An Idiographic Evidence-Based Approach to Addressing Cultural Factors in Treatment: A Case Example

Janie J. Hong, ***San Francisco Bay Area Center for Cognitive Therapy, SIG leader, Asian American Issues in Behavior Therapy and Research***

Although different frameworks have been offered on how to address cultural factors in therapy (e.g., Bernal, Jimenez-Chafey, & Rodriguez, 2009; Hwang, 2006; Zayfert, 2008), researchers and clinicians continue to struggle with questions about the cultural applicability of existing treatment models and how to adapt interventions in ways that do not reify stereotypes or undermine the integrity and efficacy of existing empirically supported treatments (for review see Sue, Zane, Hall, & Berger, 2009). One strategy has been to increase the accessibility of treatment protocols (e.g., language translations, use of culturally relevant examples or imagery; for review see Sue et al., 2009; Voss Horrell, 2008). Another has been to develop recommendations or theoretical frameworks on how treatments may be adapted for specific populations (e.g., Bernal, Bonilla, & Bellido, 1995; Hall, Hong, Zane, & Meyer, 2011; Hwang; Lau, 2006). Another promising alternative has been to actively modify existing treatments to incorporate known cultural differences in beliefs and values, and test the effectiveness of these modifications on the target populations (Hinton, Rivera, Hofmann, Barlow, & Otto, 2012; Pan, Huey, & Hernandez, 2011). For example, Hinton and colleagues (2012) describe 12 key ways they adapted CBT for PTSD to be more culturally sensitive to traumatized refugees and ethnic minority populations, and cite data supporting the effectiveness of these adaptations (Hinton, Hofmann, Rivera, Otto, & Pollack, 2011; Hinton et al., 2004).

Recommendations of integrating relevant cultural factors into treatment, while important, speak little to the difficulty of applying such adaptations to large, heterogeneous ethnic groups. For example, the label Asian American represents hundreds of ethnoculturally unique groups of individuals that vary by national origin, language, and customs. Moreover, the heterogeneity of the group is further complicated by differing levels of acculturation to Western cultural norms. Given this, it is unlikely that specific adaptations will consistently be indicated in the treatment of all Asian Americans or other large ethnic minority groups. While researchers acknowledge the diversity within ethnic groups, and even warn against overgeneralizing cultural constructs (e.g., Hwang, 2006), practicing clinicians are left with little guidance on how to address cultural factors at the individual level.

To address symptoms at the individual level, Zayfert (2008) proposes a more idiographic approach to responding to cultural concerns. This approach has the clinician asking the client a series of questions to assess

the relevance of his/her ethnocultural context on his/her symptoms. Zayfert presents example questions within the context of treating PTSD (e.g., What is the individual's perspective on … the role of women's sexuality? … the centrality of family over the individual? … the meaning of seeking professional help outside of the family?, etc.), and asserts the importance of assessing domains shown to vary culturally and are relevant to the development and treatment of a particular problem or disorder. This approach provides a framework within which a clinician can culturally adapt treatments on a case-by-case basis and in a systematic manner. Zayfert also highlights how this framework lends itself well to larger scale studies that could clarify the domains most relevant to an ethnocultural idiographic assessment for a particular disorder and, thus, provide guidance to clinicians on ways to adjust treatment delivery.

Despite its advantages, a limitation to the proposed idiographic approach is the assumption that clients will have adequate psychological insight to respond to questions about their ethnocultural values and context, and provide enough data to determine how to structure the entire treatment plan. Most individuals do not spend time thinking about their cultural values and how they may be related to their problems. This is particularly true for individuals raised in cultural contexts that are more collectivistic (e.g., those in East Asia) and do not promote self-evaluation or personal psychological awareness.

How, then, is a clinician committed to evidence-based practice to address the role of culture in treatment at the individual level? In the present paper, I describe three strategies to individually tailor a culturally responsive treatment plan, while remaining empirically driven. First, as a way to address the difficulty of directly assessing an individual's cultural values, I offer the alternative of using standardized measures of constructs that are relevant to the presenting problem and may be influenced by the client's ethnocultural context. This approach allows the clinician to collaboratively review the assessment data and discuss the functional and cultural meaning of score elevations with the client. Second, I highlight how clinicians can draw from research on specific cross-cultural differences to tailor their treatment interventions. Finally, I describe how to collect data throughout treatment and collaboratively work with the client to adapt treatment based on the data collected. These proposed strategies are illustrated by the following case example and the treatment interventions used to treat the client's depression.

Case Background

John* is a 44-year-old Chinese-American male who lives with his Chinese-American wife of nearly 15 years, and two young children. John is the youngest of three children, and was born and raised in the San Francisco Bay Area. John's parents immigrated to the United States from China shortly before their eldest son, John's brother, was born. At the time of treatment, John and his entire extended family (his parents, his brother and family, and his sister and family) all lived within 5 miles of one another, and jointly owned several drycleaners and buildings in the area. In addition to the family business, John and his siblings had their own jobs. John, with a master's degree in business administration from a top-tier university, worked for several years at a high-profile consulting firm before quitting to work as a part-time freelance financial consultant. John explained the reason he chose freelance work was to reduce his work stress and have time to explore career path options. Although John described his work as part-time, he admitted to often working over 60 hours in one week, and finding himself "obsessing" over the details of a project.

John initially sought treatment after noticing increased episodes of irritable outbursts towards his family (both immediate and extended), and reduced engagement in activities he used to enjoy. Further assessment indicated ongoing difficulties with reduced appetite, poor sleep, and hopelessness about the future, and confirmed a diagnosis of major depressive disorder. John also reported growing resentment towards his parents for being "hyper-controlling and unable to respect personal boundaries." As examples, John described how his parents frequently asked him about his financial situation and assets, and rarely left a conversation without expressing their disapproval of him leaving a stable, high-paying position to become a freelance consultant. John's parents also frequently called John asking what he had eaten that day, or would come unannounced with groceries or food his mom had prepared for him and his family. According to John, his parents also expected him to cater to their needs immediately when asked and appeared to disregard the importance of his existing obligations when they had a request for him. John perceived his parents as being highly intrusive, critical, and demanding.

John described himself as having high standards, and said others would often complain about the amount of time he spent ensuring his work and home projects met these standards. John also admitted frequently feeling frustrated when others, including his children, failed to meet his expectations, and then feeling guilty for being unable to "stay in control" of his emotions. At intake, John expressed feelings of exhaustion and low self-worth from his perceived failures, and hopes that CBT would teach him skills to make fewer mistakes and be more emotionally stable.

Culturally Informed Symptom Assessment

When working with clients who, like John, primarily identify with Western norms, identifying and presenting the possible role of Asian-based beliefs and values in their problems can be tricky. First, clinicians may be prone to biases based on a client's ethnic background and make assumptions that certain beliefs or behaviors are culturally normative, and may overemphasize or dismiss the clinical relevance of what is observed. Second, the topic of cultural identity is a sensitive one, and clinicians are at risk of offending the client by labeling behaviors as culturally based or assuming certain treatment modifications are necessary based solely on a client's ethnocultural background. Finally, even with self-report data on a client's acculturation level, the clinician has little guidance on how to use these data to individualize the treatment plan.

One way to circumvent some of these complexities is to provide standardized measures of constructs shown to be elevated in certain cultural populations and tend to be related to symptoms of distress. Several lines of research suggest Asians and Asian Americans are prone to self-criticism and perfectionistic beliefs (DiBartolo & Rendon, 2012; Heine, Kitayama, & Lehman, 2001; Kitayama, Markus, Matsumoto, & Norasakkunkit, 1997). By providing a measure of perfectionism and/or self-criticism, the clinician can objectively assess for potential elevations, and initiate a discussion about any elevations found and their implications for treatment.

John evidenced significant elevations in various aspects of perfectionism and self-criticism. Before discussing the measure results, I asked John what he thought the measure assessed, and he replied "Asian values?" Intuitively John was able to identify

*Patient name and identifying information have been changed.

aspects of perfectionism that may be promoted in Asian cultures (e.g., a self-critical orientation) but likely would have denied the role of culture in shaping his current difficulties. When discussing John's score elevations, we considered the meaning of the elevations to him, and how his perfectionism may be contributing to his depressive symptoms. We identified several examples of how John's excessively high standards increased his vulnerability to feelings of anger and frustration. From that discussion, we added the goal of targeting John's inflated standards of performance and had a metric for assessing change in this area. We also used this discussion to rework John's goals for treatment to becoming more comfortable with making mistakes (rather than making less of them) to help achieve feelings of emotional stability and engagement.

Although John agreed that his perfectionism significantly contributed to his depression, other Asian clients I have treated showing elevations in perfectionism have argued against its relevance to their symptoms and will even defend their beliefs as being culturally normative. In these instances, the relevance of their elevated scores to their distress is framed as hypothesis to be tested with treatment. Having such measures to develop treatment hypotheses (rather than the clinician pointing out perceived problematic processes) protects the therapeutic relationship and promotes a sense of collaboration between the clinician and therapist. As treatment progresses, data are collected to see if reductions in distress are related to reduced personal standards. For some clients, the relationship is not supported and mechanisms other than perfectionism are found to be driving their distress symptoms.

Culturally Informed Treatment Interventions

One common area of treatment concern related to culture is the intergenerational cultural conflict between immigrant parents and their U.S.- or Canadian-born children. In this instance, research findings from cultural psychology provide a rich evidence base for psychoeducation on stark East-West cultural differences. When presented with this information, clients are able to contextualize their parents' behaviors (or parents are able to contextualize their children's behaviors) and depersonalize the meaning of their actions.

John frequently mentioned his dissatisfaction with his relationship with his parents and how he had spent much of his childhood wishing his parents were similar to his Euro-American friends' parents. I presented John with research findings on how East Asian cultures promote markedly different views of the self and personal boundaries, relationships with family and others, and the functional role of self-criticism. We then reviewed the many examples in which John felt angered or hurt by his parents' behavior and translated the behaviors within the Eastern framework presented. For example, John's parents' insistence on asking him if he had eaten was no longer seen as an effort to control or infantilize him, but, rather, translated to mean "I care about you." John continued to practice translating his parents' behavior and increased his efforts to accept the cultural framework within which they operated. Over time, John found that not only did his relationship with his parents improve, but he could also "actually spend an entire day with them without wanting to tear all [his] and their hair out."

Collecting Practice-Based Evidence

Although the intervention of putting his parents' behavior in a cultural context worked well for John, there are other clients for whom the intervention may be less helpful or relevant. One way to address these individual differences is to approach treatment interventions as behavioral experiments to be tested by collecting progress and self-monitoring data. Although this recommendation is not new, and is implicit in empirically supported treatment protocols, it is particularly important when working to address cultural factors that are uniquely influencing an individual and when there is little external data on appropriateness of certain interventions.

As a way to monitor progress, John completed weekly symptom measures and weekly logs tracking various behaviors and interactions we identified as relevant to his treatment goals (e.g., number of hours slept, number of hours worked, overall stress levels). With each problem behavior or reaction, we worked to identify the processes that appeared to be maintaining the problem and considered and tested alternate ways to respond to triggering events. When he reported beliefs or behaviors commonly reported by Asian Americans (e.g., difficulties with assertiveness and expressing negative emotions), we first normalized the beliefs and behaviors by discussing the different social goals and processes promoted in Asian cultures, but then questioned whether they interfered or helped him move towards his treatment goals. When the answer was unclear, we would devise behavioral experiments to test the helpfulness of an alternate behavior and review data collected from the experiment.

For example, with John, we found increasing his ability to be mindful of negative emotions and willingness to experience them proved to be highly helpful in improving his relationships with family members. We also found that John's active choice to not express his anger felt more empowering to him than his past reactions of feeling forced to not express his anger, or the alternative choice of expressing his frustrations. This example highlights how cultural variables may have influenced the strategies that worked best for John and how the use of behavioral experiments allowed the discovery of these strategies without cultural biases or assumptions. By the end of treatment, John showed significant reductions in levels of perfectionism and self-criticism, reported improved relations with his wife and extended family, no longer met criteria for major depressive disorder, and prided himself on being more engaged, mindful, and flexible in his life.

The strategies presented in this paper offer a flexible framework in which clinicians can incorporate empirically based treatment strategies (e.g., exposures, mindfulness training, cognitive restructuring) while working with an individualized, culturally sensitive case formulation. Although John's treatment did not follow a specific protocol, the emphasis on ongoing assessment and data-driven interventions reflects the ethos of empirically supported treatments and allows for the incorporation of cultural factors at the level of the individual. The case also illustrates the importance of taking a curious stance to therapy, and the benefits of addressing the role of cultural factors collaboratively with the client and through data collection. Rather than assuming particular cultural constructs are relevant to a client, the clinician and client work together throughout treatment to collect data and collaboratively decide whether a particular belief or behavior is culturally adaptive or functionally impairing.

References

Bernal, G., Jimenez-Chafey, M. I., & Rodriguez, M.M.D. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice, 40*, 631-638.

Bernal, G., Bonilla, J. & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for cultural adaptation and development of psychosocial treat-

ments with Hispanics. *Journal of Abnormal Child Psychology, 23*, 67-82.

DiBartolo, P.M., & Rendon, M.J. (2012). A critical examination of the construct of perfectionism and its relationship to mental health in Asian and African Americans using a cross-cultural framework. *Clinical Psychology Review, 23*, 139-152.

Hall, G., Hong, J.J., Zane, N., & Meyer, O. (2011). Culturally competent treatments for Asian Americans: The relevance of mindfulness and acceptance-based psychotherapies. *Clinical Psychology: Science and Practice, 18*, 215-231.

Heine, S. J., Kitayama, S., & Lehman, D. R. (2001). Cultural differences in self-evaluation: Japanese readily accept negative self-referent information. *Journal of Cross-Cultural Psychology, 32*, 434–443.

Hinton, D. E., Hofmann, S. G., Rivera, E., Otto, M. W., & Pollack, M. H. (2011). Culturally adapted CBT for Latino women with treatment-resistant PTSD: A pilot study comparing CA-CBT to applied muscle relaxation. *Behaviour Research and Therapy, 49*, 275–280.

Hinton, D. E., Pham, T., Tran, M., Safren, S. A., Otto, M. W., & Pollack, M. H. (2004). CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: A pilot study. *Journal of Traumatic Stress, 17*, 429–433.

Hinton, D. E., Rivera, E. I., Hofmann, S. G., Barlow, D. H., & Otto, M. W. (2012). Adapting CBT for traumatized refugees and ethnic minority patients: Examples from culturally adapted CBT (CA-CBT). *Transcultural Psychiatry, 49*, 340–365.

Hwang, W. (2006). The psychotherapy adaptation and modification framework: Application to Asian Americans. *American Psychologist, 61*, 702-715.

Kitayama, S., Markus, H. R., Matsumoto, H., & Norasakkunkit, V. (1997). Individual and collective processes in construction of the self: Self-enhancement in the United States and self-criticism in Japan. *Journal of Personality and Social Psychology, 72*, 1245–1267.

Lau, A.S. (2006). Making a case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice, 13*, 295-310.

Pan, D., Huey, S. J., & Hernandez, D. (2011). Culturally adapted versus standard exposure treatment for phobic Asian Americans: Treatment efficacy, moderators, and predictors. *Cultural Diversity and Ethnic Minority Psychology, 17,* 11–22.

Sue, S., Zane, N., Hall, G. C. N., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525-548.

Voss Horrell, S. C. (2008). Effectiveness of cognitive-behavioral therapy with adult ethnic minority clients: A review. *Professional Psychology: Research and Practice, 39*, 160-168.

Zayfert, C. (2008). Culturally competent treatment of posttraumatic stress disorder in clinical practice: An ideographic, transcultural approach. *Clinical Psychology: Science and Practice, 15*, 68-73.

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Correspondence to Janie J. Hong, Ph.D., San Francisco Bay Area Center for Cognitive Therapy, 5435 College Ave Ste 108, Oakland, CA 94618-1590; jjh@sfbacct.com

Treatment for American Indians and Alaska Natives: Considering Cultural Adaptations

Brenna Greenfield, ***University of New Mexico***

Monica C. Skewes, ***Center for Alaska Native Health Research, University of Alaska Fairbanks***

Renda Dionne, ***Indian Child and Family Services***

Betsy Davis, ***Oregon Research Institute***

Mary Cwik, ***Center for American Indian Health, Johns Hopkins University***

Kamilla Venner, ***University of New Mexico***

Annie Belcourt-Dittloff, ***University of Montana***

American Indians and Alaska Natives (AI/ANs) are citizens of sovereign tribal nations and comprise 1.7% of the U.S. population (5.2 million; U.S. Department of Commerce, 2012). They represent a multitude of tribes and traditions and have endured genocide, forced assimilation and relocation by colonizers and the U.S. government (Shelton, 2001). AI/ANs face significant health disparities, including increased rates of diabetes, PTSD, substance use disorders, infant mortality, and suicide (Beals et al., 2005; Chinitz & Christian, 2009). The U.S. has a responsibility to provide health care to AI/ANs based on agreements in which tribes ceded land to the U.S. government in exchange for health care, yet health services for AI/ANs remain chronically underfunded (Chinitz & Christian). What can therapists and researchers do to address these injustices? One urgent need is to ensure that available mental health treatment is appropriate for and acceptable to AI/ANs. Cultural adaptations of evidence-based treatments (EBTs) make important advances in this direction.

What Is Cultural Adaptation?

Cultural adaptation has been defined as "the systematic modification of an EBT or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009, p. 362). Cultural adaptations include changes to treatment processes or content such as additions or deletions of treatment components, changes in the intensity of treatment, translation or use of local language and cultural idioms (Bernal, 2009). A meta-analysis of 76 culturally adapted treatments found that the most common adaptations involved the integration of cultural values and concepts and resulted in interventions that were more effective than unmodified EBTs (Griner & Smith, 2006).

When to Develop or Use Cultural Adaptations

Interventions for AI/ANs should integrate cultural knowledge and traditional practices with the best available science from their inception (Gone, 2004; Trimble & Mohatt, 2002). Some AI/AN researchers posit that returning to indigenous ways of knowing and traditional healing practices may be an effective solution to mental health problems (Gone & Calf Looking, 2011). However, the time and financial resources needed to develop, implement, and test interventions in partnership with AI/AN communities are sometimes not available, or treatment is needed before an