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Asian Women's Action for Resilience and Empowerment Intervention: Stage I Pilot Study

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Abstract

This study describes the development and pilot test of Asian Women's Action for Resilience and Empowerment (AWARE), a culturally informed group psychotherapy intervention designed to reduce depressive symptoms, suicidality, substance use, and HIV and sexual risk behaviors among 1.5 and second generation Asian American (AA) women. To participate, AA women had to meet the criteria for posttraumatic stress disorder (PTSD) or have a history of exposure to interpersonal violence (IPV) as determined using the Clinician-Administered PTSD Scale (CAPS) and Traumatic Life Events Questionnaire (TLEQ). This article also presents the preliminary feasibility and acceptability of AWARE from its Stage I pilot study of nine Chinese, Korean, and Vietnamese American women. To foster holistic treatment, AWARE was developed based on original research findings from Stage 0 and integrated theoretical models including fractured identity theory, empowerment theory, cognitive behavioral therapy (CBT), mindfulness-based techniques, and the AIDS Risk Reduction Model (ARRM). The development of AWARE was an iterative process informed by participant feedback, which led to frequent intervention modifications for a future randomized controlled trial (RCT) in Stage II. A qualitative analysis of participant feedback informed the following modifications: further exploration of feelings, improvements in technology delivery, learning and practicing coping skills, more specific cultural tailoring related to sexual health, decreased number of sessions and increased time per session. Findings provide support for the acceptability and feasibility of AWARE as “culturally informed” for AA young women with IPV histories, high-risk behaviors, and mental health issues.

Keywords

intervention development; mental health; trauma; translational research

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In contrast to the portrayal of Asian Americans (AA) as “model minorities” (Li & Wang, 2008), a highly successful and well-adjusted group with few psychological problems, a stark picture of the mental health outcomes of AAs has emerged (Caliendo & McIlwain, 2010). Compared with their first generation immigrant parents, AA women who are children of immigrants have a greater risk of developing lifetime depressive symptoms, substance abuse, and psychiatric disorders (Takeuchi et al., 2007). In addition, although the prevalence of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) among AAs is still lower than those of other racial groups (Centers for Disease Control and Prevention [CDC], 2015), they are the only group that has experienced statistically significant increases (4.4%) in annual diagnoses in recent years (Adih, Campsmith, Williams, Hardnett, & Hughes, 2011).

To address these unique needs and dynamics among AA women, particularly those who are children of immigrants, we developed an intervention called, “Asian Women's Action for Resilience and Empowerment (AWARE).” AWARE is a culturally informed group therapy intervention designed to reduce depressive symptoms, suicidality, substance use, and HIV and sexual risk behaviors among 1.5 and second generation (1.5 generation refers to those who immigrated to the United States before age 18; second generation refers to those born in the United States) AA young women (aged 18-35 years) with histories of interpersonal violence (IPV) victimization.

The purpose of this study is as follows: The first purpose is to describe the background, theoretical framework, and the procedures of the AWARE intervention. We used the National Institutes of Health (NIH) Stage Model (Onken, Carroll, Shoham, Cuthbert, & Riddle, 2014) as a framework to describe the systematic development process of the AWARE intervention. The second purpose is to assess the feasibility and acceptability of the pilot intervention of AWARE. In this study, we define “feasibility” as both the ability of the investigators to execute AWARE (providing initial screening and recruiting participants who are eligible, and retention), as well as the ability to treat participants with AWARE while maintaining fidelity. We define “acceptability” as the appropriateness of content of both face-to-face group psychotherapy and AWARE stories (complimentary daily text message intervention), assessment of length/duration of sessions, and overall impression of AWARE by participants (Lancaster, Dodd, & Williamson, 2004; Thabane et al., 2010). Finally, we describe how the results of the study's feasibility and acceptability informed the refinement and modification of AWARE intervention, which will be used for a Randomized Clinical Trial (RCT) in Stage 2.

Key Cultural Background Informing Intervention Development

Mental and Sexual Health Issues Among Asian and Pacific Islander (API) Women in the United States

Not only do API young women (15-34 years) in the United States have the highest rates of suicide compared with other women of different racial/ethnic groups but also have the highest proportion of deaths by suicide (Heron, 2015; National Center for Health Statistics, Vital Statistics System, 2015).

In terms of sexual health, the prevalence of HIV/AIDS among API is still low compared with other racial groups, comprising 2% of the 40,040 new HIV diagnoses in the United States. However, HIV diagnoses among AA have increased by almost 70% between 2005 and 2014 (CDC, 2016).

Interconnections Among Suicidality, Trauma, Sexual Risk Behaviors, and Substance Use

Our previous study of AA women in the greater Boston area identified an intersection among trauma, substance use, suicidality, and sexual risk behaviors among AA women. Specifically, Chinese American, Korean American, and Vietnamese American women who reported histories of childhood sexual abuse in addition to physical abuse/neglect had 12 times greater odds of attempted suicide compared with their counterparts who did not report any history of child maltreatment (Hahm, Kolaczyk, Lee, Jang, & Ng, 2012). AA women who reported histories of forced sex other than childhood sexual abuse were also significantly more likely to engage in sexual risk behaviors, drink alcohol to cope with problems, and attempt suicide compared with AA women without reported histories of forced sex or White women with sexual assault histories (Nguyen, Kaysen, Dillworth, Brajcich, & Larimer, 2010). In terms of drug use, a history of hard drug use (e.g., cocaine, lysergic acid diethylamide [LSD], or other substances) alone or in combination with soft drug use (cigarette use or marijuana) was found to have a significant association with both suicidal ideation and suicide attempts among AA women (Hahm et al., 2013).

A qualitative study by Hahm, Gonyea, Chiao, and Koritsanszky (2014) provided a framework to understand self-harm and suicidal behaviors among AA young women. The Fractured Identity Model describes the disempowering parenting styles (ABCDG parenting) commonly experienced by AA young women who engage in self-harm and suicidal behaviors. ABCDG parenting was categorized as, Abusive, Burdening, Culturally disjointed, Disengaged, and Gender prescriptive. Women exposed to ABCDG parenting while growing up were caught in a “double bind” of competing identities (e.g., being a “good Asian daughter” vs. an “independent American woman”). Difficulty navigating these multiple tensions led to fractured identities, characterized by low self-worth, emotional paralysis, and unsafe coping habits (Hahm et al., 2014). To cope, 12 of the 16 women who were interviewed excessively used alcohol and other substances and engaged in self-harm and suicidal behaviors. A follow-up analysis revealed that these women's parents were also experiencing sociocultural and psychological issues such as poor physical and mental health, substance abuse, marital discord, linguistic barriers, financial instability, fragile support networks, trauma from countries of origin, and shame regarding their personal histories (Hahm et al., 2017). Although most AA parents use supportive parenting styles (Kim, Wang, Orozco-Lapray, Shen, & Murtuza, 2013), women who were classified as at-risk in our sample reported having experienced disempowering parenting styles in their homes.

AWARE Intervention

AWARE was developed as a culturally informed intervention that aims to unpack and articulate the intertwined issues of family dynamics, trauma, mental health, and sexual health of AA young women with histories of IPV (as denoted by meeting criteria for posttraumatic stress disorder [PTSD] or having a history of IPV). AWARE sessions were

designed to be sensitive to the gender power dynamics prevalent in many Asian cultures where women are often placed in lower positions of power compared with men (Lindsey, 2015). Thus, we created a gender-specific treatment to foster feelings of safety and encourage women to freely express their emotions (Hahm, Lee, Rough, & Strathdee, 2012). AWARE aims to help AA women explore the impact of family issues (e.g., sociocultural barriers, psychological distress, and illnesses their parents experienced; conflict with parents; family violence) on their coping styles and identity development. Because many Asian cultures honor the mind–body connection (C. Chan, Ho, & Chow, 2002), AWARE sought to address mental and physical symptoms in a way that was particularly relevant for trauma survivors.

Incorporation of Culturally Informed Theoretical Models

The AWARE intervention was designed to be a present focused, culturally informed group intervention for AA women who have been exposed to IPV, with a focus on safety and stabilization (Baranowsky & Gentry, 2014). As such, AWARE helps participants achieve safety and stabilization by helping them develop coping skills, improve day-to-day functioning, identify unhealthy relationship patterns, and increase safety in their relationships and sexual practices. The nature of a present focused intervention for IPV victims is similar to that of the *Seeking Safety* intervention (Najavits, 2002).

To guide the development of AWARE and to target depression, suicide, substance use, and sexually risky behaviors in the context of the double bind and competing identities as explicated in the *Fractured Identity Model* (Hahm et al., 2014), we developed the *Model of Healing*, an empowerment-based model that incorporates critical elements of cognitive behavioral therapy (CBT), mindfulness, and AIDS Risk Reduction Model (ARRM). This model emphasizes empowerment as essential to the healing process, which Chamberlin (1997) defined as having access to information and resources, asserting one's feelings and needs, feeling connected to others, and feeling hopeful about change. In particular, AWARE aims to give AA women the opportunity to discuss and overcome their sense of disempowerment which may be learned from their homes, being an invisible minority in the United States, perceived racism and second class citizenship, and body image issues. The Model of Healing elements build upon each other as the sessions progress, focusing on skill building at the individual and family levels, followed by challenging automatic thoughts, understanding interpersonal dynamics, and connecting with the larger community. Beck's Cognitive Model (Beck, Brown, Steer, Dahlsgaard, & Grisham, 1999) was used as a tool to explain how a disparaging comment by family members or peers or unspoken expectation from American and Asian cultures can lead to automatic thoughts of self-doubt or self-hatred. These negative thoughts can develop into intermediate beliefs and, ultimately, core beliefs on one's self-worth, which often leads to depression and anxiety.

Method

Criteria for Assessing Feasibility

The feasibility of the pilot study for AWARE intervention was assessed by several aspects. The criteria of successful measures of definition were determined based on the team

discussion and literature reviews. This includes (a) our ability to recruit eight to 10 AA women who meet the eligibility of demographic and clinical criteria, (b) reaching an average attendance of 70% of sessions given previous studies which showed average attendance of 47% to 65% (Hien et al., 2010; Najavits, Gallop, & Weiss, 2006), and (c) reaching 2.5 average score (lowest 0-highest 3 score) in fidelity assessing adherence of manual and helpfulness evaluated by two raters using the adapted format of the Adherence Scale in the Seeking Safety intervention (Najavits, Kivlahan, & Kosten, 2011). We describe our study procedures based on the NIH Stage Model (Onken et al., 2014): Stage 0 (basic Research that has been the foundation for AWARE) and Stage I (Stage Ia: therapy development/manual writing; Stage Ib: pilot study). The summary of the stages is included as a table in the appendix.

Evaluation of Assessing Acceptability

Acceptability was assessed throughout 10 session discussions with the therapist and the feedback sessions with the principal investigator (PI) regarding the appropriateness of AWARE intervention contents. Both intervention contents (face-to-face group intervention as well as AWARE daily text message) were assessed whether or not AWARE was a culturally informed intervention. The posttrial feedback sessions helped assess which sessions were the most and least helpful and why. Qualitative data analysis was used to assess acceptability. All sessions were transcribed verbatim and analyzed.

Stage 0: Basic Research (2009-2014)

The Asian American Women's Health Initiative Project (AWSHIP) at Boston University was funded by the National Institute of Mental Health (NIMH) to investigate the mental health, sexual health, and substance use behaviors of Chinese American, Korean American, and Vietnamese American women. In addition, we conducted a literature review on the development of culturally informed interventions and evidence-based practices with a focus on the availability of interventions treating ethnic minority survivors of IPV, including those with a formal diagnosis of PTSD (Cheung, 2016; Chu, Huynh, & Areán, 2012; Wahab & Olson, 2004). Taken together, existing interventions focused on prevention rather than treatment and/or targeted a specific refugee population or first generation immigrants; no single intervention addressed the unique needs of 1.5 and second generation AA women with histories of IPV.

Stage Ia: Intervention Development and Manual Writing (2013-2014)

The process of developing AWARE and writing the treatment manual required extensive and continual revisions. The research team was composed of the PI, who is a researcher and clinical social worker, four clinical psychologists, one clinical social worker, and several public health student interns. Members of the research team offered feedback on the overall framework and key elements of the intervention to the PI who created AWARE, helped develop the details of exercises for sessions, refined the treatment manual, and informed clinical decision making during the pilot study (Stage Ib) to improve the cultural competency of the intervention. The PI met with the therapist for 2 hr each week during the development and pilot testing stages to provide training. The development of AWARE was an iterative process. For example, at the end of each session, the therapist collected

participants' written responses through the AWARE "Check Out" questions, which queried for culturally relevant themes, topic area relevance to participants' cultural background, and ways to facilitate self-disclosure. Weekly feedback from participants was used to modify subsequent sessions. The Community Advisory Board (CAB) members also gave feedback about the intervention procedures to ensure the safety of participants.

Stage Ib: Pilot Study to Examine Feasibility and Acceptability (2014)

Procedures—Participants were recruited using two approaches: previous Asian American Women's Health Initiative Project (AWSHIP) study participants who agreed to participate in a future study were contacted through e-mail, and new potential participants were recruited through flyers, listservs, referrals, and outreach at Asian community events in the greater Boston area. Interested women were asked to contact the AWARE study by e-mail, phone, or a website link. Study staff conducted a phone prescreening to determine interested participants' initial eligibility based on the following criteria: female, unmarried, aged 18 to 35 years at time of screening, of Chinese, Korean, and/or Vietnamese descent, 1.5 or second generation, history of penile–vaginal intercourse, and possession of a mobile phone.

Chinese American, Korean American, and Vietnamese American populations were selected because they are among the five largest Asian subgroups in Massachusetts and because these cultures have all been strongly influenced by Confucianism (Lo, 2012; Wang, 2008). We included both exclusively heterosexual and nonexclusively heterosexual women because of the high rates of suicidality and HIV risk behaviors among nonexclusively heterosexual AA women (Lee & Hahm, 2012). Particular attention was paid to ensure that the language used in the intervention was inclusive of participants of all sexual orientations.

Participants who met initial eligibility were invited to complete an in-person clinical screening at Boston University. In addition to meeting all initial eligibility criteria, participants also had to (a) have experienced IPV, as assessed by the Traumatic Life Events Questionnaire (TLEQ; Kubany et al., 2000) or (b) meet criteria for current PTSD as assessed by the Clinician-Administered PTSD Scale (CAPS; Weathers, Ruscio, & Keane, 1999). At the clinical screening, trained research assistants explained study procedures to the participants and obtained informed consent. Participants were then asked to complete a computerized self-assessment on their demographic information (see Table 1), sexual and substance use history, HIV-related outcomes (i.e., knowledge, risky behaviors, self-efficacy), depressive symptoms, suicidality, trauma history, and psychiatric symptoms. Suicidality was assessed using the Columbia Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011), substance use history was assessed using the Addiction Severity Index (ASI; Petry, Alessi, Hanson, & Sierra, 2007), and psychiatric symptoms were assessed using the Mental and Emotional subscale in the Global Appraisal of Individual Needs survey (GAIN-M90). Participants also underwent a semistructured clinical interview with trained master's-level social work interns (all female AA) using CAPS (Weathers et al., 1999). We then used the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; American Psychiatric Association, 1994) scoring algorithm recommended by Weathers et al. (1999) to determine current PTSD diagnoses. Participants who were at significant current risk of

suicide or homicide, intimate partner violence, or a psychotic disorder were excluded from the study and referred for more appropriate forms of treatment.

Adherence and helpfulness checks of the intervention therapist—All pilot sessions were documented on two digital recorders. Two trained research assistants transcribed the recordings verbatim and provided subjective ratings of the therapist's helpfulness and her adherence to the fidelity checklist. Adapting the format of the Adherence Scale used in the Seeking Safety intervention (Najavits et al., 2011), the fidelity checklist derived its content from the AWARE intervention manual and was designed to evaluate the therapist's level of engagement, empathy, and fidelity to the intervention during sessions.

For this cohort of the AWARE study, the number of items rated for each session varied from eight to 15 depending on the goals and protocol of each session (104 questions in total). For adherence and helpfulness, the raters scored each item if it occurred. If the criterion of the item was met, a rating was made on a 0 to 3 scale (0 = *poor*, 1 = *satisfactory*, 2 = *good*, or 3 = *excellent*). Two raters independently rated the fidelity, and the average of score was used to assess the adherence and helpfulness of an AWARE clinician.

Qualitative data analysis for acceptability—To assess the acceptability of AWARE, qualitative analysis was conducted on the following collected data: (a) recordings and verbatim transcriptions of the 10 pilot sessions ($n = 9$), (b) two focus group feedback sessions conducted by the PI with participants on the content and delivery of the intervention ($n = 6$), (c) written feedback provided via e-mail ($n = 1$), (d) weekly postsession reflection memos written by the therapist, and (e) one 3-month booster session facilitated by the therapist ($n = 5$).

We used thematic analysis procedures as outlined by Braun and Clarke (2006) to analyze and develop the main theme of cultural sensitivity and the eight themes. The following are the specific data analysis steps:

First, four authors (H.H., S.C., G.L., and M.T.) each thoroughly reviewed the data and made note of essential intervention elements that address the mental and sexual health of AA women. We systematically extracted common keywords and phrases such as “family issues” and “coping skills” across the entire data set. After individually extracting initial codes, we met weekly to develop possible themes by identifying repeated phrases, similarities and differences, and other meaningful patterns. We then checked the congruence between the codes and the entire data set and reviewed the relationships among the themes. Finally, we continued to revise the themes until we agreed upon the central theme and subthemes with clear definitions and names, as well as a thematic map and a written report delineating examples of each subtheme and its relation to the research question. Through this process, we developed eight subthemes that support the acceptability of AWARE and reinforce the central theme of cultural sensitivity.

Furthermore, in using thematic analysis, we established trustworthiness by addressing the criteria provided by Shenton (2004). We (a) held a debrief session among researchers to

scrutinize contents in each session (credibility), (b) provided background data that exhibited themes with meaningful patterns to be compared with each other (transferability), (c) provided detailed methodological descriptions that would enable this study to be replicated in the future (dependability), and (d) enhanced the integrity of this research by reducing investigators' bias and assumptions (confirmability).

Results

Sample Demographics

At the time of enrollment, participants identified their ethnic background as Korean ($n = 4$), Chinese ($n = 3$), Vietnamese ($n = 1$), or multiethnic ($n = 1$). Table 1 shows the demographic and clinical characteristics of the pilot study participants ($n = 9$). On average, participants had a depressive symptom score of 20.2 ($SD = 13.75$) on the Center for Epidemiologic Studies Depression Scale (CES-D), in which the cutoff score for moderate to severe depressive symptoms is 16 (Radloff, 1977).

Assessing Feasibility

We screened a total of 47 women during the initial screening and 29 women during the clinical screening, enrolling a total of 10 women who met all initial and clinical eligibility criteria. One participant dropped out before the first session, yielding a total of nine women who attended the pilot sessions. Ten weekly sessions were conducted at Boston University and led by an AA female clinical psychologist. During the intervention phase, out of nine participants, six women participated in all 10 sessions. On average, nine participants completed 8.7 out of 10 sessions, exceeding our goal of 70% attendance (seven sessions). After the conclusion of the pilot intervention, two feedback sessions (face-to-face) were held with six participants. The remaining three participants had moved outside the catchment area and one participant responded the written e-mail feedback. Figure 1 is included in the appendix to show the process through each phase of recruitment for pilot study.

The result of fidelity check was based on the therapist's adherence to the manual and her helpfulness for the participants. The number of items rated for each session varied from eight to 15 depending on the goals and protocol of each session (104 questions in total). For adherence and helpfulness, the raters scored each item if it occurred; if the criterion of the item was met, a rating was made on a 0 to 3 scale (0 = *poor*, 1 = *satisfactory*, 2 = *good*, or 3 = *excellent*). The average adherence rating for all sessions was 2.8, and the raters judged 95.2% of the sessions to be *good* or *excellent* on the Adherence Scale. The average helpfulness rating for all sessions was 2.7, and the raters judged 92.3% of the tapes to be *good* or *excellent* on the Helpfulness Scale. None of the items judged for adherence or helpfulness were rated as *poor*. Given these results, our pilot study demonstrates the preliminary feasibility of AWARE.

Assessing Acceptability

Analysis of the pilot sessions, feedback sessions, feedback e-mail and postsession memos led us to develop the following eight themes regarding acceptability.

Theme 1: Culturally informed components—Our analysis of the pilot data ($n = 9$) identified themes that were culturally consonant with the experience of growing up as AA women in the United States of AA immigrants.

- A. *Growing up as a child of Asian immigrants.* All participants reported high satisfaction with AWARE in incorporating family issues in the beginning of the sessions because they felt that many of their problems came from conflicts and struggles with their own family members. A participant stated,

What seemed different from other interventions is that we talked a lot about families. Other psychotherapy manuals don't talk about the family. So it's very individualized. I think contextualizing by race was really therapeutic for me because it finally made me realize, this isn't my fault, this isn't my parents' fault, this is a part of collective struggle that we have in America. (Pilot Study, PS11)

Considering the multiple stressors experienced by their immigrant parents including acculturative stress, discrimination, difficulty with promotion at work, social isolation, and lack of social and political power helped the women develop a deeper understanding of and empathy toward their parents. The women expressed that learning about the ABCDG parenting styles was empowering because it gave them a tool and framework to understand the impact of their cultural upbringing on their identities.

- B. *Being an AA woman in the United States: Race, gender, and body image.* Participants reported that AWARE provided a safe and nonjudgmental setting to discuss the following issues: body image, self-image, and bullying experiences. One participant explained,

With us being Asian, just like, okay you're a woman so we're going to objectify you but also objectify like, Asian woman. Like really exotic. The bias against us. [Also, it] was about how critical my parents are about our body image and then how each one of you guys are conscious about the thick legs or butt. (PS12)

The shared experience of growing up in the United States as a non-White woman strongly resonated among participants and was highly pertinent to culturally appropriate elements of this intervention. Thus, the participants' struggles to uphold the “model minority” (Li & Wang, 2008) stereotype within their families and peer groups were effectively addressed with a culturally consonant interpretation.

Theme 2: Acculturation alignment between participants and therapist—Since all the participants were either 1.5 or second generation AA females, we specifically hired an AA female therapist, lending an implicit understanding of the participants' struggles and dilemmas. The therapist documented in her progress note,

I shared quite a bit of my own experience as a way to help them see that things can be better. I also used it as a way to relate to them. They reflected back to me that it was helpful to hear me talk about my experience.

One participant concurred in the feedback session:

Having an Asian American therapist is critical. She would substantiate or validate what we just said 'cause like, "Oh, you know that happened to me. But this is how I dealt with it." I think it was helpful to see someone who's moved past whatever we're going through. (PS12)

The shared experience between the participants and therapist not only reinforced cultural congruency and aligned levels of acculturation but also secured trust and a safe emotional space.

Theme 3: Format of group psychotherapy: All AA female group—Because the psychotherapy group consisted exclusively of AA female participants, shared experiences among members helped to create a bond and decrease the sense of isolation. One participant described,

We were able to relate to the group because it was all-Asian. When we were talking about our parents and the way that we were raised. "Oh, so this is kind of normal." Just because I felt so different from the rest of my friends. So that's when I started feeling comfortable around everyone; when I realized that I'm not the only one who is going through this. (PS11)

Theme 4: Need for more exploration of feelings—The first few sessions of the pilot test included numerous handouts and writing exercises, which gave participants the impression of a classroom-like setting and restricted the flow of discussions and the formation of connections among group members. One participant noted, "I don't know if the structuredness really works because it doesn't create conversation. It kind of limits it" (PS11). Overall, participants felt that allocating more time to explore feelings would increase the acceptability of AWARE.

Theme 5: Technology content and user interface need improvement—We modified the AWARE stories to be more user-friendly. Participants were given the option to password protect messages and reread AWARE stories unlimited times. Also, after Session 4, we refined AWARE stories to be more positive and empowering. These quotes contained AA women's personal stories related to their mental and sexual health, questions to prompt participants to reflect on the prior session's main takeaways, and reminders of upcoming session times. After this modification, participants reported that the messages were more effective in engaging them engaging outside of sessions and allowed them to return to the tools and concepts covered in the intervention.

Theme 6: Learning and practicing coping skills increased emotional regulation—Participants found coping skills such as "STOP" (S: Stop and Slow down, T: Take deep, mindful breaths, O: Observe using your senses, and P: Proceed with caution) to be most helpful. These exercises helped them to identify the source of their emotions. One participant stated, "STOP really helped. And using the five senses to just calm down and create distance [helped, too]. A lot of it had to do with boundaries and understanding [who I am]. I am not tumultuous with my emotions anymore" (PS12).

Theme 7: Need for more culturally tailored materials related to sexual health—

Focus group participant feedback indicated that the adaptations of Project FIO (The Future is Ours) materials on sexual health and substance use were not congruent with their own experiences (Ehrhardt, 2013). One participant described, “I think the sessions about sexual health and drug usage could be really pertinent to other groups, but for me it just wasn’t relevant” (PS12). Previous research has shown that despite engaging in unprotected sex or using substances (Hahm et al., 2013; Hahm, Lee, Choe, Ward, & Lundgren, 2011), many AA young women do not consider themselves to be at risk of contracting HIV/STIs (sexually transmitted infections) or developing substance abuse problems (Hahm et al., 2011). Since our adaptations of the Project FIO material consisted of role plays (e.g., condom negotiation) and an advice column activity, we found that participants tended to intellectualize these exercises instead of sharing their own experiences related to HIV risk or testing. In addition, participants tended to perceive themselves to be at a lower risk in comparison with women described in the role play and other activities. Although the original Project FIO material has been shown to be effective with other at-risk ethnic groups, there was a need for a more culturally relevant approach for AA young women.

Theme 8: Increase number of sessions—Because the participants felt that the discussions in sessions were enriching, they wished for more sessions. For instance, they felt that the sessions on discrimination and body image were very important but there was not ample time to cover all relevant aspects. One participant stated,

It seems as if it came too fast. Because session nine [Giving Yourself Grace] was so powerful, you really got together and experienced togetherness. And then session 10, but it was our ending session. So I could feel a lot of sadness through the room. [I needed] a few more. We just started making good progress and then we had to stop. (PS11)

Refinements for each theme based on feedback—Our analyses on participant feedback suggested that women felt that AWARE is highly acceptable as a culturally informed group psychotherapy for young AA women. However, they also gave constructive suggestions to increase acceptability in various domains. We modified and refined the AWARE intervention based on these themes: increased exploration of feelings, improved technology and user interface, incorporation of mindfulness exercises and creating AWARE coping skills cards consisting of coping skills to use in various high-risk circumstances. In addition, we modified more specific cultural tailoring related to sexual health. Specifically, we dedicated an entire session to healthy relationships, as qualitative research by Hahm et al. (2011) has shown that reasons for forgoing consistent condom use in this population are often relational in nature (e.g., pressure from partner, presumptions of monogamy). Practical steps on how participants can empower themselves to make healthier decisions, use condom negotiation skills, and receive HIV/STI testing were also incorporated as topic guides for these discussions. In terms of modification on number of sessions, we decided to decrease the number of session from 10 to 8, while increasing duration of each session to improve adherence and to reduce participants burden. Table 2 shows session contents for original 10 sessions and modified eight session models. Further revisions were made to the Stage I manual based on suggestions and progress notes by the AWARE therapist and our experts,

discussions with the research team, and the PI's clinical judgment with attention to the group therapy process. The Boston University institutional review board (IRB) approved all changes.

Discussion

This article describes the process of how AWARE intervention was developed and refined for the full-scale testing. It also evaluates feasibility and acceptability of a pilot study. This intervention represents, to our knowledge, the first and only culturally informed and gender-specific intervention. Our pilot study provides preliminary assessment data suggesting that the AWARE intervention is highly feasible for AA women with a history of IPV, high-risk behaviors, and mental health issues. Specifically, our clinical assessment during the eligibility screening indicated that 44% of women reported fair self-assessed mental health and 78% of women reported lifetime trauma exposure. The content of the AWARE sessions incorporated various treatment modalities as well as findings from our previous empirical studies of AA women (e.g., Hahm et al., 2014; Hahm, Kolaczyk, et al., 2012; Hahm et al., 2011; Hahm, Lee, et al., 2012). Participants enthusiastically reported high acceptability especially in its culturally informed aspects of AWARE which incorporated the Fractured Identity Model because it enabled AA young women to explore the potential influence of family dynamics and parenting on their mental health. Participants in the study also reported that this model helped them to better understand the contextual factors and stressors associated with their parents' behaviors.

In the feedback sessions (Stage Ib), participants reported that it was empowering for them to discuss their shared struggles of growing up in the United States as a minority female and what it means to be a 1.5 or second generation American whose parents may be dealing with the stressors of being a first generation immigrant. AWARE provided a safe space for women to discuss issues specific to their gender, immigration status, and age. One important aspect of AWARE was that the development of the intervention incorporated immediate feedback. During the 10 weeks of the pilot study, weekly feedback from the AWARE therapist and participants led to modifications to increase acceptability of AWARE. For example, sessions on sexual health were revised to be more reflective of their experiences by incorporating actual quotes from AA participants from previous qualitative studies. Participants not only reported that they found the revised sexual health sessions to be helpful in gaining knowledge about sexual health but also echoed that they felt relieved to discuss this topic with others, as they had never talked about sex in their families. Furthermore, the use of technology in the form of daily text messages was also well accepted by the participants after we made changes to the content and user interface. The immediate implementation of feedback from various stakeholders led to increased acceptability among participants. Last, to respond to the needs of participants while maintaining treatment impact over a shorter time span, we reduced the number of sessions from 10 to eight but increased the duration of each session to match the dosage of the original intervention. These preliminary data can be used to support an efficacy trial using a larger sample in community-based settings such as university health service centers throughout the United States.

Limitations

Because the current study using qualitative methodology represents only a segment of the overall AWARE intervention development process, our results based on nine pilot participants should be interpreted with caution. Importantly, we wish to note that because this pilot study was tested for 1.5 and second generation Chinese American, Korean American, and Vietnamese American women, we have not yet been able to test the efficacy of the intervention for other AA subgroups. We expect that other cultural groups with family structures, degrees of assimilation, and value systems similar to those of our target population may also benefit from this intervention, but future studies are necessary to determine cross-cultural acceptability, generalizability, and efficacy. A methodological limitation of this pilot study was that individual or anonymous feedback was not collected. The transparent nature and group format of the feedback session could have led to biases in participant responses. Finally, while study measures have been shown to be reliable and valid across various settings, they had not been tested for cultural equivalence in our sample.

Conclusion

We utilized a comprehensive, multifaceted approach that combines various treatment modalities and incorporated culturally informed treatment contents derived from empirical studies on the lived-in experiences of AA young women who are children of immigrants. The development of the AWARE intervention reflects instant, continuous refinements and iterative processes that led to cumulative modifications to achieve improved acceptability and feasibility. The pilot study provides preliminary assessment data that the AWARE intervention was culturally “informed” and “sensitive” to AA women with a history of trauma, mental health issues, and high-risk behaviors, with participants expressing a high satisfaction with the intervention. Future RCTs will provide more definitive evidence of the efficacy of AWARE.

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Appendix

Development and Implementation of AWARE: A Stage Model of Behavioral Therapies Research, Stage 0 to III.

	Stage 0	Stage I	Stage II	Stage III
Purpose	Basic research	Intervention generation/refinement	Efficacy in research clinics	Efficacy in the community
Focus	Empirical studies and theory development	Pilot/feasibility study and internal validity	Efficacy trials and internal validity	Efficacy trials and internal validity
Timeframe	2009-2014	2013-2014	2015-2016	Future
AWSHIP and AWARE Components	A. AWSHIP epidemiological study of 1.5 and second	Stage Ia: Therapy development/manual writing	A. Revise AWARE therapy manual and “AWARE stories” based	A. Engage with CAB members and community partners to

Purpose	Stage 0	Stage I	Stage II	Stage III
	Basic research	Intervention generation/refinement	Efficacy in research clinics	Efficacy in the community
	generation Chinese, Korean, and Vietnamese women ($n = 720$)	A. Identified CAB members	on participant feedback, therapist input, and pilot study results	identify community health center for efficacy trials
	B. AWWSHIP qualitative study ($n = 36$)	B. Defined modalities informing treatment: empowerment, Fractured Identity Model, Model of Healing, ARRM, CBT, mindfulness	B. Recruit and screen potential participants	B. Revise AWARE therapy manual and “AWARE stories” based on participant feedback, therapist input, and RCT results
	C. Identified culture-specific risk and protective factors	C. Specified instruments	C. Randomization (intervention vs. wait-list)	C. Training and ongoing supervision of therapists
	D. Formulated fractured identity framework to understand mental health of AA young women	D. Wrote manual and “AWARE stories”	D. Baseline assessments	D. Implement AWARE at community health center
	E. Identified need for culture-specific interventions serving AA young women	E. Trained therapist	E. Eight group therapy sessions for intervention and wait-list groups	E. Specify guidelines and assess strategies for therapist handling of common clinical problems
		F. Developed fidelity measure	F. Ongoing supervision for therapist	F. Assess fidelity to treatment
		G. Specified safety protocols	G. Assess fidelity to treatment	G. Collect and analyze quantitative and qualitative data to assess efficacy in the community setting
		Stage Ib: Pilot Study		
		A. Recruitment and initial screening ($n = 48$)	H. Feedback sessions and postintervention assessments	
		B. Clinical screening and interviews ($n = 21$)	I. Booster sessions and 3-month postintervention assessments	
		C. Ten group therapy sessions ($n = 9$)	J. Collect and analyze quantitative and qualitative data to assess efficacy outcomes	
		D. Ongoing supervision for therapist		
		E. Feedback sessions and postintervention assessments		
		F. Booster session and 3-month postintervention assessments ($n = 5$)		
		G. Collected and analyzed pilot study feasibility outcomes		

Note. AWARE = Asian women's action for resilience and empowerment; AWWSHIP = Asian American women's health initiative project; AA = Asian American; ARRM = AIDS Risk Reduction Model; CBT = cognitive behavioral therapy; CAB = Community Advisory Board; RCT = randomized controlled trial.

References

- Adih WK, Campsmith M, Williams CL, Hardnett FP, Hughes D. Epidemiology of HIV among Asians and Pacific Islanders in the United States, 2001-2008. *Journal of the International Association of Physicians in AIDS Care*. 2011; 10:150–159. [PubMed: 21508298]
- American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 4th. Washington, DC: Author; 1994.
- Baranowsky, A., Gentry, JE. *Trauma practice: Tools for stabilization and recovery*. Boston, MA: Hogrefe Publishing; 2014.
- Beck AT, Brown GK, Steer RA, Dahlsgaard KK, Grisham JR. Suicide ideation at its worst point: A predictor of eventual suicide in psychiatric outpatients. *Suicide and Life-Threatening Behavior*. 1999; 29:1–9. [PubMed: 10322616]
- Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006; 3:77–101. DOI: 10.1191/1478088706qp063oa
- Caliendo, SM., McIlwain, CD. *The Routledge companion to race and ethnicity*. New York, NY: Routledge; 2010.
- Centers for Disease Control and Prevention. HIV surveillance report, 2014. 2015 Nov.26 Retrieved from www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2014-vol-26.pdf.
- Centers for Disease Control and Prevention. HIV among Asians in the United States. 2016. Retrieved from <http://www.cdc.gov/hiv/group/raciaethnic/asians/index.html#a>
- Chamberlin J. A working definition of empowerment. *Psychiatric Rehabilitation Journal*. 1997; 20(4): 43–46.
- Chan C, Ho PSY, Chow E. A body-mind-spirit model in health. *Social Work in Health Care*. 2002; 34:261–282.
- Cheung, S. Group therapy in Asian American communities; A training workshop presented at the Los Angeles County Department of Mental Health (LACDMH); Los Angeles, CA. 2016 Jan.
- Chu JP, Huynh L, Areán P. Cultural adaptation of evidence-based practice utilizing an iterative stakeholder process and theoretical framework: Problem solving therapy for Chinese older adults. *International Journal of Geriatric Psychiatry*. 2012; 27:97–106. [PubMed: 21500283]
- Ehrhardt, AA. Compendium of evidence-based interventions and best practices for HIV prevention. 2013 Apr 15. Retrieved from <http://www.cdc.gov/hiv/prevention/research/compendium/rr/fio.html>
- Hahm H, Gonyea JG, Chiao C, Koritsanszky LA. Fractured identity: A framework for understanding young Asian American women's self-harm and suicidal behaviors. *Race and Social Problems*. 2014; 6:56–68. [PubMed: 24563680]
- Hahm H, Jang J, Vu C, Alexander LM, Driscoll KE, Lundgren L. Drug use and suicidality among Asian American women who are children of immigrants. *Substance Use & Misuse*. 2013; 48:1563–1576. [PubMed: 23848381]
- Hahm, H., Kim, Y., Brova, M., Le, K., Maglalang, D., Rivera, A. The socio contextual factors of disempowering Asian-American parents. In: Choi, YS., Hahm, H., editors. *Asian American parenting-family processes and intervention*. New York, NY: Springer; 2017.
- Hahm H, Kolaczyk E, Lee Y, Jang J, Ng L. Do Asian-American women who were maltreated as children have a higher likelihood for HIV risk behaviors and adverse mental health outcomes? *Women's Health Issues*. 2012; 22(1):e35–e43. [PubMed: 21872488]
- Hahm H, Lee CH, Choe JYU, Ward A, Lundgren L. Sexual attitudes, reasons for forgoing condom use, and the influence of gender power among Asian-American women: A qualitative study. *Journal of AIDS & Clinical Research*. 2011; (S1):004. [PubMed: 22866240]
- Hahm H, Lee J, Rough K, Strathdee SA. Gender power control, sexual experiences, safer sex practices, and potential HIV risk behaviors among young Asian-American women. *AIDS and Behavior*. 2012; 16:179–188. [PubMed: 21259042]
- Heron M. Deaths: Leading causes for 2012. *National Vital Statistics Reports: From the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System*. 2015; 64(10):1–93.

- Hien DA, Campbell AN, Killeen T, Hu MC, Hansen C, Jiang H, Nunes EV. The impact of trauma-focused group therapy upon HIV sexual risk behaviors in the NIDA clinical trials network “women and trauma” multi-site study. *AIDS and Behavior*. 2010; 14:421–430. [PubMed: 19452271]
- Kim SY, Wang Y, Orozco-Lapray D, Shen Y, Murtuza M. Does “tiger parenting” exist? Parenting profiles of Chinese Americans and adolescent developmental outcomes. *Asian American Journal of Psychology*. 2013; 4:7–18. [PubMed: 23646228]
- Kubany ES, Haynes SN, Leisen MB, Owens JA, Kaplan AS, Watson SB, Burns K. Development and preliminary validation of a brief broad-spectrum measure of trauma exposure: The Traumatic Life Events Questionnaire. *Psychological Assessment*. 2000; 12:210–224. [PubMed: 10887767]
- Lancaster GA, Dodd S, Williamson PR. Design and analysis of pilot studies: Recommendations for good practice. *Journal of Evaluation Clinical Practice*. 2004; 10:307–312.
- Lee J, Hahm HC. HIV risk, substance use, and suicidal behaviors among Asian American lesbian and bisexual Women. *AIDS Education and Prevention*. 2012; 24:549–563. [PubMed: 23206203]
- Li, G., Wang, L., editors. *Model minority myth revisited: An interdisciplinary approach to demystifying Asian American educational experiences*. Charlotte, NC: Information Age; 2008.
- Lindsey, LL. *Gender roles: A sociological perspective*. London, England: Routledge; 2015.
- Lo, S. *Asian Americans in Massachusetts: A census profile (Paper 31)*. Institute for Asian American Studies Publications; 2012. Retrieved from http://scholarworks.umb.edu/iaas_pubs/31
- Najavits, LM. *Seeking Safety: A treatment manual for PTSD and substance abuse*. Vol. xiv. New York, NY: Guilford Press; 2002.
- Najavits LM, Gallop R, Weiss R. Seeking Safety therapy for adolescent girls with PTSD and substance abuse: A randomized controlled trial. *The Journal of Behavioral Health Services & Research*. 2006; 33:453–463. [PubMed: 16858633]
- Najavits LM, Kivlahan D, Kosten T. A national survey of clinicians' views of evidence-based therapies for PTSD and substance abuse. *Addiction Research & Theory*. 2011; 19:138–147.
- National Center for Health Statistics, National Vital Statistics System. 10 leading causes of death, United States, 2014, Asian/Pac Islander, females. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2015. Retrieved from http://webappa.cdc.gov/sasweb/ncipc/leadcaus10_us.html
- Nguyen HV, Kaysen D, Dillworth TM, Brajcich M, Larimer ME. Incapacitated rape and alcohol use in White and Asian American college women. *Violence Against Women*. 2010; 16:919–933. [PubMed: 20679187]
- Onken LS, Carroll KM, Shoham V, Cuthbert BN, Riddle M. Reenvisioning clinical science: Unifying the discipline to improve the public health. *Clinical Psychological Science: A Journal of the Association for Psychological Science*. 2014; 2:22–34. [PubMed: 25821658]
- Petry MN, Alessi MS, Hanson T, Sierra S. Randomized trial of contingent prizes versus vouchers in cocaine-using methadone patients. *Journal of Consulting and Clinical Psychology*. 2007; 75:983–991. [PubMed: 18085914]
- Posner K, Brown GK, Stanley B, Brent DA, Yershova KV, Oquendo MA, Mann JJ. The Columbia–Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *The American Journal of Psychiatry*. 2011; 168:1266–1277. [PubMed: 22193671]
- Radloff LS. The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*. 1977; 1:385–401.
- Shenton AK. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*. 2004; 22:63–75.
- Takeuchi DT, Zane N, Hong S, Chae DH, Gong F, Gee GC, Alegria M. Immigration-related factors and mental disorders among Asian Americans. *American Journal of Public Health*. 2007; 97:84–90. [PubMed: 17138908]
- Thabane L, Ma J, Chu R, Cheng J, Ismaila A, Rios LP, Goldsmith CH. A tutorial on pilot studies: The what, why and How. *BMC Medical Research Methodology*. 2010; 10 Article 1.
- Wahab S, Olson L. Intimate partner violence and sexual assault in Native American communities. *Trauma, Violence, & Abuse*. 2004; 5:353–366.

- Wang, Z. Democratization in Confucian East Asia: Citizen politics in China, Japan, Singapore, South Korea, Taiwan, and Vietnam. Youngstown, NY: Cambria Press; 2008.
- Weathers FW, Ruscio AM, Keane TM. Psychometric properties of nine scoring rules for the Clinician-Administered Posttraumatic Stress Disorder Scale. *Psychological Assessment*. 1999; 11:124–133.

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Figure 1. Consort chart of AWARE pilot study

Note. AWARE = Asian women's action for resilience and empowerment.

Table 1Demographic and Clinical Characteristics of the Pilot Study Participants ($n = 9$).

Characteristics	<i>n</i>	Proportion (%)	<i>M</i>
Total	9	100.0	
Ethnicity			
Chinese	3	33.3	
Korean	4	44.4	
Vietnamese	1	11.1	
Multiethnic	1	11.1	
Mean age			25 ^a
Place of birth			
United States	7	77.8	
Foreign country	2	22.2	
Education status			
College	4	44.4	
Graduate school	1	11.1	
Complete college (employed/unemployed)	4	44.4	
Family income			
Less than US\$32,000	1	11.1	
US\$60,000-US\$100,000	3	33.3	
US\$100,000-US\$250,000	3	33.3	
Don't know	2	22.2	
Self-assessed mental health rating			
Poor	0	0	
Fair	4	44.4	
Very good	5	55.6	
Excellent	0	0	
Suicidal ideation			
Yes	5	55.6	
No	2	22.2	
Don't know or missing	2	22.2	
Number of alcohol drinking occasions within a month			
0-4 times	5	55.6	
5-10 times	3	33.3	
More than 10 times	1	11.1	
Number of uses of marijuana within a month			
None	8	88.9	
Less than 4 times	1	11.1	
Mean depression score (CES-D)			20.2 ^b
TLEQ			
Lifetime physical or sexual abuse	7	77.8	
Lifetime physical abuse only	3	42.9	

Characteristics	<i>n</i>	Proportion (%)	<i>M</i>
Lifetime sexual abuse only	3	42.9	
Lifetime physical and sexual abuse	1	14.3	
No physical or sexual abuse	2	28.6	
Stalked	1	50.0	
Witnessed family violence	1	50.0	
Diagnosis of PTSD (CAPS) ^c			
No PTSD	7	87.5	
PTSD (partial or full)	1	12.5	

Note. CES-D = Center for Epidemiologic Studies Depression Scale; TLEQ = Traumatic Life Events Questionnaire; PTSD = posttraumatic stress disorder; CAPS = Clinician-Administered PTSD Scale; *DSM-IV-TR* = *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.).

^aThe range of age is from 18 to 35 years.

^bThe range of scores is from 0 to 60, with higher score suggesting greater depressive symptoms. Cutoff from moderate to severe depression is 16.

^cPTSD: Based on *DSM-IV-TR* criteria. One participant had missing information on PTSD.

Table 2

AWARE Intervention Session Contents for Original 10 Sessions and Modified Eight Session Models.

Original		Revisions after pilot study	
Session theme	Content	Session theme	Content
1: Introduction to AWARE	Introduction of the AWARE intervention (themes, session structure, etc.), emphasis on emergency procedures, safety, and participation agreements.	1: Introduction to AWARE	Introduction of the AWARE intervention, empowering coping skills, self-awareness in risky or unsafe behaviors. Develop group culture of safety.
2: Risk, safety, and empowerment	Empowering coping skills, self-awareness in risky or unsafe behaviors (e.g., cutting, unprotected sex, excessive drinking, drug use).	2: ABCDG parenting and coping with disempowerment	Explore impact of parenting and family dynamics on behavior, identify coping skills to reduce unsafe behaviors, CBT skills to counter disempowering self-talk with empowering self-talk.
3: ABCDG parenting and coping with Disempowerment	Explore impact of parenting and family dynamics on behavior, identify coping skills to reduce unsafe behaviors.	3: Catch-22: The double bind	Work through the double bind, identify one's desires and values, as well as conflicts between expectations set by family versus U.S. society. Process emotional impact of this internal conflict.
4: Catch-22: The double bind	Explore conflict between one's desires and expectations of family versus U.S. society, discuss emotional response to conflict.	4: Body image, stereotypes, and the media	Share stories about body image, stereotypes, racism, and the media. Guided mindfulness exercises to foster self-compassion and healthy self-image.
5: Creating new meaning for the body and mind	Navigating journey from harmful behaviors to recovery, learn coping techniques (e.g., STOP, mindful breathing), discussion of media, and body image	5: Romance, violence, and everything In between	Recognize traits of healthy, unhealthy, or abusive relationships and examine own relationships. Learn how to seek help (e.g., safety planning) in instances of abuse/assault. Learn communication skills with sexual partners, emphasize sexual rights and importance of HIV testing.
6: Romance and violence	Explore connection between one's background and emotions regarding sexual risk behaviors.	6: Sex and substance abuse	Identify substance use problems and risk for contracting STIs or HIV, reasons for engaging in unsafe sex. Become empowered to increase safety in sexual practices and substance use.
7: Harmonizing relationships	Practice sexual rights, utilize communication skills with sexual partners, learn importance of HIV testing.	7: Giving yourself grace	Through interactive exercises and guided meditations, affirm self-worth and practice self-compassion. Identify cultural forces contributing to self-blame and self-hatred to change negative self-talk.
8: Sex, substance use, and social media	Understand consequences of mixing substance use and sex, discuss impact of excessive social media.	8: New beginnings	Termination. Share stories of growth and struggles during AWARE, develop concrete, specific aftercare plans. Say goodbye as a group.
9: Giving yourself grace	Self-blame and self-hatred from cultural forces, learn value of positive self-talk		
10: New beginnings	Termination. Share stories of growth and struggles during AWARE, develop specific, concrete aftercare plans.		

Note. AWARE = Asian women's action for resilience and empowerment; CBT = cognitive behavioral therapy; STI = sexually transmitted infection.