Published in final edited form as:
Prof Psychol Res Pr. 2009 August ; 40(4): 369–377. doi:10.1037/a0016240.

The Formative Method for Adapting Psychotherapy (FMAP): A community-based developmental approach to culturally adapting therapy

Wei-Chin Hwang
Claremont McKenna College

Abstract

How do we culturally adapt psychotherapy for ethnic minorities? Although there has been growing interest in doing so, few therapy adaptation frameworks have been developed. The majority of these frameworks take a top-down theoretical approach to adapting psychotherapy. The purpose of this paper is to introduce a community-based developmental approach to modifying psychotherapy for ethnic minorities. The Formative Method for Adapting Psychotherapy (FMAP) is a bottom-up approach that involves collaborating with consumers to generate and support ideas for therapy adaptation. It involves 5-phases that target developing, testing, and reformulating therapy modifications. These phases include: (a) generating knowledge and collaborating with stakeholders (b) integrating generated information with theory and empirical and clinical knowledge, (c) reviewing the initial culturally adapted clinical intervention with stakeholders and revising the culturally adapted intervention, (d) testing the culturally adapted intervention, and (e) finalizing the culturally adapted intervention. Application of the FMAP is illustrated using examples from a study adapting psychotherapy for Chinese Americans, but can also be readily applied to modify therapy for other ethnic groups.

Keywords

Asian American; adaptation; ethnic minority; psychotherapy; treatment

Will culturally adapting psychotherapy improve treatment outcomes for ethnic minorities? Research demonstrates that ethnic minorities are less likely to receive quality health services and evidence worse treatment outcomes when compared with Caucasian Americans (Institute of Medicine (IOM), 1999; United States Department of Health and Human Services (USDHHS), 2001). Bernal, Jiménez-Chafey, & Domenech Rodríguez (2009) report that previous literature addressing cultural adaptation models is not well documented, contributing to the paucity of detailed literature in this area. Although considerable progress has been made in establishing and defining efficacious and possibly efficacious treatments for the general population, relatively little is known about the efficacy of empirically-supported treatments

Correspondence concerning this article should be addressed to Wei-Chin Hwang, Department of Psychology, Claremont McKenna College, 850 Columbia Avenue, Claremont, CA 91711. whwang@cmc.edu.

Editor's Note: This article is one of four in this special section on Evidence-based Practices and Multicultural Populations.—MCR

(ESTs) for people from diverse backgrounds (Miranda, Bernal, Lau, Kohn, Hwang, & LaFromboise, 2005; Nagayama-Hall, 2001). As the demographics of the United States (U.S.) change, this critical lacuna in our knowledge along with our under-preparedness to effectively treat ethnic minorities will become more apparent.

Today, mental health providers are faced with the dilemma of (a) implementing an "as is approach" to disseminating ESTsto culturally diverse ethnic groups, (b) adapting ESTsto be more culturally congruent in order to better fit the needs of ethnic clients, or (c) developing new, culture-specific ESTs for each ethnic group. Since the majority of therapists working with ethnic minority clientele in the U.S. are trained in western psychotherapy, developing culture-specific treatments that are based on different healing paradigms make choice number (c) less practical. Moreover, developing novel ethnic-specific treatments for each culturally different group in the U.S. may be prohibitively costly, time consuming, and lead to training difficulties, especially if treatments are based on different theoretical paradigms. Implementing an "as is approach" in disseminating ESTs to ethnic minority clients may not fully address the diverse needs of clients. Therefore, culturally adapting ESTs may be the most responsive and cost-effective approach.

Fortunately, there is growing recognition that mainstream mental health services may need modifications in order to meet the needs of our diversifying population. The American Psychological Association (APA) published a set of guidelines for multicultural education, training, research, practice and organizational change for psychologists (APA, 2003). More specific recommendations for training clinicians to be more culturally competent have also been provided (Comas-Diaz & Jacobsen, 1991; Hardy & Laszloffy, 1992; Lo & Fung, 2003; Pedersen, 1997; 2000; Sue, 1990; Sue, Arrendondo, & McDavis, 1992; Sue, Ivey, & Pedersen, 1996).

In addition, specific culturally adapted therapy programs have been developed and found to be effective (Constantino, Malgady, & Rogler, 1986; Kohn, Oden, Munoz, Robinson, & Leavitt, 2002; Kumpfer, Alvarado, Smith, & Bellamy, 2002; Munoz & Mendelson, 2005; Rossello & Bernal, 1999; Szapocznik, Santisteban, Kurtines, Perez-Vidal, & Hervis, 1984; Ying, 1999; Zhang, Young, Lee, Li, Zhang, Xiao, et al., 2002). Similarly, Nicolas, Arntz, Hirsch, and Schmiedigen (2009) have also demonstrated early success in the development of a cultural adaptation model for Haitian adolescents using the Ecological Validity and Cultural Sensitive Framework (Bernal, Bonilla, & Bellido, 1995), briefly described below, as the cultural foundation for adaptation with the Adolescent Coping with Depression Course (ACDC). There is also growing evidence to suggest that treating clients in a more culturally sensitive manner (i.e., providing client-therapist ethnic matching and treatment at ethnic-specific services) can reduce premature treatment failure (Flaskerund & Liu, 1991; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Takeuchi, Sue, & Yeh, 1995). A few theoretical frameworks have also been developed to guide therapy adaptations. For example, Bernal, Bonilla, and Bellido (1995) developed a theoretically driven framework for developing culturally sensitive interventions. This framework consisting of dimensions of treatment and culturally sensitive elements has been used to guide adaptations in cognitive-behavioral and interpersonal treatments for depressed Puerto Rican adolescents and these adapted treatments have been shown to be efficacious in randomized controlled trials (Rossello & Bernal, 1996; Rosello & Bernal, 1999). They suggested using 8 different dimensions, including language, persons, metaphors, content, concepts, goals, methods, and context to identify areas for adaptation. For example, the dimension of "context" involves consideration of changing contexts that might increase risk to acculturative stress problems, disconnect from social supports and networks, and reduced social mobility. The dimension of "persons" involves addressing cultural similarities and differences between the client and clinician. Issues of "content" involve cultural knowledge and information about the values, traditions, and customs of the culture.

For more information on the framework developed by Bernal, Bonilla, and Bellido, see Bernal, Jiménez-Chafey, and Domenech Rodríguez (2009) and Nicolas et al., (2009).

A more recent framework developed by Hwang (2006) entitled "The Psychotherapy Adaptation and Modification Framework (PAMF) offered a three-tiered approach to making cultural adaptations. It consists of domains, principles, and rationales. Domains identify general areas that practitioners should utilize when modifying therapeutic approaches for their clients. Principles provide more specific recommendations for adapting therapy for specific groups. Rationales provide corresponding explanations for why these adaptations may be effective when used with the target population. This three-tiered approach was created to help practitioners make the shift from abstract ideas of being culturally competent to developing specific skills and strategies that can be effectively implemented when working with diverse clientele. In addition, it was developed to help practitioners thoroughly think through the reasons why they were making certain adaptations and to support these modifications with compelling reasons. General domains for adaptations include: (a) understanding dynamic issues and cultural complexities, (b) orienting clients to psychotherapy and increasing mental health awareness, (c) understanding cultural beliefs about mental illness, its causes, and what constitutes appropriate treatment, (d) improving the client-therapist relationship, (e) understanding cultural differences in the expression and communication of distress, and (f) addressing cultural issues specific to the population. Specific principles and rationales are detailed more fully in Hwang (2006).

Although theoretically driven approaches to cultural adaptation provide a strong foundation for tailoring interventions, bottom or ground-up community-based approaches can also provide invaluable information by confirming theory-related adaptations, generating ideas that more theory-driven approaches leave out, or by providing more specificity in the adaptations or examples offered. Community-based formative approaches to therapy adaptation can also serve as a powerful tool for cultural understanding because they involve consumers (therapists and clients), as well as community stakeholders and collaborators. A few studies have been published that have proposed frameworks and recommended sequences for developing culturally adapted interventions. For example, in discussing parent training, Lau (2006) recommended an evidence-based approach that (a) prioritizes selectively targeting problems and identifying communities that would most benefit and (b) using direct data outcomes to justify adaptations. In a response to Lau, Barrera and Castro's (2006) commentary recommended a sequence involving (a) information gathering, (b) preliminary adaptation design, (c) preliminary test of the adapted treatment, and (d) adaptation refinement, which is similar to the model presented below. Domenech Rodriguez & Wieling (2005) proposed a Cultural Adaptation Process Model, consisting of three phases, (a) focusing on the iterative process among all those involved in the adaptation process, (b) selection and adaptation of evaluation measures and continual exchange between the community and those creating the adaptations, and (c) integrating the observations and data gathered in phase two to create a new intervention. These models argue that community-based approaches will increase ecological validity of adaptations by increasing community participation. Nicolas et al. (2009) provide an additional example of a community-based cultural adaptation model for working with Haitian adolescents where the authors outline specific steps taken to build collaborative relationships with the community as a way to adapt the ACDC in a culturally responsive manner. A book on culturally responsive cognitive-behavioral therapy with different groups has also been published (Hays & Iwamasa, 2006). See also Hays (2009) for a more recent discussion of the integration of cognitive behavioral and multicultural therapies and their effectiveness in psychotherapy.

The Formative Method for Adapting Psychotherapy (FMAP)

The purpose of this paper is to introduce the Formative Method for Adapting Psychotherapy (FMAP) framework, a community-based bottom-up approach for culturally adapting psychotherapy. It was developed to be used in conjunction with the top-down PAMF (Hwang, 2006) to generate ideas for therapy adaptation, provide additional support for theoretically identified modifications, as well as to help flesh out and provide more specific and refined recommendations for increasing therapeutic responsiveness. It was generated in parallel to other adaptation models and contributes to the growing body of literature on culturally responsive treatment development. The combination of the top-down PAMF and the community-based FMAP approaches were developed by the Principal Investigator (PI) as guiding frameworks to facilitate the creation of a new culturally adapted treatment manual for depressed Chinese Americans. This culturally adapted Cognitive-Behavioral Therapy (CBT) manual is currently being tested against a non-culturally adapted CBT manual in a National Institutes of Mental Health (NIMH) funded clinical trial on empirically supported adapted interventions. Because the PAMF has already been described in a previous report by Hwang (2006), this paper focuses more on introducing the more bottom-up FMAP framework.

The FMAP approach consists of 5-phases: (a) generating knowledge and collaborating with stakeholders (b) integrating generated information with theory and empirical and clinical knowledge, (c) reviewing the initial culturally adapted clinical intervention with stakeholders and revising the culturally adapted intervention, (d) testing the culturally adapted intervention, and (e) finalizing the culturally adapted intervention. Each of the phases of the FMAP model is described below and can be tailored to meet the individual needs of different projects. Moreover, application of the FMAP is illustrated through examples from an ongoing clinical trial. The cultural adaptation process described here overlaps with the model described by Nicolas et al. (2009), and it is hoped that in conjunction both models can be used as guides for future research and practice.

Phase I: Generating knowledge and collaborating with stakeholders

The first step of implementing the FMAP is to decide which stakeholders to involve and when to involve them. According to the FMAP, there are generally six main categories of stakeholders, including (a) mainstream health and mental health care agencies, (b) mainstream health and mental health care providers, (c) community-based organizations and agencies, (d) traditional and indigenous healers, (e) spiritual and religious organizations, and (f) clients. For the purposes of our adapting CBT for Chinese Americans project, conscious decisions were made to include the following stakeholders initially: (a) Asian focused community mental health service agencies, (b) mental health providers (psychiatrists, psychologists, social workers, marital family therapists), (c) Traditional Chinese Medicine (TCM) practitioners, (d) Buddhist monks and nuns and both spiritual and religious Taoist masters. These stakeholders were included because they have expertise in treating depressed Chinese Americans and could potentially provide direct feedback on developing and improving treatments. Eliciting client feedback is also important, however, this was done later in the process for several reasons, including that (a) many of the clients had little to no exposure to mental health services, (b) were ill and could potentially lose confidence in treatment if project staff ask them for treatment advice, and (c) had minimal ability to differentiate types of treatments offered before receiving them. Client feedback is more extensively elicited in Phases IV and V.

Asian focused clinics were included because we wanted to make sure that the intervention developed could be feasibly implemented in the parameters of real treatment centers (e.g., the frequency of sessions, staffing and assignment of caseloads, hours of operation, billing and financial limitations), and to ensure that the program developed would be sustainable. For the purposes of our project, we collaborated with seven Asian focused clinics, two of which served

as primary clinical trial sites and five as focus-group collaborators. Focus groups were not run at clinical trial sites to ensure that treatment conditions would not be contaminated.

Mental health care providers were asked to participate because they are experts in the field and have insights and expertise in working with depressed Asian American clients. In addition, getting practitioners to participate in developing the intervention facilitated their buy-in to the treatment. Two four-hour focus groups with each clinic were run and multiple focus groups were run at larger clinics. Each focus group consisted of four to six mental health practitioners with a range of clinical experiences. This helped facilitate both breadth and depth of discussions. The first four hours involved general discussions of cultural adaptation and review of different treatment manuals and interventions. Specifically, we asked therapists their impressions, whether different aspects of treatments would work, and also elicited feedback about how best to modify them for Asian Americans. It was important to involve multiple clinics because they each possess different characteristics, biases, and notions about best practices. Capturing a range of feedback allowed us to develop a less biased and more ecologically valid treatment. Because we wanted to create an intervention that could be more easily modified for other Asian groups in the future, focus groups included staff that treated Chinese American and other Asian Americans. Interviews were also conducted with Traditional Chinese Medicine (TCM) practitioners, Buddhist monks and nuns, and spiritual and religious Taoist masters. It was important to involve cultural healers because these traditions have strongly influenced Chinese culture for thousands of years. This also provided an opportunity to exchange ideas, build a sense of community, and strengthen referral networks.

Phase II: Integrating generated information with theory and empirical and clinical knowledge

Information generated from our community-based focus groups was synthesized with the PAMF framework, extant theories, empirically supported therapy literature, my previous experience conducting therapy in a variety of community-based settings, and my continued private practice experience. The PI then began writing a new culturally adapted cognitive-behavioral therapy manual. Details of the adaptations made are presented later in this paper. Focus group collaborations helped reduce personal, clinician, and agency specific biases. Collaborating with traditional healers also helped ensure that cultural adaptations were grounded in cultural belief systems. Because not all of the stakeholders possess similar opinions of what therapeutic modifications would be most beneficial to the clients, the most recurrent themes were used and the author finalized the treatment manual based on his experiences and discussions generated.

Phase III: Review of culturally adapted clinical intervention by stakeholders and further revision

After writing the culturally adapted manual, four additional hours of focus groups were conducted with the therapists. Focus groups were conducted in English, with some portions being discussed in Chinese when beneficial. Initial impressions of the new intervention (English and Chinese versions) and feedback for improvement were elicited. Feedback was used to finalize the manual before clinical trial implementation. The final manual was titled "*Improving your mood: A culturally responsive and holistic approach to treating depression in Chinese Americans"* (Hwang, 2008; 2008). Client and therapist manuals were written, and translations into Chinese were conducted throughout the treatment development process and further refined and finalized after the focus groups were completed. Translations of the treatment manuals as well as assessment measures used in the clinical trial involved forward and back translation by a team of four master's level therapists, one postdoctoral fellow, and the author. In addition, feedback from 15 undergraduate students, three master's level therapists, one postdoctoral fellow, and four graduate students was elicited. Because of the

linguistic variability even within the written Chinese languages, translators spoke languages from different Chinese regions and countries (e.g., mainland China, Hong Kong, Taiwan).

Phase IV: Testing the culturally adapted intervention

The final intervention includes a 12 week program and is currently being used in a clinical trial funded by the National Institute of Mental Health (NIMH). A variety of clinical and cultural outcome measures (from clients, therapists, and independent assessors) are being used to test the efficacy of the interventions, including symptom reduction, treatment satisfaction, premature dropout, working alliance formation, and receipt and enactment of therapy. Assessments are collected at multiple time-points (e.g., baseline, week 4, 8, 12, and 3 months after the treatment has ended). All therapy sessions are also being recorded for qualitative therapy process review and weekly ongoing supervision is provided to the therapists in both adapted and non-adapted conditions by the author. Although having one supervisor for both conditions could potentially lead to allegiance biases, the use of different supervisors could also lead to a supervisor effect. Because the NIMH R34 grant is a treatment development grant, having one supervisor supervise both treatment conditions was deemed the best option because supervision information gathered will also be used to further refine the treatment after the clinical trial is completed.

Phase V: Synthesizing stakeholder feedback and finalizing the culturally adapted intervention

Clients who finish the treatment will be asked to participate in an interview to elicit feedback regarding their experiences, what they found useful, what they did not like, and their recommendations for treatment improvement. Therapists will also participate in an exit interview, both individually and as a group so that additional recommendations can be integrated. The PI will use this information along with his experiences supervising both treatment conditions and finalize the treatment manual. Therapist focus groups will again be conducted on the finalized manual, and focus groups consisting of community participants will also be used to finalize changes.

Cultural adaptation ideas generated by FMAP Phases I thru III

Although the clinical trial that was used to illustrate the stages of the FMAP has not been fully completed, the information generated from phases I thru III were effective in producing a culturally adapted manual that will be further refined after the clinical trial is completed. Table 1 lists the cultural adaptations that were used to create the new manual for depressed Chinese Americans. It is a culmination of adaptations generated by research and clinical theory (Phase II) and from more formative focus group process (Phases I and III). Below, it is presented in the same format as the PAMF, with adaptations arranged under different domains of adaptation, specific principles of adaptation, and corresponding rationales to justify why modifications were made. Comparison with the original PAMF table (see Hwang, 2006) reveal similar adaptations, however, the new cultural adaptation table are expanded, more specific, and provide more detailed and concrete recommendations. More theory driven PAMF adaptations were retained in the table only if reaffirmed by the more generative FMAP stages.

The development and modification of therapeutic interventions to match the client's cultural background is essential if we are to provide high-quality and culturally responsive treatments. This is especially important since the concept or notion of psychotherapy and the rationale behind therapeutic treatments may be culturally unfamiliar, foreign, and stigmatizing to many groups. The goal of this paper was to introduce the FMAP framework and we hope that clinical researchers will find this stage-by-stage bottom-up approach to cultural adaptations beneficial.

Comparing the efficacy of evidence-based adapted interventions with non-adapted interventions will be important in improving care for ethnic minorities.

Acknowledgments

This study was supported in part by National Institute of Mental Health (NIMH) grant 1R34MH73545-01A2 and the Asian American Center on Disparities Research (NIMH grant: 1P50MH073511-01A2).

References

American Psychological Association. Guidelines on multicultural education, training, research, practice and organizational change for psychologists. American Psychologist 2003;58:377–402. [PubMed: 12971086]

Barrera M Jr, Castro FG. A heuristic framework for cultural adaptations of interventions. Clinical Psychology: Science and Practice 2006;13(4):311–316.

Bernal G, Bonilla J, Bellido C. Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. Journal of Abnormal Child Psychology 1995;23(1):67–82. [PubMed: 7759675]

Bernal G, Jiménez-Chafey M, Domenech Rodríguez M. Cultural adaptation of evidence-based treatments for ethno-cultural youth. Professional Psychology: Research and Practice 2009;40

Comas-Diaz L, Jacobsen FM. Ethnocultural transference and countertransference in the therapeutic dyad. American Journal of Orthopsychiatry 1991;61:392–402. [PubMed: 1951646]

Constantino G, Malgady RG, Rogler LH. Cuento therapy: A culturally sensitive modality for Puerto Rican children. Journal of Consulting and Clinical Psychology 1986;54(5):639–645. [PubMed: 3771881]

Domenech-Rodriguez, M.; Wieling, E. Developing culturally appropriate, evidenced-based treatments for interventions with ethnic minority populations. In: Rastogi, M.; Wieling, E., editors. Voices of color: First-person accounts of ethnic minority therapists. Thousand Oaks, CA: Sage Publications; 2005. p. 313-334.

Flaskerund JH, Liu PY. Effects of an Asian client-therapist language, ethnicity, and gender match on utilization and outcome of therapy. Community Mental Health Journal 1991;27(1):31–42. [PubMed: 2019097]

Hardy KV, Laszloffy TA. Training racially sensitive family therapists: Context, content, and contact. Families in Society 1992;73(6):364–370.

Hays PA. Integrating evidence-based practice, CBT, and multicultural therapy: 10 steps for culturally competent practice. Professional Psychology: Research and Practice 2009;40

Hays, PA.; Iwamasa, GY. Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision. Washington, DC: American Psychological Association; 2006.

Hwang W. The Psychotherapy Adaptation and Modification Framework (PAMF): Application to Asian Americans. American Psychologist 2006;61(7):702–715. [PubMed: 17032070]

Hwang, W. Unpublished copyrighted treatment manual. 2008. Improving your mood: A culturally responsive and holistic approach to treating depression in Chinese Americans (Client Manual – Chinese and English versions).

Hwang, W. Unpublished copyrighted training manual. 2008. Improving your mood: A culturally responsive and holistic approach to treating depression in Chinese Americans (Therapist Manual – Chinese and English versions).

Institute of Medicine. Unequal treatment: Confronting Racial and Ethnic Disparities in Health Care. U.S: National Academy of Sciences Press; 1999.

Kohn LP, Oden T, Munoz RF, Robinson A, Leavitt D. Adapted cognitive behavioral group therapy for depressed low-income African American women. Community Mental Health Journal 2002;38(6): 497–504. [PubMed: 12474937]

Kumpfer KL, Alvarado R, Smith P, Bellamy N. Cultural sensitivity and adaptation in family-based prevention interventions. Prevention Science 2002;3(3):241–246. [PubMed: 12387558]

Lau A. Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. Clinical Psychology: Science and Practice 2006;13(4):295–310.

Lo H, Fung KP. Culturally competent psychotherapy. Canadian Journal of Psychiatry 2003;48(3):161–170.

Miranda J, Bernal G, Lau A, Kohn L, Hwang W, La Framboise T. State of the Science on Psychosocial Interventions for Ethnic Minorities. Annual Review of Clinical Psychology 2005;1:113–142.

Munoz RF, Mendelson T. Toward evidence-based interventions for diverse populations: The San Francisco General Hospital prevention and treatment manuals. Journal of Consulting and Clinical Psychology 2005;73:790–799. [PubMed: 16287379]

Nagayama-Hall GC. Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. Journal of Consulting and Clinical Psychology 2001;69(3):502–510. [PubMed: 11495179]

Nicolas G, Arntz DL, Hirsch B, Schmiedigen A. Cultural adaptation of a group treatment for Haitian American adolescents. Professional Psychology: Research and Practice 2009;40

Pedersen, PB. Culture-centered counseling interventions: Striving for accuracy. Thousand Oaks, CA: Sage Publications, Inc; 1997.

Pedersen, PB. Hidden messages in culture-centered counseling: A Triad Training Model. Thousand Oaks, CA: Sage; 2000.

Rossello, J.; Bernal, G. Adapting cognitive-behavioral and interpersonal treatments for depressed Puerto Rican adolescents. (1996). In: Hibbs, ED.; Jensen, PS., editors. Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice. Washington, DC: APA; p. 157-185.

Rossello J, Bernal G. The efficacy of cognitive-behavioral and interpersonal treatments for depression in Puerto Rican adolescents. Journal of Consulting and Clinical Psychology 1999;67(5):734–745. [PubMed: 10535240]

Sue DW. Culture-specific strategies in counseling: A conceptual framework. Professional Psychology: Research and Practice 1990;21(6):424–433.

Sue DW, Arredondo P, McDavis RJ. Multicultural counseling competencies and standards: A call to the profession. Journal of Multicultural Counseling & Development 1992;20(2):64–88.

Sue S, Fujino D, Hu LT, Takeuchi DT, Zane NW. Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. Journal of Consulting and Clinical Psychology 1991;59(4):533–540. [PubMed: 1918557]

Sue, S.; Ivey, AE.; Pedersen, PB. A theory of multicultural counseling and therapy. Pacific Grove, CA: Brooks/Cole Publishing Company; 1996.

Szapocznik J, Santisteban D, Kurtines W, Perez-Vidal A, Hervis OE. Bicultural effectiveness training: A treatment intervention for enhancing intercultural adjustment. Hispanic Journal of Behavioral Sciences 1984;6:317–344.

Takeuchi DT, Sue S, Yeh M. Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. American Journal of Public Health 1995;85(5):638–643. [PubMed: 7733422]

U.S. Department of Health and Human Services. Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; 2001.

Ying Y. Strengthening Intergenerational/Intercultural Ties In Migrant Families: A New Intervention For Parents. Journal of Community Psychology 1999;27(1):89–96.

Zhang Y, Young D, Lee S, Li L, Zhang H, Xiao Z, et al. Chinese Taoist cognitive psychotherapy in the treatment of generalized anxiety disorder in contemporary China. Transcultural psychiatry 2002;39 (1):115–129.

Biography

WEI-CHIN HWANG received his PhD in clinical psychology from the University of California, Los Angeles (UCLA). He is an Associate Professor of Psychology at Claremont McKenna College. His areas of research include ethnic, racial, and cultural issues in mental health and developing cultural competent and effective interventions for ethnic minorities.

Table 1

FMAP Cultural adaptations generated for Asian Americans

Domain	Cultural Adaptation Principles	Justification for Cultural Adaptations
Dynamic Issues and Cultural Complexities	Learn when to individualize, when to generalize, and when to examine the complexities of cultural issues (e.g., Thought records do not work with Asian Americans vs. thought records work better with more educated and more acculturated Asian Americans).	Cultural issues may be moderated by other factors such as level of education or level of acculturation
	Individualize statements made to client (e.g., rather than say "Family is really important to Chinese people," say "You seem to really care a lot about your family.")	Helps client feel validated rather than stereotyped.
	Adaptations made for specific Asian groups may not work with other Asian groups (e.g., modifications that involve incorporating Buddhist concepts may not equally apply to Filipino Americans because of religious differences among these groups).	Although racially similar, those from different ethnic and cultural backgrounds have different beliefs, histories, philosophies, and religious beliefs.
	Differentiate emic (culture-specific) and etic (culture-general) constructs when providing psychoeducation (e.g., assertive communication may not carry the same benefits when used in cultures where it is less normative, perceived as being too direct and disrespectful, and can potentially exacerbate relationship problems).	What is normative or effective in one culture may be abnormal and socially ineffective in another culture.
Therapy Orientation	Provide a longer and more detailed orientation to therapy.	Asian Americans clients are less familiar with and have less understanding of how psychotherapy works.
	Spend some time getting to know each other and understanding why the client is seeking therapy at this time.	Social relationships are very important for those from collectivistic backgrounds. Reduces awkwardness of talking with someone they do not know.
	Establish goals and markers of treatment progress that is periodically reviewed.	Helps reduce ambiguity of therapy and is consistent with the problem-focused nature of clients seeking treatment. Also helps client who are less comfortable being in therapy confirm the benefits of attendance.
	Educate the client about the course of therapy (e.g., what their experience is going to be like the first few weeks, several weeks thereafter, and in the long run).	Helps increase comfort and reduce ambiguity by normalizing experiences and providing realistic expectations.
	Client-therapist roles and expectations for therapy should be clearly addressed at the beginning of therapy.	Helps client understand their role as well as therapist's actions and behaviors. Facilitates client development of realistic expectations and normalizes their experiences.
	Address premature dropout and educate clients about healthy therapy termination.	Helps normalize client feelings and increases the likelihood that they will be open and honest with the therapist.
	Directly address why clients may feel like they are not receiving as much benefit during the first few weeks of therapy (e.g., gathering of background information and accurate understanding of the client and their problems results in more effective problem-solving).	Helps reduce premature treatment dropout and normalize feelings of why they feel like they are doing most of the talking and why the therapist is not giving as much direct advice near the beginning of treatment.
	Focus on psychiatric symptoms, but do not avoid discussing the psychiatric diagnosis	Focuses on client's presenting problem rather than psychiatric labeling. Acknowledges and normalizes client's difficulties and utilizes helpfulness of diagnostic information without reinforcing cultural stigmas and taboos about discussing mental illness.

Domain	Cultural Adaptation Principles	Justification for Cultural Adaptations
	Distinguish psychological and somatic symptoms of psychiatric diagnoses at the beginning of treatment.	Highlights that psychiatric disorders are not just "mental" problems and acknowledges interrelationship of mind and body. Consistent with holistic and somatic emphasis in Asian culture and reduces stigma associated with seeking mental health treatment.
Cultural Beliefs	Reduce the emphasis on cognitions and changing the way a person thinks. Instead focus on helping client think in more effective and healthy ways.	Focusing on changing one's way of thinking is less in-line with client goals of solving their problems. Too much emphasis on cognitive biases and changing negative thinking patterns may alienate the client; whereas, a positive reframe of helping the client think more effectively and healthily is more congruent with their goals.
	Increase emphasis on problem-solving and behavioral activation.	Aligns with the problem-solving focus of client and is congruent with physical health and holistic nature of Asian culture.
	Increase emphasis on resolving social conflicts and relational problems.	The primary problems of many clients from collectivistic cultural backgrounds tend to be family or relational problems. The process of immigration and the acculturation gap between parents and children also tends to exacerbate family difficulties.
	Highlight consequences of not properly addressing one's problems. Focus on advantages and disadvantages of different actions.	Consistent with problem-focused and practical nature of Asian culture and philosophy.
	Provide psychoeducation on unfamiliar topics	Improves client understanding of topics that they may have had little previous exposure. Consistent with educational focus of client culture and facilitates concrete understanding of important issues.
	It takes more time to work through therapy materials for people who have less prior knowledge or exposure. In addition, Asian American clients have less exposure to therapy and are more likely to be intimidated by large manuals.	If using a manualized treatment, reduce the amount of different materials you cover in each session and focus on applying the most relevant materials to the client's situation. Also, try to reduce the bulkiness of the manual (e.g., number of pages, not number of sessions) so that the treatment does not seem too overwhelming.
	Simplify and consolidate topics into the basics when several variations of similar categories exist (e.g., instead of discussing 15 different types of cognitive biases, focus on a few of the most common biases).	Reduces confusion, improves learning of the materials, and makes psychotherapy less intimidating.
	For adults and children, use terms such as exercise, practice or strengthening rather than homework.	Although one may think that a strong emphasis on education is Asian culture is congruent with assigning homework, some children and adults may have an aversive reaction to being assigned homework in therapy. Children already have too much homework to do and adults were pressured to study in the past. Terms such as exercise, practice, or strengthening are more in-line with the goal, hard work, and health emphasis in Asian cultures.
	Make sure the examples used are culturally salient and meaningful. When using a manualized treatment, make sure that artwork and layout design is also culturally appealing.	Using more relevant examples helps the client understand therapy concepts and more quickly acquire skills that are being taught. Culturally appealing artwork and layout increases the manualized treatment's aesthetic appeal.

Prof Psychol Res Pr. Author manuscript; available in PMC 2010 August 1.

Domain	Cultural Adaptation Principles	Justification for Cultural Adaptations
	Use cultural bridging techniques to relate therapy concepts to Asian beliefs and traditions (e.g., Bridging Qi and balance of energy to cultivating balanced cognitions and healthy behaviors to improve mood)	Facilitates understanding and adherence to treatment. Provides cultural context for learning and reduces culture unfamiliarity to foreign psychological concepts.
	Use metaphors to relate mental health treatment to physical health treatment (e.g., psychotherapy is like physical therapy and both require exercises and practice)	Helps reduce stigma related to seeking psychological services and helps client see the importance of practice and commitment to achieve gains.
	Understand how cultural beliefs influence help-seeking and changes the nature of the client you are treating (e.g., Because of stigma, Asian American clients tend to delay treatment and by nature are more severe when they do come into treatment. This compounded with unfamiliarity and cultural barriers lead to longer therapy response times).	Helps therapist understand client concerns and also helps therapist develop realistic treatment progress expectations of their client.
	Modify worksheets so that they are more culturally congruent and translate esoteric therapy terminology into common language and understanding (e.g., add a goals column to “Thought records” and call it “Goal analysis,” or reformulate “Chaining” into “Climbing the mountain to reach your goals.”	Helps clients better understand and align with the purpose of each worksheet or exercise. Also helps clients better understand culturally unfamiliar terminology and concepts.
Client-Therapist Relationship	Use proper cultural etiquette (e.g., offer clients some tea to drink and ask them how they have been doing).	Helps client feel more comfortable, increases feelings of social connectedness, and decreases feelings of awkwardness associated with talking to a stranger about one’s problems.
	Teach therapists about the cultural background of their clients.	Helps therapist understand and empathize with their clients. Increases therapist confidence and feeling of self-efficacy.
	Join and engage the client by assessing family background and migration history. Clarify the role that family and or caregivers will have in therapy.	Facilitates building of working alliance and bonding with therapist. Provides important contextual information on experiences of client. Respects privacy and rights of the client, but also acknowledges family and caretakers who may have brought the client to treatment.
	Therapists should be professional and present themselves as experts who can help the client solve their problems.	Consistent with respect for authority figures in collectivistic traditions where caregivers are experts who can help resolve their problems.
	Therapist cultural self-awareness and self-identity should be thoroughly explored.	Improves therapist understanding of self and cultural issues. Facilitates building of positive working alliance with client and encourages therapists to take responsibility for client care. Alleviates feelings of anxiety and tension related to working with culturally dissimilar or similar clients.
	Interactional and relational models of therapeutic relations should be understood.	Facilitates understanding that cultural competence requires knowledge of client issues, therapist cultural self awareness, and understanding how the two interact to affect therapy processes. Increases understanding of professional biases and ethnocultural transference and countertransference.
	Because of cultural stigma towards mental health services and unfamiliarity with therapy, increase emphasis on normalizing client feelings. Case examples may also be helpful.	Helps reduce stigma, increase level of comfort, and increase feelings of being supported and understood. Helps client relate their experiences with others and feel less alone.
	Make an active effort to provide emotional support, encouraging words, optimistic statements, and positive feedback to the client. Validate client when they share difficult to talk about experiences.	Helps increase feelings of comfort and support. This is especially important because there is a greater emphasis on receiving support and feedback from one’s social network rather than developing positive self-statements. It is more common for people to say

Domain	Cultural Adaptation Principles	Justification for Cultural Adaptations
		positive things about you than for you to say positive things about yourself in Asian cultures.
	Help therapist develop realistic expectations for client progress. Have more patience when clients are trying to learn new skills and improve at a slower rate (e.g., learn new hobbies and self-care activities vs. revisiting old hobbies or previously practiced health activities).	Many Asian clients delay treatments and as a result are more severe when they come to treatment. Compounded with cultural barriers and unfamiliarity with therapy, clients are likely to exhibit slower treatment progress and it may take longer to develop a strong working relationship. Having realistic expectations will help normalize therapist feelings, increase their sense of self-efficacy, and develop more patience for client progress.
Cultural Differences in Expression & Communication	Psychotherapy and talking about one's problem as a way to resolve them may seem culturally foreign to those from cultures that focus more on problem-solving through actions rather than words.	Clients may need more time to understand the benefits of therapy and to become comfortable talking about their feelings and problems with someone they do not know. In addition, they may need more psychoeducation to differentiate their thoughts from their feelings.
	Understand cultural differences in communication styles (e.g., direct vs. indirect, verbal vs. nonverbal, and different meanings associated with being assertive, aggressive, and passive in different cultures).	Helps therapist teach communication skills that are more effective given the client's cultural context. Reduces the pushing of ethnocentric values that may be counter-therapeutic or counter-productive on the client given their cultural environment. Improves understanding and reduces miscommunication between client and therapist.
	Understand and address ethnic differences in expression of distress (e.g. differential emphasis on mind vs. body).	Validates somatic expression of psychiatric distress and helps the therapist normalize the client experiences. Increases understanding of client's level of distress and improves diagnostic accuracy. Helps therapist develop more holistic treatment plans that target somatic symptoms as much as they focus on cognitive reframing.
	Address and differentiate cognitive and affective experiences of client.	Helps clients differentiate their thoughts from their feelings, which is especially important for those from more holistic cultural orientations where there is less differentiation between the two. Although clients may veer away from talking about their thoughts and feelings, discussing them in a culturally sensitive manner can improve treatment outcomes.
Cultural Issues of Salience	Be aware of and understand life experiences that may act as additional stressors or place clients at additional risk for mental illness (e.g., acculturative stress, racism, linguistic difficulties, social mobility problems, feelings of nostalgia, loss of interpersonal networks, and intergenerational family conflict).	Addresses issues salient to the client's life and increases the likelihood of feeling understood and being satisfied with treatment. Also addresses topics that are sometimes overlooked by therapists who are not aware of culture-specific experiences.
	Understand how immigration and acculturation impact individual and family relationships across different generations.	Acknowledges unique roles, needs, and situations of immigrants as a culture in transition. Helps client understand their identity and development in an appropriate cultural context. Also helps client understand how cultural transition and immigration issues affect their and their family's cultural values and ability to communicate.
	Understand how social class and privilege interact and affect the treatment process.	Improves understanding of social and class dynamics and biases. Also helps the therapists become more responsive to working with disadvantaged diverse populations and decreases blaming and increases appreciation for the hardships and struggles that certain groups face.

Domain	Cultural Adaptation Principles	Justification for Cultural Adaptations
	Address and be aware of push-pull feelings and culture-related role inconsistencies that may exist between the client's culture of origin and the culture of therapy.	Reduces confusion, discomfort, and normalizes feelings when clients are asked to behave in a culturally incongruous manner (e.g. pushing an Asian client to be more independent and individualistic, and autonomous).
	Address client's individual rights, but also integrate this understanding with the realities of their roles and responsibilities. Discuss how one's rights, roles, and responsibilities change when others do not act in appropriate ways.	Contextualizes one's rights within a social context of one's roles and responsibilities. Helps highlight the importance of meeting one's own needs while at the same time reducing feelings that one is being selfish. Helps clients understand how obligations, actions, and moral responsibilities change when the family or social system is unhealthy.
	Be aware of and address shame and stigma issues that may influence treatment progress.	Helps improve client's comfort level, helps therapist be more empathic and supportive to client, and helps reduce treatment failure and premature dropout.
	Align with traditional/indigenous forms of healing, medicine, religions, or philosophies.	Better coordinates treatment services and helps promote collaboration between caregivers.
	Find ways to integrate extant cultural strengths and into the client's treatment	Capitalizes on aspects of the client's culture that may facilitate the healing process and that are culturally congruent with the client's goals (e.g., increasing focus on family strengths and improving social relationships, integrating cultural strengths related to Buddhism and acting in the right way to achieve one's goals, highlighting the importance of cause and effect or karma, incorporating popular cultural metaphors and stories that help people live in healthier ways).
	For manualized treatments, be more flexible in the ordering of sessions and also on the speed through which you move through them (e.g., whether you spend more time and repeat some sessions).	Helps ensure that the topics that you are focusing on are consistent with the client's problems and goals. Also ensures that the client sufficiently learns materials and reduces cursory exposure to information that will not be effectively utilized.