to meet their needs and was designed to address the problems that Chinese Americans face. This is very powerful from a client's perspective. How comforting is it to know that a treatment was created for you and by those who understand and want to help you with your struggles? The manual highlights these issues by discussing the purpose of the program, which included helping clients improve their mood, decrease their feelings of depression, develop insight into their problems, live healthier and more fulfilling lives, and improve their family and social relations. Moreover, the manual discusses how and why the program was developed—emphasizing that it was designed specifically to help address the needs of Chinese Americans. Moreover, the needs of Chinese Americans and other Asian heritage populations are so important that the US National Institute of Mental Health funded this program to help address the needs of the community.

Although at face value it may seem somewhat trivial, I cannot overemphasize the importance and therapeutic power of having a treatment created specifically for and by people who understand "me." This is the assumptive framework that is assumed when most White Americans attend therapy. When clients know that practitioners are trained to be culturally competent and effective at culturally adapting therapy, this also creates confidence and buy-in to the mental health service provider and the treatment. Knowing that a treatment was created for you helps normalize the treatment process, decreases stigma by letting clients know that other people from their cultural backgrounds also experience similar problems—which reduces the amount of "hiding" that they need to do to avoid humility and "save face" for themself and their family. This also provides hope because clients know that others similar to themselves who suffered from the same ailments can actually get better, and creates a safe place for people to talk about the problems that have been afflicting them for such a long time.

Client and therapist reactions about the creation of a culturally tailored program were uniformly positive. Therapists were very excited to find out that Asian heritage issues were finally being addressed in psychotherapy. Patients reported feeling comfortable coming in for treatment because the program was specifically developed for them. Emphasizing that this treatment was created specifically for a particular group is especially important given that psychotherapy never existed in Asian culture and many other cultures around the world.

As previously discussed, many indigenous, traditional, and complementary medicines never created a strong artificial separation between the mind and the body. They utilized a more holistic approach to addressing physical and mental ailments and sought help from one source (eg, typically, people sought help from a Traditional Chinese Medicine doctor for all health problems). Understanding that specific program treatments were developed for one's ethnic group is a very powerful clinical and cultural adaptation. Clients need to feel like the treatment was designed and tailored for them and their problems in order to have confidence and faith in the treatment.

CHAPTER GOAL #3: UNDERSTANDING THE IMPORTANCE OF REDUCING STIGMA

Stigma toward mental health services and mental illness is one of the most important factors that can influence treatment outcomes. Stigma can lead to delays in help-seeking, which results in greater clinical severity when clients finally come in for treatment. Stigma can create social and personal discomfort for clients as they try to engage in the therapy process, and can also increase the risk of dropping out of therapy prematurely. Normalizing client experiences and destigmatizing mental illness and its treatment can be a very powerful gift that improves retention and client buy-in to therapy. In addition, reassuring clients about confidentiality can allay cultural fears concerning privacy and social judgment by others. The adapting psychotherapy for Chinese Americans program takes a holistic and mind−body approach to improving mental well-being. A major part of culturally adapting therapy is to address stigma issues in treatment, which is one aspect of integrating cultural beliefs and to treatment (Domain 3 of the PAMF).

Corrigan (2004) found that there are two main effects of stigma for seeking treatment, diminished self-esteem and public identification. Both of these factors play an even greater role among collectivistic cultures, where social relationships and perceptions by others significantly influence a person's self-concept. Regarding Asian heritage populations, stigma toward mental illness can be highly deleterious. In Asian culture, having a mental illness is often synonymous with being "crazy," and seeking help for psychiatric issues can reify personal and social perceptions of "craziness." In Asian culture, mental illness and its treatment create a personal, family, and

societal label. This in turn diminishes a person's self-esteem as they internalize multiple negative connotations associated with mental illness (eg, shameful, weak, lazy, and damaged), and can also lead to loss of face and shame for the family (Yang, Phelan, & Link, 2008).

Stigma prevention and reduction can occur at the individual or community level. Yang (2014) has begun developing one such peer-led program to help reduce stigma when Chinese American clients do seek help. In regards to mental health services, however, a major part of culturally modifying services involves evidence- and community-based stigma prevention programs—which unfortunately are largely unavailable for Asian heritage populations. Since it is beyond the scope of individual practitioners to implement community-level stigma intervention programs, I will focus on adaptations that practitioners can implement while providing psychotherapy. Reduction of stigma needs to begin with appropriate psychoeducation—a culturally congruent, syntonic, and effective way to work with Asian heritage populations. This involves providing therapy orientation and psychoeducation about mental illness (Domain 2 of the PAMF).

CHAPTER GOAL #4: UNDERSTAND THE IMPORTANCE OF THERAPY ORIENTATIONS IN INCREASING CLIENT ENGAGEMENT, LOWERING STIGMA, AND REDUCING PREMATURE TREATMENT FAILURE

One of the most important cultural adaptations that a practitioner can offer when working with Asian heritage populations is to provide a comprehensive psychotherapy orientation. The importance of therapy orientation is underscored by clinical research, theory, and community-participatory focus group discussions. Properly orienting clients to therapy is the second domain of the PAMF. The benefits of therapy orientations are supported by our clinical experience and knowledge. For example, the Principal Investigator (PI) introduced the topic of therapy orientations in phase I focus groups when developing the culturally adapted treatment manual. There were a number of discussions including how much therapy orientation is needed and what a comprehensive therapy orientation program looks like, regardless of theoretical orientation. The cognitive-behavioral, solution-focused, and psychodynamic/psychoanalytic therapists who participated in the focus groups all believed that therapy orientations are very important and would be very useful when working with Asian heritage populations.

Therapy orientations can directly reduce stigma toward mental illness and its treatment. Unfortunately, other than to discuss issues of confidentiality and privacy, most training programs do not emphasize or elaborate on how to provide a comprehensive therapy orientation. The culturally adapted treatment manual provides a comprehensive therapy orientation program. Orienting clients to therapy is especially important for clients who have had little exposure to mental health and its treatment. This is especially relevant to Asian Americans, where lack of exposure and knowledge, and misinformation about mental illness and its treatment are rampant (Hwang, 2006). Because many ethnic minority groups are unfamiliar or less familiar with mental health treatment and Western conceptualizations of mental illness, it is very important to orient clients to psychotherapy and the treatment process. Therapy orientations can help increase awareness and understanding of the format and rationale behind therapy, and as a result help facilitate client comfort and "buy-in" to treatment.

Because mental illness and its treatment are not a separate medical system in traditional Asian medicines, there is much stigma and confusion concerning the definition of mental illness, whether it can be treated, and what an effective treatment might be. Therapy orientations may be less necessary when clients are enculturated to psychotherapy and have been to treatment before. White Americans have more exposure and understanding of the therapy process than many people of color. However, this does not mean that they would not also benefit from a comprehensive orientation. Unfortunately, few therapists provide therapy orientations as part of their regular practice.

Acosta, Yamamoto, Evans, and Skilbeck (1983) found that African American, Hispanic Americans, and White Americans who are psychiatric patients benefited from a therapy orientation prior to their first therapy session. Patients felt more comfortable and positive toward psychotherapy, which are both very important factors in therapy engagement. There is also some evidence that group therapy orientations prior to the beginning of group therapy can also be beneficial (France & Dugo, 1985). This type of orientation can include a lecture-based discussion, as well as videos that provide examples of what a typical therapy session might look like. However, this research has yet to be conducted with Asian heritage populations.

Although there is no research examining the benefits of therapy orientations among Asian heritage populations, given our extant cultural and clinical understanding of Asian groups, it would be hard to argue that

therapy orientations would not be beneficial. Many Asian heritage clients don't know how to act, what to say, feel ashamed and embarrassed, and are not sure how therapy works and whether it can help them when they first come into treatment. The therapy orientation provided in the culturally adapted treatment manual has helped clients feel more comfortable, reduced stigma, increased engagement, and gain confidence in the therapist and treatment. Therapy orientations can be a powerful method of cultural adaptation, and open the door for psychoeducation and stigma reduction.

CHAPTER GOAL #5: USING THE MANUAL AND LEARNING HOW TO PROVIDE A COMPREHENSIVE THERAPY ORIENTATION

The primary purpose of Session 1 of the treatment manual is to provide a comprehensive therapy orientation. Specific session goals are highlighted, including the purpose of the program and why it was developed, course and structure of the program, goals for each session, confidentiality and privacy issues, facts and fallacies about psychotherapy, client and therapist roles and responsibilities, course of psychotherapy, and why dropping out of therapy is problematic. Session 2 of the treatment manual also includes components of the therapy orientation, but will be discussed in chapter "Providing Psychoeducation About Depression and Its Treatment (Session 2 of the Treatment Manual)." During phase III focus groups of the Formative Method for Adapting Psychotherapy, therapist reviewed the therapy orientation program developed by the PI, and reaffirmed their belief that it would be beneficial and effective. Clients also enjoyed the therapy orientation session, which helped them feel more knowledgeable and comfortable while in treatment.

The chapter goal "Understand the power of having a treatment specifically developed for the client," and the first goal of Session 1 *Understanding the purpose of the program and why it was developed* have already been discussed above. The second goal of Session 1 (ie, orienting the client about the *Course and structure of the program*) is very important for helping the client develop a mental roadmap and basic understanding of how therapy works. For example, informing the client that this is a time-limited 12-session, manualized treatment helps them understand how long the treatment will be. This also helps clients understand how many sessions they can attend and helps mitigate feelings of abandonment when the program comes to an end.

If you are working with clients in a private practice setting, providing some kind of information about the length of the therapy session (ie, a therapy hour is actually 45–50 min) and some kind of flexible estimate of how many months (or years) they might be in treatment is important. Obviously, there are a number of factors that influence length of stay, including the nature, history, diagnosis, comorbid issues, ongoing stresses, social support, financial resources, and length of the problem. There may also be structural limitations of the clinic that impact how long and how often the therapist can see the clients. Whatever estimates the therapist provides, letting the client know that this is an initial estimate and that the length of treatment may change depending on the aforementioned issues will help reduce confusion and reactivity when the treatment runs a different length of time than what was initially proposed.

Session goal #3, helping clients *understand confidentiality and privacy*, is an integral part of an effective therapy orientation, especially since there is such a high level of stigma toward mental illness and its treatment in Asian cultures. Many clients do not know what confidentiality is, and have fears and anxiety about others discovering that they have a mental health problem and are seeking treatment. Many Asian heritage clients are also unfamiliar with the limits of confidentiality (eg, danger to oneself or others, or knowledge of vulnerable populations being hurt (children, elderly, and the disabled)).

It may also be beneficial to differentiate between thoughts, plans, intent, and action. For example, many clients think about hurting themselves, but do not have a specific plan or intent to do so. However, if insufficient time is spent on orienting clients about these differences and how it impacts breaking confidentiality, clients may hesitate to share important information for fear of being hospitalized. It is important to remember that in some Asian countries, patient rights and protections have not been fully implemented in clinical practice. Many clients have fears that they will be hospitalized if they discuss their mental health issues with doctors and other authority figures. They have fears that if they discussed suicide, they will be deemed "crazy," denied basic rights, and be restrained in the "mental hospital."

Another aspect of confidentiality is *discussing the extent to which they want their family involved* in the treatment process. For example, in the community mental health settings, family members often drive clients to their appointments. Some ethnic-specific clinics that specialize in providing services for Asian heritage populations

may also make it mandatory to at least ask this particular question in their assessment process because they take a collaborative family approach to providing services. However, many clients don't want their family involved in the treatment process and typically only make it clear if the therapist asks.

Another session goal and an important part of an effective therapy orientation involves helping the client *understand the facts and fallacies of the treatment*. It is important to correct misunderstandings and stereotyped misperceptions toward mental health treatment that are quite commonplace in Asian culture. As stated in the manual, it is important for clients to understand that psychotherapy is not a waste of time, miracle cure, quick fix for problems, time to complain, shameful, or for people who are "crazy" or "weak." Moreover, it is important for clients to understand that psychotherapy can help people feel better emotionally, develop insight into their problems, become more effective communicators, improve social relations, engage in healthier behaviors, and reach their goals and develop inner strength.

One of the most powerful metaphors that I use with clients to help them understand how psychotherapy works is to *draw an analogy between psychotherapy and physical therapy*. For example, the manual helps clients understand that physical therapy and psychotherapy are both practice- and strength-based (eg, strengthening one's body, mind, emotions, behaviors, and actions). The manual culturally adapts therapy by utilizing a holistic and strength-based focus. In addition, both physical therapy and psychotherapy involve practice and exercise, which can be extremely beneficial and reassuring for clients. Both psychotherapy and physical therapy focus on incremental improvement, flexibility, short- and long-term progress, and rehabilitating injuries.

This more holistic approach of drawing a parallel between physical therapy and psychotherapy helps reduce stigma toward mental illness, provides hope that emotional and mental issues can be healed through strengthening exercises and practice, and provides incentives for effectively dealing with problems in the present to avoid negative consequences in the future. For example, sometimes I will let clients know that if somebody tears a ligament in their knee (eg, their Medial collateral ligament (MCL)), if they don't get the proper treatment, they may have difficulties walking, running, or doing exercise in the future. Even if their knee heals by itself to some extent without physical therapy, that process may take longer, the person may be more prone to reinjury, it may heal incorrectly, and once they get older they may begin to have knee pain if the weather changes.

The treatment manual draws this analogy and similarity to psychotherapy to not only reduce stigma, but also to help increase client motivation to deal with their problems and stressors in the here and now. Clients begin learning that if they practice and work hard, they can change their lives. This also helps reduce avoidance and delayed help-seeking. Clients begin to realize that if they wait until their problems get intolerably worse, it becomes much more difficult to heal with and their problems become more chronic and enduring. Therapists can also point out that, when problems are not effectively dealt with in the present, avoidance increases the likelihood of relapse and recurrence of future problems.

Regarding orienting clients to the purpose of therapy, it is important to note that therapy helps to both highlight and understand the antecedents or cause of problems, but also to develop important skill sets that will help them navigate and resolve their stressful situations (eg, communication skills, cognitive reframing, mental flexibility, problem-solving abilities, emotional strengthening, and stress management). For example, sometimes it is very important to understand the causes of one's emotional or stressful issues, and this is where insight and awareness of problem development can be very useful (eg, if you keep playing a particular sport in an incorrect way you keep reinjuring your knee). However, sometimes the injury may have been a fluke accident (eg, somebody running by accidentally bumps into you and causes you to slip and fall). In those situations, knowing the reasons may not be as useful, but having the skills to rehabilitate and exercise one's mind, heart, and emotions is necessary either way. When a person experiences trauma or negative life events, they can be emotionally or psychologically injured. Exercising our brain to think about problems in different ways and develop effective coping strategies to best address our problems are important skills to develop.

When discussing the similarities between physical therapy and psychotherapy, the therapist can also raise an additional comparison between personal training and psychotherapy. Specifically, when an individual works out with a personal trainer, they work out much harder and more efficiently in a shorter amount of time. Similarly, those seeking help from a mental healthcare provider do not necessarily need to have a mental illness. They can also use psychotherapy in a similar way that people utilize personal training. They are strengthening their mind and emotions in a way that helps them handle problems in a more efficient manner, and in a shorter amount of time than they could do by themselves. Therapists are not only a supportive sounding board, but also experts in helping people think positively, maximizing their full potential, developing confidence, and thinking about micro- and macro-issues that affect their daily lives. This also helps clients realize that once their mental health problems go into remission and they reach a state of recovery, they do not necessarily have to discontinue

psychotherapy and can continue utilizing therapy for maintenance purposes, to help prevent future problems, as well as to help maximize efficiency in dealing with everyday problems.

In addition to drawing the parallel between psychotherapy and physical therapy, it is important to provide psychoeducation and *understand the facts and fallacies about therapy*. For example, the manual discusses that therapy can help improve a person's mood, but it is not a quick fix, and that it takes time and investment in order to effectively address long-term issues. Importantly, the manual also highlights the consequences of doing nothing to help resolve one's problems, noting that, left unaddressed, their problems can get worse and have negative personal, social, and family consequences. Pointing out the consequences is an important cultural adaptation and aligns with Asian concepts of cause-and-effect.

The culturally adapted treatment manual focuses on three ways in which psychotherapy can be beneficial. These include changing your life circumstances (eg, making changes to your life, taking charge of problems, and improving social relations), thinking in better ways (eg, increasing positive, healthy, and effective thinking), and making internal changes (eg, feeling more balanced, centered, and developing inner peace). This ordering of how psychotherapy can help the client with their problems is purposeful and is itself a cultural adaptation.

Asian heritage populations are highly goal-oriented and focused on problem-solving, particularly when engaging in something highly stigmatized like mental health treatment. This goal orientation stems from Confucian thought and philosophy. If the therapist places too much initial emphasis on changing the way people think or cognitive reframing, Asian heritage clients may be offended or react defensively. Typical client reactions include stating that it is the other person who is causing the problem, or it is the stressful situation that is the issue. When their problems are not focused on and their viewpoints are not acknowledged, clients are less open to thinking about how they contribute to their problem through behavioral actions, and are less open to changing the way they think and reframing their problems. Clients are much more willing to change the way they think and engage in cognitive reframing once they have exhausted other options for resolving the problem more actively. This is a modification from traditional CBT, which takes a much more proactive and direct initial approach to cognitive reframing.

One of the session goals and most important components of a comprehensive therapy orientation is to "*understand the client and therapist roles and responsibilities*." The patient–doctor relationship in Asian heritage cultures and medicine is very different from that of Western psychotherapy. There is more of a top-down authoritative process where the doctor takes the expert role and the client is more a passive recipient. However, the culture of Western psychotherapy is much more collaborative and Asian heritage clients are oftentimes unclear of their role and what to say during the therapy process. Moreover, they may be unsure why the therapist is not "telling them what to do to get better," resulting in loss of credibility and belief in the treatment. This expectation stems from traditional Asian medicines, where doctors are more prescriptive and authoritative.

Session 1 of the therapy manual reviews many of the roles and responsibilities of the client and therapist. This is very important to do at the beginning of therapy because it sets the tempo of how clients interact, engage, and feel during treatment. Important responsibilities of the client include coming to therapy every week, being open and honest about feelings and opinions, discussing problems with the therapist, actively listening to what the therapist says, being open to making changes, and practicing and completing the assigned exercises each week. Understanding the multiple roles and responsibility of the therapist is also important, which includes being emotionally supportive, providing psychoeducation, helping with the client's problems, providing feedback and suggestions, helping to make decisions but not making decisions for the client, and referring the client to a psychiatrist for medication evaluation.

Another very important session goal and aspect of an effective therapy orientation is to *understand the course of therapy*. For example, in the treatment manual, we discussed that therapy takes time and it may take several weeks before they begin feeling the therapeutic benefits. Moreover, it discusses how it is natural and normal to feel like they are doing a lot of talking during the initial part of therapy. This is because the therapist needs to get to know them well and fully understand the issues involved before they begin giving advice to help them resolve their problems. Orienting the client about the course of therapy involves letting them know how long it might take before they begin feeling the benefits, understanding why the therapist may not be talking as much during the initial part of the treatment and why the client feels like they are talking more, understanding why they may sometimes feel worse after attending therapy, and that ending treatment may be natural and timely or can be problematic and be the result of and feed into the cycle of their original problems.

The manual provides a metaphor that I developed called the *map of the city metaphor*, which was well received and has been shown to be very effective in clinical practice, not only with Asian heritage populations but also with other populations who may not have as much familiarity or been to treatment before. The *map of the city*

metaphor consists of letting the client know that the therapist doesn't know much about their life or their world. If the therapist starts telling them what to do and provides direct advice without an accurate understanding, they may steer them in the wrong direction (eg, driving around in circles, wasting gas, and going down one-way streets). In order to effectively provide the best guidance, they need to have a good overview or mental map of the situation. Providing psychoeducation and normalizing the initial parts of therapy can be very important and help reduce apprehension. Without it, clients may be left floundering in their own thoughts and fantasies about why they are talking so much and why the therapist doesn't say much, which dramatized in their minds comes off as therapists nodding their head, parroting emotions, and saying "uh huh."

Similarly, it is very important to help clients understand why they may sometimes walk away from therapy feeling worse. This is addressed in the *thinking more versus thinking less* section of the treatment manual. Specifically, talking about one's stressful experiences and emotional pain is naturally going to lead to thinking about an issue more, and the potential emotional aftermath of lingering worries and emotional discomfort. For example, when somebody has an injury or infection, opening the afflicted area up in surgery and healing the wound is oftentimes necessary. Ignoring the necessity for surgery can make problems worse. This section normalizes these feelings and reactions, which is a very effective and necessary cultural adaptation. Otherwise, the client may not come back if they feel like therapy is not effective and even make them worse.

In addition, it is important to remind the client that unless they are directly addressed, resolving problems can be extremely difficult. Ignoring or avoiding them will typically lead to negative outcomes, as problems fester and become worse. It is important to tell the client that if they are beginning to feel worse after coming to therapy, to talk about this with the therapist. Similar to physical therapy and exercise, sometimes clients may work out too hard and be uncomfortably emotionally rather than physically sore. Clients need to communicate with their physical therapists and personal trainers to make sure that the pace of rehabilitation sufficiently pushes them, but does not create an aversive reaction to continued training. Similarly, if the clients walks out of therapy like an open wound and experiences increased distress, therapists need to understand this dynamic so that they can better address this in treatment and end therapy sessions in a less stressful manner (eg, spending the last 5–15 min of each session focusing on providing the client with hope and emotional support, changing the topic and talking about positive things in life, implementing strengthening exercises, and doing some relaxation training such as deep breathing, meditation, or progressive muscle relaxation). This will help clients feel less fragile after leaving therapy, and provide greater incentives to return and stay in treatment.

One of the most important issues to address with Asian heritage populations is to discuss the session goal of *why dropping out of therapy is problematic*, but also to normalize why thinking about it is a natural and normal part of treatment. This is very important because compared with other groups Asian Americans tend to drop out of treatment prematurely. Nevertheless, the end of treatment can be timely and appropriate or premature and problematic. Sometimes clients want to drop out of treatment prematurely because talking about their problems triggers a flood of emotional stress. In addition, sometimes they may have a conscious or unconscious urge to drop out of treatment at a critical moment, or when the most important clinical or interpersonal issues are being raised. Sometimes the client's coping response (eg, avoidance) may be associated with dropping out of treatment at a specific juncture, which reinforces the negative cycle of avoidance of problems or interpersonal conflict.

At other times, clients may think about dropping out of treatment because they feel like their therapist is not a good match, and may feel like the therapist is not effectively helping them with their problems (and sometimes this is absolutely true). It is better for the client to switch therapists than to continually see someone who cannot help them with their problems. Otherwise, negative therapeutic experiences compound stigma as well as the impressions that "all" therapy and "all" therapists cannot help them with their problems. However, if a client has a pattern of switching therapists a number of times and being dissatisfied with a variety of therapists, this can also be an indicator of an interpersonal problem (eg, borderline personality or narcissism).

Because Asian heritage populations can be more naturally reticent to complain or ask questions of authority figures, helping the client understand that you want to know if they are starting to think about dropping out of therapy is a very important cultural adaptation. I often let clients know that therapy is a very interpersonal experience and to please let me know if they are upset at me, irritated, or feel like I'm not helping them. I ask them to tell me so that we can figure out how to best meet their needs. I let them know that I will not become angry, defensive, or upset, and that meeting and understanding their needs is of the utmost importance. In addition, I let the client know that it takes a lot of strength and courage to face one's problems and take action to make things better. I reassure the client and let them know that I am here to help. Culturally adapting therapy involves aligning yourself with the goals of the client and strengthening this interpersonal relationship, while at the same time effectively dealing with cultural-clinical issues that may interact and impact the treatment process.

Understand You and Your Problems

Another important cultural adaptation is to spend more time getting to know the client and their problems. In the culture-adapted treatment manual, the session goal of *Understanding you and your problems* was developed specifically for this purpose. In many Asian heritage cultures, people only discuss and divulge personal problems with people who they know very well and trust. Becoming familiar with your client and establishing a positive interpersonal relationship and rapport can help facilitate trust building and a strong working alliance.

Another important clinical-cultural skill is to ask an open-ended question about why the client is seeking help at this time. This is a very important question because many clients could have sought help earlier, but something must have happened recently that created a greater impetus to seek help. This affects Asian heritage populations to a larger extent than other groups because of the stigma toward mental illness, which causes delays in help-seeking. Something must have pushed them to seek help at this time. Understanding the factors that drive help-seeking initially draws attention to potential areas for intervention, highlights clinical severity issues, and increases understanding of the client's current stressful life events. Asking these questions also helps improve therapist–client relations, and consequently improves therapist credibility because they are more quickly able to hone in on issues that are important to the client. Developing a strong interpersonal relationship with Asian heritage clients is a very important aspect of individualizing treatments. Otherwise, the client may not open up and trust the therapist, nor fully engage in the treatment process.

The importance of social connectedness is exemplified in many collectivistic cultural backgrounds. Strong interpersonal relations can facilitate greater openness, trust, and belief in the practitioner. The importance of strong interpersonal relationships and connectedness is highlighted by religious and philosophical teachings. For example, there is a Buddhist teaching that states "When we realize the extent of the myriad interconnections which link us to all other life, we realize that our existence only becomes meaningful through interaction with, and in relation to, others." Understanding and strengthening interpersonal relations is an important part of individualizing and tailoring services for those from collectivistic backgrounds.

CHAPTER GOAL #6: UNDERSTAND WHY IT IS SO IMPORTANT TO ADDRESS CLINICAL EMERGENCIES AND CRISIS ISSUES WHEN WORKING WITH ASIAN HERITAGE POPULATIONS

Because of stigma and delayed help-seeking, compared to other groups, Asian heritage populations tend to be much more clinically severe when they finally do seek help (Hwang, 2006). Many of the therapists that I have supervised and many Asian heritage clients who I have treated wait until their problems got worse, often to the extent of wanting to commit suicide before coming in for help. It is important to address these issues during the very first session of psychotherapy to ensure their safety.

It is important to note that suicide is the eighth leading cause of death for Asian Americans, but only the eleventh leading cause of death for all other racial groups combined (Hijioka & Wong, 2012). In addition, Asian American college students have a higher rate of suicidal thoughts and attempts compared with White college students. Asian American women from the ages of 65 to 84 have the highest rates of suicide compared to females from all other racial backgrounds. Moreover, US-born Asian American women have a higher lifetime rate of suicidal thoughts compared with the general US population.

Therefore, actively addressing suicidal ideation, plans, and attempts is an important cultural adaptation and part of treating Asian heritage populations. Therapists need to proactively ask and address these issues in the first session, especially since Asian heritage clients often come in more severe and have delayed help-seeking. Regardless of ethnicity, I make it a habit to ask all of my clients whether they have any suicidal thoughts to ensure their safety. However, I cannot emphasize enough how important this is with Asian heritage populations, because oftentimes they are more reluctant to express their thoughts and feelings or to initiate discussions about this issue. Some clients may also have the belief that if they discuss suicide with the therapist, they will be hospitalized against their will and not be allowed to have contact with the outside world. The treatment manual provides a comprehensive suicide assessment form on page 11.

A comprehensive suicide assessment involves querying feelings about hopelessness, whether they feel like their life is worth living, thoughts of death or hurting themselves, and thoughts, ideas, plans, or methods of hurting themselves. Moreover, inquiring whether they have access to the means of hurting themselves, whether they

have tried before, the number of times they have previously attempted suicide, and whether they have ever been previously hospitalized provides important clinical information that helps ensure client safety. Moreover, asking how often they think about hurting themselves, identifying the triggers of their suicidal ideation, and asking if they have access to the means in which they might do it is extremely important.

Providing psychoeducation about why suicide is a poor option is also extremely beneficial. Letting the clients know that they can talk with the therapist about suicide and differentiating between thoughts and actual planned intentions is important. Moreover, discussing the impact that suicidal attempts can have on the family and their recovery can also be an effective cultural adaptation. In some ways, this capitalizes on the importance of saving face and reducing shame upon oneself and one's family, which often occurs after a suicide attempt and was a purposeful cultural adaptation.

It is important that the therapist periodically ask clients about suicidal ideation because the safety of the client is of the utmost importance. Flushing out whether they have the intent to hurt themselves and the specifics about the plan of how they may do it is standard clinical practice. Methods of suicide can have additional cultural meaning for Asian heritage populations. For example, when Asian heritage women hang themselves, this has a cultural meaning and oftentimes indicates that they are angry and upset at their family for not appreciating and being there for them.

Normalizing that the therapist may intermittently inquire about suicidal thoughts and that this is part of standard clinical practice helps reduce feelings of discomfort. In promoting safety, clients were asked to collaborate with the therapist and come up with an effective safety plan. This included discussing suicidal thoughts and plans with their therapist, making sure that they are not alone when they feel suicidal, calling a friend or family member, calling a suicide hotline, going to the gym or doing some other enjoyable activity, calling 911 and asking for help, going to the emergency room and asking to be hospitalized, developing a suicide contract, collaborating with the therapist to develop other ideas to ensure safety, and preventing access to the means in which somebody might hurt themselves (eg, making sure that they do not have access to pills, ropes, guns, and knives).

CHAPTER GOAL #7: EMPHASIZE THE IMPORTANCE OF GOAL SETTING WHEN WORKING WITH CLIENTS UNFAMILIAR WITH PSYCHOTHERAPY

Because Asian heritage populations are often unfamiliar with therapy and have higher stigma that increases discomfort with being in treatment, it is very important to give clients a sense of direction and establish goals for treatment. I would recommend a staged approach to setting goals in order to reduce feelings of confusion and being overwhelmed. For example, in Session 1 of the treatment manual, clients are asked to set three goals for treatment. Later on in the treatment manual, we differentiate between short-term and long-term goals and become much more specific. This is not done in this first session, so as not to overwhelm the client.

Because Asian heritage populations may evidence greater disbelief regarding therapy's ability to help them with their problems, it is very important to *develop goals and identify signs of treatment progress*. This session goal of identifying markers of improvement can be very effective in engaging the client's buy-in to treatment. Personally, I think this is good clinical practice for any population, but this is especially important when tailoring treatment for Asian heritage populations, where the clients want to see and experience concrete results. Although different therapeutic orientations may differentially emphasize the importance and directness of goal setting, because Asian heritage culture tends to be goal-oriented, setting goals is an important cultural adaptation and is a necessary part of the therapeutic process.

Because Asian American clients may be more severely ill by the time they do seek treatment, they may have greater expectations for immediate symptom improvement, and expect more structure, direct advice, goal-setting, and problem-solving. Sue (1998) recommended that therapists offer an initial "gift" of problem or symptom reduction to increase satisfaction and comfort with treatment, reduce premature dropout, and increase respect and credibility for the therapist. Other options or gifts may include normalization, cognitive clarity, reassurance, hope, goal-setting, skills acquisition, anxiety reduction, and depression relief. Moreover, helping the clients improve their understanding of their problem, utilizing a biopsychosocial or holistic approach to help reduce stigma, increasing comfort levels by being culturally knowledgeable, and helping clients develop inner peace through balance in their mind, body, and spirit can also be beneficial (Hwang, 2006). A more holistic approach may also serve as a noninvasive method of enculturating the client into the medical or therapeutic model.

Setting goals can also help focus the client on addressing each problem one step at a time. This helps reduce feelings of being overwhelmed by the myriad of stressors they experience. It also helps reduce trying to tackle every problem at the same time, which can be overwhelming and often leads to noneffective handling of problems. It is important to address specific problems to completion to help the client gain confidence in the treatment. In the West, there is an English proverb written by George Puttenham (1589) that emphasizes not putting the cart before the horse. The Chinese also have a saying "yi bu yi bu zou" (pronounced yí bù yí bù zǒu in Mandarin Chinese—一步一步走), which means taking things one step at a time. In addition, Lao Tzu, a famous philosopher in ancient China, said, "A journey of a thousand miles must begin with a single step." Incorporating a step-by-step approach in therapy and bridging it with cultural sayings can help clients feel less overwhelmed and provide them with hope.

Cultural metaphors can help reinforce goal-setting and tackling problems one step at a time. Because Asian heritage populations tend to be very severe when they finally do come in to treatment, setting goals early on can also help prevent the client from "dumping" all of their problems onto the therapist. This can also help reduce the therapist's frustration and help clients take charge of their own treatment and provide direction. Effective goal-setting can help clients engage more fully in treatment and help reduce premature dropout. It is an essential part of many evidence-based practices. Making sure that these goals are culturally congruent, achievable, focused, and measurable helps ensure clinical effectiveness.

References

Acosta, F. X., Yamamoto, J., Evans, L. A., & Skilbeck, W. M. (1983). Preparing low-income hispanic, black, and white patients for psychotherapy: Evaluation of a new orientation program. *Journal of Clinical Psychology*, *39*(6), 872–877. Available from http://dx.doi.org/10.1002/1097-4679(198311)39:6<872:AID-JCLP2270390610>3.0.CO;2-X.

Brand, D. (1987). The new whiz kids: Why Asian Americans are doing well, and what it costs them. *Time*, *130*(9), 42–50.

Chang, D., & Sue, S. (2003). The effects of race and problem type on teachers' assessment of student behavior. *Journal of Consulting & Clinical Psychology*, *71*(2), 235–242.

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, *59*, 614–625. Available from http://dx.doi.org/10.1037/0003-066X.59.7.614.

France, D. G., & Dugo, J. M. (1985). Pretherapy orientation as preparation for open psychotherapy groups. *Psychotherapy*, *22*(2), 256–261.

Freeman, S., Eddy, S. L., McDonough, M., Smith, M. K., Okoroafor, N., Jordt, H., et al. (2014). Acitve learning increases student performance in science, engineering, and mathematics. *PNAS*, *111*(23), 8410–8415.

Hijioka, S., & Wong, J. (2012). Suicide among Asian Americans. Available from http://www.apa.org/pi/oema/resources/ethnicity-health/asian-american/suicide-fact-sheet.pdf.

Hwang, W. (2006). The psychotherapy adaptation and modification framework (PAMF): Application to Asian Americans. *American Psychologist*, *61*(7), 702–715. Available from http://dx.doi.org/10.1037/0003-066X.61.7.702.

Shamas, L., & Seitz, A. R. (2008). Benefits of multisensory learning. *Trends in Cognitive Sciences*, *12*(11), 411–417.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, *53*(4), 440–448. Available from http://dx.doi.org/10.1037/0003-066X.53.4.440.

Whaley, A. (2013). *The analects of Confucius*. London: CreateSpace Independent Publishing Platform; Reprint edition.

Yang, L. H., Lai, G. Y., Tu, X. M., Luo, M., Wonpat-Borja, A., Jackson, V. W., & … Dixon, L. (2014). A brief anti-stigma intervention for Chinese immigrant caregivers of individuals with psychosis: Adaptation and inital findings. *Transcultural Psychiatry*, *51*(2), 139–157. Available from http://dx.doi.org/10.1177/1363461513512015.

Yang, L. H., Phelan, J. C., & Link, B. G. (2008). Stigma and beliefs of efficacy towards traditional Chinese medicine and Western psychiatric treatment among Chinese-Americans. *Cultural Diversity and Ethnic Minority Psychology*, *14*(1), 10–18. Available from http://dx.doi.org/10.1037/1099-9809.14.1.10.