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Cultural Adaptations of Psychotherapy: Therapists' Applications of Conceptual Models with Asians and Asian Americans

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Abstract

Although conceptual models of cultural adaptations of psychotherapy have been developed, little is known about how therapists apply these models in clinical practice. The purpose of the current study was to examine, using a directed content analysis, how therapists culturally adapt cognitive-behavioral therapy (CBT), one of the most widely used evidence-based approaches, for application with clients of Asian ancestry. The study also examined if there were major differences in adaptation strategies between therapists who practice in the United States ($N = 9$), a predominantly individualistic society as opposed to those who practice in Japan ($N = 6$), a predominantly collectivistic society. Semi-structured, open-ended interviews revealed that interdependent conceptualizations of the self and indirect communication were addressed by therapists in both countries, and therapist credibility issues were addressed only by therapists in the United States. These results imply that when culturally adapting psychotherapy, therapists incorporate elements of conceptual models that are relevant to their clients' cultures.

Keywords

Psychotherapy; cognitive-behavioral therapy; cultural adaptations; Asian Americans; Japan; directed content analysis

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Conceptual models of cultural adaptation of psychotherapy have been available for over 30 years. Early cultural adaptation models focused on therapist characteristics, such as ethnic and language match with clients (Sue et al., 1991), and modifying therapy methods to be compatible with clients' worldviews, such as incorporating indigenous healers, religious leaders, and family members into treatment (Sue, 1998; Sue & Zane, 1987). Another comprehensive early model identified eight dimensions of interventions (language, persons, metaphors, content, concepts, goals, methods, and context) that could be culturally adapted (Bernal, Bonilla, & Bellido, 1995). Several meta-analyses of empirical studies generally have demonstrated that culturally adapted interventions produce better outcomes among ethnic minority clients than unadapted interventions (Hall & Yee, 2014; Hall, Ibaraki et al., 2016; Smith & Trimble, 2016). Yet, it is unclear how the effects of these conceptual models and empirical studies have influenced the way therapists actually address cultural issues in treatment. In their meta-analysis of 79 studies of cultural adaptations of psychotherapy, Smith and Trimble (2016) concluded that there were few instances in which clinicians' cultural adaptations were explicitly based on these conceptual models.

It is unlikely that most therapists strictly adhere to manuals for evidence-based treatments without modification (Kendall & Beidas, 2007). It is also unlikely that most therapists use a complete "bottom up" approach without grounding it in an evidence-based conceptual framework (Hwang, 2006). Most therapists probably employ the primary elements of an evidence-based framework, adding cultural adaptations for particular clients (Leong & Lee, 2006).

One ethnic group that has received relatively limited attention in the cultural adaptation literature is people of Asian ancestry (Hall, Ibaraki et al., 2016). People of Asian ancestry constitute the largest ethnic group worldwide and are the fastest growing ethnic group in the United States (growing from 11.9 million in 2000 to 20.4 million in 2015), as well as the largest group of new immigrants to the United States since 2010 (Pew Research Center, 2013). Yet, there is a paucity of research on evidence-based practice with people of Asian ancestry. Part of the reason for the limited evidence base for people of Asian ancestry is the well-documented and persistent finding that Asian Americans underutilize mental health services more than any other ethnic group relative to their representation in the population (SAMHSA, 2015; Sue et al., 1991).

In addition to underutilizing mental health services, Asian Americans have been found to have higher rates of premature termination and to attend fewer treatment sessions than European Americans (Owen, Imel, Adelson, & Rodolfa, 2012; Sue et al., 1991). Premature termination may prevent clients from receiving a therapeutic dose of treatment (Ibaraki & Hall, 2014). The underutilization of mental health services by Asian Americans suggests that there are two critical issues to address when Asian Americans do enter mental health services: (a) creating a therapeutic alliance; and (b) engagement in treatment. A therapeutic alliance and treatment engagement may prevent premature termination (i.e., clients unilaterally dropping out of treatment without informing the therapist) and increase the number of treatment sessions that Asian American clients participate in.

Sue and Zane (1987), in a classic conceptualization, suggested that establishing therapist credibility and gift giving are crucial to the creation of a therapeutic alliance in initial psychotherapy sessions. Therapist credibility facilitates the therapeutic alliance by engendering a client's trust in the therapist's expertise and ability. Credibility can be established in two ways. First, it may be *ascribed* by Asian and Asian American communities to a therapist because of the therapist's assumed cultural expertise. A client's shared ethnicity with a therapist may imply that a therapist has cultural expertise. In addition, credibility may also be *achieved* by a therapist by demonstrating cultural competence, regardless of their ethnic background. Cultural competence involves the ability to demonstrate skill in providing culturally relevant help to a client (Sue et al., 2009).

A culturally competent therapist may also recognize the cultural relevance of receiving immediate, tangible benefits in psychotherapy, which for Asian Americans is analogous to Asian cultural gift giving rituals (Sue & Zane, 1987). Receiving immediate benefits is important in preventing premature attrition from psychotherapy. People of Asian ancestry may expect immediate attention to their presenting problems (e.g., somatic complaints) and may terminate treatment if the therapist does not attend to these problems or attempt to reconceptualize them (e.g., somatic complaints are emotionally based). Gift giving in psychotherapy may take the form of symptom reduction (e.g., anxiety, depression), reassurance, skills acquisition, and goal setting (Sue & Zane, 1987). The emphasis is on adapting therapy to address the client's concerns rather than having the client adapt to an established psychotherapy structure (e.g., focusing on thoughts and feelings rather than somatic complaints). In addition to a cultural rationale, immediate benefits are important because Asian American clients tend to experience greater levels of distress by the time they come to treatment than other groups (Kearney, Draper, & Barón, 2005; J. Kim, Saw, Zane, & Murphy, 2014).

Once a therapeutic alliance is established via therapist credibility and gift giving, engagement in treatment may be enhanced by culturally adapting the content of psychotherapy. Cultural adaptation is important because Asian Americans tend not to perceive psychotherapy favorably or as personally beneficial relative to European Americans (J. Kim & Zane, 2016; Wong, Beutler, & Zane, 2007). Moreover, a shared understanding between therapist and client of the cause of a problem is associated with Asian Americans viewing treatment more favorably (B. Kim, Ng, & Ahn, 2005).

The most commonly culturally adapted intervention is cognitive-behavioral therapy (CBT; Hall et al., 2016). The premise of CBT is that a person's perception of an experience has a larger influence on their emotions than the experience itself (Beck, Rush, Shaw, & Emery, 1979). Maladaptive cognitions and behaviors contribute to the maintenance of emotional distress (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). Maladaptive cognitions include negative beliefs (schemas) about the self, the world, and the future. Maladaptive behaviors often involve a component of avoidance. The treatment approach involves learning new thinking and behavioral responses to use when faced with difficult emotions (Ledley, Marx, & Heimberg, 2010). In contrast to psychoanalytic therapy, CBT is problem-oriented, present focused, designed to resolve symptoms quickly, and can be manualized. Average courses of treatment are expected to last around 12–16 weekly sessions.

Recent conceptualizations of CBT have involved conceptions of the self as a focus of cultural adaptation (Hall, Hong, Zane, & Meyer, 2011; Hwang, 2006; Leong & Lee, 2006; Shea & Leong, 2013). Conceptions of self differ in cultural values between persons of European ancestry and persons of Asian ancestry. Whereas most Western models of psychotherapy focus on the individual self, Asian and Asian American conceptualizations of the self incorporate others, such as family or community members; effective therapeutic approaches may need to incorporate a social context that extends beyond the individual self (Hall et al., 2011; Hwang, 2006; Leong & Lee, 2006; Shea & Leong, 2013).

This interdependent conceptualization of the self influences how one copes with distress. Western independent models of psychotherapy emphasize direct coping, which may focus on changing the source of stress (e.g., communicating one's feelings to someone else). In contrast, the goal in interdependent cultures is to maintain group harmony. In order to preserve group harmony, an indirect approach to distress may be required, such as accepting a situation and focusing on the strength required to be nonreactive (Hall et al., 2011). The group harmony that is maintained by indirect communication and coping may serve to save face, which is a greater concern among Asian Americans than among other groups (Leong et al., 2017). Evidence indicates that both European Americans and Asian Americans prefer direct coping (Lam & Zane, 2004). However, European Americans had significantly higher scores than Asian Americans on a measure of direct coping whereas Asian Americans had significantly higher scores than European Americans on a measure of indirect coping. Similarly, in an analogue study, both direct and indirect communication had positive effects on psychotherapy process for Asian Americans (B. Kim & Park, 2015). Thus, indirect coping and communication may be needed to supplement direct coping and communication for psychotherapy to be culturally relevant for Asian Americans.

To our knowledge, there is only one published study examining the content within actual psychotherapy sessions for clients of Asian ancestry (Ibaraki & Hall, 2014). Records of Asian Americans in a college counseling center were studied to determine the effects of therapist-client ethnic match and psychotherapy session content on attrition from psychotherapy. Those clients who saw an Asian American therapist attended significantly more psychotherapy sessions than those who were ethnically mismatched. Although therapist credibility was not assessed, it is possible that Asian American therapists were viewed as more culturally credible than non-Asian therapists. In addition, Asian American clients attended significantly more psychotherapy sessions when academic concerns were discussed, regardless of therapist ethnicity. Because of the strong emphasis on academic achievement among many Asian American families, the tangible goal of improving academic performance may be a greater priority for many Asian American college students than personal mental health, per se. Thus, a therapist's focus on academic issues for Asian American college students may constitute a form of gift giving. Nevertheless, it is unknown if the therapists in the study deliberately attempted to provide immediate benefits to their Asian American clients by discussing academic issues.

The cultural emphasis on interdependence is more pronounced among Japanese people than among Asian Americans (Oyserman, Coon, & Kemmelmeier, 2002). Moreover, the use of CBT is well-established in Japan. Japan has been a leader in the Asian CBT Network since it

was established in 1990 (Andrews & Oei, 2016). The purpose of the network has been research and training on CBT in Asia. The Japanese Association for Cognitive Therapy has existed for the past 15 years and CBT outcome research in Japan has been conducted on depression, anxiety disorders, and personality disorders (Ono et al., 2011). National health insurance coverage of CBT for mood disorders began in Japan in 2010, which has supported research, training, and practice. Cultural adaptations of CBT are particularly important in Japan because psychopathology is strongly influenced by the social context, which is at odds with the individual emphasis of CBT (Draguns, 2013). However, similar to the United States, it is unknown how therapists in Japan culturally adapt CBT.

The purpose of the current study was to identify how therapists in the United States and Japan culturally adapt CBT, one of the most widely used evidence-based approaches, for application with clients of Asian ancestry. We also examined if there were major differences in adaptation strategies between therapists who practice in the United States, a predominantly individualistic society as opposed to those who practice in Japan, a predominantly collectivistic society. Our approach was a directed content analysis (Hsieh & Shannon, 2005) to examine whether concepts from theoretical models influence therapists' clinical work, specifically therapist credibility, gift giving, interdependent conceptualizations of the self, and indirect communication (Hall et al., 2011; Sue & Zane, 1987). Unlike conventional content analysis, which is appropriate when existing theory is limited, directed content analysis is appropriate when theories exist but it is unclear how theories guide practice (Hsieh & Shannon, 2005). We developed a semi-structured interview to understand how therapists culturally adapt CBT for Asian and Asian American clients with depression (Appendix I). Depression is a common problem for which CBT is a well-established treatment (Cuijpers, van Straten, Andersson, & van Oppen, 2008). The data from the semi-structured interview were coded by two coders who sought to identify the four concepts and by a third who was unaware of the theories guiding the study.

Method

Participants

Therapist participants were recruited by utilizing purposive sampling techniques (Devers & Frankel, 2000). Known expert CBT practitioners who worked with Asian American clients or clients in Japan were invited to take part in this study, regardless of geographic location. The Japanese participants were recruited via contacts of two leading Japanese CBT researchers. The United States participants were recruited via professional listservs and via contacts of the authors of this study.

Criteria for participation were based on clinician self-report that they: (a) had treated a minimum of 10 Asian or Asian American clients over the course of their practice in psychotherapy; and (b) used CBT in the majority of their caseloads. To further identify appropriate participants, those who were interviewed were asked to refer any colleagues who were appropriate for the study.

A total of 17 therapists (11 in U.S. and 6 in Japan), all trained at the doctoral level, were asked to complete a demographic questionnaire and were interviewed using a semi-

structured interview guide. Written informed consent was obtained from each participant prior to the interview. United States participants were paid $100 for their time and effort. Because the Japanese therapists had been invited to participate by leading CBT researchers, they considered participation to be an honor and did not expect to be paid. The study was approved by the Institutional Review Boards of the University of Oregon and the University of California, Davis.

One therapist in the United States could not complete the study due to time constraints. Another therapist in the United States began the study but decided that they were not a good fit for the study and withdrew. Of the United States therapists who completed the study, seven were Asian Americans and two were European Americans. All were born in the United States. The Japanese therapists were all of Japanese ethnicity. Therapist characteristics are presented in Table 1. The United States therapists were somewhat younger than the Japanese therapists. Consistent with this age difference, United States therapists had less experience as therapists than the Japanese therapists.

Interview Procedures and Protocol

We developed a semi-structured interview guide with open-ended questions. The main topics of the semi-structured interview included a discussion of: (a) the clinician's training background in CBT; (b) the types of modifications made to standard CBT to better fit Asian or Asian American clients; (c) challenges in using CBT with Asian or Asian American clients; and (d) a specific case example in which the clinician used CBT with an Asian or Asian American client who was depressed. These general topics were included to understand how therapists culturally adapt CBT for Asian and Asian American clients without specific questions that might prime them about the concepts we were interested in. All interviews in the United States were conducted over telephone or Skype because therapists were in remote areas of the country. Interviews in Japan were conducted in person because of geographic proximity. Prior to the interview, participants completed a questionnaire to assess demographic background and information on typical caseload. The interviews were designed to last one hour, and interviewers assured that the interviews adhered to the time limits.

Two female Asian Pacific American interviewers conducted the U.S. interviews. One was a Pacific Islander clinical psychology postdoctoral fellow with training in Asian American mental health. The other was a Chinese American female advanced clinical psychology Ph.D. student with training in CBT and Asian American mental health who is one of the study's coauthors. In Japan, interviews were conducted in English by the first author of this study, a Japanese American male clinical psychologist with 40 years of experience in psychotherapy and Asian American psychology. Language translation of the interviews was provided by one of this study's coauthors, who is a male Japanese bilingual clinical psychologist with expertise in CBT. This Japanese coauthor also was one of the participants in the study and assisted with the qualitative data analyses and interpretation. Audio recordings of all interviews were transcribed manually by three research assistants.

Data Analyses

The first author of this study reviewed transcripts for each of the 15 therapists who completed the interview and identified common themes. Interview transcripts were then independently coded by a coauthor of this study who is a Chinese American female graduate student with training in CBT and Asian American mental health. She approached the data seeking themes based on her knowledge of the conceptual literature (Hall, Hong, Zane, & Meyer, 2011; Sue & Zane, 1987), and intercoder reliability was assessed between the two coders. Interrater reliability was assessed with two-way random model, absolute agreement, intraclass correlation coefficients (ICC), which account for both degree of correlation and agreement between coders (Berkman & Reise, 2011; Shrout & Fleiss, 1979). Guidelines for levels of clinical significance of ICCs are: (a) < .40 is considered poor; (b) .40 to .59 is considered fair; (c) .60 to .74 is considered good; and (d) .75 to 1.00 is considered excellent (Cicchetti, 1994).

To minimize bias, we also had a qualitative expert who was not part of the research team independently code the data. The expert is a Japanese American female clinical psychologist with approximately 40 years of experience in psychotherapy and Asian American psychology. This expert was generally aware of the broader research topic of the study (i.e., a qualitative study about cultural adaptations to CBT) but was not aware of more specific aspects of the study (e.g., conceptual models guiding the study), nor the themes identified by the first author and coauthor. We assessed intercoder reliability between the expert and first author.

Results

Four common themes based on theoretical models were identified: (a) therapist credibility; (b) gift giving; (c) interdependent conceptualizations of the self; and (d) indirect communication.

Therapist Credibility

Therapist credibility involved the persons dimension of the Bernal et al. (1995) model of cultural adaptation. Credibility was a typical theme among United States therapists. The coauthor coders agreed that none of the Japanese therapists reported addressing credibility in therapy, whereas the coauthor coders agreed that seven of the nine United States therapists did so. The ICC for the first author’s and coauthor’s ratings were .87.

Being an Asian American enhanced the ascribed credibility of some therapists. One Asian American female therapist (US5) indicated, “I'm thinking like that to deal with Asian populations, especially Japanese populations, they need to see me in the sense of being aware that I am also in the community so that it's not just someone behind the door that can never know what it's like.” Another Asian American female therapist (US7) indicated, “… there are two different camps of Asian Americans…, one that’s because of mental health stigma, actually don’t want an Asian American therapist because it feels a little bit too close to home, and they prefer that psychological distance of seeing a non- Asian American therapist. But then there’s a huge group that are really craving Asian American therapists

because they think that they'll be able to relate to them better, they have a unique understanding of Asian American psychology, etc. That's the group that I'm attracting [in my practice]."

Consistent with therapist US7's view, a European American male therapist (US8) was perceived as credible *because* he was White. "I've come to think of [being white] as a face-saving gesture. That they're wanting to talk about some things, but it's sort of uncomfortable, they're ashamed about it, that talking with someone who's either a member of their community, or looks like a member of their community might be a little too much. I haven't asked people specifically, you know? 'Are you trying to save face here?' But people have said things, like 'Oh I didn't want to meet with a Japanese therapist because, you know, it's a small community, we all know each other, and stuff like that.'"

An ascribed credibility challenge for some Asian American female therapists was being or appearing young. No American male therapists expressed this concern. For some Asian American clients, older age and male gender are associated with credibility (Sue & Zane, 1987). Emphasizing therapist expertise was a method of addressing the age issue. An Asian American female therapist (US1) indicated, "I try to communicate a level of authority to try to gain more credibility with them. This is important to me because I look younger than I am. A lot of the clients that I've treated in the past have been older than me so with a lot of clients I do find myself asking to be called Dr. ___ or emphasizing my training more so to try to get some of that credibility." Another Asian American female therapist (US11) indicated, "I think that the world that I occupied had to be negotiated very carefully because I was much younger than the clients I worked with, so to assume this role as teacher in that dynamic was kind of strange, difficult to navigate. The way that the relationship gets negotiated in those settings when the clinician is like in my case, I'm U. S. born, and, obviously, there's a lot of cultural difference because they're immigrants, recently arrived immigrants, very little experience with the mental health care system, and they're seeing me, who was born here, and even though we're speaking in the same language, we're worlds apart, in terms of our history and in terms of our lifestyles. I would say that in the initial engagement period, there was a lot of demonstrating how I could be useful and kind of working what our relationship would look like. In some cases it was like 'I'm the cultural expert, and you're here because you were referred to me, and you have to be here, the school is requiring that you come to see me.'"

In addition to the ascribed credibility of ethnicity or expertise, credibility was also achieved by creating confidence in the therapeutic approach. A European American female therapist (US9) indicated, "…it's really important, I think, to present myself as not an 'expert' as in you know, 'I'm going to tell you what your problem is', but presenting more as a confident way, because I think it is important for the therapist to present with a way that shows confidence, like 'Hey, this is going to work. This is going to be helpful for you.'"

An Asian American female therapist (US10) also discussed the importance of confidence in the therapeutic approach to achieve credibility. "I hear this a lot with Asians, they don't know if this is going to help. They want it to, but they don't quite trust. Is this voodoo science or something? They don't quite know if this is going to help. But they're willing to

give it a little bit of a chance." This therapist tried to instill confidence with evidence. "I gave her some information on the literature, how this can help. So she has this idea that 'This is supposed to be effective of all the treatment modalities'. Maybe it built up her expectations that it would be a lot more clear and concrete." Credibility was also achieved by the therapist creating realistic expectations about results. "I know and I always have to say, 'Well, it's more like an up and down, like it's a jagged line up, not a straight line up,' and I think that's hard for her. I don't know if this is an Asian thing, but she really wants to see work for her money. She kind of needs to know that she's making the right decision and it's a cost-benefit thing for her. She's very conscious of how much time and money she's spending on the treatment."

Gift Giving

Gift giving involved a therapy method to achieve a treatment goal from the Bernal et al. (1995) model of cultural adaptation. Gift giving was a variant theme among Japanese therapists and a typical theme among United States therapists. The ICC for the first author and coauthor's ratings were .12. Because of the low reliability of gift giving, identification of this theme is considered exploratory.

An Asian American female therapist (US1) explicitly addressed the construct. "I am cognizant of gift giving in the first session. I was inspired by Sue and Zane. I think about making sure the client leaves the first session feeling hopeful, and also that I'm providing them with something that they will find useful to try to make sure that they stay in therapy and come back to the next session." A Japanese male therapist (J2) indicated that he tried to produce immediate results by initially focusing on behavioral rather than cognitive aspects of CBT.

Interdependent Conceptualizations of the Self

Interdependent conceptualizations of the self involved the social context, therapist-client agreement on treatment goals, and cultural metaphors dimensions of the Bernal et al. (1995) cultural adaptation framework. The frequency of the interdependence theme differed by country. Whereas the two coauthor coders agreed that five of the six Japanese therapists reported addressing interdependence in therapy, the coauthor coders agreed that only four of the nine United States therapists did so. Thus, interdependence is a typical theme among Japanese therapists and a variant theme among United States therapists. The ICC for the first author's and the coauthor's ratings on this theme were .45.

The individual focus of CBT was typically expanded to accommodate clients' social context. A Japanese female therapist (J6) who had worked with Japanese clients in Japan and the United States described the importance of considering clients' social networks. "With Japanese clients both in United States and here, I think you need to be more aware of the context in which the person lives, works, and teaches and all kinds of activities, you need to actually identify the person's social network and it's very difficult to deal with the each individual case individually and independently of the child or the adult's living conditions. So, I often, very often, work with parents if it's a child case, even in schools. If it's in school I work with the teachers. So, you almost contextualize a person within the sociocultural and

familial environment. Without it, it's very, very difficult to just deal with autonomy of the individual."

Understanding and adjusting to prescribed social roles in society was also an important component of interdependence in Japan. One Japanese male therapist (J1) described a highly skilled female college gymnast who was experiencing major depressive disorder and generalized anxiety disorder. The basis of this distress was conflicts with more senior members of the gymnastics team who did not see her as showing proper respect to them. The therapist employed a social skills intervention to help the client fit into her social role on a team by understanding a Japanese tradition. "The skills needed in our culture are something different from the U.S. We call it the *senpai-kohai* relationship. *Senpai* is the older member and *kohai* is the younger member. The *kohai*, the younger member, has to show respect for the older member in a very strict way like their teachers or older people." The intervention, which was successful in reducing depression and anxiety, involved understanding these social roles and treating her senior teammates with respect.

A second Japanese female therapist (J4) discussed a client who was a researcher in his 40s and was experiencing depression. The source of his depression was role conflicts. He felt intense pressure to succeed in his role as the oldest son in his family. "*Chonan*, the oldest boy…..has (a) special role to take care of their parents." Part of taking care of his parents was economic success, so that his parents would not worry about him. Yet, he felt that his ability to succeed at work was compromised by competition with colleagues who did not share his research interests. The intervention, which was successful in reducing depression, involved: (a) developing more realistic expectations of being a *chonan* and reducing the pressure to succeed; and (b) balancing his own interests with those of the company.

Although interdependence was a variant theme among the United States therapists, it was typically discussed in the context of the family norms that may conflict with CBT principles. An Asian American female therapist (US3) indicated, "I think some shifting of some core beliefs could be hard. I say some. When they are intertwined so much with family...If someone's core belief is so much with 'I need to be this way because of my family, because my family needs me to be this way.' As a CBT clinician I could easily say, 'Yeah, but look at how that's impacting you, you need to change that.' But culturally, that doesn't even make sense. So, I think some core beliefs, we'll have to be very sensitive and aware that it's so intertwined, that is just may not be possible."

Similarly, a European American female therapist (US9) indicated, "Another thing that I try to do is when I talk with people on cognitive distortion, I'm really careful about even using that as a label, because it can give an idea to a client that there's something wrong with their thinking. Sometimes they have certain thoughts because of their cultural background, or because of a value that was instilled in them that might just be different than mine, or the way that I grew up. I always try to check out their cultural or their family influences on their thinking patterns. So, okay, you're thinking this is a thought that is impacting your mood. And so, where did that thought come from? Is there a cultural influence? Is there a family influence to this?"

An Asian American female therapist (US10) also described how family influences can interfere with CBT. “I think the family has a huge impact on my Asian clients, because they’re so closely attached. When the family is not supporting the client, or the change, the client sort of just stagnates at some point…. something I’ve seen as a barrier is family entanglements and enmeshed boundaries within the Asian culture. If my client has a lot of that going on where they can’t individuate, they’re very close, they’re very culturally enmeshed with their family, then I feel like CBT isn’t always getting to the core issue. Even if I do the surface skills training, they tend to resist changing on a deeper level. With those people, I tended more towards racial cultural identity model to explain why they’re having trouble moving forward. Unfortunately, a lot of those clients don’t stick, the ones with a lot of family issues: enmeshment.”

Indirect Communication

Indirect communication involved the therapist’s knowledge of the cultural content of communication and methods of communicating from the Bernal et al. (1995) cultural adaptation model. Indirect communication was a variant theme in both countries. The coauthor coders agreed that only one of the six Japanese therapists reported addressing indirect communication and the coauthor coders agreed that only two of the nine United States therapists did so. The ICC for the first author’s and coauthor’s ratings for this theme was .70.

In both countries, indirect communication involved clients not expressing themselves. An Asian American female therapist (US3) described bulimia as her client’s indirect way of communicating. “…we later found out that her bulimia is really just a way for her to exercise self-control. It comes and goes throughout her life where she's upset about something and it has to do with her depression. So, we're talking about her depression, and how sad she's feeling, or she's feeling overwhelmed, or something's going on. Her food issue is actually the way that she communicated.”

An example in Japan of indirect communication is clients not directly discussing complaints with the therapist. The clients’ seeking therapy indicates that they are distressed but they may not directly discuss the distress. Thus, the therapist needs to become more direct. A Japanese male therapist (J3) indicated, “Japanese patients tend to not declare their complaints especially to their therapist so the therapist has to see if they have any complaints or some bad feelings with therapy, so the Japanese therapist can see those kind of issues in terms of this country.”

An Asian American male therapist (US2) discussed silence as an indirect method of coping with stress in the therapy session. “Like telling your client, ‘Go ahead and take a few minutes, it's okay if we have some silence.’ Then it could potentially be problematic. Because if the client is very heavily therapeutized, then they know how to talk about their feelings, and know what to say in therapy. But if they're not, they need extra time and therapy to formulate those thoughts and to formulate those feelings. And this gets into the basic communication differences between Western and Eastern culture, and in terms of direct and indirect, verbal vs. nonverbal…. But (I)…focus on those different aspects of communication. The nonverbal, the indirect.”

Corroboration of Themes by Independent Expert

The expert identified the following seven themes: Adaptations to Assessment, Adaptations in Communication, Adaptations to CBT Techniques/Components, General Cultural Adaptations, Additional Culture-Related Intervention Strategies, Consideration of Mindfulness, and Therapist Self-Awareness. These themes were generally broader in scope than the four aforementioned themes identified by the study authors, though this was not unexpected given that the expert was only aware of the general research topic but not the specific research questions that this study was designed to address. Within each of the seven themes, the expert identified several subthemes that were illustrative examples, and the subthemes corresponded with the main findings identified by the first author and coauthor.

Therapist credibility was consistent within subthemes for General Cultural Adaptations (i.e., communicate therapist authority) and Additional Culture-Related Intervention Strategies (i.e., connect with the Asian community). Gift giving appeared within themes of Adaptations to CBT Techniques/Components (i.e., more psychoeducation, be flexible, not cookbook approach, adapt ordering/emphasis of techniques) and of General Cultural Adaptations (i.e., give a gift in the first session–instill hope/connection), and Additional Culture-Related Intervention Strategies (i.e., may do management/support for immigrant clients). Interdependent conceptualizations of the self appeared in the subthemes within General Cultural Adaptations (i.e., be aware of/address sociocultural and family context) and Additional Culture-Related Intervention Strategies (i.e., include/consult with others beyond individual client). Indirect communication was apparent within Adaptations in Communication (i.e., utilize silence more, combine verbal and nonverbal communication techniques, adjust to less linear communication).

Interrater reliability was again assessed with two-way random model, absolute agreement ICCs. The ICCs for the first author's and independent expert's coding were: therapist credibility = .46, gift giving = .39, interdependent conceptualizations of the self = .61, and indirect communication = .59. These ICCs for each theme were in the range of the ICCs for the first author and the coauthor. Consistent with the first author's and coauthor's coding, the independent expert identified none of the Japanese therapists as addressing credibility in therapy, identified interdependence as a typical theme among Japanese therapists and a variant theme among United States therapists, and indirect communication as a variant theme in both countries. In contrast to the first author's and coauthor's coding, the independent expert coded credibility as a variant theme among United States therapists. The independent expert also coded gift giving as a typical theme among both Japanese and United States therapists.

Discussion

The purpose of this study was to identify how therapists in two countries incorporate components of conceptual models of psychotherapy into their cultural adaptations of CBT with Asian and Asian American clients. This is the first study to our knowledge to examine the specific methods that practicing therapists use to culturally adapt CBT for Asian and Asian American clients. The results of this study indicate that CBT therapists in the United States and Japan do incorporate components of conceptual models of psychotherapy

adaptations into their work with Japanese and Asian American clients. These cultural adaptations presumably facilitate the creation of a therapeutic alliance and engagement in treatment. All therapists in both countries culturally adapted CBT. Psychotherapy content adaptations involving interdependent conceptualizations of the self and indirect communication were addressed by therapists in both countries. Therapist credibility was addressed only in the United States. However, gift giving could not be reliably identified.

Establishing therapist credibility facilitates the therapeutic alliance by engendering the client's trust in the therapist's expertise. Therapist credibility among therapists in the United States was both ascribed and achieved. It is possible that credibility was more of an issue in the United States than in Japan because authority structures are looser in the United States. Authority figures, such as psychologists, do not necessarily have inherent credibility. In our United States sample, the therapist's ethnicity was a form of ascribed credibility. For some clients, having an Asian American therapist signaled cultural expertise. For others, having a non-Asian therapist signaled a way to save face by not having their problems known in the Asian American community. Ascribed credibility occurred for younger therapists when they emphasized their expertise. Therapists' credibility also was achieved by instilling confidence in the therapeutic approach. Confidence in the therapeutic approach is important, as Asian Americans' intentions to seek help are associated with the perceived benefits of treatment (J. Kim & Zane, 2016).

Therapist credibility was not a theme in Japan. This may be because all Japanese therapists and clients were Japanese, which may render moot clients' concerns about therapists' cultural competence. Moreover, the Japanese therapists were older and more experienced than the United States therapists. Japanese therapists may also be modest about explicitly discussing their expertise. It is additionally possible that Japanese therapists do not need to establish credibility because it is inherently ascribed in their societal role as a psychologist. There is a common Japanese saying that "*nou aru taka wa tsume o kakusu,*" which means, "The strong hawk covers one's nails." The strong hawk does not need to show others its weapons/nails directly, because others can easily see the hawk is strong because of its confident attitude and air of dignity. Greater expertise and authority may be ascribed to a psychologist in Japan than to one in the United States.

Although the interrater reliability of ratings of gift giving was poor, Japanese and American therapists did stress the importance of achieving immediate results. Presumably, these immediate results may signal to a client that the treatment is culturally relevant and may also decrease the likelihood of premature attrition. However, the coders did not reach adequate agreement on what constituted efforts to achieve immediate results. A more precise definition of gift giving is necessary in future studies.

Beyond establishing credibility and gift giving to create a therapeutic alliance, therapists culturally adapted the content of CBT to engage clients in treatment. Interdependent conceptualizations of the self were incorporated into cultural adaptations by most Japanese therapists. The highly individual focus of CBT was adapted to accommodate clients' social contexts. United States therapists also incorporated interdependence but it was a variant theme. This difference may be a result of the relative prominence of interdependence in each

country. Interdependence in Japan often involved understanding prescribed social roles, such as younger persons respecting their elders, in family, school, and work settings. In contrast, social roles are not as strongly prescribed in the United States. Interdependent family norms in the United States were at times seen as conflicting with CBT principles. Core beliefs based on family norms were viewed as difficult to change and some family-based thinking patterns could be misconstrued as cognitive distortions. CBT also was not seen as optimal for addressing family cultural enmeshment.

Another explanation of the cross-national differences in emphasis on interdependence is that Asian American therapists and clients are more likely to be influenced by Western norms of independence than Japanese therapists and clients are. All United States therapists were born in the United States. Although we do not have formal data on the therapists' or their clients' level of acculturation, it is possible that the lower emphasis on interdependence among United States therapists was associated with their acculturation, their clients' acculturation, or both.

Addressing indirect communication is another content adaptation to engage clients in treatment. Indirect communication was a variant theme in both countries. For example, bulimia for an Asian American female client was an indirect expression of her depression. Therapists in Japan and the United States were also aware of their clients not discussing problems in therapy sessions. Therapist response in both countries was to directly ask the clients about their problems. Interestingly, the therapists' response to their clients' indirectness was to become more direct in their communication.

A limitation of this study is that the therapists were recruited from the investigators' professional networks and could have had a general awareness of the issues that we investigated. Indeed, one therapist (US1) explicitly mentioned the Sue and Zane (1987) conceptual framework. Another limitation of this study is procedural differences between countries for practical and cultural reasons. Because of geographic logistics, Japanese therapists were interviewed in person with an interpreter whereas United States therapists were interviewed in English remotely. In addition, United States therapists were paid for their participation, whereas Japanese therapists, who considered participation to be an honor, were not. These differences could have influenced participants' ease of communication and motivation. Moreover, because of cultural traditions, the responses of the Japanese therapists may have been conditioned by respect and deference to the authority of the interviewer and translator.

It is unknown how typical the therapy approaches in this study are of most CBT therapists or of therapists in general who treat Asian or Asian American clients. All therapists in this study employed a "top down" approach, beginning with a CBT framework and culturally adapting it (Hwang, 2006). This is not surprising because the therapists in this study were all experts in CBT. However, it is possible that many therapists improvise to a greater degree when culturally adapting their interventions for Asians and Asian Americans. Moreover, it is possible that cultural adaptations were inherent in the CBT training that therapists received in Japan, in which case the Japanese therapists would be implementing cultural adaptations without explicitly identifying them as such.

A limitation of directed content analysis is that the theories that guided our study may have biased us to find evidence that is supportive of the theories in approaching our data (Hsieh & Shannon, 2005). A conventional content analysis would have allowed themes to emerge from the data. Nevertheless, the independent expert who was unaware that a theoretical framework was guiding our study identified themes consistent with those from the theories. Moreover, the purpose of our study was to examine how therapists apply theoretical models of cultural adaptation into practice.

The results of this study imply that when culturally adapting psychotherapy, therapists incorporate elements of conceptual models that are relevant to their clients' cultures. Interdependence is a common element of cultural adaptation in Japan, as is establishing therapist credibility in the United States. An implication for CBT therapists is to consider how roles within a social context, such as the family, school, or work, influence depression beyond an individual's cognitions. It also may be important for CBT therapists working with Asian Americans to directly address their own credibility in treating Asian Americans, as well as the credibility of their treatment approach for Asian Americans.

This was a qualitative study in which therapists were not explicitly asked about conceptually-based cultural adaptations. Future researchers could systematically investigate which aspects of conceptual models that therapists incorporate into cultural adaptations and how these specific aspects, such as an emphasis on interdependence or establishing therapist credibility, influence treatment outcomes. Moreover, this was a study of therapist perspectives. Future research could address client perspectives on how therapists culturally adapt interventions.

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Appendix I Interview Questions

[Brief introduction of interviewer, thank interviewee for their time and participation. Reminder that the interview is being audio-recorded but that no personally identifying information will be recorded. (That is, even if names get audio-recorded, it will not be transcribed.) Brief overview of the interview process, beginning with a description of the study, asking background questions, treatment-specific items, and then eliciting a case example.]

We are very interested in understanding how mental health service providers deliver culturally competent services to multiethnic clientele. Specifically, we are interested in better understanding how clinicians culturally adapt an evidence based treatment, such as cognitive behavioral therapy (CBT), to be more culturally congruent with (Asian American/Japanese) clients. Because of your expertise, we are interested in how you work with (Asian American/Japanese) clientele, what you may do differently or similarly with clients from different cultural groups, and what some of the unique challenges may be in culturally adapting an evidence based treatment. Based on your training, experiences, and skills, we

are hoping to elicit important aspects of delivering effective and culturally competent CBT to (Asian American/Japanese) clients.

Please remember that your responses will remain anonymous and will not contain any identifying information. We are interested in your candid and honest responses to these issues.

General Information Items

1. In your clinical training (e.g., training program, internship, postdoctoral fellowship, continuing education), what kinds of specific training, if any, did you receive on cultural competence issues in psychotherapy? Please elaborate.
2. Again in your clinical training, what kinds of specific training did you receive in cognitive behavioral therapy?
    - **a.** In your training program, did you receive specific training on using CBT?
    - **b.** Are you certified as a CBT practitioner? (For example, certain institutes, such as the Beck Institute, grant certifications in CBT). If yes, when and where did you receive the certification?
    - **c.** How long have you been practicing CBT?
    - **d.** What conditions do you treat using CBT?(past and current, if different)
    - **e.** What types of clients, such as client age group, gender ethnicity, so on, do you treat using CBT? (past and current, if different)
    - **f.** Do you use a manual?
        - **i.** If so, which one?
        - **ii.** How would you describe your adherence to that manual?
    - **g.** Do you prescribe to a given number of sessions?
    - **h.** How do you generally use CBT, in terms of the cognitive and behavioral aspects? Do you present one before the other or combine them?

Treatment Specific Items

1. When treating depression in (Asian American/Japanese) clients, do you use CBT for all (or most) of your clientele?
    - **a.** If yes, do you find that certain types of clients are a better “fit” with CBT? (e.g., depending on client’s level of acculturation, language proficiencies, etc.)

b. If no, what factors impact your decision to use CBT with a particular client? (e.g., client's acculturation level, language proficiencies, anticipated problems with adherence, etc)

c. If no, do you conduct an ethnocultural assessment before you decide to utilize CBT?

d. If no, what other types of treatment approaches do you provide to your (Asian American/Japanese) clients with depression?

2. What types of modifications (if any) do you find yourself making to standard CBT to be more culturally congruent with (Asian American/Japanese) clients? Please be as specific as possible.

3. What aspects of CBT do you use without making any cultural adaptations?

4. What aspects of CBT are particularly challenging to apply to (Asian American/Japanese) clientele?

Case Example

Please think about a specific (Asian American/Japanese) client with depression that you have treated using CBT. For better recall, this should be a recent case that may be somewhat typical of your caseload. Briefly describe this client, his/her presenting symptoms, any other diagnoses, and any other relevant intake information that you can recall. Please use a pseudonym for this client, and if you have concerns regarding client confidentiality, feel free to change the client's age, gender, and ethnicity as long as it does not change the nature of your therapeutic work with this client.

1. Were there any modifications or adaptations to CBT that you made to provide culturally competent care?

2. What did you do that worked particularly well in treating this patient?

3. What were the major challenges in using CBT with this patient that were related to cultural or other issues?

4. Is there anything else you did in this case to provide more culturally competent care?

Concluding Questions

1. Is there anything else that you can think of that clinicians can do to render effective and culturally competent services?

2. Is there anything you'd like to add that maybe I didn't cover?

What is the public significance of this article?

This study suggests that therapists in the United States and Japan culturally adapt psychotherapy for their Asian clients. These adaptations may make psychotherapy more relevant to clients from diverse cultural backgrounds.

Table 1

Therapist demographic characteristics.

Characteristics	Japanese therapists (N = 6)	United States therapists (N = 9)
Women	3	7
Age	Mean = 40.17 years (*SD* = 13.35)	Mean = 36.33 years (*SD* = 4.50)
Experience as a therapist	Mean = 15.00 years (*SD* = 10.14)	Mean = 9.13 years (*SD* = 4.49)