Asian MH&A Governance Group
Appendix 10

Models and Approaches to Working with Intergenerational Issues in Asian families

Annette Mortensen

1. Executive Summary

- Asian peoples in the Auckland region are a heterogeneous group reflecting a diversity of educational, political, socioeconomic, and religious backgrounds, as well as different migration histories. The scope of this paper does not allow for an in-depth discussion of models of care for each group, but rather focuses on models of assessment and therapeutic approaches to addressing intergenerational issues in Asian families in New Zealand.
- The NSW Transcultural Assessment Module aims to increase clinician awareness of CALD issues and facilitate the collection of culturally relevant information during CALD client assessment, and the Module provides an optional form for documenting the information.
- Griner and Smith (2006) conducted a meta-analytic review of culturally adapted mental health interventions and found a pressing need to enhance the availability and quality of mental health services provided to persons from historically disadvantaged ethnic groups. They found that interventions targeted to a specific cultural group were four times more effective than interventions provided to groups consisting of clients from a variety of cultural backgrounds. Interventions conducted in clients' language were twice as effective as interventions conducted in English.
- The Te Pou (2010) *Talking Therapies for Asian People: Best and promising practice guide for mental health and addiction services* highlights the importance of Asian family involvement in the care of the client. In both East Asian and South Asian cultures, families are central to a person's self-concept and can be highly influential in decision-making and life choices. Asian people are more likely to live and operate as a family unit. For example, research from the United States indicates that Asian mental health service users are more likely to live with their family compared with European family members. In Indian cultures, formal and hierarchical family structures are common, as are strict gender roles in which females often defer to their husband's wishes. Parents may use guilt and shame to influence their children's behaviours. The guide also recognises that it should not be assumed that family involvement is preferred by all service users.
- Yang et al (2006) challenge current research in family therapy which stereotypes the Chinese family in American Chinese/Asian populations. There is no universal Chinese/Asian family system of values. Practitioners need to be aware of subcultures and specific contexts in modern Chinese families. Furthermore there is a paucity of current research on the Chinese family. Much of the most cited research and theoretical models is now more than two decades old (Ho, 1987; Davis & Harrell, 1993; Lee, 1996). Often the models were proposed by Asian Americans who migrated to the US and seldom is there mention of the influence of indigenous Chinese traumas (such as the Cultural Revolution) and social changes (such as one-child policy, modernization, urbanization, and globalization) on the family and generational systems.
- Yang and Pearson (2002) in a study of schizophrenia and structural family therapy in Beijing offer a model that incorporates psychoeducation and behavioural treatments as a theoretical guide to working in a cross-cultural context. A Beijing family, consisting of parents and their daughter with schizophrenia, were seen for sixteen months during a trial of family intervention in China. Through structural family concepts, China's sociocultural context of treatment resource constraints, population policy and stigma are examined and the impact of illness on family organization is explored.
- Bae and Kung (2000) offer a family intervention model designed to meet the unique sociocultural needs of Asian-American schizophrenia patients and their families. This five-stage model consists of: preparation, engagement, psychoeducational (i.e., survivor skills) workshop, family sessions, and an ending stage. Guidelines and specific suggestions for implementing each of these stages are offered as a means of dealing effectively with Asian Americans' differential value orientations and cultural characteristics.
- Chien et al. (2006) examine the effects of a mutual support group for Chinese families of people with schizophrenia, compared with psychoeducation and standard care. The results show that mutual

support consistently produced greater improvement in patient and family functioning and caregiver burden over the intervention and follow up periods. The number of readmissions did not decrease significantly, but their duration did.

- Hall et al. (2011) review points of intersection and divergence between Western-based mindfulness and acceptance psychotherapies and Asian American cultural values. They propose a culturally syntonic approach that accentuates certain components of mindfulness and acceptance psychotherapies and adapts other components of these approaches to be more consistent with Asian American cultural values.

- Sobrun-Maharaj & Shiu Kei Wong (2010) evaluated specific recovery-relevant components of the Wellness Recovery Action Plan® (WRAP) (Copeland 1997), the training programme most widely used with Asian clients in the Waitemata District Health Board, and the Re-covery Model (RCM) (Randal, Stewart et al. 2009), and their impact on staff knowledge, skills, attitudes and behaviours about recovery. The RCM model appears to help people to sustain their mental well-being and strive towards their own goals in life. It has been reported that clients are more capable of reframing crisis situations into opportunities, increasing their strengths and reducing their vulnerabilities.

- Tse (2004) discusses the use of the recovery approach to support Chinese immigrants recovering from mental illness in New Zealand. In Asian families the dependent relationship between the person recovering from mental illness and his/her parents or carers is easily misinterpreted as dysfunctional or even pathological. Furthermore, traditional Chinese medicine tends to treat people with acute or chronic illness as dependent individuals. In Chinese culture, people with sickness will often expect that others have an obligation to serve them. Tse (2004) discusses the use of recovery- based competencies to help Chinese New Zealand immigrants with mental illness (re)gain their healthy life roles and (re)integrate into society.

- Lee (1997) demonstrates that family therapy for Asian families does not always require all-encompassing family involvement. A flexible family subsystem approach in the establishment of therapeutic relationships with family members at the beginning phase can be very helpful. For example, an effective method is for a clinician to interview the parents first, then the identified client, and then the sibling group. The parents can discuss their adult concerns or express their emotions freely when the children are absent. The children, usually more acculturated and more fluent in English, can negotiate issues they might not bring up with their parents present. When all parties feel safe and have more control over what may be discussed in the family group, they will be more willing and ready to accept family therapy. This "staging" process requires skills in establishing trust and credibility with each family member at the initial phase of treatment.

- Baptiste (2005), finds that in the US South Asian immigrant parents and their children are increasingly being referred for family therapy because of parent-child conflicts. Many of the problems these parents and children bring to therapy result from the normative life-cycle transitions, intergenerational relationship strains, and adolescent, or young adult separation-individuation occurring in an unfamiliar context under different cultural rules. To be clinically effective with these families, therapists need to be more than minimally knowledge about the varieties of South Asian family values, norms, and traditions, be flexible in their therapeutic approaches, and create an atmosphere in which both parents and children feel valued and respected.

- Pandya and Herlihy (2009) found in a British study into South Asian family perceptions of the therapeutic alliances in family therapy that working in a more alliance-focused way may override the need for culture-specific practices; for example, developing safety in therapy may be more important when discussing cultural issues than being ethnically matched to your therapist. This is contradictory to literature recommending interventions designed specifically for certain ethnic groups. Indeed, the common factors literature may be more relevant, as this argues that specific techniques from models are less relevant to a good therapeutic outcome than generic factors which are common across all therapies, for example, qualities of the therapist and the alliance.

- Zagelbaum and Carlson (2011) outline a structural approach for counselling Asian families, with an emphasis less on insights and more on behavioural changes and the interventions that focus on a family's organization and its communication in the present. In the context of Asian immigrants' cultural

milieu, the counsellor can use the techniques of relabeling, reframing, and therapeutic paradox in his or her attempt to interrupt the sequences of problem-generating behaviours of family members. This attempt is congruent with the concept of “saving face” but is deemed more important in the context of collectivistic, hierarchical family structure of Asian immigrants in which no one in the family is blamed for the sequences of problematic behaviour, but instead the expert, in the person of counsellor, continues to honour and respect each member of the family by affirming their roles and place in the unit.

- Te Pou’s (2010) *Talking Therapies for Asian People: Best and promising practice guide for mental health and addiction services* recommends that the structured nature of CBT means that this type of therapy may be simpler to apply with Asian people who have limited English language skills than other types of therapy. Some authors and New Zealand therapists also argue that CBT is well-aligned with preferences some Asian people have for structured, problem-focused, time-limited, educational or skill-building, therapist-directed approaches. However, other aspects of CBT, such as changing thoughts and behaviour may be incongruent with some Asian philosophies that promote tolerance and acceptance of hardship. CBT requires modifications for use with Asian clients

2. Introduction

Asian peoples in the Auckland region are a heterogeneous group reflecting a diversity of educational, political, socioeconomic, and religious backgrounds, as well as different migration histories. The scope of this paper does not allow for an in-depth discussion of models of care for each group, but rather focuses on models of assessment and therapeutic approaches to addressing intergenerational issues in Asian families in New Zealand.

3. Evidence-based Interventions

Transcultural Assessment

NSW Health (2010). Transcultural Assessment. Australia: NSW: NSW Health

The Transcultural Mental Health Centre funded by the NSW Health, Mental Health and Drug & Alcohol Office worked in partnership with InforMH to review and enhance the Mental Health Outcomes and Assessment Tools [MH-OAT] and processes to become more culturally informed and appropriate for consumers and carers from culturally and linguistically diverse [CALD] communities in NSW.

- almost one half of Australia's CALD overseas-born population live in NSW
- one in five people in NSW speak a language other than English in their home
- culture influences ideas about health, mental illness and treatment
- mental health assessment requires an understanding of these concepts
- treatment plans must be meaningful to the client and family to be effective

Extensive consultations were conducted with mental health clinicians, professional health care interpreters, bi-lingual counsellors, and CALD carers throughout NSW. The Transcultural Referral Guide**,** Transcultural Assessment Checklist and Transcultural Assessment Module (see Appendix A) were developed in response to the consultations.

The Referral Guide aims to increase clinicians' awareness and utilisation of culturally or linguistically relevant services for CALD clients. The Checklist aims to increase clinician awareness of CALD issues and facilitate the collection of culturally relevant information during CALD client assessment, and the Module provides an optional form for documenting the information.

Further information about the NSW Mental Health Outcome and Assessment Tools can be found on the InforMH website for NSW Health staff: http://internal.health.nsw.gov.au/policy/cmh/mhoat/education.html

Griner, D. & Smith, T.B. (2006). Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training, 43* (4), 531-548.

There is a pressing need to enhance the availability and quality of mental health services provided to persons from historically disadvantaged racial and ethnic

groups. Many previous authors have advocated that traditional mental health treatments be modified to better match clients' cultural contexts. Numerous studies evaluating culturally adapted interventions have appeared, and the present study used meta-analytic methodology to summarize these data. Across 76 studies the resulting random effects weighted average effect size was d = .45, indicating a moderately strong benefit of culturally adapted interventions.

- Interventions targeted to a specific cultural group were four times more effective than interventions provided to groups consisting of clients from a variety of cultural backgrounds.
- Interventions conducted in clients' language were twice as effective as interventions conducted in English. Recommendations are provided for improving the study of outcomes associated with mental health interventions adapted to the cultural context of the client.

Te Pou. (2010). *Talking Therapies for Asian People: Best and promising practice guide for mental health and addiction services*. Auckland: Te Pou o te Whakaaro Nui.

Involving Families

Importance of family involvement

For many Asian people, family plays a key role in help-seeking behaviours and mental well-being. In both East Asian and South Asian cultures, families are central to a person's self-concept and can be highly influential in decision-making and life choices. Asian people are more likely to live and operate as a family unit. For example, research from the United States indicates that Asian mental health service users are more likely to live with their family compared with European family members. In Indian cultures, formal and hierarchical family structures are common, as are strict gender roles in which females often defer to their husband's wishes. Parents may use guilt and shame to influence their children's behaviours.

Japanese people may have a preference to address the parent–child relationship, before addressing conflict in marital relationships or other relationships34. Fathers and authority figures may have a strong role in help-seeking decisions, particularly in cultures that value hierarchical family interactions. Despite these generalisations, every Asian family is different and it is important to work and adapt therapy in line with the unique needs of each family.

Where possible, therapists should develop a positive working relationship with the service user's family. Many Asian people expect family members to be involved in their interactions with health providers. However, once again it should not be assumed that family involvement is preferred by all service users.

Recommendations for working with families

When working with Asian people it is often useful to convey possible therapeutic benefits to the family decision-makers, as well as the service user9. With the service user's permission, involving and considering family members in treatment planning can help to get family buy-in for the treatment process and avoid premature termination of therapy.

It is important to get a sense of family dynamics, beliefs and goals for therapy prior to full family engagement. Therapists should ask the service user if they would like the family member to be involved and explore whether family members have similar ideas about what they perceive as important outcomes for therapy. The New Zealand

consultation panel recommended that if the goals of the service user and family member are similar, then family members can be engaged. Where goals are different, mediation between family members or gaining involvement from extended family members may be useful. Inadequate preparation increases the likelihood of direct confrontation, damaging the therapeutic process and risking termination of treatment.

In delivering therapy to Asian people, therapists need to be aware of and work sensitively with the dynamics and values associated with family concepts in Asian cultures. Therapists should be careful to demonstrate respect for family members in communications with them. Respectful engagement includes addressing adult family members in formal terms and, if present, addressing the head of the family first. The New Zealand consultation panel recommend that elder family members or heads of family should not be challenged without adequate preparation. It is also important to be cautious in challenging beliefs about gender roles, particularly in Indian communities. This may be interpreted as a lack of understanding or a direct challenge to religious beliefs and can lead to service user disengagement from the therapist and treatment.

Family ties and obligations can be used as a mechanism and motivator for change. Goals of therapy can include improving family functioning, or improving the ability of the service user to contribute to their family. The value placed on children and good parenting can also be a key motivator. For example, therapy for couple issues can be reframed as improving parenting. Role plays, or using examples of a service user's situation in third party terms and asking family members how they would respond, may be useful techniques for exploring and resolving disagreements.

Family Intervention Models

Bae, S.W. & Kung, W.W.M. (2000). Family Intervention for Asian Americans with a Schizophrenic Patient in the Family. *American Journal of Orthopsychiatry,70* (4),532-541.

A family intervention model designed to meet the unique sociocultural needs of Asian-American schizophrenia patients and their families is proposed. This five-stage model consists of: preparation, engagement, psychoeducational (i.e., survivor skills) workshop, family sessions, and an ending stage. Guidelines and specific suggestions for implementing each of these stages are offered as a means of dealing effectively With Asian Americans' differential value orientations and cultural characteristics.

Chien, W.T., Chan, S.W.C. & Thompson, D.R. (2006). Effects of a mutual support group for families of Chinese people: with schizophrenia: 18-month follow-up. *BJP*, 189, 41-49.

This paper examines the effects of a mutual support group for Chinese families of people with schizophrenia, compared with psychoeducation and standard care. The results show that mutual support consistently produced greater improvement in patient and family functioning and caregiver burden over the intervention and follow up periods. The number of readmissions did not decrease significantly, but their duration did.

Table1 Five stages in development of a mutual support group for families of people with schizophrenia

Stage	Goals	Content
Engagement (2	Establishment of	Orientation to group intervention and establishing

sessions)	trust and common goals	trust and acceptance Negotiation of goals and roles and responsibilities Initial discussion of the mental illness and its effects on family
Recognition of psychological Needs (3 sessions)	Sharing and understanding of individual concerns and cultural issues	Resolution around power, control and decision-making within group Sharing of intense emotions and feelings about patient care provision and family interactions More information-sharing about schizophrenia and related behaviour Discussion of Chinese culture concerning family and mental illness Discussion of ways of dealing with negative emotions towards patient
Dealing with psychosocial needs of self and family (3 sessions)	Understanding own important needs and those of patient and family	Discussion of each member's psychosocial needs Information about medications, managing illness and available mental health services Effective communication skills in relating to patient and seeking social support from others Exploration of home management strategies, e.g. finance and budgets, environment and hygiene
Adopting new roles and challenges (3 sessions)	Learning from members the skills of coping and management of the patient's behaviour	Sharing of coping skills and mutual support Enhancing problem-solving skills by working on individual management situations Conducting behavioural rehearsals of interaction with patient and other family Members within group Practising coping skills learned during the sessions in real family life (in between group sessions) and evaluating the results
Ending (1-2 sessions)	Preparation for disbanding of the group	Preparation and discussion of termination issues, e.g. separation anxiety, independent living and use of coping skills learned Evaluation of learning experiences and achievement of goals Discussion of continuity of care after group programme, and use of community resources Explanation of post-intervention assessment and follow up in the subsequent months

Culturally Syntonic Psychotherapy Methods

Hall, G.C.N., Hong, J.J., Zane, N.W.S. & Meyer, O.L. (2011). Culturally Competent Treatments for Asian Americans: The Relevance of Mindfulness and Acceptance-Based Psychotherapies. *Clinical Psychology: Science and Practice, 18* (3), 215-231

Hall et al. (2011) offer recommendations for how alternative cultural perspectives derived from the experiences of Asian Americans, and the recommendations are more aligned with interdependent and allocentric orientations; this may enhance these approaches around issues of conceptions of self, the interdependent transcendent self, defining personal values, and coping.

The development of effective treatments for Asian Americans is important because treatment disparities continue to exist for this population. Because of their theoretical

grounding in East Asian philosophies, mindfulness and acceptance-based psychotherapies appear to constitute promising ways to provide culturally responsive mental health care to Asian Americans. However, in practice, these approaches often reflect conceptions of mental health that are more consistent with Western worldviews. We review points of intersection and divergence between Western-based mindfulness and acceptance psychotherapies and Asian American cultural values. We then propose a culturally syntonic approach that accentuates certain components of mindfulness and acceptance psychotherapies and adapts other components of these approaches to be more consistent with Asian American cultural values.

Culturally Syntonic Psychotherapy Methods

In deriving a culturally syntonic form of contextual psychotherapy, we offer several recommendations to make these approaches more culturally informed and culturally nuanced so that in practice, they resonate more with Asian American cultural worldviews, norms, values, and life experiences.

Interdependent Transcendent Self. Given the emphasis on interdependent goals and values in Asian contexts, conceptions of the transcendent self from the ''I'' not ''You'' perspective are limited and potentially less culturally relevant. What may be more viable is a transcendent self that holds a ''We'' not ''They'' perspective. To help facilitate this sense of self, the therapist would work with the patient to identify the in groups to which she or he belongs (e.g., family, work colleagues) and collaboratively work with the patient to develop an immutable interdependent sense of self that is able to view events as separate from (not defining of) the group. Consider a patient whose family member is fired from his job and the patient reports difficulties with face loss concerns. Rather than working with the patient to observe personal reactions to the event (i.e., ''how am I feeling?''), it may be more helpful to have the patient observe the family's reactions to the event (i.e., ''how are we feeling?'') and distance oneself from the reactions in a nonjudgmental, descriptive way (i.e., ''We are having thoughts that this will cause others to look down on us'' vs. ''I am having thoughts that this will cause others to look down on me'').

Defining Personal Values. Central to Acceptance and Commitment Therapy (ACT) is living a life that is guided by personal values (Hayes et al., 2006). Several therapeutic exercises are devoted to helping an individual identify and prioritize his or her values within various life domains / relationships (e.g., spouse, parents, friends, health, children, career). Underlying these exercises is the assumption that an individual's personal values are ultimately determined by the individual and shaped by his or her own preferences, desires, and interests. For example, one common exercise is to have a patient imagine that she is attending her own funeral and list what she hopes others would say about her as an individual as a way to elicit the patient's values. From a more interdependent self perspective, the values that guide one's behavior are determined more by group needs and expectations and are often situation specific. In therapy, a patient with a strong allocentric orientation may benefit more from exercises that help her better identify and prioritize social group norms and values and to flexibly apply these values depending on the group she is in at the moment. A potential parallel therapy exercise could be to ask the patient to imagine she is attending her own funeral and then list the ways she hopes the various groups to which she belongs had been successful as a result of her contributions. Moreover, the patient would likely benefit from exercises that help her specify the contexts in which certain values are helpful and those that are not. For example, the value of ''being honest'' may be important when interacting with one's close friend but may be less important when speaking with one's elders.

Family Therapy Models

Lee, E. (ed). (1997). *Working with Asian Americans: A Guide for Clinicians* (1997). New York: Guilford Press.

Structural Aspects of Family Therapy Assessing Readiness for Family Therapy

Even though family therapy can be highly effective as a treatment modality in working with Asian American families – due to the strong family orientation – Asian American clients generally are quite reluctant to seek family treatment. The following reasons highlight some of the possible difficulties:

- Asian American clients are mostly unfamiliar with the concept of family therapy or the role of the family therapist. Traditionally, family members consult family elders, village chiefs, a trusted member of the clan, monks or ministers, or indigenous healers in case of family crises.
- Asian family members usually do not see individual problems as family related. They are unfamiliar with "family system" or "family communication" theories and usually do not understand the need for family therapy as a way to improve the individual's pathological symptoms. They rarely agree to the suggestion that the problem is the groups instead of the identified client's.
- Because of the traditional hierarchical and vertical structure of Asian American families, which prohibits free verbal expression of emotions, especially true thoughts and negative feelings, family members may not be equipped with the communication skills to discuss problems and to express themselves openly in a family group setting. For example, for parents to discuss their "adult" problems or to express their sadness in front of the children is considered culturally inappropriate and is viewed as losing control.
- In view of the long years of separation among the family members of immigrant families, there are many family secrets and unresolved grief that members are not ready to share openly with each other. Family therapy may bring out the "ghosts" in the past and can be very overwhelming and at times damaging to family relationships.
- Traditional Asian husbands or fathers are quite resistant to attending family sessions or allowing the therapist to enter into the family system. Many traditional Asian men may interpret the admission of emotional problems and receiving help from outside the family network as a sign of weakness and losing face. In the event that their children are in trouble and the parents are forced to receive treatment, they usually send their wives to be the family representative to deal with service agencies. It is very difficult to conduct family therapy without the cooperation and participation of the male adult figures.
- Many immigrant Asian families do not have all the family members living in the same country or city. Sometimes, family members do not reside in the United States or in the same city.
- The great discrepancy in the degree or level of acculturation among family members may discourage individual members from accepting family therapy as the means to resolve family problems. In those families with severe intergenerational conflicts and very different value orientations and communication styles, family sessions can be overwhelming not only to the family members but to the therapist as well.

Prior to determining family therapy as the treatment of choice, the clinician needs to assess the previously mentioned factors and the readiness of family members to work together as a group. For some families, family therapy sometimes is neither the feasible nor the desired treatment modality. However, if the clinician believes in his or her best clinical judgment that family therapy is the most effective treatment strategy, the family members (especially the decision makers) should be educated on the benefits and rationales of such decision. This can be done by making the initial appointment with the head of the family (e.g., the father) and soliciting his (or her) assistance.

Involving Family Members in Therapy

The definition of "family" in traditional Asian cultures may include a wide network of kinship. For example, a Vietnamese teenager who left his homeland with his aunt when he was an infant may have many more emotional ties with his aunt and her family than with his own biological parents. In many Filipino families, trusted friends and allies serve as godparents to children and play an important role in their growth and development. If appropriate, the clinician can ask the identified client to define his or her own concept of family members and discuss who should be included in therapy. In many cases, it is advisable to encourage all family members to come to the first session so that the family dynamic can be observed. However, in many instances, family members are either emotionally not ready or physically unavailable to participate in treatment.

Family therapy for Asian families does not always require all-encompassing family involvement. A flexible family subsystem approach in the establishment of therapeutic relationships with family members at the beginning phase can be very helpful. For example, an effective method is for a clinician to interview the parents first, then the identified client, and then the sibling group. The parents can discuss their adult concerns or express their emotions freely when the children are absent. The children, usually more acculturated and more fluent in English, can negotiate issues they might not bring up with their parents present. When all parties feel safe and have more control over what may be discussed in the family group, they will be more willing and ready to accept family therapy. This "staging" process requires skills in establishing trust and credibility with each family member at the initial phase of treatment.

Setting Client-Centered Goals

Many Asian Americans find it difficult to admit having family problems or psychological difficulties. They usually present themselves as victims of some unfortunate environmental events or physical discomfort. The clinician should take their presenting problem seriously and respond immediately to the concrete needs of the clients. A problem focused, goal-oriented, and symptom-relieving approach is highly recommended in the beginning phases of treatment. Rather than defining goals in abstract, emotional terms, goals may be best stated in terms of external resolution or symptom reduction. Many clients find loosely targeted and emotionally oriented goals as incomprehensible, unreachable, and impractical (Ho, 1987). Long-term goals may best be broken down into a series of easy-to-understand, achievable, measurable short-term goals. Once the family is engaged in the therapeutic relationship and gains a sense of success, the therapist can introduce other more insight-oriented goals and renegotiate with the family members.

TREATMENT STRATEGIES

The following guidelines summarize treatment strategies Lee (1997) has found to be effective in working with Asian American families.

Forming a Social and Cultural Connection with the Family during the First Session

The most important process in working with Asian American families is "joining," that is, initiating therapeutic intervention by building a relationship with the family. Many Asian American families are often new to therapy, and they need to be prepared and "coached." During the first session, the clinician should address the family in a polite and formal manner. Giving the Asian cultures' emphasis on interpersonal relationships, the family may expect the clinician to disclose a certain amount of personal information or her family, country of origin, regarding his academic, and professional background. Appropriate self-disclosure may facilitate positive cultural alliance and a level of trust and confidence.

Asking nonthreatening personal questions can put the family at ease. It is also important to avoid direct confrontation, to demand greater emotional disclosure, or to discuss such culturally taboo subjects as sex or death. There is a need for caution in the use of paradoxical approaches. This technique is particularly problematic in the initial stage of treatment.

Acknowledging the Family's Sense of Shame

For many Asians, public admission of mental health problems can bring intense shame and humiliation. The clinician may counter those emotions by empathizing with them and encouraging them to verbalize this feeling. It is important to reassure family members about confidentiality and anonymity. One helpful technique is to reframe their courage in seeking help as love and concern for family members. If appropriate, the mobilization of the family's sense of obligation to receive help to achieve family harmony or for the sake of the children can be very effective.

Establishing Expertise, Power, Credibility, and Authority

Many Asian clients come to their first session believing that the clinician is an authority who can tell them what is wrong and how to solve their problems. It is helpful for the clinician to establish credibility right away, to ensure that the client will return. An air of confidence, empathic understanding, maturity, and professional mannerism are all important ingredients. Other ways to establish credibility and authority include (I) using professional titles when making introductions; (2) displaying diplomas, awards, and licenses in the office; (3) obtaining sufficient information about clients and their families before seeing them for the first time; (4) offering some possible explanation for the cause of the problem; (5) showing familiarity with the family's cultural background; (6) providing a set of cues that will help the family to judge the clinician's expertise (e.g., "according to my experience working with Asian families during the past 20 years ... "); and (7) utilizing the crisis intervention approach to offer some immediate solutions to the problems. It is important for family members to feel that they are in good hands and there is a sense of hope before they leave the first session.

Defining the Problem

A problem focused family therapy approach with Asian American families appears to be very effective. The clinician should focus on the immediate crisis or problem that brought the family to the agency. In most instances, family members ask for professional help because of the difficulties they encounter with one particular family member (the identified patient). Family members are either unaware of their roles in

contributing to the problem or are unwilling to discuss it openly in front of others, particularly the children. For many families, working on the parent-child issue at the beginning is safer than working on marital problems that may exist.

To engage the family in therapy, it is important for the clinician to (1) acknowledge the family's feeling that the identified patient has problems, (2) verbalize the family pain caused by the difficulties, (3) assist the family to shift from a person-focused orientation to a problem-focused orientation to minimize scapegoating, (4) focus on the effect of the problem on each family member, and (5) reinforce the sense of family obligation and the significance of solving the problem together. At times, it may be helpful to encourage family members to elaborate on previous attempts in dealing with the problem. Acknowledging their failure to cope and the unpleasant consequences if the problem remains uncorrected may motivate the family to continue in treatment. 1n some instances, the clinician may use the family's sense of guilt to induce them to participate in treatment for the sake of the family name (Lee, 1990).

Applying a Family Psychoeducational Approach

Asian cultures value education highly. The psychoeducational approach based on social learning principles may be compatible with Asian values and beliefs. Such intervention focuses on four major areas: (1) education about the illness (or problem)-printed educational materials in the patient's primary language are helpful; (2) communication training; (3) problem-solving training; and (4) behavioral management strategies (McGill & Lee, 1986). Family education about the U.S. legal system (child-abuse laws, patients' rights, etc.) may be necessary. In addition to providing education on individual and family levels, psychoeducational programs dedicated to multiple families in the Asian community can be very effective.

Building Alliance with Members with Power

An accurate assessment of the power structure of the family is essential. Generally speaking, there are two types of power in the family system: "role-prescribed power" (usually given to the grandfather, father, eldest son, or sponsor) and "psychological power" (usually maintained by the grandmother or the mother). Treatment will not be effective without permission of the leader(s). Clinicians should acknowledge and respect their power in decision making, avoid competition, and use all possible means to build a therapeutic alliance.

Employing Reframing Techniques

The technique of reframing can be helpful to build rapport with family members with power. For example, the clinician can reframe the mother's overprotectiveness as "loving too much" and the father's overly excessive working hours as "sacrificing for the economic well-being of the family."

Assuming Multiple Helping Roles

Flexibility and willingness to assume multiple helping roles enhance the therapeutic relationship, especially when working with multiproblem families. In addition to being the counsellor, the clinician should be comfort-able with playing the role of teacher, advocate, interpreter, and the like. Acting as a "cultural mediator" or using a family intermediary can be an effective tool in dealing with family conflicts. Show caring by doing and being there when the family needs help.

Restructuring Social Support System

Asian American families usually consist of strong and close-knit extended families and support systems. However, many families isolate themselves when they encounter problems. As soon as possible, the clinician should assist the family to

establish a social support network whereby the family or the individual can form friendships, ventilate frustrations, and learn social and problem-solving skills.

Integrating Eastern-Western Health Approaches

Clinicians should take advantage of the holistic model of health in Eastern cultures and integrate its elements with the best Western medical and psychological practices. For example, in the treatment of a depressive Chinese patient, it can be helpful to educate the patient on the Western biological and psychological perspectives of the illness. It is also important to explore the Eastern approaches of treatment (e.g., Chinese herbal medicine, acupuncture, and *qi gong*). It is my belief that such treatments will benefit not only Asian patients but also mainstream American society.

Mobilizing the Family's Cultural Strength

One of the functions of therapy is to mobilize the family's cultural strength. Strengths include support from the extended family, the strong sense of obligation and family loyalty, parental sacrifice for the children's future, filial piety, strong focus on educational achievement, the work ethic, and the support from their ethnic communities. In many circumstances, especially when family members are coping with death, losses, and unpredictable changes, discussions of religious stories or philosophical teachings in the Asian culture can be very therapeutic.

Understanding the Family's Communication Style

In addition to determining the preferred language and dialect used in therapy, the clinician must understand a family's communication style. Shon and Ja (1982) discussed the communication process with Asian American families in three areas: the revelation of information, the expression of feelings, and the process of disagreement in therapy. Traditionally, Asian Americans have been taught to employ indirect styles of communicating and to avoid direct confrontations. The clinician is expected to read between the lines to grasp the major issue. On the other hand, the family may perceive the clinician to be too blunt, pushy, and insensitive.

If Asian clients discuss emotional difficulties, they are often expressed in an oblique, understated way with little obvious emotion, implying that the problem is less serious than it really is (Hong, 1989). Negative emotions such as anger, grief, and depression may be expressed in an indirect way. A culturally naive clinician may mistake this style for denial, lack of affect, lack of awareness of the client's own feelings, deceptiveness, or resistance on the part of the client (Sue, 1990). Even positive feelings (e.g., love) are frequently not expressed in an open manner. Asian parents may be misunderstood as unloving and uncaring. To overcome this communication barrier, it is quite helpful to introduce the structural family therapy model (Minuchin, 1974) because of its emphasis on actively restructuring the interaction in the family to create change rather than relying on direct, open expression of feelings (Shon & Ja, 1982).

Baptiste, D.A. (2005). Family Therapy with East Asian[1] Immigrant Parent Rearing Children in the United States: Parental Concerns, Therapeutic Issues, and Recommendations. *Contemporary Family Therapy, 27*(3), 345-366

[1] South Asian groups in the United States are called South Asian groups in New Zealand. The term South Asian is used to designate people who are nationals of India, Pakistan, and Bangladesh or from the Indian Diaspora countries.

Increasingly, South Asian immigrant parents and their children are being referred for family therapy because of parent-child conflicts. Many of the problems these parents and children bring to therapy result from the normative life-cycle transitions, intergenerational relationship strains, and adolescent, or young adult separation-individuation occurring in an unfamiliar context under different cultural rules. Family therapy with South Asian Indian immigrant parents and their children experiencing intergenerational conflicts presents a significant challenge for marital and family therapists. It is a new learning experience for all participants. To be clinically effective with these families, therapists need to be more than minimally knowledge about the varieties of South Asian family values, norms, and traditions, be flexible in their therapeutic approaches, and create an atmosphere in which both parents and children feel valued and respected.

The paper focuses on South Asian immigrant parents and some of the post-immigration difficulties they experience in their attempts to rear culturally South Asian children within the United States cultural context. Concerns specific to parenting children in the US, and therapeutic issues South Asian immigrant parents bring to therapy are presented and discussed. Recommendations for culturally effective therapy are offered.

Recommendations for Therapy

South Asian families in the US are a heterogeneous group having emigrated from the Indian subcontinent as well as other countries of the world. As a result, recommendations for therapy specific to parent-child conflicts are not applicable to all families under all circumstances. However, because of the increase in the number of South Asian families being referred for family therapy many American therapists will at sometime treat a South Asian family in therapy. Therapists' cultural competency, sensitivity, and clinical skills with immigrants in general, and South Asian immigrant parents, in particular, are primary requirements for culturally effective therapy with South Asian families. Accordingly, the following recommendations are offered:

(1) Before attempting to effect any changes within the family's system, it is important that therapists initially communicate to the families an understanding and acceptance of their system and learn about the family's culture from it, especially family roles, values, and relationships, and how these affect the family's interpersonal relationships in order to lessen chances of mistakenly interpreting culturally acceptable behaviors. For example, the therapist mistakenly attributing cultural values of a Muslim to a Hindu.

(2) It also is important that therapists approach changes to the family's core values very slowly, and be able to communicate to the family an understanding of the specific issues around which the presenting problem is centered, e.g., the parents' style of discipline or the child's outright disrespect of parents. Many of the problems these parents and children bring to therapy are the predictable consequences of immigration and resettlement in a new country, the normative separation-individuation of adolescents and young adults from their families of origin, but under different cultural rules, increased parental anxieties, and uncertainties than in their respective countries of origin. Characteristically, these problems often extend beyond the family's boundaries and are difficult to resolve because both parents and children subtly demand the therapists' allegiance.

(3) It is important that therapists assume a neutral stance with both parents and children in the conflict, and be extra careful about condemning, supporting, empathizing or aligning with either side. A majority of the problems these parents and children bring to therapy are value conflicts between the parents' traditional South

Asian values and children's new ''American'' values. Consequently, American therapists are more likely to apriorially with the children because of their perceived compatibility with the children's ''American'' values, and condemn the parents with whose values they may be less compatible. However, such an alignment can exacerbate the already stressful parent-child conflicts and contribute to negative therapeutic consequences such as the family's early termination of therapy.

(4) Although any theoretical therapeutic approach can be effective with South Asian families, it is important that therapists be flexible in their therapeutic approaches and modify their usual therapeutic approaches with these families. Flexibility must include a willingness to accept the problem in the manner in which the family frames it, to vary the timing of specific interventions with the families, and to incorporate education and information about American child-rearing practices and normative separation-individuation of children, for example.

(5) It is important that therapists work with South Asian families, especially unacculturated adults, to help them to increase their trust in psychotherapy and its processes. Although significant numbers of South Asian immigrants are members of health care professions, including mental health, South Asians immigrants in general maintain a cultural distrust of psychotherapy and as a result, often under utilize such services. (Relatively few of the families seen by the author were self referred.) Distrust in part results from these families' unfamiliarity with and the minimal availability of psychotherapy in their respective countries of origin as well as their highly developed sense of privacy consistent with their South Asian cultural beliefs. This belief stresses the importance of keeping family business within the family not to be disclosed to outsiders including psychotherapists and even primary care physicians. Accordingly, helping South Asian families to decrease their therapeutic defensiveness, and build trust in the therapeutic process can help them to relax their heightened need for privacy and engage more fully in the therapeutic process.

(6) It is helpful in the process of therapy for therapists to broaden the scope of therapy beyond the initial presenting problem(s). Although parent-children intergenerational conflicts may be the primary presenting problem (s), issues of loss may need to be explored for many of the adults. For many adult family members, multiple losses are secondary to the immigration as a significant contributor to many of the parent child conflicts they experience. In this regard, Bhattacharya and Schoppelrey (2004) have noted that many South Asian immigrant parents' high expectations for their children's educational achievements may be related to the parents own frustrations in achieving career or occupational goals and may therefore be related to mental health issues among parents as well (p. 84).

(7) Keep interventions direct, active, and focused on a limited number of behavioral changes. Doing so will minimize the parent-child stresses and help the family to return to its pre-therapy equilibrium. As noted previously, many South Asian immigrant families are unfamiliar with American psychotherapeutic approaches, and seek family therapy only as a last resort, usually at the insistence of a respected relative or friend. Consequently, to engage these families in therapy, it is important that therapists not attempt to cover too much ground but keep the more substantive transitional issues in sight.

Pandya, K. & Herlihy, J. (2009). An exploratory study into how a sample of a British South Asian population perceive the therapeutic alliances in family therapy. *Journal of Family Therapy, 31*(4), 384–404.

There is currently little research on the therapeutic alliances in family therapy, and even less on those from minority ethnic backgrounds. This paper reports on how British South Asians attending family therapy perceive the alliances, and compares this to the constructs of a newly developed tool – the System for Observing Family Therapy Alliances (SOFTA). Nine participants were interviewed and thematic analysis was employed to analyse the data. The results suggest that certain aspects of the alliances may need more attention when working with this ethnic group. These are safety in front of the therapist and emotional connection to the therapist (including feelings towards the reflecting team and consideration of ethnically matching therapist and client). In general, the quality of the alliance is seen as more important than employing culturally specific techniques. The implications for diversity and family therapy training are discussed.

Summary and clinical implications

Overall it seems that the SA participants interviewed in this study do not present particular cultural issues that need to be specifically addressed, but rather that there may be certain aspects of the alliance that need more attention when working with Black and Minority Ethnic (BME) groups. These are:

1. Safety in front of the therapist.
2. Emotional connection to the therapist (including thoughts about ethnically matching client and therapist and feelings towards the reflecting team).

These are areas that the SOFTA does not cover, and so may be neglected by users of this tool.

Working in a more alliance-focused way may override the need for culture-specific practices; for example, developing safety in therapy may be more important when discussing cultural issues than being ethnically matched to your therapist. This is contradictory to literature recommending interventions designed specifically for certain BME groups (e.g. Muir et al., 2004). Indeed, the common factors literature may be more relevant, as this argues that specific techniques from models are less relevant to a good therapeutic outcome than generic factors which are common across all therapies, for example, qualities of the therapist and the alliance (e.g. Blow et al., 2007).

Essentially, the argument is that the quality of the alliance between therapist and client trumps cultural issues. In practice this should make clinical work with BME groups less complex for clinicians. This Perception of Family Therapy (FT) alliances in British South Asians could have implications for diversity and FT training in moving away from specific techniques. Blow et al. (2007) suggest focusing on therapist competence in common factors and therapist skills and aptitudes among others. As well as training, this could also be relevant for theory development in the area of FT alliance in British SA cultures. Furthermore, therapists oriented to social constructionist ideas – such as deconstructing dominant discourses around culture/ race with clients – may find that this increases the quality of the alliance by improving safety and connection to the therapist.

As with clients from all backgrounds, particular care should be taken in explaining the reason for the reflecting team and allowing an open discussion around this (Reimers, 1995). It is also important that assumptions are not made about ethnically matching client and therapist. There are no clear answers to this debate and it depends very much on individual preferences, which may be related to the size and nature of the local community.

Finally, therapists should recognize the individual needs of clients, and work according to what they bring to sessions. BME clients may differ according to whether they are first or second generation or if they are trying to assimilate or acculturate. This may be particularly relevant for FT, as the challenge will be to work

successfully with first and second-generation clients simultaneously and in the same room.

To conclude: this study demonstrates that those interviewed perceive the alliance in a broadly similar way to their white counterparts, as illustrated by the congruence with the SOFTA constructs. However, safety in front of the therapist, ethnically matching client and therapist, and feelings towards the reflecting team may need special consideration when working with British SAs.

Yang, L.H. & Pearson, V.J. (2002). Understanding Families in their own Context: Schizophrenia and structural family therapy in Beijing. *Journal of Family Therapy, 24* (3), 233-257

This paper offers an account of and eclectic model of structural family therapy that incorporates psychoeducation and behavioural treatments for schizophrenia as a theoretical guide to working in a cross-cultural context. A Beijing family, consisting of parents and their daughter with schizophrenia, were seen for sixteen months during a trial of family intervention in China. Through structural family concepts, China's sociocultural context of treatment resource constraints, population policy and stigma are examined and the impact of illness on family organization is explored.

Yang, Y., Ting, S.K. & Dueck, A. (2006). Family Therapy and Chinese Culture: Isolated, Layered or Integrated. Paper presented at the *First World Congress of Cross-cultural Psychiatry,* Beijing, China, September 23-26, 2006.

Much of current research in family therapy tends to stereotype the Chinese family as is apparent in the overgeneralization to Chinese/Asian populations. There is no universal Chinese/Asian family system of values. We will therefore need to be aware of subcultures and specific contexts in modern Chinese families. Furthermore there is a paucity of current research on the Chinese family. Much of the most cited research and theoretical models are now more than two a decade old (Ho, 1987; Davis & Harrell, 1993; Lee, 1996). Often the models were proposed by Asian Americans who migrated to the US and seldom is there mention of the influence of indigenous Chinese traumas (such as the Cultural Revolution) and social changes (such as one-child policy, modernization, urbanization, and globalization) on the family and generational systems.

Using the Wellness Recovery Action Plan® (WRAP) and the Re-covery Model (RCM) with Asian clients

Sobrun-Maharaj, A. & Shiu Kei Wong, A. (2010). *Building evidence for better practice in support of Asian mental wellbeing: An exploratory study*.
An exploratory study was undertaken to evaluate specific recovery-relevant components of the Wellness Recovery Action Plan® (WRAP) (Copeland 1997), the training programme most widely used with Asian clients in the Waitemata District Health Board, and the Re-covery Model (RCM) (Randal, Stewart et al. 2009), and their impact on staff knowledge, skills, attitudes and behaviours about recovery. The study also identifies gaps that may exist in the training programme of Asian staff, recommends modifications for enhancing the use of the models for this cultural group, and finally produces a suggested model of delivery and toolkit that could be tested further with Asian practitioners and service users.

The Wellness Recovery Action Plan® (WRAP)

WRAP is a mental health wellness tool to assist with planning recovery (Copeland, 1997). Zhang, Li, Yeh, Wong, and Zhao (n.d.) confirm that the WRAP programme has played a significant role in recovery for many Chinese consumers. They suggested some areas (e.g. use of more simple language, introducing more Chinese-style wellness tools) that need to be customised to become culturally appropriate for Chinese clients.

The Re-covery Model (RCM)

The RCM is a mental health recovery pathway to facilitate shared understanding and action between clients, clinicians and significant others (Randal, Stewart et al. 2009). Some of the core concepts of the Re-covery Model, and the therapeutic framework and multimodal skills training approach that it uses, can be explained by some of the diagrams that form part of the model, e.g. the Map of the Journey of Re-covery, which forms a basis for explaining the recovery programme, and the figure for explaining the Building a Bridge of Trust concept to clients, significant others, family members, and clinicians. These diagrams can be used in teaching the RCM concepts to mental health professionals of all disciplines, mental health clients, and significant others. The model appears to help people to sustain their mental well-being and strive towards their own goals in life. It has been reported that clients are more capable of reframing crisis situations into opportunities, increasing their strengths and reducing their vulnerabilities.

Importance of family

- In most Asian cultures, as collective societies, family is traditionally seen as of primary importance, and plays a significant role in all aspects of life. This is seen especially in terms of providing support and guidance through traditional values, such as filial piety, saving face, and maintaining harmonious relationships with others (Kuo and Kavanagh 1994; Chan, Levy et al. 2002). This is a recurring theme in studies of all Asian groups.
- Several studies have been undertaken with Chinese families, which underline this theme. For example, Hsiao, Klimidis, Minas, and Tan"s (2006) qualitative study of Chinese families, which investigated the cultural attribution of mental health suffering in Chinese societies through interviews with both consumers and their caregivers, revealed that the family is an important source of social support to individuals in Chinese societies. To understand the Chinese lived experience, as with all other Asian groups, it is important to examine them not only at an individual level, but at a family level as well (Lin, Tseng et al. 1995). These authors have attempted to understand mental health and mental illness from the perspective of the patients and their family caregivers. They underline the importance of appreciating patients' and their families' cultural values, and understanding how these values shape their reaction to mental illness and help-seeking behaviour, if health-care providers wish to provide culturally sensitive care.
- However, families can also sometimes have adverse effects on family members. Although the family is an important source of social support, it can also be a burden and source of unhappiness (Chan, Levy et al. 2002). Lin et al. (1995) analysed more than 20 studies relating to the cultural aspect of mental health in the Chinese population, and found that the family has diphasic effects – providing a source of support and, at the same time, creating stress. Hsiao et al's (2006) study confirmed that family members could be a source of stress for consumers. These characteristics also apply to most other Asian groups. Such families may need particular help to deal with their family dynamics.

- Strong gender and family roles are respected amongst Asians and adherence to these roles is considered to be central to well-being. For example, Chinese place great emphasis on interpersonal dynamics in the family and, by treating a Chinese consumer without the whole family, treatment may not be so successful (Hsiao, Klimidis et al. 2006). Similarly, for Indians, the support of family and community for a consumer is imperative, to the extent that it is sometimes not just encouraged, but is often a prerequisite of seeking help for a psychiatric illness (Stanhope 2002).
- To a large extent, the Western client-centred mental health system neglects the fact that a person is always a member of a social group. Family involvement might be seen as intrusive (Falloon 1985). Concerns with confidentiality have also limited family input (Lin and Cheung 1999). This individualistic emphasis is still strong today. Where treatment of Asians is concerned, the system needs to be more flexible and consider the well-being of the individual as part of the family unit, as well as the family.

Help-seeking behaviours amongst Asian people P.8

Because collectivists consider the family as the basic unit of society, when a family member is ill, it is automatically assumed that the other family members will take responsibility for the ill person. Help-seeking becomes a joint venture, rather than an isolated decision by the consumer. The ability to have social support and connections is crucial to recovery. These support systems could also act as a preventative foundation. However, lack of access and unwillingness to seek help could also hinder the effects of social support.

Recovery Approach to Supporting Chinese Immigrants Recovering from Mental Illness

Tse, S. (2004). Use of the Recovery Approach to Support Chinese Immigrants Recovering from Mental Illness: A New Zealand Perspective. *American Journal of Psychiatric Rehabilitation, 7* 53-68.

Traditionally, extended-family structures area a major characteristic of Chinese culture. Confucian thinking emphasizes harmonized family relationships, particularly between father and son, the care between the elder and younger family members, and mutual love and respect between husband and wife. Family is expected to and will provide practical and emotional support to family members in times of stress and ill health. In Asian families the dependent relationship between the person recovering from mental illness and his/her parents or carers is easily misinterpreted as dysfunctional or even pathological. Furthermore, traditional Chinese medicine tends to treat people with acute or chronic illness as dependent individuals. In Chinese culture people with sickness will often expect that others have an obligation to serve them.

Tse (2004) discusses the use of recovery- based competencies for help Chinese New Zealand immigrants with mental illness (re)gain their healthy life roles and (re)integrate into society. Further research is needed to help identify specific intervention methods that contribute to successful recovery among Chinese immigrants with mental illness.

10 Recovery Competencies
A competent mental health worker:

1. understands recovery principles and experiences in the Aotearoa/NZ and international contexts
2. recognises and supports the personal resourcefulness of people with mental illness
3. understands and accommodates the diverse views on mental illness, treatments, services and recovery
4. has the self-awareness and skills to communicate respectfully and develop good relationships with service users
5. understands and actively protects service users. rights
6. understands discrimination and social exclusion, its impact on service users and how to reduce it
7. acknowledges the different cultures of Aotearoa/NZ and knows how to provide a service in partnership with them
8. has comprehensive knowledge of community services and resources and actively supports service users to use them
9. has knowledge of the service user movement and is able to support their participation in services
10. has knowledge of family/whanau perspectives and is able to support their participation in services.

Collaborative partnership approach to working with Asian families

Zagelbaum, A. & Carlson, J. (2011). *Working with immigrant families: a practical guide for counsellors.* New York: Routledge

- The structural approach in counselling Asian immigrants, with its emphasis less on insights but more on behavioural changes and the interventions that focus on a family's organization and its communication in the present, seems closer to the Asian cultural milieu. Hammond and Nichols (2008) recommend that counsellors use a collaborative partnership approach, although seemingly known for its forceful directive interventions, in their attempts to make their interventions effective.
- To be effective when working with immigrant families, counsellors must develop self-awareness of their own feelings, attitudes, and beliefs about immigrants and working with them (Portland, 2009). Counsellors need to be flexible and practical to provide effective interventions that are focused and clear and to learn about their clients and the particulars of the family's culture in terms of roles, rules, values, and relationships (Portland, 2009; Poulsen, 2009).
- The goal of the intervention is for clients to develop new perspectives that will lead them to adopt new actions, not by pushing clients to change but by motivating them to accept responsibilities for changing their behaviours (Hammond & Nichols, 2008).
- The prerequisite, according to Hammond and Nichols (2008), is for the counsellors to make active efforts to elicit and acknowledge what their clients think and feel and, at the same time, work as respectful collaborative partners before embarking on the tasks of challenging them to change. As helping professionals, counsellors are working in a constant state of mediating the influences of cultural forces within self, clients, and others, and within this context, they must be proactive in responding to the needed knowledge, awareness, and skills necessary to be of service to their clients (Portman, 2009).

- From the outset, when a counsellor forms an alliance with his or her clients, the goals have always been to free the identified patient of the symptoms, to reduce

conflict and stress for the family, and for the family to learn new ways of coping (Minuchin & Fishman, 1981). Counsellors must consider the behaviours, values, and priorities relating to other developmental landmarks such as dating practices, marriage, and gender roles in the context of cultural backgrounds of their Asian American clients (Madathil & Sandhu, 2008).

- At the same time, this subtle process enables the counsellor to gather data about the family's existing hierarchies, values, and norms while affirming and acknowledging each member of the family. In a roundabout way, the joining process is conducive to the Asian cultural milieu, taking into account the Asian immigrant clients' cultural expectations such as the counsellor is a professional with expert knowledge and that he or she respects the hierarchical structure of common patriarchal Asian families.
- The counsellor is letting the clients know that he or she understands them and is working with and for them. Generally, these attempts by the counsellor to gain acceptance and admission to the family are viewed as congruent with what typical Asian immigrants expect from counselling.
- Asian immigrants tend to define their presenting problems in concrete terms, and they expect the counsellor, being an expert, to provide them with solutions.
- Coming for counselling treatment may be viewed as bringing shame to the family. Mental and emotional disorders carry a stigma within the community. Guilt and shame within the context of Asian "loss of face" carry a big stick that implies that the entire family is losing respect and status within the community when one of them is shamed. That identified patient is then positioned in an untenable place and is under heavy pressure to keep the harmony and order within the unit by minimizing any conflicts and problems that could shame and bring guilt to the family (Chung et al., 2008; Ho, 1990; Kim et al., 1999; Sue & Sue, 2008). Thus, a counsellor needs to carefully balance his or her attempts to identify the problem while appearing to respect the client's cultural background in a congruent manner.
- Often, the client's initial description of the presenting problems may appear to the counsellor as one in which the client externalizes the root causes and spends a lot of time complaining and blaming. It is not uncommon to hear a client who lost his job to attribute such loss to his wife's inability to execute household chores and duties or to attribute their child's poor school performances on the wife's spoiling and babying the child too much.
- In the context of Asian immigrants' cultural milieu, the counsellor can use the techniques of relabeling, reframing, and therapeutic paradox in his or her attempt to interrupt the sequences of problem-generating behaviours of family members. This attempt is congruent with the concept of "saving face" but is deemed more important in the context of collectivistic, hierarchical family structure of Asian immigrants in which no one in the family is blamed for the sequences of problematic behaviour, but instead the expert, in the person of counsellor, continues to honor and respect each member of the family by affirming their roles and place in the unit.
- Counsellors need to relabel or reframe the behavioral sequence of the presenting problems to make solutions of the presenting problems appear doable and within the capability and competence of the family. Once the family buys into this, it is easier to move gradually to other issues beyond the presenting problems. The counsellor, being accepted as an expert by the clients, can easily encourage the members to interact with each other and with the counsellor. The counsellor can observe the process through which the presenting problems often emerge.
- On occasion, the counsellor will be called to intensify the current transactions to gauge the family's understanding and acceptance of challenges and the ways they perceive reality. The counsellor regulates the transactions in terms of affect,

repetition, and duration. Observing interactions within the session is the hallmark of the systemic approach of counselling. Counsellors adopting this approach may attempt to shape the competence of the family members in taking care of themselves (without the presenting problem) from the very moment when they meet the family and begin the counselling relationship (Nichols & Schwartz, 2006).

- Often, an ability to converse in English can place the family unit in a hierarchical inversion situation, especially when the parents are unable to speak or master the language (e.g., English), and they have to rely on their children to translate, a dynamic that often inverses the traditional hierarchical structure of the family. The parents will find themselves more isolated from mainstream institutions and have to rely on and become dependent on their children to connect to the outside world. This hierarchical inversion can have a destructive effect on the family.
- Just as it is a major task for each of the family members to adjust to the new environment, it is also an equally challenging task for the counsellor to formulate effective intervention strategies acceptable to the family members. It can either make or break the counselling relationship with the family.
- Counsellors also need to be careful when asking each family member to describe what he or she perceives of the family patterns. Often the response is very much influenced by factors such as whether a family member was born and raised in Asia or born in the United States. Hong and Domokos-Cheng Ham (2001) illustrated such instances in which the parents, born and raised in Asia, may identify a family pattern of responsibility and sacrifice and hence the discipline ("I did that for your own good," "It hurts me more than you ever know when I punish you"), a theme consistent with Asian cultural values, whereas the children, born and raised in the United States, may identify the same values by relabeling them as stifling restriction, authoritarian, and perhaps downright abusive.
- The transactions within the family may reveal the fact that the children, exposed to the egalitarian concept in the mainstream culture, expected to be asked instead of being told, and the parents may perceive such a request as akin to reducing their position within the familial hierarchy or downgrading their status or perhaps perceive it as an act of teenage rebelliousness, defiance, or downright disrespectfulness.
- In their attempts to reestablish and maintain such traditional hierarchical structure, and not reduce their stature as parents by acquiescing to the demands of the teenage children, they will continue with the same old family patterns to maintain control, hence perpetuating the homeostasis.
- A skilled counsellor can detect such scenarios when the observed member starts using the words "demand" or "telling" as opposed to "let's see" or "asking." It is incumbent on the counsellor to be conscientious in tracking all of these family patterns and in formulating culturally appropriate treatment plans and goals.
- When working with recent Asian American families, counsellors need to be aware of the within-group diversity and how they relate to the counselling process. Acculturation issues remain a focus that counsellors must assess throughout the counselling sessions.

Cognitive behaviour therapy (CBT)

Te Pou. (2010). *Talking Therapies for Asian People: Best and promising practice guide for mental health and addiction services pp 50-52*. Auckland: Te Pou o te Whakaaro Nui. Available from: www.tepou.co.nz

CBT is a form of therapy that aims to adjust thought patterns to create more adaptive emotional and behavioural outcomes. Sessions are highly structured and focus on practical solutions to problems. These may be provided in a group or individual format.

Why this therapy is used

Extensive research has been conducted on the effectiveness of CBT in the general population. Large effect sizes in meta-analyses confirm CBT's average effectiveness for:

- depression (uni-polar)
- generalised anxiety disorder
- panic disorder
- social phobia
- post-traumatic stress disorder
- childhood depressive disorder
- childhood anxiety disorder

Moderate effect sizes have also been found for marital distress, anxiety, childhood somatic disorder and chronic pain.

Research suggests the effectiveness of CBT is likely to extend to Asian communities. Research in a variety of Asian communities has demonstrated significant improvements in symptoms of mental illness, including:

- post-natal depression in rural Pakistan
- depression and self-esteem in China
- depression, particularly in combination with the use of anti-depressants, in Japan
- social anxiety disorder in Japan
- post-traumatic stress disorder symptoms in Vietnamese refugees.

The structured nature of CBT means that this type of therapy may be simpler to apply with Asian people who have limited English language skills than other types of therapy. Some authors and New Zealand therapists also argue that CBT is well-aligned with preferences some Asian people have for structured, problem-focused, time-limited, educational or skill-building, therapist-directed approaches. However, other aspects of CBT, such as changing thoughts and behaviour may be incongruent with some Asian philosophies that promote tolerance and acceptance of hardship. CBT is widely used in Asian countries including Taiwan, China, Hong Kong, India and Pakistan, as well as in Western countries in working with Asian service users. In New Zealand, according to the therapists consulted, CBT is one of the most common types of talking therapy applied with Asian service users. Therapists report it to be highly useful and acceptable with Asian service users.

Group CBT

Some research suggests that group CBT is as effective with some Asian communities as it is with Western communities. A study of group therapy for Japanese people with social anxiety noted similar levels of improvement in self-reported and therapist-reported symptoms of anxiety, as have been noted in Western populations. Research on the use of group CBT with Chinese migrants in Canada noted that Chinese service users may be cautious of group therapy sessions and be reluctant to disclose personal issues. However, overall the Chinese service users liked the groups sessions and wished for more sessions at the end of treatment.

Possible adaptations for Asian people

A range of guidelines and recommendations have been developed for cross-cultural and Asian-specific adaptations of CBT. Cultural modifications of CBT include

alterations in the terminology used to describe the CBT techniques and inclusion of cultural concepts in the therapeutic content. Many of these recommendations are covered in the Section Two of the guide (pp27-43). Adaptations have been recommended to make CBT content more relevant to Asian values (see the section on possible adaptations for Asian people below). However, adaptations may remove aspects of the therapy that contribute to its effectiveness. While there is evidence that adapted CBT can be effective, there is no research comparing the effectiveness of an adapted CBT with a non-adapted CBT approach.

Possible modifications for Asian service users include:

- incorporating Asian values and practices for example, Qi Gong, Tao philosophy and mindfulness
- using culturally appropriate terminology
- emphasising a practical focus, rather than an analytical focus in homework for CBT
- framing assertiveness as adaptive in particular situations (for example, Western contexts), even if it is not in others (traditional and family events)67
- recording the goals of therapy in the language of the family, to promote family engagement and understanding.

It is important to consider the values discussed in Table 1 (collectivism, family focus or duty, education and wealth focus, tolerance of hardship, and potential conflict avoidance and emotion regulation) in the delivery of CBT. In particular, a focus on changing behaviours to avoid negative life experiences may conflict with values that suffering is part of life and should be expected. Promotion and education in assertiveness skills may not be useful for some people, as these skills may not apply in traditional Asian relationships or communication situations. Furthermore, a focus on rational thinking and teaching people to seek objective evidence may not align with the spiritual faith of some Asian people.

Some overseas therapists and therapists in New Zealand have also noticed a lack of adherence and negative attitudes towards the homework component of CBT. New Zealand therapists suggest that homework tasks may be more acceptable when they focus on practical goals rather than cognitive processes.talking therapies for asian people

Taoist cognitive therapy

Taoist cognitive therapy incorporates Taoist philosophies into Western models of cognitive psychotherapy. It incorporates Taoist philosophies of non-intervention (for example, benefit and not harm, strive and not fight, keep quiet and inaction, let nature take its course) into the selection of new behaviours. Taoist cognitive therapy has been widely practiced in China since 1995 for the treatment of anxiety, depression and other disorders. There is evidence for the effectiveness of this type of therapy in reducing symptoms of generalised anxiety disorder, particularly in combination with the use of benzodiazipines.

4. References

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5. Appendix: Appendix A- Transcultural Assessement Module

NSW HEALTH

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

MENTAL HEALTH

TRANSCULTURAL ASSESSMENT

SMR025065

This module provides a structured format for the documentation of cultural information, where a consumer has been identified as being from a culturally and linguistically diverse background. It can be used during assessment at any point of care. Attach to relevant base module and summarise findings where appropriate in relevant components of the base module.

People present _____

CLIENT AND FAMILY CULTURAL IDENTIFIER(S) *(e.g. country or place of birth, ethnicity / cultural groups, religion)*

COMMUNICATION ISSUES *(e.g. preferred language and dialect, proficiency in English, interpreter needed, consider potential gender / hierarchy / cultural / social communication barriers between client and health professional)*

Cultural involvement / activities: *(e.g. social, cultural and religious activities, practices, family roles and expectations)*

MIGRATION HISTORY *(e.g. when they left home country, reasons for migration, who was left behind? Migration route, time of arrival in Australia, perception of migration process, refugee camp stays)*

ACCULTURATION *(e.g. balance and / or conflict between culture of origin and Australian culture, residency status, migration intentions, involvement with and perception of Australian cultural environment, changes in activities, diet, socialising with other cultures, use of English)*

Staff Name: Signature: Designation: Date:

NO WRITING

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Holes punched as per AS2828-1999

BINDING MARGIN - NO WRITING

MENTAL HEALTH TRANSCULTURAL ASSESSMENT

SMR025.065

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