PSYCHOTHERAPY WITH ASIAN CLIENTS: AN EXPLORATORY STUDY OF THE PERSPECTIVES OF EAST ASIAN CLINICIANS

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ABSTRACT

This exploratory study examined, through the lens of East Asian therapists, how culture, diversity, and multicultural issues intersect when treating East Asian clients, so that mental health professionals may be provided with increased knowledge and insight in working with this population. Ten East Asian mental health professionals, experienced in the field of psychotherapy and having treated East Asian clients in the past five years, participated in interviews surveying their experiences working with such clients. A qualitative analysis of the participants' interviews was completed using a grounded theory approach (Corbin & Strauss, 2014). Results from this study revealed themes consistent with the currently available literature, such as the impact of stigma on help-seeking behaviors and the therapy process, adoption of a family/systems-oriented framework, interaction of therapist and client acculturation, benefits of ethnic match and shared culture in treatment, difficulties in ethnically matched pairs, and limitations of diversity-related and multicultural training. Results also indicated additional themes positively and negatively impacting the therapeutic process which expanded upon the current knowledge. These included elements related to language proficiency, therapist identity, physical appearance, therapist and client level of acculturation, countertransference, generational differences, introspection and consultation, power and privilege, shame, and a greater emphasis on family dynamics/systems. The current study revealed notable gaps in the East Asian mental health literature linked to specific therapeutic interventions and treatment modifications, and organizational barriers between access and service delivery for this population. Implications for future research and cross-racial treatment included efficacy of modified treatment interventions, inclusion of more diversity-related courses and faculty of color in clinician training,

clinical interventions, and language proficiency. Additional implications included developing updated policies on culturally competent care, advocacy and resources; strategies to address myths and stereotypes and encourage a holistic approach to mental health; and resources to attract more bilingual East Asian clinicians.

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Chapter I

Statement of the Problem

The population in the United States continues to become more diverse—a trend that is accelerating. The U.S. Census Bureau (2012) reported that by the year 2050 people of color will comprise over 50% of the population. Fuertes and Brobst (2002) found this phenomenon reflected in increasingly diverse client populations in treatment.

In the United States, 17.3 million people, approximately 5.6% of the population, identified themselves as Asian, either exclusively or in combination with one or more other races. Asian Americans were classified as the fastest growing ethnic minority in the United States (U.S. Census, 2012). Their 46% growth rate increase over the decade preceding the most recent census—a significant proportion of which could be attributed to immigration, as nearly one in three of the 9.2 million foreign-born Asian Americans entered the United States between 2000 and 2009—was four times larger than that of the U.S. population as a whole. Moreover, this trend was widespread, reflected in every region of the United States and virtually every state: 49 of the 50 states realized Asian population growth of at least 30 percent.

Considering the relatively large number of Asians in the United States and the population's growth trajectory—Asian Americans are projected to represent 9.2% of the country's population (over 41 million) by 2050 (U.S. Census Bureau, 2012)—the lack of research conducted on this population, particularly East Asian Americans, is alarming. Less attention has been focused on Asian American mental health than on other minority groups, such as African Americans and Latinos (Abe-Kim, Takeuchi, Hong, Zane, Sue, & Spencer, 2007; Lee & Mock, 2005). Additionally, findings indicating the underutilization of mental health services and poor treatment outcomes in these

populations should be of vital concern to the mental health field, particularly in light of the population's rapid growth rates (Chin, 1998; Sue & Sue, 2012).

This study was an effort to address such deficiency by investigating the perceptions of East Asian clinicians treating East Asian clients, with East Asian defined as individuals who identify themselves as Chinese-, Taiwanese-, Korean-, and Japanese-American. Although many differences may exist among each group, as discussed below, numerous commonalities are shared, such as worldviews founded in the Asian religious and spiritual traditions of Confucianism, Daoism and Buddhism, and the importance of the family unit.

Although Asian Americans often share such common cultural heritage, different countries of origin, languages, cultures, religions, health and illness models, and health-seeking patterns exist. The larger category of Asian Americans comprises at least 43 ethnic groups with 100 different languages and dialects (U.S. Department of Health and Human Services, 2001). There are additional important inter- and intra-group differences with reference to socioeconomic status, educational achievement, immigration patterns, traumatic experiences, family dynamics, and degree and process of acculturation. Thus, professionals should be wary of the danger that an improper and homogenized view of Asian Americans may result from combining distinct and unique ethnic groups and individuals into one category (Kim, Yang, Atkinson, Wolfe, & Hong, 2001).

As past research has failed to capture distinctions between the East Asian subgroup and other Asian subgroups, additional research on clinician perspectives was needed in order to determine this population's specific needs. In order to understand the mechanisms, treatment modification, cultural considerations, and clinicians themselves—

who identify themselves as having a similar, if not the same ethnicity, as their clients—this study explored four major research areas:

1. How do East Asian clinicians think about and account for the similarities and differences in culture between themselves and their clients? Specifically, how do they think about and account for the role of East Asian culture in conceptualizing client problems and diagnoses?
2. How do East Asian clinicians think about and work with the cultural stigma of mental illness in the process of therapy? Specifically, what modifications do they make in treatment, joining, building rapport, and working with barriers to treatment?
3. What role, if any, does the clinician's own level of acculturation or cultural background influence their treatment with East Asian clients?
4. What training did these clinicians receive on working with Asian clients? What did they consider to be useful and unhelpful? What recommendations would they make to enhance treatment of Asian clients?

Chapter II

Review of the Literature

Conceptualization of Mental Illness

According to Leong and Lau (2001), barriers to mental health help-seeking are comprised of three components with cultural roots: beliefs about how mental illnesses are conceptualized and treated, feelings of shame and stigma in response to mental illness, and values that form the basis of communication and emotional management.

From the perspective of many Asian Americans, the experience of psychological distress is not conceived of within the context of mental illness but, rather, is a reflection of an individual's lack of willpower, weakness of character (Lee & Mock, 2005), or a problem with the body, stemming from beliefs about the mind body relationship, i.e., illnesses of the mind and body cannot be separated from each other (Ying, 2002). Consistent with this belief's focus on the body, Asian Americans are more likely to attribute mental illnesses to organic causes than Caucasian Americans (Zhou, Siu, & Xin, 2009).

Experiencing somatic manifestations of psychological distress is prevalent across Asian American groups (Leong & Lau, 2001; Kirmayer & Young, 1998). Thus, when Asian Americans seek professional help for psychological distress, they may be more likely to seek services from Western medical professionals (e.g., physicians) or traditional Eastern healers (e.g., acupuncturists), rather than mental health professionals (Lee & Mock, 2005). This divergence between culturally-informed conceptions of managing psychological distress and the approach of Western models of psychotherapy can be so noteworthy that individuals in some Asian cultures believe close examination of psychological distress can be characterized as "dwelling on morbid thoughts" and,

thus, likely to create more harm than good (Sheu & Sedlacek, 2004; Sue, Wagner, Davis, Margullis, & Lew, 1976).

Culture-Based Responses of Shame and Stigma About Mental Illness

A further contrast between Asian culture and Western models is the expectation among most Asians that professionals are experts. Thus, when mental health professionals, consistent with their training, attempt to work with Asian clients in a non-directive, collaborative manner (Sue & Sue, 2012), and provide them with treatment options, clinicians' Western approach may result in their loss of credibility among Asian Americans regarding the effectiveness of psychotherapy services (Leong & Lau, 2001).

Culturally-based affective responses of shame and stigma (Leong & Lau, 2001; Yang, Phelan, & Link, 2008) make it less likely for Asians to publicly admit problems and seek professional help for psychological distress but, rather, to rely on family involvement in addressing such issues. Leong and Lau (2001) attribute this tendency to an emphasis on upholding family reputation and "face." Face concern is viewed as an individual's "set of socially sanctioned claims concerning one's social character and social integrity," defined by specific roles that the individual upholds as a member or representative of a social or reference group (Zane & Yeh, 2002, p. 126).

Maintaining face, with its emphasis on being mindful and referencing behaviors to their projected subsequent impact on others in the family, influences an individual's sense of self and plays a central role in cultivating positive self-regard (Heine, 2004). The concern of maintaining one's face and that of the family can also be a source of psychological distress when negative results are attributed to character weakness, leading to experiences of shame and stigma—a prominent theme for Asian Americans who experience mental health issues (Kung, 2004; Mak, Chen, Lam, & Yiu, 2009; Yang &

WonPat-Borja, 2006). The cultural emphasis on the avoidance of shame may result in heavier family involvement in help-seeking, as well as cause lengthier delays in Asian Americans seeking professional mental health care than would be the case with other ethnic groups (Okazaki, Kassem, & Tu, 2014).

Culturally-Informed Values, Communication, and Emotional Management

In addition to affective responses of shame and stigma, culturally-based values that inform norms for communication and emotional management may also contribute to Asian Americans' reluctance to discuss personal problems outside of the family (Leong & Lau, 2001). For instance, the collectivistic values prevalent among Chinese Americans often give rise to a sphere of privacy extending from an individual to incorporate immediate and even extended family members. Thus, an individual's disclosure to others of intra-familial problems can be conceived of as a violation of the privacy of other family members (Leong & Lau, 2001) and, thus, result in feelings of guilt. Furthermore, in contrast with the Western traditional psychotherapy approach of emphasizing one's individual goals, collectivistic values discourage placing such individual goals before the needs of the family (Sue & Sue, 2012). Given the nature of culturally-informed beliefs about how mental illnesses are formed and treated, affective responses of shame and stigma, and norms for communication and emotional management, research has shown that the degree of acculturation to Western values and culture is a factor in mental health-seeking attitudes and behavior (Chen & Danish, 2010; Fung & Wong, 2007; Tata & Leong, 1994).

A number of cultural beliefs and values, some arising out of the Confucianism-derived collectivistic traditions that discourage open displays of emotions in order to maintain interpersonal and social harmony, and others associated with cultural beliefs

that stress the importance of controlling emotions and resolving problems by oneself, may contribute to Asian Americans manifesting psychological distress as physical symptoms (Kim, Atkinson, & Umemoto, 2001; Leung, 1990). Asian cultures stress harmony in interpersonal relationships (Yee, 1992). This, coupled with the Confucian belief that being overly expressive is offensive and a sign of weakness, discourages emotionalism in social interactions. This has resulted in the belief among many East Asians that their Confucianism-based culture prohibits open expression of emotion, including psychological distress (Lee & Mock, 2005). Thus, certain Asian values of emotional self-control may be violated by seeking help through mental health services and verbally expressing psychological distress and emotion in counseling. This conflict between Asian and American cultural values may help to explain why Asian Americans exhibit a high level of physical and psychological distress, exacerbated by their underutilization of mental health services, and tendency, once help is sought, to terminate therapy prematurely (Abe-Kim et al., 2007; Gee, 2004; Nguyen & Peterson, 1993).

Moreover, Berry (1997) described acculturation as a bilinear model that incorporates two continua: one represents enculturation in the individual's indigenous culture, and the other represents the individual's acculturation to the dominant culture. Acculturation refers to the level of involvement in the culture of origin and the dominant culture and enculturation is defined as the process of adaptation and retention of one's indigenous culture, values, ideas, and concepts. Within this model, dimensions of acculturation and enculturation may be ascertained on an individual basis. As is the case with other ethnic minority groups, the theory of acculturation and enculturation highlights how East Asian clients undergo a personal cultural adaptation process which incorporates the interplay between the acceptance and rejection of both their indigenous and dominant

culture. Moreover, understanding an individual's level of acculturation provides a more contextualized explanation of the complexities that ethnic minority groups experience and how such complexities influence psychological health and the way in which an individual functions and behaves in various life domains, such as work, school, family, and other inter-personal relationships.

The impact of acculturation and enculturation is most often visible in the manner in which children and parents experience differences in the adaptation process, which often results in cultural conflicts that can lead to the development of certain types of mental health problems (Gudiño, Lau, Yeh, McCabe, & Hough, 2009; Kim, Hurh, & Kim, 1993; Lee & Cynn, 1991). Within one family, intergenerational conflict between parents and children can extend, paradoxically, to what can be conceived of as three generations. The first generation is defined as individuals who were born and raised in their indigenous country and immigrated as adults. The second generation is defined as individuals who were born in the United States (Hurh, 1998). A special construct, "the 1.5 generation," is often used to describe those who immigrated to the United States as children or adolescents (Lee & Cynn, 1991), and thus spent a large portion of their developmental years in the United States. Such individuals are considered to be able to operate proficiently within both their indigenous and United States cultures and are fluent in both languages (Hurh, 1998; Kim, Brenner, Liang, & Asay, 2003; Park, 1994).

Varying levels of adaption to the dominant U.S. culture among family members can result in a gap in cultural values, breakdowns in communication and functioning, increased stress, and family conflict (Hwang, 2007). These consequences are especially problematic as they challenge salient cultural values for Asian Americans, such as collectivism, conformity to norms, deference to authority figures, emotional restraint,

filial piety, hierarchical family structure, and humility (Kim, Atkinson, & Yang, 1999; Sue & Sue, 2012).

Multicultural Competence and Training

Within the field of mental health services in the United States, cultural competence is seen as an essential skill and tool when delivering clinical interventions (APA, 2003, Fouad 2006). Successful outcomes as a result of the therapeutic process are often contingent on multicultural competence: the integration of one's own theoretical and technical clinical practice with the needs of the culturally and ethnically diverse population engaged in treatment (Fuertes & Ponterotto, 2003). The increasing concern about multicultural issues, along with its concurrent need for training clinicians in multicultural competence in mental health interventions (Ponterotto, Casas, Suzuki, & Alexander, 2009), was exemplified by a finding by the U.S. Surgeon General that individuals from racial and ethnic minority groups demonstrated "a greater burden from unmet mental health needs and as a result suffer a greater loss to their overall health and productivity" (U.S. Department of Health and Human Services, 2001, p. 3).

Cultivating increased cultural competence has been demonstrated to have positive results in the treatment process, including strengthening the therapeutic alliance (Atkinson & Lowe, 1995; Sue & Sue, 2012), increased client satisfaction with treatment (Constantine, 2002), greater client self-disclosure (Thompson, Worthington, & Atkinson, 1994; Zane & Ku, 2014), and leading to positive outcomes (Zane, Sue, Chang, Huang, Huang, Lowe, & Lee, 2005). Accordingly, in 2003, The American Psychological Association devised a framework for cultural competence in the field, incorporating multicultural research, training, and practice. Their guidelines encouraged practitioners to consider an individual's sociopolitical and historical contexts, group memberships and

different facets of multiculturalism in treatment. As the literature demonstrated, a lack of cultural competence and sensitivity to the impact of culture and race on clients presents an additional barrier to treatment as racial and ethnic minority clients feel disempowered and abused by mental health professionals (Sue & Sue, 2012). Therapist actions and behaviors that particularly violate practice standards in this area include microaggressions and implicit racial prejudices (Franklin, Boyd-Franklin, & Kelly, 2006; Sue & Sue 2012). Thus, in order to promote increased help-seeking behaviors, as well as to improve the delivery of services to communities that suffer from unmet mental health needs, it is imperative that mental health service providers be held to high standards of racial and cultural sensitivity.

The importance of this focus on multicultural and racial sensitivity has been a concern of scholars in related fields who have created their own definition of multicultural competence to aid clinicians, as can be seen in the tripartite model of multicultural competence, as delineated by Sue, Arrendondo, and McDavis (1992), and Sue's (2001) reconceptualization of a multidimensional model of cultural competence. Despite the scholarly and professional acknowledgment of the importance of multicultural competence in the helping professions, information as to how to instill and teach its components to students and professionals is lacking (Kim & Lyons, 2003).

Although didactic strategies to teach multicultural principles and diversity-related issues are a common practice and approach to multicultural training (Nolte, 2007), the time devoted to this subject is disproportionately insignificant in view of its importance. According to Goode-Cross (2011), most training is limited to a single multicultural issues course, rather than integrated into the entire training experience. Activities emphasizing an experiential component have been found to be more effective than strictly didactic

learning opportunities. Experiential activities have been utilized to cultivate greater culturally sensitive attitudes, beliefs, knowledge, and relevant clinical skills (Pedersen, 2000; Toporek, 2001; Torres, Ottens, & Johnson, 1997) and offer creative and effective ways to establish safe environments that not only teach clinicians, but also allow for more open exploration of the practitioner's cultural values, norms, and beliefs that influence clinical practice. Such experiential activities include, among others, role-playing, viewing training videos, performing cross-cultural interviews, writing cultural autobiographies, studying a second language, and conducting values clarification work. Discovery of one's underlying, if unaware, biases and implicit judgments can, if addressed, serve to reduce the power differential between clinician and client and enhance the client's treatment. An additional technique, the use of games as a learning tool, has been found to facilitate experiential learning (Kim & Lyons, 2003; Randel, Morris, Wetzel, & Whitehill, 1992).

Racial/Ethnic Matching in Treatment

An issue that has long intrigued researchers is what effect, if any, a shared racial/ethnic background between clinician and client has on the treatment process and its outcome (Gamst, Dana, Der-Karabetian, & Kramer, 2001; Leong, Wagner, & Tata, 1995; Thompson, Bazile, & Akbar, 2004; Wong, Kim, Zane, Kim & Huang, 2003). Researchers have investigated the effects of racial/ethnic matching of client and therapist. Would such matching equate to shared beliefs regarding the etiology of mental illness and treatment goals, and thus facilitate the psychotherapy process and outcome? If so, then the corollary would be that an ethnic mismatch between therapists and clients might give rise to dissimilar expectations regarding treatment approaches and goals, thus threatening poor treatment compliance and outcome (Zane et al., 2005). According to Cabral and Smith (2011), clients demonstrated a moderately strong preference for therapists of their own

race/ethnicity and had a tendency to perceive therapists of them somewhat more positively than therapists who did not share their background.

Research has suggested that ethnic minorities in ethnically mismatched dyads tend to drop out from treatment in disproportionate numbers, while ethnic match correlated with positive outcomes for particular groups, specifically Mexican Americans and Asian Americans, and more decisively so for those who are less acculturated (Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Yang, & WonPat-Borja, 2006).

An analysis of data from public community health centers confirmed the benefits of ethnic and linguistic matching as lower premature dropout rates and higher treatment attendance rates (Lau & Zane, 2000; Takeuchi, Sue, & Yeh, 1995). Other studies confirmed ethnic matching as conferring certain benefits, such as increased service utilization, reduced premature termination and greater retention; however, no improvement in treatment outcomes could be demonstrated (Erdur, Rude, & Baron, 2003; Fujino, Okazaki, & Young, 2006; Le Meyer, Zane, & Cho, 2011; Wintersteen, Mensinger, & Diamond, 2005). Further research corroborated the findings above. Meta-analyses examining whether ethnic matching positively effects the therapy process and outcome found no relation (Maramba & Nagayama Hall, 2002; Shin, Chow, Camacho-Gonsalves, Levy, Allen, & Leff, 2005), but did demonstrate an increase in service utilization and retention (Maramba & Nagayama Hall, 2002; Sue et al.,1991; Yeh, Eastman, & Cheung, 1994). More generalized studies have found that subjects prefer to associate with others they perceive to be similar to themselves (Le Meyer, Zane, & Cho, 2011), as well as those with a similar appearance, as these indicators may signify shared attitudes (Uba, 1994).

According to the literature, some studies have shown support for the benefits of ethnic matching between therapists and clients, while others demonstrated that ethnic matching has no significance in the therapy process and outcome. One possible explanation for these mixed results may stem from methodological issues. For example, the analogue studies, which supported the notion that ethnic matching positively affects psychotherapy outcome, lacked external validity and may not have accurately reflected the attitudes and preferences of Asian American clients. In comparison, the studies that used real therapy dyads were limited by their small sample size, lack of randomization of treatment conditions, and failure to account for important within-group variables among clients and therapists (Karlsson, 2005). Additionally, the theory of racial/ethnic match assumed shared beliefs and values, disallowing for individual differences between the therapist and the client. For example, therapists may hold a set of mental health beliefs that are congruent with those of their professional field, while clients' mental health beliefs may be more a function of their culture.

One variable often omitted from race/ethnic matching studies is client acculturation level, i.e., the continuum between adherence to the dominant culture and traditional Asian culture. Some studies, however, have examined acculturation as an independent factor influencing other Asian Americans' beliefs and attitudes toward mental health-related issues, such as the etiology of mental illness, treatment appropriateness, help seeking, and counselor preference (Kim & Atkinson, 2002; Kim & Omizo, 2003; Mallinckrodt, Shigeoka, & Suzuki, 2005). In addition to acculturation, other factors, such as immigration history, gender, religion and political affiliation, may influence an individual's mental health beliefs, problem conceptualization, coping strategies, and treatment goals. Given the rising number of foreign born Asian Americans

in the United States, it is important that such individual variables be examined thoroughly, so that the needs of this population in terms of therapy process and outcome may be assessed properly.

Some researchers have suggested that Asian Americans are more likely to attempt to resolve problems on their own before seeking mental health services due to cultural values emphasizing control of strong emotions (Kim & Ryu, 2005; Lee & Mock, 2005; Snowden & Cheung, 1990). Research has similarly demonstrated that Asian Americans show less positive attitudes towards seeking professional psychological help than Caucasians (Kim & Omizo, 2003; Lee & Mixson, 1995). When help is finally sought, Asian Americans prefer to obtain help from family members or friends (Kim & Ryu, 2005; Narikiyo & Kameoka, 1992). Interestingly, although Asian Americans may not express a strong initial preference for a therapist based on race, they appear to perceive Asian American therapists more positively than other therapists (Cabral & Smith, 2011). When questioned on attitudes toward effective intervention and treatment modalities, Asian American clients reported that they perceived effective interventions as those which would lead to an increase in their ability to work and assume family roles and responsibilities, rather than individual autonomy and personal growth (Chou & Leonard, 2006; Fujita, Ito, Abe, & Takeuchi, 1991).

Myths and Stereotypes Regarding Asian Americans

The lack of attention and resources devoted to Asian American mental health issues may be explained by investigating the various myths, beliefs, and/or stereotypes regarding Asian Americans, most prominent among them the concept of Asian Americans as a "model minority," a term referencing the greater educational and economic success achieved by Asian Americans when compared to any other "minority"

group in the United States. This term was introduced in a January 1966 article in *The New York Times Magazine* entitled "Success story: Japanese American style." The author, William Petersen, showcased how the Japanese American community's quiet and successful assimilation into mainstream American culture contrasted with other more visible and often "louder" ethnic groups, such as African American, Latinos and Native Americans, who had not similarly availed themselves of the upward mobility opportunities offered in the United States.

Inherent in the model minority myth is the belief that Asian American individuals are obedient to authority, respectful, well-behaved, quiet, high achieving, hard-working, and successful. These attributes, however, minimized the challenges Asian Americans faced, creating a social expectation that they had fewer adjustment and mental health problems than other groups due to their relatively higher education, occupational and financial status (Sue, 1994; Sue & Sue, 2012).

The assumptions underlying the model minority label have become a justification for the lack of social, educational, and governmental services available for Asian Americans (Lee, Lei, & Sue, 2001), and have also served as a barrier for scholars and practitioners to recognize the importance of research devoted to this population's mental health. The necessity of studies investigating Asian American mental health issues and the sociocultural factors that influence them has even greater importance as a result of the rapid growth of the Asian population in the United States.

Treatment Outcomes Among Asian Americans

Underutilization of mental health services among ethnic minority clients, in comparison to Caucasian clients, has been well documented (Le Meyer, Zane, Cho, & Takeuchi, 2009), and this is especially true for Asian Americans. Mental health service

utilization studies conducted with public archival data from two West Coast counties found that Asian Americans were underrepresented relative to other ethnic groups (Chen, Sullivan, Lu, & Shibusawa, 2003). Such results were also found when both inpatient and outpatient mental health service utilization were examined throughout the United States (Snowden & Cheung, 1990). According to the most recent and rigorous epidemiological research available, the National Latino and Asian American Study (NLAAS), Asian Americans, especially those who are foreign-born, tend to underutilize mental health services (Le Myer et al., 2009). Although mental illness prevalence rates for Asian Americans are not dissimilar to those of other groups, they are less likely to access available services—only 6% of Asian Americans with mental illness sought help from mental health professionals (U.S. Department of Health and Human Services, 2001).

Although limited in number, several studies conducted with Asian Americans challenge the concept that low utilization of mental health services can be explained by a low incidence of mental illness. In fact, research has indicated higher levels of psychological distress among Asian populations than other ethnic groups (Chen & Danish, 2010). The NLAAS suggested that the underutilization of mental health services by Asian Americans might be better explained by the stigma attached to mental illness and the lack of mental health services designed to serve this population, rather than by low prevalence rates of mental illness when measured by their utilization of mental health services.

In addition to underutilization, research has shown that Asians are also more likely to terminate treatment prematurely. According to public mental health utilization data in the 1970s and 1980s, over half of Asian American clients dropped out of treatment after their first session and those who remained in treatment beyond the first

session received significantly fewer psychotherapy sessions than European American clients (Sue & Sue, 2012). More recent studies, however, have found no ethnic differences in dropout rates or treatment length, and occasionally have found better results for Asian Americans relative to other groups. The explanation for the lower dropout rates and longer treatment lengths may be that treatment is sought only in cases of severe disturbance requiring more extensive treatment.

Findings have corroborated that a range of significant mental health problems exist among Asian Americans, however, because help was sought at a later point, their conditions were more severe and chronic than patients of other cultural backgrounds (Bui & Takeuchi, 1992; Durvasula & Sue, 1996; U.S. Department of Health & Human Services, 2011). Among individuals who received inpatient or outpatient treatment, Asian Americans were more likely to be diagnosed with psychotic disorders and receive psychotropic medications than European Americans and display greater distress at intake than African Americans, Latinos, and Caucasians (Chen et al., 2003; Flaskerud & Hu, 1992). Similar results were found in a study of college students (Kearney, Draper, & Baron, 2005).

In addition, results from existing studies based on the effectiveness of psychotherapy for Asian Americans suggested that Asian Americans are less satisfied with therapy than European Americans (Lee & Mixson, 1995; Ngo-Metzger, Massagli, Clarridge, Manocchia, Davis, Iezzoni, & Phillips, 2003; Zane, Enomoto, & Chun, 1994). Asian Americans tend to have less favorable attitudes toward seeking professional psychological services despite need (Kim, Ng, & Ahn, 2005; Liao, Rounds, & Klein, 2005; Masuda, Anderson, Twohig, Feinstein, Chou, Wendell, & Stormo, 2009), and are less likely to seek therapy for psychological issues than European Americans (Abe-Kim

et al., 2007; Le Meyer, Zane, Cho & Takeuchi, 2009). Asian Americans' reluctance in seeking help may be partially explained by their dissatisfaction with counseling and mental health services (Leong, Chang, & Lee, 2006).

To address the gap between need and utilization, studies were conducted to identify cultural and ethnic-specific factors that facilitate and impede cross-racial therapy and ethnic–specific services. Ethnic-specific services have been implemented, especially in ethnically dense communities (Leong et al., 2006), with the intention that an ethnic and cultural match between provider and client would improve the cultural accessibility of services, utilization, and treatment outcome. Several studies confirmed that assumption and found that such ethnic-specific services increased Asian Americans' utilization and reduced dropout and premature termination (Flaskerud & Hu, 1992; Gamst et al., 2001; Takeuchi et al., 1995). Altogether, these findings demonstrate that such strategies to improve the utilization rates of mental health services and help-seeing behaviors among Asian Americans can be successful at countering culturally-influenced beliefs about mental illness and attitudes toward mental health treatment.

Many studies have shown that members of ethnic minority groups tend to prefer therapists with the same background. For example, research conducted with African Americans found that they preferred African American therapists to European American therapists (Thompson et al., 2004). Studies conducted with Asian Americans, however, have had mixed results. Studies have found that Asian American respondents preferred counselors who were more educated; shared similar attitudes, personalities and ethnicities; and were older. A number of analogue studies have shown that Asian Americans rated ethnically-similar counselors as more credible and approachable and preferred them (Gamst et al., 2001; Thompson et al., 2004; Wong et al., 2003). However,

other studies have shown that Asian Americans' ratings were unrelated to counselor ethnicity (Atkinson & Matsushita, 1991; Yang et al., 2008).

Judging by the increased number of studies published in professional journals over the past few decades, research investigating Asian Americans' psychological needs have been receiving greater scholarly attention. Yet the issue of Asian Americans' utilization of mental health services at a rate lower than other ethnic groups remains (Sue, Cheng, Saad, & Chu, 2012). While reluctance may often be based on the culturally-reinforced bias against asking for psychological help from non-family members, such as counselors, about personal and family-related issues (Kim & Omizo, 2003), Asian American clients may also be unfamiliar with Western styles of therapy and lack confidence in a counseling process that does not provide immediate and tangible benefits (Ngo-Metzger et al., 2003), perceiving such process to be ineffective. When considering the effectiveness of counseling, Sue and Sue (2012) suggested that it may be influenced by the match or mismatch among clients' Asian cultural values and those of therapists. Areas of future research aimed at improving Asian Americans' utilization of mental health services may be directed toward gaining a better understanding of: (a) attitudes toward mental health services, (b) willingness to seek counseling, (c) understanding the dynamics between the therapist and clients, and (d) the cultural modifications that may be implemented to help facilitate Asian American clients' engagement and positive treatment outcomes in therapy.

The limited amount of research on Asian American mental health seldom differentiates between the various subgroups that comprise this population in the United States. Past research has failed to delineate the true essence of the burgeoning East Asian subgroup—one of the larger subgroups among Asian Americans, and how it is distinct

from other Asian subgroups. Additional research investigating East Asians is necessary to provide the best level of care for a population that is in need of services. This study—through its analysis of the perspectives of clinicians who identified themselves as having a similar, if not the same, ethnicity as their East Asian clients—aimed to understand those elements of the treatment process that might be customized so as to better accord with the cultural realities of East Asians.

Chapter III

Methodology

The purpose of this study was to add to the limited body of literature on Asian American mental health, specifically that of East Asians. Qualitative research methods, in the form of in-depth interviews, were utilized to examine the experiences of East Asian clinicians treating East Asian clients, and derive insight and advice that would benefit current and future clinicians.

Participants

The study used a network sample of 10 mental health professionals practicing in the field of psychotherapy who had some experience treating East Asian clients. An advertisement recruiting potential subjects (see Appendix A) was posted on the message boards (listservs) of various Asian clinician membership user groups. The advertisement gave the requirements for the subjects sought for this research as follows: Participants identify themselves as East Asian (of Chinese-, Taiwanese-, Korean-, and/or Japanese-descent), clinicians, and were either currently working with clients who identified as East Asian (of Chinese-, Taiwanese-, Korean-, and/or Japanese- descent) or had previous experience with East Asian clients. Considerable effort was made to recruit a diverse pool of participants in terms of demographic background, practice setting and length of experience, in order to represent a broad range of clinical experiences; however, a comprehensive representation of clinical practice with East Asian clients was beyond the scope of this study.

A total of 12 clinicians agreed to participate in this study and were interviewed. Due to poor audio quality, two interviews could not be transcribed, and thus included in the study. Of the remaining 10 participants, eight (80%) were female and two (20%) were

male. Three (30%) participants identified themselves as Korean, five (50%) as Chinese, one (10%) as Taiwanese-Chinese, and one (10%) as biracial (Chinese and Filipino). Six (60%) participants were between the ages of 30-35, two (20%) participants were between the ages of 36-40, and two (20%) participants were over the age of 40.

The majority of the participants in this study (six or 60%) were in the psychology field. Of those six participants, five had doctorates and one had a master's degree. Four participants (40%) were clinicians in the field of social work, all of whom had master's degrees. Their experience treating East Asian clients ranged from 2 to 17 years, with a mean of 9.65 years and a median of 7 years.

Participants in this study completed in-depth interviews providing details on their experiences working with East Asian clients in their current and/or previous employment. As three participants (30%) stated that they were not working with East Asian clients at the time, their interviews focused on their previous experience. All of the participants reported that they had worked with an East Asian client within the five years prior to the interview.

Participants described the types of settings in which they worked as both outpatient and inpatient. The outpatient settings consisted of public or community mental health centers (two participants, 20%), private practice (three participants, 30%), a university clinic (one participant, 10%), and a United States Department of Veterans Affairs outpatient clinic (three participants, 30%). One participant (10%) worked in an inpatient psychiatric hospital setting. Almost all (nine participants, 90%) stated that they had worked with East Asian clients in more than one setting.

Participants were asked to discuss general demographic information about the clients they worked with and then, more specifically, a typical East Asian client they

treated. The youngest client specified was 7 years of age, and the oldest 56. All participants indicated that they worked with adults over the course of their careers. Only four had worked with children and adolescents as well. Each participant worked with both male and female East Asian clients. When questioned about the race and/or ethnicity of their clients, eight participants (80%) reported working with Chinese/Chinese-American clients, four (40%) reported working with Korean/Korean-American clients, three (30%) reported working with Japanese clients, and five (50%) reported working with Taiwanese clients. Whereas almost all of the participants (nine or 90%) had worked with low-income clients, often living in inner cities and recipients of public assistance, only half (50%) reported having treated East Asian clients from suburban areas.

All participants indicated that their clinical practice included treatment with second generation East Asian clients, and five participants reported having worked with 1.5 generation East Asian clients in individual therapy. Seven participants (70%) reported that they had both individual and family therapy experience with first and 1.5 generation East Asian clients. Three participants (30%) indicated having worked with first generation East Asian clients in individual treatment. Five participants (50%) also reported providing therapy with monolingual non-English speaking East Asian families in Chinese, Taiwanese, or Korean.

All participants reported having begun their clinical work treating clients, both youth and adults, from various other ethnic minority groups, including African American, Latino, and those of Asian ethnicities other than East Asian. While most subjects noted that their clients were predominantly non-Asian, persons of color comprised almost two-thirds (65%) of their caseload. The average length of treatment was 6 months, with a range of four sessions at the least to 3 years at the most. Interestingly, four participants

(40%) had an almost exclusively Asian client base—80% of their typical caseload was comprised of Asian clients.

Presenting symptoms and problems comprised a wide variety of psychopathology including anxiety, depression, academic difficulties, extreme family conflict, oppositional behavior, stress, identity issues, perceptual disturbances, adjustment-related issues and trauma, with the most common referral and presenting issues being anxiety, academic difficulties, and extreme family conflict.

Measures

A demographic questionnaire and a semi-structured interview were utilized to collect data from all participants in this study. Participants were first provided with a background demographic questionnaire (see Appendix C), which was delivered via electronic mail prior to their interview. Completed questionnaires were either returned to the researcher in person or electronically transmitted as a password-encrypted document. The questionnaire requested information from the participants regarding their demographics (including age, racial and ethnic background, experience in the field, and educational attainment) and their clinical practice (including number of years practicing psychotherapy, current and previous treatment settings, the racial demographics of their typical and current caseloads, theoretical orientation and specialty areas, and the most common type of diagnoses treated).

Interviews were conducted either in person or enabled through an electronic device utilizing the Skype application. A semi-structured interview (see Appendix D) was utilized by the researcher to gather information regarding participants' experiences with East Asian clients. The protocol included a series of open-ended questions, close-ended questions, and prompts related to four primary areas: (a) the therapist's understanding of

and training in multiculturalism and race; (b) the therapist's conceptualization of mental health and Asian culture in treatment; (c) the therapist's experience of working with East Asian clients and differences between them and those from other cultures in the therapy process (including the joining, therapeutic alliance and rapport building, treatment modifications, and encountering resistance from clients); and (d) the therapist's reflection on working with racially similar clients, the state of Asian American mental health, the psychology field's approach to working with diverse populations, and on the interview process itself.

Procedures

Individuals who expressed interest in participating in this study were provided with information about the purpose and procedures of the study. The questionnaire was sent to potential subjects who agreed to participate in the study. Completed questionnaires were reviewed by the researcher to establish eligibility. The researcher scheduled the interview with qualified participants. For those individuals deemed ineligible for the study, the researcher provided an explanation, debriefed them, and thanked them for their time and interest. Provision was made by the researcher that referrals to mental health professionals would be available in the unlikely event that participants experienced psychological distress or conveyed a need for psychological assistance during the interview process. None of the participants expressed issues with psychological distress or needing psychological assistance.

At the beginning of each in-person interview, the researcher reviewed the informed consent form with participants and requested their signature (see Appendix B). For interviews that took place by Skype, participants were mailed the informed consent form electronically and returned a signed copy to the researcher prior to the date of the

interview either via electronic mail or fax. The informed consent form included details on the purpose and procedures of participation; the risks and benefits of the study; confidentiality; limits to confidentiality; the voluntary nature of the study; and contact information for the researcher and individuals and institutions affiliated with the study. All participants were provided with a copy of the informed consent form for their records, and completed an additional consent form that gave the researcher permission to audio and/or videotape their interview. The researcher reminded the subjects that their participation was voluntary, they could decline participation in the study at any time during the interview without penalty, and that they could rescind their agreement to be recorded.

The researcher assigned case numbers to protect the identity of the participants prior to the interview. The researcher interviewed the participants using a semi-structured interview (see Appendix D). All in-person interviews were conducted by the researcher in settings that were private, comfortable and convenient for the participants. For all interviews that were done through Skype, the researcher stressed to the participant the importance of conducting their interview in a setting that ensured their comfort, privacy and confidentiality. All interviews were recorded via video and/or audiotape for later review and transcription. No identifying information was attached to audiotapes or transcriptions. Each interview was approximately one and one-half hours.

At the close of the interview, each participant was provided the opportunity to address any related issues, ask questions that were not covered during the semi-structured interview, and thanked for their participation.

Treatment of Data

Consent and Background Demographic Questionnaire

All signed consent forms were kept separately from participant interview responses and were secured in a locked file cabinet which could only be accessed by the researcher. Data provided by the participants on the demographic questionnaire were utilized to categorize participants based on age, gender, ethnicity, and clinical practice. All participants were assigned a code number to protect their identity.

Interview Data

The researcher assigned a numerical code to all of the physical copies of the semi-structured interview, which were then stored in a locked file cabinet that only the researcher could access. Audio and/or video recordings of interviewers were converted into password-protected files and stored on the researcher's password-protected computer. All transcriptions were completed by the researcher, assigned a numerical code, and stored in a password-protected file on the researcher's home computer. The researcher determined that all study data and materials would be kept for at least three years after completion of the research.

Data Analysis

The primary goal of data analysis was to identify common themes among the participants interviewed. Based on the administration of the semi-structured interviews described above, the data collected described the experiences of East Asian clinicians working with East Asian clients and was qualitative in nature.

Data were analyzed using Corbin and Strauss's (2014) grounded theory methodology. Grounded theory accounts for and examines issues of "process and[/or] change over time (Morse & Richards, 2002, pg 54)." Underlying this type of analysis is

the assumption that theory can be constructed from and *grounded* in the data (Morse & Richards, 2002). In analyzing the data, there is a continuous interplay between analysis and data collection (Corbin & Strauss, 2014), as adequate and sensitive theories are developed from the data directly. The primary goal of data analysis is to "determine the categories, relationships and assumptions that inform [participants'] view[s] of the world in general and the topic in particular" (McCracken, 1988, p. 42).

Grounded theory analysis took place in three sequential phases. These three phases included open coding, axial coding and selective coding (Corbin & Strauss, 2014). Open coding, the first phase, involved scrutinizing the data for similarities and differences. The researcher reviewed each transcript for both micro- and macro-level themes. Micro-level themes were extracted by analyzing each transcript line by line. Macro-level themes were derived from examining each transcript as a whole. Through open-coding, more general categories were extracted from the transcripts in order to categorize transcript data into smaller subsets of data. Data across transcripts were then collapsed into more general categories and coding labels were often taken directly from the language used by participants themselves (Morse & Richards, 2002).

In the next phase of data analysis in grounded theory (Corbin & Strauss, 2014), the goal of axial coding was to understand the relationships between responses, and the main phenomenon, condition and consequences of various categories that had been identified. As a result, the relationships between the categories and subcategories identified in phase one (open-coding) were explored and identified in order to understand patterns that presented themselves in a given model (Corbin & Strauss, 2014). Related categories were then grouped or collapsed into more comprehensive categories.

Selective coding was the final step of grounded theory data analysis (Corbin & Strauss, 2014). In this last phase, categories identified through the prior two phases of analysis were collapsed further so as to form the primary core categories or themes. For the current study, the researcher broke down the responses by specific concepts. Once completed, these concepts were developed into more refined categories and, ultimately, the themes of the interviews were identified.

Chapter IV

Results

In this section, participant responses to a semi-structured interview have been outlined into four major categories: (a) treatment and conceptualization of race and East Asian culture in therapy; (b) the role of the therapist's ethnicity and identity in treatment; (c) their views of their training experiences when working with Asian clients; and (d) reflections on their experiences and recommendations for clinicians working with East Asian clients. Each of the four major categories included additional relevant questions.

Treatment and Conceptualization of East Asian Culture in Therapy

This segment focused on exploring participants' perspective on the importance of experiences of East Asian culture in their overall conceptualization and treatment approach with East Asian clients. Participants were asked a variety of questions related to preparing for sessions with East Asian clients, including: (a) typical issues and common characteristics of these clients; (b) how they think about race and account for similarities and differences among clients from different Asian backgrounds in their conceptualization of clients in therapy; and (c) if and how their thoughts, feelings, and approach to working with East Asian clients and cultural issues in treatment had changed as a result of working with these clients.

Preparing to Work with East Asian Clients

During the beginning of the interview, participants were asked about how they prepared to work with individuals who identify themselves as East Asian. Seven subjects (70%) reported that they did not engage in any special preparation, often attributing this to their training. Interestingly, one subject stated that she did not need to "prep" herself

for these sessions as all of her clients were of that ethnicity. Another subject noted, "in terms of preparing, I don't do anything differently than I do with any of my other clients. I think their ethnicity doesn't really come into play until I actually see them. So the preparation's about the same."

Of the three remaining subjects (30% of the sample) who engaged in other forms of preparation, one participant indicated that after she had gotten a sense of the nature of the client's issues, she read or did research on the client's background. Another participant stated that the various causes underlying cultural conflict were considered prior to the beginning of therapy:

> I would be mindful of the educational background, social background, how long they've been in the U.S., and age….I would definitely try to engage their understanding of mental health, like how they view their problems. It's the same [thing] that's important to do with any client, but, especially [with] those clients who may have [a] different cultural understanding of mental health and what causes mental health-related problems.

A second participant discussed the generational differences as an important factor in preparation:

> Again, that depends on the generation. The adult generation…they prefer [a] Korean speaking and [a] Korean understanding person and Korean culture. But the young generation, they don't want to come to you [because they] know you're Korean….1.5 generation, they want to be identified as [an] American or English speaking person so they prefer a non-Asian [therapist]….So, there is a conflict there in the therapeutic relationship….It's not their choice to see the [Asian therapist]. If they could, they would see a non-Asian person, but because of the

> language ability they cannot communicate. So they are forced to see a [therapist of the] same ethnic background or nationality. So there's a lot of skepticism and resistance there.

Another participant emphasized the importance of acknowledging the therapist's level of language proficiency in relation to that of the client: "I let them know up front that I don't speak Mandarin, I don't speak Cantonese well enough to do therapy.…But some of them want to try anyhow because, in their search, they haven't found many Asian therapists."

Presentation of Typical Issues in Treatment

Participants were next asked what typical issues had been presented by East Asian clients in treatment. Five subjects (50%) stated that their clients often presented with adjustment issues. One participant attributed the role of family dynamics and its resultant academic pressure as triggers for adjustment issues: "There's friction between the parents and/or they want to find different ways to reach their child and help them academically." Another adjustment-related issue is associated with identity. One participant described the plight of her young patients: "They don't fit in anywhere.…They feel like they are outsiders at home, in society, and in school." Adjustment-related issues can also be attributed to past trauma, according to another participant: "They have a hard time readjusting to life….Some of them had also really stressful experiences overseas. Some of that could be trauma-related." Similarly, another participant emphasized the significance of the role of the client's immigration history and acculturation: "Trying to familiarize yourselves and finding a sense…within this very new place is a struggle. [Symptoms] typically present…in different shapes and forms. And, I feel that they often suffer from disempowerment—losing their voice in a sense."

Other participants discussed anxiety and depression as two of the most frequent presenting issues among East Asian clients. One participant indicated that clients' anxiety and depression were a result of many adverse circumstances, in addition to acculturation: "They're also under a lot of stress too, financial hardship, and then they also have immigration issues. So all those stressors added together can trigger depression and anxiety." Another participant discussed how differences in expectations and communication difficulties between parents and children often resulted in anxiety and depression:

> In the older generations, it's always about their relationship with their kids....It's the relationship with their children and what they expect of them as parents. But when that [expectation] does not happen, they look back and say, "What did I do with my life? What was the problem with them? I spent all my life for you and I'm all alone with your mommy." And then they go back to depression and living in the United States saying that, "Now, I'm here for you. I came to the United States for you….You got your education….You live your life," and they don't come to see me. "You don't send your children to [visit] me."

Interestingly, another participant noted a disparity in the severity of East Asian clients who present with anxiety and/or depression in comparison to non-Asian clients: a theme resonating throughout the literature:

> Because of their, maybe, lack of insight about mental health, they're referred to mental health treatment…A lot of these patients come in with conditions more severe than you might find in the general population. In other words, they might wait until they're too severe to come in. And by that time, they may already be suicidal, or not functioning.

One participant noted how the role as a cultural broker for the family can act as a source of shame and guilt, further exacerbating a client's anxiety and depression in treatment:

> [They act as] this bridge or gap. There's this guilt that their parents kind of put on a lot for them to come here, or [the parents] are first generation….They are kind of cultural brokers for the family….The adult child is trying to figure out…where their own life sort of fits, into [and] outside of the family life. And I think that's a struggle. There's a lot of guilt [in] relationships outside of the family, or saying no to family, or trying to empower them.

Another participant also discussed the multifaceted nature of a client's shame and guilt and the difficulty in identifying this shame and guilt, which exacerbated pre-existing anxiety and depression:

> Shame and guilt [are] kind of interesting in the sense that sometimes they don't even have the words for it, or it can be confused. Shame can be more readily accessible just because it's...the shame for the family, for my community, for if I were to do this, then this means something negative about how my mother raised me, or her own virtues.

Joining and Treatment Engagement Strategies

Participants were asked about techniques and strategies used to build a therapeutic alliance with East Asian clients and how the process differs, if at all, from joining with clients of other ethnicities. Four participants (40%) discussed the importance of transparency and use of self-disclosure as a method to build a therapeutic alliance with their clients. One participant noted how transparency is incorporated into the therapeutic process when the therapist and the client share the same cultural background:

> Sometimes also being somewhat transparent and in speaking from my own experiences is helpful if that's relevant to what's going on. If they ask me, I will share personal information. And then sometimes when they talk about cultural issues, I'll add my experience whether it's traveling back to their country, or certain foods that they're familiar with, and that they've eaten all their life. You know, we may discuss various cultural things that we're both familiar with,

Another participant pointed out how her previous training conflicted with a strategy she found effective—utilizing self-disclosure as a tool to explore and discuss a client's understanding of culture and family: "[Self-disclosure includes] being able to talk about family and some of the cultural values and taboos, and doing it in a way that's joking, or more disclosure than I was previously trained [in] or ever admitted." One participant described self-disclosure as a mechanism to encourage the client to feel more at ease with the therapeutic process:

> With East Asian clients, I feel that a lot of them don't really feel comfortable with therapy as a modality, counseling. That it's, in my experience…their first encounter...with an intervention of such a sort for…at least two-thirds of my clients. They often have no idea what I'm about, who I can be to them. So, I find that a little bit of self-disclosure about my background helps in creating a sense of safety. Let's say I meet a Taiwanese client, I will share that I'm from Taiwan as well. I'm from Taipei, and we share the same language. And I was back in Taiwan just a couple of months ago for Christmas. I'll share these things to kind of create a sense of comfort and then that helps with the joining. And with my mainland Chinese clients, I would mention that I'm from Taiwan too, so that…they're aware of this difference.

Another participant found self-disclosure a way for clients to know the therapist understood them:

> I try to convey empathy…so that I can relate to some of the issues that they're going through, and I try to normalize whatever their problem is, and it's not so hard to do that, if you consider their life circumstances. And so a lot of them, life is pretty…stressful. And they have to deal with multiple challenges.

In contrast, one participant stressed limiting the amount of information shared with clients:

> I think it's important to engage in self-disclosing judiciously. And I don't tend to do that, at least not when it comes to my own ethnic background. I think there would be a conversation around ethnicity, and just…how they imagine me to kind of connect with them being who I am, or how they see me as…what that's like. Again I think that would be in service of trying to at least present myself as someone who could relate to them…and if they don't see me as that, [there can be] a conversation about why that is.

One element of the engagement process is being mindful of generational differences when treating East Asian clients. From one participant's perspective:

> I would say not so much [to] the younger generation, and adolescents….The parents are more conservative. So, I keep that in mind and I don't necessarily ask questions that I would ask a Caucasian client. I will delay asking certain questions, specifically questions related to sexual activity.

Other participants discussed the use of the client's native language as a bridge to engage clients in therapy. One participant emphasized that language was helpful in forming the

therapeutic alliance more quickly, but also in enabling clients to state their thoughts far more easily:

> [I use the client's native language] with Asian American clients, definitely. But mostly because my Mandarin speaking clients, be it from Taiwan or China…actually are more comfortable expressing themselves in Mandarin. So, I feel that, yes, it helps with the rapport, but also if it's conducted in English, then a lot of it will be lost because of the proficiency level.

Another participant noted the connection between use of the client's native language, conveying cultural competence, and helping re-engagement:

> I am amazed by the power of language. Now, if you called parents in Korean…they just open up, or they just assume that I am on their side, something like that. So, many times they feel that I am more defending [them, and am] more culturally competent than other non-Korean speaking therapists. So, it's really interesting. It's just that, because I'm Korean, it's easier to re-engage my clients. Where sometimes I just need to verbalize, "I think I can understand where you come from because I had a similar experience," [or] something like that.

Conceptualization of Race and Client's Presenting Problem

All ten subjects (100%) responded to the question of how they consider race in conceptualizing a client and their presenting problem(s). Four participants (40%) asserted that they did not include race in their conceptualization of a client's presenting issues. One participant stated: "I don't actively pursue the cultural piece unless they bring it to me." Another participant noted that her focus was on the presenting problems, but that the factor of race had been raised by clients: "I don't conceptualize until after [the patients are] gone and I'm writing up my report, but what I found interesting is that I

don't bring up the race, but my patients do." Another participant indicated that a shared ethnic background makes the issue of race less of a factor in her conceptualization of a client's problems: "I feel that that isn't at the forefront of my mind when I work with them, because that's something that we share that's unspoken in a way."

Moreover, two (20%) discussed that race is "in the back of their minds" in their conceptualizations of clients. One participant expressed his conceptualization of race in scientific terms:

> It's kind of like I already have this working hypothesis going on in the back of my mind. And partly, yes, I know that some parts [of] it could be stereotyped, so to say, as well as some of the experiences that I've had just working with folks from that community, or ethnic identities that they more strongly connect with. So taking that and…testing those different hypotheses. Sometimes it does fit in terms of cultural. Those are nice when it's that clear, or the intergenerational kind of expectations of behavior. But, I find a lot of the time that, yea, there are little nuggets that are like, "well, okay, that makes sense in her family and her culture, identity," but, at the same time, there's this other stuff that could be more universal that's going on with this person, regardless of their ethnic identity.

Another participant discussed the inclusion of race into the conceptualization of a client as a result of experience and training:

> I think it's always in the back of my mind, and I'm aware of it, but I think about it in the way that they identify themselves. So, do they even think about it? I am definitely more sensitive to those that are immigrants, because that's what I've been trained a lot more with…working on, and, in terms of understanding, my research has been a lot on immigration issues, and acculturation, and things like

> that. So, for that reason, I am just more aware of those issues. I also think about their reaction to me. I mean…I do ask them, "Are you triggered when you see me? What comes up for you when you see me?" I'm East Asian looking.…So…I think it depends on the presenting problem.

One participant reflected that her conceptualization of a client's issues were viewed through a broader lens of factors: "I think more about…cultural factors that may be impacting their situation and how they engage in treatment, not so much race." Similarly, a participant noted that many elements contribute to the conceptualization of race: "I leave open room for cultural variables, ethnic variables,…religion,…family dynamics,…relationships with siblings,…extended relatives,…[and] parents; and the [difference in] norms of what looks normal [and] what would be very different."

Another participant emphasized the importance of considering a client's cultural context, "so it's more about social systems, and discrimination, and you're a minority, or having limited resources in terms of understanding of our system, accessibility, efficacy, power, [and] those kind[s] of contexts." Finally, one participant linked conceptualization of race to the impact of racism on a client's identity formation:

> I think I would explore how someone identifies what they feel people see….It's interesting….I work with a number of biracial and multiracial people…who phenotypically look Asian, and there's that sort of struggle, and sometimes that feeling as though they pass for something else, and is that okay? And [I consider] some internalized racism they feel, or people project onto them based on their perception of who they are, or who they are supposed to be. So…I don't think that it is validating racism, but…I guess it's not what traditionally people view as racism, but it's very subtle microaggressions, and really helping people identify

that, and validate that, and have feelings about it, and giving them permission to have feelings about it.

Common Characteristics and Differences between East Asian and Clients of Other Asian Backgrounds

In discussions concerning similarities and differences among East Asian clients and those from other Asian backgrounds and/or ethnicities, five participants (50%) emphasized the pervasiveness of the stigma surrounding mental health issues among East Asian clients, with one participant attributing it to a lack of understanding of the Western concept of mental health treatment:

> Folks who are White, middle class, and educated respond pretty well to treatment, and other people are…a little more confused about it. But they pick it up eventually. But it's just a new skill, like a different way of thinking about it... Therapy in general is weird for people, but it's even more weird for certain Asian groups.

Another participant discussed how a fear of being "found out" seeking help for a mental illness by others in the community perpetuates the gap in clients' willingness to access care: "Sometimes…it's…like that fear of actually making a call, or, 'what if it's discovered that I'm actually calling for help?'" Similarly, a participant noted how shame and embarrassment mitigate against seeking help and how counterintuitive treatment for mental illness might appear, given the cultural values and traditions of East Asian clients:

> Just a lot of shame. I mean there's a tremendous amount of shame, and not really wanting to say much. I think secrets are a very big thing, and confiding in someone that this person doesn't really know…is a very hard struggle….I think it was an unusual experience for people to seek out support for their emotional or

> just situational kind of stressors. They didn't really know how to ask for support, let alone how to answer…like, how to say, "I need help."

Similarly, a participant mentioned client fear about the visibility created by seeking help, particularly when it is from a larger organization:

> There's a big stigma about entering mental health systems. There's a concern about how they would be perceived, not only by others who would find out that they were in the mental health system, but also [by] me…as a therapist. There's just a self-consciousness.

Participants who mentioned stigma also referenced the myriad of other challenges that clients often faced. One participant described certain of her client population as "immigrants, who are living in private housing and are dealing with language barriers and financial stressors, who also work long hours [and] take care of their children, without much parenting experience."

Three participants (30%) discussed the family as the main focus of treatment. One participant pinpointed the multigenerational nature of many clients' households as a cause of contention:

> I think East Asians in general are very family oriented and that's actually the norm….Everyone is very family focused, and it's kind of the expected thing to have that multiple generations live together. So, in that way, it brings up more conflict because so many generations live together and I think a lot of people have kids pretty young here….A lot of times the grandparents, who are 50, are taking care of their grandkids.

Some participants drew distinctions between what their Asian American clients considered "family" and concepts of family composition prevalent in other ethnic/cultural

groups. Such distinctions influence the focus of treatment, i.e., is the focus the individual, the immediate family, or an intergenerationational configuration? The latter, often present in East Asian clients, was described by a participant as contrasting with other groups:

> I think that the flavor of family was [in treatment], but it was different in the sense that…it's more intergenerational [than] when I was working with Black and African American individuals in Atlanta, where it was more the immediate kind of family….And then, of course, with some of the Caucasian families that I've worked with, yes, family is important but…there's also a value of [the] individual, yourself as an individual, and having clearer boundaries that they often have [when] compared to the Asian clients that I've worked with.

One participant noted how the family is often viewed as the mechanism in which clients develop their sense of self and understanding of relationships:

> Family and relationships…it's how they make meaning, right? You are who you are based on, who you're connecting with, or who you surround yourself with. So that connection to family is huge. I definitely hear that more with Asian clients versus some non-Asian clients—meaning some Caucasian folks.

For some Asian cultures, focus extends even further, according to one participant: "Folks who are from some of the smaller islands, like Samoa and Guam…also talked more about the community….Even more so, than the [other] Asian folks. It really spreads more to the community and the hierarchy within that."

Three participants (30%) also discussed a difference in the level of treatment compliance demonstrated by East Asian clients in comparison to those from other ethnicities. As East Asian clients exhibit a high level of respect for therapists as

professionals, perhaps it is not so surprising that their efforts in treatment can be quite extensive. One participant, with reference to her East Asian clients, stated:

> They are very committed to the process…very wanting to kind of practice what we are discussing and take it out of [the session]. They…want to maximize the time, but also make it an efficient process too. [There's] a lot of reading going on outside of here.

Another participant described how reluctant clients often turn into enthusiastic clients once they find some short-term success in treatment:

> Asians…are really, really skeptical about psychotherapy. They think medication is the solution….They've been through medication, and it didn't work. So, they come and…say, "Okay what do I do?" So I go, "Change this and this, and see the result," and then they become hopeful. And then, once they taste that, they will jump in. When they jump in, they jump in 100%. "Whatever you say, I'll do it." They are very dedicated, and so treatment process is shorter than [with] other people.

Interestingly, one participant discussed how the instinct for compliance becomes a requirement for some clients, so that if they won't or can't be compliant they will remove themselves from the situation:

> When we are thinking about…compliance, [East Asian clients] are…even more compliant than other clients….So, if they come, they're not going to speak up as much, and they're going to nod their head, and kind of do what you tell them to do, but if they don't want to do [what you tell them], they'll just…not show up.

Additional common issues that arise in treatment with East Asian clients include enmeshment and difficulties related to differentiation between clients and their parents,

and anxiety and "inappropriate" guilt as related to a strong commitment to the family with its concomitant sense of over-responsibility.

Challenges in Treatment

When participants were asked to describe the challenges they faced when working with clients from this population, nine (90%) indicated that they had encountered instances of resistance to treatment. Of those nine subjects, six discussed client-related factors that resulted in resistance. One participant attributed causes of resistance to the lack of buy-in and the client's unrealistic expectations of therapy:

> For me [what has been most challenging [is] how to get them to stay long enough with me so that they can get help out of [treatment]…convincing the clients to continue with the therapy because they desperately need the therapy, but they feel like, "this is not working," because I don't give them answers in the first or second session.

Similarly, a participant described difficulty in communicating the therapeutic process to clients:

> From my point of view, [my concern is] how do I reach these people to help them? And reaching them meaning…resources, but also their understanding of how therapy works…helping them with what in their life has changed, and helping them to understand what other things…therapy can help them with.

Another participant discussed the difficulty of conveying competence to clients who may have preconceived notions—often related to previous unsuccessful therapeutic experiences—that are at odds with the treatment process or the individual clinician. The participant stated:

> I've had people on the phone that see "Chan," and ask, "Do you speak Cantonese?" and I'm really not [conversant in Cantonese]. With my clients who are biracial or even on the queer spectrum, people want to be in a box and sort of have that kind of language about that….People get angry when you are not choosing a box, or [you are] physically not in a box…and they may have some story about me that I'm open to a point, but it doesn't match up with what they thought, so they ask…,"Do I know what I'm doing?"

The same participant also indicated how resistance may take the form of clients conveying competence concerns by way of challenging educational credentials:

> I think some of my more higher level, educated clients think….I'm a clinical social worker and don't have a Ph.D. Am I competent in that way? Do I know what I'm doing? It's like I sort of "cheated," or I didn't go as far with my education to be a therapist. That's come up with a few people.

One participant commented on the difficulty of balancing the client's focus on skill building, while addressing the difficulty in tolerating negative emotions:

> Being able to regulate your emotions without jumping to action or confusion.…I feel like it's harder to get the Asian patients onboard with stuff like that. With Asian patients…they're like, "What is this? This is really weird".…I feel more anxious just sitting there doing nothing for Asian patients than I do sitting here doing nothing with non-Asian patients. I don't know if that's just me, or if that's the reality, because Vietnam [and] Korean War veterans, that's actually what they expect from therapy. They don't expect me to teach them anything….Their idea of therapy is, talk talk talk talk talk talk, [and] they feel better. With the Asian patients, it's a little different, 'cause then I tell them from the beginning, "We

> have this method available".…But then they also need to learn and they need the space as much as the other veterans do to just talk and be okay with that, so I think it's really hard sometimes to kind of take a break…from all that step-by-step, and teach the patient how to just be present with their feelings. It's hard for me. It's harder to do that with East Asian patients than it is with non-Asian patients.

One participant discussed how client ambivalence, doubt and unrealistic expectations often result in resistance. In addition, this participant hinted at the link between client resistance and therapist self-doubt, a theme echoed by other participants:

> At times they will actually say that they feel like they don't need [therapy]. They can handle their problems at home. It's a weakness. The challenge is being able to reach them, and being able to help them, in spite of their doubts. So, I feel like I haven't probably been able to reach that population who come in with a lot of ambivalence….They don't stay long enough….They have to get through the process. Sometimes they're not really sure of what the benefit is of just talking. Sometime[s] they look for concrete answers and concrete solutions in the first session. Sometimes they will literally ask me, "Tell me what to do," and the process is slow that way….I'm sure that they don't feel helped….I would say there are clients that come in with a lot of uncertainty about the benefit of therapy. I don't feel like I've been able to reach them and help them the way that they expected or wanted.

When resistance was seen as emanating from feelings of shame and discomfort, one participant found that a change to the therapeutic modality might benefit the client:

> Overall, there's definitely a sense of reserve in terms of tapping into family secrets—material that would evoke shame.…whether that [comes] from a psychodynamic perspective, tapping into the family of origin stuff is where the work is a lot of the time. So that's challenging. And if I really want to insist on conceptualizing working within that modality, it really doesn't work in its purest form. So that's why I feel that I have become more integrative and become supportive when needed.

The same participant also noted that resistance from East Asian clients who often don't view therapy as a way to improve one's life, in distinction to clients from other cultures, but more as a form of crisis management when all else has failed:

> I feel that in the U.S. therapy has become almost like a spa treatment…something that a person would feel that he or she needs or deserves as a form of self-care or wellness. It's like going to the gym almost. It's a way to maintain yourself and enhance your well-being. And there's a sense of entitlement that has been built around therapy and that's good. But, with the East Asian clients that I've worked with, I feel that that sense of…"I deserve it. This is good for me and therefore I should pursue it," is not there. It's more like, "I will come because I need it desperately"….It's more like a crisis.

One of the nine subjects discussed an inability to translate treatment concepts into the client's native language as contributing to resistance in treatment:

> Especially with the monolingual speaking population, I feel that at times my Mandarin, my therapeutic Mandarin, needs some work. There [are] psychiatric terms, professional terms or…things from the DSM that I have no idea how to translate into Chinese. So…the challenge lies in my lack of training in that area

> and….Linguistically, how does one express certain things? I find myself,…even though I'm fluent in Mandarin, I have to translate a lot of things from English into Mandarin. So, some of the flavors get lost, too.

Two of the nine subjects also discussed external-related factors that contribute to resistance. One participant discussed the impact of generational gaps in culture and experiences that results in difficulty for a therapist to empathize with certain types of client experiences in treatment, "there's definitely a gap in terms of culture and experiences for kids who spent their early childhood in China and then came back here [for school], or kids who immigrated here when they were 9, 10 or 11. It's a totally different experience and one that I don't relate to very well." Another participant discussed how the stigma of mental illness, specifically for less acculturated clients, presents higher probability of resistance: "I think the stigma is even bigger with less acculturated folks. Whereas folks who have been here [a] couple more generations, speak better English, [have] been educated here, and they tend to [be] more okay with therapy and treatment."

An additional challenge in treatment that was discussed was the high dropout rate among East Asian clients. One participant discussed how the setting of the facility influenced the length of the client's attendance in treatment:

> When I was working at the non-profit organization, [treatment] was usually between 3 to 6 months, but it also was influenced by the agency's policy….It really depends on what kind of settings you're working at. My perception is that probably this population has [a] higher dropout rate than Caucasian population.

Another participant discussed dropout rates in terms of the client's knowledge of how the treatment process works:

> There's definitely a connection between patients dropping out and the level of their awareness about mental health and understanding of how treatment could help them. A lot of times these patients who drop out, they're looking for some kind of quick fix, like the way they usually get medical services. They go to the doctor. The doctor prescribes the medication and there it is—problem resolved in a couple of weeks. But mental health service is not like that. And it can be challenging to help patients understand that mental health treatment is a commitment that needs a lot of homework for the treatment.

Despite the high dropout rate, one participant cited trust as a factor counterbalancing the client's resistance to treatment, stating:

> If I were to speculate, it would be trust issues….I think that's also the one reason why they are seeking an Asian therapist. They want to trust us...[feel] that the therapist understands them…their culture, their language, [and] they want to be comfortable with them.

For subjects who reported experience working with children, two (20%) of participants discussed their primary challenges as: (a) creating an alliance with both the parents and the children, (b) facing treatment issues pertaining to individuation between child and parent, and (c) childcare issues with the client's siblings. Interestingly, when discussing challenges in treatment, two subjects (20%) remarked on the positive aspects that accompanied challenges, with one participant describing them as an opportunity for personal growth: "It helps broaden my own understanding, my personal experience as a Korean-American, and I think it also helps me to understand what the needs [of the client] are." The second participant portrayed challenges in treatment as a way to learn how to develop rapport with more difficult clients:

> I can relate to the stressors, especially when I think about my own parents and what they went through….That can be used to the advantage of…therapy where sometimes [clients] just take extra work to empathize with…and to help them feel that you really understand.

Role of the Therapist's Ethnicity and Identity in Treatment

This next section of the interview focused on exploring how the therapist's identity, ethnicity, and acculturation impacted their treatment with East Asian clients, with an emphasis on: (a) the role of the therapist's acculturation and therapy; (b) the role of ethnicity in treatment; and (c) the impact of self-identification as an East Asian individual and its effect, if any, on rapport with clients of the same ethnicity.

Acculturation and Treatment

Subjects were interviewed about how their level of acculturation and that of their families impacted their treatment approach with the East Asian population. All (100%) of the subjects discussed how their family's or their own immigration history has influenced their view of themselves and their practice. Moreover, all of the participants described their acculturation process as a positive attribute in their treatment approach. One participant stated: "I think now, at this point, it's more positive than it has been negative."

Four of the subjects (40%) identified themselves as belonging to the "1.5 generation," and discussed the struggles of being born in another country and raised in the United States. One participant shared how having similar and/or shared memories of the process of immigrating to the United States assisted the client's perception of the therapist as more relatable:

> They say…the way you dress, the way you talk, the memories, and the whole thing. So, I take it as my acculturation, or [being] Americanized, that's definitely

worked positively with those populations. They feel comfortable. They can more easily relate to me [and] my level of acculturation positively affected my work with my clients….First generation Korean people many times feel that I understand the whole American system better so that I can help them better, or I understand their struggle better.

Another therapist discussed how the process of defining one's level of acculturation results in a deeper level of empathy and self-disclosure in treatment:

I don't experience myself as fully acculturated, or entirely new to this land. So, I am sort of always in transition and maybe more shifting towards…being integrated within a culture. But…I'm not fully there yet. So, I can still be in transit myself, [which] allows me to know where [clients are] coming from because I was once there. But, maybe slightly ahead of this path.…I can kind of trace back and kind of step back a little bit, and be with them where they're at, and use my past experiences as the mirror, or as the source of, maybe, empathy and just self-disclosure. I feel that there's something kind of special because of my experiences of being half…two-thirds acculturated.

One therapist discussed how the immigration experience resulted in greater exposure to people of other ethnicities and backgrounds and provided a greater understanding of the universality of the human experience:

Hearing people's story, whether it's Korean or European countries or [other] parts of the United States…that gives me more information about human universal reality. We may speak different languages and we might grow up in [a] different culture, but the basic thing is we want happiness.…What's right for you is what's right for them.…We learn don't hurt people, don't take advantage of them, don't

> cheat, don't steal. All of that is the same, no matter where you go. And that gives me the idea that everybody is equal. Everybody's the same. It doesn't matter who you are.

While another participant agreed that a shared background facilitates the therapeutic alliance, being mindful of each client's unique experiences was also emphasized:

> I think that my cultural background helps me to relate to my clients to some extent. But there can also be gaps in our experiences. So I have to try to be aware of that as the treatment proceeds and understand what they're going through. When the differences are quite blatant, I have to work harder to develop the therapeutic relationship.

Similarly, one participant discussed the need honor the client's process rather than allow the therapist's personal experience to influence treatment: "I would probably be more biased towards wanting the person to acculturate….I would try to be aware of those biases, and to be respectful of what the patient is actually wanting."

Of the six subjects (60%) who identified themselves as "second generation," all emphasized a similar struggle to balance two disparate cultures. Despite being born and raised in the United States, all stressed the importance of respecting their parents' immigration history. One participant described this personal dilemma of negotiating between two cultures as having not only an impact on one's own identity but also on the enhancement of an ability to respect clients who, in similar circumstances, might have opted to take a different path:

> It's interesting growing up…in a family that started off very traditional, and always having…my other identity in life outside of that. I feel like I've…juggled both and have had to…negotiate, like, what parts of me fit well with one over the

> other.…So, I'd say that the way these identities have informed my work is [that] I would try to be respectful, in the best way that I can, of where people want to be in their lives, and who people want to be, whether it's someone with more traditional values, or whether it's someone who wants to be more connected to mainstream culture.…So, I feel like I have kind of a connection to both sides of that in me….I feel like I have a better capacity now to accept what other people would want for themselves and to respect it.

Two participants discussed the impact of having different levels of acculturation and how the negotiation of two cultures impacts treatment. One participant shared how a difference in level of acculturation is not a barrier to treatment: "When we look at each other, I feel very similar….They might be born here, but we're [the] same level. We do therapy in English, we're Americans, and that's it." Another participant described the added difficulty for biracial individuals in negotiating between two cultures: "There's this internalized racism….It feels like you're forced to make a decision either way, but sometimes it's okay to not make a decision on how you identify."

Ethnicity and Treatment

Participants were also asked how their experience with identity development and ethnicity impacts their work with this population. Seven (70%) discussed the role of ethnicity by emphasizing the influence the therapist's physical appearance had on clients. One participant accorded ethnicity a helpful factor in treatment: "I think it just facilitates it….I can't really think of a time where it actually became a barrier. All of the times…the patient would just make a comment that it's good that I'm Asian."

Another participant stated how the same ethnic background and physical characteristics gave rise to a tendency on the part of some clients to view the therapist as

an ally in treatment: "Because I'm Korean…[clients] see me as their allies and they assume that I understand them, so it has definitely, positively, worked." One participant described elation and gratitude arising from a similarity in ethnic background, as it encouraged clients to "allow me into that world of theirs." Another participant commented on the influence of physical appearance in treatment: "I think people always judge by what they see first, so I definitely think that it plays a role." Additionally, a participant noted the danger for therapists in assessing how a client identifies him/herself based on the client's physical appearance:

> I just try not to make any assumptions.…I have a niece, who, I don't know if you looked at her [you] would know who she is racially. But, my sister [who is Asian] married a man with blue eyes and my niece looks nothing like her. There's no Asian in her, but it's so important to her that she's Asian and she's part-Asian. That personally, I think, challenged me to not make any assumptions about people or how they identify.

Another participant also reported the irony that physical appearance often gives rise to inappropriate comments while, at the same time, aids in increasing buy-in from clients:

> I've been told that it's very Asian of me to undermine my own successes, but I do think that being…Asian, young, and female is an advantage in the VA system. Of course, that sometimes does mean that you're dealing with inappropriate comments....But, most of the time, I think people look at your ethnicity and they judge you. They connect it with whatever assumptions that they have, so I do think sometimes that facilitates my connection with patients because then they see me like, "You Asian girls, I could talk about whatever I want," and then they'll sit and complain…and inevitably it's always [about] a white male therapist that they

> couldn't connect with….But I do think patients, just like therapists, we make first impressions and we act that way.

For one participant, shared ethnicity has been extremely important in building client trust:

> I think it plays a pretty vital role because…all of them are immigrants, and they already experience this feeling of being unsettled, and feeling alien in this country. So, seeing someone from the same ethnicity with exactly like a familiar presence, language, tone, [and] etiquette…helps tremendously. That helps with the initial trust.

Similarly, another participant accorded similar skin color a role in building trust and increasing engagement with clients from other ethnic minority groups, as well as Asian Americans:

> There's something about just the fact that [clients] look brown here [in Hawaii], just like I kind of do. Like there's something about that connection that I feel [goes] a little bit faster and it comes a little bit more natural than I've noticed then when I was working with my Caucasian clients. It's interesting, too, because even when I was working with Black and African American clients, I also kind of felt that.

Another participant noted how ethnicity is often a factor in treatment decisions:

> I may be more apt to use manualized treatment with non-Asian clients….Non-Asian clients often have been more exposed to ideas about mental health treatment. So I can present manualized treatment as effective and evidence-based treatments for their condition[s], which might not necessarily make sense to the Chinese clients, who [don't] really understand the concept.

Other subjects discussed how ethnicity in treatment creates a unique bond of shared and/or similar personal experiences between the client and therapist. One participant credited it as resulting in greater ease in joining with clients:

> Honestly, I am probably not a whole lot different from the Caucasian therapist…unless they bring up culture, and I can identify with what they're sharing. I can join in on the conversations about their experiences, the food, their uncertainty, and their questions.

Another participant illustrated how sharing the same ethnicity as clients is valuable at different stages of the treatment process:

> I think the simple fact that I am ethnically Chinese is important.…Because there's a similarity, the clients are more likely to have trust in the therapeutic relationship, in the treatment, even if they know nothing about me. Sometimes, when I think it's appropriate, I'll just share certain things about my background, my family situation, and that will help the client to feel that I understand, that I'm able to really understand. I think initially it is important in terms of engagement.

Several participants noted the role of ethnicity in the therapist's own identity development. One participant stated:

> A lot of this work also ties in with your own development....It's interesting, because I can play between two worlds, but I also don't completely fit in two worlds….In terms of my own development, it's something that I continue to work on, to take notice of.

Another participant described how her experiences with ethnicity and identity influence her empathy for clients:

> I feel that my own struggles with this topic, and my identity and ethnicity…Identity is shaped by ethnicity. And moving around in this country, I feel that that's a work in progress. And struggling with that, wrestling with these issues, helped me have a stronger understanding of people who are suffering or experiencing similar things.

One participant discussed how her perceptions of her ethnicity had undergone modifications as she immigrated from her native country to the United States, attributing that experience to an increased ability to understand the larger systemic issues faced by the underprivileged clients of similar ethnicities and backgrounds she has treated:

> It helped me to understand what it is like to be [an] underprivileged person…When I came to this country, my identity changed. When I was back in Korea, I came from a middle class and well educated [family], so I belonged to a pretty religious class. And then I came to this country, I thought about social justice a lot, but it was in my head. But when I came to this country, I became a minority, which I never thought about back in Korea, and I became a woman of color. In Korea, we talked about race, but it really didn't hit me because they were all Koreans. But when I came here, I became a minority woman. I became an Oriental woman, a woman of color. So, I respected my identity. I had to struggle, and it also had an impact on my confidence…my idea about who I am. So, I had to go through that identity revision and that really helped me to understand what it is like to be the minority [and] to have limited resources. Even though you make money, it's not just about money….I get to have a deep understanding about classes, socioeconomic status, social justice, [being] underprivileged, [those] kind

of issues. So, I get to have an understanding of what my clients go through in their lives.

Self-Identification as an East Asian Therapist and Treatment

When subjects were interviewed about their use of self-disclosure in treatment, they described how confirming their ethnicity as East Asians influenced their work with clients. Seven subjects (70%) acknowledged the positive effect of identifying oneself as Asian when treating clients. One participant described self-disclosure of identity in treatment as enhancing clients' comfort when discussing their issues in treatment: "It provides an initial entry, some context into whatever material they bring into therapy." Another participant characterized her identity as an Asian therapist as a source of strength and pride:

> I know our strength and weakness, and I also understand American culture's strength and weaknesses….I can combine them with what I know and become who I am as a Korean American. It is very important to me, and I am very proud of it. Without that it's difficult, and you need to have [pride].

A participant also noted the need to be aware that each client with a similar background has had different life experiences, and that a therapist needs to be mindful of the subtleties in a client's identity development in treatment:

> So, in terms of the identity for the client, I think it's opened me up more in the sense of just because they identify this way doesn't necessarily mean they're going to fit this box, or they're going to fit this particular mold based on these five clients that I've had, who are all similar in some way. Their identity struggles, or whatever it is that they're making meaning of [in] their own life, can look like anyone else's regardless of whatever they are, but it could have different flavors

> in that….So, in that sense, it's opened me up in that there are those common factors across the board, and yet then there's the nuances. The nuances because of the family that they grew up in, the communities, that kind of stuff.

Another participant noted that an Asian identity can only go so far when treating clients whose life experiences vary in significant ways from the therapist's:

> I suspect that some of the Asian clients that were not born here probably saw truly that I was not as Asian as they are, if you could say it that way. They could probably see pretty clearly that I was Asian American. So, with my Asian American clients [who] also identify as Asian American, I've had no issues or problems engaging and joining, and continuing the therapeutic relationship for a good period of time. But again, my Asian clients [who] are much more traditional and not born here, and when they're a little bit older too, I have not been as successful in reaching those clients for whatever reason.

Similarly, another participant stressed the importance of acknowledging the individual differences in clients despite a shared background:

> It's almost a given in terms of the family cultural value and certain assumptions, like filial piety and being deferential to one's parents or authority. I don't want to stereotype, but it's almost something that doesn't have to be challenged when I'm working with Asia-born clients. If they tell me certain things and it's hinting toward that kind of cultural value, I usually don't have to question it or clarify. However, with Asian-American clients, I definitely feel that you can't assume that this person is from a family that values education, even though he or she is so driven, industrious and well-schooled.

One participant described how the therapist's identification as Asian may be beneficial to the treatment process, but also lends an element of uncertainty:

> In terms of my own personal identification as an Asian American…what I noticed is the similarities in what my patients are doing here, and what my family has gotten through, or what I personally have gone through. I think it adds an additional flavor to the treatment because I can relate to their experiences. I may have more motivation to help them and should empathize better….But it's also something I need to be careful of when working with clients who have a similar background, and…I'm not identifying with them.

Two of the seven participants were males and discussed the impact of their identity as a male Asian therapist on their clients. One participant discussed the difficulty his gender and ethnic identity had caused some female clients, and attributed it as follows: "As a male therapist, particularly [with] females, I find that it might be because of their own relations to male figures in their culture." Another participant noted how helpful identifying himself as Asian had been in modeling and normalizing safe, emotional expression for male clients:

> I think it's been beneficial, especially for men, who seem really removed from their feelings in general….Asian men, I think, meet me and I am pretty animated, and I will go a little over the top sometimes. I think it sort of models for them that's okay to do….It's interesting that a lot of men want to see a male therapist, but I don't think they really thought it through that far.…"Well, that's so weird…to sit with a man and to talk about your feelings." And I always put that out there to men, and give them a choice about their therapist, by saying, "We're

going to get into some stuff about your feelings. Have you ever talked to men about your feelings? This might be uncomfortable."

Two subjects (20%) highlighted the potential negative effect of identifying oneself as Asian among non-Asian clients in treatment. One participant stated: "With clients of other ethnicities that I've worked with, I've noticed there tends to be a higher dropout rate….I think a part of it has to do with the difference in ethnic backgrounds." Another participant described negative experiences with non-Asian clients in which they expressed ambivalence, or worse, about the therapist's ethnicity:

> One father came to me, and spoke to me, and he didn't like me because I'm Asian....Does it bother me? No. If it bothers me, I would have to think about it, and process why does it bother me? But in my opinion, that's your loss. I know I'm good at what I'm doing, and you lost….Another lady said [in an initial phone call scheduling a therapy appointment for her child], "I hear your accent when you talk," [and] she goes to me, 'You're not an American....Will that be a problem treating my son?", and I said, "I don't think so, but why don't we find that out and why don't we meet first?", and she agreed to it. But even though she agreed, the next day she called my supervisor and she asked for a different therapist.

One participant described how her experience as an Asian therapist treating non-Asian clients has raised her consciousness about injustice:

> In the sense of thinking about diversity and other things…to be honest…it's definitely raised this anger inside of me toward White America where nobody talks about this. Why not? Our culture, our American culture, is like this, and that fits one particular mold, but then what about everybody and all of the

> other…"colored people"? Like, come on….It's definitely stirred my anger and wanting to do something about it. And, in terms of that, I don't know if I've necessarily figured out how to advocate, or turn that anger into advocacy yet, but I think it's slowly getting to that point where, at least, on an individual level, it's, "Okay," like "I'm making a difference in this way."

Another participant discussed the importance of ongoing introspection, and remaining focused on clients as individuals, in order to help them with the issues that motivated them to seek treatment:

> As a therapist, we have to…have great self-confidence and engage in self-examination and self-reflection. The moment I stop reflecting [on] myself, I'm going to become stuck and become a terrible therapist. I can't do that. You have to examine yourself constantly.....Anyone who is comfortable with who they are, and can be honest and okay with no matter who you meet with, I don't see that much [of a] difference in dealing with all different populations. I don't. I have to look at and focus on the person. Why is this person here? What's impeding him/her to become a happier person, a better person? You need to focus on the problems, rather than what the person brings [to] you [in regards to their] ethnicity or cultural background. That's only side information you need to work with.

Training Experiences in Diversity and Multicultural Issues

In this portion of the interview, participants responded to a series of questions related to the influential experiences underlying their understanding of culture in therapy, and their graduate and postgraduate training in diversity and multicultural issues in relation to the Asian population.

Graduate School Training

Three of the ten subjects (30%) reported having no formalized training or didactics in graduate school addressing diversity or multicultural issues in therapy. Two of the three participants reported not receiving any concrete training on conducting therapy with diverse clientele. Seven of the ten subjects (70%), had received some formal training on diversity and multicultural issues in graduate school. All criticized it as limited and/or deficient. One participant noted few opportunities to learn about cultural issues in treatment and working with clients from different racial backgrounds, stating that diversity was often addressed in a cursory way, and "didn't delve into things that I could use in therapy or in my own practice."

Several participants cited specific coursework as aiding their understanding of culture and diversity issues. Two participants described how case presentations of clients from various backgrounds provided unique opportunities to learn about the intersection of therapy and culture. One participant noted that completing a paper on her family of origin was particularly illuminating:

> It made a lot of sense. It made [me] understand who I am, where I come from, my relationship with my mother, and my relationship with the home….When that light bulb goes on, you get that idea. And this is the condition that needs to happen to the patient, to make them understand what they do.

Another participant described how the lack of diversity training mirrored his experience outside of the classroom: "It felt very reflective of going to a conference on culture and they say only a couple sentences. It's a real small piece in there." Three participants stated that they participated in a one-or two-semester diversity course, all of whom found the course to be helpful. Interestingly, six of the seven subjects commented that the

training they received on diversity and other related issues focused on other ethnic minority populations, and that Asian clients were completely omitted from treatment discussions.

When asked about training or didactics specifically pertaining to Asian clients, all ten subjects (100%) stated that they received no formal training in working with this population. Several participants described how therapy with Asian clients was often relegated to a very minor status in graduate classes, and that they had no experience working with Asian clients during graduate school. One participant noted that one segment of one lecture discussed the treatment of Asian clients. Another participant also remarked on the disproportionate lack of attention afforded this population:

> My graduate education didn't really mention us as a group. They definitely put much more of a focus on African American and Latino clients, some LGBT, and some religious clients. I would say I have a memory of professors saying, "Asian people…typically, you don't see a lot of Asian people in therapy."

Another participant described how diversity was not only a low priority in her training program, but that the professor engaged for teaching the diversity course was dismissive of all minority groups but one:

> I felt like, for me and my program, it was an afterthought. It was a requirement that we had to do, and [the professor] barely cared. I mean he basically…did tell us straight out that, "if you're not black, you're not a minority."

Despite the lack of specific formal training in working with Asian clients, one participant discussed how training in providing psychoeducation was sufficiently universal so as to be helpful when applied to Asian clients. Another participant praised reference materials as having expanded his knowledge of working with ethnic minority populations. Two

participants reported that they found their training to be relevant to work with clients from all groups, as certain psychological conditions were present, and needed to be treated, in clients of every background and ethnicity:

> Our classes were focused on working with different disorders [and] working with African American, Latino families, but not much on Asian population because there are not many patients in the system anyhow….I think that was a good training for me, because I don't look at a person as a different ethnicity, but a different disorder. Each individual, the reason they got the disorder is different….And another thing that impressed me was neuropsychology. That gives me huge ideas of how the human brain works, and that's universal. Whether you're Asian, or Caucasian or Black, that doesn't matter. It's a universal language that I can address.

One participant raised concerns regarding the danger of relying strictly on coursework to develop multicultural competency:

> Classes, I think, are ironic because you're teaching about stereotypes. I think the only way that you're going to help someone be really multiculturally competent is to get them to be patient-centered….That means that when you're sitting in the therapy room with a patient, you got to learn how to keep yourself together, that you're really listening to a patient, that you're paraphrasing, that you're being nonjudgmental, that you're being truly, truly naive, so [you're] not making any assumptions and taking the time. That's what I mean by patient-centered....If a therapist is really patient-centered, the multicultural competency is going to come naturally. I don't think multicultural competency can be taught, 'cause there's just so many different cultures, it's impossible. I think if the therapist is genuine, has

learned how to be mindful of his or her own thinking, and [has] the skills to learn how to deal with all that in the room with the patient, and [has] that ability to use that to their own advantage, I think that's real multicultural competency.

Eight of ten subjects (80%) indicated that experiences outside of the classroom added to their knowledge of diversity and multicultural issues in therapy, and were beneficial in working with East Asian clients. One participant described how her clinical experiences while serving an internship were responsible for a significant source of her training on diversity issues. Another participant noted that her dissertation work presented the opportunity to develop and gain further knowledge of East Asian clients. Three participants (30%) discussed how their supervisory experiences were influential in attaining a deeper understanding of diversity, multicultural issues, and working with East Asian clients. One participant stated: "Supervision with supervisors who are either Asian professionals themselves, or people who are extremely open-minded, or deeply curious about how it is, and how does the culture piece interface with working with Asian clients, was helpful."

Three participants (30%) also commented that informal conversations with peers and colleagues discussing their experiences outside of the classroom provided additional sources of developing an increased understanding of diversity. One participant fondly recalled: "Stimulating conversations amongst the cohort about diversity issues has helped because it makes me more aware of how informed others are, and how open-minded they are about working with Asian clients."

Participants also emphasized the need to advocate for themselves in order to obtain fieldwork placements, discuss relevant diversity-related issues in supervision, and achieve opportunities to work with Asian clients. One participant stated: "Sometimes I

would have that brave moment and talk about [issues pertaining to Asian clients] because we don't know, especially in grad school." Moreover, psychology-related fields, such as social work and counseling programs, were recommended as providing unique training in how to understand race and culture in the context of therapy.

Post-Graduate Training and Professional Development

Subjects were asked about training experiences addressing diversity and multicultural issues related to working with East Asian clients following graduate school, such as continuing education units, workshops, conferences, postdoctoral fellowships, and other related programs. Five of the ten subjects (50%) noted receiving formal training since finishing graduate school. Three of these five subjects reported that the clinical experience gained during postdoctoral fellowships was pivotal in achieving a greater in-depth knowledge of diversity. One subject stated that attending continuing education courses and experiences being supervised by knowledgeable and helpful practitioners presented welcome opportunities to explore how to address diversity-related factors in treatment. Another participant stated that, despite not having pursued further formal training, her clinical experience with East Asian clients since graduate school had been instructive TO her understanding of the common factors pertaining to the East Asian community.

Reflections and Recommendations in Working with East Asian Clients

At the conclusion of the interview portion concerning training, subjects were asked to offer their views on existing treatment for East Asian clients and whether they could offer recommendations to enhance future work with this population. They were asked to reflect on what they enjoy about working with this East Asian clients, whether such work had brought about any changes in attitude and thinking about this population,

what they considered to be the needs of such clients, what barriers to treatment they faced, what treatment recommendations they could offer both Asian and non-Asian therapists, and any additional relevant thoughts they wished to add to the discussion.

Change in Attitude and Thoughts as a Result of Working with East Asian Clients

Participants discussed how their thoughts, feelings, and attitudes had changed as they gained more experience working with East Asian clients. Five of the participants (50%) emphasized the role increased awareness of the stigma of mental health illness plays as a pervasive reality among these clients. One participant related the stigma to a lack of understanding within Asian communities of the Western concept of mental health treatment.

Two of the subjects (20%) denied experiencing any change in their thoughts, feelings, and attitudes as a result of their work with East Asian clients. One attributed this to her limited experience with East Asian clients, and the other had difficulty in providing any further elaboration. In contrast, five subjects (50%) discussed experiencing a greater awareness of themselves, the East Asian community, race, and culture. One participant described how her understanding of culture had broadened: "Culture is not that simple. There is this common foundation across the cultures, and there [are] subtle, complicated, different cultural nuances, and subcultural differences, even in the same ethnic group. So, cultur[e] is a way more complicated concept." Another participant highlighted the helpfulness of other professionals in gaining increased self-awareness and how that process is instrumental in being an effective clinician:

> Through supervision, I've really overcome some of my own blind spots about myself—as an immigrant, as an international student, as someone who is

developing a U.S. identity as well. I feel that those need to be recognized before I can really do good work with the clients.

Similarly, a participant stated the importance of overcoming personal discomfort in order to have the courage to discuss race and ethnicity with colleagues and clients, and thus gain the increased awareness that would enhance the treatment process:

> I've had a lot of really great supervisors to really push me, and [have] allowed me to explore that. So, increased awareness about the client and me, and that kind of dynamic, what happens with us and being able to process that and understand it more,…and having [the] courage to be aware of it in session, and then to call it out. Not in a negative way, but to bring it up so that we can talk about it, what's coming up for either one of us. And then having the courage in having uncomfortable situations with supervisors and colleagues has changed me into who I am now.

Two participants emphasized experiencing greater understanding of the efforts required to reduce the gap between service delivery and access to care for East Asian clients. One participant described the need for more well-trained East Asian psychologists, and other professionals, who understand immigration issues and the other complexities of this population. Another participant stated her realization that this population is in desperate need of more services.

Three subjects (30%) discussed how their work with this population had resulted in changes in their treatment approach. One participant discussed the need for adaptability in treatment:

> I've become more flexible and allowed for culture and ethnicity, and those histories, to…have more space in understanding someone, and not trying to fit

someone into a theory. There would also be a stronger incorporation of their Asian-ness….That's a part of their identity, of who they are, [and] that was understated when I did work with them.

Another participant described the importance of adopting an active, structured therapeutic stance in treatment in order to address client anxiety, stating: "I've learned that with this population, I should be flexible because oftentimes therapy is so new and delves into such deep stuff, and being a little bit less active could be [less] frightening and uncomfortable." A participant also explained how she has incorporated a systems perspective when treating East Asian clients:

> I've definitely changed in the way that it's more systemic.…Before, I would see it as [a] more narrow, individual focus, but I think I definitely see it more in terms of systems, families, like, what are those forces that are acting on them, and that are preventing them from change, or from progress, and why? What function does it serve in terms of this pathology? Because family is so intertwined in the Asian [culture], that a lot of the times [it] is what keeps it in status quo.

Participants also mentioned several other factors that have affected the shift in their attitudes, thoughts, and feelings in working with East Asian clients, such as: (a) the importance of more involvement in community outreach, events, and conferences in order to shed more light on the lack of services for this population; (b) geographic locations; and (c) client attitudes toward therapy.

Needs of the East Asian Community

When participants were asked to discuss the needs of this population, four (40%) commented on the role of language difficulties and, thus, the need to provide therapeutic services in a client's native language. One participant described the importance of

offering bilingual services to clients as a method to reduce the gap in service delivery and access to care. A related suggestion was that native East Asian therapists who lived in the United States for a substantial period of time might be encouraged to increase their fluency and proficiency in their native language and thus be more able to offer bilingual therapy. Another participant discussed how professional help is often viewed as a last resort, and illustrated how power differentials could be lowered between therapists and clients by educating providers to communicate information in a manner that is easily understood by clients.

Two subjects (20%) discussed how funding issues often discourage the recognition of the need in the East Asian community and, thus, the services available to this population. One participant stated the difficulty of affording therapeutic services in addition to other necessities of life, enabling clients to "come in for treatment and at the same time still be able to maintain things at home." Another participant noted the importance of weighing multiple issues: pragmatic and theoretical concerns, and the availability of providers who are able to treat non-English speaking clients, stating:

> If you asked me 3 years ago, I would've said "more research," but research takes forever to trickle down. So, I think there needs to be more incentive programs for people who are bilingual to go into the community, or those who are bilingual/bicultural [to] go into training programs [to increase their language proficiency] so that they can provide these services.

Four subjects (40%) emphasized the importance of advocacy and education about mental health issues and services within the East Asian community. One participant discussed the importance of community outreach as the method by which the community could be educated about the needs and benefits of mental health services, and suggested

that available services be streamlined between organizations and agencies. Another participant emphasized additional aspects of community outreach:

> If you know that there's a disparity in terms of mental health, access to mental health services, and Asian-Americans are [accessing services at a] very low rate, you don't expect people to come to you. You got to go out to them….And we need to establish a community network of providers we can just easily refer [clients to].

One participant mentioned that a holistic approach to treatment could be encouraged by improved promotion of the benefits of therapeutic services, and greater collaboration with individuals and organizations in related fields. Another participant stated that the mental health information disseminated into the community should include self-help techniques. One participant described how advocacy work may compensate, to some extent, for cultural norms proscribing assertiveness:

> Asians are not vocal. Extremely smart people, but that doesn't really work when you live [in the United States]. We are a forgotten group, because we don't speak, because we don't get involved….We need to get involved. We need to do action, that we're thinking, rather than be quiet.

Participants also discussed the importance of providing training programs, more clinical experiences, research, stronger supervision or classes, shifting the cultural norm of how people communicate, training on providing therapeutic services in East Asian languages, use of group therapy in order to help clients feel a sense of connection and solidarity in their experiences; and the importance of campaigning for mental health issues and advocating for the East Asian population. One participant also highlighted that the stigma of mental illness remains and must be addressed in treatment: "Therapy is something

more accessible, and it still feels like there is this stigma around it in general when I think of Asian people. It's still taboo."

Barriers to Treatment

Five subjects (50%) acknowledged that communication, often related to language, was the biggest barrier to treatment for East Asian clients. One participant emphasized the importance of utilizing language to communicate two different messages to two separate audiences: as a vehicle to educate the therapist on the conceptualization of what clients are experiencing, and to acquaint clients with available services and how to access them.

> It's about the system itself.…They don't understand how this helping system works. So, they don't know where to start. They don't know who to call. They don't know what to ask. So, they really don't have any idea about what kind of service is available and how they can access it.

One participant noted how the East Asian vocabulary doesn't include psychological terminology, and other concepts—familiar to East Asians—may be unfamiliar to others, sustaining the barriers for East Asian clients: "There's a lot of words that are in other communities/other ethnicities that we just don't have the words for, or we use words that they don't necessarily have words for." Another participant, however, discussed the use of a shared native language in positive terms:

> [Clients] feel comfortable, more comfortable speaking [to] someone who shares a similar cultural background, thinking I understand them better than a non-Korean [therapist]. But at the same time, they can communicate with me in their language that they feel comfortable with…and they feel like, finally, "I am with someone who can understand me."

One participant brought up the issue of generational differences as influencing the manner in which therapists engage and communicate with their clients:

> First generation Koreans are not open to the idea of counseling, [and] are not open to the idea of talking about their problems in the sessions, especially when they come to counseling because of their children. So, many times the parents tend to feel…like they're authoritative, or their competence as parents [is] challenged, so I have to be very careful in the beginning of the therapy and treatment, or they tend to drop out sooner, especially if they don't see changes in their children's behavior in two or three sessions.

Four subjects (40%) highlighted the importance of psychosocial stressors as another major barrier to treatment. Each participant acknowledged that money and time are very scarce and important resources for many East Asian clients, especially immigrant families. One participant stated:

> Cost can be an issue for immigrants who don't have health insurance, or who need to pay very high out-of-pocket costs. Time is another thing, because while…immigrant clients work very long hours at a restaurant, or wherever it is, they're also responsible for taking care of young children.

Another participant indicated the importance of providing scheduling accommodations to remedy the barrier to treatment created by the client's employment situation: "For immigrants, they are working all of the time. So, they're not going to be able to come in between 9 and 5….I think having the flexibility of different hours for clinical care is important." A third participant also described additional psychosocial stressors faced by younger clients: "The Asian-American patients who I see tend to be younger….That's even more of an issue since they don't have transportation or a job yet, and they [have] to

drive and [pay for] gas and all of that stuff." One participant commented that treatment often had a lower priority for clients than other facets of their lives:

> Oftentimes when their practical aspects of their lives kick in, I feel that therapy does get shoved to the side….While therapy…can be valued and is valued…I feel that it's perceived as a luxury still. Not necessarily financially, but more like it's something that should be done…could be a form of health care, a form of consultation that they seek, after other aspects of their lives have been taken care of. They can probably afford it, or it's free to them. But, they won't come if they have more crises [in their lives, other than emotional ones], or they work long hours.

One participant commented that an additional barrier to treatment was the role managed care restrictions played in requiring specific diagnoses and/or limitations on reimbursement for services: "Sometimes diagnoses or a label isn't big enough, or it's too small, to encapsulate what is going on." Moreover, as discussed above, the stigma surrounding help-seeking behaviors for mental illness was also noted as a barrier to treatment. Individual participants conceived of the stigma surrounding mental illness as follows: (a) a tool that silences individuals; (b) ingrains a belief that "something is wrong with you"; (c) perpetuates false information and limits choices in making informed decisions regarding treatment options; (d) results in negative cognitions that create additional anxiety of being shamed within the immediate family; and (e) triggers a heightened sense of hypervigilance arising out of a fear of a breach of confidentiality, and its ensuing loss of face, within tightly-knit East Asian communities.

Recommendations for East Asian Therapists

When subjects were asked to provide treatment recommendations for East Asian therapists working with East Asian clients, seven (70%) offered suggestions related to the therapist's internal process. Of those seven subjects, two participants described the importance of having space to foster self-exploration and reflection. Both participants noted the uniqueness of the experience of being an East Asian, minority therapist and the need of having an outlet, such as supervision, peer supervision, conversations with peers and colleagues, among others, to process the experience, and the countertransference often occurring when treating East Asian clients. One participant stated the importance of building language proficiency and the importance of being knowledgeable about issues facing this population:

> There are those who have a strong capacity in…certain Asian language[s], and some with less fluency. Taking classes and working on speaking more fluently would be helpful[, and] staying current with the social concerns of this population,…and how Asia as a whole is developing, would really put people at the pulse of where the client's needs are.

Moreover, two subjects discussed the importance of building a greater sense of self-awareness and the ability to distinguish their circumstances from those of their clients'. One participant stated that therapists need to "be aware of your own belief system and sense of self and how that may affect someone, who identifies differently from you." Another participant offered the suggestion of "dropping preconceptions about the person," and emphasized that therapist and client "have very different perspectives, very different socioeconomic status, and our life experiences are different, so you can

never assume that you know the whole story." A participant emphasized the dangers of overgeneralizing a treatment approach, stating:

> I think with Asian clinicians, you have to be even more careful not to make assumptions because then you assume that they are just like you when they are not….Even linguistically, you're similar, but culturally, you may not be similar."

One participant stated the importance of being mindful of one's demeanor and approach, stating: "Sometimes the patient/client's relationship has to be a little nuanced, subtle, and gentle…I know some clinicians are kind of blunt, and I don't know how well that would work with East Asian clients."

Other recommendations offered for East Asian therapists included: (a) the need for collaboration with other East Asian therapists in the form of classes, clinical placements, and workshops led by experienced Asian professionals in order to provide advanced training and opportunities to "compare notes" and dialogue on skills currently being used with East Asian clients; (b) the need to consider treatment objectives from the client's perspective—what works for the specific client, stating: "We have to focus on functionality and help them figure out what is keeping them from being happy and saying we'll help them work on that"; (c) the need to adapt to a changing therapeutic environment where treatment encompasses a "very intellectual process first, and joining someone there, and then bridging it to something more emotional"; and (d) the importance of acknowledging the role of physical appearance in treatment, as well as having patience in working with East Asian clients:

> We look very different. No matter how long you live here, you look different [and] it's difficult to do this work….There's a lot of disappointment, frustration, a lot of pain, and we need to be ready to open that up.

Recommendations for Non-Asian Therapists

When subjects were asked to offer suggestions and recommendations for non-Asian therapists that would enhance treatment with East Asian clients, eight (80%) discussed the importance of gaining a deeper understanding of a client's culture. Of those eight subjects, half noted that working with East Asian clients would give non-Asian clinicians more exposure to the culture. Two of the participants described immersion in their client's culture through research to gain a "working knowledge" of such culture, including becoming more familiar with cultural practices and food. One participant provided the suggestions of obtaining clinical placements and fieldwork in East Asian communities, along with acquiring social knowledge:

> Just being out in the Asian communities, interacting, getting a snapshot of what perhaps Asian pop culture is like, the history, the socioeconomic aspects, and maybe even some travel would be good to just really familiarize oneself with this population.

Another participant stated the importance of guidance:

> I think you can talk it to death by reading a textbook, but if you don't sit in a room with someone, then you don't really understand what it's like.…I think it's really clinical exposure, and being able to have a supervisor [with whom] you can process the reactions and what is going on in the room.

Similarly, a participant described the importance of further training, self-awareness and having assistance with cultural exploration:

> Maintaining that foundation of information of all the theories of what we know is important but, then again, you have to go above and beyond that. It's about the training and the processing of the nuances, as well as starting the exploration of

> the awareness. And students don't know how to do that. Some clinicians don't know how to do that. So, having that training and that introspection, and then the space to be able to bring it up and process it, is so important in terms of training and starting the conversations.

One participant described being open-minded and acknowledging one's own bias: "Rather than separating ourselves, you have to remember 'I'm a human, I'm a therapist, I have this background, and I have a preference for this and that.'" Another participant discussed the dangers of relying on stereotypes and using a "cookbook approach":

> Each patient is so different. I think that's why it's hard. There are certain values that are very "Asian," but they can buy into it or they don't….So you have to take into consideration their background….It's not just the label of the race.

Two participants also noted the importance of adopting an "open, interested, and teachable spirit." One participant described her process and attitude when working with individuals from a different culture: "I become curious, interested and open, and inviting them teach me, too." Another participant provided a similar suggestion: "Remain open, curious, and respectful. [Clients are] all lumped into this group, yet, at the same time, there's so many differences….There are things that we can learn from each other."

Two subjects (20%) discussed the roles of racism and power in sessions. One participant noted that: "Non-Asian therapists need to work on microaggression and racism, and what they look like in Asian people's eyes, because I don't think people see it yet. It's much more subtle and hurtful, you know." Another subject discussed the importance of reducing power differentials, so that instinctual cultural reactions to authority do not inhibit a client's honesty in treatment:

> There is that deference to authority…being able to respect that. Sometimes some clients may need that, while at the same time trying to be aware, and maybe reduce that power differential, so you can ensure the work [is] being done and they're not just saying "yes" to everything.

Additional strategies were offered to non-Asian therapists treating Asian clients. One participant stated that a therapist's cognitive rigidity may unintentionally perpetuate the cycle of shame regarding mental health issues and suggested that clinicians use very careful language when providing psychoeducation to clients so as not to reinforce pre-existing negative perceptions. Similarly, one participant described the importance of having a greater awareness of cultural barriers that may interfere with engagement in therapy and sources and levels of resistance among clients seeking treatment for mental health services. The participant also stressed the need to address stereotypes, myths, misunderstandings, and/or expectations as they arise in the treatment process.

Chapter V

Discussion

Themes

This study explored the experiences of East Asian clinicians in their work with East Asian clients, and as individuals who had faced some of the same challenges as their clients. This chapter presents the themes which emerged from the participants' responses to questions asking them to reflect on their understanding of culture; to relate their training in diversity and multicultural issues in therapy; to discuss their experiences with identity, acculturation, and ethnicity in conceptualizing and working with East Asian clients; and to offer their reflections related to their experiences, thoughts, feelings, and needs based on working with such clients, including: (a) the impact of stigma on help-seeking behaviors and the therapy process; (b) adoption of a family/systems-oriented framework; (c) therapist and client acculturation; (d) ethnic match and culture as active agents in treatment; (e) difficulties in ethnically matched pairs in treatment; and (f) the limitations of diversity-related and multicultural training. The limitations of the present study and implications of current findings for practitioners, clinical interventions, policymakers, and the field of psychology are also discussed.

The Impact of Stigma on Help-Seeking Behaviors and the Therapy Process

Throughout the interview, many participants referred to the impact the stigma of mental illness had on their East Asian clients' help-seeking behaviors and therapy process. They discussed how stigma is so pervasive an element in the treatment of East Asian clients that it influences all facets of the process, including access, treatment seeking, engagement, attendance, and compliance. The present study also confirmed research findings (Leong et al., 2006), with several participants attributing negative

perceptions of mental health-seeking behaviors to differences between culturally-informed conceptions of managing psychological distress and the approach of Western models of psychotherapy. In fact, the contrast between the two views can be so divergent that individuals from some Asian cultures often believe that the mere fact of acknowledging psychological distress can only serve to make it worse. Shame and embarrassment arising out of the stigma of mental health issues can be worsened in the case of a "cultural mismatch," i.e., when East Asian clients—having overcome their pre-existing negative views of treatment and seeking help—are treated by clinicians of other ethnicities and backgrounds who are not sensitive to the patient's culture.

Participants' responses also described a further impediment to seeking help rooted in fear that community members will learn about an individual's accessing mental health services, thereby amplifying the stigma of mental illness and its resultant attitudes of shame and embarrassment. This fear of community reaction highlights how Western concepts of mental illness and treatment can be counterintuitive to the values and traditions of East Asian culture which may promote shame-inducing beliefs about the causes of psychological distress, attributing it to an individual's lack of willpower or a weakness in character, and/or arising out of an organic cause or a problem with the body (Zhou et al., 2009; Lee & Mock, 2005; Ying 2002).

According to participants, attitudes about mental health can often be a function of the length of time an individual has lived in the United States. This is consistent with the National Latino and Asian American Study (NLAAS) findings, discussed above, which suggested that although there is a general tendency among Asian Americans to underutilize mental health services, this is especially the case with those who are foreign-born (Le Myer et al., 2009; Abe-Kim et al., 2007). Participants in this study described an

element of stigma—a subjective sense of guilt—as often mitigated or exacerbated by generational differences, which are informed by the role of the client and the client's family's immigration history, identity development, acculturation process, and family/cultural values.

The majority of the participants discussed how the stigma of mental illness also influenced them as professionals. Their understanding of culture and stigma has become more complicated and nuanced with increased exposure and experience with East Asian clients insofar as they developed a greater awareness of the barriers to seeking treatment that continue to hinder this population, and their self-perceptions as minority clinicians became heightened. Two participants acknowledged an additional factor which often impeded clients from seeking services—the fear and anxiety brought about when engaging with larger health systems.

The consequences of the long-standing pattern of Asian American underutilization of mental health services come into sharp focus when help is finally sought, at which time conditions are more severe and chronic compared to patients of other cultural backgrounds, and thus require more care and intensive treatment (Bui & Takeuchi, 1992; Durvasula & Sue, 1996; U.S. Department of Health & Human Services, 2011). This current challenge shed lights on the struggle that the mental health field continues to face, specifically the underutilization of mental health services and poor treatment outcomes in Asian populations (Chen & Danish, 2010; Chin, 1998; Sue & Sue, 2012). According to the U.S. Department of Health and Human Services (2001), only 6% of Asian Americans with mental illness sought help from mental health professionals. Since Asian Americans are underrepresented relative to other ethnic groups in inpatient and outpatient mental health services (Chen et al., 2003; Snowden & Cheung, 1990),

prevalence rates of mental illness, as measured by the utilization of those services, will be deceptively low. Reasons for such underutilization, as discussed above, include cultural beliefs and values (Kim et al., 2001, Lee & Mock, 2005), lack of appropriate mental health services available to Asian Americans, and the stigma of mental health illness (Mak et al., 2009; Yang & WonPat-Borja, 2006). At the policy level, efforts within the community will need to be undertaken to counteract messages of shame and fear of mental illness that act as barriers to Asian Americans seeking needed help. Moreover, the results of this study indicated the adaptation of current treatment approaches to accommodate the cultural beliefs and values in East Asian communities and, thus, reduce the stigma of mental illness. Another suggestion of the study is that new methods of communication through language be developed that can be effective in increasing awareness and acceptance of mental illness with the Asian American population.

Adoption of a Family/Systems-Oriented Framework

Another theme that emerged in this current study involved the importance of adopting a framework that accounts for the cultural role of the family when working with East Asian clients. Nearly all participants reported how the concept of family is integral to the way the clients see themselves and relate to the therapist in treatment. Some clients treated by the participants presented their issues within a family context, expressing the main focus of treatment as concerns regarding the family's functioning. Other participants discussed the importance of the impact of family involvement in clients' issues and relational dynamics with family members. Interestingly, one participant indicated how a client's perception of the conflict arising out of tension between family members could be resolved only by addressing the needs of the multiple generations of individuals constituting the client's "family."

Multiple-generation households are common in the Asian American community. This is consistent with the collectivistic cultural value of prioritizing the group, in this case the family, over the individual. One participant analogized the family to a mechanism wherein an individual develops his/her sense of self and begins to form his/her understanding of relationships and community. The incorporation of the family in treatment underscores how the family may also be viewed as a laboratory where children are reared by their parents to be mindful of the hierarchy within the family structure, and where children become aware of their own position in the family by referencing others. This is consistent with Confucian values of hierarchy and awareness—when an individual acts, the consequences are visited upon others.

Shame and stigma are often prominent when Asian Americans experience mental health issues (Kung, 2004). As a result of the cultural emphasis on the avoidance of shame, mental illness and treatment is often understood with respect to its impact on the family unit and results in heavier family involvement in help-seeking when the situation deteriorates to the extent that it can no longer be handled without outside assistance. Concerns for "saving face" and avoiding any shame on the family often account for Asian Americans delaying care for longer periods than other ethnic groups (Okazaki et al., 2014).

One participant described how East Asian clients often present as more complex cases than clients of other ethnicities due to multiple factors often having greater salience for this population, including, but not limited to: (a) intergenerational dynamics; (b) intrapersonal mental health issues; (c) language difficulties; (d) members of the family at different stages of the acculturation process; and (e) larger systemic issues, such as poverty, immigration concerns, prejudice and racism, community norms, and managed

health care restrictions. Due to the complexity of the above stressors on East Asian clients—in addition to an ongoing negotiation process between traditional, Confucian beliefs and Western, Americanized values within the individual and family unit—participants' responses suggested the need for a clinician to adopt a framework that included a family/systems lens. Such approach would address treatment barriers as well as gain a more comprehensive understanding of a client's symptoms, behaviors, and functioning.

Interaction Between Therapist and Client Acculturation

In this study, participants reported on the role of their own acculturation as it impacted engagement in the therapeutic process with East Asian clients. One of the themes that arose was how the therapist's and client's acculturative levels changed throughout the therapeutic process, with participants attributing the client's level of engagement in treatment to a corresponding acculturation level. This supported the hypothesis of many researchers that acculturative processes which include adoption of Western values and culture, as measured by the degree of acculturation, explained increases in mental health-seeking attitudes and behavior (Chen & Danish, 2010; Fung & Wong, 2007; Tata & Leong, 1994). Interestingly, despite their generational differences, i.e., 1.5 versus second generation, all participants shared similar mental health beliefs. Such beliefs were congruent with that of their professional field, which supported a Western conceptualization of mental health and emphasized the importance of seeking help promptly in order to address mental health concerns. Moreover, all participants acknowledged experiencing the process of acculturation themselves, a factor which often had benefits for both therapist and client: the therapist was often more easily able to empathize with the client and the client was often more confident of being understood.

While the majority of participants stated having a clear sense of their degree of acculturation, several others described themselves as still being in the process of defining their level of acculturation.

All of the participants described their immigration to the United States, or that of their parents in the case of second generation participants, as a key event shaping the development of their identity and degree of acculturation in adopting Western values and culture. Half of the participants reported considering themselves "almost like elders": Having had the experience of balancing two disparate cultures while trying to figure out how to honor their own or their parents' immigration history, they were in a position to impart wisdom and understanding of the acculturation process. All participants stated having a greater sense of empathy for their clients' struggle in negotiating and adopting Western culture and values, understanding mental illness, and accepting the difficulties of openly addressing mental health concerns in the East Asian community. Most participants demonstrated this empathy through increased self-disclosure in treatment regarding their own history, ethnicity, and cultural practices that contrasted with clients from other backgrounds. The shared experience of having to juggle and make sense of two different systems of values and beliefs contributed to the level of respect that participants had for their clients, an appreciation of the uniqueness East Asian clients bring to treatment, and added to the complexity that East Asian clinicians face working with this population. Such complexity was increased for clinicians who identified as bi- or multiracial.

Participants described a noticeable difference in engagement with more acculturated clients, those who identified themselves as 1.5 and second generation, than with those who are less acculturated, first generation or recent immigrants. Several

participants described that they found it easier to work with 1.5 and second generation East Asian clients due to their increased awareness of mental health issues and openness to the therapeutic process (Kim et al., 2005; Liao et al., 2005). This is consistent with some studies in the literature which have shown that acculturation and adherence to either the Asian or the dominant culture affect Asian Americans' beliefs and attitudes toward mental health-related issues, i.e., etiology of mental illness, treatment appropriateness, help seeking, and counselor preference (Kim & Atkinson, 2002; Kim & Omizo, 2003; Mallinckrodt et al., 2005). Interestingly, however, the one variable often omitted in race/ethnic matching studies is client acculturation level.

When working with first generation clients, participants responded to the initial incongruity between the therapist's and the client's beliefs in the importance and benefits of treatment of mental illness by offering additional psychoeducation to clients and making adaptations to their treatment engagement strategies and approach.

Nearly all of the participants described experiencing an increased level of comfort and ease when meeting with ethnically similar clients irrespective of differing acculturative levels, a sentiment shared by clients and expressed to therapists at some point during treatment. Clients attributed their increased comfort to several factors, among them: (a) the participants' language fluency, whether that was in English or in the client's native language, which enabled clients to express themselves freely; (b) client perceptions that clinicians had knowledge of the client's cultural values and shared experiences; and (c) the clinician having similar physical characteristics and traits as the client. As important as interventions are to the therapeutic process, the results indicated that being mindful of the invisible but crucial variables that influence the dynamics between therapists and clients can aid the therapeutic process.

Ethnic Match and Shared Culture in Treatment

Research has indicated that ethnic-specific services increased Asian Americans' utilization, and reduced dropout and premature termination (Flaskerud & Hu, 1992; Gamst et al., 2001; Snowden & Cheng, 1990; Takeuchi et al., 1995; Thompson et al., 2004; Wong et al., 2003). In this study, when participants were also asked to elaborate on their experience of working with ethnically similar clients, they acknowledged experiencing the positive effects of ethnically-matched therapist and client pairs in treatment. Several participants described experiencing greater empathy for and motivation to help their clients; increased engagement with them; and, on the client's part, increased compliance and lower dropout rates. Additionally, participants reported shared characteristics, such as: (a) ethnic background; (b) fluency or proficiency in the client's native language; (c) knowledge of client's culture and traditions; and (d) physical traits, proved to be opportunities for engagement. By means of such shared characteristics, participants could more easily gain access to the client's view of his or her self, world and others, in addition to being considered an ally in the treatment process. Interestingly, one participant described how shared skin tone was a factor in facilitating treatment. Participants also noted that shared characteristics tended to minimize client resistance to the therapeutic process. Moreover, several participants mentioned their perception of the use of self-disclosure as an effective method to build a therapeutic alliance and increase engagement with their clients, in addition to the importance of transparency.

Despite the many benefits cited by participants, they also noted a possible detriment: the danger of implicit judgments on the part of both client and therapists. Participants described clients' implicit judgments as arising out of clinician's gender;

age; physical appearance, if it did not fit the stereotypical "look" of an East Asian individual; command of the client's native language; and trustworthiness. Participants, in turn, described their own bias when engaging with clients of the same ethnicity and/or a similar cultural background. As a result, participants cautioned against the overgeneralizations, stereotypes, and the false judgments that may ensue when clinicians made assumptions about the client based on shared ethnicity, rather than on how the client identifies him/herself. The use of assumptions often perpetuates the power differential in the therapeutic process and contributes to the prejudice that participants and their clients alike have reported facing both inside and outside of the therapy room.

Although some of the participants did not initially consider the client's ethnicity in their conceptualization of the client's presentation, ethnicity often became more salient as clinicians considered the client's family dynamics and beliefs. Half of the participants described how the client's identification as East Asian affected treatment decisions, including treatment approach and conceptualization. Findings of this study demonstrated insights participants had gained as a result of their work with East Asian clients, such as: (a) increased respect for this population, (b) the need to acknowledge a client's individual experiences, and (c) the realization of the importance that treatment approaches and modalities fit the needs of the client.

Participants acknowledged that many clients have expressed a preference for therapists with similar ethnicities, as such therapists are often perceived by clients as more approachable, friendly, and easier to relate to than non-Asian practitioners. This was consistent with the literature which corroborated the preference of ethnic minority clients for therapists with a shared background (Cabral & Smith, 2011), and specific studies with Asian Americans who preferred ethnically similar counselors and considered

them, as with the present study, more competent and easier to relate to. Interestingly, this benefit extended to clients of other minority groups in the experience of several participants, as the participants were often viewed by such clients as an ally because they were "not white" and, thus, could relate to the struggles of a person of color living in the United States.

One aspect of a clinician's background, despite shared ethnicity, which could cause a client concern was identified by a participant as the extent of the clinician's education. This was especially important for East Asians who often demonstrated a tendency to equate education with competence and, in this particular case, show disapproval when a clinician's credentials extended to a master's degree, but not a doctorate. This was consistent with the research of Thompson et al. (2004), finding, among other qualities, that Asian Americans preferred counselors with more education.

Some of the positive findings of this present research were inconsistent with certain studies in the literature on treatment with Asian clients, which suggested higher dropout rates and premature termination of treatment among clients within this population (Atkinson, Morten, & Sue, 1998; Maramba & Nagayama Hall, 2002), and consistent with other, more recent studies, that found no ethnic differences in dropout rates and treatment length, or occasionally better results for Asian Americans relative to other groups. Lower dropout rates and longer treatment lengths have also been attributed to the fact that treatment is sought by Asian Americans only when an individual's issues are extremely severe, and thus require more extensive treatment, as discussed above. Despite the general concerns about high dropout rates and premature termination, some researchers posited that ethnic matching with this population may have positive effects, due to the shared beliefs regarding etiology of mental illness and treatment goals (Leong

& Lau, 2001; Leong, et al., 1995; Zane et al., 2005). Participants in this study concurred that ethnic matching indeed facilitated the psychotherapy process and compliance in treatment for the majority of clients. One participant noted that a shared background resulted in the clinician's increased knowledge of the larger systemic issues of being an underprivileged person of color in the United States despite the clinician's significantly higher socioeconomic status than the client's.

Difficulties in Ethnically-Matched Pairs in Treatment

The majority of participants found that engagement with their East Asian clients was made more difficult by two components associated with East Asian culture: expectations of psychotherapy services and respect for professionals and persons of authority. Half of the participants described having to clarify and provide psychoeducation to East Asian clients on: (a) the therapeutic process, (b) roles of the therapist and client, (c) myths surrounding mental illness, and (d) benefits of being in treatment. Contemporary researchers have characterized Asian clients' expectations of the professionals as an underlying source of tension that may cause Asian Americans to question the effectiveness of psychotherapy services, and their Western mental health approach may result in loss of credibility for Asian Americans regarding the effectiveness of psychotherapy services (Leong & Lau, 2001), resulting in premature termination as well as a disinclination to seek help in the future.

Participants also acknowledged a similar conflict in treating Asian American clients: the common expectation in this population that professionals are "experts" and should act accordingly, a position often contrary to the professionals' training which stressed a collaborative approach (Sue & Sue, 2012). Several participants described the importance of being flexible in treatment so as to accommodate both perspectives, and

noted the utilization of psychoeducation as a tool to increase effectiveness and credibility with this population. Furthermore, participants noted that adopting more directive, behaviorally-oriented, skill-based, and problem-focused approaches was necessary and beneficial in building stronger therapeutic alliances and trust in clients. Participants found that these types of interventions also resulted in increased engagement, compliance, and lower dropout rates in treatment, most notably with recent immigrant clients and first generation East Asian clients. This was consistent with research by Chou and Leonard (2006), which found that Asian American clients' expectations of effective treatment were very practical ones—that they would be able to meet their responsibilities at work and at home—and not ones concerned with individual autonomy and personal growth. Participants' success in adopting treatment engagement strategies to address the significance of cultural beliefs in treatment may be a reflection of how traditional client-led, insight-oriented therapeutic interventions, based on Western models, were often contraindicated when first engaging with Asian American clients at earlier stages of the acculturation process.

One participant described how an increased awareness of people of other races, ethnicities, and cultures had expanded her concept of her own cultural identity and acceptance of Western values. This is consistent with research by Sue and Sue (2012), which suggested that experiences with individuals of color foster positive associations with racial difference, allowing for greater awareness of other people's cultures and race, and a deeper understanding of racial issues. Such relationships often facilitate the emotional and affect-laden experience of race that is crucial to multicultural learning and development (Toporek, 2001; Torres et al., 1997), further highlighting how cultural beliefs and values evolve over time.

The evolution of cultural beliefs and values is often a process occurring in both the therapist and client. One participant described working with an ethnically similar client as an "opportunity for personal growth," by affording her the prospect of focusing on her own process of acculturation. Participants reported that their understanding of culture and personal beliefs often shifted as they engaged with ethnically matched clients in treatment—a process clients were undergoing at the same time. Clients developed a deeper awareness of their identity, level of acculturation, and understanding of mental illness. Clinicians experienced identity and acculturation shifts as they adapted their treatment to the client's ethnicity, acculturative level, symptoms, and functioning. The more exposure participants had to East Asian clients, the greater their knowledge of the importance of this approach.

Research indicated that the effectiveness of counseling may be a function of the match or mismatch among clients' cultural values, therapists' cultural values, and values inherent in the process of counseling (Sue & Sue, 2012). As the counseling style in the United States is based on Western values, and can be in direct conflict with Asian cultural values, as discussed above, East Asian clients may view counseling and therapy as ineffective and promoting values inconsistent with their own. Thus, by accounting for both ethnic cultural values and acculturation, the results of this study suggested that by discovering the invisible and visible factors distinct for each client as an individual, the therapist is the instrument to help facilitate the therapeutic alliance, enhance treatment engagement, and produce positive outcomes.

Limitations of Diversity-Related and Multicultural Training

Research has indicated that most multicultural training in graduate school is limited to a single course, rather than an integrated training experience (Goode-Cross,

2011). This neglect of multicultural issues has been consistent with the experience of several participants in this study. The majority of participants reported receiving minimal or limited training on diversity and multicultural issues, and several indicated having received no training at all on these subjects. Of those participants who had graduate school coursework related to diversity and/or multiculturalism, some found it to be helpful but the majority indicated that the treatment was disappointing in that diversity was often addressed in a superficial way and no attention was given to East Asians. This inadequacy highlights the need for comprehensive training in multicultural competence.

The practice of restricting diversity to one course is indicative of the "traditional pen and paper" approach to multicultural training (Nolte, 2007; Sue et al., 1991). Although participants found this method helpful insofar as they were exposed to clients of different cultures, depictions often offered stereotypes and the content was insufficient in understanding diversity and culture within the context of the treatment process. Several participants credited experiences outside of the classroom, such as supervision, informal conversations with peers and colleagues, postdoctoral fellowships, treatment with East Asian clients, and clinical placements and fieldwork, as giving them a greater understanding of diversity and issues pertinent to the East Asian population. These participants' comments regarding the significance of experiential and affective experiences underlined how little the classroom setting in most graduate courses has offered students.

Participants who provided examples of positive and beneficial experiences that fostered a greater personal and professional awareness of diversity-related issues in therapy often indicated the significance of having culturally sensitive, curious, and open supervisors, colleagues, and peers. These resources could be tapped to dialogue and guide

clinicians in self-exploration of their own bias and understand a client's culture and its possible influences on such client's symptoms, behaviors, and functioning. Preparation for the treatment of clients from diverse racial, ethnic and cultural groups required that clinicians first be helped to address their own biases, misconceptions, internalized racism and microaggressions, and implicit attitudes and preconceived notions of ethnicity, culture, and diversity. Thus, understanding multiculturalism so that practitioners are culturally competent speaks to the need for further improvements in the training of professionals in integrating multicultural theory into psychological theory and practice.

Limitations of the Present Study

A number of limitations will need to be considered in interpreting, utilizing, and applying the results obtained in this study. One limitation is generalizability due to the small sample size, non-random sample, and possible selection bias. The sample utilized in the current study was derived from a network of East Asian clinicians identified through connections to an academic institution in the mid-Atlantic, and their affiliations with national and state membership organizations in New Jersey and Hawaii. The effect of the specificity of the geographical locations and professional affiliations of the participants on the generalizability of the findings to the larger population of East Asian therapists working with East Asian clients must be considered. Based on the nature of this sample, it is important to recognize also the possible impact that selection bias may have had on the results obtained. Specifically, subjects responding to advertisements for this study and ultimately selected to participate were likely to: (a) have an interest in issues of culture, (b) have more experience or training working with Asian clients in their practice, and (c) feel comfortable with and/or have reflected on issues of culture in their work. This contribution of attributes may also limit the generalizability of the findings.

Another limitation of this study is based on its qualitative nature. The present research used neither a random sample nor a control group, further affecting the generalizability of the results obtained. The hypotheses developed were exploratory. Data analyzed and the theories resulting therefore may not necessarily be used to support or challenge research conducted by others in this area of inquiry. Moreover, as this study was restricted to East Asian clinicians working with East Asian clients, the results may not be generalizable to non-East Asian clients, non-East Asian clinicians who work with East Asian clients, or to other therapists of color and majority clients.

A further limitation of this study is possible investigator bias arising out of a high level of involvement in the conceptualization, design, implementation, and analysis of the results. The researcher was responsible for conducting all of the interviews and analysis of the data. The above, in addition to the researcher's very strong interest in the topic, should be considered when interpreting the findings of this study. Notwithstanding such issues of generalizability, this study represented a first step in which themes related to work with East Asian clients could be identified for further qualitative and quantitative research.

Implications

Implications for Future Research

As Asians and Asian Americans are the fastest growing ethnic minority group in the United States, a clear need to address their needs, and barriers that currently impede their participation in mental health services, has been indicated by the results of this study. Despite the aforementioned significant Asian population in the United States, other ethnic minority groups receive priority in funding for mental health and wellness programs and services. Among the Asian population, even fewer resources are allocated

to those from East Asia. This discrepancy highlights the need and vast opportunities for future research and inquiry into advancing the field of multicultural psychology in general, and Asian American mental health in particular.

Due to the limited number of studies on East Asian Americans and mental health, one possible avenue of future research includes a replication of this study to verify its findings. Moreover, quantitative research testing of this study's themes would be another direction for future research to pursue. Additionally, replication of this study through the lens of a more diverse research team would address the issue of possible investigator bias and, thus, act to improve the generalizability of the findings.

In this study, the dynamics of culture, acculturation, and ethnic match were evaluated as they impacted treatment engagement and the therapeutic process with East Asian clients and clinicians. As many groups share similar collectivistic values as those found among therapists and clients who are of East Asian descent, another area of future inquiry lies in the examination of the therapeutic process in ethnically matched pairs of therapists and clients from additional ethnicities and cultures, including other Asian populations, and African American, Latino, and Native American backgrounds. As there are even fewer research studies on clients and therapists who are bi- or multiracial, an issue introduced by a study participant, further investigation may be extended to them as well. Additional lines of inquiry can expand the current study's exploration of power dynamics, culture, diversity, societal disparities, and similarities and/or differences in therapeutic interventions with the other populations listed above.

A third area of exploration and future research on the effectiveness of the modified therapeutic interventions made by East Asian therapists can be conducted with the East Asian clients they treated. While most participants reported positive outcomes by

making adjustments to their treatment approach, conceptualizations, engagement strategies, and evaluation of treatment with East Asian clients, clients' perspectives would offer additional information on the effectiveness of the interventions, and might offer insight to therapists of other ethnicities who work with East Asian clients on how treatment with this population might be modified. Further studies can investigate the modification of treatment interventions to other ethnic minority clients in ethnically matched pairs, so that enhanced outcomes may be achieved with other populations as well.

Moreover, a fourth area warranting further study lies in the examination of therapy techniques in cross-racial treatment. Although there have been quantitative and qualitative studies that have measured the experience of ethnic and racial minority clients in cross-racial therapy (Chang & Berk, 2009; Pope-Davis et al., 2002), additional research is necessary in order to shed light on the therapeutic process as it is experienced concurrently by both the client and the therapist throughout the course of treatment. It was beyond the scope of the current study to examine the therapeutic interventions, process, and outcomes with populations other than East Asian clients and therapists; however, participants indicated that similar issues of diversity, racial prejudice, and stereotypes were present in their work with non-Asian clients. Interestingly, some participants described receiving comments from clients regarding their ethnicity. While some might have been rather benign in nature, others were wholly negative, challenging their competence as clinicians. Such statements reinforced for clinicians their status as minority clinicians and were illustrative of the power dynamics inherent in cross-racial treatment.

Studies exploring cross-racial work between non-Asian therapists and East Asian clients would be helpful in revealing additional factors influencing the therapeutic process and treatment outcomes, such as identifying reasons that may explain Asian clients' traditional low service utilization and premature termination from treatment. Moreover, research on examining both the therapist and client experiences of ethnicity, and how diversity-related issues are addressed in cross-racial and cross-cultural treatment, would provide additional information on the essential elements required for positive outcomes with mismatched dyads.

Furthermore, the current study also inquired about the diversity and multicultural training therapists received, specifically for those working with East Asian and other ethnic minority clients. Participants in this study reported their dissatisfaction with the limited amount of formal diversity and multicultural training in their graduate programs, with some objecting to the poor quality as well, specifically, how little attention was accorded Asian Americans. As the population of the United States becomes more diverse, cultural competence has become even more vital in the field of mental health treatment, and crucial to ensuring that clients from all backgrounds and cultures receive the highest level of care. Although cultural competence has begun to take its rightful place as an important requirement and standard in the field of mental health, additional research on the effectiveness and evaluation of the training and practice of diversity-related issues in therapy, especially for those working with ethnic minority clients, would be helpful both to therapists who would gain insight on the intersection of a client's symptoms and culture in therapy, and to clients of color in terms of a more relevant and enhanced therapeutic process.

Implications for Clinician Training

The current study highlighted several implications for training clinicians to work with East Asian clients, including a need for more intensive training in diversity and multicultural issues in graduate school, as discussed above, and the incorporation of more supervisory opportunities and experiential work with Asian clients. Additional implications include advanced training to promote fluency in East Asian languages, the need for self-exploration on countertransference and its influence on the therapist's identity and acculturation development over the course of treatment, and the provision of advanced trainings and workshops in the community led by, and conducted for, practitioners serving East Asian clients.

Participants in the current study expressed disappointment regarding the amount and types of diversity and multicultural training that they received during the course of their graduate education and careers, as discussed above, with nearly all of them reporting that they did not receive any training specific to working with East Asian and/or Asian clients in graduate school. As stated in the literature, experiential and affective experiences are necessary and critical in developing high-quality training and cultural competence (Kim & Lyons, 2003; Toporek, 2001; Torres et al., 1997). This was supported in the present study. Participants described how work with East Asian clients raised their own level of consciousness and resulted in greater knowledge of the clients themselves as well as the issues facing East Asians. Such experiences should be integrated into foundational and core graduate programming as a way to facilitate the conceptualization of East Asian and other ethnic minority clients, and to promote the integration of psychopathology, diversity, and culture in treatment—a process that may be even more critical for non-ethnically matched clinicians as they engage with their

personal attitudes regarding race and ethnicity in order to develop cultural competence in treatment.

Participants credited their work outside of the classroom (e.g., internships, dissertations, informal conversations with peers and colleagues, and field placements in communities with significant East Asian populations) as formative in shaping their understanding of diversity, multicultural issues in treatment, their own identity development and acculturation process, and issues pertinent to the East Asian community.

The majority of participants also emphasized the importance of learning from colleagues; faculty; and supervisors, particularly those who shared a similar ethnic, racial or cultural identity. Specifically, participants noted the importance of supervision for clinicians working with East Asian clients. Participants described how supervision provided a safe outlet for participants to explore the dynamics unique to work between ethnically similar therapists and clients, such as: (a) countertransference; (b) the clinician's identity development and acculturative process as it relates to the client, and its impact on the therapeutic process; (c) how clinicians' cultural values shape their behavior and approach in treatment; and (d) the ability to gain a deeper understanding of the ethnicity and cultural values of their clients. Participants also stressed certain characteristics important for supervisors, including: (a) cultural competence, (b) expressing a natural curiosity and openness to understanding East Asian culture, (c) encouraging a dialogue on clinician's experiences in working with East Asian clients, (d) highlighting dynamics in the therapeutic process that concern diversity-related issues, (e) imparting their own experience in working with East Asian clients, and (f) preferable fluency in the client's native language. One issue participants had with supervision,

however, was the lack of persons of color, particularly Asians, as supervisors in training facilities. Attracting ethnic minority supervisors, as well as faculty, graduate students, and candidates of color is essential in order to provide clinicians with opportunities to learn. More clinicians of color will act to end the perpetuation of the silence from these communities, and expand how diversity and ethnic minority-specific issues are viewed and addressed within communities, organizations, and institutions.

Participants also highlighted the importance of language, and recognized that gaining greater access to the underserved East Asian community would require that clinicians become proficient in clients' native languages. Language-specific trainings for clinicians, and the provision of other resources available for developing this skill, could have a profound impact on the delivery of culturally competent services by effectively addressing what the participants in this study identified as one of the biggest needs and barriers for this population. Trainings conducted by East Asian clinicians who can relate their experiences, instruct clinicians in interventions that have been helpful in their work with an East Asian population, and address language-specific issues would be beneficial in providing clinicians, whether currently working with East Asian clients or planning to do so in the future, with suggestions and opportunities to hone their clinical skills in conceptualization and practice with such clients.

Graduate schools and other multicultural training offerings should incorporate more discussion and focus on diversity and issues that pertain to specific ethnic minority populations in order to equip clinicians to treat clients from those cultures more effectively. Additional efforts to address the lack of attention to diversity-related issues in standard and foundational coursework would be beneficial in order to promote clinician knowledge of cultural values as they inform treatment engagement, therapeutic

interventions, and outcomes. Of particular importance to East Asian and non-East Asian clinicians treating East Asian clients, would be addressing the impact of stigma for this population, an issue shared with other ethnicities adhering to collectivistic values. Participants also noted experiencing microaggressions and other prejudicial attitudes from clients. The addition of a social justice perspective may also be indicated for inclusion in training programs. It would assist clinicians to address their own attitudes, as well as inspire dialogue as to addressing these issues as a clinician from an ethnic minority population who might be a target of prejudice and microaggressive behavior from clients with other backgrounds, as described by several of the study's participants.

The incorporation of the above strategies and suggestions into clinician training could result in more informed, empathic and culturally competent clinicians, whose interventions may lead to a reduction in the gap in service delivery and utilization in the East Asian community. This would have a profound effect on addressing the stigma of mental illness and enhancing the delivery of mental health services for not just one particular community, but for all ethnic and cultural minority populations.

Implications for Clinical Interventions

Results of this study found implications for East Asian clinicians working with East Asian clients in terms of their attitude and therapeutic stance, in addition to recommendations for clinician practice and treatment interventions. Nearly all participants discussed the importance of a clinician's attitude and therapeutic stance when working with East Asian clients. Their responses indicated the importance of the exploration of their own identities, components of which were identified as (a) level of acculturation, (b) cultural values and beliefs, (c) work with racially and ethnically similar clients, (e) self/family immigration history, (d) cultural beliefs surrounding the stigma of

mental illness and its impact on help-seeking behaviors, (e) power and privilege, and (f) experience as an ethnic minority clinician.

Several therapists discussed the importance of being mindful of racial dynamics, historical context, and the impact of relevant laws, such as immigration law, on the therapeutic process. This focus on self-knowledge and exploration is consistent with the literature, which suggested that increases in self-knowledge and awareness of personal racial experiences are critical to culturally competent practice (APA, 2003; Sue & Sue, 2012). Participants acknowledged that understanding diversity and achieving it is a difficult undertaking when treating clients and requires constant reflection and practice. Participants discussed factors that comprised cultural competence as including: (a) understanding the multifaceted nature of culture, (b) the ability to apply theoretical concepts of diversity appropriately for different communities and populations in treatment, and (c) demonstrating empathy. East Asian clinicians encouraged the use of introspection in order to foster an understanding of the role of ethnicity and diversity-related issues in therapy as well as more practical suggestions to enhance cultural competence, such as seeking out opportunities for training, supervision, and clinical work with East Asian clients through practicum, field work, and career placements.

A second implication involves the importance of monitoring the clinician's beliefs and attitudes. Participants discussed concerns about making unintentional assumptions about their clients arising out of a shared background. Specifically, participants stated that, having experienced their own process of identity development, acculturation process and cultural beliefs, they may superimpose their process on clients and automatically assume clients are at the same level of acculturation and identity development, and hold the same cultural values and beliefs as the clinician. This may also result in a tendency

for clinicians to overgeneralize their treatment approaches, inadvertently negating that clients are individuals, capable of developing their own identity, acculturation process and beliefs regarding mental health treatment.

The literature acknowledged that blurring important differences may contribute to a homogenized view of Asian Americans (Kim et al., 2001). In addition to being aware of not combining distinct and unique ethnic groups into one category, another area in which making mistaken assumptions may occur derives from generational differences. Such generational differences may prevent the clinician from honoring their individual clients' struggles and experiences in negotiating between two different cultures within their own family system, community, and society. Participants reported how their own cultural beliefs may inhibit their addressing the shame, guilt, and anxiety that clients may experience, and could also blind them to acknowledging the courage clients demonstrate by overcoming the factors comprising stigma and seeking mental health treatment.

Additional work to assist clinicians in addressing their own assumptions, biases, and belief systems may be beneficial in helping clinicians adopt and maintain a more open, patient attitude and therapeutic stance. Clinicians becoming more knowledgeable about the components of the stigma surrounding mental illness arising from such factors as: (a) sociopolitical dynamics, such as the fear of deportation; (b) more personal considerations, such as fears of demonstrating a weak character, causing shame to oneself and one's family and isolation from the community; and (c) the possibility of being hospitalized, could help to maintain rapport and facilitate a deeper sense of trust with East Asian clients. Due to the importance for clients of color of addressing racism (Sue & Sue, 2012), clinicians should seek ongoing consultation with other professionals designed

to locate clinicians' possible assumptions and biases, as well as to discuss other areas of difficulty in the therapeutic process.

A third implication involves therapeutic interventions and techniques. Participants described their East Asian clients as often demonstrating high levels of mistrust and resistance to the therapeutic process. Participants noted, however, that by adopting a more family/systems-oriented framework and utilizing problem-focused, behavioral interventions in the beginning of treatment, clients' engagement and attendance in treatment was increased. Another factor participants acknowledged as aiding clients' levels of commitment, compliance, and engagement in treatment was experiencing short-term success, either through increases in their functionality or decreases in their anxiety and/or depression, resulting in reduced dropout rates and shorter durations of treatment.

Once clients realized that mental health treatment could be effective in improving their presenting symptoms and behaviors, pre-existing negative beliefs regarding mental health treatment were challenged. They were then often able to view mental health services as helpful and useful, and thus have greater confidence in the clinician's competence. Participants also indicated that by first focusing on skill-building and improving clients' and their family's functionality, clients became more receptive to process and insight-oriented approaches as treatment progressed.

Moreover, providing psychoeducation was identified by participants as a necessary tool in order to address many elements of treatment, such as (a) myths related to mental illness and stigma; (b) clients' misperceptions regarding mental health treatment; (c) issues related to ethnicity, identity, and culture; (d) clients' experiences of racism with previous treatment providers; along with (e) providing positive experiences of mental health treatment. Furthermore, utilization of different treatment modalities, i.e.,

group or family therapy, may be warranted in certain instances in order to help clients feel a sense of connection and solidarity in their experiences.

Additional implications of the present study involved the role of self-disclosure in facilitating engagement and building rapport with East Asian clients. Nearly all participants described using some level of self-disclosure in their work with East Asian clients. Given cultural proscriptions against open displays of emotion, revealing personal information to others, and an inability to resolve problems on one's own, it is common for Asian Americans to express their psychological distress in the form of physical symptoms (Kim et al., 2001; Leung, 1990). An additional consideration is that disclosure may be a violation of the privacy of other family members (Chen & Danish, 2010). As a result of all of these inherent negative associations, disclosing personal issues, symptoms and behaviors can literally be a foreign concept to some East Asians, often giving rise to the resistance participants reported experiencing in therapy. Self-disclosure by the therapist has been found to be a tool that helped to bridge the client's cultural beliefs and values with the goals and practice of Western psychological treatment.

Participants described the benefits of self-disclosure as ranging from promoting ease and safety; inviting clients to engage in free expression; and communicating a shared level of knowledge about the client's culture, cultural practices and family dynamics. Participants also described how the readily apparent disclosure of their ethnicity, in the form of their name, use of language, gender and physical appearance, provided an initial entryway to gain East Asian clients' engagement in therapy. Additionally, participants indicated that voluntary disclosure of their own cultural practices, immigration history, identity and education resulted in modeling and normalizing safe emotional expression, and increased clients' desire and investment in

the therapeutic process. Furthermore, self-disclosure appeared to be powerful in facilitating the client's perception of sameness and safety with the therapist, and in reducing perceived vulnerability and anxiety arising out of violating the cultural value of saving face.

The positive effects of therapist self-disclosure have been found by other investigators. Studies with ethnically-matched and cross-racial dyads examining the effect of a therapist's use of self-disclosure on both the therapist and the client demonstrated an improvement in treatment outcomes for clients. Further study on the impact of the types of interventions most suitable for this population, particularly those involved in skill-building and of less intensive duration, would be helpful to ascertain additional strategies that clinicians might utilize to increase East Asian clients' willingness to remain engaged in treatment, and improve overall outcomes for this population.

Implications for Policy and the Field of Psychology

Guidelines for multicultural practice in the field of psychology were established in 2003 by the American Psychological Association. Formal guidelines, along with instructions on how to apply such guidelines to specific ethnic minority and cultural groups, however, do not exist. Without additional guidelines, it is doubtful whether all clients will receive the best level of culturally competent care, a concern made more salient by the increasing levels of diversity in the United States.

Several important implications and recommendations have arisen as a result of this present study. Examples of changes that could be implemented in the field, suggested by the present study, include coursework, continuing education programs and licensure requirements mandating extensive clinician knowledge of diversity-related issues specific

to ethnic minority groups and the role of race and privilege. Moreover, specialized and advanced trainings conducted by experts in diversity and multicultural issues are indicated to create affective experiences for clinicians, giving them an opportunity to engage in introspection, examine their own practice, and learn how to apply modified techniques and therapeutic interventions, like those stated above, to work with East Asian clients. Another recommendation would be to place a greater emphasis on underserved populations when incorporating diversity-related issues and therapeutic interventions into medical, mental health, and social services, in addition to educational organizational practice. Encouraging a national dialogue on creating more awareness of individual biases and implicit judgments is also indicated.

Participants noted the lack of resources, publicity, and knowledge of available services in the East Asian community, indicating the need for change. The lack of resources perpetuates the power dynamics of privilege and stereotype in healthcare, as well as allows the stigma concerns that prevent Asians from accessing needed care to continue unabated. Lack of funding needs to be addressed at the community, county, state, and national level. Advocacy work at each of those levels is necessary so that the concerns of East Asian and other Asian communities are no longer neglected.

Although adequate funding is much desired and necessary, current funds can be reprioritized and directed to: (a) the hiring of bilingual therapists; (b) training programs focused on raising fluency levels of current East Asian therapists in clients' native languages; (c) higher reimbursement rates for provision of services in-home and in the community; (d) publicity of events and services in local publications; (e) subsidizing the costs of mental health care for clients, including childcare for parents; and (f) offering more evening hours for clinicians to meet with clients.

Additional work must be done to address myths and stereotypes that mask the needs of the East Asian community. Scholars have found that the "model minority" stereotype is used to justify the lack of social, educational and governmental services for Asian Americans, and the consequent inadequate funding on local, state, and national levels (Lee et al., 2001). Moreover, their relatively higher status, in terms of educational attainment, employment, and income, has given rise to the perception that Asian Americans have fewer adjustment and mental health problems than other groups (Sue, 1994). Such myths and stereotypes associated with "model minority" labeling have also served as a barrier for scholars and practitioners, inhibiting important research devoted to the mental health of Asian Americans.

A lack of communication about and among East Asians can be improved in additional ways. Cooperation and collaboration between agencies and organizations will serve to streamline available services within the community and help to develop local networks of East Asian mental health professionals. Adaptation of a more holistic approach to mental health treatment with Asian clients, acknowledging both Eastern and Western perspectives, could be implemented, along with accompanying explanatory materials to be distributed to the community in the relevant language(s). Simple interventions, such as information on self-help techniques and the benefits of mental health services in a language that honors client's cultural values and recognizes their struggle, can be a start to shift the cultural norm of how people communicate about mental health in the United States. The role of the mental health profession to properly understand and address the needs of the East Asian and greater Asian community cannot be underestimated. Whether through continuing education, conferences, research or

advocacy, the profession has a responsibility to the East Asian community that it has long allowed to be unmet.

Conclusion

This study provided East Asian clinicians with the opportunity to discuss their experiences working with East Asian clients in treatment. Additionally, this study shed light on the intersection of culture, diversity, and multicultural issues in therapy through the lens of ethnically-matched therapist and client dyads in order to provide practitioners, both East Asian and non-East Asian alike, with the knowledge and the insight to work successfully with East Asian clients. Although many of the participants offered information consistent with the currently available literature, the current study revealed gaps remaining in the research related to East Asian mental health in general, and research on specific therapeutic interventions and techniques that would benefit this population in particular. As Asian American mental health has received less attention than other minority groups (Abe-Kim et al., 2007; Lee & Mock, 2005), it stands to reason that existing literature would reflect this unfortunate reality.

The results from this study indicated the need to address the lack of training in diversity and multicultural issues in graduate, postgraduate and professional development settings. Moreover, there is a noteworthy lack of information and training on the treatment of Asian and East Asian clients, particularly related to the stigma of mental illness—a major barrier cited by participants in the ability to culturally and theoretically address the needs of patients of color.

Participants emphasized how ethnically-matched dyads provided a unique opportunity to help bridge the gap between under-service utilization and access to care for East Asian clients. Moreover, all participants agreed that certain factors impacted the

therapeutic process, either in a positive or negative fashion, among them, language proficiency, therapist identity, therapist and client level of acculturation, generational differences, power and privilege, shame and varying cultural values, and family dynamics/systems.

Consistent with the literature, participants noted that an ethnic and linguistic match between an East Asian clinician and an East Asian client resulted in positive outcomes for clients, especially for less acculturated ones, and was often responsible for lower premature dropout rates and higher treatment attendance rates. Furthermore, all participants stated that modifications to their therapeutic stance, engagement strategies, and interventions were necessary in work with East Asian clients, and recommended that non-Asian providers adopt these practices as well. Participants also discussed the importance of introspection, awareness, and discussion on countertransference and the therapist's own identity development, acculturation level, and cultural values as they impact the therapeutic process. Participants spoke about how their physical appearance played an important role in facilitating the therapeutic alliance with their Asian clients but, interestingly, sometimes prompted negative comments from non-Asian clients. Participants also spoke of adopting a family/systems framework in order to comprehensively address the dynamics that influence a client's symptoms, behaviors, and functioning. Furthermore, all participants spoke of organizational and systems-level barriers that discourage access and delivery of mental health services for East Asian clients. Finally, participants stressed the need for additional resources and advocacy in order to attract and cultivate more bilingual clinicians of color, and thereby help East Asian and other ethnic minority communities to understand the process of mental health and treatment.

Incorporation of a new language of encouragement, safety, and healing would empower East Asians and other people of color to expand their view of mental health treatment and, in turn, create more prosperous and healthful communities. Before that is accomplished, efforts need to be made to inform and remind those responsible parties—whether local communities, county, state or national political entities or organizations; researchers; and mental health agencies and practitioners—that they have the power to make substantial changes for the betterment of the East Asian and Asian communities in the areas of delivery of mental health services, increasing service utilization, reduction in premature termination and stigma, and retention in treatment, so that Asian American individuals have the same opportunities to live a fulfilling life as all others in the United States.

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Appendix A

Advertisement for Listservs

Dear ____,

My name is Lydia Kim and I am a fourth-year doctoral candidate in the Clinical Psychology program at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University.

I am conducting study to assess clinician perspectives on working with East Asian clients within the past 5 years. If you are interested in participating or have any questions, please contact Lydia Kim by phone at (732) 659-0850, or by e-mail at lydiajkim@gmail.com. In addition, if you know of any Asian clinicians who work with Asian clients, please consider forwarding this email to them.

Thank you so much for your time and consideration.

Sincerely,

Lydia Kim, Psy.M.
Doctoral Student, Clinical Psychology
The Graduate School of Applied and Professional Psychology
Rutgers, The State University of New Jersey
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Appendix B

Informed Consent Agreement

Study Title: Working with East Asian clients: An exploratory study of the perspectives of East Asian clinicians

Invitation to Participate: You are invited to participate in a research study that is being conducted by Lydia Kim, Psy.M, an advanced doctoral candidate in the Clinical Psychology Psy.D. program at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University. Before you agree to participate in this study, you should know enough about it to make an informed decision.

Purpose: The purpose of the study is to explore the experiences of East Asian therapists working with East Asian clients. In doing so, this will shed light on the specific needs of this population in the hopes of providing a more holistic form of treatment. As the fastest growing group in the United States, treatment of Asian Americans will become even more of a concern as more East Asian Americans become more acclimated to the concept of therapy. There appears to an even smaller literature on East Asian Mental Health and seldom does the literature differentiate between the various subgroups that comprise the Asian American population in the United States. As one of the larger subgroups among Asian Americans, a more in-depth study of this burgeoning subgroup is necessary to provide the best level of care for a population that is in need of services. As mental health professionals, they play a major role in the delivery of treatments and a better understanding of the therapeutic process and special considerations that are necessary for treatment with East Asian Americans can become valuable information that will help mental health professionals to be more knowledgeable and effective in their interventions. Thus, this study aims to understand the mechanisms, treatment modifications, cultural considerations, and clinicians themselves, who identify themselves as having a similar, if not the same ethnicity, as their clients to help determine this population's specific needs

Participants: This study will use a network sample of approximately 10-20 experienced practitioners working with East Asian clients and will be conducted at various settings based on your geographic location. You will only be considered for participation in this study if you return a signed consent form.

Procedure: If you participate in the study, you will be interviewed individually during a designated time at an agreed upon location. It is expected that the interview will take 60-90 minutes to complete. However, the length may vary greatly depending on the depth of the answers provided. All interviews will take place in-person at a location in New York or New Jersey, mutually agreed upon by you and Lydia Kim or via phone or Skype. All in-person interviews may be conducted in your home or office or in a secure room at Rutgers University to assure settings that are private, comfortable, and convenient for the interviewees. For those interviews taking place via phone or Skype, it is important to choose a place to talk that is comfortable and private. In these cases the interviewer will be alone, at home or in a secure room in the Psychology Building at Rutgers University.

Risk/Benefit: There are no known risks associated with your consent and participation in this research study. Participation in this study may not benefit you directly; however you will play a major role in helping other researchers, social workers, psychologists, and others understand the experiences of providing treatment to East Asian clients.

Compensation: There will be no compensation for your participation in this research study.

Cost: There will be no cost to you for participating in this research study.

Confidentiality: This research is confidential. The research records will include some information about you and this information will be stored in such a manner that some linkage between your identity and the response in the research exists. Some of the information collected about you includes: your name, age, ethnicity, education history, and employer. Also, you will be asked to talk about clients as part of this interview. You will not be asked to disclose any confidential information about clients. Please refrain from providing identifying information. Any information that you provide which may be used to identify the client will be removed from the transcript. Names of people and places will be replaced with pseudonyms.

Please note that we will keep information confidential by limiting individual's access to the research data and keeping it in a secure location in the researcher's residence. Hard copies of interview data and audiotapes will be stored in a locked filing cabinet and no one other than the researcher will have access to this information. Transcriptions will be stored on password-protected computer database. In addition, you will be given an identification code and a pseudonym in which only the researcher will have access to the code key. The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law.

If a report of this study is published, or the results are presented at a professional conference, your information will be disguised to not have any identifiable information. All study data will be kept for at least three years after completion of the research, all documents with identifying information will be shredded, audio and video tapes will be erased, and any computer files will be erased by the researcher at this time.

Risks/ Benefits: Talking about challenging experiences may create discomfort for the participants. However, it is expected that this discomfort would be similar to the level experienced sharing the same information in a supervision session. You may receive no direct benefits from participation in this study. However, the present research will contribute to the literature on therapists' experiences working with this population. Participants will play a major role in helping other researchers, social workers, psychologists, and others understand the experiences of practice in this setting.

Withdrawal: Participation in this study is voluntary. You may choose not to participate, and you may withdraw from the study at any time during the study procedures without any penalty to you. You may refuse to answer any questions with which you are not comfortable.

If you have any questions about the research, you may contact me, Lydia Kim at (732) 659-0850 or email me at lydiajkim@gmail.com. You can also contact my dissertation faculty chairperson Dr. Nancy Boyd-Franklin at boydfrank@aol.com.

If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:

> Rutgers University, the State University of New Jersey
> Institutional Review Board for the Protection of Human Subjects
> Office of Research and Sponsored Programs
> 3 Rutgers Plaza
> New Brunswick, NJ 08901-8559
> Tel: 848-932-0150
> Email: humansubjects@orsp.rutgers.edu

I have read and understood the contents of this consent form and have received a copy of it for my files. By signing below, I consent to participate in this research project.

Participant (Print) _____

Participant Signature _____ Date _____

Investigator Signature _____ Date _____

Consent to Audiotape and/or Videotape

You have already agreed to participate in a research study entitled: Working with East Asian clients: an exploratory study of the perspectives of East Asian clinicians, conducted by Lydia Kim, Psy.M. We are asking your permission to allow me to audiotape/videotape the interview as part of the research study. This procedure is optional; you do not have to agree to be recorded in order to participate in the main part of the study.

The recordings will be transcribed to ensure the authenticity of your responses, which is important for data analysis to ensure that information from the research study has been recorded accurately. This analysis includes reviewing the transcripts to discover common themes, similarities and differences across all subjects.

The recordings will include the responses that you provide throughout the interview. Please avoid mentioning names of individuals or any identifying information of clients. Any names of people of places which are disclosed will be replaced with pseudonyms. If the interviews are video-recorded, recordings will include full facial features. We will not attach your name to any of the recordings. Instead, you will be given an identification code and a pseudonym. Only the researcher will have access to the code in a password secured database.

The investigator will keep this information confidential by limiting access to the research data. The recordings will be stored on a password-protected computer and any hard copies of transcriptions will be stored in a locked filing cabinet in a secure location. This information will be permanently erased and destroyed three years after the study ends.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

Participant (Print) _____

Participant Signature _____ Date _____

Investigator Signature _____ Date _____

Appendix C

Background Information Questionnaire

Name: _____

Age: ____ Gender: _____

Racial and Ethnic Background: _____

Professional degree(s) & Year(s) Attained: _____

Year in practice:

Professional settings worked in throughout career:

Percentage of current caseload that is racially different from your own racial background (& list racial background of current clients):

Percentage of typical caseload that is racially different from your own racial background if different than above (& List racial background of typical caseload if applicable):

Three most common diagnoses in your individual caseloads:

What is the average length of treatment for your typical client? Does the average length differ in any way for clients from racial backgrounds that are different than your own?

Theoretical orientation and specialization:

Treatment specialty/focus:

Appendix D

Semi-Structured Interview

I. Clinician Information

1. Tell me about yourself. How do you identify yourself and your practice?
2. How many years have you been in practice? What is your theoretical orientation?
3. What percentage of your clientele identifies themselves as East Asian? What countries are they from?

II. Treatment

1. How do you prepare to work with someone, who identifies themselves as East Asian?
2. What are some examples of the typical issues that East Asian clients present with?
3. How do you think of race in conceptualizing a client and their presenting problem?
4. How do you join with your clients and is it different from clients of other ethnicities?
5. Please describe common characteristics of the Asian client that you have seen.
    a. Give an example of a successful case and why?
    b. Give an example of a difficult case and how would you have improved your approach to treatment?
6. Do you notice any differences amongst clients from different Asian backgrounds? Clients from other ethnicities? (e.g., patterns, within group and between group differences)
7. What do you enjoy about working with East Asian clients?
    a. Has anything surprised you about working with this population?
8. What has been challenging when working with clients from this population?
9. What would you say are the needs of this community? What should be done to address those needs?
10. What are some barriers to treatment? (e.g., transportation, language barriers, systems, etc...)
11. What are some different areas that could be potential areas of difficulty in treatment?
12. How have your thoughts, feelings and approach to working with Asian clients and cultural issues in treatment changed throughout the course of your career?

III. Therapist Ethnicity and Treatment

1. How would you describe your level of acculturation and that of your family? (ex: motives for immigration - opportunities, political, cut ties to be here?)

2. What impact does your level of acculturation have on your treatment/ treatment approach with this population?
3. Did your ethnicity play a role in treatment with Asian Clients?(e.g., positive and negative direction)
    a. If so, how much of a role does your ethnicity play in your treatment with Asian clients? (e.g., overgeneralizing their experience/making it easier)
    b. If not, why not?
4. What impact does being Asian, or identifying yourself as Asian, have on your work with Asian clients?
    a. How has it helped you in joining or in treatment, if at all?
5. Are there any ways in which you find that you work differently with East Asian clients vs. other Asian clients vs. Non-Asian clients?
6. How has your experience with identity and ethnicity been impacted as you worked with this population?

IV. Training

1. What experiences have been most influential in your understanding of culture in therapy?
2. Has your training helped you in working with Asian clients? If so, how has your training helped you?
    a. Please describe the experiences you completed during your *graduate education* addressing issues in treatment and working with clients from different racial backgrounds than your own? Asian clients? (e.g., didactic/non-practicum, supervision, practicum? Personal?)
3. How has your training helped you prepare for the types of issues that come up in therapy with this population?
    a. what classes did you take that were helpful (related to the field)
    b. How much was offered?
4. Was there an area that you were unprepared for?
5. Was there anything that you wished you were trained in?
6. What would your recommendations be in terms of training clinicians to work with Asian clients? (i.e., Asian clinicians and Non-Asian Clinicians?) Cross-cultural recommendations?

V. Working with future Asian Clients

1. What advice would you have for therapists working with East Asian clients? Asian clients in general?
2. How would that advice change if it was an Asian therapist working with Asian clients compared to a Non-Asian therapist working with Asian clients?

VI. Closing

1. Is there anything else that I did not ask you about your experience with East Asian clients that would be helpful to know or consider?
2. What has been your experience of participating in this interview?