Wilder Research

Wilder's Southeast Asian Assertive Community Treatment (ACT) Team

Literature Review of Cultural Adaptations and Enhancements of the ACT Model

In 2019, Wilder Foundation's Adult Mental Health services commissioned Wilder Research to conduct an evaluation of Wilder's Southeast Asian Assertive Community Treatment (ACT) team. Nationally, the ACT model was created in the 1970's after deinstitutionalization of large state run hospitals to help individuals with severe and persistent mental illnesses function better in community. ACT relies on a multidisciplinary team of professionals in psychiatry, nursing, case management, substance abuse treatment, therapy, peer support, and vocational support with a small staff-to-client ratio for individualized and comprehensive care. An intensive nonresidential treatment and rehabilitative mental health service, services are available 24 hours per day, seven days per week, in a community-based setting such as the client or families home. ACT teams meet daily to review client needs and coordinate treatment. ACT teams work to ensure continuity of care from a hospital to an outpatient practice setting, improve clients' ability to function in the community, and reduce need for future hospitalization or incarceration.

Wilder's ACT team is unique in that it primarily serves clients who are refugees, immigrants, and asylum seekers of Southeast Asian descent (i.e. Hmong, Karen, Vietnamese, and Cambodian). All staff on the team reflect similar ethnic and cultural backgrounds as the clients served. As part of this project, Wilder Research conducted a literature review of peer-reviewed journal articles and reports published by entities that work with or advocate for this population to identify best practices in providing treatment and support. This summary presents the key findings of this literature review.

Asian Americans are the fastest growing ethnic group in the United States. According to the 2010 Census, 5.6% of the U.S. population (17.3 million residents) is of Asian descent, an increase of 46% since 2000 (Humes et al, 2011). Despite the rapid growth of the Asian American population, literature on behavioral health service delivery for Asian Americans remains sparse. Additionally, Asian Americans have the lowest rates of mental health service utilization compared with other racial and ethnic groups (Abe-Kim et al., 2007; Cho et al., 2014).

To understand barriers to mental health care among Asian Americans, this literature review will broadly review cultural beliefs and behaviors related to mental health and the mismatch with the western model of behavioral health care delivery, examining the factors that may impact service utilization, diagnosis, and treatment of mental illness among this population. It will also examine efforts to make behavioral health services more culturally relevant to Asian Americans, with a focus on cultural adaptations of evidence-based treatment models (EBTs), and frameworks for cultural adaptation. Finally, it will examine many adaptations and enhancements that Wilder's ACT team has made to meet the needs of their Southeast Asian clients.

Key cultural, historical, and contextual factors among Asian Americans that influence understandings of mental health diagnosis and treatment

Research confirms that cultural beliefs and understanding around the topic of mental health have a strong effect on Asian Americans' attitudes regarding the diagnosis and treatment of mental disorders (Chung et al., 2014). The level to which cultural factors can affect interaction with a Western medical system depends upon several individual-level variables, including the amount of time a person has spent in the United States, their rate and degree of acculturation, education level, immigration status, and socioeconomic status. Historical and contextual factors such as a history of trauma or experience as a refugee can also play a role in an individual's mental health needs, and can create barriers and stigma around seeking mental health treatment (U.S. Department of Health and Human Services, 2001).

Trauma

Many older Southeast Asian Americans endured wars, threats, and suffering in their home country before migrating to the United States. Among refugees, traumatic experiences prior to and during migration are strongly linked to mental health problems and psychological distress (Fazel et al., 2012; Kirmayer et al., 2011). Lasting migration-related stress may stem from separation from family or from having witnessed the death of family members or relatives while fleeing one's home country under life-threatening conditions (Dihn & Le, 2019). Individuals may also have experienced additional stressors such as assaults by border guards when trying to enter the neighboring countries or extended detainment in unsafe, overcrowded environments. Additionally, many migrants face common resettlement stressors that lead to uncertainty surrounding their future and the fate of their family (Abueg & Chun, 1996). As a result, many immigrants, and particularly refugees, experience various forms of psychological disorders, such as anxiety, depression, and post-traumatic stress disorder (PTSD).

Additionally, first generation Asian Americans who have immigrant parents may also experience stress as a result of differences in cultural and life experiences between them and their parents. Mescheke & Juang (2014) report that Asian American adolescents report that their parents sometimes do not understand their experiences, due to having grown up in a very different environment. Generally, Asian American elders try to maintain their tradition whereas younger generations are more likely to accept and adapt to Western culture (Tatman, 2004). This disparity between generations generates familial stress and intrapersonal conflicts for younger generations, who may feel they have to choose one culture over the other.

Further, Asian migrants who have not been exposed to Western concepts of physical and mental illness would not always label their experiences in the way that Western society would, or describe their conditions as psychological illnesses. Nor would they seek mental health treatment to cope with such experiences. It is important to acknowledge and address these considerable traumas and lack of Western medical concept Asian migrants might have experienced when developing treatment programs for them.

Language

Not speaking English, or not speaking it well, is a common barrier to seeking health and mental health services, and Asian Americans are no exception. Asian Americans are ethnically and linguistically diverse and include "more than 50 distinct ethnic groups that speak more than 30 different languages" (Chu & Sue, 2011, p. 9). The combination of a paucity of culturally and linguistically appropriate services, a dearth of providers with

appropriate language-matched abilities, and common limited English proficiency among newer immigrants and refugees leads to significant barriers to care and a reluctance to seek help (Chu & Sue, 2011).

Asian languages and dialects are usually only spoken within an individual's ethnic group, and some dialects are only available in spoken form or if they are available in writing; the people who speak them may not always be literate in those languages. Additionally, Western mental health symptoms are not easily translated into many Asian languages, and the translation can vary among languages. For instance, in Hmong, the word "depression" translates to mean "difficult, confused liver" (Goh et al., 2004), and the term that translates back to English as "broken liver" is used to describe mental health issues (Culhane-Pera et al., 2003). A study found that the Hmong language does not include terms to directly translate biomedical physiology and anatomy, which, in turn, requires the use of extensive non-direct terms to approximate meaning (Johnson, 2002, p. 1).

Although cultural matching of the clinician and client may ameliorate language barriers, it is not always possible in clinical settings. The use of cultural interpreters can help facilitate understanding of underlying problem and minimize the risk of misdiagnosis. Language interpreters who meet a set of core competencies are essential when interviewing clients not proficient in English (Lee, 1997).

In addition to language barriers between clinician and patient, there are conceptual differences between Asian and Western cultures in the expression of mental illness. Research has shown that Asian Americans are more likely to express their mental health symptoms in somatic terms rather than psychological terms (Ryder et al., 2008). For example, depression might be described in Asian cultures as problems with eating or sleeping, feeling tired or irritable, or having headaches, backaches, or digestive problems, whereas in Western cultures a patient might describe feeling sad or down. Given the different cultural expressions of psychological problems, clinicians should use assessment tools that are not only reliable, but are also conceptually valid for Asian American patients (Hsu et al., 2004).

Acculturation

Acculturation is "the process in which an individual of a different culture adapts to and adopts the values and behaviors of the dominant culture in which they reside" (Miller et al., 2011 as cited in Hynes, 2019). Many factors can contribute to a difficult adjustment to a new culture, such as a lack of opportunity for formal education, language, physical and emotional trauma associated with dislocation from war, social disruption, and cultural fragmentation (Barrett et al., 1998). In turn, challenges with adjusting may affect people's help-seeking behaviors. Acculturation varies by individual and group, but according to Kramer et al. (2002), fully adopting the lifestyle of the dominant culture often takes three generations.

Research has indicated that a lack of knowledge about Western medical care and the tendency to attribute symptoms of mental illness to physical illnesses increases delays in seeking care (Rastad, 2012). However, Lor et al. (2017) found that lack of knowledge of the adopted culture may not be the primary reason why Asian Americans often choose not to initially seek care from a Western doctor. As mentioned previously, Asian American cultures conceptualize mental illness differently than Western medicine, and these cultural beliefs and interpretations of illness can influence a person's decision to seek either traditional/culturally-based or Western treatment. This emphasizes the importance of taking into account the acculturation level of individuals experiencing mental health problems when determining diagnosis and providing treatment.

Stigma

Across cultural groups, stigma can play a large role in people's willingness to access mental health care. For Asian Americans, stigma may be compounded by different views of what it means to suffer from a mental illness (compared to Western understandings of psychological disorders) and by the perceived/anticipated and real social stigma and isolation which extends to the family of a person experiencing mental illness. Disclosing personal information about a family member who is suffering from a mental illness could reveal vulnerability, especially if the information is about negative behaviors. Seeking treatment or help from someone outside of the family may be viewed as a sign of weakness or as something that might invite negative attention from the community (Meschke & Juang, 2014; Kramer et al., 2002).

According to counseling professionals, shame and fear of social stigmatization about mental illness are common in Asian American groups, particularly among first generation immigrants. This often results in a delay in seeking professional mental health services. In Asian American communities, it is common for families to deal with mental health issues on their own or with help from their family members, as disclosing feelings or private matters to others outside of the immediate family is not encouraged (Kim-Goh et al., 2015). To help ease this barrier to seeking treatment, providers stress the importance of engaging family when working with Asian American clients throughout the therapeutic process. Given the closeness and primacy of family in Asian cultures, active involvement from family members is congruent with clients' cultural norms and expectations.

Additionally, Asian Americans, particularly first generation Americans, often have limited understanding of the process or purpose of therapy. Providers can help clients and their family members by spending extra time to provide psychoeducation (Kim-Goh et al., 2015).

Values and beliefs

Within most Asian cultures, there is a strong emphasis on family connection as a major source of identity and protection. This is part of the broader preference among Asian cultures for collectivist versus individualistic worldview. The family structure often determines cultural norms around behavior and interaction within the family and in the broader community. Each member of the family tends to have a defined role and position in them family hierarchy, often determined by age, gender, and social class. It is common among Asian Americans to have two or three generations living in the same household. With such strong family support, it is imperative that providers involve family members in the treatment process and understand the importance of family (Westermeyer & Her, 2007). For this reason, individuals may be wary of behaving in any way that would bring disgrace or dishonor to themselves or their family. The provider's understanding of the role family plays in therapy will lead to a better therapeutic relationship and rapport with the client, and ultimately to better client outcomes.

Culturally, in the context of health care, physicians are often viewed as the authority due to their professional expertise. Patients may show deference to the physician, including being less likely to raise issues or concerns, and these patients may be less comfortable with the client-centered approach frequently used among contemporary Western behavioral health care providers (Kramer et al., 2002). Gender differences between the patient and therapist may also cause problems in the treatment setting. For example, Muslim women may be especially resistant to receiving treatment from a non-Muslim male therapists (Kirkwood, 2002). These cultural differences can sometimes be a barrier to physicians in implementing best practices. For instance, many current therapeutic approaches are client-centered, but if clients are uncomfortable developing their own treatment goals or

making suggestions about their own treatment to their physician (whom they feel is the expert), providers may need to rethink their approach and be flexible.

Western-trained counseling professionals have sometimes reported difficulty working with Asian Americans in clinical settings because in many Asian cultures, it is typical to suppress or regulate feelings or emotions. Asian Americans are more likely to perceive sharing of feelings as causing an imbalance for them, or bringing shame or unwanted attention to the family. As a result, they tend to suppress the expression of feelings in comparison to other cultural groups. The expectation that Asian American clients will be emotionally expressive during a therapeutic session may be unrealistic, especially for those who are early in the therapeutic process (Kim-Goh et al., 2015).

Religious beliefs and healing practices

The causes of certain mental health conditions may viewed as religious problems. In some Asian religions and belief systems, balance is a major theme. It is widely known in the West as the "yin and yang" concept and the need to balance them (Tseng, 2003). This concept shapes many domains of traditional Japanese, Vietnamese, Chinese and other Asian societies, ranging from the conception of the body to emotions, society, and beliefs about nature (Spector, 2004). As a result, many Asian immigrants in the U.S. may believe that an imbalance of body and spirit is the cause of illness (Grantham-Cobb, 2010). Specifically, Hmong Americans believe in the imbalance of the natural and the spirit worlds (Plotnikoff et al., 2002). To heal a sick person, a shaman must retrieve their soul; otherwise, the person may die (Johnson, 2002). A discussion of the causes of a mental health condition between provider and patient may need to include an array of possibilities beyond what Western medicine might determine the cause to be.

To help address psychological issues, Asian American families often seek assistance from traditional healers or medicines before seeking Western mental health services. According to Xiong (2018), "both low levels of acculturation and high levels of traditional beliefs and practices could result in people being less likely to seek mental health services" (p. 1). Only after exhausting all religious or traditional options will some Hmong families, particularly those who are fully acculturated, seek Western mental health services (Alisa, 2007). Innovative approaches have been used to help increase Asian Americans' service access, such as collaborations between mental health providers with other care resources that are less stigma-inducing and more commonly used by Asian Americans. One collaborative approach described by Dubus (2009) is the pairing of a licensed mental health professional with a Cambodian paraprofessional to provide culturally sensitive group support for Cambodian refugee women who have Post-Traumatic Stress Disorder (PTSD).

Traditional herbal medicines are believed to be able to treat the body as a whole and are commonly used in Asian American communities (Lor et al., 2016). These findings highlight the importance of considering clients' cultural context when utilizing psychotropic medications. It is important for providers to understand that what they might consider medication non-compliance (that is, when a patient stops taking their medication or doesn't take it as prescribed) could actually be a patient exploring all of their options, including herbal medicine or other traditional treatments. Other cultural factors to consider when using pharmacological treatment is that traditionally oriented Asians may expect the medication to relieve symptoms in a short period of time and may expect medication to relieve all symptoms. As a result, they may stop the medication once they feel better or if it is not working according to their expectations. Thus, education about the use of psychotropic medication is an important step in when using pharmacological interventions (Du & Lu, 1997). Additionally, the use of herbal treatments may result in undesirable drug interactions with psychotropic medications (Chen et al., 2002). For this reason, it is important for providers to be aware of the types of herbal treatments their clients are using. A

better understanding of patients' decision-making process by health care providers has the potential to reduce health disparities among Asian Americans.

Despite the rapid growth of the Asian American population in the United States, they are still relatively invisible in the mental health sector. Asian Americans face several pervasive barriers to initiate and receive effective mental health treatment. The historical, contextual, and cultural factors described above are extremely important to consider in addressing the unique mental health needs and the diagnosis and treatment process for Asian Americans. Strategies to increase service use among Asian Americans need to address barriers to help-seeking, active family and community outreach, and education and awareness efforts aimed at reducing stigma. In addition to the need for language-matched providers, there is a need for providers who are culturally competent and able to understand and deliver mental health treatments to individuals with similar worldviews. For patients who make the difficult decision to initiate the process of accessing mental health treatment, providers and systems need to address the barriers that may prevent patients from continuing their treatment. Providers should actively develop and adopt strategies to make services more culturally relevant and to acknowledge and incorporate traditional healing practices. Finally, efforts to increase the visibility of Asian Americans as a group with mental health needs and reduce mental health disparities should be prioritized in health policies, research, and services.

Systemic barriers to implementing and sustaining culturally adapted treatment models

Many of the barriers to implementing and sustaining a cultural adaptation to a particular treatment model or practice are outside of the control of a single clinic or practitioner. Conceptual frameworks used to examine disparities in behavioral health care services divide the "mechanisms" of disparities into three categories: macro-level, meso-level, and micro-level (Alegría et al., 2016). The frameworks on cultural adaptations of evidence-based practices (EBPs) focus primarily on micro-level interactions between providers and clients. However, both macro-level factors (policies, systems, and environments) and meso-level factors (interactions between organizations, and among organizations and communities) can affect the ability to successfully implement and sustain particular adaptations.

In a 2006 qualitative study, Gensheimer explored the experiences of Hmong mental health providers in Minnesota. Her research supports the idea that system processes and requirements reflect Western expectations and may be off-putting to patients from cultural groups who have different expectations around concepts such as relationships and time. For instance, providers noted that the intake process at the initial clinic appointment did not make a positive impression on clients, who often wanted to tell providers "everything right away" (Gensheimer, 2006). Nagayama Hall et al. (2019) confirm that among Asian and Asian American patients, there is often an expectation to derive immediate benefit from a single treatment. Consequently, is important to manage patients' expectations so that they do not feel that treatment was ineffective or give up before it has ever really started or been given a chance to work. To accommodate such adaptations, an agency would need to have greater flexibility to circumnavigate intake and appointment requirements in order to use an approach better suited to a particular culture. For example, Hmong providers described the importance of building trust and rapport with clients immediately, in a "tying process" designed to build trust (Gensheimer, 2006). Having flexibility in approach and allowing sufficient time to get to know clients is one element in being able to maintain culturally adapted work.

Clinicians may also find themselves hampered by a lack of time in client-provider interactions. While the issue of time can be a factor in all client-provider health interactions, factors such as language differences, communication style, and widely different understandings of mental health concepts and practices can all increase the amount of time needed to serve patients and understand their needs. In Gensheimer's (2006) study, providers strongly believed that it was important to give clients ample time to tell their story in "whatever

indirect ways were needed." However, allowing such time can be difficult in a system where services are reimbursed based on specific time increments. Adapting systems to allow for lighter caseloads and longer appointment times would help to strengthen clinicians' ability to sustain culturally adapted services.

Providers also cited the challenges in translating Western mental health concepts and practices into terminology their clients would understand, and some reluctance among the Hmong population to seek out Western mental health services except as a "last resort." To counter this, Gensheimer (2006) suggests incorporating some traditional healing practices as an allowable part of reimbursable managed care services. She suggests that integrating traditional practices along with Western mental health services – at a system level – might encourage clients to seek help sooner, thereby potentially reducing both the need and duration of services required.

Recommendations for systemic change

Such changes in treatment delivery would require change to systems and policies in addition to individual practice. Law (2007) confirms that, despite an increase in culturally adapted mental health treatments, systems are not designed to consider the preferences of specific cultural groups in delivering care. Some researchers recommend that providers actively collect information on preferences of patients' needs, options, and barriers to receiving care in order to "inform reimbursement program administrators and state policy makers about the needs of minority behavioral health consumers" (Alegría et al., 2016, p. 8). One method they suggest for doing this is to implement or expand the use of patient and family advisory boards to provide feedback and advice on specific initiatives and strategies (Law, 2007; Alegría et al, 2016).

Information collected about client needs and systemic barriers encountered in the delivery of a culturally adapted practice could encourage collaboration between agencies and policymakers in creating behavioral health services that truly recognize and address the preferences of different cultural communities (Law, 2007). Such efforts may be especially relevant in adapting services for Asian and Asian American communities, as Nagayama Hall (2019) concludes that, to date, "there is a paucity of research on evidence-based practice [for treating severe, persistent mental illness] with people of Asian ancestry" (p. 4).

Efforts to make behavioral health services more culturally appropriate for Southeast Asian immigrants and refugees

Evidence-based treatments (EBTs) rose in popularity after a shift in the 1980s from a focus on access to care to the quality of care in the United States. However, EBTs in the U.S. are largely validated based on studies of implementation among white Americans. While there is evidence suggesting that culture and context influence every aspect of the diagnostic and treatment process, there is debate about whether well-established EBTs can be modified and still implemented with fidelity among diverse ethnic groups. Cultural adaptation of EBTs must strike a balance between fidelity and cultural/ecological validity (Castro et al., 2004). Moncher and Prinz (1991) as cited by Lee et al. (2013, p. 533) refers to fidelity as "the accurate implementation of a program as intended by the program developers." It requires a precise definition and understanding of the mechanisms of change, adequate user training, treatment manuals, supervision, and adherence to protocol." "*Cultural/ ecological validity* (or fit) refers to the extent to which a program is generalizable beyond the initial target population to other populations and cultural contexts" (Lee et al., 2013, p. 533). There is a paucity of research examining the implementation and effectiveness of cultural adaptations of EBTs specific to Asian Americans and even fewer for Southeast Asians. Asian Americans are a diverse group in terms of cultural backgrounds, and yet are combined in most research, leaving the applicability of EBTs for specific groups in question. Furthermore, Asian Americans are the ethnic group that is least likely to use behavioral health services

(SAMHSA, 2015). This reality gives rise to the exploration by many practitioners of how to make behavioral health services culturally relevant for specific Asian American populations.

As mentioned previously, the literature on culturally adapted mental health interventions suggests that although models of cultural adaptations of mental health therapies have been developed, there is still little known about their efficacy or how they are applied in clinical practice (Griner, 2006; Nagayama Hall, 2019; Cabassa, 2013). In a review of studies of evidence-based programs in health care settings, Wiltsey Stirman et al. (2012) found "very little research has examined the extent, nature, or impact of adaptations to the interventions or programs once implemented" (p. 1). As a result, Cabassa advocates that teams involved in adapting interventions document their adaptations, citing multiple potential benefits:

> *"Such documentation of the adaptation process may have several benefits. It may help generate more generalizable knowledge about the type of adaptations that produce better implementation and treatment outcomes in a new context. It can also help clarify processes, steps and methods used to adapt EBTs [evidence based treatments] to enhance their fit with a new population and/or context. In all, the careful and explicit documentation of the adaptation process can help produce a knowledge base to guide future implementation efforts" (Cabassa, 2013, p. 5).*

Wiltsey Stirman et al. (2013) recommends the strategic documentation of adaptations, both cultural and otherwise, using the FRAME framework in implementation. FRAME, a framework used to characterize modifications to evidence-based interventions was developed in 2013. In 2019, the framework was updated to include additional aspects of modification and adaptation Wiltsey Stirman et al. (2013) recommend the following elements of reporting for modifications of interventions:

1. "When and how in the implementation process the modification was made
2. Whether the modification was planned/proactive (i.e., and adaptation) or unplanned/reactive
3. Who determined that the modification should be made
4. What is modified
5. At what level of delivery the modification is made
6. The type or nature of context or content-level modifications
7. The extent to which the modification is fidelity-consistent, and
8. The reasons for the modification, including a) the intent or goal of the modification (e.g., cultural adaptations, to reduce costs, etc.) and b) contextual factors that influences the decision" (p. 4).

Thoughtful documentation of adaptations, using frameworks such as this, may be helpful to providers interested in replicating adaptations and may facilitate the expansion of literature related to the fidelity of cultural adaptations to EBTs. The implementation of adaptations may rely on changes to systems that allow for changes to treatment models (e.g., more time between provider and client).

Bernal et al. (2009, p. 362) define cultural adaptation as "the systemic modification of an evidence-based treatment 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." Ethnic matching of therapists and clients and the cultural competence of therapists has been the primary focus of adaptation efforts (Nagayama Hall et al., 2020). While these approaches have a weak association with positive treatment outcomes, a recent meta-analyses show that cultural adaptation of interventions has moderate effects on reducing psychopathology compared with interventions that have not been culturally adapted (Nagayama Hall et al., 2016; Smith & Trimble, 2016). Some adaptations to EBTs have been implemented based on frameworks developed by academic scholars and practitioners; however, no universal framework exists for culturally adapting EBTs.

Unfortunately, detailed descriptions of cultural adaptations often go undocumented and their effectiveness is largely unknown (Bernal et al., 2009).

> *"The literature on the efficacy of treatments with ethnic minorities is increasing and demonstrates some positive outcomes for both EBTs and culturally adapted treatments. However, the wide range of elements that are considered to be cultural adaptations in these studies (i.e., linguistic translations, patient–therapist match, and community involvement), combined with the lack of consistency in describing the process of culturally adapting an intervention in a systematic way, makes it difficult to draw conclusions about their efficacy with ECGs [ethnocultural groups]" (Bernal et al., 2009, p. 365-366).*

Cultural adaptations of evidence based treatment models

There are very few adapted behavioral health treatment models or EBTs for Asian Americans evaluated for effectiveness or validity. Furthermore, adapted models that have been studied and validated largely focus on people with Chinese and Korean ancestry, as they are some of the largest Asian American groups in the U.S. (Kiang et al., 2016). It is unclear whether adaptations for these populations would also be effective for Southeast Asians.

Resnicow et al. (1999) discuss two types of adaptations, characterized as "surface" structure or "deep" structure, which can improve treatment for ethnic minorities, generally. Surface structure adaptations include more superficial adaptations, such as ethnic matching or ensuring accessible clinic locations for the target population. Alternatively, deep structure adaptations involve incorporating culturally specific ideas, beliefs, and values into the treatment. Most studies about cultural adaptations examine the treatment outcomes of surface structure adaptations rather than deep structure adaptations. However, it is presumed that while more challenging to develop, deep structure adaptations have the highest potential for creating cultural congruence in treatment and, therefore, resulting in positive treatment outcomes (Hwang, 2011).

Cultural adaptations of Cognitive Behavioral Therapy (CBT) have been the most widely developed and studied. While the ACT model has been adapted by a couple of practicing ACT teams, as detailed in the next section of this report, there is no documentation of cultural adaptation of the ACT model specific to the Asian or the Southeast Asian population in the U.S. The following section of this report summarizes the extant literature related to adaptations of the CBT and ACT models for Asian Americans.

Assertive Community Treatment (ACT)

A recent systematic review of the literature looking at the effectiveness of ACT among people of color found only three relevant studies based on specific criteria. Each of these studies examined a different set of outcomes and results, making it difficult to draw meaningful conclusions. The review concluded that additional research is necessary to determine the effectiveness of ACT among people of color (Escobar-Ratliff, 2018).

There is only one culturally specific ACT team for which studies examining its effectiveness have been conducted. A case study from 2009 described a culturally specific ACT team in Toronto, Canada, that serves largely Asian immigrants. Of 90 clients, 45% are Chinese, 21% Tamil, 16% Vietnamese, 7% Korean or Japanese, 6% Afro-Caribbean, and 5% are from other minority groups. In addition to a team that matches the clients' language

and cultural backgrounds, the team also tailors its services to meet the cultural needs of their clients (Chow et al., 2009). For instance, the Toronto ACT team engages clients in culturally relevant activities:

> *"There are restaurant outings for Chinese noodles and groups for practicing yoga, baking, exercising, and singing karaoke. There is an annual music festival as well as seasonal and New Year's celebrations, including Chinese, Vietnamese, and Tamil festivals" (Chow et al., 2009, p. 847).*

The ACT team also takes into account the variety of interpretations their clients may have of mental illness and treatment approaches:

> *"The clients' wide range of views concerning the nature of mental illness (overseen by ancestral gods and astrology) and treatment approaches are assessed by the explanatory model pioneered by cultural psychiatrist Arthur Kleinman. The responses to model questions yield rich information about the clients' perceptions, expectations, insight, past experiences, and personal healing practices, which in turn inform the team's treatment plans. The team also systematically inquires about cultural identity and culturally relevant issues, such as level of community stigma about mental illness, role of family, social status changes after immigration, and subjective experience of discrimination, social defeat, psychosomatic expression of illness and suffering, and exposure to war and trauma" (Chow et al., 2009, p. 847).*

Lastly, the Toronto ACT team works with patients' families to educate them about mental health treatments and to promote family involvement in patients' care (Yang et al., 2005).

Yang et al. (2005, pp. 1053-54) identified the unique and innovative aspects of the Toronto ACT team.

- All team members are bilingual and are of the same cultural backgrounds as the patients served by the program.
- Staff are matched with patients "based on language, culture, gender, geographic location, patients' wishes, and clinical needs."
- All patients complete an acculturation assessment as part of their psychosocial evaluation.
- "Culturally sensitive and meaningful group activities are strongly incorporated into regular programming."
- They "support and promote family involvement in patients' care."
- Team members have "developed expertise in assisting patients to deal with immigration issues, refugee claims, and social assistance matters."
- "All team meetings and special "clinical situation" discussions highlight specific cultural issues, such as culturally influenced stigma, a lack of trust of authority, compliance with medications, or use of alternative health practices."

A more recent publication by Chow et al. (2011) examining the ACT team in Toronto, as well as an ACT team in Japan, mentions two more aspects of how the team culturally adapts the standard ACT model. The first is prioritizing and incorporating clients' cultural background and the role of culture in the manifestation of symptoms and dysfunction (cultural formulation) and clients' causal attributions of illness (explanatory models) in overall care. The second is having a general practitioner who is also a psychotherapist on the team in order to enhance assessment, management, and follow-up of clients' general medical and counseling needs. This study found that the ACT model could be effectively and successfully adapted for an Asian client group in Japan (Chow et al., 2011).

Outcomes measured by the culturally specific ACT team in Toronto included:

- Reduction in hospital stays or hospitalization rates (looking at one year before ACT team admission and one year after)
- Change in number of patients hospitalized more than 30 days
- Total and mean number of hospitalized days

- Change in psychopathology (using the Brief Psychiatric Rating Scale [BPRS])
- Severity of symptoms
- Client satisfaction (survey of clients and families)
- Families' knowledge of mental illness, empathy for their ill family member, and lowered rejection of the clients (using a culturally-modified version of the McFarlane model of family psychoeducation translated into the primary languages of the clients) (Chow et al., 2009; Yang et al., 2005)

It is not clear whether the BPRS was validated for the populations it was used with in the Chow et al. (2009) study. Other outcomes not examined by Yang et al. (2005), but mentioned as helpful to include in future evaluations are employment, quality of life, and life skills. Additional outcomes noted in a document developed by the California Institute for Mental Health about implementing SAMHSA evidence-based practice toolkits for ACT, included housing stability, social adjustment, jail/arrests, substance use, medication compliance, and vocational functioning (California Institute for Mental Health, n.d.).

The Toronto ACT team also participated in a study to assess the impact of the McFarlane Multi-Family Psycho-education Group (MFPG) on family members' well-being, perceived burden, and acceptance of clients. The MFPG is the leading approach used in North American for families with persons who suffer from severe and persistent mental illness and is designed to teach families coping and problem solving skills, increase knowledge and develop a support network. For the families with a family member on the Toronto ACT team, a culturally modified version of the MFPG reduced stigma, shame, and isolation among family members, increased understanding of clients' conditions, decreased helplessness and hopelessness, and improved client-family relationships (Chow et al., 2010).

Cognitive Behavioral Therapy (CBT)

Cognitive behavioral therapy (CBT) is a treatment model that has been culturally adapted and examined for effectiveness. The short-term and structured nature of this treatment model makes it amenable to empirical investigation and has led to an extensive research base. Hwang (2006) developed a framework to adapt CBT to treat Chinese Americans experiencing depression. Hinton et al. (2013) have identified specific techniques and modifications needed to tailor the model to meet the needs of the Southeast Asian refugee population. The authors describe how acceptance and mindfulness techniques have been used to treat traumatized Latino and Southeast Asian refugee patients. More recently, Hinton & Patel (2018) outline key dimensions for culturally sensitive CBT. Some examples of these key dimensions of care are: "assessing and addressing key local complaints (e.g., somatic symptoms, spirit possession, and syndromes like "thinking a lot"); incorporating into treatment key local sources of recovery and resilience (e.g., CBT-compatible proverbs and techniques in that culture). Another example of a key dimension of care is making CBT techniques more tolerable and effective for the cultural group through various means: by using a phased approach, by utilizing culturally appropriate framing of CBT techniques (using local analogies), by making positive reassociations to problematic sensations during interoceptive exposure (e.g., to traditional games), and by using trauma-type exposure as an opportunity to practice emotion regulation" (Hinton & Patel, 2018, p. 201). The authors describe these concepts as "explanatory model bridging, cultural grounding, and contextual sensitivity" (p. 201).

Nagayama Hall et al. (2019) investigated how practicing therapists in the U.S. and Japan culturally adapt CBT with clients of Asian ancestry. This study found that the intrapersonal approach of CBT was adapted to focus more on interdependence for therapists in both the U.S. and Japan and that there was greater emphasis on social roles and norms in family, school, and work.

Other culturally adapted models

Our search of the literature uncovered no further treatment models specific to those who experience severe and persistent mental illness (SPMI) that have been culturally adapted and documented or studied in the literature. More research is needed to learn more about specific strategies that are used by practitioners to adapt EBTs to culturally specific patient groups and to assess the impact or effectiveness of these adaptations.

Frameworks used for cultural adaptation of evidence based treatment models

Although specific adaptations are scarce in the research literature, frameworks are available to help guide deep structure adaptations to treatment models (Hwang, 2011). The literature describes a few frameworks used to adapt treatment models to address the needs of the Asian American population. Some well-known frameworks are summarized below.

Bernal et al. (1995) developed one of the first frameworks for cultural adaptation. Known as the "ecological validity framework," it focuses on eight different dimensions; language (linguistic match), persons (ethnic matching or discussion of racial issues), metaphors (use of culturally familiar symbols and concepts), content (incorporation and application of cultural knowledge), concepts (presenting the problem in a manner that is consistent with the client's belief system), goals (ensuring congruence between therapist and client goals), methods (ensuring compatibility of treatment methods/procedures with the client's culture), and context (considering the impact of contextual processes) when adapting therapy for culturally diverse clientele. This framework was originally conceptualized for Latino populations and has been used to adapt CBT and interpersonal therapy. Two randomized control trials examined the efficacy of these treatments for Puerto Rican adolescents with depression and found them to be effective (Bernal et al., 2009).

Leong and Lee's (2006) cultural accommodation model (CAM) is a top-down, theoretical guide to the adaptation of existing behavioral health interventions. This model involves three steps: the identification of the cultural limitations of theories assumed to be universal, the identification of culture-specific psychopathology (e.g., somatization), and the development of a culturally accommodated intervention and evaluation of whether it has increased effectiveness and validity over the unaccommodated model.

Most recently, Healey et al. (2017) conducted a content analysis of available research to identify themes across health and mental health research related to cultural adaptation. The three primary domains identified were: community outreach and involvement, changes in the structure and process of service delivery, and adaptation of content. The most commonly found adaptation made to interventions was "to modify the content of materials or dialogue to include racial, ethnic, or cultural facts, values, imagery, or other cultural components. The next most common adaptation was to change the manner in which a service was delivered, including increases in time and attention paid to recipients, cultural matching of providers to clients, and provision of additional resources" (Healey et al., 2017, p. 7).

In addition to the development of cultural adaptation frameworks, Nagayama Hall et al. (2011) identifies some treatments that may already be more culturally attuned or syntonic with some cultures than others and may therefore require fewer modifications when used with these populations. Both Nagayama Hall et al. (2011) and Hwang (2011) explore common understandings of self, cultural values, and beliefs of many Asian Americans, such as mindfulness, interdependence/collectivism, somatization, loss of face, and indirect communication, and consider how therapists or treatment models might incorporate these into practice.

Hwang (2006) developed a cultural adaptation framework for behavioral health interventions for Asian Americans based on principles guiding the adaptation of CBT for Chinese Americans. This framework, known as the Psychotherapy Adaptation and Modification Framework (PAMF), includes six therapeutic domains further classified into 25 therapeutic principles and rationales. This framework is a theoretically driven, top-down approach that emphasizes strengthening of the client-therapist relationship and understanding cultural notions of self and mental illness as integral to treatment. The researcher took this framework a step further to integrate a community-based, bottom-up approach, which includes soliciting feedback from clinicians, experts, community members, and clients. This framework is the Formative Method for Adapting Psychotherapy Framework (FMAP) and includes five phases. "These phases include (a) generating knowledge and collaborating with stakeholders, (b) integrating generated information with theory and empirical and clinical knowledge, (c) reviewing the initially culturally adapted clinical intervention with stakeholders and revising the culturally adapted intervention, (d) testing the culturally adapted intervention, and (e) finalizing the culturally adapted intervention" (Hwang, 2009, p. 1).

The therapeutic domains outlined in Hwang's PAMF model are used in the following section to examine what have been identified as adaptations and enhancements of the ACT model made by Wilder's ACT team effectively serve Southeast Asian clients.

Wilder's Assertive Community Treatment (ACT) Team

An enhancement of the ACT model to serve Southeast Asians

Cultural adaptation is defined by Bernal, Jimenez-Chafey, and Domenach Rodriguez (2009, p. 362) as "the systemic modification of an evidence-based treatment 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." While there is no uniform framework or methodology to guide the cultural adaptation of an evidence-based treatment model, some helpful frameworks exist. A widely utilized framework develop by Hwang (2006) helps to illuminate the specific adaptations that Wilder's ACT team has made to the ACT model in order to serve the Southeast Asian (SEA) population. The Psychotherapy Adaptation and Modification Framework (PAMF) was originally developed as a guide for the cultural adaptation of cognitive behavioral therapy (CBT) for Chinese Americans. It consists of 6 therapeutic domains, 25 therapeutic principles, and corresponding rationales. This framework captures some of the deep structure adaptations to the ACT model, while surface structure adaptations such as ethnic matching and language capacity are not described in the following table.

The Assertive Community Treatment model was designed to help clients with severe and persistent mental illnesses function better in community. ACT teams are made up of multidisciplinary professionals that provide services and supports to individuals in community settings 24/7. Wilder's ACT team is unique in that it serves an ethnically and linguistically diverse SEA population. Many Wilder ACT clients are first or second generation immigrants or refugees and are either English language learners or speak English as a second language. While maintaining fidelity to the ACT model, Wilder's ACT team has made several modifications and enhancements to the standard ACT model that are important to document in order to evaluate the effectiveness of the adapted model on patient outcomes and to communicate to the broader field about effective adaptations for the SEA population. The following table illustrates Wilder's ACT model adaptations based on domains of the Psychotherapy Adaptation and Modification Framework (PAMF; Hwang, 2006). Please note that Wilder's adaptations to the ACT model did not originate from a framework, but rather arose in response to the needs of the clients they serve.

Therapeutic domains	Wilder ACT team adaptations/enhancements
DOMAIN 1 | Dynamic Issues and Cultural Complexities	
Principle 1: Be aware of dynamic sizing (e.g., knowing when to generalize and when to individualize treatments on the basis of client characteristics). *Principle 2:* Be aware of and address clients' multiple identities and group memberships.	– Because Wilder's ACT team serves a diverse population (e.g., recent immigrant/native/refugee, generation, country of origin, language, age, religion) the team of providers understands and emphasizes individualized treatment and relationship building. Relevant insights are shared among ACT team members at every team meeting. – Assess for acculturation level and potential cultural differences within each ethnic group to understand the traditions and healing practices that are particular to the client. There are cultural differences based on the geographic region or refugee camps people live in. ACT team members ask their clients about where they come from as an indication of their understanding of these experiences and their importance. – Wilder ACT team members have relevant experience (e.g., identify as SEA immigrants or refugees, share same ethnicity/language/culture with clients, have experienced or have family members who have experienced trauma).

Therapeutic domains	Wilder ACT team adaptations/enhancements
DOMAIN 2 | Orientation	
Principle 3: Orient clients to therapy. *Principle 4:* Establish goals and structure for therapy early in treatment. *Principle 5:* Orient clients to a biopsychosocial or holistic approach model of disease development.	– The conceptualization of mental illness is always through the lens of the culture of the individual or family experiencing it. Wilder's ACT team spends significant time educating clients about the biomedical Western model of care, as many clients are unfamiliar with the health care system and available services and treatments. In addition to education for the client, Wilder's ACT team works to bridge the client's understanding of their illness or experience with that of the ACT model. – Include family members as part of the orientation and/or treatment process to support the understanding of service/treatment. For example, in the Hmong culture the father or elder from the immediate family may need to be present as they are viewed as the decision makers and have the most influence on treatment. Asking for formal written consent from the client to speak with these individuals may be seen as offensive towards the decision makers. – ACT team members orient clients to service by doing things for them as part of building rapport and trust. Initial sessions with the client are extended and can be spent navigating immediate resources to address basic needs (e.g., support with finding stable housing and applying for necessary benefits). – Goals may vary widely for Wilder ACT clients. The goals developed are client driven per the ACT model, however, this can sometimes be challenging for those who have a cultural understanding of their provider as the authority and expect them to assign therapeutic goals or treatment as the professional/expert. – Wilder's ACT clients may take longer to reach their vocational and educational goals due to barriers such as language and lack of past educational opportunities. Therefore, the team often uses the transtheoretical model (stages of change) that monitor a client's progression through the stages of precontemplation, contemplation, preparation, action, maintenance, and termination. – ACT team members must understand the multiple lenses used to view mental illness. In the Hmong community, mental illness may be viewed as an imbalance between the physical and spiritual world or believe that a person has "lost their soul." Treatment often combines use of spiritual ritual or interpretation in tandem with the use of Western medication and practices.

Therapeutic domains	Wilder ACT team adaptations/enhancements
DOMAIN 3 | Cultural Beliefs	
Principle 6: Focus on psychoeducational aspects of treatment. *Principle 7:* Use cultural bridging to relate concepts to Asian beliefs and traditions. *Principle 8:* Find ways to integrate extant cultural strengths and healing practices into the client's treatment. *Principle 9:* Align with traditional/indigenous forms of healing. *Principle 10:* Understand how cultural beliefs have influenced help-seeking patterns for your client.	– Stigma related to mental illness is common in SEA communities. To address this, Wilder's ACT team engages in more education with clients and their families than a typical ACT team. For example, Wilder's Karen case manager works with community leaders as an intervention effort to address stigma in the Karen community. – Wilder's ACT team adapts tools and content used to be more culturally relevant for their clients. For example, team members might focus on more of a collectivist, rather than individualistic, approach to treatment by encouraging connection with family and friends and involving family in treatment. – A client's cultural lens may cause them to interpret their mental illness differently than how a Western trained health care provider would interpret it. For example, a SEA client might view their symptoms as a result of their spirit leaving their body or a demon possessing them, or believe that the symptoms are a result of karma. Psychosis might be viewed as a symptom of something unresolved in the spirit world rather than a brain disorder. ACT team members accept this view and work within it. ACT team members support clients' engagement in their treatment along with traditional healing practices (i.e., a client might be engaged in services and at the same time on their journey to find out their illness are associated with their Shamanic calling). – ACT team members may ask "tell me your story." The Hmong and Karen language do not have words like trauma, or mental illness. What clients describe is often physical complaints or describe something that happened to them. Team members may then name that as anxiety or depression to normalize the symptom. – Herbal medicines are commonly used instead of Western medications due to fear of 'dulling the brain'. ACT team members help clients and families to understand the interactions of herbal medicines and medications and the side effects of medications.

Therapeutic domains	Wilder ACT team adaptations/enhancements
DOMAIN 4 | Client-Therapist Relationship	
Principle 11: Teach therapists about the cultural background of their clients. *Principle 12:* Therapists should be professional and present themselves as an expert authority figure. *Principle 13:* Client-therapist roles and expectations for therapy should be clearly addressed. *Principle 14:* Join and engage the client by assessing family background and migration history. *Principle 15:* Therapist cultural self-awareness and self-identity should be thoroughly explored. *Principle 16:* Interactional and relational models of therapeutic relations should be understood.	– Strengthening the client-therapist relationship is accomplished by 1) having a diverse team that is largely representative of the clients served and 2) capitalizing on the team-based approach where team members are able to learn from one another. – Therapists presenting themselves as an expert authority figure is antithetical to the client-centered approach that the ACT model is based on, yet, for some SEA clients, this is a more effective approach to building trust. – Clients' past experiences with culturally incompetent health care providers and systems require an additional layer of trust building between client and ACT team members. – ACT team members must have an understanding of historical trauma in SEA communities (e.g., war, loss of homeland, immigration journey, discrimination). – ACT team members must have an understanding of the different levels of acculturation and changes in traditional family and community structures. – ACT team members are aware of cultural norms (e.g, Hmong providers address clients by calling them as a kin of the family such as brother/sister, aunt/ uncle, and grandmother/grandfather based on the providers age.
DOMAIN 5 | Cultural Differences in Expression and Communication	
Principle 17: Understand that the notion of psychotherapy and talking about one's problems as a method of treatment is culturally foreign to Asian clients. *Principle 18:* Understand cultural differences in communication styles. *Principle 19:* Understand and address ethnic differences in expression of distress (e.g., somatization vs. worry). *Principle 20:* Address cognitive and affective symptoms of Asian clients.	– Indirect communication is common in SEA communities – when "yes" actually means "no." ACT team members may need to rely on other indicators to understand what the client is thinking and feeling. – Not sharing problems and avoiding conflict is a cultural norm among Southeast Asians; however, it does not mean the client is not experiencing any concerns. ACT team members need to be patient and understand that underlying issues may be revealed as other issues, such as barriers to basic needs are discussed. – Saving face is very important in many SEA cultures. For example, a client may be reluctant to say that did not take their prescribed medication to save face and avoid shame. – Praise is not typical in many SEA cultures (i.e., in the Hmong culture there are some spiritual connections with praise that may lead to bad omens).

Therapeutic domains	Wilder ACT team adaptations/enhancements
DOMAIN 6 | Cultural Issues of Salience	
Principle 21: Be aware of shame and stigma issues that may influence the treatment process. *Principle 22:* Address and be aware of push-pull feelings and culture-related role inconsistencies that may exist between the client's culture of origin and the culture of therapy. *Principle 23:* Collaborating with family and/or spending more time understanding family relationships may be necessary. *Principle 24:* Be aware of and understand life experiences may act as additional stressors or place clients at additional risk for mental illness (e.g., acculturative stress, racism, linguistic difficulties, social mobility problems, feelings of nostalgia, loss of interpersonal networks, intergenerational family conflict). *Principle 25:* Therapists should understand how social class and privilege interact and affect the treatment process.	– More intensive involvement with family, and sometimes the broader community, is essential to successful treatment of many Southeast Asian clients. – Shame and stigma regarding going outside of the family to resolve issues as problems are dealt within the family. ACT team members reinforce the aspect of confidentiality to address this concern. – ACT team members often focus on interdependence versus independence. For example, if a client wants to return to live at home with family members despite being an adult that is supported as this is a cultural norm in many SEA communities.

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For more information

This summary presents literature on cultural adaptations for mental health treatment models for Southeast Asians. For more information about this report, contact Anna Granias at Wilder Research, 651-280-2701.

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