CHAPTER

7

Providing Psychoeducation About Depression and Its Treatment (Session 2 of the Treatment Manual)

If you are depressed you are living in the past. If you are anxious you are living in the future. If you are at peace you are living in the present. ***—Lao Tzu (Philosopher and Poet, Founder of philosophical Taoism and author of Tao Te Ching; 5th–6th Century BCE)***

This chapter introduces Session 2 of the treatment manual entitled "Understanding How Depression Can Negatively Influence Your Life." Similar to Session 1 of the treatment manual, there is a strong psychoeducational emphasis, which is an important cultural adaptation. When working with Asian heritage populations, this cultural modification is especially needed at the beginning of treatment because many enter treatment with little understanding of mental health care. In addition, psychoeducation helps destigmatize mental illness and its treatment, which makes many people feel uncomfortable, especially when they are first seeking help. Session 2 provides a psychoeducational overview of depression and its treatment for the client. This session discusses how depression is treated, and focuses on providing hope and understanding of how to break unhealthy cycles. The client goals for Session 2 include:

- Understand what depression is like for you;
- Understand the causes of depression and that it is treatable;
- Understand the benefits of antidepressants and herbal medication;
- Understand how psychotherapy treats depression;
- Understand and break unhealthy cycles;
- Understand "Qi" (Energy) and your mood.

Each of the session goals has been incorporated into specific chapter goals for the reader. Additionally, the chapter goals may include other topics. The chapter goals include:

- Understanding how to destigmatize and educate clients about mental illness
- Understanding cultural differences in the expression and communication of distress
  - Culturally adapting the traditional DSM approach to symptom presentation
  - Including additional symptom domains that are not traditionally part of the DSM
  - Understand what depression is like for you
- Destigmatizing the causes of mental illness
  - Understand the causes of depression
- Providing hope by helping clients understand that depression is treatable
  - Understand the benefits of antidepressants and herbal medication
  - Understand how psychotherapy treats depression
- Providing hope and finding balance through the integration of cultural symbols
  - Understand and break unhealthy cycles
  - Understand "Qi" (Energy) and your mood.

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CHAPTER GOAL #1: UNDERSTANDING HOW TO DESTIGMATIZE AND EDUCATE CLIENTS ABOUT MENTAL ILLNESS

Psychoeducation is an important aspect of working with Asian heritage populations. Educating clients about various aspects of mental illness and its treatment is a cultural adaptation that is repeated and emphasized throughout the treatment manual. This is an important modification that can help bridge the cultural values of Asian heritage populations with mental health care. Specifically, the importance of education was infused into many different Asian cultures by Confucianism and other scholars. It can be used to increase client familiarity and understanding of mental illness and the therapeutic process. Moreover, psychoeducation can be a culturally effective way of engaging clients, educating them about their illness, breaking down popular misconceptions and stereotypes, reducing stigma, and increasing the client's sense of mastery and confidence.

In Session 2, psychoeducation shifts from orienting clients about the treatment process to educating clients about psychiatric illness (ie, major depression). When educating Asian heritage populations about specific psychological disorders, a number of aspects should be emphasized. They include normalizing the experience of psychiatric illness (vs the notion that mental illness is rare and only crazy people develop such problems), understanding the symptoms (going beyond the emotional and mental and providing a holistic understanding of the illness experience), and understanding the assortment of etiological factors that can precipitate and cause mental health problems. In doing so, the therapist may have to also educate by debunking stereotypes and misconceptions. For example, many people seeking help believe that depression is biologically passed down from generation to generation. Helping clients understand that psychosocial risk and protective factors can be very important in triggering a depressive episode can be very important, especially since they provide targets for intervention and prevention. An important illustration of this is helping clients understand the stress–vulnerability or diathesis–stress hypothesis, and aiding clients increase their resilience by accessing social support resources, while at the same time increasing their stress management skills. Helping clients understand the relationship between stress and mental illness is very important in reducing stigma and beliefs about shaming oneself and one's family.

In discussing psychiatric illness, it is important to provide clients with an understanding of how prevalent the problems they are struggling with are in the general population. This can help normalize their experience, and reduce the stress and anxiety clients feel in seeking mental health care. It helps the client feel like they are not alone, and that illnesses such as depression are normal and common place. Citing lifetime prevalence rate statistics about what percentage of people experience these problems not only educates, but also provides scientific evidence which is incredibly informative. Common client reactions that are typically seen among Asian heritage populations include asking the therapist if they are crazy if they are depressed, reporting feelings of embarrassment, extreme anxiety about other people finding out and losing face for themselves and their family, and disbelief about the effectiveness of psychotherapy and psychiatric medications.

For more highly educated clients, going into the methodological biases associated with establishing the prevalence rate of mental illness psychiatric epidemiology (eg, which tends to underestimate the prevalence among Asian heritage populations due to cultural norms for not talking about problems with complete strangers) may be beneficial. These methodological biases were discussed previously in chapter "Understanding Cultural Influences on Mental Health." Imagine that you belong to a culture where there is high stigma toward mental illness and where people are afraid of being labeled "crazy." Somebody calls your home or comes knocking at your door, and asks you if you ever feel like killing yourself or hear voices. What would you say? Because of this, the prevalence of mental illness among Asian heritage groups may be artificially low or underestimated.

Practitioners can also help destigmatize mental illness by discussing how they are serious medical conditions. Like physical illnesses, depression needs to be taken seriously. A combination of preventative and proactive treatment approaches need to be utilized to reduce the impact of stigma and increase treatment effectiveness. Even though depression is an episodic disorder and may come and go (even when people don't seek help), we know that it is a persistent disorder that is highly likely to recur if not properly addressed. Early intervention and prevention of future episodes is critical to reducing the number of episodes a person experiences in their lifetime. When clients do experience a temporary reprieve from feeling depressed, this is a critical moment because clients are better able to utilize therapy and focus on identifying signs and symptoms of relapse. I typically educate clients on the evidence base for depression relapse, and discuss diathesis–stress theory and thresholds for vulnerability. Specifically, with each depressive episode, a person's sensitivity to stress increases and their threshold of vulnerability decreases—which means it takes even less stress the next time around to trigger a major depressive

episode (Burcusa & Iacano, 2007). This is why it is so important to manage stress effectively and deal with problems in healthy ways. It is important to educate clients not to drop out of treatment during the times they are less depressed, and to focus on addressing the issues that triggered the depressive episode so that the likelihood of recurrence is reduced.

By helping clients understand the root causes of depression and taking a proactive approach to addressing their problems, practitioners can help their clients treat the depression to a state of full or partial remission, and decrease the likelihood of relapse. By emphasizing both the rewards and consequences of action and inaction, we provide clients with hope and a realistic understanding of their depression. This is an important cultural adaptation, and it also aligns with Chinese and Taoist cultural concepts and the principle of cause-and-effect (pronounced yīnguǒ in Mandarin Chinese—因果). Psychoeducation and understanding cause-and-effect principles are also associated with Confucianism. Specifically, the ability of an educated person in a position of power to influence and change their lives is an important one in many Asian heritage cultures. Whether these cultural issues are directly referenced, or whether their meanings are discussed but the cultural origins are referenced, may depend on the individual characteristics of the client. Some clients may benefit from this culture and therapeutic bridging; whereas, others may just benefit from direct psychoeducation. This may partially be mediated by their identification with their Asian heritage background and their level of acculturation or education.

CHAPTER GOAL #2: UNDERSTANDING CULTURAL DIFFERENCES IN THE EXPRESSION AND COMMUNICATION OF DISTRESS

A very important cultural adaptation is to emphasize that psychiatric illness is not simply a mental health problem. Symptoms are not only mental, emotional, and/or cognitive, but also physical in nature. This is another example of how studying culture-specific issues (emics) can help us improve clinical science and aid in the discovery of factors that might be culture-universal (etics). Specifically, every psychiatric disorder consists of psychological as well as physical symptoms. The treatment manual culturally adapts therapy by highlighting various symptom domains that help destigmatize mental illness. The traditional DSM approach does not group symptoms into specific domains. For example, the nine DSM symptoms of major depression are listed below:

- Depressed mood;
- Loss of interest or pleasure;
- Appetite and weight changes;
- Sleep disturbance;
- Psychomotor agitation or retardation;
- Fatigue or loss of energy;
- Feelings of worthlessness or inappropriate guilt;
- Difficulty concentrating or making decisions;
- Recurrent thoughts of death.

Culturally Adapting the Traditional DSM Approach to Symptom Presentation

As you can see and as is typical with the DSM across various psychiatric disorders, the symptoms above are not presented in a specific purposeful order or systematic manner. According to the DSM, a person needs to evidence five out of nine symptoms in order to meet criteria for major depression. Using this more traditional approach to symptom presentation, I often get client feedback that they must not be depressed because they are not feeling depressed or crying. Emphasizing that depression can manifest itself in loss of motivation and energy is very important. In addition, because there is a heavy stigma toward mental illness among many Asian heritage populations, there is a tendency to deny and avoid the mental symptoms of depression. Many Asian heritage clients also commonly ask if they are "crazy" if they are depressed. Other common questions include "Am I lazy or weak if I am depressed?" In order to help reduce stigma, a culturally adapted approach to symptom presentation is recommended. Rather than taking this traditional DSM approach to presenting symptoms without any logical order, organizing symptom clusters into mental and physical can be extremely beneficial for Asian heritage and other populations.

DSM Mental Symptoms	DSM Physical Symptoms
• Sadness or depressed mood • Loss of interest or pleasure in things • Trouble concentrating or making decisions • Feeling guilty or worthless • Having thoughts of death or suicide	• Feeling tired or fatigued • Sleeping too much or too little • Changes in appetite or weight • Feeling slowed down or restless

This helps clients visually see that four out of the nine symptoms of major depression are actually physical in nature. It also highlights that depression is not just an emotional illness, but it is also very somatic in nature and affects energy levels. Clients are often quite surprised to see that what they believed to be depression (eg, that you should be crying and sad) is not necessarily the primary way people experience depression. They also discover that many people experience depression in terms of loss of interest and pleasure, lack of motivation, and difficulties concentrating because of persistent worry and anxiety. In addition, they also visually see the physical symptoms of tiredness, sleep difficulties, changes in appetite, and feeling slowed down or restless. They begin to understand that depression truly is a psychosomatic illness.

This cultural adaptation not only provides psychoeducation about mental illness, but also helps decrease stigma by deemphasizing the "mental" and emphasizing its multifarious symptom domains. In my clinical practice, I also do this for a variety of disorders and with clients from many different ethnic backgrounds with a lot of success. It really helps educate the client, as well as normalize and destigmatize the client's problems. I feel like this is another example of how studying culture can be beneficial to improving psychological science. This cultural adaptation can be beneficial for all groups, and can be considered a culture-universal modification. Why not present the symptoms for all psychiatric disorders in this manner (ie, analyze the symptoms and group them into various categories)? In my experience, many clients benefit and are appreciative of this more balanced and holistic approach to understanding their problems. Especially for clinics that treat clients from collectivistic backgrounds or populations that evidence heavy stigma toward mental illness, this more mind–body approach is very beneficial. I would recommend individual practitioners, clinics, and hospitals revise their pamphlets and brochures to help clients understand different clusters of symptoms to reduce stigma against mental illness. The DSM may also benefit from said revisions.

This approach to presenting symptoms is also a cultural adaptation. Specifically, it utilizes a multisensory and active learning approach to symptom presentation, recognition, and endorsement. This aligns well with the educational emphasis in Asian heritage populations. For example, in the treatment manual you will see a checkbox next to each symptom where clients can actively check off and self-endorse the symptoms that they are experiencing. By having clients check off the boxes, clients recognize and accept their own symptoms. This is a more culturally sensitive approach to psychoeducation and diagnosis than a therapist directly telling a patient who may be sensitive or reactive that they have a mental illness. Although some clients may be open to being told that they suffer from a psychiatric disorder, groups that experience high stigma toward mental illness may benefit from a less practitioner-driven labeling of client diagnoses.

In order to emphasize this multisensory approach, the client is also asked to read the symptoms out loud. In order to destigmatize the problem, they are told that a lot of people experience these types of symptoms at some point in their life, which is a purposeful adaptation to normalize problems. They are asked to check off the symptoms that they are currently experiencing. They physically check off their symptoms and discuss them and their diagnosis with the therapist. This active learning approach helps the client see, hear, discuss, and kinesthetically endorse the problems that they are having—thus facilitating learning and memory consolidation.

Providing clients with pamphlets and brochures and asking them whether they relate to any of the problems that other people commonly experience is a very effective way to engage clients and reduce stigma. This can be an extremely culturally sensitive and powerful psychoeducational intervention when working with clients who struggle with highly stigmatized illness, such as schizophrenia or bipolar disorder with psychotic features. Because many of these illnesses involve paranoia and suspiciousness of others, taking an indirect or collaborative approach to diagnosis can be less intimidating and elicit less defensiveness. If the reader is interested in seeing how this is implemented in clinical practice, they can read a clinical case study that I published, which discusses how I treated a Filipino American client with psychotic features, while utilizing culturally sensitive methods (Hwang, Miranda, & Chung, 2007), or another study that I published which demonstrated that many psychiatrists are afraid to tell Chinese patients that they have schizophrenia for fear that the client will become defensive and drop out of treatment because they psychologically can't handle the label and stigma (Hwang, 2008).

INCLUDING ADDITIONAL SYMPTOM DOMAINS THAT ARE NOT TRADITIONALLY PART OF THE DSM

In addition to educating clients about the traditional symptoms of major depression, the treatment manual also culturally adapts therapy by presenting additional symptom clusters that are not typically included in the DSM. Specifically, there is an emphasis on somatic symptoms as well as social symptoms. In regards to somatic symptoms, and as discussed in chapter "Understanding Cultural Influences on Mental Health," there is some evidence to suggest that Asian heritage populations have a greater tendency to experience and/or express somatic symptoms when depressed. This may be due to a selective attentional focus on physical symptoms, or a greater tendency to ignore emotional and cognitive symptoms. In cultures where there is high stigma toward mental illness, the types of symptoms that a person expresses are related to social acceptability, feedback, and response.

Culturally competent therapists realize that people from different cultural backgrounds express distress in different ways, and will adjust for this when forming diagnoses and treatment plans. Because of the mind–body holistic approach prominent in Asian cultures and medicines, Asian clients may be more familiar with and feel more comfortable reporting somatic symptoms of distress. However, this does not mean that Asian immigrants do not experience emotional and cognitive symptoms. In fact, there is some evidence to suggest that even though Asian clients may be more likely to focus on physical complaints when they initially come in to treatment, they are also fully aware of their feelings and capable of talking about the problems that led them to seek help (Cheung, 1985; Cheung & Lau, 1982). When a client does not know the therapist, they may be more likely to report physical symptoms. However, after getting to know their treatment provider, they may be more open to sharing their emotional and cognitive symptoms.

When diagnosing clients, this may mean that practitioners may need to reassess symptoms after they get to know their clients better in order to get full disclosure of problems that they are having. This is a very important cultural adaptation because other groups may be more comfortable disclosing all of their symptoms during their first meeting; whereas, for Asian heritage populations, disclosure may be staggered across multiple meetings and depend on comfort levels and relationship closeness. Moreover, treatment plans that target physical complaints are likely to be beneficial, and understanding the social communication aspects of somatic symptom expression can be very important. It is also important for therapists to not hold overly rigid and stereotyped views of diverse clients, and be cognizant of the complexities and timing issues that influence when and what symptoms clients report. It is important to note that social and cultural forces seem to shape how people express their distress and may result in greater "somatization," which is a culturally sanctioned means of expressing distress through the body that may be less stigmatizing for the client (Kleinman & Kleinman, 1985). In order to be inclusive of the broad range of symptom experiences that are associated with depression among Asian heritage populations, the treatment manual includes some of the most common physical symptoms expressed and experienced. These include:

- Headaches;
- Stomach problems;
- Physical aches and pains;
- Inability to relax and irritability.

In regards to the somatic symptoms, this gets into the diagnosis of neurasthenia (pronounced shénjīng shuāiruo in Mandarin Chinese—神經衰弱, a Chinese form of depression) that we discussed in chapter "Understanding Cultural Influences on Mental Health." Neurasthenia is considered to be a Chinese culture-bound syndrome in the West and is included in the appendix of the DSM. In China and internationally, it is considered to be its own independent diagnosis. Unfortunately, the DSM still does not recognize neurasthenia as a disorder, even though it is recognized in other diagnostic systems. This prevents people who need help from being able to access insurance cover and also limits the number of sessions they are provided. According to the Chinese Classification for Mental Disorders (CCMD-3) and the World Health Organization's (WHO) International Statistical Classification of Diseases and Related Health Problems (ICD-10), in order to meet criteria for neurasthenia, clients need to evidence either (1) persistent and distressing complaints of increased fatigue after mental effort or (2) persistent and distressing complaints of bodily weakness and exhaustion after minimal effort (Chinese Society of Psychiatry, 2001; WHO, 1992). They also need to at least two of the following seven criteria including:

- Muscular aches and pains;
- Dizziness;

- Tension headaches;
- Sleep disturbance;
- Inability to relax;
- Irritability;
- Dyspepsia.

Although there was some controversy about the unique differentiation of a neurasthenia diagnosis from depression (Kleinman, 1982), more recent epidemiological studies in neurasthenia have found that it is a diagnostically unique disorder that can also be comorbid with major depression. For example, Zheng et al. (1997) found that of the study participants diagnosed with neurasthenia, over three-fourths of them could be characterized as having "pure" neurasthenia since they did not meet criteria for any other disorders. The remaining one-fourth of neurasthenia patients were considered mixed neurasthenia, because they also met criteria for another disorder. As previously discussed, epidemiological studies are less biased because they utilize random sampling strategies of nonclinical populations. Kleinman's initial clinic-based study was more biased or less generalizable because patients already seeking help self-select into Western mental health treatment and are more clinically severe. These methodological issues reduce the potential range of symptom variability among patients, and patients who are less severe may have more variability in types of symptoms experienced.

Emphasizing and differentiating the mental and physical symptoms is beneficial because it also links back to what we discussed in chapter "Why Is It Important to Culturally Adapt Therapy for Asian Heritage Populations?", the metaphor of comparing psychotherapy to physical therapy. This provides the client with hope and the understanding that their problems can be improved through exercise and hard work. Moreover, because many depressive symptoms are physical in nature, exercising has a direct tie-in to improving their feelings of fatigue, helping with their sleep, helping with their appetite and weight changes, reducing their feelings of being slowed down, as well as releasing excess restlessness energy.

When clients see this association and begin to feel the benefits of physical exercise on their physical as well as emotional symptoms of depression, they develop a greater buy-in and trust toward psychotherapy and the therapist's ability to help them with their problems. Indeed, there is much research to show that therapeutic life changes such as exercise can help improve mood, reduce the deleterious effects of depression, and act as a very powerful method of behavioral activation (Walsh, 2011). Moreover, introducing these issues early on in treatment is also an important cultural adaptation. This strategy helps prepare and plant the seeds for engaging in therapeutic exercises and practice in the sessions ahead.

Because of the collectivistic orientation of Asian heritage populations, it is also beneficial to culturally adapt therapy by discussing social symptoms that are commonly experienced by people who are depressed. Identifying interpersonal symptoms can be very diagnostic, as they help reduce denial and indicate to the client that they are struggling with a concrete problem. This is a very important component of problem recognition and acceptance because Asian heritage populations are less educated about the symptoms of mental illness. They are, however, acutely aware of social conflict and family stressors that cause them distress. Social symptoms that were included in the treatment manual include:

- Feeling lonely and isolated;
- Difficulty getting things done;
- Social and family conflict;
- People worrying about you.

The treatment manual does not attempt to change the Western conceptualization of major depression by adding on social symptoms. Rather, social symptoms were included as a symptom add-on that helps clients identify that they are depressed and that depression is impacting their lives. This also served as an important transition that helps clients feel comfortable expressing the broad range of symptoms and problems that they are experiencing. It also starts the conversation regarding the typical causes of depression and what might be influencing their depression.

In addition to understanding different symptom domains of mental illness, it is also important for therapists to understand broader issues related to cultural differences in communication and the expression of distress (Hwang, 2006; Hwang, Myers, Abe-Kim, & Ting, 2008). It is important to note that Asian heritage clients may sometimes appear passive, quiet, and reserved. Therapists who are unfamiliar with the client's cultural background may be more likely to misinterpret culturally influenced communication and expressive styles and see Asian American clients as being shy, uncooperative, avoidant, uncommunicative, not interested in treatment, or not taking initiative for self-care.

Making these types of interpretations can be dangerous if one is not familiar with common cultural differences in communication, as well as how communication styles change with specific people such as authority figures. For example, Asian heritage populations may be less likely to ask questions or openly disagree with the therapist whom they see as the "expert." Regardless of theoretical orientation, it is important for therapists to engage the client, ask for their collaboration and feedback, normalize illness and its treatment, and discuss why psychotherapy tends to use collaborative approaches in dealing with problems.

Moreover, those who are less familiar with therapy and who potentially feel less comfortable in treatment may also need more time to formulate and share their thoughts and feelings. Sharing personal issues with strangers is a significant issue for Asian heritage populations, where cultural values and taboos emphasize privacy and reducing loss of face for oneself and one's family. Consequently, Asian heritage populations may need even more time to feel comfortable discussing problems and to actively collaborate with the therapist. This is important for therapists to know because this may help reduce therapist emotional reactions, such as frustration or confusion about why the client doesn't talk so much. Pointing out these issues may also help increase therapist credibility, increase client engagement, and improve client impressions of the therapist's cultural expertise.

In addition, the tempo and timing of speech, as well as cultural differences in interrupting authority figures can also be a significant issue in social and treatment settings. Specifically, there can be cultural differences in the rate and tempo of speech, how people utilize silence in different ways, and how and whether people take turns versus interrupt each other while talking. Even a highly acculturated individual who grew up in the United States can feel the effects of cultural differences in communication styles. For example, I have noticed that I can communicate very differently depending on the communication styles and behaviors of those around me. This can be influenced by the individual personalities in the room, and also by their ethnic and cultural backgrounds. For example, when I go to Asian American studies department meetings (as well as other meetings that tend to be more ethnically diverse), I notice that faculty members are very cognizant of how much they are talking, whether they interrupt others, and whether the perspectives from those who are more quiet are proactively solicited. The tempo of speech tends to be slower, and there tends to be more breaks and silences that allow for people to talk without interrupting each other. However, when I attend meetings that are predominantly White, the tempo tends to be much quicker, people tend to interrupt each other, and there are very few pauses or moments of silence. Of course, this not to say that all meetings of Asian or White populations may follow this stereotype. Rather, the point of emphasis here is that there may be cultural differences in communication that therapists may need to be cognizant of.

These unrecognized cultural differences in communication can be quite problematic when people do not want to fight to talk, or when they pause to formulate their thoughts or pause to purposely accentuate their point, but get interrupted. These differences in communication styles can be problematic for interpersonal participation and engagement, especially for those from Asian heritage backgrounds where there is a greater tendency to formulate their thoughts before speaking in professional settings—the Asian heritage idea that they want to make sure their thoughts and what they have to say is relevant and important to the discussion before taking up other people's time (also related to Asian principles of loss of face, and social and professional etiquette). This can have significant implications for psychotherapy, where the use of silence can be very important.

For example, Asian heritage clients may need more time to formulate their thoughts for a variety of reasons, including feeling uncomfortable in treatment, cultural differences in communication, cultural beliefs that the doctor is supposed to talk more and tell them what to do, different perceptions of social etiquette, or simply because the client is severely depressed and has slower thinking and response times. This is an important cultural adaptation to therapy because practitioners need to ensure that they don't misinterpret the silence, or prematurely fill in the silence and give their Asian heritage clients sufficient time to formulate their thoughts before jumping in. Discussing these issues, and the roles and responsibilities of therapists and clients, can help clients feel more comfortable, engage more in the treatment process, and increase the client's perceptions of the therapist's cultural credibility and ability to help them.

Understand What Depression Is Like for You

This section concludes with an in-session discussion regarding what depression is like for the client. Starting with a psychoeducational approach followed by a personalized inquiry can help the client feel like the treatment

is individualized for them. It also gives them time to adjust when they feel uncomfortable and don't know what to say in therapy. Lack of structure and pressure to discuss topics can sometimes be disconcerting for those unfamiliar with mental health services, and normalizing and discussing the symptoms beforehand can help them feel more prepared to share and elaborate on their experiences.

CHAPTER GOAL #3: DESTIGMATIZING THE CAUSES OF MENTAL ILLNESS

An important aspect of culturally adapting therapy is emphasizing the multiple causes of depression. Many people from Asian heritage backgrounds have little exposure to education about mental illness, and consequently have many misperceptions or misunderstandings about the causes and its treatment. In fact, when you ask many people from Asian heritage cultures what causes mental illness, they will often say because those people are "crazy." This is a rhetorical answer and illustrates the high stigma associated with mental health problems in Asian cultures.

For example, I often take my ethnic minority psychology mental health class to dinner in San Gabriel Valley, an area of Los Angeles with multiple suburbs or cities that are ethnically dense with Chinese immigrants. As a class activity, students go around the shopping complex asking people their opinions toward mental illness and its treatment. One of my students asked one of the employees of the supermarket, and the response given with anxiety and trepidation was "I don't know, go ask customer service." Another one of my students tried to utilize their Mandarin-Chinese-speaking ability to ask somebody who was shopping at the store their thoughts about this issue. The person began walking away quickly, saying "I'm not crazy! I'm not crazy!" Many others would simply turn away and walk away without saying anything. These responses are a small demonstration of stigma toward mental illness, and that Chinese heritage populations may not feel comfortable sharing their opinions about mental illness with a stranger even if they themselves aren't struggling with one—let alone talk about personal problems when they do have one.

Understanding the multitude of causes for psychiatric illness is an important part of psychoeducation, especially stress education. Unfortunately, some people from Asian heritage populations hold very stereotyped views of mental illness. Some of these beliefs are problematic because they increase stigma and shame for discussing problems, and decrease the likelihood of seeking help for fear of shaming themselves and their families. For example, some believe that mental illness can only be caused by genetic factors, while others believe that they are associated with fatalism (eg, the idea that that our futures are predestined) and karma (eg, the idea that a person did something bad in a previous life, and therefore developed an illness). As a result of what they did in the past life, they believe that there is nothing that can or should be done about their problems. This also intersects with religions such as Taoism. For example, while interviewing a Taoist master, she told me that mental illness is associated with one's wrongdoings in a previous life, and that consequently, they are hunted by spirits. Religious Taoist Masters can heal patients with mental illness if they are affected by a rogue spirit that is not supposed to be there, but they can do nothing about these spirits and their associated mental illness if they are supposed to be there due to karma.

Even if the therapist does not believe in these issues, they need to respond and are supposed to respect the client's cultural beliefs. The culturally adapted treatment manual provides psychoeducation on a multitude of potential causes for psychiatric illness (eg, difficult life circumstances, family and social conflict, financial problems, job and/or academic stress, chronic and episodic stress, physical health problems, biological factors, and family history of psychiatric illness such as depression). This is an important cultural adaptation because it not only identifies problem areas for clinical intervention, but also emphasizes that proactive stress management and problem-solving can be effective in helping to resolve their issues—thus instilling hope and empowerment. The manual also discusses the triggers for the client's depression, so that prevention and intervention strategies can be focused and targeted.

A major focus of this culturally adapted intervention is decreasing stigma by normalizing the prevalence of depression. Specifically, the manual teaches the client that according to the World Health Organization, depression is a worldwide problem that is second only to heart disease in terms of its impact on society and individuals. A culturally adapted focus is again placed on the Asian cultural concepts of cause-and-effect, as well as highlighting the cultural importance of consequences for leaving problems unaddressed—which is emphasized less than Western psychotherapy. By listing the potentially severe costs of not properly managing their depression (eg, ruined relationships, job loss, academic difficulties, exacerbation of physical health problems, life

unhappiness and dissatisfaction, and even death and disability), clients are incentivized to take charge of their problems and make changes in their lives. These are critical cultural adaptations that can help motivate clients and increase their comfort while in treatment.

Understanding the Causes of Depression

This section also concludes with an in-session discussion about the causes of the client's depression. Educating clients about the wide range of causes and triggers for depression can be very helpful. This can be especially effective if clients struggle with identifying the causes of their depression, or initially feel uncomfortable talking about personal issues. Psychoeducation can be a very important strategy in transitioning clients to mental health treatment, helping them feel more comfortable, and providing a staged approach to learning and collaborating.

CHAPTER GOAL #4: PROVIDING HOPE BY HELPING CLIENTS UNDERSTAND THAT DEPRESSION IS TREATABLE

Psychotherapy can only be as effective as the client's belief in the treatment and the therapist's ability to help them. A primary emphasis of this session is to provide hope and understanding of how psychotherapy works. The arguments concerning the benefits of psychotherapy are reinforced by discussing the research evidence for its effectiveness by itself and/or in combination with antidepressants. This is a critical psychoeducational and cultural adaptation strategy that is effective with Asian heritage populations because of the importance placed on education and research. Many people from Asian heritage backgrounds often ask whether their problems are treatable and whether the therapists can really help them with their problems. This is a critical point in therapy where reassurance and instilling hope is of utmost importance. The treatment manual emphasizes the scientific evidence that supports the effectiveness of mental health treatments. Asian heritage populations may benefit from more hope-instilling strategies, given high stigma and lack of familiarity with mental health services.

The culturally adapted treatment manual also emphasizes the importance and benefits of psychiatric medications and antidepressants. Because taking medication sometimes signifies that their problems are more "real," many Asian heritage clients are reluctant to take psychiatric medications because it reifies their illness. However, research indicates that medications can be a critical part of treatment, especially for those who are more severely ill or depressed. In fact, research shows that the combination of psychotherapy and antidepressants is the best practice for those who are experiencing severe clinical depression (Elkin, Shea, & Watkins, 1989). Those who are mildly or moderately depressed seem to benefit equally from psychotherapy alone, medication alone, or the combination of both. Nevertheless, without psychotherapy, the precipitants to their problems are not likely to be addressed and the likelihood of relapse after stopping medications is much higher than without (Herbert, Callahan, Ruggero, & Murrell, 2013; Shea et al., 1992). Therefore it is important to highlight that if clients have severe and chronic depression, it may be beneficial for them to take medications while in treatment. This helps clients to have the physical and mental energy to make the most out of psychotherapy.

Because Asian heritage populations tend to delay help-seeking, they are often more clinically severe than other groups when they finally do come in (Hwang et al., 2015). Emphasizing the importance of psychiatric consultation can be a very important cultural adaptation because it increases treatment engagement and helps improve openness to taking medication. With clients who refuse to take medication, it is a good strategy to impress upon them that this strategy may not be the fastest, nor most effective (eg, the combination of psychotherapy and psychiatric medication is more likely to quickly confer additional benefits). For clients who decide not to take medications, this is an excellent opportunity to capitalize on the fact that given this decision, regular attendance in psychotherapy is a must if they want to effectively address and reduce the risk of their depression getting worse.

Some common reactions to taking psychiatric medications include becoming addicted, dependent, needing higher doses, and having to take them forever. Although therapists often defer psychoeducation concerning medication to psychiatrists, many psychiatrists do not spend the necessary time needed to educate Asian heritage clients about these issues. Linguistic barriers and cultural reluctance to ask questions of authority figures can also affect client interactions with psychiatrists. If a culturally informed therapist has a general understanding of how specific medications work, clients may benefit from the therapist providing general psychoeducation, collaborating with psychiatrists and raising important issues, and encouraging the client to ask their psychiatrists specific questions that may be of concern.

Loss of privacy and fears that friends and family may ask them why they are taking "those pills" is also a commonly expressed concern by Asian heritage clients. For example, a less acculturated Asian parent told their adult children and relatives that psychiatric medications are not beneficial, and they should stop taking them because you don't want other people to know. Another less acculturated parent told their child to stop taking medications because they will become addicted and that their depression will naturally get better if they stop being so shamefully lazy. Therapists may need to culturally adapt therapy by helping their clients come up with effective responses that address their parental concerns and ensure their confidentiality. For example, bringing in family members for a therapy session or two to discuss these issues can be very beneficial. In addition, the therapist can brainstorm how to respond to those that ask questions and help them set boundaries. They can also suggest using a pillbox, which better ensures privacy because they are not labeled as psychiatric medications. In addition, clients can put vitamins and other pills in the box so that they feel they are not being dishonest when providing a generic response. These culturally adapted and proactive concrete strategies are needed when working with diverse populations with high stigma and misunderstanding toward mental illness and its treatment.

Understand the Benefits of Antidepressants and Herbal Medications

Another cultural adaptation was to discuss how psychiatric medications, such as antidepressants, may potentially interact with Chinese herbal medications. Discussing the benefits of antidepressants and herbal medications was presented as an in-session discussion. Clients are asked to discuss the advantages and disadvantages of taking antidepressants, as well as herbal and Chinese medicines. They are also asked to think about the potential interactions between different medications, and to discuss these issues with their psychiatrists. Moreover, the discussion about medication also highlights the fact that medicine can help balance and regulate one's inner energy or Qi, and can also help people who are very severely depressed better participate in the program and listen to the advice of other people.

This is an example of a content cultural adaptation that is not typically addressed in nonadapted treatments. This modification is very important because of the high utilization rate of complementary and alternative or traditional medicines among diverse populations such as Asian heritage groups. Moreover, indigenous and traditional Asian medicines have historically used herbal medications, and have instilled upon the general population that they can be effective for all ailments. These traditional doctors are a one-stop shop and there are no separate mental health and physical health doctors. They utilize a holistic approach to treating both mental and physical health problems. Drug interactions between herbal and psychiatric medications and psychiatric ailments are a realistic concern, and needs to be further researched and understood.

Just like therapists, many psychiatrists have not gone through in-depth cultural competency training and may not take the time nor have the cultural knowledge to ask the client about traditional or alternative medicine usage. Therefore the culturally adapted treatment manual asks the client to discuss these issues with their psychiatrist, who may be less culturally competent and aware that Asian heritage populations may be using herbal medicines. In addition, it is important to collaborate with psychiatrists or the client's primary care physicians, who can also prescribe psychiatric medications. As therapists, we spend the most time with the client and can help inform prescribers of salient issues that may impact treatment. Especially for Asian heritage populations, who may be resistant to taking psychiatric medication, it is important to maximize the likelihood of a positive medication response and reduce potential side effects, which may be exacerbated by drug interactions. Otherwise, clients may stop taking medication and drop out of psychiatric care and psychotherapy prematurely. Negative experiences with psychiatric medication can often generalize to their impressions of the potential benefits of psychotherapy. In addition, psychiatrists and other mental health practitioners can culturally adapt therapy by educating clients that they should not just start and stop medications when they feel better, which many Asian heritage populations tend to do. One of the reasons why is because the discontinuation of medication when one feels better is often done when taking traditional or herbal medications, which are often taken for shorter amounts of time and are less focused on prophylactic or preventative effects.

Understand How Psychotherapy Treats Depression

Because many Asian heritage populations do not have a good understanding of how psychotherapy works, the manual culturally adapts therapy by discussing how and why mental health treatments work. In doing so, the manual continues the holistic approach and culturally modifies psychoeducation by discussing the benefits

for both mental and physical symptoms. This provides hope and sets the stage that both types of symptoms can improve with exercise and practice. The manual educates the client about three primary therapeutic mechanisms, including behavioral strengthening, cognitive strengthening, and internal strengthening.

These primary areas of foci are culturally adapted in terms of content, framing, and ordering. Traditionally, cognitive-behavioral therapy (CBT) focuses primarily on cognitions first and behaviors second. This was reordered and an emphasis was first placed on behavioral strengthening, which was redefined to include problem-solving along a variety of dimensions. Specifically, making efforts to address difficult life circumstances, manage social problems, and behave in beneficial ways. Reframing the behavioral aspect of CBT to prioritize problem-solving was purposely emphasized to match the cultural emphasis on problem-solving that is an important part of Asian heritage values and beliefs. The timing and ordering of intervention focus is an important cultural adaptation. For example, when I first started doing CBT with Asian heritage populations, many of them complained that it was not their thinking that was the problem, but the external stressor or the other person who they are having problems with who needs to change. Clients were very resistant to changing their cognitions and the way they think. Getting the clients to reframe cognitions was difficult, and some clients were taken aback or deeply offended by traditional CBT terminology of irrational thinking, cognitive errors, or biases.

The ordering of therapeutic emphasis is one of the most important cultural adaptations that can be made for Asian heritage populations. An initial focus on problem-solving helps reduce aversive reactions or mismatches between therapist and client goals. Clients are much more open and willing to change the way they think about things, reframe, or shift into a phase of acceptance once they have exhausted alternative options and have taken a proactive approach but with no avail. This also matches the Chinese saying "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), literally meaning "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." This metaphor is the theme of the manual and was previously discussed in chapter "Introduction to the Manual and Understanding Cultural Complexities." It highlights the problem-solving nature of many Asian heritage populations. Specifically, doing everything you can to resolve a problem, and when nothing else can be done to change the external issue, then changing the way one thinks and feels is the best remaining option. This initial emphasis on problem-solving is a critical and culturally syntonic method of engaging clients and preventing premature treatment failure for Asian heritage clients.

Problem-solving is also somewhat different than the traditional behavioral emphasis of CBT (ie, behavioral activation). If one were to reframe this emphasis, then perhaps the better description would be problem-solving cognitive-behavioral therapy. If one thinks of problem-solving as being a behavioral strategy, then perhaps the more appropriate description of this culturally modified strategy would be behavioral-cognitive therapy.

In culturally modifying the cognitive part of CBT, the manual redefines cognitive errors, cognitive biases, and irrational thinking in a more positive, holistic, and goal-focused manner—which in my experience has been easier for clients to accept and tolerate without an aversive reaction. Specifically, an emphasis was made on cognitive strengthening, cognitive effectiveness, and healthier ways of thinking. This theme is continued throughout the manual and in the sessions that focus on the "C" of CBT.

Finally, the culture-adapted treatment manual modifies therapy by adding on an additional therapeutic factor or mechanism of healing. This was called "internal strengthening," and is syntonic to many different Asian heritage cultural beliefs and indigenous medicines. Internal strengthening focuses on helping clients feel more centered and balanced. It also promotes healthy self-care activities and strengthening of one's inner energy or "Qi" in Mandarin Chinese (pronounced qì in Mandarin Chinese—氣). Internal strengthening has historically been an important part of many Asian heritage cultures. For example, the notion of "Qi" or energy is an integral part of many Asian medicines, religions, martial arts, and cultures (Hwang, Wood, Lin, & Cheung, 2006). Therefore internal strengthening is a very important and prominent part of Asian heritage cultures. Many Asian languages include the notion of energy in their heritage languages. For example, in addition to being known as Qi in Mandarin, the notion of energy is called Ki in Japanese, Phrana in Hindi, Gi in Korean, and Khi in Vietnamese.

If the client believes in energy, then a cultural bridge can be made emphasizing that psychotherapy and holistic medicines can help with balance (eg, emotional, physical, and spiritual centeredness). Clients can be told that cognitive reframing can help balance one's energy and cultivate intra- and interpersonal health. Such bridging can help align therapeutic goals with cultural beliefs and gain the client's buy-in to psychotherapy, thus resulting in greater treatment adherence and reduced dropout. Clients in this clinical trial responded well to the cultural bridging of therapeutic concepts to Chinese cultural notions of Qi. This is another example of how studying culture can enhance clinical practice and contribute to psychological science. Many people who are not of Chinese

descent also believe in energy and balance. Asian medicines and sports that emphasize Qi are becoming very popular (eg, acupuncture, acupressure, yoga, and tai chi). A holistic approach may help improve therapeutic outcomes for all people who believe in balancing energy; albeit, the metaphor used may be similar or different (eg, Chakras in traditional Asian Indian medicine, pendulums for balance, or a seesaw use in child therapy).

The culturally adapted manual introduces therapeutic concepts in the following order: (1) problem-solving, (2) cognitions, (3) behavioral activation, and (4) internal strengthening. However, internal strengthening is integrated throughout all of the sessions, and is also a primary emphasis in many of the sessions as well. In essence, this culture-adapted treatment approach is a problem-solving approach to CBT, with an emphasis on internal strengthening. It could potentially be called PCBI. In addition, the positive and holistic notion of "strengthening" is emphasized throughout. This strengthening approach aligns with cultural metaphors of becoming stronger, healthier, and more balanced through practice and exercise. This also provides hope and highlights that problems can be resolved by addressing them one step at a time, and that people can empower themselves through hard work and effort.

CHAPTER GOAL #5: PROVIDING HOPE AND FINDING BALANCE THROUGH THE INTEGRATION OF CULTURAL SYMBOLS

Understand and Break Unhealthy Cycles

Because the culturally adapted intervention is a cultural modification of CBT, core elements of CBT were retained, such as understanding the cognitive-behavioral cycle. The cognitive behavioral cycle was also utilized in the nonadapted CBT manual that was part of the clinical trial (Miranda et al., 2006). Traditionally, the cognitive-behavioral cycle teaches clients about the relationship and interaction between cognitions, behaviors, and one's mood. For example, when a person is feeling depressed, they are more likely to lie around in bed all day long and think that life is not worth living. Moreover, when a person thinks that they are not good enough or that there is nothing they can do to solve their problems, they are more likely to feel depressed and engage in unhealthy or unproductive behaviors, such as drinking or overeating. This is an incredibly useful psychoeducational tool that helps not only to increase understanding, but also can be a powerful clinical tool that targets specific areas for intervention.

The culturally adapted treatment manual makes a cultural modification to the cognitive-behavioral cycle by including an additional domain, internal balance. This supports the previously mentioned PCBI focus of the manual. It helped clients understand that, by strengthening our cognitions and engaging in healthier behaviors, our mood can be improved and our overall internal balance can be strengthened. Internal strengthening helps improve our overall sense of balance, centeredness, and well-being. Moreover, there are also a number of clinical tools and skills a client can learn to improve their inner strength. These include practicing meditation, mindfulness, exercise, and even healthy eating and herbal teas.

This is an important opportunity to engage the client and help them understand the myriad of factors that can influence their cognitions, behaviors, and mood. At the same time, it also helps them understand the interactive nature of these core areas, and also provides areas for intervention focus. Utilizing the visual diagram of the cognitive-behavioral cycle helps emphasize an active rather than passive approach to learning. Specifically, clients can visualize and discuss with the therapists what drives their emotional cycles and brainstorm on how to break them. This is much more effective than just talking about general or nonanchored issues, or clients trying to manage their distress by only keeping dialogs in their head.

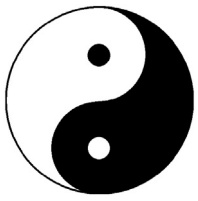
This proactive psychoeducational approach also aligns well with Asian heritage cultures. It takes away a person-only emphasis and also places the focus of attention on a directly beneficial clinical tool and activity. When clients who are uncomfortable and experience stigma seek mental health care, treatments that are too open-ended or unstructured can be anxiety-provoking and too intense. A more semistructured approach that provides initial guidance for conversation can help clients ease into psychotherapy. Because some Asian heritage clients may be more reluctant and reserved about speaking when they feel uncomfortable in mental health treatment, therapists may want to culturally adapt therapy by provide them with initial examples of how the cognitive-behavioral internal strengthening cycle works, rather than asking them to initially come up with their own examples. With populations who are more familiar with therapy, the therapist can more directly solicit examples and have the client brainstorm ideas, which can be very beneficial.

Some Asian heritage clients need more time to reflect about how their thoughts, feelings, and behaviors interact; whereas, other clients may be familiar with therapy discussions and are less likely to expect the therapist to do most of the talking. In addition, because there is not as strong of a differentiation between thoughts and feelings in many Asian languages and cultures, clients may have some difficulty distinguishing between these two constructs. Although this may occur in many cultures, because Asian heritage clients tend to be more unfamiliar with mental health issues, my experience is that this has to be addressed more so in this population. The therapist may have to modify therapy by initially being more proactive about providing examples, rather than expecting clients to generate them on their own—at least until the client feels more comfortable and learns the concepts that are being taught.

Understand "Qi" (Energy) and Your Mood

Another significant and important cultural adaptation implemented in Session 2 is the use of cultural symbols and metaphors. They can have significant therapeutic benefits and have personal meaning for many clients. The integration of cultural metaphors can be used to bridge cultural and therapeutic concepts, or they can serve as a standalone culturally focused therapeutic mechanism. Cultural bridging can help relate therapy concepts to client belief systems (Ham, 1989; Hong, 1993a,b; Hwang et al., 2006). This bridging cannot be achieved unless therapists are familiar with the client's cultural background and use a culturally adapted lens to think about the client's problems. Therapists who are culturally informed and competent understand their clients' cultural background and are in a better position to integrate psychotherapy with indigenous forms of healing and extant cultural strengths. Establishing cultural bridges early on in treatment may also reduce the cultural "shock" factor of therapy that clients feel when participating in treatments that they are unfamiliar with or that seem culturally foreign.

For cultural adaptations to be effective, they must make clinical sense and also align with the cultural belief system of the client. One of the most important cultural adaptations that we included in the manual was the Traditional Chinese Medicine (TCM) concept of Qi and the related Taoist symbol called the Tai Chi diagram (pronounced tàijítú in Mandarin Chinese—太機圖). These traditional beliefs and medicines are also related to acupuncture, acupressure, meditation, Qi-gong (a meditative practice that focuses on energy and breathing), various martial arts (such as kung fu and Tai Chi Quan (pronounced tàijíquán in Mandarin Chinese—太機拳; a Chinese martial arts form that focuses on cultivating inner strength and Qi)). Please see the Tai Chi diagram figure below.



For example, clients can be told that cultivating healthy cognitions and behaviors can help improve one's internal strength, balance, and energy or "Qi" (Hwang et al., 2006). This bridging technique can help facilitate adherence to treatment and align client and therapy goals. While developing the manual, focus group discussions during phase I of the Formative Method for Adapting Psychotherapy (FMAP) confirmed that cultural bridging is important. The techniques and metaphors derived by the Principal Investigator in phase II were thought to be effective by therapists who participated in focus groups in phase III of intervention development. In phase IV, patients responded positively to the integration of the "Tai Chi diagram" and found it clinically and personally useful.

The manual discusses how one's "Qi" or energy, and feelings of internal balance and centeredness, can affect one's mood and well-being. This emphasis on internal strengthening is one of the central goals of the treatment program. When an individual is internally stronger and healthier, they are better able to effectively address their problems. A discussion of spiritual as well as philosophical aspects of the Tai Qi diagram should also be discussed with the client. Specifically, some clients may believe in Taoism in a more religious way; whereas, others may believe in its philosophical ideas and teachings. In fact, it is important to note that Taoism not only has a religious influence, but also has a much greater philosophical influence on many different Asian heritage cultures

and medical treatment systems. It is also important to differentiate between philosophical Taoism (which is more focused on TCM concepts of balance, energy, Qi, and health) and religious Taoism (which involves a belief in spirits, gods, ghosts, and demons) with the client.

Working with diverse clientele takes a lot of conscientiousness and hard work. In the process of developing the culturally adapted treatment manual, I spent time interviewing religious and spiritual Taoist Masters in phase I of the FMAP. The religious Taoist Masters believed in animism, spirits, and ghosts. They told me that mental illness in Taoism is associated with spirits either haunting or being connected to a person because of karma or what they did in their past life. With karma-related spirits, they believe that nothing that can be done. For the nonkarma-related rogue spirits, Taoist Masters can intervene and exorcise them. Taoist masters can see and hear the spirits associated with mental illness, even over the phone when a client initially calls them. One master told me of her stories exorcising spirits, and that she has been physically injured before when some of them fought back. When listening to the stories of others, therapists need to be open to understanding their cultural beliefs and should not automatically dismiss them. It is important to remember that many clients also hold these beliefs, and that believing in spirits is not necessarily associated with psychotic disorders. Learning how to be in tune with client beliefs and listen to their stories, even if you do not believe in them, is an important clinical and cultural skill that the culturally adapted or competent therapist needs to possess. If a therapist is dismissive, clients can readily tell through nonverbal behaviors (eg, facial reactions and body postures)—which can fracture the client–therapist working alliance. Our verbal statements and our nonverbal facial and body expressions need to match.

Although most Chinese and Chinese Americans will recognize the Tai Chi diagram and have some general understanding of its meaning, most do not have a deeper understanding of its cultural and therapeutic value. One goal of cultural adaptations is to highlight the therapeutic and healing value of cultural metaphors, symbols, and stories, or even to create new therapeutic values in existing cultural traditions. Remember, cultures are in constant transition, and there are many cultural strengths and weakness that can be identified, linked, bridged, and created to confer therapeutic value. When most Chinese or Chinese Americans (as well as many people from Asian heritage cultures) look at the Tai Chi diagram, they typically only understand the general meanings of balance and harmony of energy, as well as the dualities of light and dark, male and female, solar and lunar, and positive and negative. This basic understanding of balance can be very therapeutic. However, a more enriched understanding of the deeper meanings can also be extremely beneficial.

By interviewing TCM doctors, as well as spiritual and religious Taoist masters in phase I of treatment development, I was able to delve even further into its therapeutic meaning and extant cultural strengths and values. For example, when most people look at the symbol, they have no idea why the line is curvy rather than straight. The question of why the light and dark halves of the circle are separated by a curvy versus straight line is an interesting one. In addition, why is there a small dark circle in the light and a small light circle in the dark? These deeper meanings are not well known to most. By developing a better understanding of indigenous treatment systems, a practitioner is better positioned to delve deeper into its therapeutic values, cultural roots, and philosophical strengths.

In studying these issues and interviewing TCM doctors and Taoist Masters, I learned that the line in the middle is curvy because it represents the ups and downs of life—a cultural, philosophical, and religious principle known as impermanence. Specifically, bridging the Tai Chi diagram to psychotherapy help clients understand that life is full of ups and downs. It is ever-changing and constantly in flux. Sometimes life is easy, and at other times it is much more difficult. By understanding that people in life are inevitably going to face problems, the client's struggles can be normalized (eg, they are not alone and stressful life events are common) and hope is also provided (eg, things will eventually get better).

In addition, the treatment manual discusses the question of why there is a small dark circle (pronounced yīn in Mandarin Chinese—陰) in the light area, and why there is a small light circle (pronounced yáng in Mandarin Chinese—陽) in the dark area. These smaller dots contrasting in color with the larger area in which they reside represent the idea that no matter how great things are something bad will always happen. Moreover, no matter how bad things are something good can and will always happen. Like the curvy lines, this can also normalize a person's experiences and provide hope.

The small dots and the curvy line are spiritual-philosophical, religious, and cultural symbols of the impermanence in life. They emphasize that a person should try to remain positive, have faith, and not lose hope when faced with adversity. Many different cultures have similar sayings and metaphors that emphasize things will get better. For example, there is an old Nigerian proverb that states "no matter how long the night, the day is sure to come," which the late 2PAC Shakur also rapped about. In addition, there are also many cultural sayings that

normalize the occurrence of stressful life events, but also empower people to make choices about how they handle the situation and how much suffering they experience. For example, there is an old Chinese proverb that reflects this meaning "You cannot prevent the birds of sorrow from flying over your head, but you can prevent them from building nests in your hair."

The Tai Chi diagram is inherently linked with the cultural and TCM emphasis on Qi or energy. Because of this, a specific cultural adaptation to conduct behavioral activation in a culturally bridged manner was implemented. In addition, the notion of energy is further differentiated in the diagram. For example, the dark parts of the circle represent yinqi (pronounced yīnqì in Mandarin Chinese—陰), and the light parts represent yangqi (pronounced yángqì in Mandarin Chinese—陽氣). In Chinese, as well as many other Asian heritage languages (note that many Asian languages utilize linguistic aspects of Chinese in their language), these represent positive and negative energies. Specifically, in TCM, depression is associated with too much lunar energy (pronounced yīnqì in Mandarin Chinese—陰氣), and not enough solar energy (pronounced yángqì in Mandarin Chinese—陽氣). In fact, TCM doctors often prescribe a variety of pills, herbs, and medicinal soups to strengthen or supplement (pronounced bǔ yi bǔ in Mandarin Chinese—補一補) a patient's solar energy deficits when they are depressed. This process of strengthening one's energy deficits can also be accomplished through physical activities (eg, hiking and martial arts such as kungfu and Tai Chi) and meditation (eg, Qigong).

In my interviews with TCM doctors, they described how depression has been treated by TCM for thousands of years. In Chinese medicine, there are different types of depression. Some are related to loss of energy and motivation, and being listless. For these types of depression, TCM doctors may prescribe therapeutic breathing, such as standing up and breathing in and out. This is accompanied by hand movements of lifting up and down to focus and bring out one's energy. Other types of depression are associated with anger and conflict with friends and/or family. For this type of depression, they recommended deep breathing accompanied by a more vigorous exercise, such as utilizing a squatted stance (also called the horse stance) and vigorously pushing one's arms outward to release one's anger.

Mindfulness, meditation, and deep breathing have been incorporated into many traditional healing systems for thousands of years. These cultural beliefs and practices can and have been integrated and bridged with psychotherapy. This cultural adaptation can be culture-universal etic, and be beneficial for clients from all different cultural backgrounds. Even if you don't believe in Qi, many people believe in its associative concepts of balance, centeredness, and healthy energy. The benefits of meditation and mindfulness are evidence-based, and there is increasingly more research documenting its therapeutic benefits on brain structures, pathways, activation, and neurotransmitters. In addition, we know that mindfulness and meditation can help activate our parasympathetic nervous system and downregulate our sympathetic nervous system, resulting in reduced anxiety, stress, and worry. This cultural modification is implemented throughout the treatment manual as a way to foster internal strengthening. It is not only deeply ingrained in Taoism, but also Buddhism. For example, Thich Nhat Nguyen (a well-known Vietnamese monk) has several popular books that help improve people's emotional well-being through deep breathing, meditation, mindfulness, mindful walking, and mindful stretching.

The culturally adapted treatment manual discusses the aforementioned issues and also supports them with internal strengthening exercises. Specifically, clients are asked to practice their first strengthening exercise, which was called the "Sitting in the Sun" exercise. This is the first take-home exercise and focuses on holistic strengthening and improvement of the mind and body. Clients were introduced to strengthening through this simplistic exercise to get them used to practicing various skill sets. This cultural adaptation was purposely done at the beginning of treatment without a lot of worksheets and text so that clients could start adjusting to being in therapy. We didn't want to overwhelm the client with exercises that would be too complicated or frustrating.

The "Sitting in the Sun" exercise focuses on strengthening one's solar energy or yangqi (pronounced yángqì in Mandarin Chinese—陽氣). The yang (pronounced yáng in Mandarin Chinese—氣) in yangqi (pronounced yángqì in Mandarin Chinese—陽氣) means "sun," so clients are essentially lighting up the darkness and cultivating solar energy to heal their mind, body, and spirit. The manual reminds the client that sitting in the sun can help them feel more centered, relax, and rejuvenated. Therapists help clients focus on the positive energy of the sun warming up their body, energizing their life, and soothing their emotions, while at the same time letting go of their stresses and worries. For those who don't believe in energy, this exercise can still be therapeutic. Specifically, having clients go outside and meditate in the sun can be an effective form of behavioral activation.

Before and while implementing this exercise, it is also important to get a gauge of the client's beliefs. It is important not to impose cultural beliefs on the client and assume that they identify with said beliefs. However, even though some clients may not believe in energy, many are still able to relate to the principles of feeling centered and balance. A therapist can explore this issue by asking the client if they have ever seen the Tai Chi

diagram before, and asking them what they know and think about it. If they have a negative reaction to the symbol, the therapist can reframe and use a different individualized metaphor that emphasizes internal strengthening, balance, and harmony.

The vast majority of clients in the clinical trial had a positive response to the therapeutic aspects of the Tai Chi diagram. In my clinical practice, the vast majority of clients (regardless of ethnic background) are able to understand and relate to the therapeutic value of the Tai Chi diagram. This indicates that extant strengths from one culture can be adapted or bridged into other cultures, while still retaining therapeutic meaning. While developing the culturally adapted treatment manual, we had a specific discussion on whether Christian clients of Asian descent would have an aversive reaction to the religious aspects of the Tai Chi diagram. The vast majority of Christian therapists of Asian descent believed this would not be a problem and that the majority of clients would be able to differentiate religious beliefs from philosophical and cultural values that have been ingrained in Chinese traditions and medicines for thousands of years. No clients had an aversive reaction to the diagram in the clinical trial. Nevertheless, for clients who are not able to relate to the Tai Chi diagram, it is important to individualize treatment by utilizing other symbols or metaphors.

Another therapeutic intervention that is not explicitly discussed in the manual, but that I often use with clients is to discuss the balance between hard (eg, anger) and soft (eg, depression) emotions. This can be integrated with the different sides of the Tai Chi diagram, or utilized as a standalone therapeutic intervention. Understanding that depression and anger are often two different sides of the same coin can be especially beneficial. Many Asian heritage clients come to treatment with significant interpersonal conflict, and cycle between being angry and upset and feeling depressed and emotionally drained. Helping clients understand that reducing their anger is especially important for controlling for depression, can help them let go of toxic feelings and focus on inner peace. This can be accomplished by highlighting the characteristics of the client's emotional cycles, and noting that their depressive episodes tend to be triggered after intense conflict and emotional upheaval. Helping clients reduce anger and making a linkage to traditional healing concepts (eg, Buddhist concepts of letting go or traditional medicine concepts of energy) and techniques (eg, meditation) have been found to be extremely beneficial.

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