2011

Schizophrenia, acculturation, and Chinese American families : a review and clinical recommendations for treatment

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SCHIZOPHRENIA, ACCULTURATION, AND CHINESE AMERICAN FAMILIES: A REVIEW AND CLINICAL RECOMMENDATIONS FOR TREATMENT

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Lorena Ho

December, 2011

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This clinical dissertation, written by

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under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

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TABLE OF CONTENTS

Page

LIST OF TABLES

Page

DEDICATION

To my sisters

ACKNOWLEDGEMENTS

I am immensely grateful to my dissertation chairperson, Dr. Joy Asamen, for her commitment to students, energy, wisdom, and meticulousness.

I wish to thank my committee members, Drs. Amy Tuttle and Yuying Tsong, for their knowledge, time, and contributions.

Finally, I'd like to convey my enormous gratitude and admiration for my partner and husband, Gabriel Restine, whose patience, presence, humor, and computer savvy I have come to rely upon.

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ABSTRACT

Schizophrenia is a disorder that appears across cultures, typically creating a tremendous amount of suffering and loss for both the individual diagnosed, and his or her family. While psychosocial family treatment (along with medication) has proved thus far to be the most promising treatment for schizophrenia in Western cultures, it has yet to be proven effective with ethnocultural minority groups. Furthermore, literature shows that Western treatments for schizophrenia cannot be uniformly applied to ethnocultural minority groups with the expectation of similar results. In the United States, Asian Americans, and specifically Chinese Americans, continue to underutilize mental health services for schizophrenia, yet not for the lack of need. A significant reason for underutilization is the lack of culturally appropriate treatments and culturally competent clinicians. This dissertation specifically addresses the issues and concerns that arise out of the development of schizophrenia in a Chinese American family member and seeks to propose culturally congruent recommendations for practitioners who may find themselves working with Chinese American families. Through a review of the literature, treatments for schizophrenia are identified; Asian/Asian American and Chinese/Chinese American values and beliefs about the family and mental illness are discussed; existing treatments are juxtaposed with the aforementioned values and beliefs; and clinical considerations for rapport-building, assessment, and treatment of schizophrenia within a Chinese American family are discussed.

Chapter I. Introduction[1]

Torrey (2001) describes the words of a mother whose daughter was recently diagnosed with schizophrenia, uttering she would rather her daughter have a fatal disease. This is one mother's words yet they echo the sentiments of numerous people whose lives are affected by schizophrenia; the diagnosis of schizophrenia is worse than death. Schizophrenia is a cruel diagnosis, feared by concerned family members and disdained by the misinformed public (Torrey, 2001). These characteristics of fear and misunderstanding foster shame surrounding those who receive this diagnosis. Schizophrenia continues to have a poor prognosis for those afflicted with the disorder, robbing many young adults of what might have been a promising future. Considering the fear, stigma, prognosis, and limitations of having the disorder, many afflicted individuals and their families spend a lengthy time in denial before seeking professional treatment.

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Revised* (*DSM-IV-TR*) is the guide that mental health professionals in many Western countries use to assign a clinical psychiatric diagnosis (American Psychiatric Association [APA], 2000). The *DSM-IV-TR* defines schizophrenia as "a disorder that lasts for at least 6 months and includes at least one month of active-phase symptoms (i.e., two [or more] of the following: Delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms)" (p. 298). While not all symptoms are required to receive this diagnosis, the individual's existing symptoms, more often than not, must contribute toward a marked decrease in at least one area of functioning such as work, interpersonal relationships, or self-care (APA, 2000). According to the *DSM-IV-TR*, symptoms of schizophrenia fall under two broad categories: Positive and negative.

[1] For a detailed description of the literature, see Appendix A.

Positive symptoms are characterized by an "excess or distortion of normal functions" (APA, 2000, p. 299) including delusions, hallucinations, and disorganized speech. Negative symptoms are characterized by diminished functions such as affective flattening, the inability to fluently participate in conversations or express complete thoughts, and the inability to engage in goal-directed behavior (APA, 2000).

It is an important consideration that the original *DSM* was researched by Western peoples and utilized Western populations as its frame of reference (Lewis-Fernandez & Kleinman, 1994). While versions of the *DSM* have changed over time, much of the *DSM* criteria are specific to Euro-American culture, which poses the potential to misunderstand symptoms, overpathologize, and misdiagnose non-Euro-Americans (Dana, 2001). Schizophrenia is considered to be a culture-general disorder, that is, it is a disorder found in all cultures (Dana, 2001). However, among ethnic groups, the expression of symptoms and syndromes varies, which contributes to the potential for misdiagnosis (Dana, 2001; McGoldrick, 1993).

Since 1990, the size, diversity, and geographic distribution of the Asian American population in the United States have grown 72% (Carrasco & Weiss, 2005). The U.S. Census of 2000 counted 11.9 million Asian Americans, making up 4.2% of the U.S. population (Carrasco & Weiss, 2005). While specific prevalence rates of schizophrenia for Asian American populations could not be found, the prevalence rates of diagnosable mental disorders appear similar to those of the "white population" (U.S. Department of Health and Human Services, Office of the Surgeon General [SAMHSA], n.d., p. 2) in the U.S. Although a study has yet to be conducted on the rates of mental disorders among Asian Americans, researchers have conducted studies on prevalence of symptoms; such

studies suggest an increased risk for depression, with the highest lifetime risk for depression reported among Chinese Americans (Yang & WonPat-Borja, 2007). A study conducted by the World Health Organization that examined the prevalence of psychiatric disorders (as defined by *DSM-IV*) cross-nationally was strongly suggestive that mental disorders are lower in Asian countries than in the United States (Yang & WonPat-Borja, 2007). This finding may suggest that stressors stemming from immigration to the United States may negatively affect the mental health of Asian immigrants.

The History of Treatment for Schizophrenia

Scholars debate over whether schizophrenia has existed throughout history, and some claim that certain biblical figures displayed signs of the disorder. Such individuals were kept at home or were thought to be divinely inspired (Torrey, 2001). Sporadic cases of what appear to be schizophrenia were noted from the 1400s to 1700s (Torrey, 2001). A few psychiatric hospitals in Europe were established in the middle ages where those thought to be mentally ill were restrained and hidden from public view. In the 1800s, what appear to be clear cases of schizophrenia were described (Torrey, 2001). Until the discovery of anti-psychotic medications in the 1950s, individuals with schizophrenia were either kept at home or sent to institutions, such as public mental hospitals.

The first antipsychotic, Thorazine, was shown to sharply reduce the positive symptoms of schizophrenia and a majority of patients experienced reduced symptoms (Comer, 2001). Research has consistently shown that the use of antipsychotic drugs reduce symptoms of schizophrenia for a majority of patients and are more effective than any other treatment used alone (Comer, 2001). Typically, clinicians attempt to treat an individual's symptoms of schizophrenia on an outpatient basis with a combination of

antipsychotic medication and therapy; however, there are times when such treatment is insufficient. In such cases, short-term hospitalization to stabilize the patient may be a treatment option; research indicates rehospitalization rates decrease with its use than with longer term hospitalization (Comer, 2001). After hospitalization, patients may be released into follow-up community treatment usually available in a day-treatment or community mental health centers, or back into the care of their psychiatrist and therapist (Comer, 2001).

Due to medication, psychotherapy became successful in more cases of schizophrenia. Various types of individual insight therapies have been used in cases of schizophrenia although studies suggest that effective individual therapy is less dependent the theoretical orientation of the therapist and more dependent on the therapist's level of experience in treating schizophrenia as well as the level to which therapists took an active role in "setting limits, challenging patients' statements, providing guidance, displaying empathy, and gaining trust" (Comer, 2001, p. 463).

The discovery of antipsychotic medication also resulted in the deinstitutionalization of many individuals due economic pressures and politics, forcing families to provide care for their family members. With little help, these families were unprepared to care for their ill family member who had, until then, been institutionalized (McFarlane, 2002). It is not surprising that subsequent to deinstitutionalization, scholars and clinicians began to examine more closely how family relationships might be related to the cause or course of schizophrenia (Lukens & McFarlane, 2002).

Although roughly 20% of individuals living with schizophrenia who cannot reside alone or with their families live in residential treatment homes also known as group

homes or halfway houses (Comer, 2001), approximately 25-40% of these individuals reside with at least one family member (Comer, 2001; Torrey, 2001). The observation of disturbed family relationships in the families of individuals with schizophrenia led to the conclusion that family disturbances contributed to the development of schizophrenia (Falloon, Boyd, & McGill, 1984). Moreover, a patient's recovery can be greatly influenced by the reactions, words, and behaviors of family members at home (Comer, 2001); and family members' behaviors and reactions are affected by the patient's schizophrenia symptoms of unusual behaviors or withdrawal (Comer, 2001). These observations led to closer examination of the role of family in the development of schizophrenia and treatment for the disorder.

Murray Bowen hypothesized that "schizophrenia [was] a manifestation of a process that involve[d] the entire family and that the patient [was] merely the diseased part that play[ed] the psychosis" (Falloon et al., 1984, p. 8). At the same time Bowen was treating families who resided together in a hospital unit, Gregory Bateson and his colleagues focused on family communication patterns and the "double-bind hypothesis" that described problematic communication in terms of verbal and non-verbal "simultaneous and often contradictory messages" (Falloon et al., 1984, p. 12). While poor or chaotic family interactions did not account for the development of schizophrenia as previously theorized, scholars and practitioners continued to hypothesize the individual with schizophrenia ought to be treated as a part of a dynamic family system and that treatment would be best aimed at minimizing stress and maximizing the family's problem-solving skills as a unit (Falloon et al., 1984). Family therapy combined with medication management has shown a reduction in rates of relapse for patients with

schizophrenia; therefore, many clinicians incorporate or recommend family therapy as an essential component of overall treatment for schizophrenia (Comer, 2001).

Multi-family group therapy (MFGT) has gained much attention in the last decade. This approach revolves around the principal of the biosocial hypothesis that "the state of the individual with schizophrenia is determined by a continuing interaction of specific biological dysfunction of the brain and social processes" (McFarlane, 2002, p. 75) and, therefore, biological and social determinants must be treated together. MFGT combines biological, psychological, family, community, and organizational interventions (McFarlane, 2002). Treatment is geared toward: (a) compliance with medications, (b) training family members in coping skills, and (c) organizing a social support system for all family members in the form of the MFG. In treatment, several patients and their families are brought together, led by professionals, over an extended course of treatment (McFarlane, 2002). The group is the primary source for case management. Group effort is aimed at building alliances with professionals and other families and psychoeducation about schizophrenia and its treatment, which includes how to manage the illness and practice in solving problems brought on by the illness (McFarlane, 2002).

The Current State of Psychosocial Family Treatment for Schizophrenia

Researchers studying family interventions for the treatment of schizophrenia have largely indicated positive results from psychosocial family treatments, despite the varying ways in which the treatment is operationalized and the different methods used to measure outcome (Falloon, Held, Coverdale, Roncone, & Laidlaw, 1999; McFarlane, Dixon, Lukens, & Lucksted, 2003). Psychosocial family treatment often includes elements of family therapy, psychoeducation, communication skill-building, and symptom

management. Treatment outcomes have been measured by reductions in the rates of relapse and re-hospitalization, decrease in symptom severity, improved patient functioning and independence, improved family attitudes toward the patient, increased family well-being, and increase in social support for the patient and family (Falloon et al., 1999; Glynn, 2003; Kuipers, 2006; McFarlane et al., 2003; Montero et al., 2005).

The dominant paradigm for understanding the etiology of schizophrenia is the diathesis-stress model (McFarlane, 2002). This model emphasizes that both environmental and genetic factors likely contribute to the development of schizophrenia. In other words, one's genetic composition may contribute to an individual being more vulnerable to the disorder, but stressful external forces are necessary to activate the symptoms of schizophrenia.

Although we are still incapable of altering one's genetic predisposition to develop schizophrenia, we can offer ways to intervene and minimize the impact of environmental stressors on the lives of individuals vulnerable to the disorder. It has been well-established that stress can negatively impact the onset, duration, and prognosis for those individuals with schizophrenia (Glynn, 2003; McFarlane et al., 2003). This dissertation is specifically interested in the stress experienced within the family system, as it is often the family members who have the most interactions in their roles as caretakers for the individual (McFarlane, 2002). More to the point is how clinicians can intervene to alleviate stress within the family system. Examining the role that the family plays in the patient's course of illness will assist in the development and refinement of effective therapeutic treatments for issues that individuals are capable of altering (Falloon et al., 1984).

Managing stress for the individual who is diagnosed, and his or her family, is a primary goal of psychosocial family interventions. Current psychosocial treatments for schizophrenia are a collaborative effort among patients, their families, and clinicians in order to develop and enhance the existing strengths of the individual and members of his or her family (McFarlane, 2002). Through a variety of practiced skills to improve communication, increase social support, improve individual functioning, and manage symptoms, psychosocial family treatments aim to reduce the degree of stress experienced by the individual with schizophrenia and the other members of the family system. The behaviors exhibited by the individual diagnosed with schizophrenia directly affect the manner in which the family members interact with the individual. While family members struggle to live with their loved one's odd behaviors or inability to do the minimum of what he or she was previously capable, family members might potentially become angry and blame the individual for his/her illness, perhaps become over-involved in the life of the individual and not permit him or her to make simple decisions, and/or due to unrealistic expectations, say or do things that convey anger or disappointment in the individual (Falloon et al., 1984; McFarlane, 2002). Any of these reactions can exacerbate the symptoms of schizophrenia and potentially alienate the individual from members of his or her family. Not only might family members begin to feel alienated from one another as a consequence of these stressful family interactions, the alienation may even affect extended family members or other members of one's social network, depending on how the family perceives the significance of schizophrenia (Falloon et al., 1984; McFarlane, 2002). This cycle of stress that is often observed in these families speaks to the value of family interventions designed to target the effective management of stress,

enhancement of communication skills, and broadening of understanding of the disorder through psychoeducation.

Psychosocial family treatments assume that the interactions among and attitudes of the family members have an impact on the functioning of both the individual diagnosed with schizophrenia and the members of his or her family, and these family dynamics can be altered to increase the well-being of the entire family system. Prior to the development of psychosocial family treatment approaches, conventional family therapies assumed that the dysfunction of family members was responsible for the patient's symptoms (McFarlane et al., 2003). Therefore, the target of therapy was the dysfunctional behaviors and communication of the family members (particularly the parents). This approach to treatment negatively affected the cohesiveness of the family because it ignored the needs of all members of the family system (McFarlane et al., 2003). McFarlane (2002) recommends that the patient as well as family members need a strong system of support; without the skills and education that come from family interventions, the individual and family members are caught in an interactive pattern that creates stress and hinders optimal levels of functioning.

Other practitioners also emphasize that treatment for schizophrenia must focus on relational dynamics and communication patterns within the family in a manner that enlists family members as allies in treatment, rather than assigning blame. For example, Seikkula and Trimble (2005) describe a dialogical approach to family therapy–Open Dialogue–that focuses on the utterances and new meanings that emerge when family members and professionals as a team share information, talk about their thoughts and emotions, and share their experiences. The healing process lies in the emotional exchange

of these meetings among family members and professionals in which meaning is constructed as a team. The two key elements of this process are the concept of the team, which includes family members and professionals, and the dialogic experience that is facilitated in each meeting (Seikkula & Trimble, 2005). Through the interactions among team members and communication of thoughts and emotions, meaning is co-constructed that strengthens the relationship of patient and family members. Studies suggest that among patients with their first episode of psychosis, the Open Dialogue model has demonstrated effectiveness during a psychotic crisis and has reduced rates of hospitalization, recidivism, and medication use (Seikkula & Trimble, 2005).

Despite the existence of different approaches, many family psychosocial interventions emphasize family strengths (McFarlane et al., 2003) and are based on principles of education, problem-solving, negotiation of modified roles, management of emotional experiences and loss, increased skills for both the patient and family members, and enhancement of social support (Comer, 2001; Kuipers, 2006). A consensus regarding the critical elements of family treatment for schizophrenia was set forth in 1999 by the World Schizophrenia Fellowship and refined through feedback from the world's researchers in psychoeducational family treatment (McFarlane et al., 2003). Although this process identified the core elements, it did not delineate a specific program of treatment for this population (McFarlane et al., 2003).

While a standard family intervention program for schizophrenia does not exist, a number of treatment modalities are frequently mentioned as important when serving these families, such as: (a) assessment of psychosocial and medical needs, (b) case management and drug treatment, (c) psychoeducation for families on mental illness

etiology and treatment, (d) social skills training for the patient, (e) communication skills training, (f) contextual problem-solving for caregivers and patients, and (g) relapse detection and crisis management (Falloon et al., 1999; Glynn 2003; McFarlane et al., 2003). These treatment modalities can be delivered in either a single family or a multi-family group format and in varying treatment settings, and the characteristics of families may need to be taken into account in instituting these treatments. Furthermore, these treatments differ in terms of duration, frequency, and participant composition (McFarlane et al., 2003).

While clinicians have used different treatment modalities and some treatments have gone so far as to be manualized, many family treatment researchers believe the treatment must be tailored to be congruent with each family's cultural and familial needs (Glynn, 2003; McFarlane et al., 2003; Montero et al., 2005). Efficacy studies examining psychoeducational family treatment with diverse ethnic populations have resulted in mixed findings, pointing to the need for further research and cautioning clinicians about assuming the universality of treatment with families from diverse cultures (Glynn, 2003; McFarlane et al., 2003; Montero et al., 2005). Researchers also state a need to further understand how elements of treatment can more effectively be matched to patients' clinical needs, such as length and phase of illness (Falloon et al., 1999; Glynn, 2003; McFarlane et al., 2003; Montero et al., 2005).

Sociocultural factors can influence the responses of individuals to interventions (Telles et al., 1995). Although there exists research that suggests family interventions developed from a Western perspective are appropriate treatments for schizophrenia with minority populations (Chien, Chan, Morrissey, & Thompson, 2004), the majority of the

research indicates the need for alterations and/or a different theoretical framework in which to approach family treatment with minority populations (Bradley et al., 2006; Kung, 2001; Lam, Chan, & Leff, 1995). Of particular interest in this dissertation is the use of family treatments for schizophrenia with Chinese American families. Due to the paucity of research on this specific ethnic population, the literature reviewed focuses on the family treatment research with other Asian American ethnic groups, as well as Chinese families in China. Furthermore, family treatments specifically designed for schizophrenia as well as family treatments in general are included in the review. Finally, due to the diverse cultural contexts that need to be taken into account when using a pan-ethnic approach, an emphasis is placed on the common threads that emerge among groups rather than how these cultural groups contrast.

Asian Cultural Values that Affect Family Treatment

Researchers appear to agree that cultural attitudes, beliefs, customs and practices affect the perceptions individuals have of schizophrenia, impact how the family member with the disorder is viewed, and influence how useful mental health care is regarded (Bradley et al., 2006; Chien, Norman, & Thompson, 2006; Lopez et al., 2004; Telles et al., 1995; Weisman, Duarte, Koneru, & Wasserman, 2006). One of the major challenges in reading the literature on the relevance of cultural values to psychological constructs and interventions, particularly with Asian American populations, is the inability to readily distinguish culture-specific values from those that are broadly "Asian," or those "hybrid" values that emerge as generations adapt native cultural values with those of the American cultural context (Okazaki, Lee, & Sue, 2007). Another significant challenge is the lack of operational definitions for ethnic and cultural differences among Asian groups

(Chun, Morera, Andal, & Skewes, 2007) and the tendency, even in scholarly literature, to use broad terms such as *Asian American* when such a term encompasses significant heterogeneity. Despite these challenges, clinicians must attempt to understand the potential relevance of culture in serving Chinese American patients and their families; and to have an understanding of the philosophical and religious beliefs that inform patient and family identity and values.

China consists of five separate cultural and economic regions, all of which have never been one homogenous society (Jung, 1998). The five regions have their unique languages, values, traditions, history, politics, etiquette, and economics (Jung, 1988). Chinese values and beliefs have evolved from Chinese religion and philosophy; the "Chinese have had a polytheistic tradition based on local folklore, superstition, and magical practices and beliefs in which people pray to different gods for different purposes" (Jung, 1988, p. 35). The three major belief systems in Chinese culture that continue to influence Chinese people's views of mental health are Confucianism, Taoism, and Buddhism, all which allow room for each other to co-exist or have been adapted by followers in order for them to co-exist. The characteristics of a traditional family from China are "heavily influenced by Confucianism, with its emphasis on harmonious interpersonal relationships and interdependence" (Lee, 1997a, p. 55). When Taoist and Buddhist teachings spread to China, those ideas that were in harmony with Confucianism were easily assimilated into the existing Confucian social code whereas ideas that were in conflict with Confucianism were not (Yang, 1961). To illustrate how the three philosophies coexisted, religion provided a magical value of warding off evil, but contained no moral dogma on how to live one's social life; therefore, "a common man

could worship a Buddhist god for the general happiness of himself and his family, pray to a Taoist deity for the return of his health, and at the same time practice Confucian morality" (Yang, 1961, p. 283) in regard to his social relationships. Confucianism dominated China's social value system prior to the introduction of Taoism and Buddhism (Jung, 1998) and Confucianism was the social code that most influenced traditional Chinese family characteristics (Lee, 1997a). Confucianism, Taoism, and Buddhism continue to be dominant belief systems that influence Chinese family values, community structure, and practices.

The development of Taoism in China began as rebellion against the rigidity of Confucianism. While Confucian beliefs focused on conformity with social norms, Taoism sought individuality and conformity to "patterns of nature" (Jung, 1998, p. 38) known as the Tao, or the Way. The emphasis of the Tao was to find harmony in the natural state of things as opposed to trying to change things. Taoism emphasized "themes of passivity, individuality, discovery of peace and harmony in nature, asceticism, and the search for immortality" (Jung, 1998, p. 39). While the Confucian philosophy held people to rigid cultural norms, Taoism allowed individuals to maintain some level of freedom in Taoism's honor of individuality, creativity, and asceticism which can be seen in Chinese art and poetry. Buddhism became the dominant religion at the end of the eighth century in China when China was facing numerous difficulties as a result of warring tribes (Jung, 1998). Buddhism offered the spiritual uplifting that, at the time, Taoism did not provide; literature, art, and ceremonies that offered rich imagery to the people who had put up with poverty, bleakness, and crowded conditions in their everyday lives (Yang, 1961).

Buddhism's promise of salvation for all humanity through the absence of desire (Nirvana) offered hope in a time of much upheaval and disillusionment (Yang, 1961). Traditional Chinese family values are rooted in Confucian philosophy, which emphasizes specific roles within family and society, with filial piety as the foundation of morality (Ho, Rasheed, & Rasheed, 2004). In order to ensure a child will fulfill all of his or her roles in family and society, he or she has been inculcated with a high sense of obligation and loyalty from birth (Ho et al., 2004). Individuals considered ethical people were those who were "honest, frugal, industrious, and willing to contribute to the welfare of the family and society" (Jung, 1998, p. 37). Relationships were to be mutual, reciprocal, and based upon fairness, honor, and respect; these moral principles applied to everyone, regardless of class (Jung, 1988).

The traditional Chinese family was a patriarchal one with the eldest males, usually the father and eldest son, having the dominant roles and most influence (Lee, 1997a). Due to strong family bonds and the powerful role of obligation in Chinese families, many sons did not leave their parents' homes in their adult lives and parents were expected to be cared for by their children (Lee, 1997a). In families where the eldest son remained in the home and started his new family, the grandfather of the house held the most influence in the family. In fact, grandparents and sometimes other extended family members were considered part of the "immediate family" in contrast to the Western concept of the nuclear family. The eldest son carried on the family name and received special privileges while the eldest daughter assisted her mother with chores and caring for her younger siblings (Lee, 1997a). Along with special privileges, being the eldest son in the family meant that the highest expectations of success and to bring honor

and respect to the family were placed on his shoulders. High academic aspirations for children, especially for the eldest son in the family, is a tradition dating back to centuries ago (Lam, et al., 1995). Academic success is considered especially important for the eldest male child in the family as he is expected to inherit more of the family wealth and to become the head of the family. Traditionally, "the most elevated dyad was the father-son dyad" (Lee, 1997a, p. 56) although in contemporary Chinese American families, the value of the husband-wife dyad has increased.

Confucian ethics dictate behavioral mores that define relationships between individuals (the Way of Humanity), thus protecting the social order via conformity (Bedford & Hwang, 2003). Social Identity Theory identifies the ultimate goal of Confucian self-cultivation "is to socialize individuals to suppress personal identity in social interactions, and to eliminate personal desires by following the Way of Humanity proposed by the Law of Heaven" (Hwang, 1999, p. 172). The concept of filial piety is based on the fact that one's body and self exist because one is physically born from one's parents. The family is viewed as one body with individual members having distinct functions, the way different body parts function together in one body (Hwang, 1999). Empirical data gathered by Chinese psychologist D.Y.F. Ho indicate filial attitudes are moderately associated with traditional attitudes toward child-rearing such as harshness, over-control, over-protection, emphasis on proper behavior, and repression of self-expression and independence in a child (Ho, 1994). People who hold filial attitudes more often have a passive and uncreative attitude toward learning and are more likely to endorse fatalistic beliefs (Hwang, 1999). These tendencies have implications in

considering how those who endorse filial attitudes might perceive and experience family therapy interventions.

A study of Latino, Vietnamese, and Chinese families describes the shared value of placing the needs of the family system as a collective over individual needs (Berg & Jaya, 1993). Each family member subscribes to the convention of the family system, embraces the goals of the family system over individual desires, and supplants their own needs for the welfare of the family. Family collectivism can pose an interesting challenge to the individual who develops schizophrenia as he or she may not be capable of upholding his or her responsibility to the family. At the same time, this value creates a burden for the other family members as they have a responsibility to care for their ill family member. According to Berg and Jaya (1993), treating families who subscribe to collectivistic values requires preserving each family member's dignity while working to reframe the situation in the best interest of the family as a system.

People who subscribe to collectivist values are often most trusting of those in their inner circle, and wary of outsiders, which would include those individuals who provide mental health services (Lam et al., 1995). For those who have reached a point of desperation, reaching out for mental health services has often come after a lengthy tolerance of the patient's symptoms of schizophrenia, and the family members have frequently endured a long-term state of crisis (Lam et al., 1995).

Closely related to the characteristics of collectivism and obligation are the concepts of stigma and shame, both integral to Asian/Asian American cultures. Given the collectivist nature of the family, shame is used to reinforce children's behavior, familial expectations, and maintain the patriarchal hierarchy in the family (Ho et al., 2004; Sue,

1998). Improper behavior would cause one to "lose face" and risk the loss of support from one's family and community. In collectivist cultures where interdependence is integral, potential loss of family and society support are highly motivating factors for the individual to adhere to his or her expected roles (Sue, 1998). If family difficulties arise, such as the development of a mental illness, the experience would be a source of shame for all family members. Shame leads to the experience of stigma; others will look down on them for the sources of shame that have disgraced the family (Lee, 1997a; Sue, 1998). Indeed, the development of a mental disorder creates changes in the individual's ability to function, leading to the individual's sense that he/she has failed his/her family (Root, 1998). The development of schizophrenia is a threat to the individual's ability to become a full person in traditional Chinese society, essentially making the individual unable to fulfill his/her highest goal of propagating the family line and contributing to society (Holroyd, 2003). Symptoms that can result from schizophrenia, such as bizarre behavior, inability to work, inability to maintain one's position in the family hierarchy, having unique needs, and creating more work for other family members, directly violate the essential Confucian ethics that govern family life and social identity.

The stigma associated with mental illness not only threatens the individual's ability to contribute to family and society, it affects the entire family's viability. The public knowledge of a family member's mental illness places other family members' employability at risk (U.S. Department of Health and Human Services, 2001). In Asian American cultures, mental illness such as schizophrenia is seen as an inheritable illness (Gee & Ishii, 1997), therefore the fear exists that other family members either currently have or will develop the illness, or will pass down the illness to his or her children. The

symptoms of mental illness are individualistic and do not increase belonging to society (Gee & Ishii, 1997); it follows that other members of society would distance themselves from associating with or employing individuals who appear likely to bring stigma with them, risking further stigma by association.

The stigma that a family may fear regarding a mental illness, such as schizophrenia, may be exacerbated by the status of the family member who is symptomatic, specifically if among the children, the eldest male is symptomatic. Oftentimes, the onset of schizophrenia is at an age when teenagers are expected to do well in high school and perform well on examinations for college (Lam et al., 1995). The Chinese parent who immigrated to provide his or her children with better opportunities might feel particularly devastated for the family's future and may be particular sensitive to outside scrutiny by a clinician or the community. In such a case, Lam et al. (1995) suggests that therapists be sensitive to the loss for both parents and patients, provide time and space for grieving, and eventually put effort into setting family goals that help their child improve his or her functioning.

Traditional Chinese culture believes that "mental illness is caused by spiritual unrest, hereditary weakness, metaphysical forces such as fate or an imbalance between yin and yang, or weakness of character" (Jung, 1998, p. 45). Chinese culture does not view mental or family problems from a psychological standpoint (Jung, 1998). Interpersonal problems are not viewed as the result of unconscious defenses, coping mechanisms, or the consequences of negative childhood experiences; they are a result of character weakness that is inherited through each successive generation (Jung, 1998). Family conflicts are not seen as a struggle for independence but as the result of

"disrespectful and unethical conduct" (Jung, 1998, p. 45) on the parts of those involved. Marital discord is not explained by poor communication or inequality, rather it is a result of spouses not adhering to their set, culturally prescribed roles (Jung, 1998). The search for understanding and the expression of frustration occurs within the family; interventions for difficulties are sought through "prayer, gift offerings to the gods, or attempts to change the flow of energy" (Jung, 1998, p. 46). Essentially, Chinese beliefs as to the sources of mental illness do not correspond to Western definitions of mental illness and make Western interventions unlikely to address Chinese concerns.

Western treatment interventions threaten typical Asian/Asian American family values such as respect for elders, acceptance of the power distribution in the family, interdependence over independence, and family member roles (Root, 1998). The individual diagnosed with schizophrenia risks bringing further stigma by seeking help from outside the family, which parents may view as an indication to others that they do not know how to take care of their own children (Root, 1998). In a study by Yang, Phelan, and Link (2008), the level of stigma endorsed by family members was significantly linked to a longer delay in patients seeking treatment. Not only does stigma discourage help-seeking, it encourages "treatment noncompliance via denial and minimization" (Gee & Ishii, 1997, p. 227). Lin (1982) states that in Chinese families, once assistance external to the family is sought, thus bringing the family's problem into the public eye, the family becomes less tolerant of the family member with mental illness. This potential rejection puts the individual at risk for abandonment by his or her most powerful source of identity and support.

Saving face is a notion strongly linked to shame and stigma that also has implications for the treatment of Asian/Asian American families. Berg and Jaya (1993) state that Asian relationships are based on shame; therefore, emphasis in treatment must be placed on not embarrassing family members. This is a particularly important consideration when treating families with a member diagnosed with schizophrenia. Saving face has implications for the quality of the therapeutic relationship that is established between the family and the "outsider" clinician.

When taking into account Chinese values specifically, it has been observed that in treatment, there is a strong preference for negotiation over the Western view that values direct confrontation. Communication that could be perceived as aggressive denies the other person a chance to "save face" and subsequently, is avoided (Kirkbride, Tang, & Westwood, 1991). There is also the tendency of Westerners to label Chinese parent-child relationships as "enmeshed." Family interventions framed in a Western worldview often ask members to speak directly about conflicts, disclose personal information, and promote the patient's independence. Alternatively, Chinese negotiation values maintenance of the appropriate interpersonal roles and power distribution, and is non-confrontational (Kirkbride et al., 1991). Judging Chinese families based on Western individualistic behaviors and attitudes is likely to offend the aforementioned family's sensibilities.

As previously discussed, in a collectivist-oriented family, such as the Chinese American family, the notion of saving face, specific individual roles, and communication style all moderate how one is perceived in the community. Maintaining proper manners that are appropriate to one's role is one manner of preserving the social order.

Specifically for Chinese American families, the joining process with families may present the most challenging portion of treatment. Out of respect for the family system and its hierarchy, Lee (1997a) suggests that clinicians must first meet with the decision maker in the family. This may involve letters, home visits, and phone calls to engage crucial family members; if such members are not engaged, they might later object to or sabotage parts of the treatment (Lee, 1997a). The Chinese American family is likely to expect a level of professionalism and confidence from their doctor or clinician; members might also expect to be told how to "fix" (Lee, 1997a, p. 66) their problem. Less acculturated family members may be more accustomed to nonverbal communication over verbal communication; beginning with non-threatening questions or somatic issues may help put the family at ease (Lee, 1997a).

Values regarding the use of Western medication will have a great effect on treatment. Asian families tend believe that Western medicines are too strong, causing them to take lower doses without consulting their doctors (Lee, 1997a). There is evidence that Asian groups are more sensitive to neuroleptic medication and need less medication than Black or Caucasian groups in order for their symptoms to remit (Lee, 1997a). Some Asian Americans might believe in the magical power of both herbal and Western medications, although some might also be resistant to the idea of using Western medication (Juthani & Mishra, 2009). For Asian American patients, long-term medication compliance might present a challenge as many Asian Americans believe in the curative power of short-term treatment (Juthani & Mishra, 2009). Other Asian patients may be unwilling to commit to a medication regimen due to fear of bodily harm or addiction (Lee, 1997a). The stigma attached to addiction has been noted as delaying

treatment-seeking for Asian drug users (Nemoto et al., 1999). Although the use of pills is considered less stigmatizing than injecting narcotics (Nemoto et al., 1999), it is plausible that the stigma regarding any drug use might be relevant to patients who are legally prescribed medications for legitimate mental health problems. There may be a face-saving issue involved in having to remain on medication that is similar to the shame experienced by Asian drug users.

Acculturation among Asian Americans

Asian Americans comprise an extremely heterogeneous group with over 25 different ethnic groups and significant differences in immigration status, education, economic status, language, proficiency in English, generation, and length of residence in the United States (Rhee, 2009). It is, therefore, difficult to make generalizations about the values, experiences, practices, and mental health of Asian Americans or Chinese Americans as if either represents a homogenous group. The values of any Asian American patient and family are moderated by their levels of acculturation and enculturation. Acculturation refers to "the process of adapting the norms of the dominant culture" while enculturation refers to "the process of (re)socializing into and maintaining the norms of the indigenous culture" (Kim, 2007, p. 143). Acculturation and enculturation are moderated by a number of factors including family make-up, gender, educational status, religion, immigration history, immigration status, generation, and economic status. Current theory hypothesizes that Asian Americans who are closer in recency to immigration will maintain more traditional Asian cultural norms than their counterparts whose families may have immigrated one or several generations prior (Kim, 2007).

John Berry (2005) discusses a bilinear model of adaptation based on the individual's preference toward one's own group or the majority group. On one continuum, the individual's level of "contact and participation" (Kim, 2007, p. 142) is measured based on the person's preference for being involved with the majority culture's group or remains primarily in his/her group of origin (Berry, 2005; Kim, 2007). The second continuum represents "cultural maintenance" (Kim, 2007, p. 142) or the length to which cultural identity and the maintenance of cultural characteristics are valued (Berry, 2005; Kim, 2007). Berry further defines four acculturation strategies utilized by ethnocultural groups: (a) integration (individuals retain proficiency with their native culture and are also proficient with the dominant culture); (b) assimilation (individuals are proficient with the dominant culture and reject their native culture);(c) separation (individuals maintain and perpetuate their native culture and do not absorb the dominant group's culture); and (d) marginalization (individuals have no interest in maintaining or gaining proficiency in the native or dominant culture); (Kim, 2007). The bilinear model may well represent the acculturation process for recent Asian immigrants who were "fully socialized into their Asian cultural norms before arriving in the United States" (Kim, 2007, p. 142). In contrast, the model may be unrepresentative of the experiences of U.S. born Asian Americans, or Asian Americans who have resided in the U.S. for a number of generations and who were never completely enculturated into the cultural norms of their family of origin (Kim, 2007).

The behavioral dimensions of acculturation are witnessed in language usage and participation in cultural activities, whereas the value dimensions of acculturation include relational patterns, time orientation, and beliefs about human nature (Kim, Ahn, & Lam,

2009). Scholars theorize that individuals who are "biculturally competent" —those capable of meeting the demands of indigenous and dominant cultures (Kim, 2007, p. 143)—may exhibit better psychological health than their counterparts.

Subsequent to immigration, there are inevitable stressors and psychological sequelae. Within a single family, different family members will acculturate at different levels. The differential rates of acculturation and enculturation between parents and children (Acculturative Family Distancing [AFD]) lend themselves to the development of differing worldviews, which can lead to an increase in parent-child conflict and other negative psychological effects (Kim, Ahn, & Lam, 2009). Asian American parents tend to adhere to traditional Asian values more strongly than their children. Immigrant Asian American children arrive in the United States at a younger age than their parents and are exposed to more of the dominant culture's norms than their parents are via school, peers, and media (Kim, Ahn, & Lam, 2009). Such value differences will affect both parents' and children's attitudes and decisions.

A number of Asian Americans in the Unites States have limited proficiency in the English language (Carrasco & Weiss, 2005). For example, in 2000, there were over 4 million Asian American and Pacific Islanders (AAPIs) in the United States who had "Limited English Proficiency" (LEP), defined as individuals who do not speak English "very well" (Carrasco & Weiss, 2005, p. 8). Language preference and ability also affect AFD. As immigrant children may have more opportunity to become conversant in English, they may become language interpreters for their parents who may be much less able to understand the English language. This may present a challenge to the typical role of the Asian parent as authority, as the child with English proficiency wields the power to

communicate with the host culture. As AFD increases, communication difficulties and incongruent values continue to deepen, creating a values gap between parents and children, which may contribute to intergenerational family conflict and stress (Kim, Ahn, & Lam, 2009). Furthermore, due to different levels of acculturation, family members may have different conceptualizations of mental health and illness, treatment, coping attitudes, and treatment goals (Chun & Akutsu, 2009).

Another psychological outcome that can potentially occur in the process of immigration is the phenomenon of "acculturative stress," referring to stressors that arise out of the acculturation process, i.e., lowered social status, racism, and language barriers (Kim, 2007). Many Asian immigrants experience various combinations of difficulties upon immigration, which may include facing a language barrier, migratory grief, isolation, decline in social status, limited social support, unfamiliarity with Western practices, and inability to engage in common social activities (Rhee, 2009). Acculturative stress heightens emotional stress and a sense of hopelessness and also may cause identity confusion, increased psychosomatic symptoms, anxiety, depression, and feelings of alienation (Kim, 2007). Because AFD and acculturative stress both put strain on the family system, they are important concepts to include when considering the Asian American patient and family.

Considering the potential varying levels of acculturation within one family, a clinician approaching the family that is seeking treatment needs to invest time in building rapport with the family, reaching out to extended family members, and engaging the "decision maker" in the family regarding treatment (Lee, 1997a). Since acculturation level affects communication style, the importance of varying acculturation levels within

one family become salient upon first contact with the family or individual family member. With Chinese American families, having a level of "interpersonal grace" (Lee, 1997a, p. 66) and formality, especially at the start of the relationship, are essential for creating a positive working relationship. Acculturation level will contribute to how comfortable a family member is with varying levels of eye contact. For the more traditional family member, staring or receiving another's consistent gaze is considered inappropriate and rude; "gentle" (Lee, 1997b, p. 488) eye contact that frequently shifts away from the speaker is preferred. Asian American families tend to be sensitive to believing others might be judging them (Lee, 1997a). Avoiding direct confrontation and using non-blaming language are two ways that may enhance communication with less acculturated family members.

Acculturation level is not only important to consider during rapport-building, it is a vital consideration during the assessment process (Kinoshita & Hsu, 2007) and beyond. Early assessment of the Asian American patient and family's acculturation provides a framework that guides the clinician's thought process (Kinoshita & Hsu, 2007). Specific instruments have been developed to measure acculturation for Asians and specific Asian populations (Kinoshita & Hsu, 2007), allowing clinicians to gather a breadth of information rather quickly. Measures assessing ethnic identity, cultural values, enculturation, and loss of face may also be useful as such constructs are often related to the patient's acculturation level.

Chinese Cultural Attitudes and Beliefs about Schizophrenia and Mental Health Issues

In many Asian cultures, the body and mind are seen as united (Kung, 2001) and traditional Asian medicine believes that different types of distress are connected to specific corresponding systems or body organs (Root, 1998). Specifically in Chinese medicine, mental problems relate to specific organs in the body depending on the symptoms or behaviors the patient describes (Root, 1998). For example, a "hasty organ" (Root, 1998, p. 68) is one that has lost homeostasis and causes irritable or explosive behavior. Given the conceptualization of the body and health as a somatopsyche system, it seems natural that a disorder such as schizophrenia is perceived as having its roots in a somatic disturbance. In fact, somatic and biological explanations for psychiatric illnesses are acceptable to a number of Chinese Americans (Kung, 2001). In addition to somatic explanations for psychiatric difficulties, social and moral explanations are often used to explain psychiatric or behavioral difficulties in Asian and Asian American cultures (Ho et al., 2004). In light of the values of collectivism and filial piety that govern social and familial interactions, disturbance in the appropriate balance of relationships, imbalance or conflict in these relationships causes considerable distress. Interpersonal harmony is a key characteristic of maintaining one's mental health; therefore, being unable to fulfill family obligation, experiencing conflict with one's family relationships, or feeling disgraced in public inculcates a great degree of shame and guilt (Hsiao, Klimidis, Minas, & Tan, 2006), which may be viewed as the cause of schizophrenia (Yang & Pearson, 2002).

In addition to the somatic and relational explanations of mental illness in Asian/Asian American cultures, there exists a Chinese etiological belief that mental illness is the result of the misdeeds of one's ancestors, failure to bring honor to one's ancestors, present disregard of one's family, or literally bad blood or bad genes (Yang & Pearson, 2002; Jung, 1998). The fear of genetic transmission of a mental disorder shames the entire family by lowering the family's status and puts blood relatives at risk of rejection by potential suitors (Gee & Ishii, 1997). Western mental health professionals emphasize genetic heritage in the development of schizophrenia, which to a Westernized family, might ease the family's guilt about the manifestation of the disorder; however, one must consider that having "bad genes" is seen as a disgrace in Chinese families and reinforces the family's sense of guilt (Kung, 2001).

Asian American Help-Seeking Behaviors and Attitudes

The differing worldviews of Western and Asian American groups yield differences in concepts of illness, health, and spirituality (Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004). The individual and family's conceptualizations will determine their help-seeking attitudes and practices. As discussed above, the Asian American individual and family conceptualizations and values are moderated by acculturation, enculturation, and those factors that modify both. Research on coping within Asian and Asian American groups indicates that such individuals show a strong preference for using indigenous healers and alternative treatments (Inman & Yeh, 2007). They may prefer to seek out indigenous or personal sources of healing before considering Western mental health treatment (Yeh et al., 2004). A clinician's suggestions regarding sources of support must be sensitive to and congruent with the family's values. An inadequate assessment of

the family's acculturation and enculturation status may result in offensive assumptions about what might be best for the family, indicating a lack of cultural understanding by the clinician (Kokanovic, Peterson, & Klimidis, 2006).

Underutilization of mental health services by Asian Americans, despite apparent need, may be explained by incongruence in concepts of mental health between Western practitioners and Asian American groups (Yeh et al., 2004). Research based on Asian American college students indicates that patient-therapist match on the belief of problem etiology is closely related to the client's seeing positive results from the counseling session (Kim, Ng, & Ahn, 2009). Moreover, patient-therapist ethnic match has also shown to be predictive of continuation of treatment and number of sessions attended for Asian American adolescents while language match between patient and therapist has been shown to predict number of sessions attended for Asian-American adults (Yeh, Eastman, & Cheung, 1994).

The tendency for Asian Americans to seek informal or alternative sources of healing may be explained by the interdependent and collectivistic perspectives that are frequently held by these groups. Based on the views of interdependence and harmony, illness is seen as a disruption in the balance of the individual and his or her group, or of imbalance between the self's internal and external forces (Yeh et al., 2004). The psychological unit that experiences difficulties is the group rather than the individual, and the source of disharmony may be a group member or members acting in an autonomous manner (Yeh et al., 2004). For this psychological unit, healing would likely involve striving for group harmony, family cohesion, and family privacy (Inman & Yeh, 2007). A Western medical and individualistic approach to healing is thus poorly matched to the

Asian American patient and family's conceptualization of problem etiology and treatment, and is, therefore, inadequate to meet their needs. Integration of indigenous healing perspectives into Western mental health treatment may be one means to more adequately address the diverse mental health needs of Asian American individuals and families (Yeh et al., 2004).

Inman and Yeh (2007) discuss three salient facets of indigenous healing. Such approaches emphasize an interdependent perspective and preference in treating the individual's concerns in the context of community and family network. The spiritual traditions of the community are incorporated into the healing process and the help of a shaman is often enlisted. Shamans are indigenous healers known in their community for their wisdom and healing abilities (Yeh et al., 2004). An individual or a family who embraces a more interdependent perspective on healing might consult an herbalist, an acupuncturist, and a QiGong healer, all of whom are concerned with the balance of yin and yang and energy flow through the body (Yeh et al., 2004).

Reliance on family support during distress or for difficulties is reinforced among many Asian American groups, especially those with strong family ties (Inman & Yeh, 2007). Other forms of coping for such individuals may include relying on friends or other social peer networks; however, Inman and Yeh (2007) suggest that fear of shaming the family and emphasis on group harmony may discourage social support-seeking. Asian Americans may also rely on religious and spiritual coping, such as prayer, attending church, or confiding in their religious leaders (Inman & Yeh, 2007). Religious coping among Asian Americans may reflect strong ties to a community and to religious and spiritual beliefs (Inman & Yeh, 2007).

Asian/Asian American Families and Psychosocial Family Treatment Interventions

Studies with Asian/Asian American families and family treatment interventions are sparse, and existing studies have not focused on identical interventions, populations or group participants. Existing studies indicate that treatment with Asian families has revealed an increase in patient and family treatment compliance, decrease in patient symptoms, lower rates of re-hospitalization, shorter duration of re-hospitalization, reduction of maltreatment by family members, improvement in families' problem-solving and communication skills, and improvement in family members' perceptions of the patient with mental illness and knowledge of mental illness (Chien et al., 2004; Li & Arthur, 2005; Xiang, Ran, & Li, 1994; Xiong et al., 1994).

Results from Xiang et al. (1994) revealed a significant improvement in patients' treatment compliance after the psychoeducational component of treatment was administered, which also resulted in patients' families willingly visiting the doctor, cooperating with treatment, and monitoring of patients' symptoms. Researchers also noted a decrease in patient maltreatment. It can be anticipated that such a reduction would also decrease the amount of stress experienced among family members, thereby having positive effects on the patient's symptom manifestation and family members' interactions with the patient. Moreover, a decrease in symptom manifestation leads to fewer hospitalizations. Hence, emphasizing the educative value of psychoeducation, rather than emphasizing its therapeutic nature, may appeal more to the Chinese American family's sensibilities (Lau, Fung, Ho, Liu, & Gudino, 2011).

Chien et al. (2006) explored the benefits of a mutual support group for Chinese family caregivers and patients with schizophrenia in Hong Kong. Results indicated a

positive change in caregivers' perception of mental illness and adoption of new coping skills, such as better communication skills and an increased ability to sympathize with the patient. Group members found that empowerment occurred from learning from other group members' knowledge and experiences. It was noted that the ability to develop trust in the group was a vital component of deriving benefit from the group. Group members indicated that they had developed friendships outside of the group setting and that this characteristic provided ongoing benefit. Some members reported feeling that intense emotions were not tolerated by other group members. This observation seems congruent with the Confucian values of self-restraint, conformity, and the avoidance of aggressive communication.

A common challenge to family treatment is treatment compliance in regard to patients' adhering to a medication regimen, family members' attendance at groups or psychoeducation, and patient and/or family attendance at follow-up appointments. The lack of culturally appropriate or competent services or providers is often cited as the reason for treatment noncompliance (Yeh et al., 2004). These challenges are affected by family members' lack of confidence in treatment, limited knowledge of mental illness treatment, and the perceived stigma of mental illness (Xiang et al., 1994). The aforementioned challenges to effective family interventions are further impacted by a lack of culturally congruent treatment characteristics with Chinese American family values. Cultural competence is a professional standard of care of mental health clinicians and refers to having the cultural knowledge and skills to provide effective treatment to individuals of a particular culture (American Psychological Association, 2002; Tewari, 2009). Based on the work of multicultural researchers and clinicians in psychology,

Tewari (2009) summarizes that Asian Americans would be best served by psychologists who are familiar with the client's culture, have similar patient/therapist values and worldviews, and are similar in race or ethnicity to the client, although this last element remains controversial (Tewari, 2009). Moreover, D.W. Sue (2001) describes the essential elements of cultural competence as (a) understanding one's own culture and how it shapes one's values, beliefs, and attitudes; (b) knowledge of worldviews across cultural groups; and (c) the use of culturally appropriate techniques and communication styles. Despite the existence of guidelines and efforts of the profession to practice with multicultural competence, applying guidelines and theory to practice remains a challenge for clinicians.

Research Objectives and Purpose

Although researchers of psychosocial family interventions with individuals diagnosed with schizophrenia note the importance of considering the cultural context of the family in planning treatment, it is obvious that little effort has been made to propose culturally congruent recommendations for family treatment. Using the data quality concept of "transferability" (the researcher supplies enough detail for the reader to determine if the findings are appropriate or applicable in a different context), this dissertation attempts to address this need (Mertens, 2010).

Furthermore, there is limited research on the use of family treatment with Asian American families, and much of this work has not taken into account the unique issues that arise when a member of the family is diagnosed with schizophrenia. This dissertation offers recommendations for conducting family therapy with Chinese American families

when a family member has been diagnosed with schizophrenia. More specifically, this dissertation addresses the following:

1. Makes a case for the importance of taking into account the cultural values, beliefs, and practices in the treatment of psychiatric disorders such as schizophrenia.
2. Makes a case for providing ethnic specific treatment rather than the current universal or pan-ethnic approach to treatment.
3. Makes a case for the cultural relevance of engaging in family treatment over individual treatment in addressing psychiatric disorders such as schizophrenia of family members.

Chapter II. Review and Analysis Plan

This dissertation offers a comprehensive and critical review of existing literature on the Asian/Asian American families' experiences with family treatment, their understanding of schizophrenia, and specific Chinese/Chinese American beliefs, values, and attitudes with regard to general and specific mental health issues. The primary goal of this effort is to propose clinically relevant treatment recommendations for clinicians involved in the family treatment of schizophrenia with Chinese American families.

Defining the Search

The general topic areas that were researched include family treatment of schizophrenia, family treatment with Asian/Asian American groups, Asian/Asian American attitudes toward and experience with mental illness and mental health treatment, traditional and alternative treatment for schizophrenia, and specific Chinese/Chinese American values that potentially affect how mental illness and family treatment may be perceived. Within the discussion of specific values, indigenous concepts of healing, concepts of acculturation, enculturation, and moderators of acculturation (e.g., gender, religion, generational status), and Asian American help-seeking behaviors are discussed. Although the focus of the study is aimed at recommendations for Chinese American families, the review of literature has been cast wider to include Asian and Asian American families due to the relative dearth of literature available specifically discussing Chinese American families in treatment. In itself, this fact speaks to the difficulties of treating Chinese American families when the field of knowledge has much to still uncover.

Search Strategy

Words and phrases used to conduct the search included "family therapy/treatment/interventions/work and schizophrenia," "Chinese and schizophrenia/mental illness," "Chinese/Asian and traditional/values," "indigenous healing," "acculturation and Chinese/Asian," and "Chinese/Asian/minorities and family therapy/work/treatment/interventions." Articles published in the Unites States, the United Kingdom, Australia, mainland China, and Taiwan were included.

Data Sources

The review of literature relied on publications found in PsycINFO electronic database, PsycArticles, ProQuest databases, and RefWorks. Books on schizophrenia/mental illness and family treatment were included as seminal pieces that have laid theoretical foundations for the current treatment of schizophrenia in Western society. Books discussing Asian, Asian American, Chinese, and Chinese American populations and therapy with minority populations were also included in the review of literature. Manual searches through relevant article or chapter reference lists were also used to identify relevant literature. Online mental health resources for mental health providers and consumers were included. Legitimacy of online resources was determined by: (a) authority, i.e., the owner/operator of the website; (b) legitimacy/relevance of the material; (c) objectivity and accuracy; and (d) currency of information.

Restrictions to Scope

Date of publication. The search was not confined to a particular time span due to the sparse availability of research documented with Asian/Asian American families and family treatment, and due to the existence of literature on cultural values that pre-dates

literature specifically related to family treatment. Research regarding family therapy, psychosocial treatments, and schizophrenia were limited to the last 10 years, with the exception of seminal or foundational pieces of work.

Type and quality of publications. In order to evaluate the extent of existing literature, empirical studies, theoretical papers, and literature reviews published in peer-reviewed academic journals were considered; quantitative, qualitative, and meta-analytic studies were included despite variance in sample size, sample composition (i.e., U.S. or Asia, pan-Asian or Chinese specific), design/approach, and methodology.

Data Management Strategy

Following a general discussion of schizophrenia and prevalence rates, the review of literature begins with a brief history of the treatment of schizophrenia under the heading, *The History of Treatment for Schizophrenia.* The first major heading, *The Current State of Psychosocial Family Treatment for Schizophrenia*, discusses the current state of family therapy for schizophrenia, including modalities, the effects of treatment, and current challenges. The second section, *Asian Cultural Values that Affect Family Treatment*, discusses cultural values and beliefs prominent in various Asian cultures, how mental health treatment is viewed, what values might affect the choice to seek or avoid treatment, and the challenges to treatment that clinicians might face. The third major heading, *Acculturation among Asian Americans,* discusses how the constructs of acculturation and enculturation moderate the specific Asian cultural values that one may believe and/or practice. The fourth section provides an overview of Chinese cultural attitudes with regard to mental health issues under the major heading, *Chinese Cultural Attitudes and Beliefs about Schizophrenia and Mental Health Issues*. The fifth section

describes the importance of indigenous and alternative healing among Asian American groups under the major heading, *Asian American Help-Seeking Behaviors and Attitudes*. And the final section, *Asian/Asian American Families and Psychosocial Family Treatment Intervention*, reviews the existing, albeit limited, body of literature on the use of family treatment with Asian/Asian American families.

Data Analysis Strategy

Relevant clinical recommendations for Chinese American families were identified by triangulating what the literature indicates with the clinical and personal experiences of the researcher. From these data sources, the researcher focused on the intersection of cultural themes for understanding schizophrenia and its treatment. More specifically, the following steps were followed:

1. Evidence that triangulated across two or more literature sources was identified as relevant themes.
2. The themes from the literature were compared and contrasted with the clinical and personal experiences of the researcher, although themes were not eliminated if triangulation did not occur with the experiences of the researcher. But if researcher-specific themes emerged, they were noted.
3. Finally, the comments of the reviewers were compared and contrasted with the themes from the literature and researcher's experiences to add credibility to the proposed clinical recommendations.

Evaluation of Proposed Clinical Recommendations

Upon proposing clinical recommendations for the treatment of Chinese American families in which a family member has been afflicted with schizophrenia, five clinicians

with expertise in the treatment of Chinese American families and schizophrenia evaluated the researcher's proposed recommendations. The following questions were posed via a questionnaire to the reviewing clinicians:

1. Indicate your profession and years of practice, number of Chinese American families you have treated, and how many of these families had a family member with schizophrenia.
2. Does the literature considered in proposing the recommendations adequately capture the needs of Chinese American families living with schizophrenia?
3. Are there key pieces of literature that you believe have been overlooked in proposing the recommendations?
4. Given your professional experience with this population, do you believe the proposed recommendations are culturally relevant to working clinically with Chinese American families with schizophrenia?
5. Which of the recommendations, if any, require further elaboration? Has anything been overlooked, and if so, why do you believe it is important to add the recommendation(s)?
6. Should any of the proposed recommendations be eliminated, and if so, why?
7. Please provide any further comments and/or suggestions.

Clinicians for Peer Debriefing

Selection criteria. Five clinicians out of 43 with clinical experience working with Chinese American families accepted the invitation to participate in the evaluation of the clinical recommendations proposed by the researcher (a minimum of five clinicians were sought to serve as reviewers). Among the clinicians who volunteered to

serve as peer reviewers, one was a marriage and family therapist intern, one was a marriage and family therapist and three were psychologists. All five reviewers had conducted therapy in a Chinese language and self-rated themselves as fairly knowledgeable to knowledgeable on familiarity with traditional Chinese values and minimally knowledgeable to knowledgeable on assessment and treatment for schizophrenia. See Appendix B for reviewer comments.

Recruitment procedure. Upon obtaining approval from the Pepperdine University Graduate and Professional Schools Institutional Review Board, an email invitation was forwarded to a pool of clinicians who were identified from the following sources: (a) clinicians who advertised bilingual Chinese and English mental health services in the Los Angeles and North Bay areas of California; (b) GSEP Psychology Division faculty members and the researcher's dissertation committee members who can identify agencies and individuals in the greater Los Angeles area and surrounding counties that serve the Chinese community; (c) an online search of agencies in the Los Angeles area that serve the Chinese community from which service providers can be identified; and (d) the researcher's current and former colleagues who qualify as appropriate peer reviewers or who can identify agencies and individuals who serve the Chinese community. The email included the following: (a) information about the researcher and her faculty advisor; (b) the purpose of the invitation, the approximate time commitment required, and a brief explanation of what the clinicians would be asked to do; (c) the questions to elicit the opinion of clinicians regarding the researcher's proposed clinical recommendations (see Appendix C); and (d) a copy of the document entitled, "Psychosocial Interventions for Schizophrenia with Chinese Americans" that

presented the researcher's recommendations (see Chapter III for a final draft of the recommendations after addressing the reviewers' comments).

Chapter III. Results

Clinical Recommendations: Family Treatment for Schizophrenia with Chinese Americans

In the field of psychology, research and theories have traditionally assumed the universality of mental health issues and treatment approaches. The clinical guide for Western health professionals in assigning clinical psychiatric diagnoses, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), utilizes Western populations as its frame of reference (Lewis-Fernandez & Kleinman, 1994). Despite revisions to the *DSM*, much of the diagnostic criteria are specific to Euro-American culture, which poses the potential for misunderstanding and misdiagnosis of non-Euro-Americans (Dana, 2001). Furthermore, the assumption that treatment that works for the dominant culture will be helpful and appropriate to minority groups denies the significance of sociocultural factors on the conceptualization, manifestation, and treatment of mental disorders. In more recent years, the field of psychology has pushed for the recognition of how multicultural issues mediate mental health. In fact, in 2002, the American Psychological Association (APA) published its *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* to emphasize the importance of working from a cultural frame.

In proposing these clinical recommendations, there exists the assumption that the clinician reading these recommendations is learning to work from the client's cultural frame. Cultural competence is a professional standard of care and a necessary aspiration for mental health clinicians to practice ethically and effectively (Kinoshita & Hsu, 2007); it refers to having the cultural knowledge and skills to provide effective treatment to

individuals of a particular culture (APA, 2002; Tewari, 2009). Based on the work of multicultural researchers and clinicians in psychology, Tewari (2009) summarizes that Asian Americans would be best served by psychologists who are familiar with the patient's culture, have similar patient/therapist values and worldviews, and are similar in race or ethnicity to the patient, although this last element remains controversial (Tewari, 2009). Moreover, D.W. Sue (2001) describes the essential elements of cultural competence as (a) understanding one's own culture and how it shapes one's values, beliefs, and attitudes; (b) knowledge of worldviews across cultural groups; and (c) the use of culturally appropriate techniques and communication styles.

Mental health clinicians are responsible for assisting individuals, families, and communities in alleviating suffering related to mental disorders, although some groups remain underserved by the field. Among the underserved is the growing population of Asian Americans in the U.S. (Carrasco & Weiss, 2005), for which mental health clinicians must be prepared to competently serve (Rhee, 2009; Yang & WonPat-Borja, 2007). The underutilization of mental health resources among Asian Americans is not due to a lack of need. In fact, research suggesting that the prevalence of *DSM* psychiatric disorders is higher in the U.S. than among Asian countries (Yang & WonPat-Borja, 2007) intimates that stressors related to life in the U.S., in general, as well as the immigration and acculturation experiences of newer citizens may have profound effects on the mental well-being of Asian Americans. Hence, clinical recommendations to clinicians who serve the mental health needs of Asian Americans, with a particular emphasis on Chinese Americans, are offered.

Why Family Treatment?

In Asian cultures, family is crucial to the individual's social structure (Hsiao et al., 2006), and managing illness is a family obligation (Bradley et al., 2006). For Chinese Americans who highly value collectivism, being cut off from the family unit or posing a threat to the collective are highly distressing (Berg & Jaya, 1993; Hsiao et al., 2006). Schizophrenia is a force that presents such threats to the family. Families are likely to be involved in the patient's treatment based on the family's moral beliefs and sense of duty, and the family unit will most likely live with and care for the individual. Therefore, treatment with Chinese American families, particularly families with lower acculturation, would be most effective through family interventions. Moreover, psychosocial family treatment (along with medication management) is the standard of care for treatment of schizophrenia and has shown to effectively prevent relapse better than other therapy modalities (McFarlane et al., 2003). Family-based stress management, including but not limited to techniques such as family psychoeducation, problem-solving training, social skills training, and crisis management, is considered a highly effective component of treatment for individuals with schizophrenia (Falloon et al., 1999). Moreover, family involvement is critical to the care of individuals with schizophrenia across cultures (Bradley et al., 2006; Kung, 2001; Li & Arthur, 2005; Xiang et al., 1994).

Multi-family group therapy (MFGT) has gained in popularity as the optimal treatment for schizophrenia (McFarlane, 2002); however, the use of this intervention with Chinese American families may be contraindicated. The shame associated with a mental disorder (Gee & Ishii, 1997; Lam et al., 1995; Lin, 1982) and "losing face" for seeking professional support (Yang et al., 2008) and appearing incapable of caring for one's own

family members (Kung, 2001; Lam et al., 1995) may prevent a Chinese American family from feeling comfortable addressing clinical issues in the presence of other families. Hence, individual family treatment may be preferred to a group modality since it affords the family space for expressing emotional vulnerability and acknowledging family conflict (Kung, 2001). Working individually with the family may also provide the clinician with more latitude on structuring the sessions to the particular needs of the family (Lam et al., 1995; Root, 1998).

Many aspects of typical family treatments are incongruent with Chinese American values, rendering these interventions useless should the family decide to decline treatment, or rendering these treatments minimally effective by not addressing the family's true concerns and insulting the family's beliefs and practices. Culturally congruent treatment refers to assessment, communication, intervention, and implementation that take into account the family's culture, background, and values. Researchers in the field of family treatment for schizophrenia have found mixed results regarding efficacy with minority populations and they believe that treatment must be congruent with the minority family's cultural values and needs (Glynn, 2003; McFarlane et al., 2003; Montero et al., 2005). This chapter sequentially addresses the rapport-building, assessment, and intervention components of family therapy. Within each component, culturally congruent recommendations are presented for treatment with Chinese American families in which a family member is diagnosed with schizophrenia. To provide illustrations of the recommendations, a fictional case is presented and the application of the recommendations discussed.

Working with Chinese American Families

The discussion that follows is divided into the two major sections. The first section focuses on the proposed clinical recommendations that emerged from a review of the literature. The second major section applies the recommendations to a fictional case, the Chen family.

Clinical recommendations. Through a review of the literature, recommendations are offered for working clinically with Chinese American families for the following components of the therapeutic process: (a) rapport building, (b) assessment, and (c) intervention. Following this discussion, the delimitations of the recommendations are detailed.

Rapport-building. The first contact the family makes with the helping professional can set the tone for the family's expectations of how they will be treated and what to expect from treatment. There is a chance that the family has been referred by hospital staff after the identified patient has had his/her first psychotic break or that the patient's family members have tried other forms of healing that have not produced the desired results. It is highly likely the family is under a great deal of stress and heightened frustration. Research suggests that Chinese Americans tend to delay seeking treatment longer than Whites, African Americans, and Hispanic Americans and exhibit more "severe disturbances" when compared to non-Asians (Carrasco & Weiss, 2005); hence, one can hypothesize that the Chinese American family has endured a number of challenges related to the illness and may have already exhausted other avenues of treatment.

In building rapport, it may be useful for clinicians to implement a technique borrowed from the psychoeducational multifamily group treatment model. The first objective is to "join" with the family–"Joining means to connect, build rapport, convey empathy, and establish a collegial alliance" (McFarlane, 2002, p. 104). The technique of joining with Chinese American families, especially those with high adherence to Chinese cultural values, is based on research that suggests that: (a) such families may be highly sensitive to stigma (Yang et al., 2008) and may perceive Western practitioners as outsiders; and (b) more time may be needed as negotiation with such families requires careful attention to interpersonal equilibrium rather than being confrontational (Kirkbride et al., 1991). During the joining process, the clinician is simultaneously building rapport and assessing many of the family's characteristics described in the following section. Most families seek treatment subsequent to a crisis, hospitalization, or exacerbation of psychiatric symptoms, so the patient with schizophrenia is in the early stages of re-stabilization. McFarlane (2002) suggests meeting first with family members as family discussions at this stage might be too stimulating for the patient. They encourage separate meetings with patient and family promptly after the crisis to convey the message that the clinician is an advocate for all family members. Such a practice would be beneficial as it can be used to support the varying levels of adherence to collectivism found in various families.

The family member who first initiates contact with the clinician likely has a powerful role in the family, as this individual may be the family's liaison whose function it is to bridge communication between the family and the dominant culture. This individual may be the adult in the family with the highest level of English proficiency.

Establishing rapport with this family member will require the clinician to be simultaneously assessing this family member's role and relationship to the identified patient, in addition to other important family dynamics. If this individual is not the head of the household, it will be important to establish contact and build rapport with the individual who is considered the head of the household. Lee (1997a) states that it is important for the first appointment to be made with the family "decision maker" and not to use English-speaking children to convey messages to other family members.

The clinician will need to build rapport with all relevant family members, perhaps those residing with the patient or those who have daily contact with the patient. It will be important for the clinician to address concerns of the family in accordance with the family hierarchy in order to both build rapport and earn the family's respect (Berg & Jaya, 1993). This might require meeting separately with different family members at the outset to "join" with the family and appropriately assess their needs before the initial meeting with the family, with or without the patient (Berg & Jaya, 1993). Separate meetings might allow family members with various allegiances to cultural values to express their concerns more openly without the threat of offending other family members. Ultimately, the clinician would want to meet with the family as a group, both with and without the patient, to assess the family's intrafamilial dynamics. In such a family meeting, negotiation and mediation are the preferable styles of communication rather than using direct confrontation (Berg & Jaya, 1993). Traditionally, the father is the head of household, with the wife showing deference to the husband, and younger children showing deference to older siblings (Jung, 1998). The position of the identified patient in the family hierarchy will be an important consideration in the assessment of the family.

With Chinese American families, particularly families with a more traditional orientation, Lee (1997a) recommends in the first session (if not the several following), the clinician should use a polite and formal manner in addressing the family. The clinician should:

> [P]ay attention to "interpersonal grace" and show warm expressions of acceptance, both verbally and nonverbally. Greeting the family with a smile, hanging up [elder family members'] coat[s], offering a cup of tea, and providing comfortable chairs to older family members are pragmatic ways to convey genuine concern. (Lee, 1997a, p. 66)

The use of a title with the last name over the use of a first name further demonstrates respect of the hierarchical order of the family.

Eye contact is another cultural element that merits consideration. An intense gaze is not recommended (Lee, 1997b) as it may be construed as disrespect toward the views of family members; hence, occasional eye contact with averting one's gaze regularly would likely be more comfortable for the family and facilitate joining the family. Chinese American family members might be particularly sensitive to feeling blamed (Lee, 1997a) and feel a loss of face as a result. Phrasing observations in the third person rather than second person and the use of passive rather than active voice may prevent family members from feeling blamed about issues their family faces. For example, "when you were hospitalized" as opposed to "when you made a suicidal threat."

Assessment. In assessing the clinical needs of Chinese American families, some unique cultural elements merit consideration. These elements include: (a) acculturation and related constructs that influence values, beliefs, and behaviors; (b) the roles of family

members; (c) language proficiency; (d) attitudes and beliefs about psychopathology; and (e) goal setting.

Acculturation and related constructs. Consideration of acculturation is integral to the assessment of an Asian American client (Kinoshita & Hsu, 2007). For Chinese American families in which members may be at various stages of the cultural adaptation process, assessing for acculturation may be an important source of data. Acculturation measures are available, and the administration of such instruments could yield information valuable for the case formulation and planning of treatment strategies. Table 1 provides a list of common measures of acculturation, cultural values, enculturation, and ethnic identity. One's acculturation level is often intertwined with one's cultural values, level of enculturation, and ethnic identity; therefore, these constructs are included along with acculturation in considering the use of assessment instruments. Not only might these measures be helpful in making decisions regarding treatment planning for the family, but they may also be relevant to determining the degree of importance of ethnic match between therapist and client. Some of these measures are designed for Asian Americans while others were developed for specific Asian populations.

Table 1

Assessment Instruments for Acculturation and Related Constructs

Instrument	Construct	Reference
Asian American Multidimensional Acculturation Scale	Acculturation	Chung, Kim, and Abreu (2004)

(continued)

Instrument	Construct	Reference
Asian American Values Scale-Multidimensional	Acculturation	Kim, Li, and Ng (2005)
Suinn-Lew Asian Self-Identity Acculturation Scale	Acculturation	Suinn, Rickard-Figueroa, Lew, and Vigil (1987)
Taiwan Aboriginal Acculturation Scale	Acculturation	Cheng and Hsu (1995)
The Acculturation Scale for Southeast Asians	Acculturation	Anderson, Moeschberger, Chen, and Kunn (1993)
The Hawaiian Acculturation Scale	Acculturation	Rezentes (1993)
The Asian Values Scale-Revised	Cultural Values	Kim and Hong (2004)
Loss of Face	Enculturation	Zane and Yeh (2002)
Multigroup Ethnic Identity Measure	Ethnic Identity	Phinney (1992)

The use of acculturation scales may assist the clinician in gathering a breadth of acculturation information in a short amount of time. At a quick glance, large discrepancies in ratings from different family members may indicate which family relationships may undergo the greatest amount of conflict due to an acculturation gap; similar ratings among certain family members may suggest which family members align with each other. When the acculturation of a client is assessed early on, it may guide the clinician's approach and thinking process (Kinoshita & Hsu, 2007).

Family roles. The assessment of family members' roles within the family system holds important cultural meaning. The family's choice to enlist outside help from a psychologist or other clinician introduces a foreign influence on the family, and this

influence might be perceived as a threat to each family member's culturally prescribed role. For example, the offer to have someone outside the family help with cleaning and cooking might be perceived by the family members who own those roles as an insinuation that they are doing a poor job rather than an offer of support. It is, therefore, of sound clinical and ethical judgment to conduct a thorough needs assessment before engaging in treatment or offering any type of support (Kokanovic et al., 2006). Specific family roles and family hierarchy are not only relevant to Chinese American families; they are relevant in Western family treatment for schizophrenia. A clear family hierarchy, family roles, and family rules are needed so that each family member's caretaking functions can be carried out (McFarlane, 2002). A clear family structure works to reduce tension and increase routine and predictability within the family, all of which function to alleviate the cycle of stress so often seen in such families (McFarlane, 2002). The assessment of family members' roles will assist in determining areas of reinforcement, modification, and growth for each family member in his/her role in achieving the family's goals.

Language proficiency. Research indicates that many Asian Americans in the United States have limited proficiency with the English language (Carrasco & Weiss, 2005; Shin & Bruno, 2003). Different family members are likely to have differing levels of fluency, with older generations having less fluency in English, and younger generations having various linguistic ability, to include bilingual, English-speaking with limited proficiency in the older generation/parents' native language, limited English-speaking with fluency in their native language, or monolingual English.

Given the various language abilities that can be seen in any family, the availability of bilingual clinicians is ideal. In a study of linguistic minority communities, including Chinese communities in Perth, Australia, by Kokanovic et al. (2006), caregivers of people diagnosed with mental illness were provided with the option of being interviewed in their native language or in English. A large number of the participants relied on both languages to communicate, but reverted to their native language when discussing emotionally charged content. Past difficulties communicating with service providers, such as general practitioners, even with the presence of an interpreter, contributed to underutilization of services and doubt regarding the usefulness of such services. The lack of bilingual clinicians is one of the multiple reasons that Chinese Americans underutilize mental health services. Research has reported that when non-English speaking Asian American clients are seen by therapists who speak their language, the clients remain in therapy for a greater number of sessions (Yeh et al., 1994).

Within immigrant families, children have a tendency to become the "language-broker" between non-English speaking parents and grandparents and the structures of the dominant culture, whether they are communicating with school teachers, store clerks, or health care providers. This role gives the English-speaking child a position of power. In situations in which the family's primary language-broker is the identified patient or his or her younger sibling, issues of appropriate translation, maturity, and bias become a consideration.

The lack of availability of bilingual clinicians makes the use of interpreters necessary to bridge the gap between languages and cultures, although it is not an ideal

means of communication (Lee, 1997b). A competent interpreter should meet certain technical, cultural, interpersonal, and ethical criteria in order to be a cultural interpreter, that is, one who is "an active participant in a cross-cultural/lingual interaction, assisting the provider in understanding the beliefs and practices of the client's culture and assisting the client in understanding the dominant culture, by providing cultural as well as linguistic links" (Lee, 1997b, p. 478). Cultural interpreting gives the interpreter the latitude to convey either party's message in a way that is congruent to cultural background and understanding of each party; the interpreter functions as a "cultural broker" (Lee, 1997b, p. 484) to minimize potential verbal and nonverbal misunderstandings. Lee (1997b) recommends that the clinician prepare the interpreter before the assessment to discuss objectives of the interview, logistics, potential sensitive areas, background information on the family, and the interpreter's experience with the discussion of emotional problems.

Attitudes and beliefs about psychopathology. Another challenge that may arise during the assessment phase is the discussion of the patient's *DSM-IV-TR* diagnosis. Regardless of the cultural worldview of family members, the discussion of a client's diagnosis can be a source of anxiety. For more traditionally oriented families, the stigma of being labeled with a mental illness can often be more problematic than the symptoms of the illness itself (Yang et al., 2008). For Chinese American families, protecting the family from losing face might create a particular challenge when discussing a disorder such as schizophrenia. Kung (2001) states that for Chinese immigrant families, mental illness diagnoses often sound repulsive and frightening since the diagnostic labels suggest a "definitive nature and severity of illness" (p. 99). Clinicians working with such families

face the dilemma of whether or not they should discuss the diagnosis with the family (Kung, 2001). Gee and Ishii (1997) note that it is common for Japanese psychiatrists to "practice benevolent diagnostic deception, which may be of value in working with some Asian persons with schizophrenia; they offer vague diagnoses [in direct discussion with the patient]…to avoid giving the patient the stigma of schizophrenia" (p. 242). The psychiatrist discusses the patient's diagnosis more frankly with the patient's family in order to mobilize the family (Gee & Ishii, 1997).

The diagnosis of any mental illness for family members holding more traditional values presents the threat that the individual will never achieve full personhood (Holroyd, 2003), and potentially poses a threat to the livelihood (marriage and employment opportunities) of other family members (U.S. Department of Health and Human Services, 2001). In Asian American cultures, mental illness such as schizophrenia is seen as an inheritable illness (Gee & Ishii, 1997) causing siblings and other family members to fear that they or their children will also develop schizophrenia. The symptoms of mental illness are individualistic, create family dishonor, and do not increase belonging to society (Gee & Ishii, 1997); therefore, it follows that other members of society would distance themselves from associating with or employing individuals who pose the risk of stigma by association.

Oftentimes, Chinese families migrate because the parents want better opportunities for their children (Lam et al., 1995). Chinese tradition places high academic expectation on children, which is especially salient for the eldest son, since he is expected to eventually become head of the family and is expected to inherit more of the family's assets (Lam et al., 1995). The onset of schizophrenia often occurs in the teenage years,

the same time when Chinese children are expected to perform well on school examinations to enter universities (Lam et al., 1995). Lam et al. (1995) recommend that therapists: (a) "[B]e sensitive to the implications of the loss of academic aspirations for both the parents and the patients[,]"(p. 284) and (b) provide the time and space for family to grieve the loss of these aspirations. It is after the grieving process, the therapist may skillfully plant the idea that "all is not lost" (Lam et al., 1995, p. 284) and begin to help the family set goals for the client to begin functioning more effectively.

Despite the expressed anxieties, it is important to understand that each family member has good intentions and is concerned about the welfare of the family. With collective oriented cultures, it is critical not to misconstrue the importance placed on the family as a whole over a single family member as a lack of concern for the identified patient. The therapist's role is to help the family recognize that they share a common goal, while also allowing room for the family to have differing ideas on how to approach the situation.

Goal-setting. Given that each family member has a different acculturation level, and therefore will have different levels of adherence to various traditional values, the clinician must pay attention to both the overt and subtle differences among family members regarding attitudes toward mental illness and different modalities of treatment, expectations of the patient and family members, patterns of communication, and the goals for treatment. Often times, such differences can be observed in nonverbal reactions of family members, such as degree of eye contact, facial expression, or smiling. As mentioned previously, Lee (1997b) recommends utilizing cultural interpreters to help with this process.

Typically, a Chinese American family will value, to some degree, the notion of doing what is good for the family over individualistic concerns. Negotiating common family goals that each family member can "buy into" will be a critical tool in keeping the family task-oriented and focused on common goals. Research suggests that pragmatic solutions, framed in terms of how to bring harmony to the family, may prove useful in negotiating family goals for families that value more traditional Chinese values (Berg & Jaya, 1993). Frequently, it may appear that different family members' goals might seem at odds. In such a situation, the clinician's role is to intervene by helping reframe and negotiate the family member's goals in light of the agreed-upon family goals.

Lam et al. (1995) suggest that goal-setting may take more time with immigrant Chinese American families as family members who adhere to more traditional values may engage in "avoidance behaviors" as opposed to other behaviors due to cultural values that embrace the inhibition of strong feelings, saving face, and maintaining equilibrium; denial protects the family's reputation and from the stress of shame (Gee & Ishii, 1997; Kirkbride et al., 1991). Negotiation will require the clinician's keen sensitivity to adjust expectations and time required for appropriate assessment. The clinician's attention to nonverbal behavior is essential; both what the family members might be communicating, and how nonverbal behaviors on the part of the clinician might be interpreted (Root, 1998). Silence and lack of eye contact are nonverbal ways of communicating respect for individuals (Lee, 1997a) who value intrafamilial harmony in Chinese American families. Family members who embrace the value of maintaining equilibrium and allowing others to have the opportunity to save face may be more

reticent and may not wish to promote an idea that appears to differ from or challenge the opinion of other family members or the clinician.

Treatment. Clinicians must be aware of their own culture, values, and biases and be familiar with their client's culture, values, worldview, and sociopolitical factors that influence their patient's mental health (Tewari, 2009). The structure and values of Chinese American families demand that clinicians use a framework that views the problem and potential solutions from within the patient's belief system. This discussion proposes that the framework for conceptualizing treatment with Chinese American families of low acculturation takes into consideration the family's (a) beliefs about mental illness and etiology; (b) value of collectivism including family honor, family hierarchy, and family roles; and (c) emotional self-control and communication style.

Bedford and Hwang (2003) assert that within Chinese families and society, shame ensures conformity, thus protecting the social order. According to the literature on Chinese values, the value of saving face makes shame a common barrier to acknowledging mental illness by family members. In a collectivist-oriented society, shame helps to preserve harmonious, group-oriented behavior, in fact, "[n]o person ever has just cause to disrupt group harmony, as disruption impacts everyone's identity" (Bedford & Hwang, 2003, p. 131). The stigma that fosters a sense of shame is another factor that contributes to secrecy or denial of the mental illness; denial functions to protect the family from the stress of shame (Gee & Ishii, 1997). Gee and Ishii (1997) further state, "the patient's inability to control psychotic and social symptoms as well as the family's inability to control the patient can raise individual and family shame that disables help seeking" (p. 233).

For Asian American and Pacific Islander families, having mental illness in the family brings shame to the entire family (Yang et al., 2008) and potentially threatens the possibility of marriage and employment opportunities (U.S. Department of Health and Human Services, 2001) for all of the family's progeny, which sometimes results in the family hiding the illness (Gee & Ishii, 1997; Lam et al., 1995; Lin, 1982). Both Eastern and Western ideals for treatment of schizophrenia agree that the focus should benefit the quality of life for the entire family (Falloon et al., 1984; Kung 2001). The impact of schizophrenia on families and the lives of those afflicted can be mediated by family interventions. Due to the cycle of stress that frequently occurs within such families, interventions that improve family members' coping have a direct positive effect on the patient, creating positive outcomes for all family members. Chinese American families who adhere strongly to traditional values tend to see the family, rather than the self, as a single body. In using this metaphor, when other parts of the body are strengthened, they are better suited to nurture the part of the body that is injured or ill. Research comparing Asian and Caucasian American families found that Asian families were more likely to attend clinic visits with their family member (Kung, 2001). It was noted that there was a significant association between the family's involvement and reduction in medical noncompliance and lower drop-out rates (Kung, 2001). It serves patients, families, and clinicians well to harness the resources that Chinese American families offer their ill family member.

Psychoeducation. Depending on their differing levels of education and exposure to Western values, Chinese Americans will have varying levels of knowledge about etiology and treatability of schizophrenia (Kung, 2001). A psychoeducational approach,

especially given the families' tendency to expect concrete information from experts, seems to be a suitable intervention with which to begin (Kung, 2001). Psychoeducation should include explanations for basic characteristics of schizophrenia, how to cope, the role of medication, and the role of a supportive environment (Yang & Pearson, 2002). The role stress plays on the patient's symptoms and within the family system should also be explained. Western medicine has emphasized a biological explanation to describe the etiology of schizophrenia while early family therapists focused on disorganized family interactions. The current diathesis-stress model explains the development of the disorder as a combination of inherited genetic risk paired with psychosocial stressors. How the clinician approaches psychoeducation about the etiology of schizophrenia with Chinese American families will depend on the assessment of the family's acculturation level. Unfortunately, Western explanations of etiology that emphasize the heritable component of the disorder tend to reinforce a sense of guilt for Chinese Americans with more traditional values and may discourage seeking further treatment due to the family's sense of grave disgrace (Juthani & Mishra, 2009; Kung, 2001). Different studies suggest that in utilizing psychoeducation, clinicians should emphasize the etiology as a biochemical imbalance, rather than emphasizing genetic heritage (Kung, 2001). Even the term "psychosocial stressor" can be a guilt-laden term. Kung (2001) suggests reframing psychosocial stressors as an imbalance in interpersonal harmony or as environmental stressors; doing so may help alleviate the family's sense of guilt that they somehow caused their family member's illness. Efforts to reframe definitions and explanations about etiology and the cycle of family stress may help the family "save face," allowing

the family to continue with treatment rather than discontinuing treatment due to a sense of shame.

For Chinese American families, seeking treatment from a medical doctor is a more acceptable form of help-seeking than consulting a mental health professional (Juthani & Mishra, 2009). To compound the issue of stigma in seeking mental health treatment, Chinese American families may know little about what mental health clinicians offer and of what mental health treatment consists (Kung, 2001). Treatment for schizophrenia typically begins with assessment and psychoeducation. Perhaps one way to make treatment more appealing to Chinese American families is to name it something that will be less stigmatizing, such as using the terms "education" or "class" rather than using the term "therapy." Chinese Americans have a deeply embedded view that everything from work to play has an educative purpose behind it (Lau et al., 2011). The value of education to Chinese American families makes it such that treatment framed as an educational experience rather than a therapeutic process may appeal to such families. Kung (2001) suggests that a didactic psychoeducation model would be most suitable for the initial stage of intervention with the family. In such a setting, mental health clinicians play the role of educators, and thus it might be more fitting to call them "educators" rather than "therapists" in this context. Within the psychoeducation class with the individual family, the educator would present the information on etiology, the role of medication, and the role of stress on the disorder, being mindful of how issues such as genetic heritability and similar concerns commonly shared among Chinese American families may influence the experience.

Minimizing family stress. When the family's tolerance for the patient's behavior is low, family stress and relapse rates will be high and chronic relapses are a source of stress for all family members (Falloon et al., 1984). Research with Western populations and schizophrenia indicates that family-based stress management is highly effective in treating schizophrenia (Falloon et al., 1999). Because the family unit has traditionally been of utmost significance in Chinese American families, we can hypothesize that strategies that reduce family stress and strengthen family bonds will be of great importance in the treatment of schizophrenia with Chinese American families. What is considered "stressful" will be mediated by the family's cultural values. For example, caregiving in Chinese American families may be viewed not as a choice, but as a moral obligation (Kung, 2001). To family members who adhere highly to the value of family collectivism, the duty to provide care for an ill family member is congruent with the sense of self (Kung, 2001). There can be positive results stemming from such cultural beliefs in providing "emotional and material support to patients [and] contributing to better prognosis" (Kung, 2001, p. 100). This is certainly not to suggest that Chinese American families do not experience stress from caregiving. In fact, such a deep sense of responsibility within such families can lead to high levels of resentment, criticism, shame, and high expressed emotion (EE); (Kung, 2001). In such a situation, Kung recommends encouraging relatives to foster greater independence in the patient. Such a recommendation may be couched in terms of its benefits to the family unit.

Research by Lopez et al. (2004) with Anglo American and Mexican American families suggests that family members who believed that the patient could control their symptoms displayed higher levels of criticism and decreased warmth toward the patient.

Yet families who have more traditional Chinese values may not perceive "criticism" in the same way Anglo American or other minority populations perceive criticism. Confucian philosophy stresses the importance of "cultivating discipline for the acquisition of personhood" (Holroyd, 2003, p. 15). Criticism is often used as a means of ensuring that children are brought up according to what is "right and proper" (Holroyd, 2003, p. 4) and has the power to elicit fear of the emotions of shame, blame, and disgust in both private and public realms. Patients with family members who are highly critical or intrusively involved (high EE or emotional over-involvement [EOI]) tend to have increased rates of relapse, and high EE levels are associated with the family's ability to cope with such stress (Yang & Pearson, 2002). According to a Confucian-based belief system, it might be assumed that criticism and discipline are the ultimate acts of love on the part of parents in order for their children to become right and proper persons who are able to sustain a living in society. While there is no existing study that examines how family criticism is perceived by Chinese American individuals with schizophrenia, some research suggests that regardless of adherence to traditional Chinese values, criticism of the Chinese American individual with schizophrenia will indeed increase the patient's stress, which has ripple effects throughout the family system (Lam et al., 1995; Yang & Pearson, 2002). Working with Chinese American families will require sensitivity to various parenting styles and types of communication. It is likely that those parents who tend to criticize may need to be validated in showing their care for the patient, but be gently shown how criticism may lead to interpersonal imbalance (stress), and instructed on alternate forms of showing their concerns in a way that promotes family harmony.

Differing family members' expectations regarding the patient's autonomy can become a source of conflict in the family. In traditional Chinese families, children do not leave the home until they are married. Children of immigrant parents who have been exposed to Western culture may, along with the dominant culture and Western treatment models, expect a higher degree of independence beginning in their early adulthood (Lam et al., 1995). There is a risk of pathologizing the Chinese American child as "too dependent," and the Chinese American family as "enmeshed" when compared to Anglo American children and families. Empirically validated family treatment for schizophrenia promotes a certain degree of patient autonomy and responsibility (Falloon et al., 1984). Expectations of the patient must be clearly renegotiated, regardless of the family's culture; but for the health of all family members, the patient must still have responsibilities to fulfill that are commensurate with his or her present mental state and overall abilities (Lam et al., 1995). For example, a male child in a more traditional Chinese American household may not have any household duties such as washing dishes or doing laundry; he may be expected to focus solely on his academic achievement. If he is temporarily or permanently unable to continue with his education, he will need some responsibilities so that he can have a sense of accomplishment, reduce stress, and prevent boredom which can frequently increase stress. Negotiating appropriate responsibilities for the patient in the Chinese American family can be framed as the patient's contribution to the well-being of the family. For families in which the tendency is for protective family members to over-function and the patient to under-function, the goal should be to re-focus the discussion on how to provide appropriate opportunities for the patient to fulfill role demands within the family, with the goal of resetting a homeostatic place for the

family that "incorporates the limitations of the patient and maximizes the role flexibility in other family members needed for…continued care" (Yang & Pearson, 2002, p. 240). Generally, younger generations will value having more independence than the older generations. Within the context of family negotiation, the concept of independence might be better framed as the patient's need to establish new and satisfying relationships both to increase positive life experiences and to develop the skills necessary to sustain oneself as an adult (Lam et al., 1995).

Problem-solving and communication skill-building. Western family treatment for schizophrenia teaches family members to improve communication via direct confrontation and focuses on skill-building from a framework that emphasizes individuation of the self from the family. These are two particular practices that would likely prove ineffective with Chinese American families due to their values regarding the family hierarchy (Berg & Jaya, 1993; Jung, 1998), communication style that allows others to save face (Berg & Jaya, 1993), and family collectivism (Inman & Yeh, 2007; Kirkbride et al., 1991).

Berg and Jaya (1993) explain that traditional Asian families solve problems through negotiation rather than head-on confrontation. A therapist using confrontation with a family member, particularly one with higher status in the family, places that family member at risk for losing face in front of the rest of the family. Such a practice is not only inconsistent with a preferred Chinese American communication style; it is also an affront to the family hierarchy and family roles. Chinese American families, being socially oriented, emphasize conformity, self-suppression, and parent-centeredness (Lam et al., 1995). In the West, family relationships such as these have been labeled as "enmeshed"

although these relationships are seen as normal among those with more traditional Chinese American family values. It would be a mistake for the therapist to attempt to restructure the family hierarchy by promoting the patient's increased independence from the family, though this practice is common among Western mental health practitioners. Given the research on family therapy and cultural values of Chinese Americans, it is clear that the approach to treating the family when a member is diagnosed with schizophrenia, will be a process requiring attention to many facets of the family's unique composition and the varying cultural values that different members hold.

In a situation where family members might disagree on etiology of the family member's illness, a focus on problem-solving may be more useful than focusing on etiology. Berg and Jaya (1993) suggest that Asian Americans are more problem-solving focused. They also suggest that explanations of cause and effect are better couched in interpersonal terms (Berg & Jaya, 1993). To manage differing opinions, it can be valuable for the clinician to clearly show respect to the family hierarchy, while still encouraging each family member to state his or her opinion.

In general, it can be beneficial for the clinician to integrate and validate traditional healing methods along with Western medicine (Gee & Ishii, 1997), although caution must be exercised in the concomitant use of medications (Gee & Ishii, 1997). This does not mean the clinician should discourage herbal medication or alternative healing methods, but that clinicians and psychiatrists must creatively integrate the use of indigenous practices and Western medicine (Gee & Ishii, 1997). It may benefit the family for the clinician to discuss how anti-psychotic medication can bring balance to the client's mental and physiological state or create the body's homeostatic balance between

yin and yang. Additionally, because the clinician is in a professional role, his or her leadership and knowledge may be expected, therefore, decisive action or advice may be welcomed by the family (Gee & Ishii, 1997).

Problem-solving is often a feature of various forms of family therapy. It is an important intervention in empirically supported family treatment for schizophrenia, and it can be implemented in a manner that can prove useful for Chinese American families. The process of problem-solving slows down the planning and decision-making process and is, therefore, better suited for people with schizophrenia who frequently are sensitive to pressure and may need more time to process information (McFarlane, 2002). The focus on problem-solving has the added benefit of offering goal-directed treatment with measurable outcomes to those who may adhere to more traditional Chinese values (Yang & Pearson, 2002). Observing measurable, positive results in the short-term can provide motivation for all family members to continue with and comply with treatment (Yang & Pearson, 2002).

Given what has been discussed about family roles and family hierarchy, it is critical to consider how clinicians can facilitate each family member's participation in the problem-solving process, rather than having all family members defer to the family patriarch. During problem-solving, it will be necessary for family members and clinicians to show appropriate respect to the hierarchy and rules of the existing family system. The clinician must legitimize the authority of the parent(s) while allowing and encouraging other family members to be active negotiators (Yang & Pearson, 2002). While it may be customary for more traditionally-oriented Chinese parents to be greatly involved in their children's lives, it is important to allow the family member diagnosed with schizophrenia

the opportunity to become an active participant in negotiating changes in his or her own behavior. Moreover, allowing family members an opportunity to practice the skill of negotiation with the patient directly empowers the family's coping and skill with seeking their own solutions.

Communication skill-building, like problem-solving for families with rigid and hierarchical roles, poses the challenge of respecting the family structure and showing appropriate respect while allowing all members to have a voice. Yang and Pearson (2002) recommend relabeling emotions so as to place the emphasis on the positive aspects of what the family is attempting to communicate, for example, by relabeling a parent's "criticism" as "worrying." Direct expression of emotion may be difficult for more traditional family members; eye contact and nonverbal behaviors such as silence must also be attended to (Yang & Pearson, 2002). It is imperative for the clinician who is unfamiliar with Chinese American communication patterns to consult a cultural expert to become aware of the cultural meanings of nonverbal communication. If the clinician's assumptions about the meaning of family members' communication patterns are incorrect, the family members may be offended and view the clinician as culturally incompetent, ultimately leading to premature termination.

Group treatment. The research on Chinese American cultural values suggests that Chinese Americans who adhere to more traditional values may be unlikely to participate (and therefore benefit from) Western mental health treatment due to mistrust, shame, and the desire to keep matters private (Juthani & Mishra, 2009; Lam et al., 1995). One might hypothesize that a group treatment format in which the Chinese American family is expected to share its problems with other families who are strangers, might be even more

disagreeable. In spite of this hypothesis, the research available based on Chinese populations receiving some form of group treatment has shown largely positive results (Chien et al., 2004; Chien et al., 2006; Lam et al., 1995; Xiong et al., 1994; Yang & Pearson, 2002). In a study of family-based interventions for schizophrenia conducted with families from two medium-sized cities in mainland China, non-attendance of the multi-family group support component was lower in comparison to a Western study of non-minority families, while the noncompliance with individual family sessions was higher for the Chinese families. Researchers also found that the overall refusal of treatment rate was slightly higher in the Chinese groups when compared to Western studies. Although studies based in China cannot be generalized to populations in the U.S. due to differences in population characteristics, culture, and values, the studies may provide potential hypotheses on how such groups might be replicated in the United States.

In their study of a mutual support group for caregivers of individuals with schizophrenia in Hong Kong, Chien et al. (2006) found that Chinese family caregivers actively participated, were open to discussing their situations, and perceived themselves gaining various benefits from the group. This study contradicts previous studies among Chinese people indicating passivity and reservation as the cultural expressions of Chinese people. They also found that once *gan qing* "(emotional love), which symbolizes mutual good feelings, empathy, and friendship among Chinese people" (pp. 977-978) had been cultivated and affirmed in the context of offering mutual support, group participants became "highly interdependent and committed to helping one another" (pp. 977-978). This study highlights the benefits family members perceived and poses the hope that

families with Chinese American values will also benefit from group treatment, although there are many contextual differences between non-minority Hong Kong Chinese families and minority Chinese American families in the United States. Some of these contextual considerations, such as being a part of the majority group versus being a visible minority who resides in enclaves in the U.S., particularly among the less acculturated Chinese American families, might influence the family's receptivity to engaging in family therapy.

Depending on the family's values, it is natural to question whether individual family treatment, family group treatment, or a combination of the two would be the most optimal treatment. What the research shows is that in the few studies performed with Chinese families, family group treatment in the form of mutual support and psychoeducation showed largely positive results. It is not clear whether family group treatment, individual family treatment, or a combination of the two, are any more successful than the other.

What we know from the literature on schizophrenia and families is that, quite frequently, family members and patients feel isolated and alone in their struggles. Family support or family group treatment has been shown to alleviate stress that stems from such feelings of isolation and increase a sense of community support. While clinicians are typically accustomed to pushing their clients beyond their "comfort zones" in a therapeutic manner, it is important to assess a family carefully and process the recommendation with the family, so that a recommendation for a family support group is not a cultural insult. Based on my research on Chinese American values, I believe that individual family treatment is the best way to initiate treatment with a Chinese American

family that adheres strongly to traditional values. Beginning treatment in this way allows the clinician to build rapport and trust with the family, while continually assessing its needs along with the potential benefits that a mutual support group might offer. The recommendation of an adjunctive support group might follow later in treatment. The selection or development of such a group would be based on the family's values and progress in treatment. Perhaps the development of an ethnic specific group, such as a Chinese American family group, would create an environment more inclined to foster mutual support and positive results. One of the challenges to creating such a group is finding enough families to participate. While the benefits of being with others who share similar values might create a positive therapeutic environment, a formidable challenge is the family's concern for privacy and the fear that family secrets will be exposed to others in the Chinese American community. This is a potential drawback that might discourage participation and jeopardize the prospective success of a Chinese American family group.

For Chinese American families with low adherence to Chinese American cultural values, MFGT can provide the ideal combination of psychoeducation, communication and problem-solving skill building, and mutual support in one treatment modality. In MFGT, a minimum of three joining sessions (1 hour spent with the family and 30 minutes separately with the patient) is spent with each family and each patient prior to the educational workshop where all families attend (McFarlane, 2002). Chinese American families with low adherence to Chinese American values, like other families, will vary in their level of openness to sharing in groups or discussing emotionally charged material. Adequate time should be spent discussing the family's concerns about the group format prior to the first group meeting. It will be of the utmost importance to cultivate the

family's trust, to answer questions, and to be flexible by allowing as much additional time needed to thoroughly explore the family's concerns, providing feedback, and encouraging families to share only at their comfort level. Clinicians should thoroughly explain what typically occurs in the psychoeducational and group meetings; this may have the added benefit of dispelling some fears or misconceptions. Clinicians might share how families similar to theirs have benefitted from participation. Emphasis both in joining sessions and in early MFGT sessions should emphasize the belief that family members did not cause the patient's illness to ease feelings of guilt and shame, which can frequently contribute to families dropping out of treatment (McFarlane, 2002).

After joining sessions with all families individually have been completed, the typical course of MFGT will bring families together for a psychoeducational meeting led by the same professional clinicians who joined with the families. The families and patients meet regularly with each other and the clinicians in one group over an extended course of treatment and rehabilitation (McFarlane, 2002) that can last from 6 to 24 months and onward. After the psychoeducational component has been completed, the group focuses on relapse prevention through the use of problem-solving activities and then transitions to vocational and social rehabilitation within the same group (McFarlane, 2002).

Chinese American families with low adherence to Chinese American values, like any other group, will naturally have diversity in the values they hold and challenges they face. It is the "culturally astute clinician" (Juthani & Mishra, 2009, p. 180) who must be alert to the differences among individuals and families from any culture so that

familiarity with a particular culture lends itself to the use of a cultural hypothesis rather than a cultural stereotype.

Delimitations of the recommendations. In offering clinical recommendations for serving the needs of Chinese Americans, there are several critical delimitations that warranted discussion. Of specific importance to this discussion is the acknowledgment of (a) the diversity of Asian cultures included in the Asian American collective; (b) the lack of an operational definition for what constitutes Chinese American values; (c) the relevance of acculturation to family presentation; and (d) the selection of schizophrenia as the psychiatric disorder for framing the discussion.

Diversity of Asian cultures. The Asian American population is comprised of members from diverse cultures with diverse immigration histories (Kim, 2007). The great range in length of residence in the U.S. suggests that Asian Americans will have varying degrees to which they have adapted to norms of the dominant culture, and to which they have retained the norms of their respective Asian cultures (Kim, 2007). Diversity within Asian American cultures is partially due to factors such as political, historical, and other contextual factors surrounding the family's immigration and reception in the U.S., region from which the individual and family emigrated, and the family's social background (Rhee, 2009). The challenges and acculturative stress that immigration presents can place a great deal of strain on families, e.g., discrimination, loss of status, loss of support network, and language barrier (Yang & WonPat-Borja, 2007). Asian Americans vary widely in educational level, economic status, generation, and English proficiency (Rhee, 2009). In addition, significant differences in income and poverty rates exist among ethnic Asian American groups (Rhee, 2009). For example, recent Indochinese refugees will

typically have less education and are less able to speak English, thus, their skills are less marketable in the United States compared to other Asians who have attained higher levels of education and have higher language proficiency (Rhee, 2009).

The diversity of Asian American groups suggests that different groups will have varying challenges and needs for services, and that services should be tailored to each group (Rhee, 2009). It is necessary to emphasize both the heterogeneity among Asian American groups, as well as the diversity within each group in order to understand the complexities and challenges of a particular group. To consider "Asian Americans" as a discrete population upon which to base theories and develop clinical recommendations is apt to produce overgeneralized and/or ineffective theories and strategies.

Chinese Americans comprise the largest Asian subgroup in the U.S. at a population of 3.8 million in 2009 (U.S. Census Bureau, 2011). In 2006, immigrants from China (including Hong Kong) formed the fourth largest immigrant group in the United States with 50,900 new legal immigrants each year (U.S. Census Bureau, 2007). Among non-English languages, the Chinese languages were the second most commonly spoken in the U.S. in 2009 (U.S. Census Bureau, 2011). There were 2.6 million people aged 5 and over who spoke a Chinese language at home in 2009 (U.S. Census Bureau, 2011) and just under half of Asian-language speakers spoke English "very well" in 2000 (Shin & Bruno, 2003, p. 3). In light of the size and growth of the Chinese American population in the U.S., in addition to the population's unique characteristics and heterogeneity, it follows that focus on this population's complexities and unique challenges is warranted and necessitates culturally appropriate ways of addressing the mental health needs of this population.

Defining Chinese American values. While the field of Asian American psychology has grown over the last 20 years, researchers continue to be concerned with the limitations of current ethnic and racial classifications and operational definitions for culture, and ethnic and cultural differences among Asian American groups (Chun et al., 2007). For example, it is not uncommon for textbooks on Asian American psychology to discuss issues relevant to Asian Americans and Pacific Islanders as one group, despite the substantial heterogeneity both within the assemblage of cultural groups within each collection as well as between these two major collections of cultures. While methodological reasons are often cited for the limited progress in deriving such specificity, e.g., limited community participation in research due to issues of trust and the need to build rapport, there is a lack of practical advice available for addressing these recommendations (Chun et al., 2007). In discussing the literature, when the terms "Asian," "Asian American," "Chinese," and "Chinese American" are referenced, the concept used by the original author was retained.

One of the major challenges in reading the literature on the relevance of cultural values to psychological constructs and interventions, particularly with Asian American populations, is the inability to readily distinguish culture-specific values from those that are broadly "Asian," or those "hybrid" values that emerge as generations adapt native cultural values with those of the American cultural context (Okazaki et al., 2007). For example, there are cultural similarities shared among Asian cultural groups, such as the significance placed on family values (Lee, 1997a). Yet, in comparing two Chinese American families, the manner in which the families present might be unique and influenced by the acculturation levels of family members. As an illustration, the Chinese

immigrant parents in one family may strongly endorse ancestor worship as practiced by their family in China, while the second, more acculturated family not only does not endorse ancestor worship but may disapprove of such practices. Moreover, the former family might self-identify as Chinese while the latter family as Chinese American. Hence, in this discussion, the concepts of "Chinese" and "Chinese American" and the associated values are viewed as dynamic and fluid rather than static and rigid.

Relevance of acculturation. Families that identify as Chinese American may have family members who are at various levels of acculturation. Even among family members who were born and raised in the U.S., the influence of their ethnic cultural values may be passed down from previous generations and influence how they conceptualize their lives (Chun & Akutsu, 2009; Juthani & Mishra, 2009; Kim, Ahn, & Lam, 2009). An individual's level of acculturation may be measured by how much the individual is involved with other cultural groups or chooses to remain with their group of origin, in addition to what length his/her cultural identity is valued and maintained (Berry, 2005; Kim, 2007). Berry (2005) provides one model of conceptualizing acculturation that describes four different strategies or attitudes that ethnocultural individuals may have toward maintaining and participating in their indigenous culture and participating in and absorbing the dominant culture. Berry's four acculturation strategies are as follows: (a) integration (individuals are proficient in the dominant group's culture and yet retain proficiency with their indigenous culture); (b) assimilation (individuals absorb the dominant culture and reject their indigenous culture); (c) separation (individuals maintain and perpetuate their indigenous culture and do not absorb the dominant group's culture); and (d) marginalization (individuals have no interest in maintaining or acquiring

proficiency in the indigenous or dominant culture); (Berry, 2005; Kim, 2007). Kim (2007) cautions that Berry's model, while appropriate for recent immigrants, may be unrepresentative of the experiences of U.S. born Asian Americans, or Asian Americans who have resided in the U.S. for a number of generations and who were never completely enculturated into the cultural norms of their family of origin.

In this discussion, it is assumed that at least one family member is less acculturated due to the salience of acculturation in how families view mental illness. Differences in acculturation contribute to Acculturative Family Distancing (AFD), or the acculturation gap between family members, the results of which are communication breakdown and differing values based on the different rates of acculturation among family members (Kim Ahn, & Lam, 2009), both of which lead to an increase in family stress. AFD poses the risk of increased family discord, identity formation problems, stress, adjustment problems, somatic complaints, and mental health and behavioral issues (Kim, Ahn, & Lam, 2009; Rhee, 2009). For example, more traditional family members may adhere to the Confucian family hierarchy and the well-defined roles it has for family members based on birth order, gender, age, and sex (Chun & Akutsu, 2009). The practices and expectations related to such roles will come into conflict with family members who are more acculturated to American cultural family practices that value "independence, self-reliance, autonomy, assertiveness, open dialogue, and competition" (Chun & Akutsu, 2009, p. 106).

Chinese American values, which are moderated by factors related to acculturation (Kim, 2007; Kim, Ahn, & Lam, 2009), affect the Chinese American individual and family's concept of mental health, healing, and treatment (Bradley et al., 2006; Chien et

al., 2006; Lopez et al., 2004; Telles et al., 1995; Weisman et al., 2006). Several cultural factors influence acculturation including gender, immigration status, age at immigration, generational status, education, socioeconomic status (SES), and religion. Families who have members possessing more traditional Chinese values tend to practice behaviors that emphasize family collectivism, preserving reputation ("saving face"), respecting elders, acceptance of the power distribution in the family, and less flexible family member roles (Lee, 1997a). Hence, Chinese American families who are less acculturated tend to see "the expression of agitation, hallucinations, delusions, and disorganization" (Gee & Ishii, 1997, p. 233) as "a volitional deviation from conformity to family and society" (Gee & Ishii, 1997, p. 233), which poses some unique clinical challenges in working with these families.

Family members whose values are more traditional may be less inclined to look to Western medicine and medication for issues regarding mental health, especially because of the difference between Eastern and Western concepts of mental health treatment. Some Asian patients may be unwilling to commit to a medication regimen due to fear of bodily harm or addiction (Lee, 1997a). The stigma attached to addiction has been noted as a reason for delay in treatment-seeking for Asian drug users (Nemoto et al., 1999). There may be a face-saving issue involved in having to remain on medication that is similar to the shame experienced by Asian drug users. Research on coping within Asian and Asian American groups indicates a strong preference for using indigenous healers and alternative treatments (Inman & Yeh, 2007). Traditional Chinese medicine, indigenous healers, alternative treatments, clergy, and family and friends are all sources of healing that fit the more traditional family member's view of healers and treatment

(Inman & Yeh, 2007; Yeh et al., 2004). For these family members, the etiology of such problems is considered to be an imbalance in the individual's somatic system or due to an unresolved moral issue (Ho et al., 2004). Less acculturated family members may conceptualize treatment in native ways such as turning to religion for its magical power of warding off evil or praying to a Taoist deity for good health (Yang, 1961). In the realm of religion, schizophrenia might be seen as retribution by the gods and patient's ancestors for inappropriate behavior in his or her past or current lives (Gee & Ishii, 1997). Such beliefs clearly point the patient in the direction of religious healers or those who understand Buddhist reincarnation and Taoist beliefs regarding the supernatural (Gee & Ishii, 1997). Such beliefs are not necessarily incompatible with the Western conceptualization of treatment for schizophrenia. Gee and Ishii (1997) suggest that traditional healing methods can be creatively integrated with Western pharmacotherapeutic strategies. It could be beneficial for the clinician or psychiatrist to ask the family's permission to consult with any alternative healer or member of clergy on whom the patient and his or her family rely, promoting the sense of an interdependent team approach to healing. Due to a strong belief in the unity of mind, body, and spirit (Inman & Yeh, 2007), the clinician might encourage Eastern practices such as yoga and meditation in conjunction with medication and family treatment. Frequently, family members are concerned about balance between yin and yang in the patient (Yeh et al., 2004). To address this concern, QiGong and acupuncture might be adjunctive treatments that Western clinicians can encourage in addressing the family's concern. Lastly, it might be useful to describe the function and use of Western medication as another tool that promotes better balance in the patient's energy and internal states.

Selection of schizophrenia for the psychiatric disorder. Chinese American families with traditional values are often compelled to conceal a mental disorder from the community and perhaps even the extended family, yet much to the family's humiliation, the hallmark symptoms of some mental disorders are often apparent to the public. Schizophrenia is often one such disorder. To further complicate the clinical picture, Chinese American families with traditional values may hold views on the disorder's etiology that emphasize hereditary/genetic weakness, disharmony in interpersonal relationships, imbalance of yin and yang, spiritual unrest, or character flaws (Jung, 1998), all of which may be viewed as influencing the family's standing in the community.

For the Chinese American family, there can be a high level of stigma and shame surrounding the diagnosis of mental illness, especially given that traditional values indicate that the self's highest obligation is to propagate the family's longevity (Holroyd, 2003). Based on Holroyd's description of the traditional Chinese view that successful adulthood entails propagating the family line, the ability to be a "right and proper person" (p. 5) with full membership in society, and the ability to maintain familial and societal order, it is assumed that an illness causing the most disruption to the natural order and the individual's ability to meet his familial obligations as an adult will be the one that is most stigmatizing. The development of schizophrenia in a family member is particularly disruptive and is a profound threat to the family and its obligation to society. Individuals who have mental illnesses internalize society's attitudes toward mental illness. They may (a) be ashamed and avoid seeking help, (b) have less access to resources, (c) experience a decrease in self-esteem, (d) experience an increase in hopelessness and isolation, and (e) experience deterioration of family relationships (U.S. Department of Health and Human

Services, 2001). Furthermore, the less predictable and sometimes bizarre nature of the positive symptoms in schizophrenia may place family members at higher risk for public embarrassment than disorders such as depression and anxiety. Hence, schizophrenia was selected as the disorder for discussion.

Clinical application. To demonstrate how the clinical recommendations proposed in this dissertation might be applied in practice, a fictional Chinese American family, the Chens, serves as an illustration. The case summary of the Chen family is followed by a demonstration of how the recommendations might look in practice.

Case summary of the Chen family. The Chens are a multigenerational Chinese American family in which a young family member is diagnosed with schizophrenia and varying degrees of acculturation are present among family members.

Identifying information. Matthew Chen is a 17-year-old, Chinese American senior at a prestigious Catholic high school. His mother, An (Ann) Chen, is a Chinese, Christian, 41-year-old public high school math teacher married to Jun-Wen (John) Chen, a 48-year-old, Chinese engineer and atheist. Matthew has a 15-year-old sister, Lisa, who attends the same school. Matthew's 70-year-old paternal grandfather, Ji-Wen Chen, a retired engineer, moved from Mainland China 6 months ago to live with his son's family. All family members reside in the home that Ann and John purchased 5 years ago–a 4-bedroom home in an upper middle class, suburban area of Silicon Valley.

Presenting problem. Matthew has been experiencing intrusive thoughts, avolition, anhedonia, and an increased desire for sleep since the beginning of his sophomore year. His grades have gone from straight As to Cs and Ds, and he has stopped attending all of his extracurricular activities. Teachers and classmates have reported that Matthew

sometimes talks to and even yells at himself while alone or in class, and often seems like he is in "another world." A school counselor requested multiple meetings with Matthew's parents, and Ann attended one of these meetings. During the meeting, Ann was mostly concerned with Matthew's grades; however, at home, Ann admonished him for embarrassing the family by talking to himself at school. Ann hired tutors for Matthew and even gave him some of her own math assignments to do at home for practice. Ann was convinced that Matthew's behavior was willful, and a sign of his weak faith in God. She frequently berated him, begged him to pray more frequently, and blamed his problems on his lukewarm attitude toward faith.

This week, Ann received an emergency call from Lisa. Matthew was hospitalized for making a suicidal threat. After a social worker and psychiatrist speak with Ann, John, Ji-Wen, and Lisa, they develop a treatment plan. Matthew is to see a psychiatrist who will find the right medication for treating his symptoms. Along with regular psychiatrist visits, family therapy is recommended. Matthew's grandfather and parents say little at the meeting, nod in agreement, sign papers, and wait for the time he will be released.

At home, the discussion of Matthew is quite different and family members take turns blaming each other. John yells at Ann, stating that her poor parenting skills are the cause of Matthew's poor grades and behavior in school. Ann blames Matthew's lack of faith for his current situation and dares to say that John's lack of faith may have something to do with their son's poor grades and health; this enrages John. Ji-Wen, who has become head of the household in the last 6 months, primarily blames Ann for Matthew's health and behavior in school, but also faults John for not being a harsher disciplinarian; Ji-Wen believes that harsher consequences at home (specifically corporal

punishment and scolding) would have prevented Matthew's poor grades and strange behavior over the last 2 years. Lisa's parents and grandfather are also angry with Lisa for reporting her brother to the school counselor after Matthew threatened to kill himself. They are afraid the family has been publicly embarrassed and feel that Lisa has been a "traitor" to her family by not keeping problems within the family. In an outburst of anger, Lisa declares that her parents have been ignoring Matthew's problems for 2 years, which further isolates her from her family. While Lisa is not fully considered in family discussions regarding Matthew, she feels increased pressure to continue to be the model student and to continue her involvement in extracurricular, church, and volunteer activities to help the family save face. Matthew is not angry with Lisa. While he and Lisa were closer during childhood, they began to drift apart when Matthew's symptoms began.

None of the family has actually sat down with Matthew to ask him what he is going through, but grandfather and parents have both sat down to tell him how they must fix the situation. Matthew appears to be somewhat sedated with the medication and also appears depressed. He is nervous about sharing too much information with the psychiatrist and social worker. While he wants someone to listen to him, he is afraid of his parents' and grandfather's reaction should he reveal too much about himself or the family.

Immigration history and acculturation. John and Ann were introduced to each other by a mutual family acquaintance and began their courtship when Ann was 21 and finishing her undergraduate degree in mathematics and John had just completed his Ph.D. in electrical engineering at the same university. John was eager to immigrate to the U.S. after hearing the success stories of former classmates who had moved to the U.S. John

quickly proposed to Ann and pressured her to move to the U.S. with him. They waited one year for Ann to finish her degree, got married, and immigrated to the U.S. in 1988. John was able to secure a lower level position through alumni from his school. He was ashamed that he was unable to secure a higher level position; however, his employers were uneasy about his poor English proficiency. Ann, having had a knack for the English language and a natural interest in learning languages, spoke and comprehended English moderately well, although speaking with an accent. She was quickly able to find part-time work as a Chinese and math tutor while attending a one-year teaching credential program at the state university nearby.

Ann is able to communicate with her children moderately well in English. Matthew and Lisa speak some Cantonese, but not fluently. John has difficulty communicating with his children in English, and therefore speaks mostly in Cantonese; however, he feels it is his wife's duty to convey his message to their children. While he recognizes that better English fluency could improve his life, he does not feel he has the ability to become more fluent.

Matthew and Lisa were raised speaking English first and Cantonese second. Matthew and Lisa consider themselves "Chinese American." Matthew primarily enjoys American television shows and American music, although he also watches Chinese action movies. Until his sophomore year in high school, Matthew excelled in school and extracurricular activities, had a small group of close friends, and generally managed his home and social identities well.

John's father, Ji-Wen, immigrated to the U.S. in the last 6 month to live with John and his family. As the eldest male member of the household, Ji-Wen is considered the

head of the household. He only speaks Cantonese. The traditional expectation is that all family members must listen to and obey Ji-Wen; for the most part John aligns with his father.

Applying the proposed recommendations. To facilitate the demonstration of application, the following discussion highlights the key clinical considerations using illustrations from the Chen family. Moreover, the discussion is organized around the three components of the therapeutic process used to present the clinical recommendations, i.e., rapport-building, assessment, and treatment.

Rapport- building. For the Chen family, business that requires speaking English has always fallen on Ann's shoulders. Ann is frightened that Matthew made a suicidal threat, and is willing to find a family therapist as recommended by the hospital social worker and psychiatrist. She consults her father-in-law first, and then her husband, regarding this matter. While both Ji-Wen and John are in favor of Matthew using medication to control his symptoms, they are skeptical about the usefulness of a family therapist and dislike the idea of discussing family issues with a stranger. Ann feels torn between following up on the treatment plan, which comes from a voice of authority (Matthew's doctors), and loyalty to her father-in-law and husband.

Despite feeling torn, Ann sets up an appointment with one of the clinicians on the referral list she was provided by Matthew's doctors. In order to have some understanding of the family dynamics before the initial appointment, Ann is asked for some preliminary information, including who makes up the family, who is the head of household, and how prescribed and formal their relationship is with one another. Ann was also asked to

briefly describe what she believes are the concerns of the family members about engaging in family therapy.

Based on the preliminary evidence uncovered from Ann, the clinician recognizes a level of formality (e.g., using a title with surname rather than a first name) when meeting the family for the first time will likely facilitate the joining process, especially considering Ji-Wen and John's more traditional orientations. Ji-Wen and John fear that their credibility as a good grandparent and a good parent, respectively, as well as their authority in the family might be undermined by a clinician. Hence, due to the hierarchical and patriarchal nature of the family's culture, the clinician is apt to best connect with the family by first greeting Ji-Wen who is the eldest male of the family and head of household, followed by John. By acknowledging the hierarchical order, the clinician demonstrates his or her respect to the head of the household, which is essential for establishing a working relationship with the family.

In conversations with the family members, the clinician must be particularly sensitive to not engage in verbal and nonverbal communications that imply blame and contribute to losing face. For example, an intense gaze while Ji-Wen is speaking might be construed as the clinician questioning Ji-Wen's judgment as head of the household. Also, verbal communications that are more confrontational are generally ill advised as such exchanges elicit feelings of blame among family members.

In this particular case, an acute incident precipitated the family seeking therapy; therefore, to facilitate the joining process, the initial meeting with the family may not include Matthew as it might be overwhelming for him to hear the expressed angst of his family, although a meeting with Matthew is a necessity before bringing all members of

the family together. To successfully join with the family, the clinician must convey his or her role as an advocate for the family, not particular members of the family.

Assessment. The Chen family illustrates the diversity of language abilities that can exist in a single family and influence the quality of evidence uncovered during the assessment process. Ji-Wen is a monolingual Cantonese speaker, John is a Cantonese speaker with limited English fluency, Ann is bilingual but a native Cantonese speaker, and Matthew and Lisa are English speakers with limited fluency in Cantonese. Ann frequently serves as the family interpreter. Although an adult member of the family, as a female and the youngest of the adult members, Ann is serving in a role incongruent with the traditional hierarchical and patriarchal power structure of the family. These observations speak to the complexity of family members' roles in Chinese American families and the need for bilingual clinicians or to engage cultural interpreters to avoid the use of family members as interpreters for other members of the family.

Based on information Ann has shared over the phone regarding her husband and father-in-law's reservations regarding participating in family therapy, the clinician decides to administer the Loss of Face scale (Zane & Yeh, 2002). This measure reveals that John and Ji-Wen show high sensitivity for the hypothetical, face-threatening situations and behaviors listed in the measure. This information gives the clinician guidance on which topics may be more or less face-threatening to discuss and where to be gentle in eliciting information. Furthermore, the information may be critical in developing hypotheses about how the family functions. For example, John's responses might help the clinician formulate a hypothesis regarding Matthew's interactions with his father, e.g., perhaps John's sensitivity to showing emotion in front of his children contributes to Matthew's

avoidance of consulting with his father, leading John to believe his son does not respect him. Such a hypothesis would then help the clinician plan a specific discussion reframing Matthew's avoidance of his father as not wishing to burden his father and John's hurt feelings as concern over his son's withdrawn behavior. The clinician would then implement communication-based interventions to help father and son articulate their concerns in a mutually respectful manner.

During the assessment process, the topic of mental illness is unavoidable. For the Chen family, mental illness is particularly challenging since Matthew's role in the family, as the eldest child and only son, carries a greater burden for sustaining the family. The family will likely experience disbelief over this situation, hold negative stereotypes about individuals with mental disorders, and worry about the future of the family and its reputation in the community. The clinician must explicitly connect the importance of actively managing the symptoms and engaging in interventions that prevent relapse to influence a better prognosis for Matthew. It is important to validate the feelings of anger, fear, and disappointment of the family members as well as acknowledge the different ways in which each family member reacts to Matthew's condition. The family will benefit if the clinician allows its members to grieve the loss of the family's ambitions for Matthew while deemphasizing the feelings of shame associated with the family's loss. Moreover, it is important for the clinician to help the family members recognize that they share the same good intention and are working toward a common goal, despite their differing views on how one achieves the goal.

Based on the information uncovered during the assessment process, the clinician must guide the family in setting treatment goals. Setting goals for treatment is particularly

challenging when there exist different levels of adherence to traditional values that influence the expectations of family members. For example, John indicates that his goal for Matthew is that he attends a good university and graduates with a degree in engineering. Ann states that her goal is for Matthew to marry a Christian woman and have children. While Matthew would like to please both of his parents, his goals are more immediate; he is overwhelmed by his symptoms and simply wishes his symptoms would remit. In this situation, it appears that the stated goals of each family member may seem in conflict with one another. It is the clinician's job to help distill the underlying goals behind the stated goals. For Ann, the underlying goal might be the promotion of future generations of the family. For John, the underlying goal might be for financial security of the family, and, therefore, economic stability for the family. For Matthew, the underlying goal might be to be a functioning member of his family and community, and consequently promote the goals of his parents. In all of these goals, there is a common thread of promoting the sustainability and longevity of the family. While their short-term goals may differ, they share a larger, common goal. The clinician reframes each family member's short term goal in a manner that promotes the family's sustainability and longevity, e.g., "Matthew's desire to be symptom free will allow him to be a better student, husband, and father, thereby preserving the family's stability and longevity." Stemming from the theme of the family's sustainability, more realistic goals can be negotiated to reduce family stress and restore family harmony.

Treatment. Family therapy with Chinese Americans must consider the acculturation of family members, the associated values and beliefs, and how these considerations may influence treatment and the selection of treatment modalities.

Recognizing that Ji-Wen and John are hesitant to participate in treatment due to reasons explained by Ann, the clinician avoids using the term "therapy" and "therapist." Being more compatible with the expressed value the family places on education, the clinician elects to treat therapy as an educative experience with sessions referred to as "consultations" or "classes" and the clinician as a "consultant" or an "educator."

Despite the research literature supporting the efficacy of multi-family group therapy (MFGT) for Western populations, given the initial assessment with the family and Ji-Wen and John's particular feelings about loss of face, the clinician feels individual family treatment is a more appropriate for the Chens. In later consultations, the more acculturated members of the family – Ann, Matthew, and Lisa – voice interest in knowing how other individuals and families cope with schizophrenia and related disorders. The clinician provides them with media resources (books, websites, and movies) and a list of drop-in support groups they may be interested in pursuing, emphasizing that participation is voluntary, not all family members need to attend, and if family members want to participate, they can ascertain each group's policy on confidentiality.

Psychoeducation is typically a component in the treatment of schizophrenia, focusing on the symptoms of the disorder, its etiology, and how the disorder is treated. Valuing education, a psychoeducational approach may allow the family members, including Ji-Wen and John, a relatively safe way of becoming better informed about schizophrenia and its treatability. But it is important to note that a decidedly Western discussion of the genetic heritability of schizophrenia and the relevance of psychosocial stressors in the development of the disorder may reinforce the stigma associated with

mental illness and compound feelings of guilt for a family such as the Chens where there remains a relatively strong adherence to traditional values. The discussion of etiology may be more effective if reframed as a biochemical imbalance and an imbalance in interpersonal harmony where medications for Matthew and consultations with the family can help re-establish its homeostasis.

A key treatment consideration is the minimization of stress among family members and the significance of problem-solving and communication skill-building to successfully influence the cycle of stress experienced within the family context. But unlike Western views that value direct confrontation and the independence of the patient from the family, therapy with Chinese American families must consider the degree to which family members adhere to traditional values and beliefs such as negotiation and maintaining the family role and structure. For example, John is considered highly critical by Matthew and other family members, but he believes a parent who does not criticize is one who does not truly love his child. When a parent expresses such a view, it is important for the therapist to clarify John's intent from its effect to John and the members of the family. The use of criticism is John's way of comfortably expressing his concern and love for Matthew and the rest of the family, and is not just to be mean-spirited. On the other hand, it is important to help John understand his intent may not be understood by the members of his family as concern. It would also help John understand how such expressions may contribute to family disharmony rather than bringing his family back into balance, which is his intent.

Ji-Wen is often reticent in problem-solving discussions. Based on previous family interactions, the clinician hypothesizes that Ji-Wen may have been angered by a previous

experience when he gave Matthew advice on how to ignore his symptoms and Matthew reported that the suggested technique did not work. The clinician makes a special effort to align with Ji-Wen by reiterating how valuable his thoughts are to the family, and how his family can gain from the wisdom that only comes with age. When Ji-Wen gives advice rather than participating in problem-solving, the clinician helps reframe Ji-Wen's advice in terms of how it fits with the family's underlying goal of family sustainability. In doing so, the clinician helps to avoid situations in which family members might ignore Ji-Wen's advice, thereby insulting Ji-Wen. It is imperative for the clinician who is unfamiliar with Chinese American communication patterns to consult a cultural expert to become aware of the cultural meanings of nonverbal communication. In the case of the Chen family, if the clinician assumed that Ji-Wen's silence meant that he had nothing to add, this assumption might result in Ji-Wen feeling insulted and family members viewing the clinician as culturally incompetent, ultimately leading to premature termination.

The negative symptoms associated with schizophrenia also create challenges in families that are achievement oriented, such as the Chens. During initial consultations, the clinician notices that Ji-Wen and John do not ask Matthew for his opinion, while Ann does occasionally. The family members also engage in pejorative references such as "useless" or "lazy" to describe Matthew when he oversleeps or neglects his school work. It is important to validate the opinion of the grandfather and parents by reframing the intent of such descriptions as concern for Matthew's welfare while also educating the family members about how these observations are connected to the nature of negative symptoms. Moreover, it is important to negotiate solutions as a family by encouraging Matthew's participation; and to guide all family members in practicing negotiation skills

so they can successfully seek their own solutions and re-establish balance. For example, Matthew and his family decide that Matthew will take a leave of absence from school and return in the fall. The family has learned from the psychoeducation component of family consultation that maintaining responsibilities will actually help reduce Matthew's stress. Matthew dislikes the idea of having to do dishes or laundry as he associates these tasks with the work of women, even if it is for the good of the family. In order to negotiate goals that will reduce stress for Matthew and benefit the family, the clinician and the family give Matthew a list of household chores that would help the family and Matthew is asked to choose which tasks are more amenable. The clinician also reframes the value of each chore or the benefit it provides to the family in having that chore completed. Giving Matthew a choice may allow him to choose tasks that feel less demeaning and also give him a sense that he still has some special privileges and autonomy as the eldest male child. Matthew ultimately decides he will be in charge of taking care of the front and back yards, and taking out garbage and recycling. It would be beneficial for the clinician to continue emphasizing the therapeutic value of Matthew having responsibilities that promote the good of the family for decreasing family stress.

Issues related to medication use can also pose challenges for families. Matthew's stabilization at this time depends on regular anti-psychotic medication use. Although the family members agree that Matthew requires medication, there may be differing opinions as to the type of medication that would most benefit him. For example, Ji-Wen may prefer Matthew switch to herbal medications and discontinue his anti-psychotic medication once he is stabilized. But Matthew prefers to stay on his anti-psychotic medication because it controls his symptoms. In this case, the clinician would do well to

honor both Ji-Wen and Matthew's opinions. The clinician might ask Matthew, "Why do you think your grandfather prefers traditional herbal medicine?" This would give Matthew an opportunity to speculate on his grandfather's good intentions and his understanding of his grandfather. The grandfather might be asked a similar question about Matthew, allowing the grandfather to better understand how Matthew is experiencing his illness. In this situation, the clinician has honored each family member's opinion and has also asked them to step inside another's shoes. The clinician should not dismiss the use of herbal medications or other forms of alternative treatments but work with the family and psychiatrists to find safe ways to integrate these practices.

Chapter IV. Discussion

Summary of Key Clinical Considerations and Recommendations

Based on a synthesis of the relevant literature, comments from clinicians who served as peer debriefers, and the professional and personal experiences of the researcher, the following is a summary of the key clinical considerations and recommendations for providing mental health services to Chinese American families in which a family member is diagnosed with schizophrenia:

- It is important to take into account the intersection of the values and demographics of the specific Asian ethnic culture, English proficiency, acculturation level of each family member, and the etiology of the psychiatric disorder and associated symptoms when planning treatment with the family. The clinician may require consultation with a cultural expert in order to understand differences in culture and communication style and/or the use of a professionally trained interpreter in the event the clinician is not bilingual and family members are not English proficient.
- Other forms of treatment for the patient may have been exhausted, leaving the family members feeling distressed, frustrated, and perhaps hopeless about the patient's situation, which may influence their expectations about meeting the clinician or what to anticipate from treatment.
- The rapport-building phase of therapy must take into account the potential of the clinician being viewed as an intruder by the family members; hence, emphasis should be placed on establishing interpersonal stability between family members and the clinician as well as identifying and respecting the family hierarchy. It may

be necessary to engage in a number of separate meetings with individual family members or combinations of family members to acquire relevant clinical information about the family and how it functions, to facilitate a comfortable therapeutic relationship, and to gain the trust of the family.

- Acculturation levels among family members may differ considerably, influencing the degree of adherence to traditional cultural values. Despite this potential variability, it is not uncommon for Chinese American families to prioritize the needs of the family as a whole over the individual family members. Hence, an important consideration in planning treatment is negotiating practical therapeutic goals that all family members identify as important to restoring family harmony. There may be times that the goals of individual family members appear at odds with the goals of other family members. When such situations arise, it is essential for the clinician to reframe each of the goals to illustrate the underlying goals all family members share in common.
- In traditional Chinese families, the family is viewed as a single body for which family members have an obligation or a duty to take care of one another in illness; hence, the family can serve as a valuable resource for the patient. Given these cultural values, the use of family interventions appears a natural treatment modality.
- While appealing to the family's expectation for expert information, reframing therapy as an educational experience may help minimize the stigma associated with seeking mental health services.

- In offering psychoeducation about schizophrenia, the clinician must consider the family's understanding of mental illness. For less acculturated Chinese American families, the Western heritability explanation for the disorder may exacerbate the degree of disgrace experienced by family members, while referring to a biochemical imbalance may feel less threatening and more manageable.
- It is also essential that the clinician not filter what he or she hears or observes through a Eurocentric lens or prematurely formulates clinical hypotheses and acts accordingly before fully understanding the cultural framework of the family. For example, how are "criticism" and "discipline" and "autonomy" versus "enmeshed" understood from a traditional Chinese worldview? How might these concepts be reframed to decrease the patient's stress while still validating the beliefs of the other family members? Clinicians treating Chinese American families must be committed to serving in a culturally competent manner and must seek resources that will best help them serve these families.
- Developing communication and problem-solving skills are essential elements of treatment. But instructing the family on building these skill sets cannot be separated from three key cultural considerations: (a) respecting the family hierarchy, (b) not threatening the ability to save face, and (c) family collectivism. Western problem-solving and communication styles emphasize direct confrontation, egalitarianism among family members, and individuation of the patient from his or her family. To successfully work with more traditional Chinese American families, the clinician must engage in practices that respect the family hierarchy and allow face saving, while giving a voice to the other family

members; reframe negative emotions to emphasize the positive over emphasizing the negative (e.g., re-label "criticism" as "worrying"); and promote realistic responsibilities for the patient within the context of contributing to family harmony, but not encouraging that the patient become independent of his or her family.

- Chinese American families who adhere to more traditional Chinese values may be better suited for individual family therapy with a family support group recommended when the family is ready. Chinese American families who have higher levels of acculturation (this will still vary among family members) may be better suited for multifamily group treatment. The clinician's assessment with the family using both interview and formal instruments to assess for acculturation level can help the family and clinician determine whether individual or multigroup family treatment is the preferred treatment.

Recommendations for Future Directions

Culture and moderators of culture ultimately influence the individual and family's conceptualization of mental illness and help-seeking (Chun & Akutsu, 2009; Kim, Ahn, & Lam, 2009). Despite developments in the last two decades in the field of psychology, especially the push for multicultural competence, clinicians and researchers struggle to discover, create, and implement interventions that are appropriate to minority cultural groups, Chinese Americans included. It is clear that there is a need for theories and interventions that are appropriate to Chinese Americans and other cultural groups for whom the Western models and interventions do not fit, such as family treatment models that more fittingly address collectivist family values.

While schizophrenia is a disorder that affects people of all ethnicities, for Chinese American families, the diagnosis of schizophrenia can create a high level of stigma. In particular, the disruptive behavior or bizarre symptoms puts the family at risk for embarrassment, perhaps more so than other mental illness diagnoses. The high need for treatment paired with low utilization rates for Chinese Americans highlights the need for both better access to services and the availability of culturally appropriate services. Because stigma is often viewed as the most important problem brought on by schizophrenia (Lee, 1997a), it is around this topic that more attention is needed. Further exploration is needed on how to address and ameliorate the effects of stigma so that individuals and families will feel able to seek treatment and seek it sooner. A campaign against stigma utilizing mental health public service announcements in Chinese languages for the television, radio, and similar printed announcements on billboards, newspapers, and magazines may be one place to begin. Moreover, building alliances with indigenous healers and member of the medical community that serve the Chinese American community might be a fruitful path to pursue.

Psychosocial family treatments have shown positive treatment results and the most promise for preventing relapse, though the question remains of how to create or implement a type of family treatment that is culturally appropriate for Chinese American families. The traditional family-orientation of Chinese Americans may make family treatment particularly amenable to such families, yet the field still lacks evidence to support this assumption. For example, further consideration regarding how different acculturation levels within the family system influence the therapeutic process and how one negotiates these differences in treatment is warranted. Furthermore, a common

dilemma for clinicians new to working from a multicultural frame is finding scholarly literature that adequately describes how one engages in culturally relevant clinical practice, but does so in a manner that balances the details without become prescriptive. The concept of "transferability" in qualitative research has merit for addressing this need (Mertens, 2010). By multicultural scholars and clinicians offering a "thick description" (Mertens, 2010, p. 259) of how to build rapport, assess, and treat schizophrenia among Chinese American families (or other cultural groups), less experienced clinicians are better positioned to judge whether the evidence presented is a good fit with their own client's needs and/or how their practices may require adjustments to meet their client's needs.

The need for documentation of treatment effectiveness for Chinese American and other ethnic communities points to the need for research that is conceptualized and designed within a cultural framework. Just as cultural competence is necessary for engaging in clinical practice, research must also place import on producing culturally competent scholarship and government and other entities that grant funding for said research must serve as gatekeepers. Chun et al. (2007), based on the work of D. W. Sue (2001), suggest that members of a culturally competent research team understand how the researcher's culture influences his or her values, beliefs, and attitudes; seek knowledge of the worldview of the cultural group with which the team wishes to conduct research; and engage in culturally appropriate research methods and communication styles. Engaging in self-reflection and peer debriefing with colleagues and others, participating as members of the community one wishes to conduct research, and allowing the evidence

uncovered in these exchanges with community members to inform the research process would increase the cultural authenticity of the research.

Methodologically, more attention to effective recruitment strategies to broaden the participant pool is critical. To more effectively gain access to the community, Chun et al., (2007) suggest identifying civic and other leaders in the community who might serve as gatekeepers to potential recruitment sites. Moreover, Chun et al. suggest framing studies in a culturally meaningful way to potential participants that appeal to their collectivistic orientation. For example, describing how a study benefits the community's ability to maintain harmony among its members to recent Chinese immigrant families may create the "buy in" necessary to secure a more comprehensive sample pool. Similar to engaging in therapy, it is important to appeal to the collectivistic nature of families by conveying how the family and community of families with which they reside benefit from the experience.

Conclusion

The search for culturally appropriate treatment for schizophrenia holds the potential to alleviate a great deal of suffering, alienation, and stigma endured by the individual who is diagnosed and for his or her family. The development and implementation of culturally appropriate family treatments provides an opportunity for families whose needs have traditionally been neglected, to become more cohesive and to gain strength from the challenge of living with schizophrenia. Families who receive appropriate treatment will cope better with their family member's diagnosis and symptoms. My hope is that families who cope better vis a vis culturally appropriate treatment will ultimately experience a decrease in the crippling stigma and shame

associated with schizophrenia, and become mobilized to work together for the benefit of all family members.

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APPENDIX A

Literature Spreadsheet

Table of Acronyms and Common Abbreviations

AAPI or AA/PI	Asian American and Pacific Islander
AAVS-M	Asian American Values Scale-Multidimensional
AFD	Acculturative Family Distancing
ARSMA	Acculturation Scale for Mexican-Americans
ATSPPH	Attitudes Toward Seeking Professional Psychological Help Scale
ATSPPH-SF	Attitudes Toward Seeking Professional Psychological Help Scale-Short Form
AVS	Asian Values Scale
BFT	Behavioral Family Therapy
BPRS	Brief Psychiatric Rating Scale
BSI	Brief Symptom Inventory
CAF	Community Adjustment Form
CBT	Cognitive Behavioral Therapy
CCCI-R	Cross-Cultural Counseling Inventory-Revised
CERS	Counselor Effectiveness Rating Scale
CFCG	Chinese Family Caregiver
CFI	Camberwell Family Interview
CHIP	Coping Health Inventory for Parents
CMQS	The Causal Models Questionnaire for Schizophrenia
CT	Cognitive Therapy
Ct	Client
DEPTH	Session Depth subscale (of the Session Evaluation Questionnaire)
DUP	Duration of Untreated Psychosis
Dx	Diagnosis
EAVS-AA	European American Values Scale for Asian Americans
ECLMs	Ethno-Cultural and Linguistic Minority communities
ECS	Expectation for Counseling Success Scale
EE	Expressed Emotion
EOI	Emotional Over-Involvement
EUS	Empathic Understanding Subscale (of the Barrett-Lennard Relationship Inventory)

FBIS	Family Burden Interview Schedule
FEP	First Episode Psychosis
FI	Family Intervention
FPC	Filial Problem Checklist
FPST	Family Problem-Solving Task
FSSI	Family Support Services Index
Fx	Functioning
GAF	Global Assessment of Functioning
GAS	Global Assessment Scale
HoNOS	Health of the Nation Outcome Scale
ISL	Index of Self-esteem
KASI	Knowledge About Schizophrenia Interview
LOF	Loss of Face Scale
LEE	Level of Expressed Emotion Scale
MBAPE	Match on Belief About Problem Etiology
MEACI	The Measurement of Empathy in Adult-Child Interaction
MFG or MFGT	Multi-family Group Therapy
MH	Mental Health
NOS	Network Orientation Scale
NOSIE	Nurses' Observation Scale for Inpatient Evaluation
PANSS	Positive and Negative Syndrome Scale
PAS	Psychiatric Assessment Scale
PPAS	The Porter Parental Acceptance Scale
PSE	Present State Examination
PSI	Parental Stress Index
PSPCSAYC	The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children
Pt	Patient
QOL	Quality of Life Scale
RG	Relatives' Group

RSES	Rosenberg Self-Esteem Scale
SANS	Scale for the Assessment of Negative Symptoms
SAS	Social Adjustment Scale
SCS	Self-Construal Scale
SDS	Social Desirability Scale
SDSS	Social Disability Screening Schedule
SL-ASIA	Suinn-Lew Asian Self-Identity Acculturation Scale
SLOF	Specific Level of Functioning Scale
SPMI	Severe and Persistent Mental Illness
SPPC	Self-Perception Profile for Children
SWL	Satisfaction with Life
SERS	Self-Esteem Rating Scale
Sx	Symptoms
Tx	Treatment
WAI-SF	Working Alliance Inventory-Short Form

Table 1. Schizophrenia and Family Therapy: Current State of Affairs

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
American Psychiatric Association (2000)					• Listing of diagnostic criteria for schizophrenia.	
Comer (2001)	Description of treatments for schizophrenia from past until present			Literature review	• Past institutionalized care: Asylums and private/public psychiatric hospitals. • Institutionalization led to social breakdown syndrome. • Lobotomies in the 1940s and 1950s, not based on sound methodology and unethical. • In the 1950s, institutions focus on Milieu therapy and token economy program. • Discovery of antipsychotic medications put an end to lobotomies. • Unwanted side effects of conventional antipsychotic medications: "Parkinsonian and related symptoms, neuroleptic malignant syndrome, tardive dyskinesia" (p. 458). • New antipsychotic drugs appeared to be more effective, helping 85% compared to 65% and also seemed to affect negative Sx: Clozapine, risperdone, olanzipine. • Effects of deinstitutionalization: Community care, short-term	• Many individuals receive appropriate community mental health services primarily due to poor coordination and shortage of services. • As a result of inadequate community treatment, many do not receive treatment at all, others spend a short time in state hospitals and are prematurely discharged, some enter nursing homes, single-room-occupancy hotels, boardinghouses (often in run-down, inner-city locations). Many remain homeless.

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Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					hospitalization, halfway houses, coordinated services. • Psychotherapy: Insight Therapy, Family Therapy, Social Therapy.	
Falloon, Boyd, & McGill (1984)	Discussion of aspects of caring for a schizophrenic family member			Literature review	• Refer to pp. 31-66. • Treatment should focus on benefiting the quality of life for the entire family. • Chronic relapse is a major source of stress for all family members. • When tolerance for behavior is low, family stress and relapse rate are high. • Stress can result from both intrafamilial and extrafamilial sources. • Two potential modifiers of stress are neuroleptic drugs and problem-solving/coping capacity of patient and his/her social environment that enables stress to be effectively resolved.	• The major component of family intervention is the enhancement of problem-solving effectiveness of the Pt and his/her household members.
Falloon, Held, Coverdale, Roncone, & Laidlaw (1999)	International review of 43 controlled studies since 1980 looking at validity of study and effectiveness of strategies applied to clinical practice			Literature review	• 10/11 studies show stress management reduces residual Sx. • Increase in social Fx 18% mean gain for experimental and 2% in control group. • Reduction in caregiver stress	• "Family-based stress management is a highly effective addition to long-term clinical treatment of schizophrenic

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					mean reduction 34% for experimental in 4 studies, 9% mean reduction for case management/drug conditions. • Enduring benefits had mixed results, studies varied in length of Tx, studies that looked at benefits over at least 2 years showed 23% advantage of stress management minimizing relapse, 1 long-term follow up (at least 5 years after active Tx) suggested some clinical benefits may endure. • 5 studies show best results with social skills training and family stress management, 19% of Pts had poor outcomes with this Tx. • Limitations in Tx: High attrition in MFGs, interventions must be adapted to specific Cts needs, few strategies have described clear guidelines and few use Tx manuals. • Limitations of study: Tx couldn't be blind to subjects, clinicians and assessors, studies varied greatly on intervention strategies, methods of outcome assessment varied, varied levels of therapist skill/time/enthusiasm.	disorders" (p. 283). Refinement needed in effectiveness and efficiency—requires better methods of assessing clients' & relatives' needs and targeting specific stressors & strategies in an individualized manner. • Strategies needed to promote enduring benefits when Tx has ended. • Clinicians need training to employ methods competently. • Many components of stress management approaches exist (assessment of biomedical and psychosocial needs, case management, drug Tx, psychoeducation for Pts and caregivers, problem-solving training, strategies

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						for Tx compliance, social-skills training, CBT for residual Sx, and planning for relapse and crisis) and it is unclear what combination of Tx methods is most effective and efficient.
Glynn (2003)	Discussion of Sx control and social adjustment in schizophrenia followed by overview of 4 main empirically-validated rehabilitation methods: Family interventions, CBT, social skills training, vocational rehabilitation and supporting data Additional discussion on recent onset and older Cts			Literature review	• Relapse and rehospitalization rates for those in single family or MFG Tx were half of that of those who received routine care and no family Tx (usually behavioral models). • CT Sx-focused interventions showed reduction in positive Sx but didn't affect relapse/rehospitalization rates; different meta-analysis reported 0.65 effect favoring CT, increasing to 0.93 in 4 studies that reported post-Tx follow ups. • Social skill training-moderate improvement, difficulty with generalizing; efforts being made to modify delivery and environment. • Rates of employment double or	• Goal of behavior should be to not just control positive Sx and reduce relapse but to create a live worth living. • Family interventions have proven valid but dissemination problems exist. • Need to develop generalization techniques. • Need to identify when specific interventions are appropriate during Tx. • Participation in a program is stressful for the Ct.

Table 1. Schizophrenia and Family Therapy: Current State of Affairs

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					triple with vocational rehabilitation compared to traditional services; however, rates are still only 20-40%.	• Professionals are pessimistic about the population. • Lack of training with the interventions and mental health funding may not support the use of the interventions. • Mental health obstacles to dissemination: Confidentiality; staff availability; ambivalence about encouraging family dependence; participant obstacles-finances, stigma, transportation, ignorance of mental health issues, multiple demands.
Kuipers (2006)	"To look at the theoretical and empirical basis of family interventions for psychosis, review outcome data, and discuss a recent study which relates to			Literature review	• High rates of health concerns for carers and financial strain. • Higher levels of relapse for those returning to highly critical, high EOI families. • High EE levels also found in staff carers; this also affects	• "There is an empirical rationale for calming family interactions as a way of reducing patient anxiety during family intervention.

Table 1. Schizophrenia and Family Therapy: Current State of Affairs

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
	mechanisms in family interventions" (p. 73)				perceived burden for staff members. • "EE and burden are more dependent on an appraisal of the client's problems than on actual deficits" (p. 75). Higher EE is associated with higher subjective burden. • FI helps by assisting relatives to understand and relate to the patient; helps with problem-solving; helps reappraise problems; helps contain and manage Sx; helps process loss. • FI is helpful but it is not clear why; hypothesis that changing affect through FI helps carers and patients.	It is also useful to improve carer self-esteem, depression and coping" (p.79). • Exactly how family intervention improves outcome is still unclear.
Lukens & McFarlane (2002)	Discussion of the relevance of family, social networks, and schizophrenia			Literature review	• Refer to pp. 18-35. • Course, outcome, and Sx are worsened by stress. The most prominent stressor for the family and Pt is the illness itself. • Absence of meaningful stimulation can increase stress. • Clinicians should work with families to understand the impact of stigma and sort out reality from the label. • As Pt's Sx increase, family burden increases; family ends	• Knowledge/comprehension of schizophrenia and correct attribution and appraisal of situation contribute to family's ability to cope with stress.

Table 1. Schizophrenia and Family Therapy: Current State of Affairs

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					up caring for ill member compared to past when the Pt was institutionalized.	
McFarlane (2002)	To provide a rationale, overview of, and guide to multifamily group treatment for psychiatric disorders.			Literature review	• Joining is essential to treatment; it is an intervention to develop a relationship with patient and family. • Families often seek help after a crisis. • Family education is essential for members to gain a sense that they have can have an effect and to correct disabling beliefs members may have about the illness. • Dominant family stressors are the illness itself, lack of resources, and lack of personal and professional supports. • Patients and their families are often more isolated than others; MGFT provides a necessary social network for patients and families. • Psychiatric (as well as medical) illnesses are exacerbated by stress. • The object of treatment is the disorder; the afflicted person is a collaborator in treatment. • Interfamily assistance is reinforced among group	• MFGT has shown improvement in family communication. • MFGT also helps absorb family anxiety, widens the family's ability to problem-solve, and promotes humor and warmth, a tone that encourages and supports members. • Cross-parenting often enables family and patients able to take in vital information they might be unable to hear from their own family members. • Psychoeducation is necessary to improve family well-being but is not alone sufficient in treatment of psychiatric disorders within the family.

Table 1. Schizophrenia and Family Therapy: Current State of Affairs

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					members.	• Social support is a necessary component of rehabilitation and results of studies suggest that longer term work (for at least a year) may be necessary to achieve the desired effects.
McFarlane, Dixon, Lukens, & Lucksted (2003)	To review the efficacy and progress of family psychoeducation for schizophrenia			Literature review	• Family psychoeducation has established efficacy and effectiveness; however, actual practice is limited.	• Research must target low-cost strategies and identifying barriers to implementation in various settings. • Practitioners need to be aware that new approaches are applicable and more effective than previous models.
Montero et al. (2005)	To determine whether "all people with schizophrenia receive the same benefit from different family intervention programs" (p. 187)	• Dx of schizophrenia • Comorbid drug/physiological/neurological issues included • Referred immediately after the episode • Behavioral	• PAS • DAS II (social disability) • CFI Spanish language version • Clinical interviews with family and patient records	Experimental design	• BFT/RG compliance 67%/51%. • No statistical difference between relapse rates. • Readmit rates similar. • Older patients RG group lower relapse than BFT. • "In younger patients, no association was observed between the relapse and type of intervention" (p. 191).	• Tx modality informed by the patient's length of illness. • RG program was better for older Pts diagnosed long time ago but with fewer hospital admits, living w/ 3 or more

Table 1. Schizophrenia and Family Therapy: Current State of Affairs

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
		family therapy *n*=46; Relatives' Group *n*=41 • Low education and employment levels • Mean illness length 5.8/5.3 • Control group received standard 1-year FI program (Spanish public health system) • Study conducted in Spain			• Lower hospitalization rates in past had lower relapse rate in RG than BFT. • Relapse rates for individuals with Dx of greater than 5 yrs lower in relapse in RG than BFT/lower EE families and extended families had more significant decrease in relapse in RG than in BFT. • No negative results for low EE families in recent onset patients in BFT. • For first episode cases, relapse frequency was higher in RG 40% than BFT 19%.	relatives and w/ key relative showing low level of psychological distress; partially supports EE studies. • Groups are efficient use of professionals' time but there are large numbers of individuals who decline or discontinue Tx than in other formats. • Evidence of effectiveness in non-research settings is limited. • Needs of high vs. low EE families may be different. • What characteristics could identify patients who respond better to different Tx modalities. • This study had a higher # of EOI families (rather than overly critical) as compared to other

Table 1. Schizophrenia and Family Therapy: Current State of Affairs

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
						EE studies.
Seikkula & Trimble (2005)	To "analyze the basic elements of dialogue" and how "dialogue becomes a healing experience in a network meeting" that includes family its network of providers (p. 461)			Literature review and case illustration	• "Understanding requires an active process of talking and listening" (p. 461). • "Dialogue is a precondition for positive change in any form of therapy" (p. 461). • When a person or family is in crisis, "a team of colleagues is mobilized to meet with the family as promptly as possible within 24 hours, usually at the family's chosen location—the team remains assigned to this case throughout the treatment process" (months to years) (p. 461). No conversations and decisions are performed unless all members of network and family are present. All decisions and meetings include team members, patient, patient's relevant social relations, and relevant authorities. • Team members must tolerate intense emotional states in meetings and the conversations among members in meetings "serve the function of a reflecting team, expanding the network members' possibilities for making sense of their	• Meaning develops within the interpersonal space and dialogue between people. • The more voices, the more possibilities for understanding. • Feelings of solidarity are created when painful feelings are shared among people in the session and not stifled • Experiences that mark turning points in healing: "feelings of sharing and belonging; emerging expressions of trust; embodied expressions of emotion; feelings of relief" (p. 473); and "ourselves becoming involved in strong emotions and evidencing love" (p. 473).

Table 1. Schizophrenia and Family Therapy: Current State of Affairs

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					experiences" (p. 462). • Several outcome studies "have demonstrated utility and effectiveness of the Open Dialogue approach, especially during crisis" (p. 462). • Open Dialogue is unique in "its integration of two key elements, the organization of the treatment system and the dialogic process of its meetings" (p. 463). • Creation of a new shared language involves: gathering information in a manner that facilitates story-sharing with ease, listening intently and compassionately, and commenting on network members' responses and each other's utterances about members'.	
Torrey (2001)	Overview of schizophrenia and guide for families living with schizophrenia			Literature review	• Refer to pp. xxi-xxii. • Purpose of book to provide a scientific framework for understanding causes, Sx, and Tx and how families can come to terms with the disease. • Author refers to the despair voiced by thousands of family members regarding the diagnosis of schizophrenia.	• Pts' fates are worsened by the public's tendency to misunderstand, lack of appropriate treatment, and lack of high-quality research.

Table 1. Schizophrenia and Family Therapy: Current State of Affairs

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					• Schizophrenia affects individuals resulting in "constricted experiences, muted emotions, missed opportunities, and unfulfilled expectations" (p. xxi).	

Table 2. Schizophrenia, Family Therapy, and Culture

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
American Psychological Association (2002)	To provide guidelines for the changing needs in the field of psychology in order to address multiculturalism and diversity				• The development of 6 guidelines, along with research to back up the guidelines, regarding items such as their own beliefs and how to foster multicultural awareness in the work they may engage in as professionals	• The guidelines were designed to increase the knowledge and skill of practitioners as past biases have caused detriment to different cultural groups seeking help.
Bradley et al. (2006)	Exploring the effectiveness of a MFG in Australia with 1st generation Vietnamese immigrants and with English-speaking families	• 34 English-speaking families • 25 Vietnamese-speaking families • 18-55 years old • Recruited from outpatient continuing care • Dx of schizophrenia,	• BPRS • SANS • HoNOS • QOL • Family Burden Scale	Experimental design	• Relapse rates immediately after Tx were 12% and 36%, follow up 25% and 63%. • BPRS significantly lower for MFG and job results increased. • Relapse and Sx rate reduction were	• Higher rates of perceived family burden noted in Vietnamese families could perhaps be due to ethnicity (sociocentricity where family assumes a high level of responsibility for the patient) or due

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		schizoaffective disorder, or schizophreniform disorder • Minimum of 10 contact hours with family • Comorbid substance use d/o • Psychiatrists had min of 15 years in public mental health settings using DSM-IV for Dx			similar for both groups.	to migration-resulting in high rates of efficacy in both the control & experimental groups. • Proposes that this study supports continued use of the MFG with migrant families (with cultural modifications) though no specific. modifications suggested • Study did not take into account spousal vs. parental caregivers.
Gee & Ishii (1997)	Discussion of the "assessment and treatment of schizophrenia among Asian Americans" (p. 227)			Literature review	• Conclusions from one Asian group cannot be blindly applied to other Asian groups. • As viewed by Asian families, the most important problem caused by schizophrenia is stigmatization; denial protects family reputation and protects from the stress of shame.	• Effective treatment for schizophrenia in Asians involves rapport building, cultural attunement, effective use of translators, engagement of the family, and judicious discussion of Dx and Tx with the family. • There may be limits to optimizing treatment with Asians with

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					• Mental illness is stigmatized because Sx are individualistic and do not increase belonging to family or society. • For Chinese families, having a family member with mental illness brings shame upon entire family and makes marriage difficult for the Pt and for the rest of the family's progeny. • Help-seeking behavior (specifically the Chinese) can be described as: initial denial, attempts at containment of illness within family, use of traditional healing methods, referral to a general practitioner, reluctant attempts to use psychiatric Tx and hospitalization, and eventual scapegoating and rejection of the ill family member.	mental illness due to stigma, sporadic attendance in treatment, delay in seeking treatment until Sx are severe, and longer length of untreated psychosis.

Table 2. Schizophrenia, Family Therapy, and Culture

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					• Sx must be evaluated in context of Pt's cultural beliefs such as beliefs in spirits and power of past misdeeds.	
Lopez et al. (2004)	To "test a more complete model of attribution theory" in the course of schizophrenia that included "attributions of control, families' negative and positive affect, and patients' relapse" (p. 430) To "assess the role of families' prosocial functioning" (p.430) To suggest "family warmth" should be considered in predicting patient relapse and contrasting findings among Mexican-American families and Anglo-American families (p. 430)	• *n*=98 dyads (one patient and one key relative in each dyad) • 54 Anglo American • 44 Mexican American • From inpatient facilities • Ages 17-50 • Anglo American or Mexican American descent • Living with a close relative at least 1-3 months prior to admission	• Abbreviated CFI • PSE • PAS • BPRS	Correlational study	• Families' attributions of controllability were positively correlated to families' level of criticism $r = .52$) and negatively related to families' level of warmth ($r = -.49$). • Families' criticism (r = .33) and warmth ($r = -.26$) were significantly related to relapse, though attributions of control ($r = .23$, $p = .08$) were marginally related to outcome. • Patients using street drugs, who did not comply with medication, or who had little family contact were more likely to relapse. • Gender was not significantly related	• "The relationship between families and the course of schizophrenia is more diverse than prior research has indicated" (p. 438). • Family warmth can be as important as criticism depending on sociocultural context. • There is a need to examine prosocial family factors and the course of schizophrenia.

Table 2. Schizophrenia, Family Therapy, and Culture

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					to course of illness. • The degree of warmth in Mexican American families is inversely related to relapse, not significantly related in Anglo American families. • For Anglo American families, relapse tended to increase with criticism, not so for Mexican American families.	
Telles et al. (1995)	Comparison of "effectiveness and cross-cultural applicability of Behavioral Family Management and standard case management in preventing exacerbation of symptoms and relapse in schizophrenia" (p. 473)	• 40 low-income Spanish-speaking people w/ Dx of schizophrenia or other psychotic disorder **Sociodemographic variables** • Mexican • Guatemalan • Salvadoran • L.A. Department of Mental Health • 18-55 years old • Live in community with family member at least 6 months	• UCLA-Mental Health Clinic Research Center expanded version of the PSE • Psychiatric and Social History Schedule • ARSMA • Abbreviated CFI • BPRS • GAS	Experimental design	• Less acculturated individuals were at significant greater risk for exacerbation of Sx with the BFM. • More acculturated patients risks were predicted by medication compliance but not by type of intervention and Tx outcomes differed little between experimental and control group/ at 1 year follow-up. • Less acculturated individuals had	• "Sociocultural factors affect responses to different intervention" (p. 473). • Results don't support findings of others that BFM is beneficial when applied to diverse populations. • EE level (low) & acculturation level may affect course & outcome of schizophrenia, suggesting different responses to different types of Tx.

Table 2. Schizophrenia, Family Therapy, and Culture

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		prior to admission • Originally 15 women, 27 men			significantly poorer outcomes in the BFM group than the case management group. • Medication compliance poorer with less acculturated group but not significantly related to any outcome variable.	
Weisman, Duarte, Koneru, & Wasserman (2006)	Discussion of the "development of family-focused, culturally-therapy for schizophrenia (CIT-S) that is being pilot tested" (p. 171)	• Current enrollment in study approximately 20 families • Family member with schizophrenia • Other specific family variables not listed	• Self-report measures / efficacy evaluations • Clinical interviews	Literature review and description of pilot phase of a study	• Family members completing Tx have rated high satisfaction, though efficacy evaluations will not be completed until the study is completed. • Cultural challenges: (1) how ethnicity is defined and coded, (2) how to choose the language in which sessions are conducted, and (3) how the concept of time is understood among Latino families.	• Authors hypothesize that CIT-S will significantly decrease schizophrenia Sx for Pts and improve general emotional/mental health for Pts and families.

Table 3. Family Therapy and Chinese Families

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
Berg & Jaya (1993)	Cultural sensitivity can be learned in working with Asian-American families Therapist does not have to be of same ethnic background	• Elderly Korean woman, her husband, and adult son		Theoretical discussion, including a case example	• Tradition that problems solved through negotiation/mediation —not head-on confrontation; better to meet parties individually before meeting altogether. • Exclusion from family is worst punishment. • Independence and "normal" development delayed because not expected (self-care, chores, sleeping with parents etc). • Earning outside praise through good manners etc brings honor to the family. • School=discipline, rules, orderliness. • "[H]ow things are done is sometimes more important than what is done" (p. 33). • Important to establish proper social	• Each group has their own distinct heritage and a different reason(s) for immigration. • Respect Ct's ability to set pace for Tx. • Techniques of reframing in relationship context used to respect the world view of the Ct. • Most ethnic minority Cts want to cooperate with professionals regardless of therapist's origin.

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Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					relationship and therapist answer personal questions honestly (age, education, family). • Respect hierarchy. • Pragmatic solutions not exploration of feelings; suggestions better couched in terms of how to perform one's duty, increase peace in a relationship, help others. • Working on what is good for the family—getting consensus. • Pay attention to what Ct sees are the social consequences.	
Chien, Chan, Morrissey, & Thompson (2004)	"To examine the effects of a mutual support group for Chinese families of people with schizophrenia compared with psychoeducation and standard care" (p. 41)	• 96 families of outpatients with schizophrenia • 32 received mutual support • 33 received psychoeducation • 31 received standard care • Study conducted in Hong Kong	• Family Burden Interview Schedule (FBIS) • Family Support Services Index (FSSI) • Specific Level of Functioning Scale (SLOF)	Randomized control trial; pre-, during, and post-test experimental design	• "Mutual support consistently produced greater improvement in patient and family functioning and caregiver burden over the intervention and follow-up periods, compared with the other two conditions" (41).	• "Mutual support for families of Chinese people with schizophrenia can substantially benefit family and patient functioning and caregiver burden" (p. 41).

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Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					• Number of readmissions did not increase significantly but duration of hospital stay decreased.	
Chien, Norman, & Thompson (2006)	Exploration of participants' perspectives of benefits and difficulties "in a mutual support group for Chinese family carers of patients with schizophrenia in Hong Kong" (p. 962) Perceived benefits and difficulties "might be important in explaining the development of group integrity and observable effects in the families themselves" (p. 962)	• 30 family carers (child, parent, spouse) • 10 patients randomly (20 patients refused) selected from patient lists of 2 outpatient clinics • No comorbidity • Dx no more than 3 years • 18 years and older • Read and understand Cantonese or Mandarin • Carers did not have a psychiatric Dx	• Caregiver and patient report gathered by in-person, in-depth, semi-structured interviews (also audiotaped) and examination of audiotaped group sessions.	Case study	• Positive personal changes in the perception of their relative's mental illness, reconstructing a more positive identity, insight into a meaningful life and adoption of new coping methods/skills such as a sense of internal control, communication skills, sympathy. • Group ideology/consensus aided in trust building and feeling /getting value from the group and 13 carers indicated friendship development outside the group setting; some reported the group moved too quickly for them to build trust; some	• Empowerment occurs from learning from other group members efforts, knowledge, and from practicing skills learned from others in similar situations • Flexibility in time meeting and venue (informal outside meetings) suggested as helpful to increase group involvement. • Leadership from facilitator to address dominant/critical members. • Facilitator and members to demonstrate effective coping strategies might be helpful. • The positive results are contradictory to previous studies

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					reported they felt intense emotions were not accepted; most reported experiential learning and advice were useful. • Inhibitory factors: low/irregular attendance, negative pressure from dominant/experienced members, overexpression of intense and negative feelings in sessions.	showing this population to be reserved and passive in emotional and personal disclosure and as deferring to authority.
Jung (1998)	To discuss a paradigm shift from Western to Chinese culture to address how to work with Chinese American families			Literature review	• Refer to pp. 31-56. • Tx of immigrant Chinese families must be examined from a Chinese, rather than Asian or Western perspective. • Confucianism dominated social values in China for approximately 2000 years. • Ethical people are honest, frugal, industrious, and willing to contribute to the welfare of the	• Confucianism values clearly defined roles for everyone reflected in the five famous relationships; hierarchical nature of rules for governing these relationships is explicit: individual subordinates to group, young to the aged, wife to husband, children to parents, daughter-in-law to mother-in-law. • Chinese believe mental illness is caused by spiritual

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Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					family and society. • Taoism as a philosophy and religion gained popularity in part as a rebellion against the despotism of rules and rigidity of the time; Taoism also complemented Confucianism. • Confucianism embraced conformity while Taoism met the needs of those who appreciated creativity and asceticism. • Taoism emphasizes finding harmony in the natural order of things, rather than trying to change it. • Buddhism was the dominant religion from 4th-8th centuries, providing spiritual uplifting at a time that seemed hopeless. • Couples marry for functional reasons: taking care of parents, improving the	unrest, hereditary weakness, metaphysical factors such as fate or imbalance of yin/yang, or weakness of character. • Interpersonal problems and unconscious defenses or coping mechanisms are considered a consequence of weakness of character passed on from one generation to the next. • Chinese relationships are based on structure, conformity, and custom. • In order to show respect for others, it is important to speak to individuals in a way that avoids bringing shame or disrespect to self or others.

Table 3. Family Therapy and Chinese Families

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					position of the family, and bearing sons; romantic love was frowned upon. • As in any other culture, henpecking of husbands, gossiping among older women regarding their daughters-in-law, spoiling of children, infidelity, and abusive behavior occurred frequently. • Marital conflicts are a seen as consequence of spouses not honoring their prescribed roles. • There is no "pop psychology" in Chinese culture. • The search for support/understanding happens within the natural confines of family or community, among family members, friends, or community leaders. • Changes or interventions are	

Table 3. Family Therapy and Chinese Families

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					sought through prayer, offerings to the gods, or attempts to change the flow of energy. • Acceptance of psychosomatic medicine is a part of Chinese culture. • Suicide is an acceptable way to save face and resolve problems. • Strict adherence to hierarchy and role expectations create problems such as resentment in girls resulting in oppositional behavior, drug abuse, and dysfunctional relationships; many wives stay in exploitative/abusive relationships which may lead to depression or physical illness; individuals acquiesce to unwanted marriages to oblige their families.	

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Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					• Children are expected to perform exceptionally well in school and help with chores and child-rearing. • Because mature behavior is emphasized, children are ushered into adulthood too quickly resulting in a loss of childhood experiences important for adult development. • Much of Chinese society is agrarian. Immigrants must find harmony between their native and adopted country worldviews. • Greater value, honor, and prestige are placed on altruism than materialism. • Morality is based on shame, allowing individuals to feel remorseful and to correct inappropriate behavior. Unlike	

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Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					guilt, shame reflects on both individuals and their families and ancestors. • Chinese do not believe in being aware of their feelings or verbally expressing them; controlling strong feelings is necessary for maintaining mental health.	
Kung (2001)	To discuss cultural Chinese American beliefs in relation to caring for a mentally ill relative and to propose elements of a family intervention model compatible with these beliefs Implications for mental health practitioners	• Chinese American families with a mentally ill relative		Literature review	• Biological or somatic explanations are often held for etiology. • Psychological stress can take on the meaning of imbalance of inter- and intrapersonal harmony to explain environmental vulnerability. • Sense of obligation can be both positive in providing care, can also result in increased burden, resentment, shame, intrusiveness, all which can lead to	**Recommendations:** • Describe etiology more as biochemical imbalance rather than genetic heritage. • Describe etiology more as imbalance in interpersonal harmony rather than "psychosocial stressor" (tends to be more guilt-laden). • Clinicians take active role in determining meaning of illness to family/dispel myths. • Tx goals must be agreed upon and support the value of

Table 3. Family Therapy and Chinese Families

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					higher EE. • Social support more difficult for immigrants who have left much family behind; social supports must be carefully selected. • Attrition rates for Asian Americans are lower and use of mental health services are higher than in the 1970s possibly from Tx being available in the community and with clinicians speaking the language. • Asian Americans expect expertise and instruction from the clinician. • Lack of community resources especially in light of immigrant status.	interdependence. • Encourage some patient independence by emphasizing the need to enhance their coping ability (reframe to assist caregivers' sense of duty). • Find select members of extended family to disclose to and include in support network (minimizes threat to family disgrace). • Supportive yet DIRECTIVE style for clinician. • Individual family sessions, sessions without patient, multifamily sessions with medium-sized group of families of same dialect. • Sensitivity in timing of disclosure of Dx.
Lam, Chan, & Leff (1995)	Discussion of issues significant to immigrant Chinese families in context of individual	• One Chinese immigrant family living in Britain, 2 parents, eldest	• CFI • Clinical interview	Literature review and a case example to illustrate authors' points	• Seeking professional help is often seen as losing face. • Utilizing mental	• Reframing different goals was often helpful for getting family on board.

Table 3. Family Therapy and Chinese Families

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
	family treatment for schizophrenia and a case study is presented	son (Pt) Dx with schizophrenia for 6 years, 2 younger siblings			health services is not the first choice (mistrust and foreign culture). • Isolation of immigrant family; working long hours; language barriers; misunderstanding of local people; fear of judgment. • Negotiation and mediation must occur before problem solving; parents and Pt meet separately with patient before they all meet together. Family education for relatives to precede family meetings with patient. Parents negotiate w/ therapist on what they want for patient. • High academic ambition is often large part of reason to immigrate—better life—opportunity (education) for kids (old tradition in which educated lead to	• Independence reframed as building social skills better for health (and finding a partner) and allaying family anxiety. • Communication skills difficult but reframe as to reduce stress in long-term—necessary to show alliance w/ family and show helping behavior helps family trust therapist—open discussion. becomes less dissonant • CT to deal with Sx and help all members see Pt's value in family • Address EE in terms of lowering stress level for better Pt Fx.

Table 3. Family Therapy and Chinese Families

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					Imperial Civil Service). Sons—more expectation as will be heads of own families. • "Enmeshment/overprotection"—socially oriented society emphasis on dependency, modesty, parent-centeredness, self-suppression, conformity; parents try to sort out child's future if he is less able; hide illness to get him married so he can be cared for. • Therapist as expert but not authoritarian; Chinese saying that puts value on avoidance behavior to make a problem disappear—more time may be needed to set goals. • Blurring of gender roles in the West may confuse immigrant family and individuals may feel threatened.	

Table 3. Family Therapy and Chinese Families

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
Li & Arthur (2005)	To conduct a study examining the effects of patient /family education in a group of Chinese families (Beijing) who have a family member diagnosed with schizophrenia	• 101 patients and their families, data collected at admission, discharge, 3 and 9 months post-discharge • n=46, Experimental group received standard Tx plus education program • *n*=55 Control group received standard Tx • 16-65 years • with family 3 months prior to relapse • no learning disorder • no alcohol/drug use • no other organic brain disorder	• KASI • Chinese version BPRS • Chinese version GAS • Chinese version NOSIE • Relapse rate (rehospitalization of BPRS score >5) and med compliance (interruptions or change against advice on scale of 1-4)	Randomized control trial, pre- and post-test experimental design	• KASI revealed significant difference in experimental group between admission and discharge, admission, admission and 3 months, admission and 9 months; not found in control group. • BPRS revealed significantly lower score for experimental group although mean scores for somatic concern and motor retardation significantly higher. • GAS showed higher mean in experimental group at 9 months after discharge and overall increase in GAS at each point, control group highest score was at discharge. • NOSIE experimental group higher mean at discharge and at 9 months compared to control.	• Education program had significant effect on families' knowledge of patient Sx and overall Fx of patient, especially at 9 months after discharge; culturally valid Tx for future implementation.

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					• Relapse and medication compliance showed no significant difference.	
Root (1998)	To describe characteristics to consider in facilitating psychotherapy with Asian American clients			Literature review	• Heterogeneous group but all share a collectivistic family orientation. • Somatic expression of distress; valid healers include community networks, spiritual/religious, traditional healers. • Assimilation level. • Cultural beliefs play a role in etiology, Sx, help-seeking behavior, and acceptance of Tx. • Family as center of life and reference point of individual's Fx. • Criticism of family is not displayed in public. • Hierarchical system of relationships, male entitlement, value on harmony, privacy	• Education to the process of therapy involves communicating the therapist's understanding of the distress and explaining how therapy works; this must incorporate the client's context. • Brief therapy may be most culturally congruent and still allow the client to maintain some privacy and sense of dependence on self. • Indirect or subtle communication style requires that therapist adjust their expectations of what can be done in each session or adjust the length of therapy sessions.

Table 3. Family Therapy and Chinese Families

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					about sexual relationships. • Experiencing psychological distress and a decrease in Fx may lead to the feeling one has failed to achieve what is expected of them, thus leading to stigma and shame.	• Nonverbal behavior can have multiple meanings.
Sue (1998)	To summarize the interplay of sociocultural factors on the psychological development of Asians in America			Literature review	• Filial piety is a strong value. • Family member roles are highly interdependent. • Patriarchal families. • Inculcation of guilt and shame are techniques used by parents to control the behavior of family members. • Reserve and formality in social relationships, restraint and inhibition of strong feelings, obedience to authority, obligation to family, high academic and occupational	• Psychological characteristics exhibited by Asian Americans are related to culture and interaction with Western society. • Personality differences have been found but they are interpreted from the Western perspective and often viewed negatively. • Acculturational forces have a strong impact on psychosocial development; influence varies among different groups, generational

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					achievement. • Historical experiences of prejudice and discrimination. • Internalized racism. • Asian American children often express more negative feelings about their physical appearance than their Caucasian counterparts. • Chinese and Japanese American students tend to evaluate ideas on their immediate practical application and avoid abstract, reflexive, and theoretical orientation. • Asian American students appear more socially introverted.	status, and response to acculturation. • Women and children appear to acculturate more quickly than older males.
Xiang, Ran, & Li (1994)	To test the hypothesis that family intervention increases patients' and families' treatment compliance	• Patients in three rural townships with schizophrenia or affective psychoses • Experimental group *n*=36 ages	• Medical records • PSE • SDSS • Instruments used to measure compliance of drug Tx, understanding of	Experimental design	• After family intervention Tx, "full" compliance increased to 47.2%/14.6% experimental/control. • Partial compliance 75%/41%. • In experimental group	• Family intervention is an effective method of increasing Tx compliance and should be incorporated into community mental health care.

Table 3. Family Therapy and Chinese Families

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
		18-66 • Control *n*=41 ages 19-80 • Illness length 1-38 years	and changing attitude towards mental disease, adaptation of caring for patient, effectiveness of Tx, improvement in work ability, decrease in social disturbance		recognition of mental disorder increased to 22% from 5.6%. • Maltreatment and insufficient care decreased from 38.9% to 16.7%. • After Tx total rate of improvement for experimental 16.7% increased to 77.8% and control 24.4% increased to 31.7%.	• Trial period lasted only 4 months. • Study did not indicate if Pt was included in the psychoeducation workshops. • It appears that few standardized measurements were used to measure outcome.
Xiong et al. (1994)	To develop & evaluate interventions for families of schizophrenia patients that is appropriate for China's family relationships and social environment	• Experimental *n*=34 • Control *n*=29 • Ages 17-54 • Pts from two medium-sized cities • Pts live with at least one adult family member • Standard care=2-3 months • Prescription & recommendation to see outpatient facility in hospital for follow-up care • No appointments	• SAPS • SANS • BPRS • GAF • SDSS, • Scales for families' emotional/financial/social functioning and sense of burden	Experimental design	• Duration of rehospitalization shorter/ duration of employment longer/ lower levels of family burden. • At interim analysis, 34 experimental group families made a mean of 14 visits to the clinic and received a mean of 2.7 home visits per year of follow up (total of 18 months). • 56% of the experimental group Pts were actively compliant, 21% were	• Authors believe this study can be generalized to at least ¾ of urban schizophrenic Pts in China. • Treatment utilized in this study is suitable for China and other countries with limited MH resources because of minimal staff requirements, provision from existing institutions, and because it is significantly less expensive than standard care.

Table 3. Family Therapy and Chinese Families

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
		• Psychoeducation pamphlets to families • 2-3 sessions during hospitalization period • 1-2 years of Tx, ongoing maintenance			passively compliant (only attended when reminded by letter or accepting home visit), 23% were non-compliant. • Family member compliance: 41% actively compliant, 32% passively compliant, 27% non-compliant. • Despite regular reminders, 32% of families never attended a monthly family group meeting due to fear of exposure of the 'family secret.' • One Pt from the experimental group and one from the control group committed suicide, one Pt from the experimental group died due to inadequately treated diabetes. • More of the control group than	

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					experimental group experienced rehospitalization at the 6-, 12-, and 18-month time points (statistically significant at the 12-month) and duration of hospitalization was shorter for experimental group compared to controls (6.8 days/31.6 days), differences for hospital duration were statistically significant at 12- and 18-month follow-ups. • Statistically significant improvements on GAF, BPRS, and SDSS at 12-month for experimental group. • Statistically significant improvements on the SAPS, BPRS, GAF, SDSS at 18-month for experimental group. • Experimental group Pts worked for a greater proportion of	

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Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					the follow-up period than controls, difference statistically significant at the 18-month follow-up. • Experimental group more compliant with medication but not statistically significant. • Despite similar levels of drug utilization, actively compliant experimental Pts had much better outcomes than compliant control Pts.	
Yang & Pearson (2002)	Description of structural family therapy applied to Chinese families and an account of an eclectic model of structural family therapy that incorporates psychoeducation and behavioral Tx for schizophrenia as a theoretical guide to working with a family in Beijing	• One family consisting of father, mother, and daughter with schizophrenia • Dx of schizophrenia in a Chinese family in Beijing		Literature review and case example for illustration	• Parents align with therapist. • Parents try to improve their relationship in order to lower daughter's stress. • Mother and father continue to disagree about daughter's motives but able to argue less (father has made much effort to avoid arguments). • Daughter finds motivation to perform	• Use of an eclectic model that borrows from psychoeducational and behavioral models but allows clinician to conceptualize Tx and outcome considering cultural issues such as (1) maintaining generational boundaries, (2) preference of goal-directed, measurable objectives, (3)

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					some daily activities. • Mother becomes less critical when daughter has hallucinations. • Daughter able to report events differently than parents.	involving extended family members in care, (4) relabeling emotions, i.e. criticism becomes worry, and (5) joining with the system and valuing their cultural views

Table 4. Chinese Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
Bedford & Hwang (2003)	Exploration of "guilt and shame in Chinese culture" to provide a framework for morality and identity (p. 127)			Literature review	• In guilt, self-regard remains undamaged; in shame, self-regard is doubted. Shame (loss of esteem in one's own eyes or eyes of significant others) is always connected to conclusions about the person. • Shame protects social order by ensuring conformity; it isn't necessarily connected to responsibility and	• This study supports the "hypothesis that not only are the situations that arouse the affects of guilt and shame different for Chinese and Americans, the actual experience of the emotion differs as well since the Chinese make discriminations that Americans do not make" (p. 140). • The "[e]xistence of different categories of

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					can be imposed on by others. • Asian Americans tend to experience shame more frequently than Caucasian Americans. • Confucian ethics requires everyone to practice certain familial responsibilities: take care of your parents and children first, then you can extend the care outward (as opposed to negative duties such as do not…). • People must act in line with behavioral rules that define the relationships; right and wrong are socially defined. • Shame is for social control of community values, maintaining relational harmony over individualism; one will lose group approval when one fails a group	shame allows for the possibility that the categories are differentially linked to the negative impact of shame on individual development and social relations…perhaps only specific subcategories of shame are responsible for negative outcomes" (p. 140).

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					obligation. • Mandarin language has different terms for different types of shame and guilt, which are separated by public shame, private shame and different types of responsibilities.	
Ho (1994)	To examine the role of Confucian filial piety in relation to parental attitudes, the function of personal and social cognition	• 11 samples of adults and students in Hong Kong and Taiwan	• Filial Piety Scale (FP) • Child Training Scale (CT) • Paternal Discipline questionnaire • Parental Attitude Scale • Study Orientation Scale	Empirical study	• Attitudes toward filial piety tend to be moderately associated with traditional parental styles regarding child rearing: "overcontrol, overprotection… harshness…emphasis on proper behavior" (p. 353) and neglecting and inhibiting the expression of opinions, independence, self-mastery, creativity, and all-round personal development. • Individuals who endorsed traditional filial piety and child-training attitudes were	• Chinese patterns of socialization lean strongly toward the fostering of cognitive conservatism and high achievement motivation. • Cognitive conservatism exerts a powerful inhibitory effect on the development of critical thinking and creativity.

Table 4. Chinese Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					more likely to hold fatalistic and superstitious beliefs. • Traditional attitudes toward child training did not seem to be associated with personality variables but were moderately associated with authoritarianism, belief stereotypy, dogmatism, and conformity. • Attitudes toward filial piety were not associated with verbal intelligence or fluency.	
Ho, Rasheed, & Rasheed (2004)	To describe pre-therapy considerations with Asian and Pacific Islander Americans			Literature review	• Values governing family life are heavily influenced by Confucian philosophy, Taoism, and Buddhism. • Emphasis on extended family. • Immigration's effects on social support network. • Patriarchal family	• Influences exerted by value patterns acquired throughout childhood are often considerable even among those whose behavior is highly Westernized.

Table 4. Chinese Cultural Values

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					system with wife in a low status, crucial factor of marriage is the birth of a male progeny, shifts are occurring toward more egalitarian roles. • Well-defined role of parent-child subsystem, father is breadwinner, primary disciplinarian, decision-maker, child's responsibility is to be deferential and not bring shame to the family, children are taught strict control of aggression. • Divorce rate lower than other minorities due to shame and social ostracism. • Five major areas of cultural transition challenges: economic survival, American racism, loss of extended family support systems, cultural conflicts, cognitive reactive patterns to new	

Table 4. Chinese Cultural Values

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					environment. • Social, moral, and organic explanations are used to account for behavioral difficulties; psychiatric or psychological theories are not typically considered.	
Hwang (1999)	Examination of filial piety and loyalty in Confucianism and psychological implications of filiality under the impact of modernization			Literature review	• Decision making power is determined by the principle of superiority. • Resource allocation should be made by the principle of favoring those closest. • 5 cardinal rules: "Between father and son there should be affection; between sovereign and subordinate, righteousness; between husband and wife, attention to their separate functions; between elder brother and younger brother, a proper order; between friends,	• The content of familism under Westernism has changed but cultural ideas regarding family tend to be enduring.

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Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					friendship" (p. 168) (last one is the only equal power relationship). • Human nature is evil, humans need teachers and laws for proper conduct and justice, individuals must control personal desires and maintain Confucian standards in everyday interactions to maintain society. • To be worried about personal interests and daily pleasure is to be a small minded person or animal. • Social identity theory: major goal of Confucian self-cultivation is to socialize people to conform (suppress personal identity/wants) by following the Way of Humanity. • Research data shows that filial attitudes	

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					tend to be "moderately associated with traditional parental attitudes toward child-rearing…over-control, overprotection, harshness, proper behavior, neglect, and inhibition of self-expression, independence, and creativity in the child" (p. 178). • "People holding filial attitudes tend to adopt a passive, uncritical, and uncreative orientation toward learning. They are more inclined to endorse fatalistic, superstitious, stereotyped beliefs and are disposed to… characteristics as authoritarianism, dogmatism, and high conformity" (p. 178). • Filial attitudes are more common among individuals of low	

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					socio-economic status; education shows a significant negative relationship to these attitudes. • "Filial attitudes of elderly people were positively correlated with higher expectation of…support from their family members and negatively correlated with self-reported life-satisfaction" (p. 179).	
Kim, Li, & Ng (2005)	"The development of the Asian American Values Scale - Multidimensional (AAVS-M)" (p. 187)	• Study 1; *n*=163 • Study 2; *n*=189 • Study 3; *n*=38	• Asian Values Scale (AVS) • Attitudes Toward Seeking Professional Psychological Help—Short Form (ATSPPH-SF) • Rosenberg Self-Esteem Scale (RSES) • Loss of Face scale (LOF) • Self-Construal Scale (SCS) • Cultural	Instrument development	• Results of Study 1 yielded a 42-item measure of adherence to Asian cultural values with five subscales: "collectivism, conformity to norms, emotional self-control, family recognition through achievement, and humility" (p. 187). • Unable to establish coherent filial piety subscale.	• Study results illustrate the value of using subscales, for example, "adherence to dimensions of emotional self-control and humility was negatively correlated with positive attitudes toward seeking professional psychological help whereas the other factors were not significantly related to these attitudes" (p. 199).

Table 4. Chinese Cultural Values

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			Identification Scale (CIS) • Willingness to See a Counselor (WSC) • Social Desirability Scale (SDS)		• Results of Study 2 supported a hierarchical factor structure underlying the AAVS—M; AAVS—M total and subscale scores were found. • Study 3 yielded evidence of AAVS—M total and subscale scores' test-retest reliability.	• Results indicate varying and sometimes low degrees of correlations among subscales. • Possible explanations for inability to establish filial piety dimension perhaps because filial piety may need to be understood as more than one dimension. • "[T]here was a lack of significant relationships between adherence to Asian Values and cultural identification in terms of either Asian or Anglo orientation" (p. 199).
Kirkbride, Tang, & Westwood (1991)	To analyze the "extent to which both traditional Chinese cultural values and Chinese psychology influence Chinese perceptions and approaches to conflict resolution and thus affect Chinese			Literature review	• Confucianism and Taoism. • Harmony and collectivism promote avoidance of conflict and compromises to maintain collectivity. • Conformity is a core tenet.	• Personal relationship, interpersonal equilibrium, and relationship centered-ness are features of business relationships. • Time and negotiation is roundabout.

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	negotiating behavio[u]r" (p. 365)				• Power distance: societies accept large power distance between individuals and groups; this is right and natural. • Holism: issues are part of a whole, high sensitivity to context. • Antagonism and aggression deny the other face and are avoided. • Favors are considered social investments in which generous returns are expected.	• Chinese negotiation with Westerners reveals "compromising" and "avoiding" styles; social structure indicates the need to maintain interpersonal equilibrium over being overtly competitive or confrontational.
Lau, Fung, Ho, Liu, & Gudino (2011)	To present the procedure and results of a randomized trial of "[p]arent training with high-risk immigrant Chinese families" (p. 413)	• n=54 parents	• Demographic questionnaire • The Stephenson Multigroup Acculturation Scale • Child Behavior Checklist • The Parenting Stress Index—Short Form • The Alabama Parenting Questionnaire	Randomized trial	• "Retention and engagement were high with 83% of families attending 10 or more sessions" (p. 413). • 83.3% retention rate • Positive involvement, $F(1, 49)=9.29$, $p=.004$ • Negative discipline, $F(1, 49)=6.56$, $p=.014$ • Parent-reported internalizing, $F(1, 49)=6.12$, $p=.02$ • Externalizing child	• Results indicate that "treatment was efficacious in reducing negative discipline, increasing positive parenting, and decreasing child externalizing and internalizing problems" (p. 413). • "Treatment effects were larger among families with higher levels of baseline behavior problems

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					behavior problems, $F(1, 49)=5.39$, $p=.02$	and lower levels of parenting stress" (p. 413). • "Qualitative impressions from group leaders suggested that slower pacing and increased rehearsal of skills may improve efficacy for immigrant parents unfamiliar with skills introduced in parent training" (p. 413).
Lee (1997a)	To describe characteristics of Chinese American families			Literature review	• Refer to pp. 46-77. • Silence and avoidance of eye contact are ways of communicating respect. • Traditional Chinese families highly influenced by Confucian values, see Jung 1999 in earlier table. • "Contemporary Chinese American families are heavily influenced by US immigration policy changes" (p. 56) and	• "[F]avoritism of sons has slowly decreased because daughters now attain education and can be counted on to care of aged parents (p. 57). • Somatization may be a socially acceptable way of expressing complaints, avoiding shame, and protecting family name. Strong adherence to mind-body unity; organ-oriented idea of disease path promotes correspondence between emotions and

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					communist takeover of China in 1949 (Confucian religion was largely banned and a one-child family system enforced). • "During 10 years of cultural revolution, many families suffered forced separation. Red Guard youth openly challenged their parents and teachers; filial piety and respect for elderly no longer dominate life" (p. 56). • Economic boom in China after WWII bring industrialization, Westernization, and urbanization; older and middle-generation Chinese embrace some traditional beliefs but new generation shows some turning away from conservatism and traditionalism. • Focus on nuclear	organs. • Traditional conceptualization of mental illness: imbalance of energy, supernatural intervention, karma, genetic vulnerability, physical/emotional strain and exhaustion, organic disorders, character weakness (poor self-discipline, poor will power, pondering morbid thoughts).

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					rather than extended family. • Move toward a biarchal from patriarchal family system. • Husband-wife dyad has gained more importance while parent-child dyad has become less important. • "[R]omantic love occurs before marriage and when adult children leave the home" (p. 57).	
Yang (1961)	To provide a review of the function of religion in China and the historical context for which beliefs and changes occurred			Theoretical discussion	• Refer to pp. 278-293. • Chinese (Confucian) government was infamous for repeated persecution of religion on the one hand, and lack of thorough suppression on the other. • Due to political chaos and economic misery, kinship relations failed to provide physical and	• The major role of religion was magical not moral. • New moral values introduced by new religions/philosophies that were in line with existing Confucian values were adopted into the current traditions of the time; conflicting ideas were less apt to be absorbed.

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					emotional security and forced individuals to seek salvation elsewhere. • Ethical systems for institutional religion were not systematically practiced by common people in secular life the way Confucian ethics were observed. For common people, religion was sought for its magical value in obtaining happiness and warding off evil. • Common man could worship a Buddhist god for general happiness, pray to a Taoist deity for health, and at the same time practice Confucian morality. • Encouragement of moral conduct occurred via the classical conception of fate and the deification of men who had shown exemplary moral	• Religion played the role of supernatural sanctioning agent but was not a dominant source of ethical values or the seat of disciplining authority against immoral conduct; religion functions as part of the traditional moral order but did not occupy the status of a dominant, independent, moral institution.

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					conduct. • Religious enforcement of practicing morality was limited to psychological reassurance and deterrence. Religion and ethics belonged to two separate aspects of the institutional structure of traditional Chinese society; religion did not embody ethics but sanctioned it.	

Table 5. Moderators of Asian Cultural Values

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Chun & Akutsu (2009)	Presentation of reasoning for assessing acculturation in Asian American families, discussion of acculturation issues, and presentation of guidelines for assessing			Literature Review	• "[K]ey Asian American family acculturation issues: family dynamics, family structure, developmental considerations, and family ecologies" (p.	• New research on acculturation highlights the multi-faceted nature of acculturation, improving on the previous linear models that proposed

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	Asian American family acculturation				99). • Immigration, relocation, and resettlement present psychological implications. • Links between mental health and acculturation are evident; acculturation stress puts one at higher risk of developing depressive and anxious Sx. • Protective factors that guard against acculturation stress and psychological dysfunctions: social support, age at immigration (younger), some familiarity with the U.S. prior to migration. • Current measurements for acculturation have primarily been developed using college students; utility and	that there would always be loss of cultural traits and behaviors resulting from exposure to the host culture. • Evaluation of acculturation has often been focused on the experience of the individual however; acculturation must be assessed on a familial level given that among Asian American immigrant families, acculturation occurs in multiple family contexts or ecologies. • Clinicians can best serve families by assessing acculturation across the many different subsystems in the family and with consideration of the various structures and roles within the family.

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					appropriateness with new immigrants is not always clear, practical, or feasible. • Family systems theory: families are wired together; the facets of one member's acculturation potentially affects the acculturation experience of the rest of the family • New challenges require family members function with more flexibility or to try new methods of being/acting with each other. • If new or modified interactions cannot be formed, homeostasis and acculturation stress can often arise especially in the parent-child subsystem. • Asian American families, often multigenerational,	

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					have many subsystems; each has their set ways of behavior and communicating. This leads to the value of having multiple points for assessment of acculturation. • Acculturation rates vary for individual family members depending on what context members are in at the moment. • Acculturation is linked to developmental skills and tasks; different developmental stages influence what an individual finds most stressful during acculturation. • Structural family therapy framework illustrates the importance of evaluating various life cycles of functioning. • Family members navigate many	

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					contexts during any given day, experience of acculturation and acculturation stress vary across the demands of the different ecologies. • New information garnered from the various ecologies can expand family members' joint ability to adapt or create acculturative stress and conflict. • Ethnic minority status and experiences of prejudice/racism are an important ecological consideration; assessment of this consideration should include racism, community ethnic and cultural characteristics, and ways of coping with minority status. • Asian American immigrant family traditions are frequently Confucian	

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					in nature; American cultural family practices/values promote Western ideas such as "independence, self-reliance, autonomy, assertiveness, open dialogue, and competition" (p. 106). • "Asian American children might acculturate faster than their immigrant parents…leading to parent-child conflicts over family roles, career goals, dating, and marriage" (p. 106). • In reaction to their children's speed of acculturation, parents may try to become even stricter, but this often has the opposite of the desired effect—children become more opposed to the traditional values. • Having a sense of ethnic pride often is seen in immigrant	

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					families that foster warmth and independence; having a supportive family may be needed to foster exploration and retention of one's native culture among minority youth. • Interdependence is frequently a value within Asian American immigrant families but how caring is expressed is often via instrumental support rather than emotional support; children sometimes report displeasure regarding lack of warmth and open communication when relating to parents. • Traditional Asian American families tend to follow unidirectional communication along a family hierarchy; Asian American children may interpret this as mistrust.	

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					• Asian American children may use other forms of support in response to the established family rules of communication and behavior in order to receive the positive feedback they do not get at home. • Parents tend to label their children's acculturation as a sign of assimilation, and a threat to the parent-child rule/duty bound relationship. • Immigrant parents see acculturation as a unidimentional process: it destroys attachment to tradition. • Immigrant parents may feel ambivalent regarding their children's acculturation concerns because they don't recognize the difficulties in	

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					negotiating different cultural identities; parents expect their children to be quiet/obedient but may not recognize certain behaviors/ values (assertiveness, independence) learned during acculturation are necessary for external achievement in Western education. • Asian American children often serve as language/cultural brokers; studies show mixed findings regarding positive and negative feelings and internalizing and externalizing psychological Sx across Asian ethnic groups and family members. • Shifts in gender attitudes and roles can lead to re-evaluation of new roles and can contribute to acculturation stress	

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					and DV. • Older couples may have existential concerns that frame their acculturation experience.	
Juthani and Mishra (2009)	Discussion of particular clinical challenges managed when working with Asian American Immigrants using five clinical cases (composites).	• 5 fictionalized composites of several cases the authors have treated		Theoretical Discussion	**Case 1: "Conflict Secondary to Intra- and Intergenerational Acculturation"** (p. 130). • "[I]ndividual family members may emerge from the acculturation process with different identities… (a) hyper identified, (b) over-identified/more assimilated, (c) more equally bicultural, or (d) more marginalized (p. 180). • In this case, clinician helped reframe the son's choice as a way of being honor to the family rather than a disobedient act; also helped family view the choice as a sacrifice for the whole family to achieve this honor.	**Implications for Practice: Subcategories** • "Asian immigrants tend to tolerate their feelings of discomfort to a greater degree than many Americans" (p. 193). • "Families tend to be more accepting of suffering because of their beliefs about paying off karmic debts.. as part of their destiny" (p. 193) this may lead to resilience, but also fatalistic attitudes toward life. • Each individual negotiates native and host cultures based on one's own acculturative factors. **The Asian Woman**

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					Case 2: Generalized "Anxiety and Panic Attacks: Recent Acculturation Stressors" (p. 183). • Anxiety for Asian immigrants may come from adjusting to an unfamiliar environment, learning a new language, embarrassment talking to other Americans, taking low-paying jobs, little work fulfillment, decline in SES/lifestyle, ambiguity in social relationships, and difficulty making friends. • The clinician in the showed cultural competence by taking careful history and assessment of immigration factors and history to understand the family's stressors and coping. • Clinician took an	• "[I]s socialized to be adaptable…[quick] to sense what is expected of her under different circumstances and then change her attitude and behave accordingly" (p. 193). • "She is reared to have her self-esteem based on the approval of others rather than her own achievements" (p. 193). • "There is less tolerance for illness in women because her worth is measured in usefulness to the family" (p. 193). • Abandonment of wives when health is not restored in not uncommon. • Denial of illness by the individual and her family is very common. **The Asian Man** • "For the first-generation Asian

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					active educational role and used CBT when Pt disregarded exploratory therapy. • Clinician approved Pt to utilize alternative treatments in tandem with her own Tx, this increased Pt's trust. • Pt's father included in Tx with Pt's consent; confidentiality issues may be different with interdependent families. • Clinician's sensitivity to values such as interdependence, family roles and hierarchy, and spirituality was effective for working with the Pt and his father. **Case 3: Somatization and Attitudes Toward MH TX Based on Degree of Acculturation** • Tendency to somatize • Depression may present as: "lack of	man, American society provides economic opportunity but also challenges the roles at home" (p. 194). • Racism, sexism, poverty, and discrimination compound stress. • Potential for narcissistic injury if wife becomes more successful. **The Asian Elderly** • May have been brought over by family or immigrated as an older adult. • Feelings of isolation, exploitation, or being held captive. • Many lack places to practice their spiritual beliefs. • Grandchildren may be ashamed of their grandparents' inability to communicate or traditional practices. • May perceive

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					energy, headache, chronic fatigue, aches and pains, chest pain, gastrointestinal [Sx], skin allergies, rash, intractable itching, leucorrhea, hysterical seizures, blindness, and fugue states" (p. 186). • "These [Sx] can lead to substance abuse, domestic violence, decreased work/school effectiveness, irritability, social isolation, impaired relationships, controlling behaviors, insecurities, self-doubt, and extreme possessiveness" (p. 186). • "Asian immigrants may culturally express their distress in ways that are acceptable and not stigmatized within native culture" (p. 186) …physical complaints allow for	grandchildren as too assertive/offensive. • Health insurance challenges. • "Loss of role, identity, and independence" (p. 194). **The Asian Youth** • "In Asian cultures, there is no clearly identified developmental stage comparable with that of adolescence in the West" (194). • In Asia, emphasis is not on becoming independent from family… but assuming one's role in the family" (p. 194). • Asian youth tend to adapt to Western culture more rapidly. • "They often straddle two cultures and some live dichotomized… 'all Asian' at home and 'all American' outside of the home"

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					medical Tx without shame of having a psychological problem which is understood as "character weakness." • In the vignette, the social worker highlighted and validated the mind-body-spirit connection to the Pt. • Having a social worker for this Pt, was less stigmatizing, thereby helping the Pt feel less shame for seeking help. • Social worked accepted Pt's practice of alternative treatments and encouraged short-term treatment from a psychiatrist and remained the primary MH provider; team approach to treatment carried less stigma for the Pt. **Case 4: Alcoholism, DV, and Intragenerational**	(p. 194). • "[DSM-IV] prevalence rates for the major mental illnesses such as schizophrenia and BPD are same across all cultures" (p. 195). • Individuals and families show lower MH utilization rates. • Barriers to help-seeking include stigma and shame, failure to diagnose MH issues by Pts and clinicians. **Psychopharmacological Management** • "Most Asian American Pts enter [Tx] at later stages of…illness" (p. 195). • "[Pts] may trust the magical curing power of medications , although some might be resistant to… medication" (195). • Asian Americans tend to require smaller daily doses of

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					Stress • "Asian Americans view substance abuse, especially alcoholism, as a medical as well as behavioral problem needing moral [Tx] to rebuild character (p. 188). • In their native countries, Asian immigrants find help from extended family and wise (wo)men in their communities when faced with conflicts. • Many immigrant families are isolated, work 2-3 jobs, have less opportunity/resources for cultivating support, placing them at risk for addiction and social problems. • In many Asian cultures, work is a means to gain respect, face, and status; underemployment in the host culture leads	neuroleptics, antidepressants, anti-manic agents, and benzodiazepines to achieve steady-state levels [and]…have a more tolerable side-effect profile" (p. 195). • Asian Americans often self-medicate with herbal remedies; clinician must take a careful Hx. • Pts often believe in short-term use of medication; adherence may be a problem in the long-term. • Clinicians should discuss adherence to medication, side-effects, and potential outcomes of nonadherence.

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					to loss of social standing. • The Asian male in a heterosexual couple is expected to make more money; there may be difficulty with the success of wives. • Alcohol use is common among Asian immigrants. • In some cultures, "drinking to excess is seen as a negative reflection on the family, so it is denied or tolerated until it starts to severely impact the proper functioning of a family" (p. 190). • Intervention should be integrative and include healthy life style, diet, and exercise. • "Many Asian immigrants do not accept self-disclosure in public (e.g., AA). They are more likely to accept individual or	

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					family therapy" (p. 190). • DV is not uncommon but requires cultural sensitivity in Tx; clinician needs to inform Pts that DV is a crime in this country. **Case 5: Stigma of Major MH** • Asian American immigrants approach major MH with denial and secrecy to prevent loss of face. • Mental illness may bring shame and dishonor to the entire family, making it more difficult for the Pt as well as others in the family to marry. • Asian American immigrants may tolerate odd behavior or hide the person to protect the family's reputation. • Herbal remedies. • Traditional healer or an exorcist.	

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					• "Asian culture may conceptualize hallucinations, delusions, and inappropriate behavior as being cause by the spirit possession from ancestors, evil spirits, and ghosts" (p. 191). • "By the time a hospitalization is indicated, the patient may be very ill…the family…in great distress" (p. 191). • Psychoeducation may help engage the Pt and family in Tx. • Family concerns are more focused on face rather than the individual's pain. • Genetic and psychological explanations of etiology may not be tolerated; alternative theories such as "imbalance of yin and yang or imbalance of Kapha, Vatta, and	

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					Pitta" (p. 192) may carry more meaning. • Medication may be temporarily acceptable, although non-adherence with long-term medication is frequent. • Clinician's acceptance of alternative Tx in along with Western medication. • Illnesses requiring long-term medication require clinician's alliance with Pt and family and stressing that Pt's well-being will benefit the family. • Clinicians must remember that family's goal may be return to social conformity and Fx of the subsystems of the family.	
Kim (2007)	Exploration of Psychological theories related to acculturation			Literature review	• Enculturation is the process of (re)socializing to the	• More research is needed on acculturation and

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	and enculturation, measurement, and research findings bearing relations between these constructs and psychological functioning among Asian Americans				customs of one's indigenous culture. • Acculturation describes adaptation to the dominant culture. • Acculturation and enculturation attitudes: integration, assimilation, separation, and marginalization. • Biculturalism theorized to be the psychologically healthiest attitude/status. • Acculturative stress: stresses arising from the acculturation process. • Acculturative stress results in hopelessness and emotional stress. • Biculturalism in Asian Americans is related to "cognitive flexibility, general self-efficacy, and… collective self-esteem" (p. 150).	enculturation as they relate to Asian Americans' experiences in the U.S; future research should employ samples that represent community populations across wider geographical areas. • More theoretical and empirical work on the relationship between acculturation and enculturation on psychological functioning is needed. • The process of biculturalism should be examined. • More research is needed on the role of acculturation and enculturation on therapy process and outcome.

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					• Studies suggest high acculturation is associated with increased positive help-seeking attitudes. • Studies suggest negative relations between adherence to Asian cultural values and help-seeking attitudes and willingness to see a counselor. • Those with more traditional values evaluated counselors with more traditional values to be more empathic, while clients with less traditional values felt European American counselors were more empathic. • Across all conditions, Cts who held more traditional beliefs perceived stronger counselor empathy and working alliance than Cts with less	

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					traditional values.	
Kim, Ahn, & Lam (2009)	Discussion of "concepts of acculturation and enculturation…theories and research on the consequences of acculturation and enculturation... [exploration of] the roles acculturation and enculturation play on parent-child values gap and family conflict, the role of cognitive flexibility in this relationship, and clinical implications…" (p. 25)	• n=146 (Korean American Parent-child dyads) • Children were college students recruited from 1 of 4 large West Coast Universities or 2 West Coast Korean churches • Child sample had 80 females and 66 males; age range 17-33 • 41(28.1%) first-generation children; 101 (69.2%) second-generation; 4 participants did not report • 55 (37.7%) students lived with parents; 90 (61.6%)	• Asian Values Scale-Revised (AVS-R) • Cognitive Flexibility Scale (CFS) • Intergenerational Conflict Inventory (ICI)	Experimental Design	• Asian American families have diverse immigration histories; there exists a wide range of ways in which they have acculturated and enculturated. • Acculturation first defined by Redfield et al. (1936): "Acculturation comprehends those phenomena which result when groups of individuals sharing different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups" (p. 26). • "Graves (1967) used the term 'psychological acculturations' to describe the effects of acculturation at the individual level" (p. 26).	• Theory and research suggests differing world views between parents and children lead to conflicts and other psychological difficulties. • Rates of acculturation differ between parents and children. • Parents hold on to traditional values more than their children. • "[C]ognitive flexibility served as a moderator in the positive relationship between the Asian values gap and child-reported education and career conflict" (p. 39). • "[C]hildren with high cognitive flexibility tended to have increased conflict as the values gap increased whereas children with low cognitive

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		lived away from parents; 1 did not report • First-generation students mean number of years in the US was 12.48 (SD=4.84) with range of 2 months to 22 years • Parent sample had 96 mothers and 50 fathers; Age range 42-64 • 127 (87%) parents completed the Korean version of survey; 19 (13%) completed the English version • 87% of parents were foreign born with average length of stay in US = 22.65 years;			• "John Berry and colleagues developed a bilinear model of acculturation in which one linearity represented "contact and participation (to what extent should they become involved in other cultural groups, or remain primarily among themselves)" and the other linearity represented "cultural maintenance (to what extent are cultural identity and characteristics considered to be important, and their maintenance striven for)" (p. 26). • Herskovits (1948) first defined enculturation. • Cultural maintenance as a concept might not be appropriate for generations more removed from immigration.	flexibility tended to have decreased conflict" (p. 39). • Authors suggest that future studies should include a measure of social desirability to measure if fear of shame might affect how much participants disclose.

Table 5. Moderators of Asian Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
		range of stay 5-61 years • 112 (76.7%) parents married; 23 (15.8%) divorced; 3 (2.1%) separated; 5 (3.4%) widowed; 2 (1.4%) single; 1 did not respond • 7 (4.8%) mothers had less than a high school degree; 51 (34.9%) had high school degree; 62 (42.5%) bachelor of arts degree; 13 (8.9%) masters degree; 1 (0.7%) MBA; 2 (1.4%) Ph.D.; 10 (6.8%) reported other • Fathers' educational background			• "BSK Kim and Abreu (2001) proposed that enculturation describe the process of (re)learning and maintaining the norms of the indigenous culture, and acculturation describe the process of adapting to the norms of the dominant culture" (p. 27). • For Asian American families, levels of acculturation and enculturation are moderated by recency of migration. • BSK Kim and Abreu (2001) propose that acculturation and enculturation constructs encompass four dimensions: "behavior, values, knowledge, and identity" (p. 27). • In understanding experiences of Asian American families in	

Table 5. Moderators of Asian Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
		consisted of 4 (2.8%) with less than a high school degree; 32 (22.4%) high school degree; 60 (42%) bachelor or arts degree; 18 (12.6%) masters degree; 6 (4.2%) MBA; 9 (6.3%) Ph.D.; 11 (7.7%) listed other; 6 did not report			light of MH, it is important to explore the results of differential rates of acculturation. • Acculturative Family Distancing (AFD) is "the problematic distancing that occurs between immigrant parents and children that is a consequence of differences in acculturative [and enculturative] processes and cultural changes that become more salient over time…AFD has two dimensions: breakdown of communication and incongruent cultural values that develop as a consequence of different rates of acculturation and the formation of an acculturation gap" (p. 28). • Rosenthal et al. (1989) propose that because children	

Table 5. Moderators of Asian Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					arrive to the US at an earlier age, they have more experiences with its cultural norms; problems can surface when the norms of the culture of origin are vastly different from the dominant culture; this dynamic has been labeled "dissonant acculturation." • Parents may feel anxious at their children's desire for independence; children feel angry at their parents' rejection of their desire to be self-reliant. • LaFromboise et al. (1993) described acculturative stress. • Acculturative stress leads to a number of MH Sx. • Cognitive flexibility refers awareness of options at any given moment and ability to	

Table 5. Moderators of Asian Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					adapt. • "Ahn et al. (2005) found that increased cognitive flexibility was related to decreased likelihood and seriousness of child-parent conflicts among Korean Americans" (p. 30); cognitive flexibility in this study was "examined as a possible moderator on the relationship between parent-child cultural values gap and family conflict" (p. 30). • Sociopolitical stressors impact parent-child conflicts such as racism, stereotypes, exclusion from representation in media, glass ceiling, lower wages, racial violence, and occupational segregation. • Nguyen and William (1989) study found that Asian American	

Table 5. Moderators of Asian Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					parents might send conflicting messages regarding which traditional values to keep. • Gender may be important to consider in family conflict; daughters had higher conflict than sons. • "Kwak and Berry (2001) revealed that in comparison with European Americans, Asian Americans experienced more parent-child disagreements in the areas of independence, roles in decision-making, and intercultural contact" (p. 31). • "Asian American parents tended to view parental authority and children's rights from the perspective of their culture of origin, adolescents tended to adopt more independent values of	

Table 5. Moderators of Asian Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					dominant US culture" (p. 31). • Lowinger and Kwok (2001) found that Asian American parents tend to engage in parental overprotection…[referring] to the stifling of a child's emotional autonomy and independence…[and] non-responsiveness to the child's need for acceptance and approval" (p. 31). • Studies show negative results for overprotection of Asian American children raised in US culture; it can lead to lower self-esteem, doubt regarding parents' love, and decreased ability to be extroverted. • "[C]hildren who experience academic pressure from parents without support and praise for accomplishments may	

Table 5. Moderators of Asian Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					become anxious, obsessive-compulsive, and depressed" (p. 32). • In a study of Korean Americans and their parents, offspring held less traditional values than their parents. • In dealing with problems, participants used problem-solving strategies most frequently, then social support, and lastly, an avoidance coping strategy. • Inverse relationships found between cognitive flexibility and the intensity of conflicts (especially in dating and marriage issues). • There was an interaction effect where student-perceived student-parent values gap and cognitive flexibility were related to a rise	

Table 5. Moderators of Asian Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					in disagreements around dating and marriage. • Limit to study was that parents' perceptions were gathered from their children rather than from parents themselves. • In this study (Kim, Ahn, & Lam), incentive to participate (money) did not appear to affect variables. • Whether child lived with parent or not did not appear to affect variables. • There were no significant relationships between age and ICI totals (family expectations, education and career, dating and marriage). • MANOVA conducted to examine for the effects of gender and generation of the child on parent-child	

Table 5. Moderators of Asian Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					conflict variables; no main effect found for gender or generations level; data were combined for these variables. • "The present study yielded a significant positive relationship between the child-parent Asian values gap and child-reported conflict in expectations about family relationships…consistent with existing literature that suggests that parent-child gap in cultural values is associated with parent-child conflict" (p. 38). • This study supports the hypothesis that an increase in the values gap leads to increased number of conflicts. • Results show "that cognitive flexibility served as a moderator in the positive relationship between	

Table 5. Moderators of Asian Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					Asian values gap and child-reported education and career conflict" (p. 39). • "[C]ontrary to previous literature, the direction of the interaction was reversed: children with high cognitive flexibility tended to have increased conflict as the values gap increased, whereas children with low cognitive flexibility tended to have decreased conflict" (p. 39).	
Rhee (2009)	Overview of clinical issues in Asian American [MH and]… focus on psychological distress and manifestation within different subpopulations, looking at common acculturation stressors as a background for understanding emotional health" (p.			Literature review	• More than two-thirds of 12.5 million Asian Americans are foreign-born residents. • Asian Americans are a heterogeneous group with a variety of variables; over 25 ethnic groups in the U.S. • Key factors:	• Variations in Asian Americans' backgrounds will lead to different Sx manifestation and expression. • "New immigrants usually go through a few exclusive phases of adaptation" (p. 94) representing different life challenges.

Table 5. Moderators of Asian Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
	81)				Language barrier, intergenerational conflict, identity crisis, domestic violence, prejudice and discrimination. • "Asian American children and adolescents with immigrant backgrounds often report confusion, anger, and frustration attributable to relationship difficulties with their more traditional parents" (p. 87). • "[I]ntergenerational conflict significantly mediated the effect of perceived acculturation gap on the development of depression [Sx] among later-staged adolescents" (p. 88). • "[L]evel of ethnic identity, perceived discrimination, and academic performance were significant predictors	• Phase 1 (Exigency): Language barrier, social isolation, and culture shock. • Phase 2 (Resolution): Between 2 to 10-15 years during at which life satisfaction might reach the highest point. • Phase 3 (Social Marginality): Stagnation due to identity crisis related to feeling deprived or excluded from the mainstream. • Recent study showed the majority of immigrant Asians groups surveyed indicated structural and practical barriers as major obstacles to Tx (price, language, transport, lack of awareness of available services).

Table 5. Moderators of Asian Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					of both internalizing and externalizing problems" (p. 88). • Most studies support that some immersion in academic achievement promotes psychological adjustment. • Community samples of Asian Americans exhibited slightly more depressive Sx than European Americans. • From National Latino and Asian American study: immigration-related factors such as being US or foreign born, have some influenced on mental disorders for Asian Americans; more acculturated males with English proficiency had lower rates of lifetime and 12-month disorders compared to non-English speaking males; immigrant	

Table 5. Moderators of Asian Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					women had lower rates of MH disorders in contrast to US-born Asian American women. • Elderly Asian immigrants at higher risk for depression than non-Hispanic European American counterparts. • "[H]ealth status, poverty, length of residence in U.S., educational attainment, and English ability were significant predictors of depression" (p. 92) in immigrant Chinese American elders. • Delayed initiation of treatment related to loss of face and stigma, lack of bicultural/bilingual professionals, and incompatibility of MH treatment models.	
Shin & Bruno (2003)	To present statistics on language use and				• 18% (47 million of	• There was an increase

Table 5. Moderators of Asian Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
	English-speaking ability in the United States during the year 2000				262.4 million people aged 5 and over) spoke a language other than English at home. • The above figure is up 14% from 31.8 million in 1990 and 11% from the 23.1 million in 1980. • Slightly less than half of the 7.0 million Asian and Pacific Island-language speakers spoke English "Very well." • Chinese was the second most commonly spoken non-English language at home (2.0 million) after Spanish.	in the amount of people who spoke a language that was not English at home between 1990 and 2000. • Spanish was still the most frequently spoken non-English language in the home. • The West had the greatest number of non-English speakers. • "A linguistically isolated household is one in which no person aged 14 or older speaks English at least 'Very well'" (p. 10). • In 2000, "4.4 million households encompassing 11.9 million people were linguistically isolated, compared to 2.9 million households and 7.7 million people in 1990" (p. 10).
U.S. Census Bureau (2007)	To present a portrait of the Asian population in	• *n*=13.5 million		Survey	• "In the federal government…'Asian'	• "More than two-thirds of Asians were U.S.

Table 5. Moderators of Asian Cultural Values

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
	the U.S. (part of the Asian Community Survey [ACS])				refers to people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent" (p. 1). • There were an estimated 13.5 million Asians (4.7 of U.S. households) residing in the U.S., including individuals who identified their race as Asian and another race(s). • "Among Asians, Chinese (excluding those of Taiwanese origin) were the largest group with a population of 2.8 million" (p. 2) (19% of the Asian-alone population).	citizens, either through birth (about 33 percent) or naturalization (about 37 percent)" (p. 11). • Over half of foreign born Asians were naturalized citizens. • About 33 % of foreign born Asians arrived during the 1990s and about 17 % entered in 2000 or later. • "About 63 percent of Asians aged 5 and older spoke only English at home or spoke English very well" (p. 14). • "About 12 percent of Asians were living below the poverty level in the 12 months prior to being surveyed" (p. 18). • "Among Asians, the poverty rate was about 10 percent or less for Asian Indians, Filipinos, and Japanese. The poverty

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Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
						rate for Chinese, Koreans, and Vietnamese was about 13% or higher" (p. 18).
U.S. Census Bureau (2011)	To present a fact sheet on the Asian population in the U.S.				• 17.3 million residents of Asian descent; 14.7 Asian alone; 2.6 Asian along with one or more other races. • The growth of the Asian population in the U.S. from 2000-2010 was 46% (includes mixed race). • In the U.S. in 2009 there were approximately 3.8 million people of Chinese descent. • Those aged 5 and above who spoke Chinese at home in 2009 were about 2.6 million.	• Asian/Pacific American Heritage Week began in 1978. • In 1997, the API racial category was separated into Asian and Native Hawaiian or Other Pacific Islander.

Table 6. Chinese Attitudes Toward Mental Illness

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
Dana (2001)	Discussion of clinical diagnosis of cultural populations in the U.S.			Literature review	• DSM criteria and tests have Euro-American histories and bias. • DSM fails to recognize a self that does not have rigid boundaries; many cultures have an altered consciousness that were characteristics of survival techniques. • An alien self-disorder occurs when societal standards of the larger society are adopted and subsequent behaviors become inimical to the person's wellbeing. • Five common stressors that occur in multicultural populations: 1) culture-general conditions, 2) culture-bound syndromes, 3) problems-in-living depending on	• Cultural differences in Sxs, syndromes, and conditions can lead to erroneous Dxs and overpathologization or minimization. • Remediation for bias: tinkering with tests, acceptance of null hypothesis reversal, cross cultural research on etic-emic theory. • Long-term remediation of bias: training, practice, and research that places culture at the focus of attention.

Table 6. Chinese Attitudes Toward Mental Illness

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					acculturation, 4) oppression-induced conditions, and 5) acculturative stress-related Sxs • Cultural, individual, and institutional biases have effects on research and practice using tests and the DSM: stereotypes, hospital admissions, survey findings, language of test, metric bias.	
Holroyd (2003)	To describe the challenges of Chinese families caring for children with disabilities (Down syndrome, Autism, "overactivity")	• *n*=15	• In-person interview and nonparticipatory observation	Phenomenological study	• "Chinese socialization lays the foundations for morality in later life…it is here that patterns for meeting family obligations are established, developed, and transferred into adulthood" (p. 4). • "Confucian guidelines are a duty-bound set of obligations of what a 'right and proper' person should and	• Themes that emerged: "disruptions to natural order, public opinion on what constitutes personhood and ordered bodies, and the establishment of moral reputations linked to shame and blame and the gendered division of parenting" (p. 8). • "[T]he centrality of parenthood in Chinese society [is] the acceptance of responsibility and its

Table 6. Chinese Attitudes Toward Mental Illness

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					should not do. Being proper is central to the social role" (p. 4). • Reciprocity as a central theme, moral debts and credits throughout family life and afterlife. • Socialization involves a great deal of learning by example. • Chinese childhood socialization emphasizes "obedience to authority and what children should do for their parents" (p. 5). • Children with disabilities "blurs all boundaries of what can reasonably be expected under kinship" (p. 5). • The handicapped child "represents the inability to transmit cultural knowledge, such as bestowing	cyclic enactment and emphasizes how the care of children with physical and mental handicaps strains and violates the Chinese culturally expected order of parental obligations" (p. 4).

Table 6. Chinese Attitudes Toward Mental Illness

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					respect or being 'good,' and so disturbs the family harmony." • Can a child with a handicap ever become a right and proper person with full membership in society? • Family experiences highlighted abandonment and rejection, social stigma, public opinion, shame and blame, discipline (more discipline is means one cares more about the child).	
Hsiao, Klimidis, Minas, & Tan (2006)	To examine "the cultural attribution of distress in the Chinese, the special role of family in distress and the specific emotional reactions within distress dictated by culture" (p. 998)	• *n*=56 28 Chinese-Australian patients and caregiver dyads interviewed in their homes Criteria: • <18 years old • Diagnosed	• In-person interview	Phenomenological study	• Confucian philosophy—interpersonal harmony is how one maintains mental health; identity is based on how one behaves and relates in the context of the group. • Chinese patients'	• Traditional Chinese women's self is highly dependent on concern for family and other members fulfilling their roles in the family; they are more susceptible to interpersonal stressors because of this. • Confucian value of

Table 6. Chinese Attitudes Toward Mental Illness

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
		mental disorder • Mandarin speaking			failure to fulfill cultural expectations of appropriate behaviors as family members contributed to difficulties/imbalance in interpersonal relationships. • Patients' failure to fulfill family obligation contributed to low self-worth and increase sense of guilt and shame. **Cultural aspects** • Guilt and shame are seen as Sx of mental illness. • Shame is the sense of loss of face in others' perceptions due to failure to fulfill one's expected role, failure to attain desired self-image; Shame in Confucian culture failure to fulfill one's roles in family and social hierarchy.	obedience and submission may have an effect on repression of emotions and discussing emotions, which women reported led to depression. (Lack of socially sanctioned emotional outlet may lead to exacerbation of Sx in Pt and depression in female caregivers.) • Knowledge of cultural challenges in the family like specific traditional values helps clinicians understand Pt's suffering. • Psychotherapy may need to foster harmony within family and social relationships.

Table 6. Chinese Attitudes Toward Mental Illness

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
Kokanovic, Petersen, & Klimidis (2006)	Exploration of under-utilization of services and of the roles caregivers play in caring for their ill relative within enthno-cultural and linguistic minority communities (ECLMs) in Perth, Western Australia	• *n*=20	• In-person interviews	Phenomenological study	• Impact of caregiving: "psychological and emotional distress, physical illness, disruption to family and to social and sexual relationships, curtailment of social activities" (p. 126) financial hardship, frustration, anger, loneliness, and despair. • Caregivers do not always evaluate their duties as a burden when it regards loved ones. • Themes: worry, exhaustion, lack of support from other family members, changes in identity, cultural expectations, lack of faith in support agencies, difficulties communicating with health providers, stigma.	• Evidence suggests underutilization of MH services is related to insensitive public policies and insensitivity/lack of training found in the existing services. • "[P]articipants lacked information regarding mental distress and available support services…[due to the following factors:] (a) not seeking information regarding support due to perception that the caregiving role is the responsibility of close family, (b) information not provided in a culturally appropriate way, (c) the language barrier between services and caregivers, (d) social isolation of caregivers and families, and (e) concealment, due to stigma, of mental illness in family

Table 6. Chinese Attitudes Toward Mental Illness

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
						members" (p. 134).
Lin (1982)	Discussion of "major psychoses, minor mental disorders, and patterns of help-seeking among the Chinese [and author's proposition] that problems basic to psychiatry (i.e., the identification, diagnosis, and treatment of patients…the… perception and conception of mental disease) cannot be divorced from the cultural context in which they occur" (p. 236)			Literature review	• Using current psychiatric diagnoses from Western theories, "a comparable group of major psychoses can be found among the Chinese…[but] when applied, exclude large groups of [Pts] whose behavio[u]r is judged to be abnormal in their own cultural contexts" (p. 239). • Although the diagnosis of neurasthenia began in the West and has been discontinued, it is still used in China. • "[Pts] who evidence somati[s]ation… describe their [Sxs] in terms of dysfunction or imbalance of certain body organs…which is based on the notion of a unitary	• Psychocultural interaction influences normal behavior of the Chinese at different levels including "cognition, affect, and communication as well as the perception and management of both universal and culture-specific stresses" (p. 244).

Table 6. Chinese Attitudes Toward Mental Illness

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					psychosomatic system" (p. 241). • Becoming a Pt involves many factors such as perception of the disease, Pt's support network, expectations for recovery, perceptions of health care, system of delivery of services, knowledge of services. • Typical pattern of Chinese cases: Chinese tend to keep Pts within the family for a long time during the prodromal and early phases of illness; many are isolated within the home. "[A]dvanced psychotic Sx were tolerated as long as there was no excessively violent or disruptive behavior and … family resources were capable of	

Table 6. Chinese Attitudes Toward Mental Illness

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					coping with the [Pt]...[w]hen external help was sought, the family physician was consulted [for a behavioral etiology]... [o]nce the line into the public sector was crossed there was decreasing acceptance of the [Pt] by the family" (p. 242). • Defense mechanisms: Denial and somatization. • Labeling the Pt's condition may destroy the defense mechanism of denial but increase the family's intolerance of the Pt. • Scapegoating functions to externalize the causes and blame for the illness.	
Yang, Phelan, & Link (2008)	To examine "community attitudes of efficacy and	• *n*=90 • 63 interviews	• Telephone interviews using	Survey	• "[R]espondents were significantly more	• A "future empirical question involves

Table 6. Chinese Attitudes Toward Mental Illness

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
	shame…that may underlie mental health underutilization among Chinese Americans" (p. 10)	in English • 27 in Cantonese or Mandarin depending on participant's preference	one of two randomly assigned experimental vignette		likely to endorse a Western mental health professional as being able to help with a mental disorder" (p. 14). • Significantly greater proportion of respondents indicated that they "somewhat or strongly agreed that it was shameful to see a mental health professional…for a mental disorder than to visit a practitioner of [traditional Chinese medicine]" (p. 14). • "Differences in perceived shame using Western psychiatric services vs. [traditional medicine] varied by whether respondent was born in China/Taiwan or the [U.S]…The China/Taiwan group found Western services to be more	examining whether a combined [traditional medicine] and Western psychiatric regimen might be perceived as less shameful, and thus more accessible to immigrant Chinese Americans in comparison to Western treatment alone" (p. 17). • The perception of a treatment's effectiveness is related type of service sought; results of this study show shame and stigma have a significant effect on help-seeking. • The type of treatment sought considerably influences the perception of shame. • Targeting traditional medicine practitioners "may be an effective means of outreach for immigrant Chinese Americans and that public education

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					shameful for psychiatric disorders when compared with using traditional Chinese medicine" (p. 15). • "…China/Taiwan born group found Western psychiatric treatment to be more shameful in treating mental disorders when compared with the U.S. born Chinese-Americans… no differences were found between the two groups comparing shame toward [the use of traditional medicine]" (p. 15). • Country of birth revealed a trend interaction effect with perceived effectiveness of Western services vs. traditional medicine: The U.S. group found Western treatment to be more	should address potential issues of potential shame toward accessing Western psychiatric services" (p. 16).

Table 6. Chinese Attitudes Toward Mental Illness

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					helpful for psychiatric disorders; the China/Taiwan group saw Western Tx as effective but by a smaller margin. Being U.S. born magnified the perception of efficacy of Western Tx compared to traditional medicine. • China/Taiwan group had a higher number of respondents endorsed traditional medicine as helpful for psychiatric disorders than the U.S. born group. • No differences were found when comparing beliefs of efficacy of Western Tx.	

Table 7. Psychopathology Among Asian Americans

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
Carrasco & Weiss (2005)	Overview of AAPIs and mental health			Literature review	• AAPIs originate from 50 countries and 100 languages. • Census 2000 counted 11.9 million Asian Americans and 900,000 Native Hawaiians and Pacific Islanders. • Geographic growth is higher in areas that have not typically had large AAPI groups. • Asian American population grew 72% between 1990 and 2000. • 4 million AAPIs in the U.S. have limited English proficiency; Chinese Americans had the highest rate of number at 1,127,008 million. • API cultural explanations for schizophrenia: imbalance of yin and yang, supernatural intervention, religious beliefs, genetic vulnerability, physical/emotional strain or exhaustion,	• Recommended Tx approach: combined family and individual Tx that is culturally competent. • Family-friendly approach vs. blaming. • Role-modeling culturally sensitive parenting practices. • Cognitive and behavioral approaches to enhance self-esteem and coping. • Facilitating communication of positive feelings among family members.

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Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					organic D/Os, and character weakness. • Types of family: "Americanized," Interracial, Bicultural, and Cultural Conflict Families. • Strong community ties may affect MH utilization. • 30% of Asian American girls in grades 5-12 stated experiencing depressive Sx. • Asian American boys were more likely to report physical or sexual abuse compared to their White, Black, and Hispanic peers. • Asian American females 15-24 show a greater rate of suicide than Whites, Blacks, and Hispanics of the same age bracket. • Cultural values that may contribute to depressive D/Os: identity involves	

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Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					meeting family's expectations, complete acquiescence toward authority, communication that sanctions repression of bad feelings and indirect communication of love, educational accomplishment perceived as validation.	
Nemoto et al. (1999)	To identify "patterns of drug use behaviors in relation to cultural factors among Asian drug users in San Francisco, CA" (p. 823)	• *n=92* • 35 Chinese • 31 Filipino • 26 Vietnamese • No participants were enrolled in treatment programs	• Structured questionnaire with open-ended questions regarding past/current drug use, alcohol use, injectable drugs, relationships with family and nonfamily, and anchored questions on demographics	Descriptive study	• 52% of drug users used one or more drugs every day. • "Filipinos were most likely to cite having used three or more drugs (81%) compared with Chinese (71%) or Vietnamese (35%) participants" (p. 831). • "American-born participants were far more likely to report having used multiple drugs than were immigrants…84% vs. 54%" (p. 831).	• "[D]rug abuse prevention programs should address both common factors among Asian drug users, as well as unique factors in specific target groups (e.g., ethnic groups, Asian immigrants, Asian women, refugees, and adolescents)" (p. 837).

Table 7. Psychopathology Among Asian Americans

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					• "Vietnamese and Chinese immigrants reported using drugs with mostly other immigrants from their own ethnic group" (p. 831). • "Drug user networks among Chinese participants consisted of only Chinese (30%) or Chinese and other Asians (61%)" (p. 831). • "[P]atterns of drug use among Asian drug users are unique to their ethnicity, gender, immigrant status, and age groups" (p. 837). • "…Asian drug users share cultural constructs related to drug use such as fear of addiction and injecting drugs, and stigma attached to drug users in the community" (p. 837).	
US Department of Health and Human	To provide a report of the demographics of			Descriptive study	• AAPIs speak over 100 languages; estimates	• Culturally competent/effective

Table 7. Psychopathology Among Asian Americans

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
Services (2001)	AAPIs and the status of MH care for AAPIs in the US				from the 1990s indicate that 35% of AAPIs live in linguistically isolated households. • AAPIs are more likely to live in family households. • On average Asian Americans have attained more education than other ethnic groups in the US. • Culture shapes how psychiatric problems are expressed and recognized. • Asian cultures often do not distinguish between mind and body. • Mental illness is highly stigmatizing in many Asian cultures. • AAPIs may have unique ways of expressing psychological distress. • Acculturation affects symptom expression and help-seeking.	services are often inaccessible or unavailable. • Approximately half of the AAPIs access to care is limited by lack of English proficiency. • Asian Americans use psychiatric clinics less than the general population. • Limited evidence is available on outcomes of MH treatment for Asian Americans. • Outreach on prevention could provide very useful to the community, in addition to more educational and training programs for the community members. • Stigma and shame strongly influence MH utilization. • More research is needed on the AAPI population.

Table 7. Psychopathology Among Asian Americans

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					• AAPIs are not highly represented in homeless and incarcerated populations.	
US Department of Health and Human Services, Office of the Surgeon General (n.d.)	To publish a fact sheet on the demographics of Asian Americans in the U.S. and describe the need for mental health care			Descriptive study	• Approximately 4% of U.S. population (over 11 million) identifies as Asian American or Pacific Islander (AA/PI). • About 43 different ethnic subgroups. • Over 100 languages and dialects. • 35% live in family units where there is limited English proficiency in for individuals 13 years and older. • Average income for AAPIs is higher than national average but they have smaller per capita income and greater poverty than non-Hispanic white Americans; poverty rates range from 6% for Filipino	• "AA/PIs speak over 100 languages and dialects, and about 35% live in households where there is limited English proficiency in those over age 13" (p. 1). • "Some subgroups have more limited English proficiency than others: 61% of Hmong-, 56% of Cambodian-, 52% of Laotian-, 44% of Vietnamese-, 41% of Korean-, and 40% of Chinese-American households are linguistically isolated" (pp. 1-2). • CAPES "study found lifetime and one-year prevalence rates for depression of about

Table 7. Psychopathology Among Asian Americans

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					Americans to 64% for Hmong Americans. • AAPI rates of diagnosable mental D/Os similar to "white" population based on symptom scales, AAPIs have greater depressive Sx. • Asian American women have the highest suicide rate of women over the age of 65. • 70% of Southeast Asian refugees receiving MH services meet PTSD criteria. • 1 out of 2 AAPIs will have difficulty accessing MH services due to language. • Extremely low MH utilization rate compared to other U.S. populations.	7% and 3%, respectively. These rates are roughly equal to general rates found in the same urban area" (p. 2). • "…Chinese Americans are more likely to exhibit somatic complaints of depression than are African Americans or non-Hispanic whites" (p. 2).
Yang & WonPat-Borja (2007)	Review of the evidence relevant to prevalence of mental disorders in Asian			Literature review	• Meanings of illnesses are interpretable by understanding what is at stake for	• Estimations of mental disorders among Asian Americans appear higher than

Table 7. Psychopathology Among Asian Americans

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
	countries and how the experience may change due to processes linked to immigration Review research on psychopathology in Asian Americans				participants in their social contexts. • Culture shapes the manifestation and experience of Sx; interpretation of these Sx is determined by cultural values and meanings; Sx may be organized into differing syndromes according to historical and sociopolitical influences. • Somatization is prevalent in all cultural groups. • Local ideas about how body and physiology communicate suffering result in culture-specific syndromes and somatic complaints; medical complaints about the body tap into cultural models of sickness. • In Chinese cultures, emotional communication takes place through	those in Asia, suggesting that acculturative stress during immigration process may contribute to higher prevalence of mental D/Os. • When Chinese Americans immigrate they may face a higher risk of developing mental D/Os but subsequent acculturation may provide an overall protective effect.

Table 7. Psychopathology Among Asian Americans

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					metaphors that are associated with the body rather than words that symbolize emotions. • Although Chinese patient groups may present greater somatic Sx in lieu of emotional distress, this pattern does not appear to extend to the Chinese general community. • Somatization does not appear to be a conscious denial of affective distress among Asian Americans but instead an initial culturally accepted "negotiating tactic." • Results of a World Health Organization survey (2004) strongly suggest that prevalence of mental disorders as classified by DSM-IV is lower in Asian countries than in the U.S.; these results are consistent	

Table 7. Psychopathology Among Asian Americans

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					with earlier group studies reporting low prevalence of psychiatric disorders in Asian countries. • Two alternative theories of how immigration affects psychopathology: (a) acculturative stress and (b) process of cultural assimilation (immigrants gradually absorb characteristics of psychopathology found in the U.S.). • Regional and national data show significant underuse of MH services for Asian Americans compared to Anglos. • Neurasthenia (weakness Sx, physical fatigue, memory loss, concentration problems; emotional Sx including dysphoria, worry, and irritability; excitability; nervous pain; sleep	

Table 7. Psychopathology Among Asian Americans

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					disturbances. • Current Neurasthenia 10% rate in general population in Chinese societies; rates have decreased since the 1980s and depression has increased. • Rates for OCD and phobia among Asian Americans did not differ significantly compared to Anglos. • Low prevalence of anxiety D/Os compared to U.S. general population. • Rates of social anxiety, social avoidance/distress were higher among Asian Americans compared to Anglos. • Asian Americans demonstrated a lifetime prevalence of 0.2% for schizophrenia, which was not significantly different than the Anglo population. • Asian Americans	

Table 7. Psychopathology Among Asian Americans

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					demonstrated a significantly lower rate of schizophreniform D/O compared to Anglos. • In one sample, Asian American patients diagnosed with psychotic-spectrum D/Os had an average treatment delay of 17.3 months. • In a treatment study with Korean Americans with a schizophrenia-spectrum D/O, psychoeducation was effective in facilitating use of MH services. • Elevated depression scale scores do not necessarily signal the greater prevalence of MDD among Asian Americans. • There is some evidence that recent immigrant Chinese American adults within primary care	

Table 7. Psychopathology Among Asian Americans

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					and Asian American girls in MH treatment are at higher risk for developing MDD. However, community samples suggest prevalence of MDD among a=Asian Americans is equal to or less than the general U.S. population rates, but still higher than rates found in Asian countries. • Higher risk of suicide among Asian American elderly, particularly females. • Data was divided on an association between gender and depressive disorders. • Data on the effect of immigration on depressive D/Os was mixed and mainly found no association after accounting for other SES variables; CAPES study found that as length of time in U.S. increased, risk	

Table 7. Psychopathology Among Asian Americans

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					of depression decreased and that Chinese immigrants faced greatest risk of developing depression at or soon after migration.	

Table 8. Asian American Help-Seeking Behaviors and Attitudes

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
Inman & Yeh (2007)	To discuss Asian American stress and coping			Literature review	• Stress and coping must be understood from a systemic and sociocultural perspective. • Collectivist perspective. • Religious perspectives. • Stressors: acculturative stress, familial and intergenerational stress, cultural conflicts and bicultural identities, model minority stress, racism and discrimination.	• Asian Americans face numerous challenges related to immigration, adaptation, adjustment, racism, discrimination, and intergenerational differences. • Coping involves multiple approaches such as use of social support networks, family systems, religious institutions, and indigenous healers. • A common thread

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Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					• Asian Americans tend to cop using social support networks, family ties, indigenous healers, and religious/spiritual outlets. • Western healing often measures progress via action-oriented coping; Asian Americans have been characterized in coping literature as avoidant and indirect. • Preference for Asian Americans use of indigenous copings. • 3 approaches of indigenous coping: (a) preference for community and family, (b) spiritual and religious beliefs and community traditions, and (c) use of shamans. • Familial support and keeping matters private. • Using family support is reinforced but	linking the above coping methods is their interconnectedness with others; coping must be conceptualized as interdependent.

Table 8. Asian American Help-Seeking Behaviors and Attitudes

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					intergenerational differences can create more tensions in the family; Asian American college students report greater family conflict compared to their Hispanic and European American counterparts. • Culturally similar peers and support networks beyond the family also provide support for immigrants. • Intracultural coping: use of support networks consisting of people of the same or similar racial background. • Collective coping: actions of multiple individuals aimed at one problem. • Religious and spiritual support may reflect beliefs and also a cultural need for community and	

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					interrelatedness with others.	
Tewari (2009)	To discuss the topic of "seeking, receiving, and providing mental health services with a focus on Asian Americans" (p. 576)			Literature review	• Asian Americans seek counseling less frequently than other cultural groups. • Barriers to help-seeking include: financial limitations, lack of available services, suspiciousness toward therapy, and a lack of culturally competent MH providers. • Client-therapist ethnic and worldview match play some role in having positive results in therapy. • Acculturation and enculturation levels affect a client's perception of the stigma of seeking help. • Emphasis on using community, religious/spiritual, ethnic sources of support rather than outsider/professional	• Factors of diversity and acculturation all impact a person's decision to seek therapy. • The objectives of several Tx goals is to normalize what may be seen as stigmatizing, educating, and providing objectivity.

Table 8. Asian American Help-Seeking Behaviors and Attitudes

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					support. • Description of multicultural guidelines included in this discussion. • Description of therapy process provided.	
Yeh, Hunter, Madan-Bahel, Chiang, & Arora (2004)	To present a discussion "on understanding the role of spirituality, balancing energies, close social networks, and interconnectedness in indigenous healing perspectives and philosophies" (p. 410)			Literature review	• Indigenous healing takes a holistic view toward health and emphasizes interdependence in healing. • Healers' duties are to cure the ailment and deal with the problems associated with the distress or behavior. • "Indigenous healing…refers to helping beliefs and practices that originate within a culture or society, that are not transported from other regions and that are designed to help the inhabitants of that group" (p. 410). • Healers act as a conduit of positive energy from the	• "Counselors should be sensitive to specific needs of the client and be willing to encourage…use of indigenous healing methods" (p. 417). • Counselors should validate Ct experiences and incorporate "information from indigenous healers/healing" (p. 417) in Tx. • Counselors should collaborate with community healers • Counselors may have to become advocates. • Counselors should know their limits and be ready to refer to indigenous sources when appropriate.

Table 8. Asian American Help-Seeking Behaviors and Attitudes

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					"realm of spirits." • Ethnic minorities tend to use informal healing sources such as clergy, traditional healers, family and friends, rather than utilizing Western mental health services. • Western conceptualizations of MH treatment and health exclude those of interdependent cultures. • 3 approaches of indigenous coping: (a) preference for community and family, (b) spiritual and religious beliefs and community traditions, and (c) use of shamans. • Robust view of oneness of spirit, mind and body. • Strong belief in interconnectedness with cosmic forces in the form of energy that envelop and infiltrate	• "[S]pirituality should be seen as an integral part of the therapeutic process" (p. 417).

Table 8. Asian American Help-Seeking Behaviors and Attitudes

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					the corporal body and world. • Healing practices that focus on energy balance include practices such as Reiki, chakras, "QiGong, pranic healing, yoga, breath work, and meditation" (p. 413). • Active helping role. • Circular perspective rather than linear. • Spiritual basis of well-being over cognitive-affective basis.	

Table 9. Diagnostic Issues Related to Ethnicity and Culture

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
Berry (2005)	To conceptualize how groups of people engage in intercultural contact and "the dual process of cultural and psychological change that takes place as a result of			Literature review	• During acculturation, people of different cultures connect and clash—there exists the need to negotiate so that both parties can benefit and adapt. • Key element of	• A "mutual accommodation is required to achieve integration involving the acceptance by both groups of the right of all groups to live as culturally

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	contact between two or more cultural groups and their individual members" (p. 698) Author wishes to address whether acculturation always includes clashes and leads to unwanted consequences for both groups involved				acculturation is variability: in families, members acculturate at different rates; members may have differing goals leading to conflict. • "Adaptations can be primarily psychological (e.g., sense of well-being or self-esteem) or sociocultural, linking the individual to others in the new society as manifested, for example, in competence in the activities of daily intercultural living" (p. 702). • It is important to understand the historical and attitudinal situation faced by immigrants in the dominant culture. Some societies are more accepting while others are not. • "Other societies seek to eliminate diversity	different peoples. This strategy requires non-dominant groups to adopt the basic values of the larger society, while at the same time the dominant group must be prepared to adapt national institutions (e.g., education, health, labor) to better meet the needs of all groups living together in the plural society" (p. 706). • "For both forms of adaptation, those who pursue and accomplish integration appear to be better adapted, and those who are marginalized are least well adapted...[T]he assimilation and separation strategies are associated with intermediate adaptation outcomes" (p. 709). • "Psychological adaptation largely

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					through policies and programs of assimilation, and still other societies attempt to achieve the segregation or marginalization of their diverse populations" (p. 703). • The strategies chosen by an individual are based on cultural and psychological factors. • Four acculturation strategies based on preferences for native or dominant cultures. • "From the point of view of non-dominant groups when individuals do not wish to maintain their cultural identity and seek daily interaction with other cultures, the assimilation strategy is defined. Here, individuals prefer to shed their heritage culture, and become absorbed into the dominant society" (705).	involves one's psychological and physical well-being, whereas sociocultural adaptation refers to how well an acculturating individual is able to manage daily life in the new cultural context" (p. 709. • "For behavioral shifts, the fewest behavioral changes result from the separation strategy, whereas most result from the assimilation strategy; integration involves the selective adoption of new behavior s from the larger society, and retention of valued features of one's heritage culture; and marginalization is often associated with major heritage culture loss and the appearance of a number of dysfunctional and

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					• "When individuals place a value on holding on to their original culture, and at the same time wish to avoid interaction with others, then the separation alternative is defined. Here, individuals turn their back on involvement with other cultural groups, and turn inward toward their heritage culture" (p. 705). • "When there is an interest in both maintaining one's heritage culture while in daily interactions with other groups, integration is the option" (p. 705). • "[W]hen there is little possibility or interest in heritage cultural maintenance (often for reasons of enforced cultural loss), and little interest in having relations with others (often for reasons of	deviant behaviors (such as delinquency and substance and familial abuse)" (p. 708).

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					exclusion or discrimination) then marginalization is defined" (p. 705). • "This formulation is from the perspective of non-dominant peoples, and is based on the assumption that such groups and their individual members have the freedom to choose how they want to acculturate" (p. 705). • "When the dominant group enforces certain forms of acculturation, or constrains the choices of non-dominant groups or individuals, then other terms need to be used" (p. 705). • One current issue is whether the 4 assimilation strategies have an empirical basis; some argue that "there is no evidence that integration is usually the preferred way to acculturate" (p.	

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					707). • "Researchers often presume to know what acculturating individuals want, and impose their own ideologies or their personal views, rather than informing themselves about culturally rooted individual preferences and differences" (p. 710). • "[D]iscrepancies in family obligations scores (but not [adolescent] rights scores) were associated with poorer psychological and sociocultural adaptation of the adolescents" (p. 710).	
Chun, Morera, Andal, & Skewes (2007)	To describe and discuss cultural and practical considerations in working with diverse Asian American groups during an investigation			Theoretical discussion	• Challenges include building competent research teams, entering the community, and recruiting participants. • Authors recommend D.W. Sue's three	• There is a fundamental aim to more accurately and fully comprehend psychological phenomena for Asian Americans. • Both qualitative and

Table 9. Diagnostic Issues Related to Ethnicity and Culture

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					components of cultural competence. • Entering the community may require identifying community leaders who can legitimize the research and help gain access to the community. • Researcher's identity characteristics may require him/her to negotiate those differences with community leaders and members in order to develop trust. • Attention is needed regarding logistical problems such as location and hours. • Reframing research in a culturally meaningful way may appeal to community members.	quantitative methods have their rightful place in Asian American psychology. • Improvement to methods will include taking stock of current methods and determining where we may have inadvertently privilege some over others.
Kim, Ng, & Ahn (2009)	Purpose is "to examine (a) Asian American clients' adherence to Asian cultural values, (b)	• *n*=61 (40 women; 21 men) at a large, West Coast university	• AVS • Expectation for Counseling Success scale (ECS)	Correlational	• "In partial support of [the] hypothesis, the results indicated that the independent variable of client-	• "[R]esults provided strong support for the hypothesis that client perception of a shared worldview with their

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Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
	expectation for counseling success, (c) perception of client-counselor match on belief of problem etiology, and (d) the relationship of these variables to client evaluation of the counselor and the session" (p. 133)		• Match on Belief About Problem Etiology (MBAPE) • Counselor Effectiveness Rating Scale (CERS) • Empathic Understanding Subscale (EUS) of the Barrett-Lennard Relationship Inventory • Cross-Cultural Counseling Inventory-Revised (CCIR-R) • Working Alliance Inventory-Short Form (WAI-SF) • Session Depth subscale (DEPTH) of the Session Evaluation Questionnaire • Two 1-item measures to asses clients' overall perceptions of counselors and the		counselor match on belief about problem etiology was a significant positive predictor of the six dependent variables"(p. 137). • There was an interaction effect between ECS and MBAPE scores with a medium effect size • "[C]lient perception of a strong client-counselor match on belief about problem etiology and high client expectation for counseling success were associated with client perception of strong client-counselor working alliance" (p. 137). • "[T]he likelihood of the client returning for the next counseling session was not significantly related to the shared worldview variable" (p. 139). • "[T]here was not a	counselor, as operationalized in terms of a client-counselor match on belief about problem etiology, is related to a positive counseling session outcome" (p. 137). • The above "effect was observed on six of the seven dependent variables: Counselor credibility, counselor empathic understanding, counselor cross-cultural competence, client-counselor working alliance, session depth, and likelihood of the client recommending the counselor to another person" (p. 137). • "[P]rovides evidence of external validity of this effect in relation to an actual client population" (p. 139) rather than volunteer clients.

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			likelihood of client returning for the next session		main effect for client expectation for counseling success on session outcome" (p. 139).	• The "relation between client-counselor match on the belief about problem etiology and client-counselor working alliance is conditional on the level of client expectation for counseling success" (p. 140). • "Similarly, the relation between client expectation for counseling success and…client-counselor working alliance is conditional on" (p. 140) client-counselor MBAPE.
Kinoshita & Hsu (2007)	To discuss fundamental issues and clinical applications related to the formal assessment process with Asian Americans			Literature review	• Steps to culturally competent assessment include the following: 1)Self-awareness and self-assessment; 2) Building and establishing rapport; 3)Multidimensional interview assessment; 4) Collateral input from family and/or community members;	• Without adequate assessment development and expansion, it is possible that Asian Americans will be misdiagnosed and provided with improper MH treatment. In the meantime, clinicians must carefully select

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					5) Culturally appropriate choice and use of assessment instruments; and 6) Culturally appropriate analysis, interpretation, and generalizability of assessment results. • Cultural competence is a necessary aspiration to practice ethically and effectively. • Hays (2001) recommends therapists reflect on the following: 1) Understand the effect of culture on one's own convictions and perspectives; 2) Make personal the exploration we may later repeat with clients; 3) Acknowledge that our experiences are drawn from multiple dimensions of identity and sociocultural contexts; and 4) Become more aware	assessment methods and instruments and interpret the results with special care.

Table 9. Diagnostic Issues Related to Ethnicity and Culture

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					of the role of privileges in one's experiences. • Hays (2001) suggests the following when working with interpreters: 1) Plan extra time for the assessment; 2) Use a certified interpreter whenever possible; 3) Discuss expectations with the interpreter prior to the assessment meeting; 4) Allow time for the interpreter and client to talk together before the initial session to establish rapport; 5) Do not use an interpreter with prior personal or social relationship with the client who may distort or omit the client's self-report or contribute to problems with confidentiality. • Collateral sources can provide important perspectives and information on the	

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					presenting problem or target of assessment. • When using standardized measurements, one must be aware of different education norms from one country to another and what education level the original data was normed on; the majority of available standardized tests do not include an Asian American normative sample. • When deciding on the appropriateness of an assessment measure, consider: 1) On what population was this measure originally normed? What were the characteristics of the sample? 2) What is the acculturation level of the client? What is the language proficiency/literacy level of the client? What is the education level of the client? and	

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					3) Does the client understand the purpose of the assessment? Has s/he been exposed to such measures in the past? • When considering whether to use adapted measures, one must consider linguistic equivalence, content equivalence, procedural and normative equivalence, conceptual equivalence, functional equivalence, and whether the adapted measure has been pilot and field tested with the target population. • Researchers suggest that clinicians initially consider using methodologies that minimize subjective interpretation and speculation to decrease bias that may affect accuracy.	

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					• When choosing assessment methodologies, consider: Does the client exhibit distress in the same way as non-Asian Americans? If differences are detected, how do I know if the difference is due to maladjustment or to non-pathological cultural factors? • Criticisms of acculturation measures: Unidirectional conceptualization of movement from native culture to mainstream; it is likely multidirectional and multidimensional. • Limited psychometric information is available regarding adapted intelligence batteries for Asian Americans such as the WAIS.	

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					• There is no official central body to guide professionals or to set standards/guidelines for assessment procedures and measurement development. • Lack of normative data collected using Asian American samples, making funding of normative studies a priority at a national level, should be required.	
Lee (1997b)	To offer clinicians recommendations for building their skills in working with interpreters			Theoretical discussion	• Cultural interpreting is more than translating. It is a cross cultural interaction whereby assistance in understanding practices and cultures occurs. • There are different models of interpreting, depending on the MH institution, some are not ideal. • 4 Stages of	• Clinicians should know their own style of communication. • Trust should be built between clinician and interpreter. • The clinician should always address the patient rather than the interpreter during the interview. • Clinicians and interpreters must be aware of class differences among the players.

Table 9. Diagnostic Issues Related to Ethnicity and Culture

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					interpreting include: Language assessment and interpreter assignment; pre-interview meeting with the interpreter; interview with patient, and; session review. • There are different types of role expectations for the interpreter. It is best if the interpreter is in the role of a team partner, rather than as a robot. • Cultural interpreting allows the interpreter to share clinician and client messages in a manner that matches the understanding of the speaker and listener. • There are a number of technical interpretation difficulties to be aware of.	• Clinicians must practice nonverbal communication throughout the interview and must be aware of the meanings of such communications. • Clinician should match client's tone and avoid jargon. • Clinicians should be alert to errors or omissions and gently ask the interpreter to repeat the translation with more accuracy. • Clinician should encourage the interpreter to share if he or she is having difficulty or to comment on the patient's diction or emotions.
Lewis-Fernandez & Kleinman (1994)	To describe the culture-bound nature of North American mental health conceptualizations			Literature review	• North American culture-bound assumptions: "a) Egocentricity of self,	• Current Western and North American theories continue to rely on egocentric and

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	and illness and to illustrate how "indigenous interpersonal models of personality and psychopathology that focus on social processes" (p. 67) can assist North American clinicians' understanding				b) Mind-body dualism, c) Culture as an arbitrary superimposition on a knowable biological reality" (p. 67). • The realities of health and illness are shaped by ongoing interpersonal interactions: negotiations at the levels of perception, cognition, [EE], and values" (p. 68). • "[I]nterpersonal processes bridge the social world and the body. Individual reality is the lived experience of perceptions, meanings, affects, and actions that come together (aggregate) at different levels and shame the individual as…self… and member of…network[s]" (p. 68). • "Personality and psychopathology take	individualistic assumptions that remain unexamined and that deemphasize interrelatedness and social categories. • Clinicians and researchers ought to be trained to view behaviors in their appropriate contexts rather than being quick to pathologize.

Table 9. Diagnostic Issues Related to Ethnicity and Culture

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					form in distinct local worlds characterized by behavioral environments consisting of orientations to self, objects, space, time, motivation, and moral norms…Behavioral environments vary greatly both across and within local worlds, leading to multiple versions of self and personality" (p. 68). • Western theories' five factor model not empirically tested on wide samples. • Experiences of oneself and personality are more varied than presumed by egocentric or sociocentric philosophies.	
McGoldrick (1993)	Discussion of concepts of ethnicity, cultural diversity, and normality			Literature review	• Having a sense of home is crucial to our sense of personal and cultural identity. • Ethnicity is	• Ethnic patterns are retained much longer than consciously recognized and are modified by complex socioeconomic forces,

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					transmitted through family; major family therapy models make little reference to ethnic differences. • Family culture determines whether its members will even define a Sx as a problem and what Sx develop in which cultural contexts, bringing into question the usefulness of diagnostic nomenclature. **Influences to consider** • Reasons for immigration. • Time since immigrations and impact of acculturation conflict. • Place of residence (of same ethnic background?). • Order of migration. • Socioeconomic status, education, upward mobility of family. • Political and religious ties to ethnic group.	ethnic intermarriage, geographic mobility, and changing patterns of the family life cycle. • We can never be too sure that the way we see things is correct; we are responsible for recognizing and not romanticizing diversity. • Just because a culture proclaims a certain value/belief does not make it sacrosanct.

Table 9. Diagnostic Issues Related to Ethnicity and Culture

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					• Languages spoken by family members. • Intermarriage with or connection to other ethnic groups. • Family members' attitudes toward the ethnic group and its values.	
Okazaki, Lee, & Sue (2007)	To review theoretical and conceptual contributions to Asian American psychology and to note the consequences of particular approaches			Literature review	• Asian American psychology has focused on the notion of Asian Americans as a cultural group rather than a racial group. • Existing theorized elements of Asian American psychology: individualism vs. collectivism, independent vs. interdependent, and Confucianism. • Asian subgroups develop hybrid values based on their contexts. • There is current widespread acceptance of the bidimensional model of acculturation.	• Important theoretical advances have been made but mostly without reference to perspectives found in Asian American/ethnic studies such as critical theory, feminist theory, queer theory, and indigenous psychology. • Constructs of race/ethnicity/culture, acculturation, and identity have emerged but they reflect Western thought and orientation. • Current theories lack integration with emerging issues (globalization,

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					• Current acculturation theories continue to reflect middle-class, voluntary immigrant, upwardly mobile perspective. • Asian American experience cannot be reduced to a single index. • Theory must integrate a global perspective and contextual factors.	migration, transnationalism, diaspora, social identity and so forth), other theories, and Western orientation. • New theories must be able to deal with contemporary issues and that address the criticisms of Western approaches.
Sue (2001)	To discuss a "multidimensional model of cultural competence (MDCC) [and] its uses in education and training, practice, and research" (p. 790)			Theoretical discussion	• "[P]roposed multidimensional model of cultural competence (MDCC) incorporates three primary dimensions: (a) Racial and culture-specific attributes of competence, (b) components of cultural competence, and (c) foci of cultural competence (p. 790). • "Based on a 3 (Awareness, Knowledge, and Skills) x 4 (Individual, Professional,	• This model "allows us to identify culture-specific and culture-universal domains of competence that are either unique or common across several or all racial/ ethnic groups" (p. 815). • "[M]uch of our focus on cultural competence falls into two main cells across racial/ethnic groups: individual focus at the components of awareness and

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					Organizational, and Societal) x 5 (African American, Asian American, Latino/Hispanic American, Native American, and European American) factorial combination, the MDCC allows for the systematic identification of cultural competence in a number of different areas" (p. 790).	knowledge" (pp. 815-816). • "We tend to neglect the areas that focus on skill development…and those requiring intervention at the macro levels" (p. 816). The model is useful for pointing out areas of neglect. • The "model places the Euro-American group on an equal plane with others and conceivably begins the task of recognizing that the invisible veil of Euro-American cultural standards must be deconstructed" (p. 816). (As long as Euro-American standards are the norm, a hierarchy between groups is unwittingly set up). • "[P]sychologists must play different roles in to move toward cultural competence"

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						(p. 816). • "Because psychology concentrates primarily on the individual, it has been deficient in developing more systemic and large-scale change strategies" (p. 816). • Sometimes "psychologists treat individuals who are the victims of failed systemic processes (cultural conditioning and biased education)" (p. 816). Intervention needs to be broad and integrated.
Yeh, Eastman, & Cheung (1994)	To investigate the "effect of language and ethnic therapist-client match on [MH] treatment of…Asian American, African American, Mexican American, and Caucasian American adolescents in the Los Angeles County [MH] system" (p. 153)	• *n*=4616 • 1219 African Americans • 903 Asian Americans • 996 Caucasian Americans • 1498 Mexican Americans • 1517 children • 3099 adolescents		Correlational	• "Ethnic match was a significant predictor of adolescent dropout for Mexican American and Asian American adolescents after one session and total number of sessions, and of dropout rate alone for African Americans" (p. 159)	• "Conclusive support for the cultural responsiveness hypothesis was not found for children, but some validity for adolescents was found" (p. 153). • Recruiting bilingual, bicultural and ethnic minority MH workers

Table 9. Diagnostic Issues Related to Ethnicity and Culture

Author/Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Results	Major Findings
					• "When language match was added to the model, for Mexican adolescents, language match was a significant predictor of dropout after one session and total number of sessions, whereas ethnic match was no longer a significant predictor" (p. 153). • "[W]hen language match was added for Asian adolescents, language match was not a significant predictor of dropout after one session or total number of sessions, whereas ethnic match remained a significant predictor for both variables" (p. 153).	may be the best method to bettering service for minority adolescents.

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APPENDIX B

Reviewer Comments for Questions 5-9

Question 5: Please share your thoughts about the manner in which the cultural values and clinical recommendations are presented. Consider any or all of the following issues in formulating your thoughts.

a. *Was it tedious and boring or an interesting read?*

Reviewer 1: "I thought the values and clinical recommendations were presented in an interesting and informative manner."

Reviewer 2: "rather tedious, I'm afraid. But you're asking a person (me) who is already knowledgeable about Chinese culture and assessment and treatment for schizophrenia. I would expect that if your treatment recommendations are designed for non-Chinese, the information would be helpful."

Reviewer 3: "I found the document quite interesting and found myself nodding as I read."

Reviewer 4: "Time-issue aside, there are some interesting ideas and culturally relevant ways of attending to the issues.

Reviewer 5: "Interesting read."

Action taken: No action required.

b. *Was it condescending or respectful to the reader?*

Reviewer 1: "It was presented in a respectful manner."

Reviewer 2: "Not condescending. But, some of the terms need to be further defined and explained. E.g., what are "Chinese American values"? Are they different from Chinese values? What are some of the traditional Chinese values? Are they different from modern Chinese values? I suspect that for new immigrants, even for those who have taken US citizenship, might still consider themselves as just Chinese, rather than Chinese American. I would think that a clear recommendation on how to systematically assess ethnic identity of the individual client as well as the 'family unit (head & other members)' is important."

Reviewer 3: "I did not feel that the document was written in a condescending manner it neither assumed no knowledge or complete knowledge of Asian culture and points were made in a way that was respectful regardless of the level of acculturation."

Reviewer 4: "Nope, it is not condescending in part because I am Chinese and am reading the materials from that culture and lens. Therefore it is quite

refreshing to have a writer who understands the Chinese context and being very mindful on how to attend to that population."

Reviewer 5: "Respectful writing style."

Action taken: The comments of Reviewer 2 regarding the potential differences between Chinese versus Chinese American values and self-identification are addressed in the section entitled, "Defining Chinese American Value" under **Delimitation of the Recommendations.**

c. *Were there enough details presented or an excessive amount of unnecessary detail?*

Reviewer 1: "Details were sufficient."

Reviewer 2: "The introduction is clear in terms of explaining the purpose of the dissertation. I think a vignette describing how each recommendation can be implemented would be helpful."

Reviewer 3: "The examples were quite useful, like reframing criticism as worry."

Reviewer 4: "Yes, you have presented adequate materials."

Reviewer 5: "There are areas which had enough detail, and other areas I actually would have liked more detail." "And how will a clinician use this knowledge to effectively join with each family member, and work with the family as a whole? Also, how will the clinician start the initial discussion with the family to specifically address stigma towards mental health and any mistaken beliefs about professional services?" "However, the acculturation gap comes into play here. How will you resolve different needs of generations? Parents may want more interdependence, but the children and teens may want more independence due to their higher exposure and integration of Western culture. The Berry (1997) bidimensional model sheds more light on this as well." "Perfect! I see you have summarized what I mentioned earlier nicely here. Perhaps a little more emphasis in earlier sections will be even better to drive the point home."

Action taken: To address the recommendation of Reviewers 2 and 5, a fictional "Case Summary" was introduced and illustrations for **Working with Chinese Americans Families** were based on elements of this case. John Berry's bilinear model of acculturation was included in the section entitled, "Relevance of Acculturation" under **Delimitations of the Recommendations**.

d. Was there a logical flow to the presentation of content? If the organization of content could be improved, please offer suggestions.

Reviewer 1: "The content flowed nicely and was logical. I don't know if this type of paper would permit it, but including a case study or vignette on working with a Chinese American patient/client with schizophrenia could have helped show how the recommendations could be applied."

Reviewer 2: "Yes, overall, there was a logical flow to the presentation of content. I would suggest the following: Check out the formatting templates of Evidenced-based treatment books and manuals. Such as, effective ways to use subheadings. E.g., rapport building component, it seems that there are several ways to build rapport, so good place to add an informative subheading for each skill/strategy. Also, you might want to consider using tables and bullets to summarize important information."

Reviewer 3: "While the subject matter is quite complex, the presentation did flow."

Reviewer 4: "I read the paper a while back and nothing strikes me as something that needs to be changed or re-organi[s]ed"

Reviewer 5: "I like the organization."

Action taken: The comments of Reviewer 1 were addressed by introducing a fictional "Case Summary" and using illustrations from the case in the **Working with Chinese American Families** section.

In response to the comments of Reviewer 2, specific illustrations of "Rapport Building" strategies under **Components of the Therapeutic Process**, e.g., paying attention to family hierarchy, eye-contact, the initial greeting, and avoiding the use of blame, were added to the discussion. The one action not taken was the suggestion to re-organize the material as an evidenced-based book or manual. This discussion is not intended as a manual for doing therapy but rather a set of recommendations that are worthy of consideration in working with Chinese American families. Since there was consensus among the other four reviewers regarding the organization of material, my chairperson and I elected to not act on this suggestion.

Question 6: Were there any important traditional Chinese American values that were overlooked in the discussion? Please identify any omissions.

Reviewer 1: "The paper did a great job in giving an overview on Chinese Cultural values covering such important areas like: family collectivism, stigma around mental health, and family roles and hierarchy. More information regarding how gender and birth order plays a role in family expectations could be useful (e.g. expectations of success placed on the

oldest son in order to bring honor and respect to the family, and the grief or denial the family endures when that son is diagnosed with schizophrenia)."

Reviewer 2: "Taoist beliefs and rituals. Use of Chinese food (specific dishes and soup), and Chinese medicine. Implications: conceptualization of illness, help seeking behaviors, and adherence to western medication."

Reviewer 3: "Perhaps the value of Education could have been a bit more overt as perhaps contributing to the idea that psycho-education might be a more amenable reframe to "therapy." I guess a value that factor's prominently (at least in my life) is the goal of being Productive (i.e.: read "able to bring in revenue" or "rich"). For good or bad or indifferent, this may add additional stressors to an individual coping with schizophrenia in that they might be less likely to "make it as a doctor or lawyer."

Reviewer 4: "You have done well in highlighting the relevant issues. However tension usually arises between the ABC and the OBC with regards to revealing the diagnosis to the IP. I don't remember reading that piece in your paper (address in area of expectations of the family members, refer to acculturation levels), discuss diagnosis of pt in the assessment section"

Reviewer 5: "Yes, and I have indicated them in the actual document under track changes." "GOOD. You should also check out the USDHHS 2001 Surgeon General's Report Addendum – it's got some great info about what having a mental health illness means for Asian families…they are considered not marriage material, not productive members of society, creating further isolation. The addendum has a great Asian American chapter!" "How so? This warrants a little more explanation regarding the rationale of why schizophrenia was chosen above depression, anxiety, etc."

Action taken: The comments of Reviewer 1 were addressed by adding "Discussing Psychopathology" to the **Assessment** subsection of the **Components of the Therapeutic Process** section.

The comments of Reviewer 2 regarding Western medication and Chinese medicine are addressed in the section "Problem-solving and Communication Skill-building" under the **Treatment** subsection of the **Components of the Therapeutic Process** section. The comments of Reviewer 2 regarding help-seeking behaviors and conceptualization of illness are addressed in **Relevance of Acculturation** under the section **Delimitations of Recommendations in** Chapter III.

To address the comments of Reviewer 3, content that emphasized the importance of education to serve as the basis for using "Psychoeducation" as a treatment approach was added to the **Treatment** subsection of the **Components of the Therapeutic Process** section.

The comments of Reviewer 4 regarding intergenerational tension over discussing the client's diagnosis were addressed by adding "Discussing Psychopathology" to the **Assessment** subsection of the **Components of the Therapeutic Process** section.

The comments of Reviewer 5 regarding the decision of focusing on schizophrenia over other psychiatric disorders are addressed in "Selection of Schizophrenia for the Psychiatric Disorder" under the **Delimitations of the Recommendations** section in Chapter III.

The comments of Reviewer 2 regarding the use of Chinese food as an alternative form of healing were not addressed. None of the existing literature I have already searched has mentioned Chinese food as a specific alternative remedy for mental illness. After searching specifically for the use of Chinese food as an indigenous treatment, I was able to find reference to its use; however, food is only mentioned, not discussed. The use of food is likened to the use of Chinese herbal remedies for the treatment of mental illness.

Question 7: Does the literature considered in proposing the recommendations adequately capture the needs of Chinese American families living with schizophrenia?

Reviewer 1: "I found the recommendations to have been on point with my experience. I have found it helpful when working with Chinese families to focus on concrete tangible goals as a vehicle with getting them on board with treatment. Treatment can be framed to the family as a way achieving something more concrete such as grades, but at the same time still addresses symptoms such as auditory hallucinations."

Reviewer 2: "It has laid out a very good foundation. I would suggest looking into non-psychology, non-American Chinese writings about Chinese culture for ideas on "traditional Chinese values and culture."

Reviewer 3: "I wonder how potential self-medication (read "substance abuse") plays into individuals and families coping with schizophrenia, yet another opportunity to experience shame."

Reviewer 4: "You have provided recent literature! I think those interventions appear useful for the families."

Reviewer 5: "I think these are nice recommendations overall, but certain areas need to be further explained or reinforced with literature. In particular, there is some current literature – in the past 5 years or so - by leading researchers missing (which I have suggested in the document under track changes)." "This is great. Also, add that one of the most promising and effective treatments for schizophrenia (and also one to prevent relapse) is family therapies. These studies have been conducted in western literature and family involvement is crucial to the care of schizophrenia across cultures. "How are you defining cultural congruence? Present the operational definition." "This is a great section. You might also consider the role of psychoeducation for Chinese American families – Chinese American families highly value educational systems and sometimes prefer if

treatment is framed in this fashion versus in a "therapeutic" fashion – there is more information on this in the works of Anna Lau at UCLA." "Explain problems with generalizability. Perhaps some of it can be generalized but not most of it." "This is pretty generalized – not sure what the last sentence means. Do you mean families who have higher acculturation to U. S.? What if it's a mix, perhaps there needs to be more explanation here?"

Action taken: In response to the comments of Reviewer 2, a review of the literature from other disciplines was undertaken. Although material on Chinese native culture and values was found, none of the literature appeared relevant to proposing clinically relevant recommendations. Examples of literature identified included business and dining etiquette, consumer values, consumption values, and so forth. In discussing the identified literature with my chairperson, the decision was made to not include the material in the dissertation. Although the inclusion of non-Chinese American literature is not extensive, the work of Yang (1961), a sociologist, is rooted in a non-Chinese American perspective. Yang is Chinese-born and completed his undergraduate studies in the U.S., although his doctoral work was completed in the United States. Yang's work was particularly valuable in providing the religious basis for understanding traditional Chinese values and culture.

In response to the comments of Reviewer 3, a review of literature using the search words "Asian/Chinese," "Substance abuse/Alcohol/Alcohol use," "Culture/Cultural/Values," and "Schizophrenia/Mental illness" was undertaken. None of the literature found directly addressed dually-diagnosed Asian/Asian American or Chinese/Chinese American individuals or families and issues of self-medication and shame. One article discussing Asian drug users in San Francisco, CA who were not diagnosed with an additional mental illness, reported that a sense of shame and concern for stigmatizing their families often presented a barrier to or a delay in seeking treatment for these individuals (Nemoto, et al., 1999). Nemoto et al. (1999) suggest that drug prevention programs should address cultural concerns, specifically the stigma attached to drug users in the community. The issue of the potential for stigma in adhering to legitimately prescribed medication has been added to the section **Relevance of Acculturation** under the section **Delimitations of Recommendations in** Chapter III. One might hypothesize individuals with a diagnosis of schizophrenia or other mental illness in addition to substance use might carry a double burden of stigma, exacerbating the self-care difficulties, poor self-image, and challenges to mobilizing the family as a support network that already occur when an individual has a single mental illness diagnosis. If more research on the experience of dually-diagnosed Asian/Asian American or Chinese/Chinese American individuals were available, such information could provide a potentially rich topic for discussion.

To address the comments of Reviewer 5, information on family treatment for schizophrenia was incorporated under the subsection **Why Family Treatment?** Cultural congruence is addressed in the section **Why Family Treatment** Current research on cultural competence is discussed in the second introductory paragraph to the **Clinical Recommendations.** The value of educational systems and reframing treatment as education rather than therapy are discussed in "Psychoeducation" under the **Treatment** subsection of **Components of the Therapeutic Process.** Anna Lau was cited in the

Treatment subsection of **Components of the Therapeutic Process.** Problems with generalizability are addressed in **Group Treatment** under the **Treatment** subsection of **Components of the Therapeutic Process.** Clarification of the type of family that might be more appropriate for group treatment is provided under point number 10 in the **Summary of Key Clinical Considerations and Recommendations** in Chapter III.

Question 8: In the discussion of potential clinical considerations, were there any important issues overlooked? Please identify any omissions.

Reviewer 1: "See answer to Ques 6. Family hierarchy was covered in the paper. To add to the discussion I wanted to share that what I have experienced is often grandparents have a large role in child rearing responsibilities, especially in new immigrant families with parents who work long hours due to limited financial resources. The grandparents' role in childrearing can affect the dynamics between child and parent (e.g. grandparents undermine parent's authority) and treatment (e.g. parents want meds for child, but grandparents don't)."

Reviewer 2: "Medication, religious beliefs, gender roles and expectations, process/history regarding emigration to America, If any, major cultural differences between Chinese vs. other Asian cultures."

Reviewer 3: "See responses to number 6 and 7 above."

Reviewer 4: No response offered.

Reviewer 5: "I have identified some areas to be beefed up in the document." "What about Berry's (2007) conceptualization of Acculturation on a bi-dimensional scale?" "Yes, but socioeconomic diversity also exists in other populations. What makes Asian American groups different? Perhaps explain some of these rates a little further?" "(this is technically not an acculturation factor by operational definition…and SES.)" "Great! You can also add that there are assessment instruments used to examine a person's acculturation level and ethnic identity. For example, PAN Acculturation Scale (Soriano and Hough, 1999) as well as the Multi Ethnic Identity Measure by Jeanne Phinney (she is a professor at CSLA)." "There is a great study by May Yeh 2002 that discusses ethnic matching (and to a degree Language matching) and how that improves retention in services and keeps clients coming back. Some info from this article may be relevant to add to this paragraph." "You may want to consider the literature regarding Cultural Competence and the guidelines, and integrate into this paper in some way (Chamberlain, 2005). In addition, Stanley Sue's work may apply and as he is a huge expert in this area you might want to include his research as well. Others include May Yeh, Anna Lau, and David Takeuchi." "Talk about how to assess for acculturation here – e.g., using measures, interview methods, etc. And the acculturation gap and its implications." "This is where that cultural competence literature and its recommendations (Chamberlain, 2005) will come in very handy. What you are describing here is one of the key elements of cultural competence that is described in this article."

Action taken: The comments of Reviewer 1 regarding the role of gender and birth order as well as the child rearing responsibilities of the grandparents are addressed in "Discussing Psychopathology" under the **Assessment** subsection and "Problem-solving and Communication Skill-building" under the **Treatment** subsection of the **Components of the Therapeutic Process** section**.**

The various issues raised by Reviewer 2 were addressed in the **Delimitation of the Recommendation** section under "Diversity of Asian Cultures", "Defining Chinese American Values", and "Relevance of Acculturation"; this material was also included in "Discussing Psychopathology" under the **Assessment** subsection of the **Components of the Therapeutic Process** section**.** As previously reported for actions taken for Questions 6 and 7, Reviewer 3's comments were addressed in the following sections: "Psychoeducation" under the **Treatment** subsection of the **Components of the Therapeutic Process** section.

The comment of Reviewer 5 regarding Berry is addressed in the **Relevance of Acculturation** subsection under **Delimitations of Recommendations** in Chapter III; socioeconomic diversity and SES are clarified in the subsection **Diversity of Asian Cultures** under **Delimitations of Recommendations**; acculturation measures and related constructs are addressed in the **Assessment** subsection under **Components of the Therapeutic Process**; and May Yeh's work on language matching is addressed under **Language** in the **Assessment** subsection under **Components of the Therapeutic Process**. As stated in response to the recommendations of Reviewer 5 for Question 7 (regarding current research on cultural competence), current research on cultural competence is discussed in the second introductory paragraph under **Clinical Recommendations**. Assessing for acculturation is discussed in "Family Roles" and "Acculturation" of the **Assessment** subsection of **Components of the Therapeutic Process**. Implications of the acculturation gap are discussed in the subsection, **Relevance of Acculturation**, under **Delimitations of the Recommendations.** After reading Chamberlain (2005), it appears that the works of Sue, Lau, and other authors under the **Relevance of Acculturation** and **Asian/Asian American Families and Psychosocial Family Treatment Interventions** focus specifically on Asian and Chinese groups and seem to raise the same issues Chamberlain does, yet from a clinical perspective. In consultation with my chair, we decided not to include the work of Chamberlain.

Question 9: Given your professional experience with this population, do you believe the proposed recommendations are of practical value and culturally relevant to working clinically with Chinese American families with schizophrenia? Why or why not?

Reviewer 1: "See answer to Ques 7. They are of value because they address what is at the core of any treatment, which is to build rapport. Without any rapport there is no treatment, or at least sustainable and successful treatment. In order to build rapport cultural and family values always need to be considered."

Reviewer 2: "Yes, particularly for those who have limited knowledge about Asian cultures."

Reviewer 3: “Yes, I think that overall, the information presented was quite thorough and provided real and practical suggestions (in comparison to other documents that I have read that are too general in nature because of the focus on taking everyone as an individual – of course this is sound advice, but it has to be balanced with real suggestions.”

Reviewer 4: “I think those interventions will work if the families accept the problem as an imbalance of chemicals in the brain and do not think of the problem as related to some kind of spiritual problems or bad omen.”

Reviewer 5: “I think this is a helpful paper and can be practical for clinicians who have little knowledge about how to approach therapy with Chinese American families.”

Action taken: No action required.

APPENDIX C

Email to Recruit Mental Health Professionals for Peer Debriefing

Dear _____:

My name is Lorena Ho and I am a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology. I am conducting a study for my dissertation entitled, "Psychosociocultural Interventions for Schizophrenia with Chinese Americans," under the direction of Joy Asamen, Ph.D., my dissertation chairperson.

The purpose of this study is to propose culturally appropriate clinical recommendations for assessment and treatment with Chinese American families who have a family member who may potentially have a diagnosis of schizophrenia or who already has been assigned such a diagnosis. The clinical recommendations will provide mental health clinicians with guidance in working with Chinese American families in a manner that respects a range of cultural worldviews that exist within the family while considering the realities of residing in a context that may be less understanding of these values. The target audience for this resource includes therapists who may be less familiar with traditional Chinese American values and how these values influence how families conceptualize mental health issues and cope with a diagnosis of schizophrenia in a family member.

As part of the development of the clinical recommendations, I am interested in obtaining feedback from clinicians with experience working with Chinese American families. I would like to invite you to share your insights about the way I presented the clinical recommendations and the content of the clinical recommendations themselves. Your participation in this study is strictly voluntary and you may elect to discontinue your participation at any time. Moreover, your feedback will be kept confidential. Your input would be greatly appreciated and would be a substantial contribution to my work.

If you agree to participate, you are asked to do two things. First, please review the attached document with the proposed recommendations. And second, please REPLY to this email to provide responses to the questions that are listed below in **blue** font. You may simply insert your response under each question. I have also attached a Word document that contains the same questions, if you prefer responding in this manner rather than providing your responses directly in the email. Once you have answered each of the questions contained in the Word document, simply REPLY to this email and attach the completed Word document.

I anticipate that it will take about 30 minutes to read through the clinical recommendations and another 30-45 minutes to respond to the questions. I would be most appreciative if you could offer your response by _____.

There is no more than minimal risk in electing to consider this invitation, although I realize you are very busy so there is the inconvenience of the amount of time required to read over the clinical recommendations and offer your responses to the questions. Furthermore, you derive no direct benefit from accepting this invitation, although your participation may strengthen the proposed recommendation, which may

benefit the community. I can offer a copy of the final set of clinical recommendations when it is available. If you are interested in receiving a copy of the recommendations, please let me know by responding to Question 10, which is the final reviewer question.

I realize that you are very busy, so I am most grateful for your time, consideration of this request, and any assistance you can provide. If you have any additional questions concerning this invitation, please feel free to contact me or my dissertation chairperson. If you have issues related to your rights as a participant, please contact Yuying Tsong, Ph.D., Chairperson of the Pepperdine University Graduate and Professional Schools Institutional Review Board, at yuying.tsong@pepperdine.edu or (310) 568-5768.

Sincerely yours,

Lorena Ho, MA, Doctoral Candidate
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(661) 487-2804

Joy Asamen, Ph.D., Professor of Psychology
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(310) 568-5654

Reviewer Questions

Question 1: What is your profession? (Please check what you consider your primary profession)

__ LCSW __ MFT __ Psychiatrist __Psychologist

__Other (Please specify: _____)

Question 2: Have you conducted therapy in a Chinese language?
__Yes __No

Question 3: How would you rate your knowledge of traditional Chinese American values?
__ Minimal knowledgeable __Fairly knowledgeable __Knowledgeable

Question 4: How would you rate your knowledge of assessment and treatment for schizophrenia?
__Minimal knowledgeable __Fairly knowledgeable __Knowledgeable

Question 5: Please share your thoughts about the manner in which the cultural values and clinical recommendations are presented. Consider any or all of the following issues in formulating your thoughts.

a. Was it tedious and boring or an interesting read?
b. Was it condescending or respectful to the reader?
c. Were there enough details presented or an excessive amount of unnecessary detail?

d. Was there a logical flow to the presentation of content? If the organization of content could be improved, please offer suggestions.

Question 6: Were there any important traditional Chinese American values that were overlooked in the discussion? Please identify any omissions.

Question 7: Does the literature considered in proposing the recommendations adequately capture the needs of Chinese American families living with schizophrenia?

Question 8: In the discussion of potential clinical considerations, were there any important issues overlooked? Please identify any omissions.

Question 9: Given your professional experience with this population, do you believe the proposed recommendations are of practical value and culturally relevant to working clinically with Chinese American families with schizophrenia? Why or why not?

Question 10: Finally, please indicate if you would like to receive a copy of the final set of clinical recommendations. __Yes __No