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Guest Editors' Introduction to the Special Section: Cultural Adaptation of Mental Health Interventions for Americans of East Asian Descent

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Introduction

Mental health disparities among racial/ethnic minority groups in the United States is a pervasive problem. When compared to White Americans, racial/ethnic minority populations have less access to mental health care, are less likely to receive care, and when they do, it tends to be poorer in quality (Institute of Medicine, 2001; Sue, Zane, Nagayama Hall, & Berger, 2009; U.S. Department of Health and Human Services [DHHS], 2001). In response to this, there has been an increase in the development and testing of evidence-based treatments (EBTs) among minority populations. Yet, there remains a significant lag in robust evidence on the efficacy and effectiveness of EBTs among minority populations, and in particular, among Asian Americans (AAs). Even among EBTs adapted specifically for minorities, relatively fewer studies focus on AAs, compared to African Americans and Latinx Americans (Huey & Polo, 2008; Miranda, Bernal, Lau, Kohn, Hwang, & LaFramboise, 2005). The paucity of evidence on the effectiveness of EBTs for AAs is alarming, given their significant mental health needs.

Complexities Surrounding Asian Americans Mental Health and Suicidality

AAs have surpassed Latinxs to be the most rapidly growing ethnic group in this country. Between 2000 to 2015, there has been a 72% increase in the AA population (approximately 12 million to 21 million). It is projected that there will be a 213% population increase between 2015 and 2050, which will result in 33.4 million AAs in the U.S (U.S Census Bureau, 2017).

AAs as a whole are often portrayed as “model minorities,” who are successful in school, at work, and have the highest-earnings. However, behind the rosy picture of success, AAs deal with issues such as high rates of depression and anxiety, wide income inequality, lack of adequate health care utilization, immigration-related issues, lack of opportunities for upward

mobility, and a long history of discrimination (Gee, Ro, Shariff-Marco, & Chae, 2009; Iwamoto & Liu, 2010). The complexity of mental health needs is further compounded by the diversity within AAs, with variations across ethnic groups.

Mental health needs among AAs are significant. AA young women have the highest proportion of deaths by suicide (age 15–24), and one of the highest rates of suicide of all racial/ethnic groups of women. AA male adolescents (age 15–19) have half the rate of suicide deaths than do White adolescents; however, AA male adolescents have much higher rates of suicide ideation and attempts (The Center for Disease Control and Prevention, 2016).

It is important to note that unlike other racial groups, suicidal ideation and behaviors among AAs were less linked to mental illness, and more linked to psychosocial factors such as trauma, conflict with family, racism, or functional limitations (Maru et al., 2018; Hahm, Gonyea, Chiao, & Koritsanszky, 2014). In particular, the effect of trauma on suicidal ideation seems to be more salient than other psychosocial factors among AAs. Evidence indicates that exposure to child maltreatment was associated with 9-fold odds for suicidal ideation (Beristianos, Maguen, Neylan, & Byers, 2016), and AA women with a history of childhood sexual abuse and physical abuse/neglect had 12 times greater odds of attempted suicide compared to those who did not report a history of child maltreatment (Hahm, Kolaczyk, Lee, Jang, & Ng, 2012). Accumulating evidence also show that perceived discrimination, microaggressions, and race-related stress are associated with poor physical and mental health outcomes among AAs (Hahm, Ozonoff, Gaumond, & Sue, 2010; Hwang & Chan, in press).

Mental disorders such as depression, anxiety, and PTSD are also of concern among AA adults with rates of depression found to range from 41.6% to as high as 51% and rates of PTSD ranging from 20% to as high as 70% (Kinzie et al., 1990; Marshall, Schell, Elliott, Berthold, & Chun, 2005). Exposure to trauma due to catastrophic environmental stressors including torture, genocide, detainment in refugee camps is associated with elevated levels of depression and PTSD. Studies among Cambodian refugees have found rates for PTSD and depression as high as 51% and 62% within the sample (Marshall, Schell, Elliott, Berthold, & Chun, 2005).

Overall, the existing evidence highlights the pressing mental health concerns among AAs; hence, the need for evidence-based interventions that are specifically tailored for AAs. This special section addresses this gap, through three interventions (AWARE, Compassionate Meditation, Culturally Adapted Multiplex CBT) that aim to reduce mental illness symptoms such as depression, PTSD, or anxiety by targeting specific psychosocial factors that AA experiences including trauma, race-related stress, and conflicts with family in their curriculums.

Low Utilization of Mental Health Treatment Among AA

Despite the evidence highlighting high clinical need, AAs are found to have low rates of mental health treatment utilization. In a nationally representative survey, only 8.6% of AAs were found to seek help from mental health specialists compared to 17.9% of the general

population (Abe-Kim et al., 2007). Among AA young women, 60% of those with current depression or lifetime suicidal ideation/attempt did not seek any mental health care (Augsberger, Yeung, Dougher, & Hahm, 2015). The two most salient factors were (1) a deep and pervasive stigma related to mental health problems and seeking mental health care among both AA families and AA communities; and (2) a mismatch between cultural needs and available services in the U.S. mental health service system. Specifically, AA women reported that there were too few clinicians who understood their lived experiences, identity conflicts, and their sources of well-being, leading them to forego treatment, and for some, to experience a downward spiral to the point of self-harm (Augsberger, Yeung, Dougher, & Hahm, 2015). Thus, a lack of culturally appropriate intervention models led them to reject the care offered and left them on their own to find alternative coping methods. Developing and testing a culturally specific intervention for AAs is critical to improve their health and to reduce morbidity and mortality.

Culturally Adapted Intervention Versus Culturally Grounded Intervention

Behavioral health interventions currently available for AAs consist primarily of therapy modalities “as is,” rising from Western paradigms. While mindfulness and acceptance-based therapies such as Dialectical Behavior Therapy (Linehan, 1993) and Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999) have roots in Asian philosophies, these treatments tend to be centered on the realities and experiences of the majority group such as the conceptualization of self versus others (Hall, Hong, Zane, & Meyer, 2011). Among the interventions specifically tailored to AAs, there are only a handful of recent “culturally adapted interventions.” These include specific adaptations to Cognitive Behavioral Therapy (Hinton, Safren, Pollack, & Tran, 2006; Hwang et al., 2015) and Problem-Solving Therapy (Chu, Huynh, & Areán, 2012) in order for the treatment to be more effective in treating AAs.

Culturally grounded interventions for AAs are also scarce because culturally grounded treatment starts with the particular ethnic/racial groups and the cultural aspects are to be systematically integrated throughout the curriculum (Hecht et al., 2003). Systematic integration includes symbolic representation of the culture, cultural values, and specific risk and protective factors of the cultural groups.

In this special section, we present culturally grounded (AWARE) and culturally adapted (Compassionate Meditation and Culturally Adapted Multiplex CBT) interventions designed to treat AAs of East Asian descent. The three interventions in this special section share a common core principle – all are based on the worldview of AAs. In fact, all three interventions incorporated mindfulness and loving kindness to increase emotional regulation. As Hwang and Chan (in press) indicates, incorporation of mindfulness into therapeutic practice may be “a culturally syntonetic method” for addressing needs of AAs. We introduce the highlights of these cultural adaptations below.

The first article in this special section presents Asian Women’s Action for Resilience and Empowerment (AWARE) intervention by Hahm et al. (2019). AWARE consists of 8-weekly group psychotherapy sessions led by AA therapists and delivered face-to-face via group psychotherapy and daily text messages to participants. AWARE uses the “Model of

Healing”, an empowerment-based model, to explain why AA women feel “disempowered” and “trapped.” It is a model that incorporates gender and culture-specific elements in the therapeutic process. Based on identified culturally specific risk and protective factors for suicidality among Chinese-, Korean-, and Vietnamese-American women, Hahm et al. (2019) translated risk and protective factors into a treatment manual.

As the first study to rigorously evaluate a culturally grounded, integrative, and holistic intervention for AA women, AWARE’s therapeutic approach combats challenges that are central to AA women’s identity and well-being: dysfunctional family dynamics, physical and sexual trauma, health risk behaviors, and related issues that are often avoided due to fear of stigma and shame (Augsberger, Hahm, Yeung, & Dougher, 2015; Hahm et al., 2014; Maru et al., 2018).

Such elements include enhancing participants’ understanding of their self-identities as AA women, ways to navigate the dynamics of living in an immigrant family, methods for facing discrimination, and common gender-roles. The results show high feasibility and acceptability.

Components of AWARE are especially beneficial for individuals with a PTSD diagnosis. Using mixed linear effect modeling, after controlling for baseline depressive symptoms, there was no significant difference between the intervention and control groups with respect to changes in depressive symptoms over time. However, the intervention group with a PTSD diagnosis at baseline experienced significant reductions in depressive symptoms over time, compared to the wait-list controls (treatment $d=0.84$, control $d=0.23$).

The second article of this special section, Rivera et al. (2019) explored the therapeutic mechanisms of AWARE intervention. Ideal psychotherapy research not only illuminates the efficacy or effectiveness of its intervention, but it also reveals the mediators of therapeutic change (Kraemer, Wilson, Fairburn, & Agras, 2002). Treatment mediators are designed to identify possible mechanisms through which a treatment might achieve its effect; thus, the mediators help explain why treatment works and does not work (Kraemer, Wilson, Fairburn, & Agras, 2002). In general, mechanisms are considered as causal links between treatment and outcomes.

Rivera et al. (2019) analyze 16 AWARE cohorts’ post-intervention focus group discussion after participants completed 8 sessions group psychotherapy. This study identified that mechanisms of action which contribute to the improvement of mental health outcomes were four distinctive and culturally specific mediators: (a) psychoeducation on disempowering parenting, (b) the reduction of mental illness-related stigma, (c) community and relationship building, and (d) a heightened sense of empowerment. This article highlighted the importance of incorporating culturally relevant ingredients in AWARE such as discussions on immigration, acculturation, AAs specific family systems approach and intentional ethnic and gender matching between the therapists and participants. From the AWARE intervention, the AA women reported a renewed sense of commitment to their lives.

In the third article in this special section, Hwang and Chan (in press) attempted to specifically deal with race-related stress through a novel, peer-led, culturally adapted pilot

intervention aimed at reducing the negative effects of perceived discrimination and race-related stress on the mental health outcomes of AA young adults. By uniquely integrating cognitive behavioral techniques adapted for AAs with compassion meditation (CM), that stems from the Buddhist concept of compassionate healing, this intervention illustrates the importance of interventions that are culturally grounded and responsive. The pilot intervention, which was tested on a sample of 11 young adults of Asian heritage, indicate promising effects – with participants reporting roughly 50% decrease in symptoms of depression and significant decreases in anxiety and PTSD. Considering the increasing attention to issues of diversity and inclusion across college campuses and beyond, this innovative pilot intervention is timely and illustrates a potentially effective approach to addressing race-healing across diverse populations.

In the final article in this special section, Hinton and Jalal (in press) illustrate the cultural adaptation of a cognitive behavioral intervention for trauma, the Culturally Adapted Multiplex CBT. This intervention was initially developed to treat somatic and panic symptoms in Cambodian refugees who have experienced significant trauma, and now has been tested across other Asian ethnic groups as well as with Latinos and African samples. The current article outlines how the intervention was adapted to the local conceptualization and experience of mental distress through three distinct areas: (1) assessing and addressing somatic-focused emotion regulation, (2) emphasis on mindfulness and the cultural value of loving kindness, and (3) the promotion of flexibility. To promote somatic-focused emotion regulation, the authors targeted key local concerns including somatic complaints, culturally specific syndromes and idioms of distress. The article details the approaches to culturally grounding specific behavioral and cognitive techniques that integrate mindfulness and the cultural tradition of loving kindness, the use of local metaphors and proverbs, and further, integrating CBT consistent aspects of local and religious healing traditions. The authors' demonstration of infusing culturally anchored beliefs, values, meanings and practices into evidence-based intervention to address cultural experiences of distress and promote resilience highlights emergent approaches to developing efficacious cultural adaptations of EBTs for AA populations.

Conclusion

Overall, this special section makes a timely and significant contribution to providing various types of culturally specific interventions as well as the evidence of clinical trials. Although the sample size of each study is rather small, each intervention illustrates innovative methods in both reaching and treating underserved and under-studied populations. Moreover, these interventions provide critical groundwork for building an evidence base of interventions tailored specifically to AAs. These articles demonstrate the significance of development and testing of culturally adapted or culturally grounded interventions for intervention science that effectively treat and engage culturally diverse and hard to reach populations.

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