The Psychotherapy Adaptation and Modification Framework

Application to Asian Americans

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Although effective treatments for many mental disorders have been developed, little research has been conducted to determine whether these interventions are effective in treating those from diverse backgrounds. Recent reports have suggested that ethnic minorities are less likely to receive quality health services and that they evidence worse treatment outcomes when compared with other groups. To improve care for those from diverse backgrounds, Western-developed psychotherapies may need to be culturally modified or adapted to become more effective in treating ethnic minorities. This article addresses the need for adapting psychotherapy and provides a conceptual framework for making such modifications. The psychotherapy adaptation and modification framework model is applied to recent Asian American immigrants as an illustrative example. However, it may also serve as a point of departure to adapt therapies for other ethnocultural groups.

*Keywords:* adaptation, psychotherapy, ethnic minority, Asian American, cultural competency

Mental illness is a worldwide health problem that affects people from all cultural and socioeconomic backgrounds. Despite the enormity of this public health burden, few published studies have examined or demonstrated the efficacy of treatments for ethnic minorities. Although substantial evidence suggests that psychotherapeutic treatments are effective in treating Caucasian Americans, research demonstrates that ethnic minorities are less likely to receive quality health services and evidence worse treatment outcomes when compared with other groups (Institute of Medicine, 1999; U.S. Department of Health and Human Services [U.S. DHHS], 2001). As the demographics of the United States change rapidly, this critical lacuna in psychological knowledge, along with psychologists' underpreparedness to effectively treat ethnic minorities suffering from mental illnesses, will become more apparent.

In recent years, there has been an initiative to establish, define, and validate empirically supported treatments (ESTs) in the United States (American Psychological Association [APA] Task Force on Psychological Intervention Guidelines, 1995; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). The importance of this initiative is underscored by the contrasting results between efficacious outcomes of clinical interventions conducted in controlled research environments and the less-than-effective results of interventions conducted in community-based practice settings, where clients tend to be more ethnically diverse, to be lower in socioeconomic status, and to present with more complex clinical issues (Weisz, Donenberg, Han, & Kauneckis, 1995). Although considerable progress has been made in establishing and defining efficacious and possibly efficacious treatments for the general population, relatively little is known about the efficacy of ESTs for people from diverse ethnic and cultural backgrounds.

Currently, mental health providers are faced with the dilemma of whether to (a) implement an as-is approach to disseminating evidence-based treatments (EBTs) to culturally diverse ethnic groups, (b) adapt EBTs to be more culturally congruent in order to better fit the needs of ethnic clients, or (c) develop new, culture-specific EBTs for each ethnic group. Recent reviews underscore the limitations of EBT literature, stating that few studies have been conducted confirming whether EBTs are efficacious when treating ethnic minorities, and provide several recommendations for moving beyond this impasse (Miranda et al., 2005; Nagayama Hall, 2001). Although better than no treatment at all, implementing an as-is approach in disseminating EBTs to ethnic minority clients may not fully address cultural differences salient to ethnic minority groups. Developing novel ethnic-specific treatments for each culturally different group in the United States may be prohibitively costly and time consuming and may lead to clinician-training difficulties, especially if the treatments are all based on different theoretical paradigms. For immigrant Asian Americans, where cultural differences are likely to be distinct and to impact treatment, adapting EBTs to better address their needs may be an improved and more cost-effective approach. According to the 2000 census, approximately 12 million Asian Americans live in the United States, and Asian Americans are proportionately the fastest growing racial group (Barnes & Bennett, 2002). In addition, because discriminatory immigration laws were

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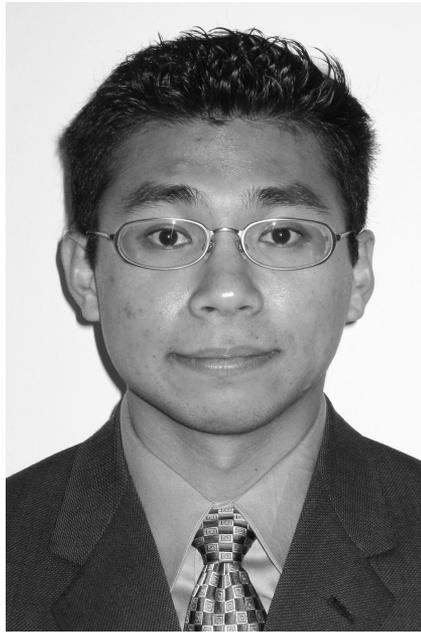
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not lifted until 1965, the surge of Asian migration to the United States has resulted in the majority of Asian Americans (61.9%) being foreign born (Barnes & Bennett, 2002).

Many immigrant groups come from backgrounds where there is little education or exposure to mental health or its treatment. Cultural differences in the presentation of illness (i.e., the tendency to report more somatic symptoms and the tendency not to report psychological symptoms) and the stigma associated with mental illness may result in lower treatment usage and help seeking in different sectors of care (Chun, Enomoto, & Sue, 1996; Corrigan, 2004). Because Asian American clients are less likely to seek treatment (Hu, Snowden, Jerrell, & Nguyen, 1991; Snowden & Cheung, 1990), are more likely to be severely ill at point of entry (Lin & Lin, 1978; D. W. Sue & Sue, 1987; S. Sue, 1977) and are more likely to have worse treatment outcomes or to drop out of treatment prematurely than other groups (S. Sue, 1977; Zane, Enomoto, & Chun, 1994), adapting EBTs to be more culturally syntonic for Asian Americans and other groups may be critical to improving quality of care.

Some evidence suggests that treating clients in a more culturally sensitive manner (i.e., providing client–therapist ethnic matching and treatment at ethnic-specific services) can reduce premature treatment dropouts (Flaskerud & Liu, 1991; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Takeuchi, Sue, & Yeh, 1995). The beneficial effects of being treated at a culturally sensitive treatment center seem to outweigh the positive effects of being matched with an ethnically similar therapist (Takeuchi et al., 1995), indicating that training therapists to be culturally competent and developing culturally congruent interventions can serve as a form of quality improvement and should be a top priority if effective care is to be provided.

Cultural Competency and Conceptual Frameworks for Adaptation

A number of overlapping and distinct cultural literatures evolved out of the civil rights movements of the 1960s. These literatures have made several advances, progressing from the call for cultural awareness and acceptance to highlighting the need for cultural competence, the need for understanding of relational therapeutic dynamics, and the need to attend to the complexities involved in treating ethnic minority clients. Recently, the U.S. Surgeon General's report *Mental Health: Culture, Race, and Ethnicity* identified several key areas in which culture is likely to have an impact (U.S. DHHS, 2001). The report described the historical context and current status of multiple groups, the prevalence of problems, key cultural influences, and issues affecting diagnosis. It identified high-need populations and discussed the availability, accessibility, and utilization of mental health services. Other authors have also highlighted significant areas in which culture is likely to play a role. For example, D. W. Sue and Sue (2003) underscored the importance of understanding differences in cultural worldviews, sociopolitical issues, assumptions and biases as barriers to effective treatment, and cross-cultural communication styles. In developing a framework for research, Rogler, Malgady, and Rodriguez (1989) recommended improving cultural understanding along five domains, including understanding (a) cultural factors in the emergence of a problem, (b) help seeking and service utilization, (c) factors that may affect accurate diagnosis, (d) therapeutic and treatment issues, and (e) posttreatment adjustment. This framework is important because it underscores the temporal sequence of problem development in relation to service delivery and highlights areas where culture is likely to play a role.

Although understanding cultural influences on mental health is a good first step, professionals who want and need cultural competence are left with little insight about how to implement this understanding into actual improvements in clinical practice. Culturally competent practice guidelines for adapting treatment for diverse clientele are sorely needed (APA, 2003; President's New Freedom Commission on Mental Health, 2003; U.S. DHHS, 2001). The most widely accepted definition of cultural competency refers to the possession of cultural self-awareness, knowledge, and skills that facilitate delivery of effective services to ethnically and culturally diverse clientele (D. W. Sue, 1982; D. W. Sue, Arredondo, & McDavis, 1992). In describing the complexities of cultural competence, Lo and Fung (2003) added that it is also important to distinguish between generic and specific cultural competencies, or between the knowledge and skill sets needed in any cross-cultural encounter versus those that are necessary to work with a specific ethnocultural group.

Two basic aims of cultural competence are to enhance the therapist's ability to deliver culturally effective clinical services and to broaden their perspective on how to improve the helping relationship. A common but problematic assumption made by health care professionals is that learn-

ing about the client's culture will help these professionals become more culturally effective. However, this way of thinking reinforces the problematic assumption that the difficulty of culture is located in the client as the other, rather than in the cultural difference between the client and the provider. Hardy and Laszloffy (1995) stressed the importance of an interactional perspective between the client and the provider, noting that cultural competence requires therapist cultural self-awareness as well as an understanding of the client. They developed a cultural genogram to help clinicians become more aware of their cultural identities. This genogram consists of (a) understanding the influence that culture can have on the family system, (b) helping therapists identify the groups that contribute to the formation of their cultural identity, (c) identifying and challenging culturally based assumptions and stereotypes, (d) helping therapists uncover their culturally based triggers or conflicts, and (e) encouraging therapists to explore how their cultural identities influence their therapeutic style and effectiveness.

Also emphasizing an interactional perspective, S. Sue, Ivey, and Pedersen (1996) proposed a theory of multicultural counseling and therapy composed of six propositions each with multiple corollaries. Abbreviated here, the propositions include (a) multicultural counseling and therapy is a meta-theory of psychotherapy that takes culture into account, (b) both client and therapist identities are formed and embedded within a cultural context and multiple levels of experience, (c) therapist and client identities influence attitudes and self–other relations, (d) therapy outcomes are likely to improve if the therapist uses modalities and defines goals that are consistent with the cultural values and life experiences of the client, (e) helping roles should be defined broadly and multiple resources should be utilized, and (f) a liberation of consciousness and an improved understanding of self–other relations should be a basic goal. These corollaries were developed to help provide a framework for the multicultural counseling movement, which has been labeled the fourth force among therapy movements (Pedersen, 1990).

Cultural competence training programs that focus on interactional issues have also been developed. For example, Pedersen (1988, 1997) developed a program that focuses on awareness and understanding of the culture-centered context and on developing and implementing culture-centered skills. Key to understanding interactional perspectives is the ability to identify and address hidden messages in therapy dialogue. Pedersen (2000) proposed a triad training model composed of understanding the verbal exchange between the two parties, including the internal dialogues of the therapist and the client. He emphasized that culturally competent therapists strive to hear the positive and negative messages that their clients are thinking, but not necessarily saying. In addition, a number of books have been written to provide greater instruction on addressing clinical issues relevant to specific populations, including women of diverse identities (Comas-Diaz & Greene, 1994), minority families and children of color (McGoldrick, Pearce, & Giordana, 1996; Webb, 2001), those with diverse sexual orientations (Perez, DeBord, & Bieschke, 2000), the elderly (Duffy, 1999), and the poor (Acosta, Yamamoto, & Evans, 1982).

Despite these advances, there is still no uniform methodology or framework for adapting and modifying treatment interventions for ethnic minority groups or for implementing such adaptations into widespread practice. Rogler, Malgady, Costantino, and Blumenthal (1987) recommended that consumer-oriented practical approaches be taken, such as increasing accessibility to bilingual/bicultural staff, selecting therapy orientations that are congruent with the client's cultural background, and modifying treatments to fit the needs of the client. However, even in ethnic-specific centers, where clinicians are bilingual and have had some training on cultural sensitivity and awareness, training mechanisms may not have systematically provided specific skills or frameworks for incorporating cultural issues into treatment. Many training programs in cultural competency tend to be general and descriptive in nature, leaving professionals with an increased awareness of important issues but with few practical skills to incorporate into clinical practice.

Culture-Based Interventions and Programs That Address Cultural Adaptation

Some scholars have tackled these difficult issues by developing treatment modalities that favor the particular values and traditions embedded in the culture of origin, such as Morita therapy and Naikan therapy for the Japanese (Morita, 1998; Reynolds, 1980) and *cuento* or folktale therapy for Puerto Rican youths (Costantino, Malgady, & Rogler, 1986). Others have developed interventions to target specific issues that acculturating immigrants might encounter; such interventions include bicultural effectiveness training and family effectiveness training, which target intergenerational conflicts exacerbated by acculturation and adaptation problems (Szapocznik, Santisteban, Kurtines, Perez-Vidal, & Hervis, 1984; Szapocznik, Santisteban, Rio, Perez-Vidal, & Kurtines, 1989), and the strengthening of integenerational/intercultural ties in immigrant Chinese American families (Ying, 1999). These approaches address diversity issues related to the culture of origin as well as issues related to adjustment, acculturation, and cultural transitions to the United States. Because many immigrants encounter adaptation and acculturation problems, instead of focusing solely on cultural differences with a client's culture of origin, adapted treatments need to be flexible in addressing cultural changes over time. This is especially important because many minorities share similar immigration experiences that could be targeted in prevention and treatment programs.

Initial Adaptations of ESTs

One major problem with the therapy adaptation field is that it is still in its infancy and has not yet been able to demonstrate that cultural adaptations lead to superior results, thus leaving it open to criticism. Kazdin (1993) indicated that there is little empirical support for the superiority of adapted treatments to justify the additional cost it

would take to develop and train mental health practitioners to deliver such services. It is important to note that the term *adaptation of treatments* has been used loosely, with few studies clearly articulating and defining how they went about adapting treatments. Lack of methodological vigor (e.g., nonrandom assignment to groups, small sample sizes, use of simplistic structural or single point adaptation strategies) weakens the conclusions that can be drawn from extant studies. Nevertheless, adaptations to treatment have been attempted for a variety of ethnic groups and problematic situations.

Zhang et al. (2002) combined elements of cognitive therapy with Taoist philosophy and developed Chinese Taoist cognitive psychotherapy for Chinese clients with generalized anxiety disorder. Kumpfer, Alvarado, Smith, and Bellamy (2002) have used various approaches to adapt the strengthening families program for use with multiple ethnic groups. Kohn, Oden, Munoz, Robinson, and Leavitt (2002) adapted a manualized group cognitive–behavioral therapy (CBT) intervention for use with low-income African American women. To modify the treatment, they used both structural change (e.g., limiting the group to African American women, adding experiential meditative exercises, changing some of the language used to describe CBT) and didactic adaptations (e.g., attending to four issues salient to this group: creating healthy relations, spirituality, African American family issues, and African American female identity). Although not developed for use with a particular ethnic group in mind, Linehan's (1993) dialectical behavioral therapy also uses principles of adaptation and draws on cultural strengths by adapting CBT for use with those with borderline personality disorder. This therapy integrates elements of the *wise mind*, which some would liken to principles of Zen, Buddhism, and Taoism (Linehan, 1993).

Emerging Conceptual Frameworks to Guide Adaptations

Many mental health practitioners already make their own personal modifications to therapy to better meet the needs of diverse clientele. However, these modifications may not be systematic or driven by a clear conceptual framework. Experts of cultural competency have addressed this concern by developing frameworks to guide therapeutic adaptations. For example, D. W. Sue (1990) suggested targeting three major domains to improve client–therapist relationships when treating ethnic minorities, including culture-bound communication styles, sociopolitical facets of nonverbal communication, and counseling as a communication style. These recommendations highlight understanding and improving subtleties in communication that may interfere with the therapeutic process. Other psychologists, such as Bernal, Bonilla, and Bellido (1995), created a framework for developing culturally sensitive interventions. They suggested considering eight different dimensions, including language, persons, metaphors, content, concepts, goals, methods, and context, when adapting therapy for culturally diverse clientele. For example, the dimension of persons involves addressing ethnic/racial similarities and differences between the client and the clinician. Issues of content involve cultural knowledge and information about the values, traditions, and customs of the culture. The principle of context involves consideration of changing contexts that might increase risk for acculturative stress problems, disconnect from social supports and networks, and reduced social mobility. This framework has been used to guide adaptations in cognitive–behavioral and interpersonal treatments for depressed Puerto Rican adolescents, and these adapted treatments have been shown to be efficacious in randomized controlled trials (Rossello & Bernal, 1996, 1999).

Psychotherapy Adaptation and Modification Framework

These frameworks serve as initial foundations from which to understand cultural issues in treatment. However, much more work needs to be done to help psychologists understand and apply adaptations in clinical practice. Given the shortage of frameworks available to guide adaptation of ESTs, I developed the psychotherapy adaptation and modification framework (PAMF) to help guide therapeutic adaptation for ESTs. In creating this framework, I reviewed the literature on cultural competency, discussed issues of cultural adaptation with expert therapists, and reflected on my own personal experiences in treating ethnic minorities in community, medical, and school settings. Furthermore, I combined two systems of cultural principles I have developed in my previous work on cultural competency (Hwang, Lin, Cheung, & Wood, in press; Hwang, Myers, Abe-Kim, & Ting, 2006). This work lays the foundation for my current line of research, which focuses on developing and testing the effectiveness of a culturally adapted CBT manual for Chinese Americans.

The first framework, the cultural influences on mental health model, was developed to identify salient domains that culture influences (Hwang et al., 2006). Culture is posited to affect different domains including (a) the prevalence of mental illness, (b) etiology of disease, (c) phenomenology of distress, (d) diagnostic and assessment issues, (e) coping styles and help-seeking pathways, and (f) treatment and intervention issues. Because of the multitude of ways in which culture can influence mental health, these domains are not all inclusive, but rather provide a starting point for understanding the most salient ways in which culture influences the development and treatment of psychopathology. For example, cultural differences in the expression of distress (e.g., somatization vs. worry) could influence diagnostic accuracy, which could in turn impact psychologists' ability to reliably estimate the prevalence of certain psychiatric disorders. What people believe about the causes of their problems (e.g., bodily problems causing depression or depression causing physical health problems) also plays a role in where they seek help (e.g., a primary care or mental health facility) and their confidence in the treatment given (e.g., talk therapy is effective or talking about the problem makes it worse). Moreover, how a culture defines mental illness and people's own self-definitions of having or not having a mental illness can also

affect these different domains. The cultural influences on mental health model focuses on highlighting the systematic interrelations of each of these domains and provides target areas for treatment interventions.

The second framework is part of a model that incorporates 18 therapeutic principles for understanding and treating Chinese American clients. These principles were initially developed in an effort to modify CBT for Chinese Americans (Hwang et al., in press). The principles fall into three core areas, including general guidelines for adapting CBT to meet the needs of Chinese American clients, strengthening the client–therapist relationship, and understanding Chinese notions of self and mental illness. I have synthesized these frameworks to create the PAMF, which consists of six therapeutic domains and 25 therapeutic principles. The domains include the following: (a) dynamic issues and cultural complexities, (b) orienting clients to psychotherapy and increasing mental health awareness, (c) understanding cultural beliefs about mental illness, its causes, and what constitutes appropriate treatment, (d) improving the client–therapist relationship, (e) understanding cultural differences in the expression and communication of distress, and (f) addressing cultural issues specific to the population. Table 1 lists each domain, the therapeutic principles associated with each domain, and a description that explains the rationale for each modification.

I used a practical and consumer-driven approach to help practitioners who want and need cultural competency to make the shift between cultural awareness and clinical application. Broader domains identify general areas that practitioners should think about when modifying their approach for treating their clients. More specific therapeutic principles provide detailed instruction on the types of adaptations that may be important to make for a particular group. Corresponding rationales help the practitioner understand why some of these modifications should be made and how they might be beneficial. This three-tiered approach to presenting cultural adaptations to therapy was developed to make the PAMF more accessible, user friendly, and adaptable for use with other diverse populations. Clinical illustrations of some of the therapeutic principles, as well as a case study exemplifying its use, are described more fully in Hwang et al. (in press).

How to Implement the PAMF

The PAMF was initially designed to help clinical researchers adapt ESTs for use with diverse clientele and to help facilitate the training of practitioners to be more culturally competent. It was meant to be a useful and practical road map to provide mental health professionals with an overview of the nonautomatic issues and processes they should think about during their journeys toward becoming more culturally competent. In addition to increasing understanding, recommendations for addressing issues pertinent to ethnic minority clientele are provided (e.g., how to establish cultural bridges, the importance of therapy orientations, integrating cultural activities into client activities, and addressing issues salient to the client's background). Expert clinicians and researchers are encouraged to think of ways to improve on this model or to develop alternative models that can further advance this area of study.

Improving clinical training. The PAMF can also be used by educators as a guiding framework to facilitate clinical training and to identify foci for further discussion in didactic seminars, clinical supervision, and case discussions. It could be used as a structural overview for introducing students and clinicians to critical areas that are important to address. Educators and practitioners could then move toward more in-depth training in each of the domains, discuss any additional principles that may need to be addressed when working with specific groups, and focus on practical skills implementation (e.g., how to do a therapy orientation, how to bridge cultural divides, how best to integrate indigenous beliefs about healing with treatment, and how to improve the client–therapist relationship). The three-tiered framework of the PAMF (i.e., thinking about broader domains, developing specific therapeutic adaptation principles, and critically thinking about the rationale for modifications) provides a sequential framework for approaching therapy adaptation. It provides a systematic structure from which practitioners can test and organize their hypotheses.

It is important to underscore that there is no shortcut to becoming culturally competent and that learning to work effectively with diverse clientele is a complex process that takes time, commitment, and hard work. Moreover, learning how to use group knowledge to effectively inform and individualize treatment requires the therapist to have sufficient knowledge of that group, cognitive flexibility, introspection, clinical experience, and willingness to consult with supervisors or colleagues. Although a therapeutic framework such as the PAMF may aid in identifying salient issues and providing initial suggestions, it should be seen as a grounding point that is insufficient in and of itself. Because it is difficult for practitioners to know whether they are responding to a client in a culturally sensitive manner or whether they are blinded by their own biases, ongoing training, consultation and hypothesis testing are essential in the search for cultural competence.

Using the PAMF to culturally adapt ESTs. When adapting a therapy, a top-down theoretically driven approach that uses the PAMF can be beneficial and helps to provide structure and meaning to adaptations. However, a combination of both bottom-up and top-down approaches may be most comprehensive. Specifically, a team of investigators could run separate and/or combined focus groups with clinical staff and nationally recognized experts who have experiences working with specific groups to discuss what potential adaptations could be made and how they might be best implemented. At the same time, focus groups could also be run with community members and consumers to discuss barriers to treatment and how to best modify treatments so that they are more accessible. After initial ideas are generated, they could be incorporated into the PAMF model, which could then be presented. The advantages and disadvantages of each modification could be discussed and recommendations for additional adaptations or revisions generated.

Additionally, the team should think about how to empirically validate which changes lead to better outcomes and how to measure these changes. Researchers need to think critically about how to disaggregate the effects of traditional intervention mechanisms (e.g., working alliance, prior treatments, current medications) and cultural intervention mechanisms (e.g., introduction of cultural bridges, more direct therapy orientations, improved cultural competence of the clinician). Moreover, widely used definitions of outcome may have to be expanded to include not only symptom reduction and premature dropout, but also functional disability, client satisfaction, treatment adherence, and knowledge, attitudes, and beliefs about the treatment. Because modifications along all domains may not produce equally efficacious results, dismantling studies could be used to determine which adaptations are most important in facilitating change.

Adapting treatments to address issues broadly and deeply is especially important because it will help increase the ecological validity of Western psychotherapies when used to treat culturally diverse clientele. The PAMF provides a systematic three-tiered approach to adapting psychotherapy that can also serve as a framework for adapting for other groups. As the field moves forward, psychologists need to ensure that the therapy adaptation movement is clinically informed, theoretically grounded, systematic, and empirically driven. Using clinical expertise to inform treatment is especially important given that ethnic minorities have historically been left out of efficacy studies and given that evidence-based practices have not been specifically developed with minorities in mind (Miranda et al., 2005; U.S. DHHS, 2001). Although researchers complain that clinicians are too slow to adopt ESTs, some clinicians argue that narrow diagnosis-specific treatments tested in rigorously controlled laboratory conditions have limited clinical utility when used with real-world complexities and comorbid conditions (Goodheart, 2006). More work needs to be done to ensure that treatments are clinically informed, scientifically grounded, and sufficiently capture the cultural complexities involved with treating America's diverse population (Comas-Diaz, 2006). These issues will only become more important as the demographics of the United States rapidly change and health care disparities become more evident. To provide a more in-depth demonstration of how the PAMF can be used to modify treatment for culturally diverse clientele, I illustrate how it can be used to adapt psychotherapy for less acculturated Asian Americans.

Dynamic issues and cultural complexities.
Providing culturally competent and effective care is a complicated task that requires a good deal of effort, openness, and self-reflection. The PAMF was designed to give professionals a foundation from which to ground their journey toward becoming culturally responsive clinicians. Specifically, it provides an overarching framework and structure for thinking about cultural issues and experiences and also focuses on how to adapt ESTs to diverse populations. It was not designed to trivialize the learning of cultural competency or to give readers the impression that they can go through a simple checklist or use a cookbook approach to

miraculously become culturally competent therapists. Those who are truly invested in becoming culturally competent should take advantage of the rich and informative literature on culture and therapy, some of which is referenced in this article.

Being aware of the complexities involved in working with diverse populations is one of the most important components of the PAMF. S. Sue (1998) cautioned that one danger associated with trying to be more culturally competent is the stereotyping of ethnic minorities and the use of general strategies when treating diverse clientele. Specifically, he warned that those trying to become more culturally competent may inadvertently take general recommendations to heart, apply what they have learned rigidly, and not consider the diversity of people within each cultural group. Clients that I have worked with have reported difficulty in working with less culturally informed therapists because the therapists have sometimes inadvertently stereotyped the clients, making them feel uncomfortable. For example, one client indicated that her therapist was generally helpful, but made her feel uncomfortable at times because he stereotyped her by saying that making money is really important for Asians. Although this may be true for many Asian Americans, the therapist made the mistake of not individualizing his statements and also further estranged the client by not referring to her as Asian American, which some Asian American clients may prefer. *Dynamic sizing*, or the skill of knowing when to generalize and when to flexibly individualize treatments on the basis of the client's individual characteristics, is an important skill to learn if practitioners are to prevent rigid overgeneralizations and increase their cultural competence (S. Sue, 1998).

In highlighting other cultural complexities, Hays (2001) underscored that individuals hold multiple interacting group memberships, not just one. She offered the ADDRESSING framework to help clinicians understand and respond to these complexities. This framework calls attention to dynamic cultural influences that professionals should consider when working with diverse populations, including age and generational influences (A), developmental (D) or acquired disabilities (D), religion and spiritual orientation (R), ethnicity (E), socioeconomic status (S), sexual orientation (S), indigenous heritage (I), national origin (N), and gender (G). For example, a client is not just Vietnamese American. The client may have multiple overlapping identities and could be Vietnamese American, female, highly acculturated, and also depressed. In addition, the client may identify with issues related to being female more than she does with issues related to being Vietnamese, but she may also identify with being female in a uniquely Vietnamese American way. In adapting therapy for this client, general cultural principles that apply to less acculturated Vietnamese Americans may not be sufficient. The therapist should make adjustments based on the characteristics of the client's composite identity.

Understanding dynamics issues and cultural complexities is a central component of the PAMF. The first tier of the PAMF (therapeutic domains) identifies areas where

Table 1
Psychotherapy Adaptation and Modification Framework

Domain	Therapeutic principle	Rationale for treating Asian Americans
Dynamic issues and cultural complexities	1. Be aware of dynamic sizing (e.g., knowing when to generalize and when to individualize treatments on the basis of client characteristics)	Helps reduce stereotyping and cookbook approaches to treating diverse clientele; reduces therapeutic rigidity, increases therapist flexibility, and individualizes treatments
	2. Be aware of and address clients' multiple identities and group memberships	Helps therapists understand that minority status is not a simplistic category (e.g., clients have multiple and dynamic identities and group memberships); helps therapists understand the complexities in treating diverse clientele
Orientation	3. Orient clients to therapy	Decreases stigma, increases familiarity, increases comfort, reduces premature dropout
	4. Establish goals and structure for therapy early in treatment	Is congruent with goal-driven aspects of Asian culture; reduces ambiguity and provides markers of improvement
	5. Orient clients to a biopsychosocial or holistic approach model of disease development	Facilitates client understanding and is congruent with the holistic and mind–body integration extant in Asian culture
Cultural beliefs	6. Focus on psychoeducational aspects of treatment	Is consistent with educational emphasis in Asian culture; empowers clients and provides them with a sense of mastery; decreases stigma and misconceptions about mental illness
	7. Use cultural bridging to relate cognitive–behavioral therapy concepts to Asian beliefs and traditions	Facilitates understanding and adherence to treatment; provides cultural context for learning and reduces culture shock to foreign psychological concepts
	8. Find ways to integrate extant cultural strengths and healing practices into the client's treatment	Capitalizes on aspects of the client's culture that may facilitate the healing process; uses methods of healing that are culturally congruent
	9. Align with traditional/indigenous forms of healing	Integrates treatment services; improves physical functioning and engagement in healthy behaviors
	10. Understand how cultural beliefs have influenced help-seeking patterns for your client	Underscores stigma against mental illness, client's level of discomfort in seeking care, and severity of distress at point of entry
Client–therapist relationship	11. Teach therapists about the cultural backgrounds of their clients	Facilitates development of understanding and empathy; increases therapist sense of confidence and efficacy
	12. Therapists should be professional and present themselves as expert authority figures	Consistent with hierarchical traditions in Asian culture; provides assurance to clients that they are receiving expert care
	13. Client–therapist roles and expectations for therapy should be clearly addressed	Helps clients understand their role and the therapist's actions and behaviors; facilitates development of realistic expectations
	14. Join and engage the client by assessing family background and migration history	Facilitates building of working alliance and bonding with therapist; provides important contextual information on experiences of client
	15. Therapist cultural self-awareness and self-identity should be thoroughly explored	Improves therapist understanding of self and cultural issues; facilitates building of positive working relation with clients; encourages therapists to take responsibility for client care; alleviates feelings of anxiety and tension related to working with culturally similar or culturally diverse clients; improves understanding of ethnocultural transference and countertransference

Table 1 (continued)

Domain	Therapeutic principle	Rationale for treating Asian Americans
	16. Interactional and relational models of therapeutic relations should be understood	Helps therapists realize that cultural competence requires awareness of client issues, therapists' cultural awareness, understanding of biases, and a unique interaction of client–therapist dynamics; increases understanding of individualistic and professional biases evident in psychotherapy
Cultural differences in expression and communication	17. Understand that the notion of psychotherapy and talking about one's problems as a method of treatment is culturally foreign to Asian clients	Asian clients may need more time to become comfortable with talking about their feelings and discussing their problems
	18. Understand cultural differences in communication styles	Reduces miscommunication and misunderstanding; facilitates understanding of verbal and nonverbal behaviors
	19. Understand and address ethnic differences in expression of distress (e.g., somatization vs. worry)	Reduces stigma associated with mental illness by targeting somatic symptoms; increases cultural congruency by providing greater mind–body balance; improves diagnostic accuracy; increases understanding of the meaning of symptoms; prepares clients to discuss cognitive and affective symptoms
	20. Address cognitive and affective symptoms of Asian clients	Although clients may veer away from talking about feelings and thoughts, discussing them in a culturally sensitive manner can improve treatment outcomes
Cultural issues of salience	21. Be aware of shame and stigma issues that may influence the treatment process	Tempers loss of face issues and stigma associated with having a mental illness; addressing these issues may reduce premature treatment dropout
	22. Address and be aware of push–pull feelings and culture-related role inconsistencies that may exist between the client's culture of origin and the culture of therapy	Reduces confusion and discomfort and normalizes feelings when clients are asked to behave in a stereotypically culturally incongruous manner (e.g., pushing an Asian client to be more independent and individualistic and autonomous)
	23. Collaborating with family and/or spending more time understanding family relationships may be necessary	Is congruent with Asian culture, which values family relationships; increases understanding of development and communication styles
	24. Be aware of and understand life experiences that may act as additional stressors or place clients at additional risk for mental illness (e.g., acculturative stress, racism, linguistic difficulties, social mobility problems, feelings of nostalgia, loss of interpersonal networks, intergenerational family conflict)	Addressing issues of salience in clients' lives will help them feel more understood and satisfied with therapy; many of these issues are overlooked when therapists do not understand or can't relate to what their clients are experiencing
	25. Therapists should understand how social class and privilege interact and affect the treatment process	Improves understanding of dynamic social and class dynamics and biases; helps therapists become more responsive to working with disadvantaged diverse populations; decreases blaming and increases appreciation for the hardships and disadvantages that some groups face

adaptations for different groups might take place. The second and third tiers (therapeutic principles and their corresponding rationales) may need to be modified before they can adequately address the dynamic issues involved with treating clients from particular backgrounds. It is important to remember that the 25 therapeutic principles presented here were developed specifically for use with immigrant or less acculturated Asian Americans and may have less clinical utility and appropriateness when used to adapt therapy for more acculturated Asian Americans, other ethnic minority groups, or other dynamic issues that are part of the client's identity. I encourage readers to keep principles of dynamic sizing and cultural complexities in mind so that they can avoid overly rigid application and stereotyped approaches to working with Asian Americans.

Orientation. Orienting clients to therapy is especially important for clients who have had little exposure to the formal concept of mental health and its treatment. It helps increase awareness and understanding of the format and rationale behind therapy, and as a result helps facilitate clients' comfort and helps them buy into treatment. Acosta, Yamamoto, Evans, and Skilbeck (1983) found that providing Hispanic, African American, and Caucasian psychiatric clients with an orientation program prior to their first therapy session resulted in clients feeling more knowledgeable and positive toward psychotherapy. Asian American immigrants may also benefit from psychotherapy orientation aimed at preparing clients and demystifying the therapy process. For example, many Asian Americans that I have talked with reported feeling uncomfortable during their initial therapy sessions and eventually dropped out of therapy because they were unclear of how they should act and what they should say, were not sure if therapy would help them, felt embarrassed and ashamed, and were unsure of where things were going. They reported that being oriented to what therapy was all about would have been extremely beneficial.

Part of orienting someone to therapy is helping to establish culturally congruent goals early in therapy. Because Asian American clients may be more severely ill by the time they do seek treatment, they may have greater expectations for immediate symptom improvement and may expect more structure, direct advice, goal setting, and problem solving (T. Y. Lin & Lin, 1978; D. W. Sue & Sue, 1987; S. Sue, 1977). Therapists may also have to be more flexible with regard to self-disclosure to create a culturally safe and supportive environment for the client. S. Sue (1998) recommended that therapists offer an initial gift of problem or symptom reduction to increase satisfaction and comfort with treatment, reduce premature dropout, and increase respect and credibility for the therapist (S. Sue, 1998). Other options include framing the problem with a biopsychosocial or holistic approach to help reduce stigma, increase comfort levels, and facilitate understanding because of the strong link between the mind, body, and spirit extant in Asian culture and traditional medicines (Hwang et al., in press). A more holistic approach may also serve as a noninvasive method of enculturating the client into the medical or therapeutic model.

Cultural beliefs. Understanding how cultural beliefs influence the treatment process is an integral part of effective service delivery. For example, psychoeducation is congruent with the importance of education that was infused into Asian culture by Confucianism and can be used to increase client familiarity with and understanding about mental illness and the therapeutic process. Moreover, psychoeducation can be a culturally sensitive way of engaging clients, educating them about their illness, breaking down popular misconceptions and stereotypes, reducing stigma, and increasing clients' sense of mastery and confidence.

Being familiar with the client's cultural background increases the therapist's ability to engage in *cultural bridging* or relating psychotherapeutic concepts to Asian cultural beliefs and practices (Ham, 1989; Hong, 1993). For example, CBT principles of relaxation training can be bridged to Chinese cultural traditions (e.g., traditional Chinese medicine, meditation, qi-gong [a meditative practice that focuses on energy and breathing], and tai qi quan [a Chinese martial arts form that focuses on qi or energy]) that are believed to improve mental and physical health through a balance of yin and yang (negative and positive energies). Establishing cultural bridges early on in treatment may reduce the cultural shock clients feel when participating in treatments that are culturally foreign and unfamiliar. It may also facilitate client belief in and acceptance of specific skills being practiced and may increase adherence to homework assignments.

Drawing links and using culturally familiar terms and values could also increase feelings of comfort, give treatment more meaning, and increase treatment adherence. For example, drawing a link between Chinese four-word metaphorical sayings known as *chengyu,* which are used to teach ethical and moral principles in Chinese culture, to therapeutic principles may help bridge therapeutic concepts to the cultural background of the client (Hwang et al., in press). *Shuang guan ji xia* means literally two brushes painting together and refers to the story of a famous artist who painted with two brushes in one hand simultaneously (Hong, 1987). This story could help facilitate understanding and simultaneous engagement of two core CBT principles, challenging maladaptive cognitions and replacing them with coping thoughts and engaging in behavioral strategies, such as exercise and meditation, to improve depressed mood. Cultural bridges and metaphors may be particularly helpful for less acculturated Asian Americans but may also be beneficial for those who are more acculturated, as well as for clients from different cultural backgrounds, just as meditation, tai qi, and yoga have been used by many Americans. In fact, one of the drawbacks of the current literature is its focus on delineating risk factors, rather than providing an equal emphasis on identifying cultural strengths and protective factors that may shield immigrants from harm as they acculturate.

Therapists who understand their clients' cultural backgrounds are in a better position to forge alliances with indigenous forms of healing and to integrate extant cultural strengths and healing practices into the treatment. For example, it may be advantageous for less acculturated

Chinese American clients to join a group that practices Tai Qi in a park during the morning as they do in China as both a form of prevention and intervention. Filipino American immigrants who grew up in farming communities may feel more centered if they grow vegetables in a small garden. Japanese American immigrants who are experiencing headaches and bodily pains may benefit from receiving a shiatsu massage or engaging in Zen meditation. If clients live in communities where fewer cultural activities are available, then it may be beneficial to talk about what cultural options or healing practices normally help them feel better, identify how they are beneficial, and brainstorm some alternative activities that may achieve the same purpose.

Client–therapist relationship. Training therapists to be more culturally aware can help forge a strong working alliance. For instance, therapists who participated in cultural orientation programs designed to increase their knowledge and understanding of ethnic minority clients reported feeling more knowledgeable, sensitive, and effective when working with their clients than those who did not (Evans, Acosta, Yamamoto, & Skilbeck, 1984). Their clients also reported feeling more satisfied with treatment and confident in their ability to handle problems, and they indicated that they would be more likely to utilize mental health services in the future (Yamamoto, Acosta, Evans, & Skilbeck, 1984). Since less acculturated Asian American clients may lack the basic knowledge and understanding of mental illness and its treatment that would allow them to fully believe in and feel comfortable in treatment, clarifying client–therapist roles and discussing the limitations of therapy may help demystify the therapy process, help the client develop more realistic expectations, and foster a stronger therapeutic relationship.

Many Asian cultures place great importance on hierarchical relationships, social structure and harmony, and respect for authority figures (Y.-N. Lin, 2001; Zhang et al., 2002). Immigrant Asian clients may see the therapist as an expert authority figure who can help them solve their problems. Therefore, the therapist may need to be more proactive in providing direction, giving advice, and teaching skills and practices that provide immediate symptom relief. More time may need to be spent up front joining and engaging the client with social and cultural traditions and etiquette (Lee, 1997). For Asian Americans, this may involve offering the client a cup of tea, spending time talking about their background and immigration history (e.g., what country they are from, where they grew up, how old they were when they came), and discussing family issues and stressors that led them to seek treatment. Strengthening the working relationship with a client may sometimes involve flexibility on the therapist's part, which may include divulging some personal information because of culturally normal expectations. Failure to do so may be interpreted as being rude and lead to relational distancing. If the therapist chooses not to accommodate the client's cultural beliefs because they are inconsistent with the therapist's treatment beliefs, they should at the very least correct misunderstandings and explain why accommodating the client's beliefs would be countertherapeutic.

Cultural responsiveness involves not only an understanding of the client's cultural background, but also awareness of one's own cultural self-identity and how it interacts and influences one's practice and attitudes toward those from similar and different backgrounds (Hardy & Laszloffy, 1992; McIntosh, 1989; Ring, 2000; D. W. Sue, 1982). Specifically, understanding one's cultural self and the role it plays in therapy is at least as important, if not more so, than understanding the culture of the other. Therapists need to be aware of biases that may lead them to conceptualize problematic cultural issues as being located in the other (client), rather than being relational problems that stem from cultural differences. Understanding the interactional and relational nature of cultural differences in therapy is especially important because the therapeutic relationship contributes substantially to treatment outcomes and is identified by clients as the most beneficial aspect of therapy (Norcross & Lambert, 2005). Many graduate students whom I have trained reported that self-exploration and learning about interpersonal racial dynamics were the most valuable experiences in their cultural competency class, but also the components that were most likely to be left out by many instructors.

Recently, there has been a move toward more process-oriented approaches to learning. Seminal works include McIntosh's (1989) reflections on White privilege and Pinderhughes's (1989) work on racism, power, and therapy. A number of other works have also discussed how privilege and racist tendencies (conscious or unconscious) can damage the therapeutic process and increase client resistance (Jackson, 1999; Laszloffy & Hardy, 2000; Ring, 2000; Rothenberg, 2005). Cultural self-awareness is perhaps the most difficult-to-learn aspect of cultural competency because it requires a degree of openness, vulnerability, and ability to experience a wide range of potentially uncomfortable feelings (e.g., guilt, frustration, fear, anger, anxiety) before one can be fully cognizant of salient issues.

In addition, therapists who are less aware of their cultural selves are in danger of pushing clients toward potentially maladaptive cultural changes. This can be problematic for matching intracultural dyads just as easily as it can be for intercultural dyads. For example, if second generation Asian American therapists grew up in predominantly White neighborhoods and identified with mainstream American culture as an adaptive reaction to fitting in, they may not have gone through different stages of ethnic identity development and thoroughly explored their ethnic selves. As a result, they may be in danger of pushing a less acculturated Asian American client who is having family problems toward using individualistic self-care strategies. When value-based decisions are made without considering the sociocultural context in which the client lives, recommendations that were meant to be beneficial can lead to problematic outcomes (e.g., the family is collectivistic and reprimands the client even more for being selfish and unappreciative). The culture of psychotherapy is often biased in that it teaches clients to be more individualistic, and this may be problematic when applied to those from collectivistic backgrounds. Comas-Diaz and Jacobsen

(1991) provided an excellent discussion of why therapists need to understand and skillfully negotiate ethnocultural transference and countertransference. In doing so, they made an important distinction between interethnic and intraethnic dyadic issues and pointed out how problematic situations could potentially arise even if there is an ethnic match between client and therapist.

Cultural differences in expression and communication. Therapists should be cognizant that Western psychotherapy may be foreign to Asian immigrants, and that clients may need more time and understanding before they feel comfortable freely expressing themselves in treatment (Hwang et al., in press). Asian immigrants may be less culturally inclined to talk about their problems to someone with whom they have not developed a close relationship. However, this does not mean that they are unable to express their emotions; rather, a stronger therapist–client alliance may need to be established before clients are willing to open up.

Therapists should also be aware of cultural differences in communication and the expression of distress (Hwang et al., in press). For example, therapists can help strengthen the working relationship with the client by understanding cultural nuances in communication. Asian American clients may sometimes appear passive, quiet, and reserved and may be less likely to openly disagree with the therapist whom they see as the expert. Consequently, therapists who are unfamiliar with a client's cultural background may be more likely to misinterpret culturally influenced communication and expressive styles and to see Asian American clients as being shy, uncooperative, avoidant, uncommunicative, or not taking initiative for self-care. In addition, they may be in danger of interrupting clients before they have the opportunity to speak, rather than giving clients space to develop their thoughts and help them work through difficult silences that may be culturally healthy.

Moreover, awareness of ethnic differences in expression of distress can also improve diagnostic accuracy and treatment planning. Social and cultural forces seem to shape how people express their distress and may result in greater somatization, which is a culturally sanctioned means of expressing distress through the body that may be less stigmatizing for the client (Kleinman & Kleinman, 1985). Because of the mind–body integration prominent in Asian cultures and medicines, Asian clients may be more familiar with and feel more comfortable reporting somatic symptoms of distress. Treatment plans that target physical complaints are likely to be beneficial. However, this does not mean that Asian immigrants do not experience emotional and cognitive symptoms. In fact, there is some evidence to suggest that even though Asian clients may be more likely to focus on physical complaints when they initially come in to treatment, they are fully aware of their feelings and capable of talking about the problems that brought them to treatment (Cheung, 1985; Cheung & Lau, 1982). It is therefore important not to hold overly rigid and stereotyped views of minority clients, and practitioners should be cognizant of the layers and timing issues that

influence the complexities involved in treating diverse clientele.

It is also important to take cultural context into consideration when determining whether clients' communication styles and methods are normal versus abnormal. For example, even though some evidence suggests that Asian immigrants may be more restrained in therapeutic settings, what should therapists think if they get an Asian American client who is very expressive and even aggressive? How would therapists know when to generalize their understanding of Asian clients (e.g., this client is behaving abnormally and may have a personality disorder) versus when to develop a more nuanced individual interpretation of the client's behavior (e.g., this client has a more demonstrative personality, but is it within normal limits?)? In these situations, use of dynamic sizing becomes especially important. Therapists need to investigate further and ask additional questions to ensure an accurate interpretation. For example, does the client's manner of communication lead to interpersonal difficulties with others in his or her life as well as with the therapist? Has the client been enculturated into therapy through previous experiences? Although the client may be less acculturated, are there aspects of his or her employment or upbringing that would make a more expressive personality normative or adaptive? Does the therapist have a rigid and stereotyped view of Asian communication styles that would lead to an overly restrained view of appropriate expression?

Cultural issues of salience. To help clients buy into therapy, therapists should also address issues that are salient and important to the clients. Many of the cultural complexities involved in treating the dynamic identities of diverse clients can be addressed in this domain through modifying therapeutic principles and developing appropriate rationales. For example, addressing issues of face, shame, and stigma may increase the clients' comfort level and reduce premature dropout (Hwang et al., in press). Because Asian American clients are at greater risk for having worse outcomes or dropping out of treatment prematurely (S. Sue, 1977; Zane, Enomoto, & Chun, 1994), anticipatory therapeutic measures may need to be taken to prevent treatment failure (e.g., therapists telling clients that in their experience, the biggest difference between those who benefit and do not benefit from treatment is that those who benefit stay in treatment and are able to talk about therapy-interfering thoughts and feelings that lead to premature dropout). Talking about issues such as stigma, demystifying the therapeutic process, and developing an a priori plan to reduce treatment failure are essential to treatment success.

Inconsistencies between Western therapy norms and cultural norms may also exacerbate push–pull feelings and lead to mixed role expectations, which should be identified and clarified. For example, clients may come to treatment expecting therapists to take a directive-expert role and solve their problems in a timely manner, whereas therapists may expect clients to talk more about their problems and feel that these are long-standing issues that may take time to resolve. Moreover, therapists may also expect clients to

communicate freely and openly, whereas clients may expect therapists to ask questions and resolve the problems with their expert knowledge and intuition as is typically done when they visit indigenous healers. To avoid confusion and misunderstanding, therapists may need to take the lead in discussing different areas where incongruence may occur and may need to take an authoritative position in clarifying expectations and role inconsistencies.

A great deal of literature has also been written about the importance of family in Asian cultures and how involving families in therapy improves treatment for Asian Americans (Lee, 1997). Thinking about cultural complexities, I often worry about the potential for stereotyping and wonder what would happen if therapists who know little about a person's cultural background rigidly apply this recommendation. In my experience with treating Asian Americans, many do not want their families involved in treatment and react adversely to such a recommendation, especially given the shame they would experience or the additional problems they believe it might cause. Although sometimes beneficial, it would be detrimental if therapists rigidly pushed a family treatment agenda without considering whether their clients are ready for such a move, considering the advantages and disadvantages of doing so for the specific problems clients are facing, and determining if they have the appropriate skills to therapeutically manage the family given their minimal understanding of Asian culture. For example, if a gay Asian American male client were in his initial stages of awareness and his family were extremely homophobic, it may not be wise to involve the family early in treatment, which should be focused on helping the client gain a sense of identity, develop self-confidence, and deal with immediate stressors. In addition, therapists who have little experience working with Asian American families may not be able to effectively resolve family issues in therapy, which could exacerbate problems at home. Again, cultural complexities and dynamic issues need to be considered and careful reflection on clinical issues should be exercised.

Recently, Smith (2005) called attention to the decades of research indicating that poor and disadvantaged clients need and want appropriate clinical services and showing how class bias and other issues have led the mental health field to continually fall short in addressing the needs of these clients. Other authors have also highlighted the salience of this problem, noting how class differences can affect therapeutic relations (Kliman, 1998; Lott, 2002). Because each of the major ethnic minority groups remains overrepresented among those meeting criteria for poverty (European Americans = 8.1%, African Americans = 24.9%, Asian Americans = 12.6%, Hispanic Americans = 22.6%, American Indians = 25.7%; Bishaw & Iceland, 2003; National Congress of American Indians, 2000), incorporating issues of poverty and social disadvantage should be considered when treating ethnic minorities.

Therapists working with Asian Americans need to be cognizant of the diversity of clients they may come across. Asian Americans come from a variety of different countries, migration circumstances (e.g., voluntary, refugee,

study, work), immigration cohorts, and socioeconomic and educational backgrounds, and they have distinct pre- and postmigration circumstances that contribute to diversity of identity and experiences. However, because more than 60% of Asian Americans are foreign born (Barnes & Bennett, 2002), they face a variety of cultural, linguistic, economic, and structural barriers that increase risk for adjustment difficulties and reduce social mobility, despite stereotypes of Asian Americans being the model minority. When treating Asian American clients from lower socioeconomic backgrounds, therapists should not simply concentrate on general poverty issues, nor should they focus on issues specific only to Asian Americans. Therapists need to address the dynamic issues that are involved with being poor in ways that are uniquely Asian American (i.e., addressing acculturative stress, linguistic barriers, social mobility, intergenerational family conflict, social isolation, premature adultification of children because of parental disempowerment, lack of exposure to mental health issues, distrust of authority figures, clinician class and cultural bias, stigma issues, financial and employment issues).

Conclusion

Adapting treatments so that they are culturally congruent with clients' backgrounds may be one way to improve consumer satisfaction and improve treatment efficacy for ethnic minorities. For many Asian Americans, this issue is further complicated by marked cultural, philosophical, religious, and societal differences between Eastern and Western cultures. Although a clear plan for preventing health disparities at the systems level has yet to be developed or implemented, individual practitioners can do much to improve the treatment of ethnic minorities. Development and/or modifications of interventions that are culturally compatible or congruent with a person's cultural background are essential to providing high-quality culturally effective treatments. This is especially important since the concept or notion of therapy and the rationale behind therapeutic treatment may be culturally unfamiliar, foreign, and stigmatizing to many ethnic minorities. Because the current efficacy–effectiveness debate has for the most part left ethnic minorities behind, committing resources to develop and test adapted versus nonadapted interventions will be very important if psychologists are to improve quality of care.

Some may believe that cultural adaptations are not necessary for current interventions to work. Although growing evidence supports the finding that nonadapted evidence-based interventions may work when used with some minority groups (Miranda et al., 2005), this literature is still quite limited even for the few groups on which it is available. Even if evidenced-based interventions do generalize to other populations, this does not account for differences in treatment outcomes or access to equitable health services (Institute of Medicine, 1999; U.S. DHHS, 2001). The extant literature also does not address issues of treatment satisfaction or whether clients would be more likely to use interventions that they perceive to be more culturally familiar and congruent. Because we know that ethnic mi-

norities are less likely than the majority to receive evidence-based care (U.S. DHHS, 2001), addressing issues of how to make mental health services more accessible to and effective for ethnic minorities should be a top priority.

In this article, I presented a conceptual framework for adapting and modifying therapy for ethnic minorities. The PAMF builds on the cultural competency movement and offers specific guidelines for applying cultural adaptations to therapy and evidence-based practices. Although the importance of culture is recognized in the APA's guidelines on multicultural education, training, research, and practice (APA, 2003), a detailed and specific plan needs to be developed if professionals who want and need appropriate cultural competency training are to receive it. Given the low mental health care utilization rates and poor treatment outcomes of ethnic minorities, cultural modifications that make health services more culturally congruent are a necessity rather than a luxury.

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