The Formative Method for Adapting Psychotherapy (FMAP): A Community-Based Developmental Approach to Culturally Adapting Therapy

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How is psychotherapy culturally adapted for ethnic minorities? Although there has been growing interest in doing so, few therapy adaptation frameworks have been developed. The majority of these frameworks take a top-down theoretical approach to adapting psychotherapy. This article introduces a community-based developmental approach to modifying psychotherapy for ethnic minorities. The formative method for adapting psychotherapy (FMAP) is a bottom-up approach that involves collaborating with consumers to generate and support ideas for therapy adaptation. It involves 5 phases that target developing, testing, and reformulating therapy modifications. These phases include (a) generating knowledge and collaborating with stakeholders, (b) integrating generated information with theory and empirical and clinical knowledge, (c) reviewing the initial culturally adapted clinical intervention with stakeholders and revising the culturally adapted intervention, (d) testing the culturally adapted intervention, and (e) finalizing the culturally adapted intervention. Application of the FMAP is illustrated using examples from a study adapting psychotherapy for Chinese Americans, but it can also be readily applied to modifying therapy for other ethnic groups.

Keywords: Asian American, adaptation, ethnic minority, psychotherapy, treatment

Will culturally adapting psychotherapy improve treatment outcomes for ethnic minorities? Research has demonstrated that ethnic minorities are less likely to receive quality health services and evidence worse treatment outcomes when compared with White Americans (Institute of Medicine, 1999; U.S. Department of Health and Human Services, 2001). Bernal, Jiménez-Chafey, and Domenech Rodríguez (2009) reported that previous literature addressing cultural adaptation models is not well documented, contributing to the paucity of detailed literature in this area. 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 empirically supported treatments (ESTs) for people from diverse backgrounds (Miranda et al., 2005; Nagayama-Hall, 2001). As the demographics of the United States change, this critical lacuna in our knowledge and our underpreparedness to effectively treat ethnic minorities will become more apparent.

Today, mental health providers are faced with the dilemma of (a) implementing an "as-is" approach to disseminating ESTs to culturally diverse ethnic groups, (b) adapting ESTs to be more culturally congruent to better fit the needs of ethnic clients, or (c) developing new, culture-specific ESTs for each ethnic group. Because the majority of therapists working with ethnic minority clientele in the United States are trained in Western psychotherapy, developing culture-specific treatments that are based on different healing paradigms make choice (c) less practical. Moreover, developing novel ethnic-specific treatments for each culturally different group in the United States may be prohibitively costly and time consuming and lead to training difficulties, especially if treatments are based on different theoretical paradigms. Implementing an as-is approach in disseminating ESTs to ethnic minority clients may not fully address their diverse needs. Therefore, culturally adapting ESTs may be the most responsive and cost-effective approach.

Fortunately, there is growing recognition that mainstream mental health services may need modifications to meet the needs of our diversifying population. The American Psychological Association (2003) published a set of guidelines for multicultural education, training, research, practice, and organizational change for psychologists. More specific recommendations for training clinicians to be more culturally competent have also been provided (Comas-Díaz & Jacobsen, 1991; Hardy & Laszloffy, 1992; Lo & Fung, 2003; Pedersen, 1997, 2000; D. W. Sue, 1990; D. W. Sue, Arrendondo, & McDavis, 1992; S. Sue, Ivey, & Pedersen, 1996).

In addition, specific culturally adapted therapy programs have been developed and found to be effective (Constantino, Malgady,

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& Rogler, 1986; Kohn, Oden, Munoz, Robinson, & Leavitt, 2002; Kumpfer, Alvarado, Smith, & Bellamy, 2002; Munoz & Mendelson, 2005; Rossello & Bernal, 1999; Szapocznik, Santisteban, Kurtines, Perez-Vidal, & Hervis, 1984; Ying, 1999; Zhang et al., 2002). Similarly, Nicolas, Arntz, Hirsch, and Schmiedigen (2009) have also demonstrated early success in the development of a cultural adaptation model for Haitian adolescents using the ecological validity and cultural sensitive framework (Bernal, Bonilla, & Bellido, 1995), briefly described later, as the cultural foundation for adaptation with the Adolescent Coping With Depression Course. There is also growing evidence to suggest 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 failure (Flaskerund & Liu, 1991; S. Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Takeuchi, Sue, & Yeh, 1995). A few theoretical frameworks have also been developed to guide therapy adaptations. For example, Bernal et al. (1995) developed a theoretically driven framework for developing culturally sensitive interventions. This framework, consisting of dimensions of treatment and culturally sensitive elements, 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). They suggested using eight different dimensions, including language, persons, metaphors, content, concepts, goals, methods, and context, to identify areas for adaptation. For example, the context dimension involves consideration of changing contexts that might increase risk of acculturative stress problems, disconnect from social supports and networks, and reduced social mobility. The persons dimension involves addressing cultural similarities and differences between the client and the clinician. Content issues involve cultural knowledge and information about the values, traditions, and customs of the culture. For more information on the framework developed by Bernal et al. (1995), see Bernal et al. (2009) and Nicolas et al. (2009).

A more recent framework developed by Hwang (2006), the psychotherapy adaptation and modification framework (PAMF), offers a three-tiered approach to making cultural adaptations that consists of domains, principles, and rationales. Domains identify general areas that practitioners should use when modifying therapeutic approaches for their clients. Principles provide more specific recommendations for adapting therapy for specific groups. Rationales provide corresponding explanations for why these adaptations may be effective when used with the target population. This three-tiered approach was created to help practitioners make the shift from abstract ideas of being culturally competent to developing specific skills and strategies that can be effectively implemented when working with diverse clientele. In addition, it was developed to help practitioners thoroughly think through the reasons why they were making certain adaptations and to support these modifications with compelling reasons. General domains for adaptations include (a) understanding 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. Specific principles and rationales are detailed more fully in Hwang (2006).

Although theoretically driven approaches to cultural adaptation provide a strong foundation for tailoring interventions, bottom- or ground-up community-based approaches can also provide invaluable information by confirming theory-related adaptations, generating ideas that more theory-driven approaches leave out, or providing more specificity in the adaptations or examples offered. Community-based formative approaches to therapy adaptation can also serve as a powerful tool for cultural understanding because they involve consumers (therapists and clients) as well as community stakeholders and collaborators. A few studies have been published that have proposed frameworks and recommended sequences for developing culturally adapted interventions. For example, in discussing parent training, Lau (2006) recommended an evidence-based approach that prioritizes (a) selectively targeting problems and identifying communities that would most benefit, and (b) using direct data outcomes to justify adaptations. In a response to Lau, Barrera and Castro's (2006) commentary recommended a sequence involving (a) information gathering, (b) preliminary adaptation design, (c) preliminary test of the adapted treatment, and (d) adaptation refinement, which is similar to the model presented in the next section. Domenech-Rodriguez and Wieling (2005) proposed a cultural adaptation process model consisting of three phases: (a) focusing on the iterative process among all those involved in the adaptation process, (b) selecting and adapting evaluation measures and continual exchange between the community and those creating the adaptations, and (c) integrating the observations and data gathered in the second phase to create a new intervention. These models argue that community-based approaches will increase ecological validity of adaptations by increasing community participation. Nicolas et al. (2009) provided an additional example of a community-based cultural adaptation model for working with Haitian adolescents in which the authors outlined specific steps taken to build collaborative relationships with the community as a way to adapt the Adolescent Coping With Depression Course in a culturally responsive manner. A book on culturally responsive cognitive–behavioral therapy with different groups has also been published (Hays & Iwamasa, 2006; see also Hays [2009] for a more recent discussion of the integration of cognitive–behavioral and multicultural therapies and their effectiveness in psychotherapy).

FMAP

The purpose of this article is to introduce the FMAP framework, a community-based bottom-up approach for culturally adapting psychotherapy. It was developed to be used in conjunction with the top-down PAMF (Hwang, 2006) to generate ideas for therapy adaptation, provide additional support for theoretically identified modifications, and help flesh out and provide more specific and refined recommendations for increasing therapeutic responsiveness. It was generated in parallel to other adaptation models and contributes to the growing body of literature on culturally responsive treatment development. I developed the combination of the top-down PAMF approach and the community-based FMAP approach as guiding frameworks to facilitate the creation of a new culturally adapted treatment manual for depressed Chinese Americans. This culturally adapted cognitive–behavioral therapy man-

ual is currently being tested against a non-culturally adapted cognitive–behavioral therapy manual in a National Institute of Mental Health-funded clinical trial on empirically supported adapted interventions. Because the PAMF has already been described in Hwang (2006), this article focuses on introducing the more bottom-up FMAP framework.

The FMAP approach consists of five phases: (a) generating knowledge and collaborating with stakeholders, (b) integrating generated information with theory and empirical and clinical knowledge, (c) reviewing the initial culturally adapted clinical intervention with stakeholders and revising the culturally adapted intervention, (d) testing the culturally adapted intervention, and (e) finalizing the culturally adapted intervention. Each of the phases of the FMAP model is described in the following sections and can be tailored to meet the individual needs of different projects. Moreover, application of the FMAP is illustrated through examples from an ongoing clinical trial. The cultural adaptation process described here overlaps with the model described by Nicolas et al. (2009), and it is hoped that in conjunction both models can be used as guides for future research and practice.

Phase 1: Generating Knowledge and Collaborating With Stakeholders

The first step of implementing the FMAP is to decide which stakeholders to involve and when to involve them. According to the FMAP, there are generally six main categories of stakeholders, including mainstream health and mental health care agencies, mainstream health and mental health care providers, community-based organizations and agencies, traditional and indigenous healers, spiritual and religious organizations, and clients. For the purposes of the project to adapt cognitive–behavioral therapy for Chinese Americans, conscious decisions were made to include the following stakeholders initially: (a) Asian-focused community mental health service agencies, (b) mental health providers (psychiatrists, psychologists, social workers, and marital family therapists), (c) practitioners of traditional Chinese medicine, and (d) Buddhist monks and nuns and both spiritual and religious Taoist masters. These stakeholders were included because they have expertise in treating depressed Chinese Americans and could potentially provide direct feedback on developing and improving treatments. Eliciting client feedback is also important; however, this was done later in the process for several reasons, including that many of the clients had little to no exposure to mental health services, were ill and could potentially lose confidence in treatment if project staff were to ask them for treatment advice, and had minimal ability to differentiate types of treatments offered before receiving them. Client feedback was more extensively elicited in Phases 4 and 5.

Asian-focused clinics were included because I wanted to make sure that the intervention developed could feasibly be implemented in the parameters of real treatment centers (e.g., the frequency of sessions, staffing and assignment of caseloads, hours of operation, and billing and financial limitations) and to ensure that the program developed would be sustainable. For the purposes of our project, I collaborated with seven Asian-focused clinics, two of which served as primary clinical trial sites and five of which served as focus group collaborators. Focus groups were not run at

clinical trial sites to ensure that treatment conditions would not be contaminated.

Mental health care providers were asked to participate because they are experts in the field and have insights and expertise in working with depressed Asian American clients. In addition, getting practitioners to participate in developing the intervention facilitated their buy-in to the treatment. Two 4-hr focus groups with each clinic were run, and multiple focus groups were run at larger clinics. Each focus group consisted of four to six mental health practitioners with a range of clinical experience. This helped facilitate both breadth and depth of discussions. The first 4 hr involved general discussions of cultural adaptation and review of different treatment manuals and interventions. Specifically, I asked therapists their impressions of whether different aspects of treatments would work and also elicited feedback about how best to modify them for Asian Americans. It was important to involve multiple clinics because they each had different characteristics, biases, and notions about best practices. Capturing a range of feedback allowed me to develop a less biased and more ecologically valid treatment. Because I wanted to create an intervention that could be more easily modified for other Asian groups in the future, focus groups included staff who treated Chinese Americans and other Asian Americans. Interviews were also conducted with practitioners of traditional Chinese medicine, Buddhist monks and nuns, and spiritual and religious Taoist masters. It was important to involve cultural healers because these traditions have strongly influenced Chinese culture for thousands of years. This also provided an opportunity to exchange ideas, build a sense of community, and strengthen referral networks.

Phase 2: Integrating Generated Information With Theory and Empirical and Clinical Knowledge

Information generated from our community-based focus groups was synthesized with the PAMF framework, extant theories, empirically supported therapy literature, my previous experience conducting therapy in a variety of community-based settings, and my continued private practice experience. I then began writing a new culturally adapted cognitive–behavioral therapy manual. Details of the adaptations made are presented later in this article. Focus group collaborations helped reduce personal, clinician, and agency-specific biases. Collaborating with traditional healers also helped ensure that cultural adaptations were grounded in cultural belief systems. Because not all of the stakeholders had similar opinions regarding what therapeutic modifications would be most beneficial to the clients, I used the most recurrent themes, and I finalized the treatment manual on the basis of my experiences and discussions generated.

Phase 3: Review of Culturally Adapted Clinical Intervention by Stakeholders and Further Revision

After the culturally adapted manual was written, an additional 4 hr of focus groups were conducted with the therapists. Focus groups were conducted in English, with some portions being discussed in Chinese when beneficial. Initial impressions of the new intervention (English and Chinese versions) and feedback for

Table 1

Formative Method for Adapting Psychotherapy Cultural Adaptations Generated for Asian Americans

Cultural adaptation principles	Justification for cultural adaptations
Dynamic issues and cultural complexities	
Learn when to individualize, when to generalize, and when to examine the complexities of cultural issues (e.g., thought records do not work with Asian Americans vs. thought records work better with more educated and more acculturated Asian Americans).	Cultural issues may be moderated by other factors such as level of education or level of acculturation.
Individualize statements made to client (e.g., rather than say "Family is really important to Chinese people," say, "You seem to really care a lot about your family").	Helps clients feel validated rather than stereotyped.
Adaptations made for specific Asian groups may not work with other Asian groups (e.g., modifications that involve incorporating Buddhist concepts may not equally apply to Filipino Americans because of religious differences among these groups).	Although racially similar, those from different ethnic and cultural backgrounds have different beliefs, histories, philosophies, and religious beliefs.
Differentiate emic (culture-specific) and etic (culture-general) constructs when providing psychoeducation (e.g., assertive communication may not carry the same benefits when used in cultures in which it is less normative, perceived as being too direct and disrespectful, and can potentially exacerbate relationship problems).	What is normative or effective in one culture may be abnormal and socially ineffective in another culture.
Therapy orientation	
Provide a longer and more detailed orientation to therapy.	Asian Americans clients are less familiar with and have less understanding of how psychotherapy works.
Spend some time getting to know each other and understanding why the client is seeking therapy at this time.	Social relationships are very important for those from collectivistic backgrounds. Reduces awkwardness of talking with someone they do not know.
Establish goals and markers of treatment progress that is periodically reviewed.	Helps reduce ambiguity of therapy and is consistent with the problem-focused nature of clients seeking treatment. Also helps clients who are less comfortable being in therapy confirm the benefits of attendance.
Educate clients about the course of therapy (e.g., what their experience is going to be like the first few weeks, several weeks thereafter, and in the long run).	Helps increase comfort and reduce ambiguity by normalizing experiences and providing realistic expectations.
Client–therapist roles and expectations for therapy should be clearly addressed at the beginning of therapy.	Helps client understand their role as well as therapist's actions and behaviors. Facilitates clients' development of realistic expectations and normalizes their experiences.
Address premature dropout and educate clients about healthy therapy termination.	Helps normalize clients' feelings and increases the likelihood that they will be open and honest with the therapist.
Directly address why clients may feel like they are not receiving as much benefit during the first few weeks of therapy (e.g., gathering of background information and accurate understanding of the client and their problems results in more effective problem solving).	Helps reduce premature treatment dropout and normalize feelings of why they feel like they are doing most of the talking and why the therapist is not giving as much direct advice near the beginning of treatment.
Focus on psychiatric symptoms, but do not avoid discussing the psychiatric diagnosis.	Focuses on clients' presenting problem rather than psychiatric labeling. Acknowledges and normalizes clients' difficulties and uses helpfulness of diagnostic information without reinforcing cultural stigmas and taboos about discussing mental illness.
Distinguish psychological and somatic symptoms of psychiatric diagnoses at the beginning of treatment.	Highlights that psychiatric disorders are not just "mental" problems and acknowledges interrelationship of mind and body. Consistent with holistic and somatic emphasis in Asian culture and reduces stigma associated with seeking mental health treatment.
Cultural beliefs	
Reduce the emphasis on cognitions and changing the way a person thinks. Instead, focus on helping clients think in more effective and healthy ways.	Focusing on changing one's way of thinking is less in line with client goals of solving their problems. Too much emphasis on cognitive biases and changing negative thinking patterns may alienate clients, whereas a positive reframe of helping clients think more effectively and healthily is more congruent with their goals.
Increase emphasis on problem solving and behavioral activation.	Aligns with clients' problem-solving focus and is congruent with physical health and holistic nature of Asian culture.
Increase emphasis on resolving social conflicts and relational problems.	The primary problems of many clients from collectivistic cultural backgrounds tend to be family or relational problems. The process of immigration and the acculturation gap between parents and children also tends to exacerbate family difficulties.

(table continues)

Table 1 (*continued*)

Cultural adaptation principles	Justification for cultural adaptations
Highlight consequences of not properly addressing one's problems. Focus on advantages and disadvantages of different actions.	Consistent with problem-focused and practical nature of Asian culture and philosophy.
Provide psychoeducation on unfamiliar topics.	Improves client understanding of topics that they may have had little previous exposure to. Consistent with educational focus of client culture, and facilitates concrete understanding of important issues.
It takes more time to work through therapy materials for people who have less prior knowledge or exposure. In addition, Asian American clients have less exposure to therapy and are more likely to be intimidated by large manuals.	If using a manualized treatment, reduce the amount of different materials you cover in each session, and focus on applying the most relevant materials to the client's situation. Also, try to reduce the bulkiness of the manual (e.g., number of pages, not number of sessions) so that the treatment does not seem too overwhelming.
Simplify and consolidate topics into the basics when several variations of similar categories exist (e.g., instead of discussing 15 different types of cognitive biases, focus on a few of the most common biases).	Reduces confusion, improves learning of the materials, and makes psychotherapy less intimidating.
For adults and children, use terms such as *exercise, practice,* or *strengthening* rather than homework.	Although one may think that a strong emphasis on education in Asian culture is congruent with assigning homework, some children and adults may have an aversive reaction to being assigned homework in therapy. Children already have too much homework to do, and adults were pressured to study in the past. Terms such as *exercise, practice,* or *strengthening* are more in line with the goal, hard work, and health emphasis in Asian cultures.
Make sure the examples used are culturally salient and meaningful. When using a manualized treatment, make sure that artwork and layout design are also culturally appealing.	Using more relevant examples helps the client understand therapy concepts and more quickly acquire skills that are being taught. Culturally appealing artwork and layout increases the manualized treatment's aesthetic appeal.
Use cultural bridging techniques to relate therapy concepts to Asian beliefs and traditions (e.g., bridging qi and balance of energy to cultivating balanced cognitions and healthy behaviors to improve mood).	Facilitates understanding and adherence to treatment. Provides cultural context for learning and reduces culture unfamiliarity with foreign psychological concepts.
Use metaphors to relate mental health treatment to physical health treatment (e.g., psychotherapy is like physical therapy, and both require exercises and practice).	Helps reduce stigma related to seeking psychological services, and helps client see the importance of practice and commitment to achieve gains.
Understand how cultural beliefs influence help seeking and changes the nature of the client you are treating (e.g., because of stigma, Asian American clients tend to delay treatment and by nature are more severe when they do come into treatment. This, compounded with unfamiliarity and cultural barriers, leads to longer therapy response times).	Helps therapist understand client concerns and also helps therapist develop realistic treatment progress expectations of their clients.
Modify worksheets so that they are more culturally congruent and translate esoteric therapy terminology into common language and understanding (e.g., add a goals column to "thought records" and call it "goal analysis" or reformulate "chaining" into "climbing the mountain to reach your goals."	Helps clients better understand and align with the purpose of each worksheet or exercise. Also helps clients better understand culturally unfamiliar terminology and concepts.

Client–therapist relationship	
Use proper cultural etiquette (e.g., offer clients some tea to drink and ask them how they have been doing).	Helps clients feel more comfortable, increases feelings of social connectedness, and decreases feelings of awkwardness associated with talking to a stranger about one's problems.
Teach therapists about the cultural background of their clients.	Helps therapist understand and empathize with their clients. Increases therapist confidence and feeling of self-efficacy.
Join and engage with clients by assessing family background and migration history. Clarify the role that family or caregivers will have in therapy.	Facilitates building of working alliance and bonding with therapist. Provides important contextual information on clients' experiences. Respects clients' privacy and rights but also acknowledges family and caretakers who may have brought clients to treatment.
Therapists should be professional and present themselves as experts who can help clients solve their problems.	Consistent with respect for authority figures in collectivistic traditions in which caregivers are experts who can help resolve their problems.
Therapist cultural self-awareness and self-identity should be thoroughly explored.	Improves therapist understanding of self and cultural issues. Facilitates building of positive working alliance with clients, and encourages therapists to take responsibility for client care. Alleviates feelings of anxiety and tension related to working with culturally dissimilar or similar clients.

(table continues)

Table 1 (*continued*)

Cultural adaptation principles	Justification for cultural adaptations
Interactional and relational models of therapeutic relations should be understood.	Facilitates understanding that cultural competence requires knowledge of client issues, therapist cultural self-awareness, and understanding of how the two interact to affect therapy processes. Increases understanding of professional biases and ethnocultural transference and countertransference.
Because of cultural stigma toward mental health services and unfamiliarity with therapy, increase emphasis on normalizing client feelings. Case examples may also be helpful.	Helps reduce stigma, increase level of comfort, and increase feelings of being supported and understood. Helps clients relate their experiences to those of others and feel less alone.
Make an active effort to provide emotional support, encouraging words, optimistic statements, and positive feedback to clients. Validate clients when they share difficult to talk about experiences.	Helps increase feelings of comfort and support. This is especially important because there is a greater emphasis on receiving support and feedback from one's social network rather than developing positive self-statements. In Asian cultures it is more common for people to say positive things about you than for you to say positive things about yourself.
Help therapist develop realistic expectations for client progress. Have more patience when clients are trying to learn new skills and improve at a slower rate (e.g., learn new hobbies and self-care activities vs. revisiting old hobbies or previously practiced health activities).	Many Asian clients delay treatments and as a result are more severely ill when they come to treatment. Compounded with cultural barriers and unfamiliarity with therapy, clients are likely to exhibit slower treatment progress, and it may take longer to develop a strong working relationship. Having realistic expectations will help normalize therapist feelings, increase clients' sense of self-efficacy, and develop more patience for client progress.

Cultural differences in expression and communication

Psychotherapy and talking about one's problems as a way to resolve them may seem culturally foreign to those from cultures that focus more on problem solving through actions rather than words.	Clients may need more time to understand the benefits of therapy and to become comfortable talking about their feelings and problems with someone they do not know. In addition, they may need more psychoeducation to differentiate their thoughts from their feelings.
Understand cultural differences in communication styles (e.g., direct vs. indirect, verbal vs. nonverbal, and different meanings associated with being assertive, aggressive, and passive in different cultures).	Helps therapist teach communication skills that are more effective given the client's cultural context. Reduces the pushing of ethnocentric values that may be countertherapeutic or counterproductive to clients given their cultural environment. Improves understanding and reduces miscommunication between client and therapist.
Understand and address ethnic differences in expression of distress (e.g. differential emphasis on mind vs. body).	Validates somatic expression of psychiatric distress and helps the therapist normalize clients' experiences. Increases understanding of clients' level of distress and improves diagnostic accuracy. Helps therapist develop more holistic treatment plans that target somatic symptoms as much as they focus on cognitive reframing.
Address and differentiate cognitive and affective experiences of client.	Helps clients differentiate their thoughts from their feelings, which is especially important for those from more holistic cultural orientations in which there is less differentiation between the two. Although clients may veer away from talking about their thoughts and feelings, discussing them in a culturally sensitive manner can improve treatment outcomes.

Cultural issues of salience

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, and intergenerational family conflict).	Addresses issues salient to clients' life and increases the likelihood of feeling understood and being satisfied with treatment. Also addresses topics that are sometimes overlooked by therapists who are not aware of culture-specific experiences.
Understand how immigration and acculturation affect individual and family relationships across different generations.	Acknowledges unique roles, needs, and situations of immigrants as a culture in transition. Helps clients understand their identity and development in an appropriate cultural context. Also helps clients understand how cultural transition and immigration issues affect their and their family's cultural values and ability to communicate.

Table 1 (*continued*)

Cultural adaptation principles	Justification for cultural adaptations
Understand how social class and privilege interact and affect the treatment process.	Improves understanding of social and class dynamics and biases. Also helps the therapist become more responsive to working with disadvantaged diverse populations, and decreases blaming and increases appreciation for the hardships and struggles that certain groups face.
Address and be aware of push–pull feelings and culture-related role inconsistencies that may exist between clients' culture of origin and the culture of therapy.	Reduces confusion and discomfort and normalizes feelings when clients are asked to behave in a culturally incongruous manner (e.g., pushing an Asian client to be more independent, individualistic, and autonomous).
Address clients' individual rights, but also integrate this understanding with the realities of their roles and responsibilities. Discuss how one's rights, roles, and responsibilities change when others do not act in appropriate ways.	Contextualizes one's rights within a social context of one's roles and responsibilities. Helps highlight the importance of meeting one's own needs while at the same time reducing feelings that one is being selfish. Helps clients understand how obligations, actions, and moral responsibilities change when the family or social system is unhealthy.
Be aware of and address shame and stigma issues that may influence treatment progress.	Helps improve clients' comfort level, helps therapist be more empathic and supportive to client, and helps reduce treatment failure and premature dropout.
Align with traditional–indigenous forms of healing, medicine, religions, or philosophies.	Better coordinates treatment services and helps promote collaboration between caregivers.
Find ways to integrate extant cultural strengths into clients' treatment.	Capitalizes on aspects of clients' culture that may facilitate the healing process and that are culturally congruent with clients' goals (e.g., increasing focus on family strengths and improving social relationships, integrating cultural strengths related to Buddhism and acting in the right way to achieve one's goals, highlighting the importance of cause and effect or karma, and incorporating popular cultural metaphors and stories that help people live in healthier ways).
For manualized treatments, be more flexible in the ordering of sessions and also on the speed with which you move through them (e.g., whether you spend more time and repeat some sessions).	Helps ensure that the topics that you are focusing on are consistent with clients' problems and goals. Also ensures that clients sufficiently learn materials and reduces cursory exposure to information that will not be effectively used.

improvement were elicited. Feedback was used to finalize the manual before clinical trial implementation. The final manual was titled *Improving Your Mood: A Culturally Responsive and Holistic Approach to Treating Depression in Chinese Americans* (Hwang, 2008a, 2008b). Client and therapist manuals were written, and translations into Chinese were conducted throughout the treatment development process and further refined and finalized after the focus groups were completed. Translations of the treatment manuals and assessment measures used in the clinical trial involved forward- and back-translation by a team of four master's-level therapists, one postdoctoral fellow, and me. In addition, feedback from 15 undergraduate students, 3 master's-level therapists, 1 postdoctoral fellow, and 4 graduate students was elicited. Because of the linguistic variability even within the written Chinese languages, translators spoke languages from different Chinese regions and countries (e.g., mainland China, Hong Kong, and Taiwan).

Phase 4: Testing the Culturally Adapted Intervention

The final intervention includes a 12-week program and is currently being used in a clinical trial funded by the National Institute of Mental Health. A variety of clinical and cultural outcome measures (from clients, therapists, and independent assessors) are being used to test the efficacy of the interventions, including symptom reduction, treatment satisfaction, premature dropout, working alliance formation, and receipt and enactment of therapy. Assessments are collected at multiple time points (e.g., baseline;

Weeks 4, 8, and 12; and 3 months after the treatment has ended). All therapy sessions are also being recorded for qualitative therapy process review, and I provide weekly ongoing supervision to the therapists in both adapted and nonadapted conditions. Although having one supervisor for both conditions could potentially lead to allegiance biases, the use of different supervisors could also lead to a supervisor effect. Because the National Institute of Mental Health R34 grant is a treatment development grant, having one supervisor supervise both treatment conditions was deemed the best option because supervision information gathered will also be used to further refine the treatment after the clinical trial is completed.

Phase 5: Synthesizing Stakeholder Feedback and Finalizing the Culturally Adapted Intervention

Clients who finish the treatment will be asked to participate in an interview to elicit feedback regarding their experiences, what they found useful, what they did not like, and their recommendations for treatment improvement. Therapists will also participate in an exit interview, both individually and as a group so that additional recommendations can be integrated. I will use this information and my experiences supervising both treatment conditions and finalize the treatment manual. Therapist focus groups will again be conducted on the finalized manual, and focus groups consisting of community participants will also be used to finalize changes.

Cultural Adaptation Ideas Generated by FMAP
Phases 1–3

Although the clinical trial that was used to illustrate the stages of the FMAP has not been fully completed, the information generated from Phases 1–3 was effective in producing a culturally adapted manual that will be further refined after the clinical trial is completed. Table 1 lists the cultural adaptations that were used to create the new manual for depressed Chinese Americans. It is a culmination of adaptations generated by research and clinical theory (Phase 2) and from more formative focus-group process (Phases 1 and 3). It is presented in the same format as the PAMF, with adaptations arranged under different domains of adaptation, specific principles of adaptation, and corresponding rationales to justify why modifications were made. Comparison with the original PAMF table (see Hwang, 2006) reveals similar adaptations; however, Table 1 is expanded and more specific and provides more detailed and concrete recommendations. More theory-driven PAMF adaptations were retained in the table only if reaffirmed by the more generative FMAP stages.

The development and modification of therapeutic interventions to match the client's cultural background is essential if we are to provide high-quality and culturally responsive treatments. This is especially important because the concept or notion of psychotherapy and the rationale behind therapeutic treatments may be culturally unfamiliar, foreign, and stigmatizing to many groups. The goal of this article was to introduce the FMAP framework; it is hoped that clinical researchers will find this stage-by-stage bottom-up approach to cultural adaptations beneficial. Comparing the efficacy of evidence-based adapted interventions with non-adapted interventions will be important in improving care for ethnic minorities.

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