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Adapting Brief Exposure Treatment for Phobic Asian Americans

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### Abstract

Asian Americans are underrepresented in the behavior therapy literature, and empirically-based guidelines for tailoring treatments for Asians are non-existent. This paper describes a promising approach to adapting brief exposure treatment for phobic Asian Americans. Cultural adaptations were derived from psychological research with East Asians and involved modest changes in service delivery (e.g., maximizing therapist directives/commands) and intervention content (e.g., extensive psychoeducation). Results from a pilot randomized trial indicated that phobic Asian Americans showed greater benefit when treatment incorporated cultural adaptations. Implications for optimizing treatment outcomes for Asian Americans were discussed.

### Adapting Brief Exposure Treatment for Phobic Asian Americans

Asian Americans are underrepresented in the behavior therapy literature, and little is known about the efficacy of cognitive-behavioral treatments with this population (Iwamasa, 1999; Leong & Lau, 2001; Miranda et al., 2005; Sue, Zane, & Young, 1994). This is a significant oversight given that Asian Americans represent an increasing percentage (4%) of the U.S. population (U.S. Census Bureau, 2002), but are overrepresented among those with untreated mental health problems (Harris, Edlund, & Larson, 2005; Zhang, Snowden, & Sue, 1998).

There are several possible reasons for this gap. First, many investigators may simply assume that evidence-based treatments are effective for all cultural groups, and conclude that clinical trials with Asian Americans are unnecessary. Although meta-analytic research shows some support for the “ethnic equivalence” perspective (Stice, Shaw, & Marti, 2006; Tobler, 1997; Weisz, Jensen-Doss, & Hawley, 2006; Wilson, Lipsey, & Soydan, 2003), none of these reviews include Asians in significant numbers, and thus say little about the comparative efficacy of treatment with Asian Americans.

Alternatively, clinical investigators may be reluctant to recruit Asians given how little we know about best practices for treating Asian Americans. Although much is written about the need to address “Asian values” in the treatment context and several models of Asian cultural sensitivity have been proposed (e.g., Chen & Davenport, 2005; Hwang, 2006; Sue & Zane, 1987), few treatment evaluations have been informed by such models. One exception is a recent series of pilot trials by Otto, Hinton, and colleagues for Southeast Asian immigrants with post-traumatic stress disorder (PTSD) (Hinton et al., 2004; Otto et al., 2003). CBT was adapted for Cambodian and Vietnamese refugees by targeting culture-specific fears, providing language-

appropriate services, and making other modifications to treatment content. They found that culturally-modified cognitive-behavioral therapy (CBT) was more effective than wait-list or sertraline at reducing PTSD and associated symptoms (Hinton et al., 2004; Otto et al., 2003). However, most cultural modifications were not well-specified and the authors reported no evidence showing that culture-based adaptations enhanced treatment efficacy.

In this paper, we address this gap by summarizing recent efforts to adapt One-Session Treatment (OST; Ost & Ollendick, 1999) for Asian Americans with simple phobias. Specifically, we describe OST and discuss the potential benefits and limitations of using standard OST with Asian Americans. We then identify seven cultural adaptations to increase OST's relevance for Asian Americans, and provide empirical and conceptual support for each. Finally, we briefly show data from a pilot trial suggesting that Asian-focused cultural adaptations enhance the clinical efficacy of OST.

### *One-Session Treatment*

OST is a brief exposure-based treatment that occurs within a single three hour session. The protocol for administering OST is specified in a treatment manual developed by Ost and Ollendick (1999) and validated in nearly a dozen clinical trials (e.g., Ost, 1996; Ost, Brandberg, & Alm, 1997; Ost, Svensson, Hellstrom, & Lindwall, 2001). Below, we briefly describe this intervention, focusing primarily on procedures for treating spider phobics.

With standard OST, a functional assessment is first conducted involving analysis of phobic triggers, avoidance responses, and coping behaviors. The treatment session occurs approximately one week later, consisting of gradual exposure to four spiders of increasing size (0.5 cm to 2 cm). Each step is modeled by the therapist then attempted by the client. Clients

report their subjective anxiety throughout treatment, and progression to subsequent steps typically occurs when anxiety ratings decrease by at least 50%.

The first step involves teaching the subject to trap the smallest spider under a glass, slide paper underneath the spider, and simulate throwing it out of the room. During step two, the subject chases the spider around the cage with his/her finger or a pen. Subsequent steps involve letting the spider crawl on the subject's hands, arms, legs, chest, and eventually the head. After completing these steps with the smallest spider, the next largest spider is introduced and the sequence repeated. The final step requires that participants hold the two largest spiders simultaneously on one hand and manipulate them until low levels of anxiety are reported. Throughout the session, the therapist also (1) emphasizes ways that subjects can control and predict the behavior of the spider, (2) corrects false or catastrophic beliefs (e.g., spider will bite) vis a vis in-session experiences and psychoeducation, and (3) uses praise and feedback to reinforce progress. The basic protocol is similar for other phobic stimuli.

There are two reasons why OST in its standard form may be particularly well-suited for Asian Americans. First, like many behavioral approaches, OST is a brief, pragmatic, and highly structured treatment. Because East Asians report lower ambiguity tolerance (Wong, 2003) and may benefit less from verbal communication of thoughts/emotions (Kim, 2002), unstructured counseling that focuses on emotional expression, enhancing relationship quality, or promoting insight may be less effective with Asian Americans (Atkinson, Kim, & Caldwell, 1998) and perhaps counterproductive. Instead, Asians prefer and may benefit from highly structured and concrete treatments directed towards immediate symptom relief (Atkinson, Maruyama, & Matsui, 1978; Atkinson & Matsushita, 1991; Chun, 1997; Exum & Lau, 1988; Kim, Li, & Liang, 2002; Li & Kim, 2004).

Second, East Asians may be particularly receptive to modeling-based interventions such as OST. Some evidence suggests that, in comparison with North Americans, Chinese authority figures more often emphasize modeling as a behavior modification strategy (Lu, 1997), and are more frequently perceived as role models by subordinates (Chen, Greenberger, Farruggia, Bush, & Dong, 2003). Also, other scholars note that traditional Chinese values emphasize modeling as one of the most important vehicles for academic and moral education (Benson & Fung, 2005; Chen, 1995; Munro, 1975).

However, a closer look suggests that OST in its standard form might actually be *less* effective when applied to Asians. For example, exposure treatment often evokes high levels of distress among anxiety-disordered patients, leading to a significant loss of emotional control (e.g., Jaycox, Foa, & Morral, 1998). Given the value of personal restraint among East Asians (Kim, Atkinson, & Umemoto, 2001), the inability to control one's emotions in phobic situations could make Asians reluctant to continue with treatment even when exposure is gradual in nature. Similarly, Asians more often perceive psychiatric problems and help-seeking as stigmatizing (Atkinson, Ponterotto, & Sanchez, 1984; Sue, Wagner, Ja, Margullis, & Lew, 1976; Whaley, 1997; Zhang et al., 1998), and may require greater assurance that privacy is guaranteed, problems are remediable, and therapists are effective agents of change.

Thus, standard OST (OST-S) was modified to account for the cultural values that Asian Americans bring to the treatment context. Culturally-adapted OST (OST-CA) incorporates these cultural elements (Huey & Pan, 2005), with adaptations derived primarily from research on the clinical, cognitive, and social psychology of East Asian populations, in addition to recommendations offered by scholars who study Asian American mental health issues. Below, we describe these adaptations and offer empirical and conceptual support for each.

*Cultural Adaptations and Rationale*

Borrowing from Hong (1988), we define Asian Americans broadly as immigrants, refugees, or U.S.-born individuals of East Asian heritage. Of course, Asian Americans are extremely diverse, representing more than a dozen distinct ethnic groups (e.g., Chinese, Korean, Vietnamese) (U.S. Census Bureau, 2002). Despite this diversity, many argue that Asian Americans share cultural characteristics that warrant specialized attention in the treatment context.

One common thread that links East Asian societies is the philosophy of Confucianism, a system of social and ethical thought originating in China more than 2000 years ago and now prevalent throughout much of East Asia and the Asian diaspora (Reid, 2000). Confucianism is a code of interpersonal behavior which advances ideals about morality and the proper ordering of human relations. Specifically, Confucianism promotes the values of a strong group orientation, knowledge and acceptance of one's role in the family and society, obedience and attention to mutual obligations, and interpersonal harmony (Bond, 1986; Kim et al., 2001; Reid, 2000). Treatments that fail to account for such values may be culturally-insensitive and thus less effective with East Asian populations (Chen & Davenport, 2005; Kim et al., 2001; Lin, 2002). Next, we discuss the potential relevance of East Asian values in the psychotherapy context, and specify treatment adaptations based on these considerations. The cultural adaptations and justifications for each are summarized in Table 1.

*Assess/address cultural identification and acculturation.* Understanding how Asian clients identify culturally may be important for several reasons. First, recent evidence shows that low acculturation and foreign-born patients tend to benefit less from conventional therapies, even when treatment providers are bilingual and bicultural (Hovell et al., 2003; Martinez & Eddy,

2005; Telles et al., 1995). Simply ensuring “cultural match” between therapists and clients may be insufficient when clients are unfamiliar with the conventions of Western-oriented therapies. Second, analog research suggests that counselor credibility may be enhanced when (1) Asian clients perceive their counselors as similar in attitudes, values, and beliefs (Atkinson, Poston, Furlong, & Mercado, 1989), and (2) therapists acknowledge the importance of the Asian client’s ethnicity and cultural values (Gim, Atkinson, & Kim, 1991).

In light of these findings, we adapted OST to attend to issues concerning client ethnicity, cultural identification, and acculturation. During the assessment phase, OST-CA therapists evaluate the client’s acculturation status and consider possible effects on problem etiology, coping strategies, and perceptions of treatment. For example, soon after informed consent, the therapist states “Often, I ask my clients about their racial and ethnic background because it helps me have a better understanding of who they are. Is that something you’d feel comfortable talking about?” Depending on client response, the therapist then elicits further information regarding the client’s ethnic identification, family of origin, or culture that might inform the treatment plan. We expect that a brief discussion of the client’s cultural background will enhance the counselor’s credibility and increase treatment engagement.

*Evaluate/address client’s explanatory model of target problem.* As noted earlier, perceived attitudinal congruence between client and counselor may help enhance therapist credibility (Atkinson et al., 1989). Similarly, therapist-client agreement with regard to problem etiology may contribute to an improved therapeutic alliance, greater therapist empathy (Kim, Ng, & Ahn, 2005), and positive post-treatment psychosocial functioning (Zane et al., 2005) when working with Asian Americans. These findings suggest that therapists who assess and attend to the “explanatory model” of Asian American clients may implicitly communicate their respect for

the client's worldview, and hence build greater trust and credibility (Brown, Abe-Kim, & Barrio, 2003).

Therefore, OST was adapted to require that therapists elicit the client's multifaceted perception of the presenting problem. Specifically, OST-CA clients are asked to report their understanding of the causes of their phobic anxiety and ability to control it, whether their fears are unusual by community standards, how problematic they perceive the fears to be, and whether they feel treatment is likely to help. Although corrective information is offered when clients report factual errors (e.g., all spiders will bite or be poisonous; contact with the phobic stimulus will cause a heart attack), more often therapists empathize with the client's perspective/concerns and/or normalize the client's experiences (see below). Thus, although actual congruence in problem conceptualization may be helpful, this approach does not require that therapists actually alter their beliefs to match those of clients (Zane et al., 2005).

*Normalize problem.* Compared to Euro-Americans, East Asians often harbor negative beliefs about the causes and consequences of mental health problems (Sue et al., 1976; Whaley, 1997). Similarly, Asians generally attach greater stigma than Euro-Americans to professional help-seeking for psychosocial problems (Atkinson et al., 1984; Zhang et al., 1998), with low acculturation Asians having the least favorable opinion of counseling (Atkinson & Gim, 1989; Kim & Omizo, 2003; Leong, Wagner, & Kim, 1995; Tata & Leong, 1994)<sup>1</sup>. Moreover, when Asian Americans do pursue counseling, they are more often concerned about academic and career issues whereas Euro-Americans tend to report emotional or interpersonal problems (Gim, Atkinson, & Whiteley, 1990; Tracey, Leong, & Glidden, 1986).

This pattern may derive in part from cultural values that foster interrelatedness, norm conformity, and fear of disengagement from one's social group (Kim, Atkinson, & Yang, 1999;

Kim & Markus, 1999). For many East Asians, adhering to group norms is not only an intrinsic preference that enhances one's sense of self-worth, but also a strongly sanctioned moral obligation (Kim & Markus, 1999; Markus & Kitayama, 1991). Because psychiatric disorders are by nature deviations from a functional norm (Wakefield, 1992), East Asians who acknowledge mental health problems and seek professional help may reinforce notions of difference from others, risk social distancing from family or friends, and hence perceive potential threats to social harmony.

Thus, therapists who work with Asians should consider treatment strategies that normalize psychiatric symptoms and minimize the stigma derived from treatment-seeking. To some extent, standard OST adopts this approach. For example, OST clients are often told that their phobias are “logical” given how intensely they believe in possible catastrophe (Ost & Ollendick, 1999). However, several adaptations were made to further normalize the treatment experience for Asian Americans. In OST-CA, clients are given a one page “fact sheet” that describes the symptoms, prevalence, and likely consequences of their phobias. In addition, OST-CA therapists minimize the use of diagnostic terms – words or phrases that suggest the presence of a mental disorder. For example, although most Asian subjects in a recent pilot trial met diagnostic criteria for simple phobia (Huey & Pan, 2006), the therapist was careful not to offer a diagnosis to clients. Also, borrowing from Ito (2002), OST-CA therapists generally avoid the use of pathologizing adjectives such as “excessive,” “extreme,” “unusual,” “strange,” or “abnormal” when describing the subject's fears.

*Emphasize confidentiality.* Although attention to client confidentiality and its limits is an ethical imperative regardless of client ethnicity (American Psychological Association, 2002), some argue that confidentiality concerns are of particular importance when treating Asian

Americans (Chen & Davenport, 2005; Lin, 2002). As noted earlier, admitting to emotional distress or seeking help for emotional problems carries significant stigma for East Asians (Sue et al., 1976; Whaley, 1997; Zhang et al., 1998). Asian American clients may fear that community awareness of mental health treatment reflects poorly on their emotional strength and ability to cope, or brings shame to self and family.

Reassuring clients that confidentiality will be strictly maintained may be necessary to address the negative connotations of help-seeking among Asian Americans (Chen & Davenport, 2005; Hong, 1988). To highlight the importance of confidentiality during informed consent, OST-CA therapists actively elicit concerns about privacy from the client then respond to any confidentiality-related issues. If the client expresses no apprehension, the therapist offers an example of a concern that someone might have and what the response would be. For example, the therapist might say “Many clients worry that other people will discover that they sought out treatment for their problems. Is this a concern of yours?” and then provide a response that reassures the client that confidentiality will be maintained.

To further convey and reinforce the importance of confidentiality, OST-CA therapists are trained to reiterate guarantees made earlier during the informed consent process. Specifically, therapists note that: (1) a videorecording of the session is available for viewing and can be destroyed if requested, (2) research and clinic records are stored in locked cabinets in locked rooms, and (3) the data storage computer is activated by password, and thus secure.

*Emphasize and facilitate emotional control.* East Asian cultures also value personal self-restraint and the suppression of potentially disruptive emotions (Chen & Davenport, 2005; Kim et al., 2001; Kim et al., 1999). Compared to other ethnic groups, Asian Americans are less emotionally expressive, less likely to disclose traumatic experiences to others, more likely to

conceal “disruptive” thoughts and feelings, and more likely to consider emotional disclosure as inappropriate (Hsu, Tseng, Ashton, McDermott, & Char, 1985; Park, 2004; Soto, Levenson, & Ebling, 2005). Moreover, work by Tsai and colleagues (Tsai & Levenson, 1997; Tsai, Levenson, & McCoy, 2006) indicates that Asians and Asian Americans value calm and other low arousal states more than Euro-Americans. Finally, Toyokawa and Nedate (1996) argue that when negative emotions are communicated by Asian Americans, it is more appropriate to express them indirectly or in an understated manner.

For East Asians, emotional control may function as a culturally-sanctioned means for maintaining interpersonal harmony. Verbal expression of negative emotions may be perceived by Asians as a counterproductive response that triggers social discomfort and discord, whereas stoicism and self-restraint may help maintain harmonious relations by avoiding the imposition of one’s feelings on others (Bond & Hwang, 1986; Ino & Glick, 1999; Kim et al., 2001).

This cultural value may have one important consequence in the treatment context: Asian Americans may be more reluctant to express or tolerate strong emotions in therapy, particularly at the beginning phase of treatment (Leong & Lau, 2001; Lin, 2002). Indeed, some argue that therapists who strongly encourage overt emotional expression are perceived as less credible and competent by Asian American clients (Ito & Maramba, 2002). Furthermore, given the cultural value of maintaining self-control, Kim et al. (2001) speculate that traditional Asian Americans should experience greater comfort when treatment focuses on expression of thoughts rather than feelings.

OST was therefore modified in two ways to better address potential concerns over inadequate emotional control. First, early in treatment, OST-CA therapists explicitly describe OST as a self-control method that helps clients better control their emotional reactions when

fearful situations arise. Therapists explain that OST will help the client remain calmer and show more restraint. If clients subsequently express reluctance to continue with treatment, therapists remind clients that exposure ultimately facilitates greater self-control over their fears. The second change requires therapists to reframe anxiety reporting as a cognitive activity. In standard OST, clients are periodically asked to report their subjective units of distress (SUDs) to evaluate how anxious they feel in response to feared situations. However, providing SUDs ratings may prove difficult for many Asians because it involves continuous attention to and verbal communication of intense negative emotions. Thus, we implemented a simple semantic change that reframed SUDs reporting from an affective to a cognitive task. Specifically, subjects in the culturally-adapted condition are told to report their “SUDs *thoughts*” over the course of treatment.

*Exploit vertical nature of therapeutic relationship.* Among traditional Asian Americans, power differentiation is often apparent in interpersonal interactions, requiring those in lower status positions to defer to and show respect for higher status individuals (Chen & Davenport, 2005). East Asians and Asian Americans are more likely than Euro-Americans to hold positive beliefs about the legitimacy of authority and social hierarchy in varied social contexts (Cheng, O’Leary, & Page, 1995; Ching et al., 1995; Kim et al., 1999; Wink, Gao, Jones, & Chao, 1997). Such cultural priorities are probably rooted in early socialization patterns. Whereas Asian parents are more likely to promote relatedness by encouraging children to obey and respect authority, Euro-Americans are more committed to encouraging choice and free expression in their children (Chao, 1995; Rothbaum, Morelli, Pott, & Liu-Constant, 2000). Thus, Asian Americans may be more likely to ascribe greater trust and credibility to therapists with authority-

enhancing credentials or who behave like respected professionals such as teachers or physicians (Chen, 1995; Kim et al., 2001).

Fortunately, standard OST already includes procedures that establish the clinician's authority as an expert in treating phobias. These include (1) clearly explaining the nature of phobias and how/why exposure works, (2) answering questions knowledgeably, (3) handling feared stimuli with ease and comfort, and (4) making accurate predictions about therapy process (e.g., caged spider will not crawl up client's finger; anxiety will decrease with repeated exposure) (Ost & Ollendick, 1999). To build on this foundation, we made two modifications that further exploit the hierarchical nature of the therapist-client relationship. First, early in treatment, OST-CA therapists highlight aspects of their professional background that establish their expertise as credible clinicians. For example, therapists with "extensive" prior experience (i.e., previously treated more than a dozen phobic patients) are encouraged to reassure clients that, because they have successfully treated similar cases in the past, they are confident that the client can be helped. This change is consistent with evidence that counselors who disclose how they resolved problems similar to those reported by the client are perceived as more helpful by Asians (Kim et al., 2003).

Second, given the preference among Asian Americans for directive, solution-oriented counseling (Atkinson et al., 1978; Atkinson & Matsushita, 1991; Exum & Lau, 1988; Li & Kim, 2004), OST was adapted to maximize therapist directives and commands while minimizing queries. In standard OST, the therapist gives clients considerable control over the pace of treatment by regularly asking permission to proceed with exposure. For example, immediately prior to an exposure trial, the therapist might ask the client "Can you touch the spider with your finger? Is this something you'd feel comfortable doing?" This procedure capitalizes on the

intrinsic value of primary control and personal choice among North Americans and Western Europeans (Markus & Kitayama, 1991; Weisz, Rothbaum, & Blackburn, 1984). However, the exercise of personal control may have considerably less import for East Asians (Iyengar & Lepper, 1999; Ji, Peng, & Nisbett, 2000; Sastry & Ross, 1998). Recent evidence suggests that Asian American youth show their highest levels of intrinsic motivation and performance in problem-solving when decisions are made by trusted authority figures, whereas Euro-Americans respond optimally when personal choice is permitted (Iyengar & Lepper, 1999). Culturally-adapted OST takes advantage of this “authority orientation” among Asian Americans by requiring that therapists issue mild directives that inform the client that exposure will commence (e.g., “Now I’d like you to touch the spider with your finger”), rather than eliciting explicit permission to continue.

*Provide extensive psychoeducation.* While psychoeducation is a basic component of many evidence-based treatments (Nathan & Gorman, 1998), Asian American clients may find psychoeducation particularly beneficial. Chun (1997), for example, found that Asian American undergraduates expected more information regarding their psychological functioning and the nature of therapy than Euro-Americans. Others argue that East Asian cultural values emphasize the importance of rational explanations for one’s behavior, in particular understanding the purpose for doing something before acting (Chen, 1995). Thus, some recommend that counselors explicitly educate Asian American patients about problem etiology, treatment rationale, expectations for treatment, and the role of therapists as experts (Chen & Davenport, 2005; Kim, Bean, & Harper, 2004). If the counselor does not appear sufficiently knowledgeable, he/she may be perceived as incompetent and less credible by Asian Americans (Chen & Davenport, 2005).

As noted earlier, standard OST does have a significant psychoeducational component (Ost & Ollendick, 1999). However, additional steps were taken to further enhance the cultural relevance of OST for Asian Americans. First, based on recommendations by Brown et al. (2003), clients are given a one-page “fact sheet” that describes how phobias function and why OST should serve as an effective treatment. In addition, clients receive two book chapters that describe the nature and etiology of specific phobias (Antony, Craske, & Barlow, 1995). This information is then discussed at the beginning of the treatment session and clients are prompted to ask questions about their phobias or the treatment process.

In summary, OST was modified to correspond with cultural values and worldviews that Asians bring to the treatment context. The adaptations involve modest changes in both intervention content (e.g., more extensive psychoeducation) and service delivery (e.g., maximizing therapist directives/commands). Although many conceptually-based adaptations were initially considered (Chen & Davenport, 2005; Kim et al., 2001; Kim et al., 2004; Sue & Zane, 1987), we adopted only those that were consistent with existing research yet did not conflict with standard OST practice.

#### *Evidence From A Pilot Trial*

In contrast to other models of cultural sensitivity for East Asians, our approach has garnered tentative empirical support in a randomized pilot trial. We tested whether cultural adaptations enhanced the efficacy of OST by randomly assigning phobic Asian Americans to OST-S, OST-CA, or manualized self-help (Huey & Pan, 2006). Self-help participants were given a condensed version of Antony et al.’s (1995) *Mastery of Your Specific Phobia* and instructed to read through the manual and follow all required steps. At post-treatment, OST (combined standard and culturally-adapted) led to greater reductions in phobic avoidance and

anxiety than self-help (Huey & Pan, 2006). Moreover, analyses comparing the two active treatments showed trends favoring OST-CA over OST-S. In particular, OST-CA showed significantly greater reductions in catastrophic thinking and marginally greater improvement in behavioral approach (e.g., approaching the feared stimulus) than OST-S (Huey & Pan, 2006). In terms of clinical significance, all OST-CA participants were able to hold the feared stimulus in their hands for at least 20 seconds at post-treatment, whereas OST-S participants were somewhat less improved, and self-help participants least improved (Figure 1).

### *Discussion*

Although many argue that Asian Americans benefit optimally when treatments are congruent with Asian cultural values (e.g., Lee, 1997; Uba, 1994), empirical support for this view has been lacking. We tried to address this gap by adapting brief exposure therapy for Asian Americans, and evaluating whether cultural enhancements augmented treatment effects. For several outcomes, OST was most effective for Asians when treatment incorporated empirically-derived cultural adaptations.

The relative success of culturally-adapted OST may derive from our approach to treatment modification. In general, intervention researchers differ widely in their methods for making treatments culturally appropriate. Past efforts have focused on training therapists to work with ethnic minority populations (Lopez et al., 1989; Wade & Bernstein, 1991); utilizing ethnic-specific counselors, models, or facilitators (Fantuzzo, Manz, Atkins, & Meyers, 2005; Heppner, Neville, Smith, Kivlighan, & Gershuny, 1999); involving ethnic minorities in intervention development and planning (Lochman, Curry, Dane, & Ellis, 2001; McCabe, Yeh, Garland, Lau, & Chavez, 2005); and identifying broad principles or dimensions that guide treatment adaptation (Bernal, Bonilla, & Bellido, 1995; Sue & Zane, 1987). Although each

provides a useful template for contextualizing treatments for minority populations, we chose an approach that relies heavily on existing research. To reduce the problem of culturally appealing but scientifically indefensible adaptations (Castro, Barrera, & Martinez, 2004; Lau, 2006), we required that each modification be consistent with available psychological research on East Asian populations (see Table 1), but not interfere with core OST clinical procedures (Ost & Ollendick, 1999). This focus on conceptually- *and* empirically-driven adaptations may help explain the modest additive effects for our cultural adaptations (Huey & Pan, 2006).

Notably, several intuitively appealing adaptations were considered but subsequently omitted following a careful review of the literature. For example, despite conventional wisdom regarding the importance of social support seeking for Asian Americans (Kim et al., 2004; Lee, 1997), we abandoned earlier plans to encourage clients to utilize their support networks (i.e., family members, friends, or partners) for help with post-treatment maintenance because recent work suggested this might be counterproductive. Taylor, Kim, Sherman and colleagues found that East Asians were consistently *less* likely than Euro-Americans to call on support networks in times of stress, and generally found support-seeking less effective in dealing with stressors, particularly when close others were involved (Kim, Sherman, Ko, & Taylor, 2006; Taylor et al., 2004). Because Asians are more concerned about burdening family and friends, the authors suggest that social support transactions that emphasize social assurance rather than explicit solicitations of help may be more useful for Asians (Kim et al., 2006; Taylor, Welch, Kim, & Sherman, 2007). This possibility should be explored in future intervention research with East Asians.

Future research might also consider the role of ethnicity and acculturation status as moderators of intervention effects with Asians. Although “disadvantaged” minorities (i.e.,

African Americans and Latinos) and Euro-Americans often benefit equally from evidence-based treatments (Huey & Polo, in press; Miranda et al., 2005), how Asians fare when compared to other ethnic groups is still unknown. Some scholars speculate that standard, “Eurocentric” treatments might actually be most effective with less acculturated East Asians. Kim et al. (2001), for example, argue that some Asian cultural values (e.g., respect for authority, preference for interpersonal harmony) may facilitate client self-disclosure and compliance in the context of highly structured therapies and thus enhance CBT effects with Asians. Another interesting possibility is that many Asian-orientated adaptations could work equally well for Euro-Americans. The emphasis on directive counseling is a case in point. Although Asians generally prefer structured treatments (Atkinson & Matsushita, 1991; Li & Kim, 2004), other evidence suggests that client preference for directive and concrete counseling may be a universal expectation independent of client ethnicity (Park, 2004; Tinsley, Bowman, & Barich, 1993).

Admittedly, our modifications do not exhaust the range of possible adaptations for Asian Americans. Indeed, social cognition and social influence research suggests many other avenues for intervention adaptation with Asian Americans. For example, recent studies indicate that East Asians show a strong orientation towards self-criticism and self-improvement (e.g., exerting greater effort on tasks at which they previously failed), whereas North Americans more often evidence self-enhancing tendencies (e.g., working harder on tasks at which they previously succeeded) (Heine et al., 2001; Kitayama, Markus, Matsumoto, & Norasakkunkit, 1997). These findings suggest that Asians may be more likely to exert maximum effort in treatment when clinicians highlight skills deficits or frame therapeutic activities as methods for self-betterment. This literature also shows that East Asians and Asian Americans feel better, perform better, and report greater self-efficacy when working with in-group members, whereas Euro-Americans

function optimally when working alone (Sastry & Ross, 1998; Yamaguchi, Gelfand, Ohashi, & Zemba, 2005). Thus, treatment in group contexts may facilitate greater comfort and engagement, enhance perceived efficacy, and improve patient compliance for East Asians with mental health problems.

In summary, our model may offer a useful framework for treatment development and validation with ethnic minority populations. Cultural tailoring is probably the norm when ethnic minorities are targeted in randomized trials (Griner & Smith, 2006; Huey & Polo, in press), but rarely are the adaptations themselves scrutinized by investigators. Thus, we made empirical validation a critical part of our therapy refinement process by selecting an evidence-based treatment, incorporating research-derived cultural enhancements, and then assessing whether Asian Americans benefited from these enhancements. Results showed the potential importance of deriving cultural adaptations from contemporary psychological research. It is our hope that future research of this sort will better facilitate mental health care for minorities that is both culturally-competent and empirically-supported.

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Footnotes

<sup>1</sup>However, contrary to expectations, Gim et al. (1990) found an inverse relationship between Asian American acculturation and willingness to see a counselor.

Table 1

*Summary of Culture-Responsive Adaptations to One-Session Treatment and Rationales*

<i>Adaptation</i>	<i>Rationale</i>
1. Assess/address cultural identification and acculturation status	<ul style="list-style-type: none"> <li>• Asian Americans prefer therapists who share similar values (Atkinson et al., 1989)</li> <li>• Counselors are rated as more credible when they acknowledge the importance of the Asian client's ethnicity and cultural values (Gim et al., 1991).</li> </ul>
2. Assess/address client's "explanatory model" of target problem	<ul style="list-style-type: none"> <li>• For Asian American clients, therapist-client agreement regarding problem etiology is associated with higher client perceptions of working alliance and therapist empathy (Kim, Ng, &amp; Ahn, 2005)</li> <li>• For Asian Americans, therapist-client similarity in perception of target problem is associated with client improvement in psychosocial functioning (Zane et al., 2005)</li> </ul>
3. Normalize problem	<ul style="list-style-type: none"> <li>• Emotional distress and help-seeking is more stigmatizing for Asians than for Euro-Americans (Atkinson et al, 1984; Sue et al., 1976; Whaley, 1997; Zhang et al., 1998).</li> <li>• Asians more often endorse norm conformity as a value compared to Euro-Americans</li> </ul>

(Kim, Atkinson, & Yang, 1999; Kim & Markus, 1999)

- |   |  |
|---|--|
| 4. Emphasize confidentiality  | <ul style="list-style-type: none"> <li>• Emotional distress and help-seeking is more stigmatizing for Asians than for Euro-Americans (Atkinson et al, 1984; Sue et al., 1976; Whaley, 1997; Zhang et al., 1998).</li> </ul>  |
| 5. Emphasize and facilitate emotional control by: (a) describing OST as a self-control method, and (b) Reframing SUDs reporting as a cognitive activity | <ul style="list-style-type: none"> <li>• Asians more often endorse emotional control as a value compared to Euro-Americans (Kim, Atkinson, &amp; Yang, 1999)</li> <li>• Asian Americans are more likely than Euro-Americans to believe that mental health problems can be controlled through willpower and avoidance of morbid thoughts (Sue et al., 1976)</li> <li>• Compared to Euro-Americans, Asian Americans are less likely to disclose traumatic experiences to others, more likely to conceal “disruptive” thoughts and feelings, and more often consider emotional disclosure as inappropriate (Hsu et al., 1985; Park, 2004; Soto et al., 2005).</li> <li>• East Asians and Asian Americans value calm and other low arousal states more than Euro-Americans (Tsai &amp; Levenson, 1997; Tsai et al., 2006)</li> </ul> |
| 6. Exploit vertical nature of therapeutic   | <ul style="list-style-type: none"> <li>• Asians prefer directive, solution-oriented counseling over non-directive approaches</li> </ul>  |

relationship by: (a) emphasizing professional credentials, and (b) Using directives or commands to prompt exposure

(Atkinson et al., 1978; Atkinson & Matsushita, 1991; Chun, 1997; Exum & Lau, 1988; Kim et al., 2002; Li & Kim, 2004)

- Asian Americans hold more positive beliefs concerning authority and social hierarchy than Euro-Americans (Cheng et al., 1995; Ching et al., 1995; Kim et al., 1999; Wink et al., 1997)
- Asian Americans show higher motivation and performance when choices are made by trusted authorities or peers versus self (Iyengar & Lepper, 1999)
- Asian clients perceive counselors as more helpful when counselors disclose how they resolved problems similar to those reported by client (Kim, Hill et al., 2003)
- Americans perform better on judgment tasks and are more confident in their decisions when greater direct control is permitted, whereas Chinese perform somewhat less accurately with greater control (Ji et al., 2000).
- Asian American clients expect to receive more information regarding their psychological functioning and the nature of therapy than Euro-Americans (Chun, 1997).

7. Provide extensive psychoeducation

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Figure Caption

*Figure 1.* Mean performance on behavioral approach test, by treatment condition. (*Note.* From “Culture-Responsive One-Session Treatment for Phobic Asian Americans: A Pilot Study” by S.J Huey and D. Pan, 2006, *Psychotherapy: Theory, Research, Practice, and Training*, 43, pp. 549-555. Copyright 2006 by the American Psychological Association. Reprinted with permission.)

