

Cognitive-Behavioral Therapy With Chinese Americans: Research, Theory, and Clinical Practice

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In this article, we discuss how to conduct cognitive-behavioral therapy with Chinese Americans. We present an integration of theory, research, and clinical practice to help mental health practitioners understand how Chinese culture may potentially influence the CBT treatment process for Chinese immigrants. Several recommendations are provided as to how to adapt and modify CBT to better meet the therapeutic needs of Chinese American clients. A case example demonstrates how cultural modifications of CBT can lead to effective psychotherapy outcomes for Chinese American clients.

IN RECENT YEARS, there has been an initiative to establish, define, and validate empirically supported treatments (ESTs) in the U.S. (APA Task Force on Psychological Intervention Guidelines, 1995; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Although considerable progress has been made in establishing and defining efficacious treatments for the general population, relatively little is known about the efficacy of ESTs for people from diverse ethnic and cultural backgrounds. While cognitive-behavioral therapy (CBT) has been identified as an efficacious treatment, some have questioned the limited attention given to cultural issues by cognitive-behavioral therapists (Iwamasa, Nangle, & Larrabee, 1995; Iwamasa & Smith, 1996).

Whether Western psychotherapies are appropriate and effective for people from diverse ethnic and cultural backgrounds is a critical lacuna in the field. For Asians and Asian Americans, this question is further complicated by marked cultural, philosophical, religious, and societal differences between Eastern and Western cultures. In this paper, we address some of these concerns by reviewing, analyzing, and integrating the extant clinical, theoretical, and empirical knowledge base concerning CBT with one Asian American group, Chinese Americans. First, a general overview of mental health and treatment of Chinese Americans is provided. Next, CBT principles and practices are related to Chinese culture, and specific recommenda-

tions for adapting CBT to meet the needs of Chinese American clients are highlighted. Finally, a case example is used to illustrate how cultural modifications to CBT can lead to effective therapy outcomes for Chinese Americans.

Chinese Americans and Mental Health

According to the 2000 census, there are approximately 12 million Asian Americans in the U.S., with people of Chinese ancestry comprising the largest group (2.7 million) (Barnes & Bennett, 2002). As a whole, Asian Americans are the fastest growing ethnic group in the U.S. and it is projected that their numbers will quadruple by the year 2050. While there are many similarities among the 43 ethnic groups encapsulated under the pan-ethnic label of “Asian American” (Lee, 1998), it is important not to take for granted the diversity that exists among the different Asian American ethnic groups who vary in experiences, beliefs, values, histories, migration patterns, religions, and languages.

Even among people of Chinese descent, who account for approximately one-quarter of the world’s population, there is much heterogeneity. Chinese Americans have unique migration patterns and come from multiple countries and regions of China, including mainland China, Hong Kong, Taiwan, Singapore, and Vietnam. They speak a variety of different languages, a small sampling of which includes Mandarin, Cantonese, Taiwanese, Toishanese, Hakka, and Vietnamese. Moreover, if one were to travel around the 31 provinces, autonomous regions, and municipalities in China, one would find that while most people are fluent in Mandarin (the national language), many people actually speak mutually incomprehensible local dialects on a daily basis.

The diversity among Chinese Americans is further complicated by differences in acculturative status. Chinese Americans have been migrating to the U.S. in large numbers since the middle of the nineteenth century. Their immigration was restricted due to discriminatory immigration laws, and it was not until 1965 that these restrictions were relaxed, leading to a resurgence of migration to the U.S. As a result, approximately 61.9% of Asian Americans in the U.S. are foreign-born (Barnes & Bennett, 2002). Because it is impossible to fully address treatment issues associated with treating Chinese Americans of differing acculturative levels in the space provided, this paper focuses on working with less acculturated Chinese Americans for whom cultural factors are more likely to be most salient. Moreover, while we acknowledge the political complexities of the terms “Chinese” and “Chinese American,” for the sake of simplicity they are used synonymously in this paper to refer to less acculturated Chinese Americans. While some of the principles highlighted in this manuscript are specific to working with less acculturated Chinese American clients (i.e., immigrant Chinese, bicultural individuals, and/or those who grew up in Asia) and may also generalize to Chinese in Asia, others are broader cultural issues that may also apply to working with clients from other cultural backgrounds.

Treatment Studies

To our knowledge, no randomized controlled trials examining the efficacy of CBT or other ESTs have been conducted on Chinese Americans. This gap in the literature is reflected by reviews of the overall treatment literature on Asian Americans, which tend not to differentiate among the different Asian ethnic groups, and are limited to descriptions of naturalistic treatment outcomes. The extant literature indicates that Asian Americans are less likely than other ethnic groups to seek treatment (Bui & Takeuchi, 1992; Hu, Snowden, Jerrell, & Nguyen, 1991; Snowden & Cheung, 1990; Sue, 1977; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). When Asian Americans do seek treatment, they tend to evidence more severe psychiatric impairment (Lin & Lin, 1978; Sue, 1977; Sue & Sue, 1987), are less satisfied with treatment, and have worse treatment outcomes than do European Americans (Zane, Enomoto, & Chun, 1994). There is also some evidence that Chinese Americans have higher premature dropout rates than European Americans (Sue, 1977) and that premature termination can be effectively addressed when cultural issues are taken into consideration (Sue et al., 1991).

One factor that has been shown to be beneficial to Asian Americans seeking mental health treatment is ethnic match between client and therapist. Specifically, ethnic match for Asian American clients was found to be

significantly associated with longer stays in treatment, lower probability for premature dropout (Flaskerud & Liu, 1991; Sue et al., 1991; Takeuchi, Sue, & Yeh, 1995), and better treatment outcomes among primary Chinese language speakers (Sue et al., 1991). When treated in a culturally sensitive manner at ethnic-specific mental health service centers, Asian Americans tend to remain in treatment longer and to have lower premature dropouts (Takeuchi et al., 1995; Zane, Hatanaka, Park, & Akutsu, 1994). Research findings from the child and adolescent literature on Asian Americans also support the cultural responsiveness hypothesis, indicating that Asian American children who receive services at ethnic-specific clinics are less likely to drop out after the first session, are more likely to utilize services, and attain higher functioning at discharge than those seen at mainstream centers (Yeh, Takeuchi, & Sue, 1994). Ethnic match, which is assumed to be related to cultural responsiveness, has also been found to be associated with reduced premature dropout and increased number of treatment sessions for Asian American adolescents (Yeh, Eastman, & Cheung, 1994). The aforementioned research findings provide an initial examination of important issues related to cultural competency and treatment outcome. However, they do not disaggregate potentially overlapping but distinct issues that may influence treatment outcome when patients are seen at an ethnic-specific program (i.e., ethnic and/or linguistic match, actual level of cultural competence). Despite these limitations, there is some evidence to suggest that ethnic-specific programs, whether or not clients were ethnically matched with their therapists, are associated with lower premature dropout and increased length of treatment (Takeuchi et al., 1995; Yeh, Eastman, & Cheung, 1994), suggesting that cultural competency and sensitivity is beneficial above and beyond the effects of ethnic matching. These findings highlight the importance and benefit of training culturally competent and sensitive clinicians.

Overall, these results suggest that Chinese Americans with mental illnesses are less inclined to seek treatment, have more severe and chronic psychiatric difficulties by the time they do come in, and are at a greater risk for treatment failure when services are not culturally sensitive. Many factors may further complicate the treatment of immigrants, including migration histories (reasons and circumstances for migrating), immigration stress (language difficulties, limited social mobility, living in poor neighborhoods, lack of understanding and coverage by the health care system), separation from social and family networks, changes in family dynamics (intergenerational family conflicts, shifts in role and power structures of the family), ethnic identity issues (negotiating cultural aspects of self), and difficulties negotiating unmet expectations (Lee, 1997a). These issues should be considered when

assessing and treating Chinese American clients. Moreover, treatment providers should adopt an ecological approach to understanding and treating the patient (i.e., understand how cultural norms and the factors listed above contextualizes the patient's cognitive and affective experiences and behaviors).

CBT and Chinese Americans

Chinese American mental health scholars have hypothesized that CBT may be more compatible with Asian culture and belief systems than other therapies (Lee, 1997b; Leong, 1986; Y. Lin, 2001). Although this belief has yet to be empirically tested, CBT seems to be one of the more popular treatment approaches used to treat clients of Chinese descent (Y. Lin, 2001) and may be preferred over psychodynamic approaches because it is more structured, directive, and symptom focused (Hong & Ham, 2001).

For example, an analogue study conducted on Chinese American students found that they rated therapists with a more directive approach as more attractive and effective than therapists with a nondirective approach (Exum & Lau, 1988). Yuen and Tinsley (1981) found that Chinese college students expected their therapists to be more directive and nurturing than did European American students. Moreover, a recent study asking Asian American students to rate the credibility of cognitive therapy (CT) and time-limited psychodynamic (TLDP) therapy found that those who had less of a White identity and more of an Asian identity rated CT as more credible than TLDP (Wong, Kim, Zane, Kim, Huang, 2003). Asian American clients may prefer therapies that emphasize practical problem solving and external control over problems rather than dynamic therapies that place greater emphasis on intrapsychic conflicts (Sue & Zane, 1987).

Although we do not have sufficient space to fully explicate the philosophical and historical underpinnings of Chinese culture and personality development, it is important to note that Chinese culture has been influenced by Buddhist, Confucian, and Taoist traditions. Some say that the Chinese people are Confucian in public life and ethics, Taoist in private life, and Buddhist at the time of death (Smith, 1991). These three philosophical and religious traditions have shaped much of Chinese culture, notions of self, socialization, family, beliefs, and practices. Practically speaking, they influence social relationships (i.e., social status and methods of communication and expression), value emphases (i.e., family and education), and conceptualizations and beliefs about illness (i.e., Qi or energy and the balance between yin and yang). However, they have become so integrated into Chinese society that it is hard to clearly differentiate the individual effects of one over

the others. The influence of these traditions will be discussed in greater detail in relation to specific therapeutic principles.

Key Therapeutic Principles

In the following sections, three core areas are discussed: (a) general principles for adapting CBT to meet the needs of Chinese American clients, (b) strengthening the client-therapist relationship, and (c) understanding the Chinese notions of self and mental illness. We outline 18 therapeutic principles for understanding and treating Chinese American clients.

General Principles for Adapting CBT to Meet the Needs of Chinese American Clients

Principle 1: Initially educating Chinese American clients about psychotherapy may increase their understanding, familiarity, and satisfaction with therapy, decrease the likelihood of premature treatment dropout, and improve treatment outcome. Chinese clients may be more responsive to CBT treatments because it is more directed, structured, task oriented, and symptom focused. However, it is important to remember that psychotherapy can be very foreign and unfamiliar to those from non-Western cultural backgrounds. Specifically, less acculturated Chinese American clients may lack the basic knowledge and understanding of mental illness and its treatment to fully believe in and feel comfortable in treatment. Therefore, when working with Chinese American clients in a CBT framework, it may be particularly helpful to orient, prepare, and demystify the therapy process for the client. Acosta, Yamamoto, Evans, and Skilbeck (1983) found that providing Hispanic, Black, and White psychiatric outpatients with an orientation program prior to their first therapy session resulted in clients feeling more knowledgeable and positive toward psychotherapy. It would seem reasonable to assume that Chinese Americans would also benefit from psychotherapy orientation.

Principle 2: Treatment outcomes for Chinese American clients will improve if a therapist makes an effort to learn more about their client's cultural background. Therapists should not assume that it is the sole responsibility of the client to learn to adjust to Western treatment practices. Therapists who treat ethnic minorities should make a concerted effort to learn about their client's cultural background. Therapists who participated in orientation programs designed to increase their knowledge and understanding of ethnic minority clients reported feeling more knowledgeable, sensitive, and effective when working with their clients than those who did not (Evans, Acosta, Yamamoto, & Skilbeck, 1984). Moreover, minority clients seen after their therapist went through such an orientation program reported feeling more

satisfied with treatment, confident in their ability to handle problems, and indicated that they would be more likely to utilize mental health services in the future (Yamamoto, Acosta, Evans, & Skilbeck, 1984).

Principle 3: Establishing goals for treatment and identifying markers of improvement early on in therapy is likely to reduce confusion about treatment, improve the client-therapist relationship, and facilitate treatment outcome. Because of stigma against mental illness and the greater likelihood of being more severely ill when they do seek treatment, Chinese Americans may be more goal-driven, have greater expectations for immediate symptom improvement, and expect more directive advice and problem solving than other clients. They may also have less tolerance and understanding of less structured therapies, where therapist and client roles are less clearly defined. Therefore, the CBT therapist is in an ideal position to collaborate with Chinese American clients by setting up concrete goals and markers of improvement, which may ultimately help to reduce ambiguity and confusion for the client.

Principle 4: Focusing on the psychoeducational aspects of mental health treatment and reinforcing client efforts to learn may help empower Chinese American clients and reduce stigma and misconceptions about mental illness. The importance of education that was infused into Chinese culture by Confucianism is consistent with the psychoeducational principles of CBT and can be used to help the client become more familiar with and understand their mental illness as well as the rationale behind psychotherapy. Using psychoeducation to engage the client can be a culturally sensitive way of educating the client about his or her illness, breaking down popular misconceptions and stereotypes, and increasing the client's sense of mastery and confidence. For example, CBT for child anxiety typically includes affective education, which engages children in a familiar "student" role working with an instructor to learn about different expressions and experiences of emotional states through standard educational techniques such as instruction, practice, and testing. One aspect of this affective education is normalization-explaining that all children experience fear and other emotions, which serves to reduce stigma and shame. The CBT therapist can also use positive reinforcement to praise clients for coming in to treatment and for learning concepts that are particularly hard to master (e.g., "It takes a lot of courage, strength, and insight to come in to learn how to cope with problems that may eventually get worse if unattended to, especially for someone with little prior exposure to Western psychotherapy").

Principle 5: Another way to adapt CBT to better meet the needs of Chinese American clientele is to engage in "cultural bridging" of CBT concepts to Chinese cultural beliefs and traditions. Cultural bridging can facilitate client understanding and adherence to treatment (Ham, 1989; Hong,

1993). This term refers to tying foreign psychological concepts to a client's cultural beliefs and practices in order to facilitate client understanding and belief in CBT. For example, in Chinese culture, physical and mental health is brought about by cultivating one's Qi (or energy) through a balance of yin and yang (positive and negative energies) (Lin, 1980). CBT principles of relaxation training can be bridged to Chinese cultural traditions that focus on rebalancing one's Qi, such as meditation, Tai Qi Quan (a Chinese martial arts form), and Qi Gong (a meditative practice focusing on energy and breathing). Moreover, establishing cultural bridges early on in treatment (e.g., spending more time on meditative breathing and relaxation training) may reduce the cultural "shock" clients may feel when participating in treatments that are culturally foreign and unfamiliar. Drawing links and using culturally familiar terms and notions can also facilitate client belief and acceptance of specific skills being practiced and increase adherence to homework assignments. For example, the Chinese have many culturally specific metaphors couched in four-word sayings known as *Chengyu*, which are ethical and moral guiding principles that can be transformed into effective clinical tools for helping people reframe their thinking and engage in healthier activities. One well-known *Chengyu* (*shuang guan ji xia*; literally "two brushes painting together") refers to the story of a master artist who practiced using two brushes simultaneously in one hand to create unsurpassed paintings (Hong, 1987). This story could be used to engage the client in simultaneously employing two core CBT principles (a) challenging maladaptive cognitions and developing replacement coping thoughts and (b) engaging in behavioral strategies such as exercise to improve depressed mood.

Strengthening the Client-Therapist Relationship

Principle 6: Therapists can gain credibility by presenting themselves as expert authority figures who can help the client resolve problems. This is just one way in which the therapist can modify CBT to strengthen the client-therapist relationship. Chinese culture places great importance on hierarchical relationships, social structure, social harmony, and respect for authority figures (Y. Lin, 2001; Zhang et al., 2002). Consequently, Chinese clients often see the therapist as an authority figure, an expert who can help them solve their problems. In order to maintain credibility, the therapist may need to be more proactive in providing direction, giving advice, and teaching skills and practices that provide immediate symptom relief.

Principle 7: Carefully defining and addressing client-therapist roles and expectations for therapy will increase client understanding and satisfaction with treatment. Discussing client-therapist roles and talking about the limitations of therapy are critical in helping the client develop realistic

expectations. Therapists should highlight that therapy is not a miracle cure that will immediately take away their pain and suffering; rather, it is an effective treatment method that can help with sufficient time and practice. At the same time, the therapist should offer an initial “gift” of problem or symptom reduction to increase satisfaction and comfort with treatment, reduce premature dropout, and increase respect and credibility for the therapist (Sue, 1998).

Principle 8: Understanding cultural differences in communication and expression toward authority figures will help reduce misinterpretations of client's intents and behaviors. Therapists can help strengthen the working relationship with the client by understanding cultural nuances in communication. For example, some Chinese clients may appear deferential to the therapist out of respect. Some Chinese clients may be more passive, quiet, reserved, ask fewer questions, and may be less likely to openly disagree with therapist whom they see as the “expert.” Consequently, therapists who are unfamiliar with the client's cultural background may be more likely to misinterpret culturally influenced communication and expressive styles and see Chinese clients as being shy, uncooperative, avoidant, uncommunicative, or not taking initiative for self-care.

Principle 9: Spend more time joining and engaging the client by finding out more about them, their migration histories, and their family backgrounds. Therapists can strengthen the working alliance with the client by taking more time to join and engage the client using social and cultural traditions and etiquette (Lee, 1997a). For Chinese Americans, this may involve offering the client a cup of tea, spending more time talking about the client's background (what country they are from, what city they grew up in), and discussing family issues (family relationships are very important in Chinese culture). This may also involve therapist disclosure of specific information aimed at increasing therapist-client commonality (being from the same country or village, having similar family backgrounds, speaking the same languages, or having gone through the same difficulties learning English, etc.). Spending some extra time talking with the client and increasing their level of comfort sets the stage for a collaborative relationship throughout the rest of therapy.

Chinese Notions of Self and Mental Illness

Principle 10: Chinese culture is family-oriented, and when warranted, families may be asked to collaborate in the treatment process. Cultural notions of self are likely to have profound effects on beliefs, reporting, presentation, and experience of mental illness (K. Lin & Cheung, 1999). For Chinese Americans, conceptualizations of one's public and private selves are likely to influence

interpersonal and intrapersonal functioning. For example, the Chinese are believed to be more interdependent, collectivistic, and family oriented than those from Western cultures who are stereotypically more individualistic and self-oriented (Lee, 1997a). It is not uncommon that family members will accompany the client to therapy on the first or subsequent visits, especially for those with more severe psychiatric impairment. The therapist's ability to incorporate the family into traditionally individual-focused CBT can, in some instances, mediate enhanced consumer satisfaction. Some CBT programs for youth have formal family CBT variants (e.g., Barrett, Dadds, & Rapee, 1996) that may be especially appropriate for Chinese Americans if adapted properly. In the case of the treatment of child anxiety problems, family involvement and acceptance of the treatment model could facilitate increased in vivo exposure at home, which is a key active ingredient of such treatments.

Principle 11: When working with Chinese clients, be aware of the shame and stigma associated with having a mental illness. Be prepared to address these issues by normalizing experiences, providing psychoeducation, and praising clients for their active efforts to take care of problems that may become worse if unattended to. Sometimes Chinese clients may come into treatment and not want to let their family know about their illness. In societies that are more collectivistic or socially interdependent, having a mental illness is often highly stigmatizing and shameful, and can be associated with being “weak” or “crazy.” Clients may blame themselves and attribute their problems to personality flaws such as being lazy, weak, or stupid, leading to feelings of low self-worth. Current CBT treatments do not formally address cultural issues of stigma, shame, and loss of face. Modifying CBT to address stigma, shame, and self-blame is especially important given that these issues that may lead to premature dropout. Normalization and psychoeducation may need to be done with both the client and the family if the family is actively collaborating.

Principle 12: Chinese clients may not feel as comfortable talking about their feelings with their therapist. They may require more time and practice in order to feel comfortable expressing themselves freely. Chinese American clients may also cope with emotional difficulties by avoiding, suppressing, or denying their feelings (Lee, 1997b). Suppression of emotions can also be perpetuated by rigid beliefs that one needs to endure the hardships and suffering of life, have emotional restraint and self-control, and resolve problems through perseverance and working hard. While Chinese traditions such as Buddhism, Confucianism, and Taoism do convey these principles in their teachings, clients who

are mentally ill are more likely to misinterpret and overgeneralize these principles. A particular set of cognitive distortions experienced by some Chinese Americans involves self-punitive interpretations of Buddhist/Confucian/Taoist teachings that lead to self-destructive behavior. Rather than disputing the underlying philosophies, the CBT therapist can help the client challenge their interpretations of these teachings as a form of cognitive restructuring. For example, while all people endure hardships, it is a misinterpretation of these traditions to think that suffering and/or engaging in self-destructive behavior will make one more devout.

Principle 13: Be sensitive and 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. Framing the goals of therapy to help the client “adapt” to specific problems may facilitate the healing process. Western therapies tend to push clients to be more independent, autonomous, and assertive than what is typically taught in Chinese socialization processes. Chinese culture places greater importance on interdependence as well as family and group needs (Lee, 1997a). Even if the client's problems stem from lack of assertiveness or enmeshed and maladaptive family structures, pushing a Chinese client to be more independent, individualistic, and autonomous may be culturally incongruous and foreign, leading to feelings of discomfort. When cultural clashes occur, it is important to acknowledge the discrepancies in cultural expectations and reframe the goals of treatment to developing “adaptation” skills that are necessary for a healthy life. Moreover, therapists may be placed in situations where they may have to help clients acculturate faster and negotiate, understand, and skillfully play out their bicultural selves. For instance, assertiveness may be taught as a way of adapting to the demands of Western culture (rather than as a skill to “correct” a deficit in the client's personality). The concept of “codeswitching” from the field of bilingual education may be useful in CBT. Switching back and forth between different styles of communication depending on whom one is talking to (e.g., work setting vs. family and social settings) may help clients develop bicultural skills that help them effectively negotiate different cultural milieus (Murshad, 2002).

Principle 14: Finding ways to integrate extant cultural strengths and healing practices into the client's treatment plan is one way to modify CBT to be more culturally sensitive and effective. Cultural bridging techniques can also be used to capitalize on traditional cultural strengths and healing practices. For example, while Buddhism may teach that life is suffering and that one needs to endure life's challenges, it also provides people with guiding principles that help them structure their lives and deal with life's difficulties. The Buddhist “Eightfold Path” (right view, right intention, right speech, right action, right liveli-

hood, right effort, right mindfulness, and right concentration; Novak, 1994) can be integrated with CBT principles (e.g., psychoeducation, practice and skills building, and cognitive reframing) to help the client recover from his or her illness. Taoist principles can also be used to help facilitate client improvement. For example, Taoism emphasizes that emotion should be expressed in moderation, and that one should find balance in the world by being flexible, letting go of excessive control, and conforming to the natural laws of the earth (Zhang et al., 2002). While an ill Chinese client may take these teachings to an extreme (i.e., not express, repress, or deny their emotions), the therapist can help the client find balance by using CBT techniques, while at the same time relating CBT principles back to Chinese traditions (e.g., cognitive restructuring will help clients balance their Qi). Asking clients to talk and think more about the problems that they are trying to get rid of may seem counterintuitive and lead to feelings of loss of control for the client unless a cultural bridge is made to the client's underlying schemas and beliefs. It is equally valuable to help clients understand that the focus in CBT is on coping with symptoms rather than on complete amelioration of symptoms. Thus, difficult feelings are expected to continue, but more disciplined responses to them may be achieved through hard work. CBT can be equated to focusing one's energy on the difficult task of learning self-control over the body, mind, and feelings—similar to the goals of Chinese martial arts. Clients can be reinforced for returning to therapy and taking small, meaningful steps toward this goal.

Principle 15: Awareness of ethnic differences in expression of distress can improve diagnostic accuracy and treatment planning. The Chinese notion of self as it relates to the mind-body experience is very different from that of Western conceptualizations of self. In Western cultures, there is a clearer split between the mind and body, and more weight is given to cognitive and affective domains. Contrastingly, in Chinese culture, the mind and body are more integrated and equally important. This can be seen in traditional Chinese medicine (TCM) which conceptualizes illness based on an integrated mind-body paradigm that relates illnesses to imbalances in different bodily systems (K. Lin, 1980). Social and cultural forces seem to shape how people express their distress, resulting in greater “somatization,” which is a culturally sanctioned means of expressing distress through the body that may be less stigmatizing for the client (Kleinman & Kleinman, 1985). Because of the mind-body integration prominent in Chinese culture and medicine, Chinese clients may be more familiar with and feel more comfortable reporting somatic symptoms of distress. Treatment plans that include physical health interventions may be beneficial.

Principle 16: Chinese clients also experience emotional and cognitive symptoms of depression. Cultural bound syndromes such as “neurasthenia” (*shengjing shuairuo* in Mandarin Chinese), a Chinese form of depression, is more heavily weighted with somatic symptoms than cognitive and affective symptoms (K. Lin & Cheung, 1999). While Chinese clients may initially report more somatic symptoms and suppress or ignore emotional symptoms, this does not mean that they do not experience emotional and cognitive symptoms. In fact, clinical experience tells us that after developing a good therapeutic relationship with Chinese clients, they may begin to express more cognitive and affective symptoms. Studies have found that although clients were more likely to focus on physical complaints when they initially came in for treatment, they were fully aware of and capable of expressing feelings and talking about social problems that brought them into treatment (Cheung, 1985; Cheung & Lau, 1982).

Principle 17: It may be helpful to teach clients the relationships between biomedical and psychosocial models of disease development to facilitate their understanding of and identification with the treatment. Experience of somatic symptoms is also likely to influence client beliefs about the causes of their illness. Therapists working with Chinese clients may encounter clients who believe that their problems are somatic and only caused by medical problems such as chemical imbalances. This type of Chinese client may only want to take medication for their problems, look for quick-fixes to long-term issues, and may not be fully invested in psychotherapy, which may be seen as foreign, taking too long, and ineffective. Their beliefs are reinforced by medical practices in Chinese communities where doctors see clients briefly (as opposed to short-term and long-term therapy), prescribe medications and herbs for problems, are very symptom focused, and often do not provide the client with medical diagnoses for fear of humiliating or stigmatizing the client. Targeting psychosocial aspects of clients’ lives that they may have control over can help empower clients and help them better cope with their illnesses.

Principle 18: It may be helpful for therapists to align with traditional forms of healing, target physical symptoms, and reformulate behavioral treatments to help engage clients in healthy behaviors and exercise. Herbal therapies, acupressure, and acupuncture treatments are also traditional forms of healing that are less stigmatizing and may be more familiar to the client. Since Chinese clients may be accustomed to seeking alternative treatments, therapists should be careful not to negate clients’ cultural beliefs in indigenous healing practices but try to bridge the two forms of healing together to create a culturally sensitive and congruent treatment plan. Therapists can also align

with the client’s cultural beliefs to increase adherence to exercise and healthy activities common in Chinese culture. For instance, drawing a cultural bridge between the mind-body balance in TCM and the CBT technique of behavioral activation to reduce depression can help clients understand the importance of exercise and physical fitness, regardless of whether the type of fitness activity is culturally Chinese or American (e.g., learning Tai Qi, practicing meditation, doing yoga, dancing in the park, joining physical fitness groups, or singing in the choir).

In sum, there are numerous ways in which Western psychotherapies such as CBT can be adapted or modified to meet the mental health needs of Chinese American and other culturally diverse clients. However, being culturally sensitive and effective in clinical practice is not automatic and requires conscientious effort from the therapist to learn about their client’s background, beliefs, and needs. This is true for all therapists, regardless of whether or not the therapist shares the same ethnic or cultural background as the client. Therapists will need to be creative in modifying CBT to meet the needs of their individual clients. Although many of these principles are sound therapeutic principles that can be used across groups or generations, they were developed for the purpose of working with less acculturated Chinese American immigrants and it is up to the reader to determine if they apply to the specific needs of his or her client. If properly conducted, adapting psychotherapy to meet the needs of the client’s specific cultural background should increase consumer satisfaction and improve treatment efficacy. A clinical case study that highlights some of these principles and recommendations is provided below. However, it is important to note that this is just one of many ways that cultural adaptations can be made to enhance therapy and providers need to creatively evaluate which principles to use in treating clients suffering from a range of illnesses.

Case Study

Billy, a 12-year-old Chinese American male, was referred to a university mental health clinic by his pediatrician and child neurologist after experiencing 2 weeks of medically unexplained retrograde amnesia, drop attacks, and apparent loss of consciousness for several minutes followed by confusion and agitation lasting an hour. A drop attack is a medical symptom—not a diagnosis—involving a sudden spontaneous fall while standing or walking. In most American patients, drop attacks are not definitively linked with a medical condition (Meissner, Wiebers, Swanson, & O’Fallon, 1986), but they are sometimes associated with cardiovascular disease or seizures.

During an initial phone conversation with the family, the therapist gathered general and culture-specific background information. The family had migrated from mainland China 9 years earlier in search of better economic opportunities in the U.S. Both of his parents worked in food services full-time, and his father worked a second job in janitorial services. They spoke Mandarin Chinese at home, but Billy usually responded in “Chinglish” (a mix of Mandarin and English). This initial information gathering exemplifies Principle 9 (i.e., learning about migration histories and family backgrounds).

With regard to the patient, he attended seventh grade in a public middle school in a large metropolitan area of the Western United States. The school was middle-class and modestly culturally diverse, but Billy was in the minority, while Caucasians made up the majority in the school. Billy was small in stature, had not begun puberty, and was not athletic. He was, however, engaging and articulate in conversations with adults, and was very interested in Japanese cartoons (“anime”) and the violin.

Because Billy’s father worked multiple jobs, only Billy’s mother was available to actively collaborate in treatment—and, as noted in Principle 10, collaboration with his parents was viewed as critical to treatment success in this case. The initial session was conducted in English because a Mandarin speaking therapist or translator was not available. Subsequent sessions were conducted in English because the mother could speak sufficient conversational English to collaborate as an adjunct to therapy and because English was Billy’s language of preference. However, because the therapist was not an expert in treating Chinese clientele, he actively sought consultation from a Chinese American therapist in order to adapt the treatment to better meet the client’s specific needs (following Principle 2, i.e., learning about the patient’s cultural background).

In the first meeting, Billy’s mother expressed concern that the physicians had not understood the severity of Billy’s symptoms. She minimized the role that psychological factors and “mere thoughts” might play in Billy’s unusual behavior. Following Principle 1, an initial orientation was provided to his mother on CBT treatment (including the length, procedures, and rationale), and a cultural bridge was formed between CBT theory, the mind-body relationship evident in TCM, and Billy’s behavior (Principle 5). As suggested in Principle 4, the therapist provided psychoeducation on drop attacks to normalize the experience, decrease stigma associated with her son being “mentally ill,” and discussed possible social and developmental bases of such behaviors.

In order to build a positive relationship with Billy and make him more comfortable—since he had already been seen by numerous “doctors”—the therapist spent some

time during the first visit to play with Billy and talk about his interests. A functional analysis of Billy’s drop attacks was conducted at the second appointment. Knowing that distressing topics may be discussed in an indirect and euphemistic manner by some Chinese Americans and in an attempt to forestall potential discomfort experienced during the direct discussions required for a functional analysis, the psychologist light-heartedly warned the family that sometimes he would ask the same question in several different ways. During several episodes of “loss of consciousness,” Billy had been observed to crawl closer to his parents when they had moved away from him. Furthermore, amnesia symptoms were intermittent, intensifying at times when the parents discussed sending the client back to school. These inconsistencies in symptom expression raised the question of malingering. A consequence of the seizure-like behaviors was school avoidance; Billy had also received considerable attention for the symptoms from various adults.

Although Billy said it didn’t bother him, he had few friends other than his same-aged cousin. After developing a positive relationship with the therapist, he admitted that he was often teased at school and that some other boys had used racial slurs such as “chink” and “jap.” The psychologist reflected on how awful that must feel, and the client’s eyes filled with tears. Billy explained that he had never told anyone about it because he felt ashamed, weak, and afraid because he was unable to stand up to them. These experiences seemed to be possible antecedents of the drop attacks, which had first occurred at school.

Billy’s mother denied that he had a history of other psychiatric symptoms, but stated that he did have problems sleeping and eating as well as stomachaches—evidence of psychosomatic symptoms consistent with depression and anxiety in children and in Chinese culture (i.e., Principle 15). Moreover, she stated that the family was not experiencing any problems and that everything at home was fine. However, she did mention that they worked a lot and that Billy complained that they didn’t spend enough time playing with him.

The clinical data suggested that the client’s drop attacks might be either hysterical or malingering in nature, in the former case reflecting somatizing of anxiety—a less stigmatizing and more culturally appropriate expression of anxiety—and in the latter case serving as an escape behavior triggered by the antecedent of teasing. The therapist emphasized that Billy’s problems were serious, but reassured his mother that they could be effectively dealt with if properly treated. In addition, he capitalized on the importance of children’s welfare in Chinese culture by stating that the problems wouldn’t just go away by themselves and could even become worse if ignored (this strategy was another example of cultural

bridging, i.e., focusing on factors that would motivate the parents to take appropriate action based on their cultural beliefs; see Principle 5).

To maintain the family's treatment engagement in therapy, the therapist focused first on minimizing the frequency of drop attacks at school so that Billy could return to his studies (establishing a goal for treatment that the family valued; see Principle 3). The third session began with continued dialogue about the client's interests, including Japanese anime cartoons (Principle 2). The subject of peers was then reintroduced. The plan for this discussion was to minimize shame and stigma related to peer victimization by remaining highly empathic; it was suggested that the teasing was "very unfair and something that no kid should have to deal with." The client wept spontaneously as the psychologist noted that most kids would do anything they could to avoid such interactions, which was completely understandable (attempting to normalize and depathologize escape/avoidant behaviors, and exemplifying Principle 11). Billy nodded quietly.

The therapist then discussed with Billy how feeling upset can "make us lose power or Qi, like in anime cartoons; that is, bad feelings can make our bodies act strangely" (this analogy was used as a cultural bridging technique to link children's cartoon culture, Chinese culture, and the connection between emotions and somatic experiences; see Principles 5 and 15). Traditional CBT examples were then used to illustrate this observation, including the link between fear and stomachache; the client participated actively in this discussion, as stomachache was a symptom familiar to him. A link was then drawn to the client's primary symptom: If the client felt *really* upset when he was teased, he might lose *all* of his "Qi power" briefly, possibly explaining the drop attacks. This comment was an attempt to reduce the client's sense of personal weakness and shame by focusing on the role of mind-body disharmony, expressed with an age-appropriate cartoon analogy to explain the behavior. The psychologist sympathetically reflected on the client's plight at school and continued to depathologize the client's feelings by equating his reaction to that of "any normal kid." Looking down and speaking softly, the client then clarified, "I don't think I lost *all* of my power. ... I did it [had a drop attack] the first time because it was the only way I could think of getting out of gym class [where much of the teasing occurred] the day it happened ... and once I saw how people acted [taking him out of school], I kind of just kept doing it. ... I knew it was wrong, but I couldn't stop." In retrospect, it appeared that a combination of therapist empathy and hypothesis-testing during conversations with Billy allowed him to make this important disclosure.

Role-playing was used to help prepare the client for a conversation with his family. After much encouragement and practice, Billy agreed to "do most of the talking" so that he could apologize and explain to his parents why he behaved the way he did.

Prior to Billy discussing his problems with his parents, the therapist also spent time with Billy's mother discussing differences in empathic responding and parenting evident in American culture (more direct, emotional, and affirming) and Chinese culture (more hierarchical, filial, and guilt-inducing). In order to respectfully engage Billy's mother, this was done by treating her as a cultural expert and asking her about how she thought American and Chinese parenting diverged (an example of Principle 2). While the merits of both parenting styles were acknowledged, it was suggested that a child growing up in a mixed cultural milieu may or may not understand the nuances of how feelings and caring are conveyed in the parent's country of origin. This point was an initial way of introducing the idea of adapting one's communication patterns to the realities of living in a Western culture (Principle 13). Billy's mother agreed that since Billy was raised in the U.S., he may not understand all of the Chinese cultural nuances implicit in Chinese communicative styles and may misinterpret such parenting methods as being more critical and less supportive. Therefore, Billy's mother attempted to adapt to Billy's bicultural needs by modifying her parenting strategies to include some culturally American empathic ways of responding.

When Billy's mother entered the room, Billy stood up and began to cry, stating, "Mommy ... I faked the whole thing. I never really fainted. I'm sorry." Billy's mother initially expressed disappointment by saying, "You have wasted many doctors' time." However, she was able to become more affirming when Billy discussed being the victim of racism at school. This early breakthrough in treatment appeared to be experienced as a "gift" to the family (see Principle 7), and the initial reservation that had been expressed by his parents about mental health services was replaced with confidence in both the therapist and the treatment.

Billy's mother solicited the psychologist's advice for an appropriate punishment or consequence for Billy, which is often viewed as necessary by Chinese parents when children misbehave and embarrass the family. Given the culturally normative role of professionals as expert authority figures, and contrary to a typical CBT family problem-solving strategy, several direct suggestions were provided to the mother, following Principle 8. However, the therapist also attempted to preserve the parent's authority by asking the mother to make the final decision. After a discussion with Billy's father, the mother asked Billy to write apology letters to his

physicians and his school principal as the punishment; this was used to illustrate the concept of “natural consequences” to the parents.

Following the standard CBT model for school phobia (Kearney, 2001), a plan was made with the principal and staff for accommodations to be made that would allow an immediate return to school—bearing in mind the family’s desire to keep private as much personal information as possible (this can be crucial in working with Chinese families, for whom mental illness is a matter of considerable shame and stigma; see Principle 11). This was accomplished by focusing on the antecedent conditions underlying the drop attacks (i.e., teasing) in discussions with the school, rather than on Billy’s anxiety symptoms. From the family’s perspective, this approach allowed the family to save face and maintain a comfortable relationship with the school.

Accommodations included moving the client near his teacher to increase supervision of peer interactions and to a different area of the locker room so that he could be near other children he viewed as possible friends. Several modules of an efficacious social skills training program (e.g., Frankel, Myatt, Cantwell, & Feinberg, 1997) were also presented to help the client cope with teasing and learn how to ask potential school friends over for a get-together. The client selected other Asian students with similar interests to ask over to his house and soon made some good friends. The client also learned cognitive restructuring techniques to cope with ongoing anxiety about teasing and peer harassment. When anxious, he reminded himself that he could always stay within the sight of an adult or friend at school to increase his sense of safety, that the changes to his program would probably reduce the likelihood of teasing, and that he had learned some pretty good comebacks to being teased.

Billy returned to school full time after the third session, although as typically occurs with school phobia, the transition involved resistance and increased psychosomatic symptoms on Billy’s part. Nevertheless, as the incidents of teasing decreased, his developed a greater sense of security. The brief evaluation and treatment was completed in six sessions, and a diagnosis of adjustment disorder with anxious and depressed mood was confirmed and explained to the parents. Psychodiagnostic testing ruled out PDD, and a primary anxiety or mood disorder was ruled out due to the presence of a stressor as a precipitant of Billy’s symptoms.

In terms of outcome measures, the objective criteria of “school refusal” were assessed before and after treatment (Kearney, 2001). Billy had refused to attend school due to psychological factors for more than 40% of all school days prior to treatment. At the end of treatment, Billy was attending school more than 90% of the time, an indicator of “best outcome” for cases of school refusal.

In addition, psychosomatic symptoms at home decreased as the treatment moved from helping Billy transition back to school (which was a culturally important goal for the parents) to helping Billy better communicate his needs to his parents without using physical complaints as a means to an end, to learning how to relax and challenge his anxious thoughts when his parents argued.

In private, Billy’s mother admitted to the therapist that she had been feeling depressed and that Billy may have mimicked some of her psychosomatic symptoms. She stated that she and her husband were having marital problems, and that financial stresses and being separated from her family (which was an important source of support for her) made things worse. Because of her positive experiences with the therapist in Billy’s treatment, the mother agreed to see a Mandarin speaking therapist.

The family returned to visit a month after termination and reported that Billy had maintained his school attendance, had had several play dates with new friends from school, had improved sleep and appetite, and was feeling more confident. The therapist complimented Billy for his ability to “power up” like his cartoon heroes, and the parents for their considerable efforts to follow through on the school-reintegration plan and to spend more time engaged with Billy in positive activities despite their busy schedules. Reaffirming culturally valued behaviors such as parental sacrifice on behalf of children was important in the final stages of treatment, leading to a positive final experience with therapy. Problems were attributed to external acculturative stressors (i.e., racism and economic stress), which decreased parental self-blame and increased their sense of competence as parents. Finally, Billy’s mother reported that her depression had lifted and that her relationship with her husband had improved, which facilitated them being more emotionally available to Billy.

References

- Acosta, F. X., Yamamoto, J., Evans, L. A., & Skilbeck, W. M. (1983). Preparing low-income Hispanic, Black, and White patients for psychotherapy: Evaluation of a new orientation program. *Journal of Clinical Psychology, 39*, 872–877.
- American Psychological Association Task Force on Psychological Intervention Guidelines (1995). *Template for developing guidelines: Interventions for mental disorders and psychological aspects of physical disorders*. Washington, DC: Author.
- Bui, K. V., & Takeuchi, D. T. (1992). Ethnic minority adolescents and the use of community mental health care services. *American Journal of Community Psychology, 20*, 403–417.
- Barrett, P. M., Dadds, M. R., & Rapee, R. M. (1996). Family treatment of childhood anxiety: A controlled trial. *Journal of Consulting and Clinical Psychology, 64*, 333–342.
- Barnes, J. S., & Bennett, C. E. (2002). *The Asian population: 2000. Current Population Reports C2KBR/01-16*. Washington, DC: U.S. Census Bureau.
- Cheung, F. M. (1985). An overview of psychopathology in Hong Kong with special reference to somatic presentation. In W. S. Tseng, & D. Wu (Eds.), *Chinese culture and mental health*. Orlando, FL: Academic Press.

- Cheung, F. M., & Lau, B. W. (1982). Situational variations of help-seeking behavior among Chinese patients. *Comprehensive Psychiatry*, 23, 252–262.
- Evans, L. A., Acosta, F. X., Yamamoto, J., & Skilbeck, W. M. (1984). Orienting psychotherapists to better serve low income and minority patients. *Journal of Clinical Psychology*, 40, 90–96.
- Exum, H. A., & Lau, E. Y. (1988). Counseling style preference of Chinese college students. *Journal of Multicultural Counseling and Development*, 16, 84–92.
- Flaskerud, J. H., & Liu, P. Y. (1991). Effects of an Asian client-therapist language, ethnicity, and gender match on utilization and outcome of therapy. *Community Mental Health Journal*, 27(1), 31–42.
- Frankel, F., Myatt, R., Cantwell, D. P., & Feinberg, D. T. (1997). Parent-assisted transfer of children's social skills training: Effects on children with and without attention-deficit hyperactivity disorder. *Journal of the Academy of Child and Adolescent Psychiatry*, 36, 1056–1064.
- Ham, M. D. (1989). Immigrant families and family therapy. [Special issue]. *Journal of Strategic and Systemic therapies*, 8(2).
- Hong, G. K. (1993). Synthesizing Eastern and Western psychotherapeutic approaches: Contextual factors in psychotherapy with Asian Americans. In J. L. Chin, J. L. Liem, M. D. Ham, & G. K. Hong (Eds.), *Transference and empathy in Asian American psychotherapy: Cultural values and treatment needs* (pp. 77–90). Westport, CT: Praeger.
- Hong, G. K., & Ham, M. D. (2001). *Psychotherapy and counseling with Asian American clients: A practical guide*. Thousand Oaks: Sage Publications, Inc.
- Hong, Y. N. (1987). *Chinese saying told in pictures*. Taipei: Sinora Magazine.
- Hu, T. W., Snowden, L. R., Jerrell, J. M., & Nguyen, T. D. (1991). Ethnic populations in public mental health: Services choice and level of use. *American Journal of Public Health*, 81, 1429–1434.
- Iwamasa, G. Y., Nangle, D. W., & Larrabee, A. (1995). AABT and ethnic diversity: A review of convention programs of the past decade. *The Behavior Therapist*, 18, 49–51.
- Iwamasa, G. Y., & Smith, S. K. (1996). Ethnic diversity in behavioral psychology: A review of the literature. *Behavior Modification*, 20, 45–59.
- Kearney, C. A. (2001). *School refusal behavior in youth: A functional approach to assessment and treatment*. Washington, DC: American Psychological Association.
- Kleinman, A., & Kleinman, J. (1985). Somatization: The interconnections in Chinese society among culture, depressive experiences, and the meanings of pain. In A. Kleinman, & B. J. Good (Eds.), *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder* (pp. 429–490). Berkeley: University of California Press.
- Lee, E. (1997a). Overview: The assessment and treatment of Asian American families. In E. Lee (Ed.), *Working with Asian Americans: A guide for clinicians*. New York: The Guilford Press.
- Lee, E. (1997b). Chinese American families. In E. Lee (Ed.), *Working with Asian Americans: A guide for clinicians*. New York: The Guilford Press.
- Lee, S. M. (1998). Asian Americans: Diverse and growing. *Population Bulletin*, 53(2) Washington, DC: Population Reference Bureau.
- Leong, F. T. L. (1986). Counseling and psychotherapy with Asian-Americans: Review of the literature. *Journal of Counseling Psychology*, 33(2), 196–206.
- Lin, K. (1980). Traditional Chinese medical beliefs and their relevance for mental illness and psychiatry. In A. Kleinman, & T. Y. Lin (Eds.), *Normal and abnormal behavior in Chinese culture* (pp. 95–111). Boston: Reidel.
- Lin, K., & Cheung, F. (1999). Mental health issues of Asian Americans. *Psychiatric Services*, 50(6), 774–780.
- Lin, T. Y., & Lin, M. C. (1978). Service delivery issues in Asian-North American communities. *American Journal of Psychiatry*, 135, 454–456.
- Lin, Y.-N. (2001). The application of cognitive-behavioral therapy to counseling Chinese. *American Journal of Psychotherapy*, 55, 46–58.
- Meissner, I., Wiebers, D. O., Swanson, J. W., & O'Fallon, W. M. (1986). The natural history of drop attacks. *Neurology*, 36, 1029–1034.
- Murshad, A. H. (2002). Tools for talking: The purposeful and inventive use of languages by bilingual children in primary classrooms. *Reading: Literacy and Language*, 36, 106–112.
- Novak, P. (1994). *The world's wisdom: Sacred texts of the world's religions*. San Francisco: HarperCollins.
- Smith, H. (1991). *The world's religions*. San Francisco: Harper.
- Snowden, L. R., & Cheung, F. K. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist*, 45, 347–355.
- Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist*, 32, 616–624.
- Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, 53, 440–448.
- Sue, S., Fujino, D., Hu, L. T., Takeuchi, D. T., & Zane, N. W. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*, 59, 533–540.
- Sue, D., & Sue, S. (1987). Cultural factors in the clinical assessment of Asian Americans. *Journal of Consulting and Clinical Psychology*, 55, 479–487.
- Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist*, 42, 37–45.
- Takeuchi, D. T., Sue, S., & Yeh, M. (1995). Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. *American Journal of Public Health*, 85, 638–643.
- Task Force on Promotion and Dissemination of Psychological Procedures (1995). Training in and dissemination of empirically-validated psychological treatments: Report and recommendations. *Clinical Psychologist*, 48, 3–23.
- Wong, E. C., Kim, B. S., Zane, N., & Huang, J. S. (2003). Examining culturally based variables associated with ethnicity: Influences on credibility perceptions of empirically supported interventions. *Cultural Diversity and Ethnic Minority Psychology*, 9, 88–96.
- Yamamoto, J., Acosta, F. X., Evans, L. A., & Skilbeck, W. M. (1984). Orienting therapists about patients' needs to increase patient satisfaction. *American Journal of Psychiatry*, 141, 274–277.
- Yeh, M., Eastman, K., & Cheung, M. K. (1994). Children and adolescents in community mental health centers: Does the ethnicity of the language of the therapist matter? *Journal of Community Psychology*, 22, 153–163.
- Yeh, M., Takeuchi, D. T., & Sue, S. (1994). Asian-American children treated in the mental health system: A comparison of parallel and mainstream outpatient service centers. *Journal of Clinical Child Psychology*, 23, 5–12.
- Yuen, R. K., & Tinsley, H. E. A. (1981). International and American Students' expectancies about counseling. *Journal of Counseling Psychology*, 28, 66–69.
- Zane, N., Enomoto, K., & Chun, C. (1994). Treatment outcomes of Asian- and White-American clients in outpatient therapy. *Journal of Community Psychology*, 22, 177–191.
- Zane, N., Hatanaka, H., Park, S. S., & Akutsu, P. (1994). Ethnic-specific mental health services: Evaluation of the parallel approach for Asian-American clients. *Journal of Community Psychology*, 22, 68–81.
- Zhang, Y., Young, D., Lee, S., Li, L., Zhang, H., Xiao, Z., et al. (2002). Chinese Taoist cognitive psychotherapy in the treatment of generalized anxiety disorder in contemporary China. *Transcultural Psychiatry*, 39, 115–129.

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