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Commentary on Integrating Cognitive-Behavioral and Cognitive-Interpersonal Case Formulations: A Case Study of a Chinese American Male

Considering Culture One Client at a Time: Maximizing the Cultural Exchange

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ABSTRACT

Cultural competency is a process that requires knowledge, diligence, and availability of resources. For the individual practitioner, it may be unfeasible to expect expert-level knowledge of any more than a few cultural groups. This commentary provides a general approach that clinicians can use to become oriented to a culture, make use of evidence-based frameworks, and treat the therapy as an ongoing cultural exchange. Using this approach a clinician may be able to flexibly adapt his or her individual case formulation approach to match the needs of a diverse set of clientele. Examples from the case of TC are used to illustrate the model and to highlight the cultural competence of the therapist.

Key words: Asian-American; Chinese-American; cognitive-behavior therapy (CBT); cultural competence

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There is a considerable evidence base for the use of cognitive-behavioral therapy (CBT) in the treatment of anxiety and depressive disorders. However, the notable absence of Asians as research participants in randomized clinical trials make it difficult to be confident about how CBT translates to work with Asian Americans or recent Asian immigrants (Huey, 2005; Miranda et al., 2005). The early research shows promising results for CBT in treating anxiety and depression related problems with Chinese populations (Miranda et al., 2005) and core CBT principles seem consistent with Chinese world views and values (Hodges & Oei, 2007). Thus, we should expect that, with appropriate adaptation, traditional CBT interventions would impart similar benefits to Asian clients as they have with other groups.

The qualities that comprise cultural competence and the necessary knowledge base needed to deliver culturally sensitive treatment are still being understood (S. Sue, 1998). Appropriate adaptation for Asian clients is complicated by the magnitude of diversity represented. Asians in America can trace their roots to one or more of 24 Asian countries of origin or ethnic groups (Okazaki & Nagayama Hall, 2002). Even among people of Chinese

descent, there is significant heterogeneity. Chinese Americans evidence unique migration patterns, come from multiple countries and regions of China, and speak a variety of languages and dialects (Hwang, Wood, Lin, & Cheung, 2006). Such diversity requires therapists to consider a number of unique cultural factors, including individual immigration history, generational status, language proficiency, and level of ethnic identity, acculturation and cultural orientation (Hwang et al., 2006; Tsai, Chentsova-Dutton, & Wong, 2002).

The good news is that recent years have witnessed a boon in social and clinical research dedicated to understanding Asian values, attitudes, behaviors, and needs (Okazaki, 2002). The number of scholarly publications focusing on Asian Americans more than doubled between 1991 and 2000 (Okazaki, 2002), and research specifically targeting mental health, accessibility, and treatment has become increasingly sophisticated and refined (S. Sue, 1998). At the same time, the abundance of information can be overwhelming. A scholar conducting a comprehensive literature review could occupy him or herself for weeks to sort through and identify the relevant literature. For the individual clinician, this process is often unfeasible and unlikely to produce relevant information for immediate clinical needs. Another approach to enhancing one's cultural competence is to seek out specific competency training (e.g., continuing education) or supervision with experts, but such opportunities are not always available. Ultimately, staying current with relevant literature and best practices is a significant challenge for the individual practitioner.

In the case of TC, Liu (2007) makes the most of available resources, supervision, and evidence-based theories and practice to individually adapt her interventions to her Asian American client. First, Liu applies a cognitive-interpersonal approach integrating elements of traditional cognitive therapy with interpersonal concepts and techniques. The therapist presents thoughtful examples of how to use within-session process to increase awareness about a client's interpersonal deficits and his impact on others. These examples are valuable to novice and experienced therapists alike who are seeking methods to implement greater process work in their cognitive therapy. The therapist is very creative in giving feedback and in using non-verbal tactics (e.g., arranging chairs to experiment with eye contact and proximity to each other) to assess her client's interpersonal deficits and experiment with ways to increase his comfort.

Liu also employs a substantial knowledge of Chinese culture and values in conceptualizing, assessing, and treating TC. The author is to be commended for her awareness of the possible cultural influences on her client's behaviors and emotional well-being. She is also to be commended for her willingness to make culture an explicit focus of therapy. In the write-up, Liu references numerous scholarly articles, dissertations, and personal experience and reflection. Her therapeutic approach displayed many of the essential elements of cultural competence described by S. Sue (1998), including culture-specific expertise and scientific-mindedness.

Of course, the current case study benefits from close supervision and retrospective self-reflection. In preparation for the case write-up, the author had the time and ability to conduct a thorough literature review to place the case in context. How might this differ from the individual practitioner working independently or in community practice? Access to library resources, expert

training, and close supervision may not always be available, particularly at the moment a client presents for treatment. This question is particularly relevant for clinicians who provide services to a diverse and heterogeneous client population. When possible, a clinician might consider referring a client to ethnic-specific services, since research suggests that such clinics may enhance a variety of positive outcomes (S. Sue, 1998). But when such resources are limited, how does a clinician adopt a culturally sensitive orientation on an individual basis? This commentary highlights several steps a therapist can take to become oriented to a culture, make use of evidence-based frameworks, and treat the therapy as an ongoing cultural exchange. This approach is not designed to replace other comprehensive formulations for achieving cultural competence (e.g., Huang, 1994; Hwang, 2006; Lau, 2007; S. Sue, 1998), but is meant to provide guidance to practitioners who want to apply cultural sensitivity to their traditional individual case formulation. Viewing therapy as an ongoing process of mutual learning and exchange can help the therapist avoid unfounded stereotyping and learn how culture may be influencing the client.

STEP 1: ADOPT AN ORGANIZING FRAMEWORK

The first step in any clinical work is to start with a conceptual framework. Much like one uses a treatment theory (e.g., CBT) to guide assessment, case conceptualization, and therapeutic strategies, there are several general frameworks, supported by the best available research, that can help clinicians adopt a culturally sensitive perspective. Huang (1994) presents an integrative ecological approach that highlights the similarities and differences of standard and ethnocultural assessment strategies. Designed for work with adolescent clients, the framework highlights the special considerations one should weigh along individual, family, school, and peer domains. For example, at the individual level, dimensions of age, appearance, speech, language, affect, and interpersonal relatedness would be assessed in a standard assessment. The ethnocultural assessment would also include an assessment of generational status, acculturation level, ethnicity and self-concept. At the family level, beyond the typical issues of family composition, communication patterns, and family roles, an assessment of Asian Americans might include additional attention to concepts such as migration history, salience of ethnicity, and acculturation gaps.

In the case of TC, there are a number of compelling individual and cultural assessment issues. At the individual level, TC has a history of depressive episodes that follow stressful events, such as his first episode that followed news that he was not accepted by his colleges of choice. This suggests his depressive symptoms may be reactive to stressful life events. Still, he persisted in attending a community college after which he transferred to a four-year college and is now pursuing an advanced degree. These suggest a certain resilience to initial set-backs and dedication to education. At the same time, family history and a number of cultural factors seem to influence his current presentation. He is first generation, having immigrated at 11-years-old, and his parents struggled with significant language, financial and support issues. This seems to have contributed to severe marital problems and family distress, which may have added to the isolation and alienation that immigrants may experience (Huang, 1994). Although TC and his sisters seem to have acclimated in some ways (e.g., fluent in English, completed school), TC may feel torn between his family's traditional values and the new values he is learning as an

American. His interpersonal difficulties appear subject to both individual and cultural influences. TC seems to have genuine interpersonal deficits, but his skills seem influenced by both anxiety and acculturation issues (e.g., familiarity or comfort with social norms and interpersonal styles).

As described by Liu (2007), Hwang and colleagues (2006) provide an integrative framework to guide theory, research, and treatment with Chinese Americans. They summarize relevant research literature, describe an overall therapeutic framework, and provide specific clinical recommendations. For example, Hwang et al. describe 18 key therapeutic principles covering three core areas to aid treatment: general principles for adapting CBT to Chinese American clients, methods for strengthening the client-therapist relationship, and specific techniques for understanding Chinese notions of self and mental illness. The authors then provide concrete examples of techniques that match these principles and conclude with a case example illustrating the framework in operation. For the interested reader, Hwang (2006) also provides a broader framework (the Psychotherapy Adaptation and Modification Framework) for adapting evidence-based treatments for work with Asian Americans.

Huang (1994) and Hwang et al. (2006) may be ideal initial references for clinicians just beginning work with Chinese Americans. They each summarize valuable research, describe organizing frameworks, and provide practical guidelines targeted for work with Asians. Other approaches have been developed for additional populations and may be relevant to work with Asian Americans. For example, Bernal, Nonilla, and Bellido (1995) present a framework for culturally sensitive treatments with Hispanics that describe eight dimensions for adapting treatments and research to be ecologically valid, including language, persons, metaphors, content, concepts, goals, methods, and context. Hays (2001) offers a broader organizing system that incorporates traditional cultural factors, such as ethnicity, heritage, and national origin, but also includes age, disability, religion, gender, socioeconomic status and sexual orientation as culturally influenced factors to be considered in assessment and treatment.

Each framework provides evidence-based principles that help organize ones assessment and treatment strategies. The emphasis on principles helps promote an open-ended exchange and prevent any rigid, stereotyped techniques. It also allows the clinician to account for a greater variety of cultures and more flexibly incorporate individual variation into one's conceptualization.

STEP 2: BE CREATIVE WITH RESOURCES

With a guiding framework, one will want to make use of available resources to self-educate about the client's culture. Accurate cultural knowledge by the therapist has been shown to increase credibility with the client (S. Sue & Zane, 1987), and knowledge of a client's culture can help bridge certain topics (S. Sue, 1998; APA Office of Ethnic Minority Affairs, 1993). Liu (2007) makes use of a creative set of resources, both to inform her cognitive-interpersonal work and to make ethnic-specific adaptations. To supplement her own experiences as a Taiwanese American, Liu conducted a very thorough literature review of Chinese values and treatment adaptations – I refer you to her reference list. She also made use of a number of standard

cognitive-behavioral resources, including three books: David Burn's (1989) *The Feeling Good Handbook*, Greenberger and Padesky's (1995) *Mind over Mood*, and Safran and Segal's (1990) *Interpersonal Process in Cognitive Therapy.*

I encourage therapists to be creative about the resources they employ. Even without access to university library services or expert consultation, publicly available resources can provide a baseline of knowledge about Asian American health and living. There are traditional resources, such as Laura Uba's (1994) *Asian Americans: Personality Patterns, Identity, and Mental Health*. This text, over a decade old, is still an excellent introduction to the history, culture, and attitudes of Asian Americans. She then relates historical culture and research on values and beliefs to current issues of psychological health and treatment. The internet provides several publicly available and easily digestible sources of information. Advocacy organizations, like the Asian and Pacific Islander American Health Forum, supply fact sheets on key health issues for a number of Asian groups (www.apiahf.org/resources/index.htm). The interested reader can also find several thoughtful independent websites, such as Asian Nation (www.asian-nation.org), that offer brief summaries of Asian history, culture and health issues, and supply links to local community organizations.

It is more challenging to find publicly available clinical guidelines. The American Psychological Association (APA, 2002) has created guidelines on multicultural training (available at www.apa.org/pi/multiculturalguidelines/homepage.html), but no specific advice for therapeutic adaptations for specific ethnic groups or cultures. Likewise, the Asian American Psychological Association website (www.aapaonline.org) supplies links to resources for teaching, research, and funding, but offers no guidelines for therapy adaptations for treatment or assessment. The National Research Center on Asian American Mental Health (NRCAAMH, at http://psychology.ucdavis.edu/nrcaamh), an independent research center, provides information on ongoing research and training opportunities, but no specific treatment recommendations.

The Society for the Psychological Study of Ethnic Minority Issues (APA, Division 45) (http://www.apa.org/divisions/div45) does not provide explicit recommendations for assessment and treatment, but it does provide links and resources for training and research with ethnic minorities. The organization's website also provides links to therapy training videotapes and regularly posts educational and conference opportunities in multicultural training.

A review of library and public resources reveals that clinical guidelines for psychological therapy with Asian Americans are still very rare. Developing fact sheets that translate ethnographic research into practical treatment recommendations should be a major priority for the field. Until then, therapists are encouraged to be creative in seeking out resources that will help them bridge cultural gaps. Therapists are still encouraged to seek out specific cultural competency training, avail themselves of scholarly research, and make use of expert consultation. Nevertheless, every effort the clinician makes to gain knowledge of the client's culture, history and values can help bridge cultural gaps and increase the relevancy of their therapy.

STEP 3: MAXIMIZE THE CULTURAL EXCHANGE

Although accurate cultural knowledge by the therapist is essential, it is unlikely that any individual clinician will be able to develop insider-level expertise with any more than a few cultural groups (Hays, 2001; S. Sue, 1998). Thus, developing a general approach for incorporating cultural factors into one's practice is key to enabling a clinician to accommodate a range of diverse cultural differences. To accomplish this, the therapist is encouraged to view therapy as an ongoing *cultural exchange* where mutual learning occurs and cultural hypotheses can be tested (Lopez et al., 1989; D.W. Sue, 1990).

There are several important reasons why information should be openly exchanged and for cultural assumptions to be questioned. Whenever working with clients where cultural factors play a part (and this is likely true in varying degrees for nearly all clients!), there is a natural tension between cultural knowledge and cultural stereotyping (Bernal et al., 1995). In response to limited information by therapists on cultural background of clients, a problem may arise from either not contemplating cultural information when in fact it may apply (a "type II" cultural error) or assuming that a cultural process is at work when in fact that is not the case (a "type I" cultural error, which may lead to stereotyping; Bernal et al., 1995). An example of a type II error might come from a therapist reacting to Asian parents who want to meet with the therapist before bringing in their child. During the meeting, the parents question the therapist about his or her credentials and ask details about potential treatment. Some may interpret this interest as demanding or skeptical, but this may reflect a desire for greater orientation to psychotherapy and an interest in determining the expertise of the therapist, common among many Asian clients (Hwang et al., 2006).

A type I cultural error is just as dangerous. A client who is consistently late and uses the excuse that he or she is on "Asian time" may be obscuring a lack of treatment motivation. Some have described such events as "cultural camouflage" (McGoldrick, Giordano, & Pearce, 1996), and therapists should not shy away from considering these possibilities. To limit these types of errors, the therapist is encouraged to form hypotheses and ask questions to test their clinical inferences (S. Sue, 1998). In this simple example, the therapist might question the client to determine if he is late to other types of engagements, whether other Asians he knows arrive on time, or to ask how others might perceive this behavior. Maintaining an open exchange and a hypothesis-testing approach (see "scientific mindedness;" S. Sue, 1998) allows the therapist to assess the degree to which cultural factors are important to the client and in what ways behavior is culturally influenced.

There is a subtler form of cultural error that can occur in either type I or II fashion. Often times, it can be difficult to distinguish individual thoughts, attitudes and beliefs from group-wide cultural values and attitudes. Indeed, individual thoughts are influenced by group values, but individual variation should be expected and individuals are generally subjected to multiple cultural influences. This can be particularly challenging in the context of cognitive therapy where one objective is to identify and test negative or anxious thinking. Maladaptive thinking can

appear masked in value-laden language making it difficult to challenge. A client may resist challenging the thought believing that doing so would violate cultural values he or she respects. A tentative therapist may be hesitant in labeling or challenging a thought because he or she fears insulting the individual's cultural sensibilities or appearing ignorant. This is where a combination of cultural knowledge and a hypothesis-testing approach is essential.

In the case of TC, effective treatment required the therapist to separate individual maladaptive thoughts and attitudes from culturally-referenced values. A number of the client's self-defeating beliefs (e.g., "I am not good enough") were difficult to challenge because the client seemed to believe they served positive motivating functions. Further, the client presented these beliefs as appropriately in line with traditional Chinese cultural values. It is here where a deft therapist must disentangle the individual distortion from the cultural value. In this case, the thought "I am not good enough" may reference traditional cultural values, such as an emphasis on achievement and humility, but TC applies his own dichotomous filter by assuming there is only one acceptable outcome and that everyone believes the same way. For example, TC often commented, "Having a B.A. is nothing. That degree can only help you stay out of working at McDonalds." These automatic thoughts informed his higher-order intermediate thoughts (e.g., "If I am not perfect then I will be ignored or rejected"), which TC used to justify his negativity and hopelessness. While "Family recognition through achievement" may indeed be an important traditional value, it does not follow that TC's family truly thinks a B.A. is unacceptable (despite verbalized criticism) nor would one be limited in his career opportunities. Even if his parents are critical of his degree or his non-traditional route, there is no evidence that other family members (e.g., his sisters) share this belief. Certainly others in his community would consider a B.A. a meaningful accomplishment and would treat his willingness to attend a 2-year college first as a sign of resilience and determination.

As an aside, there are a number of examples that raise questions about the parents' psychological health and judgment. The mother has trouble with hoarding, the father has a history of gambling problems and depression. It is not clear what version of traditional Chinese values the parents conveyed to TC. Indeed, many teachings could have been distorted, filtered by the parents' own perceptions. At this level, a therapist can help the client gain insight by learning to differentiate one's individual beliefs from the individual family's beliefs and from the larger cultural values held by the group. For example, TC recounted an incident in which he, as a child, happily told his mother that he obtained good grades in school and was criticized for his pride. The therapist made use of her familiarity with the values of humility and modesty to normalize her client's experience. She then emphasized the value of seeing "the whole" and helped the client analyze the adaptive and maladaptive functions of this thinking. These all helped smooth the transition to cognitive challenging. An additional approach may have included a discussion of how TC's family differed from other families, even of similar cultural background. The therapist might also have noted how TC's parents seemed to emphasize the value-referenced lessons that were more critical ("always be vigilant") than encouraging (e.g., the value of *human-heartedness* which represents kindness, patience and courtesy in dealings with others; Hodges & Oei, 2007).

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In fairness, there is a real palpable generation gap between TC's parents, who had spent their formative years in China, and TC, who immigrated when he was younger. Given the challenges that the parents faced in immigrating to America and the mental fortitude required to persevere in the face of initial failures, it is understandable that they might perceive the world as particularly unforgiving. The context in which TC now exists (college educated, previously employed, seeking an advanced degree) likely does not demand the same level of constant vigilance and cynicism – the parents' own hard work contributed to ensuring this. In cases like this, the therapist might consider conducting a mediation between parent and child (i.e., cultural brokering; Huang, 1994). Such a meeting could help foster cross-generation communication and increase understanding of the different challenges that each have faced. The therapist can then help each understand how different contexts call for different rules. In the case of TC, the mother could be shown how the value-referenced lessons to which she adhered may have been helpful in the face of great challenges. But in TC's current context, they may act to discourage more than support his hard work and perseverance.

S. Sue (1998) refers to this process of clinical responsiveness as "dynamic sizing." Dynamic sizing refers to a clinician's appropriate use of knowledge and skill to know when to generalize and be inclusive and when to individualize and be exclusive. In other words, cultural sensitivity and competence comes from the therapist's ability to flexibly generalize in a valid manner. It allows one to avoid stereotypes of members of a group while still appreciating the importance of culture. At the family level, it allows the therapist to communicate across generations, placing values, beliefs and behaviors within context.

Ultimately, true cultural competence is a complex process that takes investment, time and diligence (Hwang, 2006; S. Sue, 1998). The current recommendations provide basic steps to help clinicians begin their education in cultural sensitivity and provide some methods for adjusting to the myriad of diversity that is likely to present for treatment. A culturally sensitive therapist may not have expert-level knowledge of the cultural background for each client he or she treats, but maintaining an open-ended approach that involves a baseline of knowledge, genuine curiosity and earnest questioning can help elicit the data needed to assess cultural influences. Consultation and supervision are always helpful, but the suggested steps can also fit into one's general individual case formulation approach.

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