**Te Pou**
o Te Whakaaro Nui

# TALKING THERAPIES

## FOR ASIAN PEOPLE

Best and promising practice guide for mental health and addiction services

## Disclaimer

TALKING THERAPIES
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# Acknowledgements

# Executive summary

Traditional Asian beliefs about mental illness and sources of support can differ from the assumptions that underlie Western models of talking therapy[1,2]. These differences may have implications for the acceptability and relevance of talking therapies for Asian people. Therapist and service user feedback form a New Zealand consultation and papers from international experts note that there is sometimes misalignment between talking therapy and the needs and goals of Asian people. Research also suggests that Asian people are less likely to access talking therapy and that those who do access therapy have high rates of drop-out[3].

Talking therapies aim to alleviate diagnosed symptoms of mental illness, help people who are experiencing stress relating to difficult life events, or assist people who want to learn more about themselves. This guide provides an overview of what is known about the most effective ways to deliver talking therapies with Asian service users. The guide is based on a combination of evidence from research, expert opinion and consultation with New Zealand therapists. In many cases, recommendations are based on expert opinion in the absence of relevant empirical research evidence. This guide is intended as a starting point for gathering information on the delivery of talking therapies for Asian communities.

## Who is Asian?

Over 9 per cent of New Zealand's population identifies with one or more Asian ethnic group[4]. Asian ethnic groups include people originating in the Asian continent, east of and including Afghanistan, and south of and including China[5]. This document will focus on Asian people who were born in New Zealand, or arrived as migrants, rather than Asian people who arrived as refugees. Refugee experiences, and the associated implications for therapy, are covered in the guide on *Therapies for refugees, asylum seekers and new migrants: Best and promising practice guide for staff working in mental health and addiction services* available from www.tepou.co.nz.

On average, Asian people appear less likely to experience mental illness or addiction disorders than many other ethnic groups in New Zealand. However, there are a number of Asian groups who appear to be more at risk than the general population, such as refugee people, the elderly, and Indian youth[6,5]. Nonetheless, substantial numbers do experience mental illness or other stressors that could benefit from talking therapies. Within the Asian population, there are a number of at-risk groups who may be at greater risk of mental illness than the average level of risk in the New Zealand population[6].

Most Asian cultures are collectivist in orientation and place a high value on family duty, tolerance of hardship and achieving success[2]. Spirituality is important for a number of Asian people, and the relative importance of indirect and non-verbal communication, and hierarchical communication patterns may differ from common communication norms in New Zealand.

Traditional Asian health beliefs emphasise the interconnectedness of physical and mental health, and in some cases a third dimension of spirituality[7, 8]. These health beliefs have implications for what types of help Asian people believe will be effective and how people with mental illness are treated by their community. These factors in turn impact on the timing and type of help sought in response to symptoms of mental illness or difficult life events.

These generalisations should be read with caution because there is a lot of variation between people who identify as Asian. A wide range of migration experiences, and differences in how closely an Asian service user identifies with Asian values or common New Zealand values, also means that individual assessments of these factors are critical.

## Principles of engagement

A number of therapeutic and cultural competency skills can be applied when engaging with people of Asian ethnicity. Therapists can:

- explore and respect cultural values and experience of distress
- adapt communication styles to fit with service user preferences
- ensure treatment goals fit with the service user's preferences and needs
- use trained interpreters if a person's English language is limited and monitor the quality of interpretation
- assess and address any limits in understanding of mental health or the New Zealand mental health system
- broaden assessment
- educate and involve families
- draw on the support of the community
- address experiences of stigma.

Some of these skills may not be necessary for working with every Asian service user. For example, some Asian people may completely identify with New Zealand culture and values, be highly experienced with our health system, and be highly fluent in English.

### Assessment of each individual key to tailoring therapy

Each Asian person brings a unique set of values, beliefs and service needs to the therapy session. These in turn influence what type of communication, goals, recommendations and talking therapy models are likely to be most effective for each individual. Evidence from New Zealand therapists and research suggests that assessment should go beyond symptoms to explore:

- the service user's perception of the cause of their symptoms
- migration history[9]
- views and knowledge about traditional and Western styles of therapy and help seeking
- family and other social support, and current family functioning
- culturally appropriate goals for therapy
- past trauma and grief
- cultural values[10]
- religious values[10].

## Models of talking therapies

A number of Western forms of talking therapies have been used with Asian service users in Western countries and talking therapies are also increasingly being used in Asian countries. Few research studies have investigated the effectiveness of talking therapies approaches for Asian people and most of the research literature relies on expert experience and some feedback from Asian service users[11].

Evidence of improved functioning following therapy exists for cognitive behaviour therapy (CBT) with Asian people; improvements relative to no treatment have been noted for some Asian populations[12]. There is also tentative evidence for the use of family therapy, but there is limited research evidence available on other therapies. Recommendations for adapting CBT have been developed for the broad Asian population, and specifically for Chinese service users[13, 14]. To date, research does not appear to have tested whether implementing these recommendations will improve the effectiveness of CBT for Asian service users.

A number of Western forms of talking therapies have been used with Asian service users in New Zealand. Consultation for this guide collected feedback from 29 therapists in New Zealand about their work with Asian communities. This feedback suggests the following therapies are commonly used: CBT, family therapy, social supportive counselling, problem-solving, counselling and motivational interviewing. Therapists generally considered these to be useful and well accepted by Asian service users. Acceptance and commitment therapy, dialectical behaviour therapy, and psychodynamic psychotherapy were less commonly used. However, this may reflect the relative number of therapists who have received training in these models, rather than the degree of relevance for Asian service users.

The consultation indicated that many therapists take a flexible approach to how therapies are used and introduced to service users. Therapists often draw on multiple forms of therapy and incorporate aspects of the engagement principles discussed above. Some therapists have altered the content of therapy to incorporate mindfulness training or incorporating Taoist principles in therapy with some service users. Therapists emphasise that one model will not be appropriate for all Asian service users. Therapy selection should consider each individual's culture, language, acculturation, family dynamics, previous help-seeking experiences and preferred help-seeking strategies, as outlined in the list of assessment areas above.

## Resources

Section Four of this guide details services and resources that may support culturally-appropriate talking therapy with Asian people.

## Summary

Asian refers to a group of people who identify with a range of cultural and religious viewpoints. Asian people each have unique values, opinions and needs, and thus therapy should be adapted based on assessment of each individual's preferences and needs. Cultural, linguistic, communication, religious and other factors, as well as symptoms can be considered, when deciding on the goals, communication and type of therapy. This can support delivery of talking therapies in a way that is more likely to be acceptable for Asian service users.

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# 1. Introduction

## Background

### Why this guide is important

Therapists routinely tailor the way that they deliver therapy to respond to the individual needs of each service user. Due to increasing ethnic diversity, it is increasingly common that tailoring therapy will involve adapting it to accommodate thoughts, beliefs, symptoms, goals and practices that relate to the culture, ethnicity and migration experiences of individuals[2].

Treatment drop out, low rates of service access and service user feedback suggest that Western[1] models of talking therapy are not necessarily perceived to be a relevant tool for working with Asian people[2, 3]. Many Western models of therapy are underpinned by Western ideals, values and perceptions about appropriate ways of responding to symptoms of mental illness. These are not always consistent with traditional methods of responding to symptoms of mental illness in Asian cultures[2]. Western therapies can be adapted for different cultural groups and research suggests that when treatment is provided in a manner that is culturally tailored, rates of access and treatment completion improve[15].

## Purpose and target audience

### Purpose

This guide summarises what is known about the most effective ways to deliver talking therapies to Asian[2] service users in New Zealand. It is intended as an adjunct to professional training in the use of talking therapies. It is also intended as a starting point for gathering together what is known about best and promising practices for delivering talking therapies for Asian service users. Section One provides background information for delivering talking therapies to Asian people by summarising key characteristics of Asian communities. Section Two focuses on principles of engagement that practitioners can employ to strengthen the therapeutic relationship with Asian service users. Section Three discusses specific therapies and how they might be adapted for Asian people.

The guide assumes that readers are familiar with the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services, as described in the Ministry of Health *Let's get real* framework. The *Let's get real* framework is explicit in stating the expectations for people who work in mental health and addiction services, irrespective of their role, discipline or position in an organisation. Further information on *Let's get real* is discussed in Section Two – Principles of Engagement.

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1 Western typically refers to people or therapies originating outside the Asian continent, primarily in the United States, the United Kingdom, Canada, Australia, New Zealand and continental Europe.

2 The Asian population includes a number of people who arrived in New Zealand as refugees from their home country. Asian people from a refugee background have a number of unique experiences and risk factors that should be considered in providing talking therapies to these groups. Issues relating to the refugee experience are discussed in Te Pou's *Therapies for refugees, asylum seekers and new migrants* guide and, in the interests of non-duplication, will not be discussed in this guide.

## Target Audience

This guide is aimed at practitioners who deliver talking therapies to Asian communities. This may include alcohol, drug and gambling workers, counsellors, GPs, occupational therapists, psychiatrists, psychologists, psychotherapists, registered nurses working in mental health or addiction services, social workers and family advisors.

# Development of the guide

Service users, families and practitioners have called for greater access to evidence-based talking therapies across the mental health and addiction sector. This guide is part of a suite of best and promising practice guidelines for staff delivering talking therapies for older adults, Pacific people, refugees, asylum seekers and new migrants, Maori, Asian people and people with addiction problems. These guides draw from national and international literature, as well as consultation with experienced practitioners in the sector, to identify best and promising practice when working with these service user groups. A key focus for these guides is identifying the practices that are most effective for engagement, both during the assessment and delivery stages of talking therapies.

This Asian talking therapies guide was developed in 2010 through consultation with New Zealand practitioners who work with Asian communities, combined with a review of the research literature and international expert opinion. It is a start at collating best-practice recommendations for delivering talking therapies and is not a comprehensive outline of the use of talking therapies in New Zealand. In particular, it does not include knowledge from non-English language resources.

Due to the diversity of the Asian population, the document focuses on Asian values that extend across many ethnic groups. Where possible and relevant, the guide suggests recommendations for different ethnic groups. More information on the development of the guide is presented in Appendix A.

# Asian communities in New Zealand

## Who is Asian?

The term Asian is used to refer to people originating from the Asian continent, east of and including Afghanistan, and south of and including China[5]. On average, the Asian population in New Zealand is relatively young; in 2006, 31 per cent were between 15 and 29 years old, and only 5 per cent were aged over 65[4].

Some of these people come from refugee backgrounds. The *Therapies for Refugees, Asylum Seekers and New Migrants. Best and Promising Practice Guide for Staff Working in Mental Health and Addiction Services*[16] guide should be consulted for best and promising practice when working with these people. A number of people arrived in New Zealand under refugee catagories or with refugee like experiences from Cambodia and other parts of South East Asia during the 1970's and1980's and more recently refugee intakes to New Zealand have included a number of people from Afganistan and Burma.

Chinese and Indian ethnic groups are the two largest Asian communities living in New Zealand. Both ethnic groups have histories of settlement that mean that there are many second and third generation families, as well as recent migrants from these ethnic groups[17]. The next largest Asian ethnic groups in New Zealand are Korean, Filipino, Japanese, Sri Lankan and Cambodian[4].

## Population size and location

Asian ethnic groups make up a significant proportion of New Zealand's population. In 2006, 9 per cent of New Zealand's population identified with one of the ethnic groups originating in Asian countries. By 2026, it is predicted that 16 per cent of New Zealand's population will identify as Asian, making this our third largest ethnic group behind European and Maori[18]. Asian communities tend to settle in urban areas, particularly in the Auckland region where they make up over 23 per cent of the population[18]. However, Asian communities also make up 13 per cent of the population in Wellington, 11 per cent in Hamilton, 8 per cent in Christchurch and 7 per cent in Palmerston North.

## Economic situation and language skills

Asian communities tend to have lower income, higher unemployment and lower home ownership rates compared with the New Zealand average[17]. The English language skills of Indian communities are similar to the overall population. However, Chinese and other Asian groups have lower average levels of English language competence[17].

## Diversity in the Asian community

The Asian population also includes a range of cultures, languages and religions[19] and people with vastly different migratory experiences. Some may come from large Westernised cities, others from rural towns or villages. People may be highly educated, or illiterate, and may come to New Zealand by choice, or after being forced to flee as refugees from their home country.

## Impact of diversity on delivering mental health and addiction care

The diversity in Asian communities provides a strong argument for avoiding stereotypes when working with an individual. A key task for therapists is to understand each service user as a unique individual by applying active listening, empathy and other communication skills. What may be appropriate for one Asian person will not necessarily be appropriate for another Asian person, even when two people may share the same ethnicity, language or other characteristics.

Some differences in the prevalence of mental illness, addiction disorders and preferred interventions between Asian ethnic groups have been noted in recent research[5, 6, 20]. In particular, the service and policy needs of South Asian communities are predicted to differ from the needs of Chinese and other East Asian groups, due to differences in settlement histories, culture, community structures and cultural patterns of responding to stress (A. Mortensen, personal communication, 11 September 2008).

# Common health issues for Asian communities

## Health status and common conditions

Traditionally, Asian communities have been thought of as a healthy minority ethnic group. Recent data confirms that on average Asian communities in New Zealand experience longer life expectancy, compared with Maori, Pacific and European New Zealanders. However, recent data also suggests that Indian and other South Asian communities experience a range of health risks, including higher risk of cardio-vascular disorder, ischemic heart disease, diabetes, stroke, low birth-weight and obesity[17].

## Reductions in health status over time

Research suggests that health indicators tend to worsen the longer Asian people spend in New Zealand[21]. Second generation migrants tend to have higher rates of physical illness than their parents' generation of overseas-born Asian New Zealanders. This trend has been classified as a "healthy migrant effect", partly attributed to the health requirements for overseas-born Asian people to migrate to New Zealand.

## Service access

Low rates of service access are observed across the Asian population. Chinese, Indian and other Asian ethnic groups are less likely to have made recent doctor and dentist visits or consulted alternative healthcare providers[17]. For some groups this may reflect better health status. However, as noted, some indicators of health are worse for Indian communities, but this is not reflected in increased access to health services.

## Refugee health

A discussion about the health status of refugee communities is beyond the scope of this guide. Some of the more common health issues for some refugee communities include hepatitis B, infectious and parasitic diseases, HIV, dental disease, and body modifications[22]. See *Therapies for refugees, asylum seekers and new migrants*[16] and *Refugee healthcare: A handbook for health professionals*[22] for more information.

# Mental health issues for Asian communities

## Prevalence of mental illness

There is very little research relating to the prevalence of mental illness in Asian communities, particularly from New Zealand[6]. According to existing research, on average the Asian population appears to experience low rates of mental illness and addiction. Research notes that rates are lower in migrant Asian groups[5, 6, 21, 23] and in Asian countries[24], relative to Western populations. This trend has been noted across a variety of disorders[25] and ethnic groups. A recent US study focusing on East Asian groups (Chinese, Korean, and Vietnamese) and including people from a refugee background noted 9.2 per cent of people experienced any disorder in the past 12 months[26].

It has been argued that low estimated prevalence rates may be partly due to limited sensitivity of psychological tests developed in the West to the signs and symptoms of mental illness in Eastern cultures[27]. It is also argued that Asian people are less likely to disclose when they experience a mental health condition, due to the stigma associated with mental illness[7]. Alternative rationale for low rates of mental health issues in Asian communities relate to cultural resilience factors, or to the relatively good socioeconomic status of many Asian migrant families.

Life stressors, particularly those associated with migration and intergenerational family conflict, also exist for people in New Zealand's Asian communities. Talking therapies are not solely for those who experience a diagnosable mental illness and have been used to help Asian people to work through difficult life events.

## Risk Factors for mental illness

Following are some risk factors believed to relate to rates of mental illness for Asian people: [26, 28-33]

- low socioeconomic status
- unemployment
- low English language skills
- limited social networks
- trauma or stress related to migration and pre-migration experiences
- discrimination, or lack of acceptance, by the general population or their own communities.

New Zealand research has found the following Asian sub-groups are at greater risk of mental illness than the general population:

- Indian students[5]
- Asian refugees (Cheung & Spears, 1995, as cited in[6])
- Chinese older people[20]
- Indian female youth (who have higher rates of intentional self-harm than the general population of youth)[17].

These groups may be at risk due to associations with the above risk factors. For example, refugee people may be more likely to have low socioeconomic status, limited social networks or experience of trauma.

Students (particularly secondary), women, and Asian people from isolated ethnic groups may also be at increased risk of mental illness, but prevalence for these groups has not been measured in New Zealand[6, 20].

## Mental health help-seeking behaviours

The concept of specific talking therapy or psychological therapy as a means of support is not common in many Asian cultures. Traditional therapies are often used to alleviate the same symptoms that talking therapies would seek to address. In particular, physical forms of therapy, such as meditation or herbal remedies are often used in Asian cultures[34]. Although these may not fit into a strict definition of talking therapy, they may be a more acceptable way of addressing symptoms for many Asian service users.

The types of help sought, and the delays and methods of seeking help differ between Asian groups. This is believed to be partly a result of levels of acculturation[5, 35], and partly a result of treatment norms in the different home countries. For example, therapists and Asian communities report Asian people rely on self-help measures in the first instance, followed by drawing on their immediate social network for support. Young and educated Asian people may differ in their help-seeking behaviour relative to older adults; research from Pakistan demonstrated that preferences for talking therapies over pharmacological therapy were higher amongst the young and the educated[36].

Research also demonstrates a tendency for Asian people to initially present with physical symptoms, rather than psychological symptoms[28]. This relates to the concept of somatisation, which is when a person identifies multiple physical symptoms in the absence of an identifiable physical causal mechanism. In some cases somatisation (non-attributable physical symptoms) may occur in the presence of a psychological disorder. In other cases, somatisation may occur when a psychological disorder is not present[37].

An extensive review of somatisation is beyond the scope of this guide. The research identified in a limited search outlines that:
- some people may reject any attempt to attribute their symptoms to psychological causes[37]
- while somatisation occurs in all cultures, therapists and researchers have noted that verbally expressed somatising (i.e. describing mental health in terms of physical symptoms) is particularly common in Asian communities[38]
- there is some evidence that talking therapies can be particularly effective at reducing and alleviating somatic symptoms[39].

# Addiction issues for Asian communities

## Alcohol addiction

Similar to mental illness statistics, rates of alcohol dependence and addiction tend to be lower in Asian communities than is typical in Western communities[5, 40]. Recent data from the United States National Survey on Drug Use and Health[41] found that the percentage of people engaging in binge drinking in the past month were lower for the Asian population relative to the national average (13.2 versus 24.5 per cent). There was a lot of variation among Asian sub-groups in binge alcohol use (for example, 25.9 per cent in Korean adults versus 8.4 per cent in Chinese adults). One source of variation is that Asian adults born in the US had higher rates of alcohol use and binge drinking compared with Asian people born overseas.

Differences in the prevalence of alcohol use disorder appear to relate to alcohol use norms in Asian countries. For example, Korea has higher rates of alcohol use disorder (7.1 per cent annual prevalence, 17.8 per cent lifetime prevalence)[24] compared with China (4.6 per cent lifetime prevalence)[42].

There is no New Zealand data on prevalence rates of alcohol dependence or addiction. However, New Zealand service access data suggests that alcohol and drug services are accessed by very few Asian people[40]. Low rates of access have been attributed to a lack of information about available alcohol and drug treatment services, language barriers and perceived lack of cultural responsiveness[40]. Low rates are also likely to be linked to low prevalence of alcohol and drug use typically noted in Asian communities.

**Resources:**

- ***Alcohol and drugs in New Zealand. An Asian perspective: A background paper*[40]**
  This document contains a range of background information on alcohol and drug use, and associated values and help-seeking behaviours in Asian communities.

## Drug addiction

Similar to mental illness statistics and alcohol statistics, rates of drug use and addiction tend to be lower in Asian communities than the major ethnic groups in Western communities. Recent data from the United States Survey on Drug Use and Health found that the percentage of people engaging in illicit drug use in the past month was lower for the Asian population relative to the national average (3.4 versus 7.9 per cent)[41]. Within the Asian population, rates were highest for Asian people born in the United States, and there was a lot of variation between ethnic groups[41].

Rates of drug use vary across Asian countries, as do the types of drugs of abuse that people seek treatment for. Depending on the country, common drugs of abuse in Asia can include opiates or amphetamines[43].

**Resources:**

- ***Alcohol and drugs in New Zealand. An Asian perspective: A background paper[40]***
  This document contains a range of background information on alcohol and drug use, and associated values and help-seeking behaviours in Asian communities.
- ***The NSDUH report: Substance use among Asian adults[41]***
  See this report for further information about the prevalence of drug and alcohol use in Asian–American populations.

## Risk factors for addiction

Few studies have been undertaken looking at addiction in Asian communities[40]. A recent large (n=6000) study in mainland China[44] noted the following risk factors:

- youth
- male
- married
- employed
- low education level
- rural residence
- other psychiatric disorders.

## Problem gambling[3]

There are a number of Asian people in New Zealand that experience difficulties with problem gambling. In 2007, over 6.9 per cent of new gamblers seeking help were of Asian ethnicity[46]. Data on prevalence of problem gambling in Asian communities has produced different estimates of rates, possibly due to national differences or methodology.

Problem gambling appears to be more common in Chinese communities, where some forms of gambling are a popular and acceptable past-time when undertaken in moderation[47], and lower in Muslim Asian communities where gambling is strictly forbidden. Thus rates across New Zealand's Asian community appear to be lower (0.1 per cent) relative to studies of Chinese migrant communities (2.9 per cent)[48].

New Zealand research suggests that Asian immigrants involved in shift work, and young Asian adults studying English are particularly at risk[49]. Rates also appear to be higher in males[50] and high rates of co-morbidity have been noted with other psychiatric disorders for example, substance abuse, alcohol abuse and mood disorders[49].

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3  Problem gambling refers to; "harm or distress of any kind caused or exacerbated by a person's gambling, and includes personal, social or economic harm suffered by the person, their spouse, partner, family, whänau and wider community, or in their workplace or society at large" [45].

# Cultural world views for Asian communities

Asian refers to a group of people who identify with a range of cultural and religious viewpoints. Most Asian cultures focus on collectivism and place value on family duty, tolerance of hardship and achieving success[51]. Cultural norms around spirituality, and preferences for non-verbal and hierarchical forms of communication are less consistent across Asian cultures.

It is important to remember that individuals from any Asian culture will differ in the extent to which they identify with the values described below, or with a Western individualistic focus and communication norms. Western world views may be adopted more quickly by Asian children and youth, at times conflicting with a parental focus on traditional Asian cultural values and practices.

## Table 1. Common values in Asian communities

| Value | Explanation |
|---|---|
| **Collectivism** | In many Asian cultures individual needs are placed secondary to the needs of the community and their family[7, 52]. Collectivism often involves a shared sense of honour and shame in the behaviour of others in the family and community. It often also focuses on acceptance of social order, and a responsibility to follow those in positions of authority to facilitate pleasant and courteous relationships. |
| **Family focus or duty** | Family is a core part of the lives of many Asian people. Families are often highly-involved in life and health decisions[53]. Particularly in Indian and South Asian cultures, family relationships are often highly structured and formal, with specific gender roles[8]. |
| **Education and wealth focus** | Many Asian cultures value education and wealth, and a person's self-worth may be defined in terms of the material and occupational status they achieve, as part of their duty to their family[8, 51]. |
| **Tolerance of hardship** | Many Asian philosophies put high value in letting things take their own course, and emphasise that life events are part of fate and that people should learn to accept their circumstances[2]. |
| **Conflict avoidance and humility** | Particularly in East Asian cultures, there is a strong focus on avoiding conflict with others, and on modesty in communication and in discussing one's achievements[51]. |
| **Emotional regulation** | Particularly in East Asian cultures, strong feelings and emotions are avoided[51]. For example, Chinese and Japanese people favour reservation and subtle means of communication, whereas Indian people may be more expressive[7]. |

## Beliefs about health and mental health

Beliefs about health and well-being differ across Asian cultures. However, there are a number of common elements to these beliefs.

In Asian cultures, poor physical or mental health is often assumed to arise from imbalances in bodily states (energy or heat) or to be a result of negative past behaviour[7]. For example, ill-health may be attributed to an excess of heat or darkness, not following religious practices, dishonouring the family with particular behaviours, or not being sufficiently successful in wealth, education or employment.

Typical traditional therapies attempt to reduce imbalances using herbal remedies, massage, body manipulation or interactions with the spiritual world[54]. Other mechanisms to restore balance include establishing feng shui in a person's residence, or restoring hot and cold imbalances with types of food or drink[7].

**Resources:**

- **Asian mental health training and development CD for Real Skills**[55]. This resource includes information about Asian world views, beliefs and philosophies, as well as references and links to other resources.

## Religious and spiritual beliefs

Spiritual beliefs, religious beliefs and associated philosophies play a major role in the lives of many Asian people. For example, in the Islamic faith there are rules that guide appropriate interactions between males and females, and certain foods, activities and thoughts are forbidden.

Common religions in Asian communities include Islam, Hinduism, Buddhism, Christianity, Taoism and Shintoism. Atheism is also common. Spiritual beliefs may follow a religion or they may be a self-directed, personal inner search for something bigger than oneself that is carried out independent of religion[56]. Asian communities in New Zealand have set up a number of churches, temples and mosques to facilitate continued practice of their faiths. These places are important forms of spiritual, cultural and social support for many Asian people.

## Table 2. Summary of religions and faith systems common in Asian communities

| Religion or faith | Explanation | Common countries[1] |
|---|---|---|
| **Confucianism** | An ethical system that focuses on achieving social harmony in five relationships; with the state, and between parent and child, brothers, marital partners and friends[57]. | East Asia and China |
| **Taoism** | Religion based on a belief in pre-determination. It views individuals as passive creatures with no control over life, and focuses on nature, and on achieving flow and acceptance of one's destiny[57]. | East Asia and China |
| **Buddhism** | This religion focuses on four noble truths: life is about suffering, suffering results from unfulfilled or inappropriate desires, these desires in turn arise from ignorance or illusion, and the way to salvation is through enlightenment. Loyalty, respect, compassion, self-control and ancestor worship are highly valued[57]. The Buddhist faith is not prescriptive about daily life activities, but looks down upon cravings for physical or material pleasure. Meditation is an important part of the journey to enlightenment. | Throughout Asia |
| **Islam** | Muslims (people who follow the Islamic faith) believe in a single god (Allah), and in pre-determined destiny. They closely follow the teaching of the Qur'an and the prophet Muhammad, and believe that five acts of worship and Islamic law are central to one's life. In the Islamic faith, certain foods, activities and thoughts are forbidden, such as alcohol, pork, casual touching and thinking about (or committing) suicide. There are also rules that guide appropriate interactions between males and females. | South Asia, Indonesia, Pakistan, India and Bangladesh |
| **Hinduism** | Hinduism is a faith made up of philosophical, religious and cultural beliefs, closely tied to ancient Indian culture. Two central concepts are the belief in an Absolute Being of multiple manifestations, and the belief in karma (the belief that one's own deeds determine one's destiny in the cycle of birth and rebirth). | India, Nepal |
| **Shintoism** | This religion focuses on interaction with the spiritual realm and connection with nature. Natural places are seen as having spiritual forces. Rituals include giving thanks, cleansing of impurities, visiting shrines, using amulets for good luck and protection. | Japan |
| **Christianity** | Christians believe in a single God, and the religion closely follows the life and teachings of Jesus Christ as outlined in the Bible. Religious practices and beliefs differ within Christianity according to the denomination of a person's faith, for example Catholic, Protestant and Orthodox. | Korea, Philippines, minority religion in India and other Asian countries |

**Resources:**

- **Mental health concepts in Southeast Asia: Diagnostic considerations and treatment implications**[58]
  This article outlines common mental health beliefs in a range of religions and how they relate to diagnosis and treatment for mental health disorders.

## Stigma in Asian communities

Stigma around mental health is an important consideration in the delivery of talking therapies for Asian service users. Many Asian cultures are known as shame-bound, meaning that shame is often applied when social and family expectations are not fulfilled, and can be a common part of interpersonal interactions and self-regulation.

People with mental illness typically experience high degrees of stigma and discrimination in Asian cultures[59, 60]. In many Asian countries there is a strong tendency to avoid people who experience mental illness. Therapists report that these people are typically looked down upon, segregated from normal society and avoided by others.

Mental illness is often considered shameful as it is typically viewed as arising from past wrong-doings, or failure on the part of a person's parents[61]. Some people still view mental illness as a transmittable disease[57]. Furthermore, emotional and behavioural symptoms of mental illness may be offensive to cultural norms that prohibit displays of anger and hostility in Indian culture, or Chinese norms where expression of strong emotions tends to be avoided. People with mental illness may be seen as possessed by demons or cursed, or to have failed to fulfil the duty owed to their ancestors.

Seeing a psychiatrist or mental health professional is typically considered to be shameful in Asian cultures[2]. Not only is mental illness strongly stigmatised, but many Asian people consider seeking help and talking about one's problems to be a sign of weakness or lazyness[57, 61]. There may also be fear about what may happen if help is sought. In China and Hong Kong, people with mental illness are treated badly, for example they may be locked in their homes or arrested for crimes[57]. Therapists report that many Asian migrants come from countries where only seriously unwell or psychotic people would visit a mental health professional. Seeing a mental health professional is often associated with a high degree of un-wellness, and thus greater stigma, and considered to be inappropriate for milder distress.

Stigma and discrimination may also be self-directed, as shame for not fulfilling family obligations or for bringing shame on other family members. New Zealand work suggests these phenomenon occur in our Asian communities. However, there is little discussion about the occurrence or impact of self-stigmatisation in the literature[62].

Attitudes towards mental illness within New Zealand's Chinese, Korean and Indian

communities were investigated through focus groups with service users and other community members[61]. Discussions in these groups suggested the following attitudes.

- In Chinese and Korean cultures, there is a focus on personal responsibility for your own health status[61]. Ill health may be seen as a failure to maintain this responsibility.
- Some Chinese New Zealanders view mental illness as caused by bad parenting.
- Many migrant Asian communities focus on developing financial security and it is believed that people should get on with life and stop being indulgent about their emotions and concerns.
- Asian people who identify with Christian faith may be particularly accepting and supportive of people with mental illness as an act of pastoral duty.
- A number of Indian people may view anxiety, depression and phobias with some tolerance. In Indian cultures, there are beliefs that people should be supported through such distress, and thus less shame may be attached to mental illness than in other Asian communities.
- In Indian cultures, stigma and discrimination towards people with serious mental illnesses, particularly schizophrenia, is common.

**Resources:**

- See the Kai Xin Xing Dong website for mental health resources for service users and community members that aim to reduce stigma and discrimination in the Chinese community www.mentalhealth.org.nz/kaixinxingdong/page/5-Home.
- For examples of the application of recovery perspectives with Chinese service users see *Use of the recovery approach to support Chinese immigrants recovering from mental illness: a NZ perspective[63]*, available at www.fmhs.auckland.ac.nz/soph/centres/cahre/amh/recovery(p1).pdf
- For information on stigma and beliefs about mental illness in Chinese, Korean and Indian communities in New Zealand see *Like Minds, Like Mine target groups[61]*.

# National evidence

### Overview of New Zealand Asian Mental Health research

New Zealand research has identified risk factors for mental illness and addiction in Asian communities[5]. New Zealand service use statistics consistently demonstrate that Asian people are under-represented in their access to services, relative to their population size[17, 64]. Research collecting feedback from service users and therapists has identified recommendations for how services could be more responsive to Asian communities[65].

### Talking therapies New Zealand evidence

Most of the evidence about how to deliver talking therapies with Asian communities is based on expert opinion and the practice of therapists working in the field. There is very limited empirical research in New Zealand that relates to the use of talking therapies with Asian communities. There appears to be no research trials investigating the effectiveness of any talking therapy model (for example CBT) or of methods for adapting talking therapies with Asian service users. In New Zealand, we do have a body of expert knowledge from practitioners who work closely with Asian service users. Much of this knowledge has been drawn on in this guide.

# International evidence

### Overview of International Asian Mental Health research

A number of international studies demonstrate that, on average, Asian communities experience better mental health, but that there are key at-risk groups for whom prevalence rates may be higher than in the general population. International research also demonstrates that Asian people are more likely to delay accessing treatment and have overall lower rates of access to health and mental health services. International cross-cultural research demonstrates that providing interventions in ways that are culturally relevant can improve service access, service user satisfaction and treatment outcomes[15].

Research has confirmed that mental illness and addiction needs and preferred interventions differ between Asian ethnic groups, and between migrants and non-migrant Asian communities living in Western countries[6]. Thus averages for the Asian population as a whole will have limited application for service and policy development, as they prevent identification of the various needs within the distinct communities[21,46].

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4  For further discussion on the utility of the term 'Asian' please refer to the issues and options paper: The use of the term 'Asian' in New Zealand and implications for research, policy development and community engagement.[66].

TALKING THERAPIES FOR ASIAN PEOPLE

### Talking therapies international evidence

International research on the use of talking therapies includes a number of controlled studies demonstrating the efficacy of CBT for Asian groups. Research has also investigated the efficacy of family therapy and of one bibliotherapy programme for Asian populations.

The bulk of the literature and recommendations focuses on expert opinion based on experience, which has not necessarily been verified by empirical research. Recommendations on how to engage with Asian service users have been made in academic journals and books on the basis of therapist and service user feedback.

Various recommendations have been developed for adapting talking therapies to be more culturally relevant for Asian and other ethnic groups[1, 67]. Many of these models are based on expert opinion, with limited work done to specifically assess the impact of each recommendation on the quality or effectiveness of therapy.

## Gaps in knowledge and evidence base

In general, there is very little empirical research from New Zealand or overseas that tests the effectiveness of applying recommendations for talking therapies to Asian communities. A comprehensive search of the English language literature located very few studies that report empirical outcomes evidence on the effectiveness of talking therapies for responding to mental health, addiction or other life stressors among Asian service users.

International and New Zealand research on Asian migrant communities has focused mainly on Chinese and South Asian communities and there is less information on the specific needs of other Asian community groups[6]. There is also a need for more research on other specific Asian sub-groups who are at high risk of mental illness, such as older people, students, women and refugees[68].

Guidelines on culturally-appropriate service delivery for Asian service users have been developed within the English language literature. However these guides typically focus on a collective Asian grouping or the Chinese population. Few guidelines and recommendations have been developed for other specific Asian ethnic groups within the English language literature[9]. See Appendix B for a list of cross-cultural recommendations developed by Waitemata District Health Board as part of its training programme for working with culturally and linguistically diverse (CALD) communities.

TALKING THERAPIES
FOR ASIAN PEOPLE

# 2. Principles of engagement

The following section outlines principles that can be drawn on to make the delivery of talking therapies more appropriate for people of Asian ethnicity in New Zealand. These came from recommendations from community members, researchers, international experts and research studies. There are no universal guidelines when working with Asian service users, or service users of any culture. Therapists must use their discretion and flexibility in applying these recommendations. In particular, it is important to remember that a number of Asian people in New Zealand may operate within a Western social context and identify to a greater extent with Western values than Eastern values.

To assist engagement with Asian service users a variety of adjustments can be made to how talking therapies are introduced, delivered or completed. Key recommendations are listed below and covered in further detail in this section:

- explore and respect cultural values and experience of distress
- adapt communication styles to fit with service user preferences
- ensure treatment goals fit with the service user's preferences and needs
- use trained interpreters if English language skills are limited and monitor the quality of interpretation
- assess and address any limits in understanding of mental health or the New Zealand mental health system
- broaden assessment
- involve and/or educate families
- draw on the support of the community
- address experiences of stigma.

## Engagement – general

### Explore and respect values and experience of distress

Respect for a person's values, practices and beliefs is an important prerequisite to effective therapeutic engagement. As outlined in *Let's get real* (p. 3) "the values of each service user and of their community are the starting point for all our work"[70]. Furthermore, the Health and Disability Service core standards (2008) outline that "consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs"[68].

Therapists report that a key skill in any cross-cultural work is a therapist's willingness and ability to step into the service user's cultural shoes. To do this, therapists should be curious about the service user's culture, spirituality and beliefs, and be aware of their own values and assumptions about other cultures and spiritual philosophies. Therapists who are not aware of the influence of their own cultural values (particularly the implications of individualism) are more likely to pathologise Asian beliefs and behaviours that are normal in the service user's cultures[71]. Even if therapists and service users are from the same culture, there will still be differences in communication and values to be negotiated[34]. In some cases, individuals from the same country or culture may be more dissimilar than individuals from different

cultures. It is also important to remember that a number of values may apply cross-culturally, for example the need to respect and care for others, and such points of similarity can be used to build rapport and be drawn upon during therapy.

Therapists should demonstrate an interest, understanding and acceptance of each service user's culture, and a willingness to learn about a service user's beliefs, practices, family dynamics and other aspects of their reality[8]. To do this a therapist can use therapy as a learning process, for example by asking "Is this a value in your culture", or discuss points of familiarity with the service user's country or culture and identify areas of agreement in values. Therapists consulted also highlighted that culture can be explored in relatively simple terms, for instance by asking "What would happen in this situation in your country" and "How would people in your country respond to these feelings". Therapists may also want to explore if a gender matched therapist is important for the service user.

As discussed in Section One, some Asian people tend to initially present with physical symptoms rather than psychological symptoms[28]. Research has noted that some people may reject any attempt to attribute their symptoms to psychological causes and in some cases physical symptoms that have no identifying physical causal mechanism do not indicate underlying psychological issues[37].

Exploring concepts of mental illness with people who view the origins of these illnesses in terms of physical or spiritual means can be challenging. The therapists consulted indicated that the starting point for such exploration is to listen to the service user's symptoms and attributions for these symptoms. In discussing symptoms and feelings, indirect references may be useful. For example a therapist may ask "How is your spirit today?" or "How is your heart?", then explore responses with the service user .

Respecting cultural values and experience of distress may require acknowledging physical concerns as legitimate. Many Asian service users believe that emotional symptoms will be remedied if physical symptoms are addressed[67]. Traditional help-seeking strategies in Asian cultures focus on the alleviation of physical symptoms, for example body manipulation and traditional herbal therapies[72]. Targeting physical symptoms in therapeutic goals can help to build greater confidence in the therapist, build acceptance of therapy by the service user and enhance the therapeutic relationship. Particular points to remember are:

- symptoms may sometimes be a somatic representation of emotional distress and these can be directly included as goals of the talking therapy process
- physical symptoms may also have an unrelated biological basis. Practitioners can build trust and confidence from their service user by assisting them to address these by referring them to medical practitioners and continuing to liaise closely with general practitioners.

## Same ethnicity staff can support treatment or your understanding of the issues and cultural context

The therapists consulted indicated that having an ethnically-matched therapist is not critical to effective delivery of talking therapies. Many authors argue that the quality of the alliance is more important than the ethnicity of the therapist[73, 74]. However, therapy delivered by therapists of the same ethnicity may improve the quality of the alliance and the effectiveness and acceptability of therapy. This may be particularly useful if a person identifies strongly with traditional Asian values. Recent research with South Asian communities suggests that having an ethnically matched therapist may be useful for improving clinical outcomes, due to the impact

on the bond between a person and their therapist[75]. Positive outcomes have also been noted for ethnic-specific services in some instances. Some studies note that in ethnic-specific services, people are more likely to continue treatment beyond the first session, while other studies have found ethnic-specific services to be no more effective than mainstream services[76].

If ethnic-specific therapists are available, it can be useful to offer this option to service users, particularly for individuals with traditional values, or where language may be a key issue. In New Zealand, some Asian people are also employed in roles that support therapists to understand cultural concepts, for example as cultural support workers, cultural advisors and cultural competency trainers. New Zealand services that employ ethnic-specific therapists or support workers are listed in the Section Four of this guide.

**Resource:**

- ***Cultural awareness tool for mental health workers in primary care*** [77].
  This book provides guidance to primary care mental health workers about delivering culturally sensitive care. See Section Four of this guide for further information.

## Ensure treatment goals fit with the service user's preferences and needs

Effective goal-setting practices for service users who identify with Asian values include ensuring cultural appropriateness, incorporating short-term goals and encouraging active participation of the service user in goal setting.

Therapists need to ensure goals are culturally appropriate and align with the service user's perceptions and desires for their own situation. It is important for therapists to explore what kind of characteristics and skills the service user needs to develop to function successfully in their social and cultural setting[34]. For example, assertiveness or a focus on personal needs over others may not be adaptive in some traditional Asian social contexts. Culturally-appropriate goals may move beyond a focus on symptoms, to target better functioning in the family or community, or on fulfilling work obligations.

Therapists consulted reported that small, tangible and observable goals can help build motivation, confidence in the benefit of the therapeutic relationship and trust in the therapist. Asian people often focus on immediate and practical goals from therapy, particularly people who identify with Asian cultures that view a focus on emotional distress as indulgent. There is also a strong focus on education and financial attainment and security, particularly for migrant families. Thus it may be useful to:

- focus on a limited number of behaviour changes[8]
- begin discussions by exploring practical concerns[67]
- use approaches that are problem-focused, goal-orientated and directed towards the current symptoms[9]
- offer the service user direct benefits as soon as possible within treatment[52].

An emphasis on active participation in goal setting and on confirmation of goals is important. There is a risk that some Asian service users may accept a goal offered by a therapist because it comes from a person in a position of authority, even if they do not fully agree with or understand the goal. Thus it is important that the service user be asked to explain the goal in their own words. Therapists consulted reported that linking goals with the therapist's and service user's analysis of the situation may help to build understanding and commitment to the goal. It is important to continue to check expectations about preferred goals in subsequent therapy sessions, as these may change as a person develops further understanding about their situation.

## Adapt communication styles to fit with service user preferences

Limited English language may influence the type of therapy used, as well as the techniques and support for delivery of therapy. An appropriately trained interpreter should be used for every person who does not have sufficient English language ability to explain emotional or cognitive experiences. See page 32 and Appendix C for recommendations about using interpreters.

Therapists consulted highlighted that communication styles may differ between Indian, Chinese and other cultures, with resulting implications for how communication and talking therapy can best be approached. Cultural norms about what types of communication and emotional expression are considered appropriate may also differ from New Zealand norms. For example, some Asian cultures value suppression of emotion, humility and the use of non-verbal communication. Other cultures are more direct in their communication, but still prohibit open hostility and anger. It should not be assumed that any person of Asian ethnicity will necessarily follow a particular communication preference. Communication preferences should be explored on an individual basis.

Therapists may want to look out for the following communication behaviours noted by therapists consulted in the development of this guide:
- shying away from direct verbal communication
- indirect communication of distress using cultural idioms or physical explanations
- positive answers and avoiding disagreement to avoid upsetting the therapist[67]
- difficulty labelling and discussing emotional states (some Asian people are not experienced at talking about these[67])
- feelings of incompetence if they cannot answer questions[67]
- avoiding eye contact, as in some cultures looking people directly in the eye can be offensive.

To address these communication needs, therapists consulted for this guide identified a variety of actions:
- monitor non-verbal behaviour – does it communicate further information about the service user's state and is this information consistent with the service user's verbal communication
- use non-verbal communication and reassuring comments to build trust
- check out inconsistencies and potential under-disclosure or inaccurate disclosure due to cultural norms or shame avoidance
- ask the service user to clarify any uncertainties or discrepancies in their communication
- consider using storytelling, parables, third person discussions and culturally rooted proverbs as indirect methods of exploring a service user's situation. These may help the person maintain face and understand their issues on a deeper level
- tailor the balance between direct and indirect exploration of sensitive issues according to the service user's apparent feelings of shame, fear of rejection and concerns about the therapist developing a negative opinion
- carefully word observations and analysis. If using confrontation, this should be gentle and applied only when rapport is already built to avoid feelings that the therapist is disrespectful. For example a therapist might say, "I've noted some discrepancy between how you feel and how you act, for

example [give example]? What are your thoughts about this?"

- structure the level of sophistication of explanations to match the knowledge and understanding of the service user[34]
- video-conferencing facilities have been used in New Zealand and, while not considered ideal, therapists in the consultation of this document consider this method of providing therapy to be superior to no therapy.

## Directive counselling styles

There is debate about the extent to which therapists should use a directive counselling style when working with Asian service users. Directive styles see the counsellor as an expert and responsible for leading the conversation.

Some therapists and research advocates for a directive style of therapy with some Asian groups. Therapists consulted indicated that many Asian cultures promote observance of the wisdom of authority figures and thus may expect to be guided by the therapist. This literature suggests that service users may perceive a therapist as incompetent if they fail to provide active responses or suggestions[67].

Nonetheless, recent New Zealand research suggests that therapists often use indirect approaches, such as open-ended questioning and active listening, in their work with Asian service users[78]. At the same time, therapists reported that techniques such as direct questioning may lead some Asian people to feel ashamed if they do not have the answer to the question. Particularly for Asian people who are highly acculturated to New Zealand society, directive styles may be less appropriate.

## Build service user confidence in your role as a therapist

To build service user confidence it is important to respond to their needs and expectations regarding therapy.

For Asian service users this may mean that it is useful to engage in practical support, particularly in the early stages of therapy. As mentioned, many Asian people are interested in responding to practical needs. Some clinicians consulted have noted that in particular Chinese service users and their families may expect a relatively immediate solution to their concerns.

Some therapists recommend that highlighting tangible benefits, or summarising the results of each session are important for building confidence in therapy. Tangible benefits that can be pointed out to the service user may include a goal that is set, a reduction in their anxiety around an issue, or a new skill that they have acquired. Some therapists indicate that using cue cards that summarise homework tasks or reflections from therapy can be useful, not only for embedding learning, but also to give a service user a firm sense that they have gained something from the therapy session.

To build rapport and trust, the therapists consulted reported that it can also be useful to establish areas of common life experience, for example displaying an interest in the service user's culture, or discussing how people from the practitioner's own culture have similar experiences. To do this, and demonstrate credibility as a therapist, New Zealand therapists have noted that some initial self-disclosure may be useful, particularly when working with Chinese service users. Nonetheless, as with any clinical encounter, it is important that the therapist does not self-disclose unrelated

personal details. Too much self-disclosure may also be viewed as arrogant. The New Zealand consultation panel recommend the following self-disclosure can sometimes be useful and appropriate to establish professional credibility in the first session:

- therapist training or education
- therapist experience, particularly in dealing with the presenting problem
- knowledge about cultural practices
- experience of family life, such as whether or not they have had children
- if in doubt about what to disclose, ask the service user if they have any questions.

Therapists consulted indicated that early assessments can be useful in building trust and confidence in the therapeutic relationship. To limit the risks in making an assessment before issues have been thoroughly explored, the consultation team recommend using phrases such as "…this my impression. But it is too early to be accurate. Please let me know if I am wrong" or "…your issue seems to be similar to a number of other service users. Their issues seem to be…Does this apply to you?"

Once rapport is built, therapists may then begin to discuss therapeutic concepts framed in ways that are culturally appropriate. Therapists consulted suggested that for Chinese, cultural parables may be one possibility for framing such concepts. For example, the Emperor's shoes illustrates that changing yourself may be an easier approach to addressing problems with the world, rather than expecting the world to change for you. In this proverb, the Emperor asks his servants to have all the roads in his kingdom paved with leather. That evening his servant comes to him with a pair of shoes that have the soles covered in leather. The servant says to the Emperor, "Now Emperor, all the roads in your Kingdom will be paved with leather". Some traditional Chinese people reportedly prefer indirect discussions of the problem they are experiencing such as the one noted above.

Therapists suggest that in many cases it may not be necessary to discuss abstract concepts associated with the different therapy modalities. Many modalities can be applied as needed, and as appropriate for the situation of the service user, without a lengthy discussion of the therapeutic concepts. When working with Asian service users it is likely that flexible application of different models of talking therapies will be required.

**Resources:**

- A list of Chinese proverbs and stories is available on the internet and in books. One website that may be useful is Chinese-Cheungyu.com www.chinese-chengyu.com/chengyu-dictionary.

## Use trained interpeters and monitor for discrepancies

Therapists consulted reported that trained interpreters should be used whenever a therapist does not speak the same language or dialect as the service user. Interpretation by friends, family (especially children) and other untrained interpreters is not advised. Interpretation by such non-trained people has been shown to increase the likelihood of miscommunication, with flow-on effects for clinical practice and completion of therapy, and creates ethical issues around confidentiality[79]. See Appendix C for a detailed list of recommendations for working with interpreters.

Members of the New Zealand consultation panel recommend that when using an interpreter therapists should:

- hold an interpreter briefing prior to the clinical session. Such briefings can be used to identify the aim of the session and the type of interpreting

required. Types of interpreting include concurrent (at the same time as a service user group is talking, which is useful in a family session) and consecutive (the interpreter translates when there are gaps in the service user's comments)

- brief the service user on the purpose of the interpreter's presence and on confidentiality issues
- talk to the service user not the interpreter
- monitor for signs that the interpreter's translation does not match the non-verbal signs and the amount of information being conveyed by the service user.

When there is a choice of interpreters, practitioners should give preference to those they have worked with previously and to those who have experience of working with sensitive issues. Therapists should attend training about how to work with interpreters, and likewise interpreters should be trained in interpreting in a mental health or addiction setting.

Training for therapists and interpreters is important because interpretation can limit the effectiveness of skills, such as exploration or rapport building. The inclusion of an interpreter as a third party also introduces additional communication, rapport and transference issues that therapists need to be aware of and be able to respond to. Training for interpreters is important as untrained interpreters have been known to express their own opinions, misinterpret and mis-translate symptoms of mental illness, and damage rapport and therapeutic relationships.

**Resources:**

- ***Refugee health care: A handbook for health professionals***[22]
  Section Three of this book has information about communicating effectively with refugee service users, including how, when and why trained interpreters should be involved in service delivery. It is available for download at www.moh.govt.nz/moh.nsf/49ba80c00757b8804c256673001d 47d0/d85ce7cd090faaa4cc256b050007d7cb?OpenDocument.
- ***Cross-cultural resource for interpreters and mental health practitioners working together in mental health***[80]
  Includes information about the need for interpreter training, common communication errors, and interpreting tips, as well as basic information on mental health, mental health interventions and cultural influences on symptoms. See Section Four of this guide for further information.
- ***Therapies for refugees, asylum seekers and new migrants: Best and promising practice guide for staff working in mental health and addiction services***[16]
  This guide includes a section on recommendations for working with interpreters when delivering talking therapies to refugee, asylum seeker and migrant service users in New Zealand.
- See also Appendix C: CALD recommendations for working with interpreters.

### Assess and address limits to understanding about mental health or the New Zealand mental health system

Therapists consulted indicated that it is important to identify and address gaps in the service user's or their family's knowledge about mental health and the New Zealand mental health system. Key areas of knowledge and understanding to explore and address are discussed in Table 3 below.

### Table 3. Areas of mental health knowledge to explore

| Type of information to discuss or explore | Comments from the New Zealand consultation panel |
|---|---|
| Confidentiality, informed consent and service user rights, including privacy from family members[67] | This is important to dispel misconceptions and fears that others may find out about their visits to a mental health professional. Written confidentiality agreements may also reduce service user concerns around confidentiality. Some New Zealand therapists recommend that service users should not be greeted in public, unless it is agreed otherwise. Particularly when working with Indian teenagers, it is important to communicate the necessity for privacy and trust to their parents. This can help to reduce the likelihood that the parents may become concerned about the lack of information they are receiving and remove their child from therapy. |
| Treatment plan, fees, number of sessions, service user rights, appointment procedures[67] | Therapy and health visits in Asian countries often follow different norms, for example appointments may not be required to see health professionals. |
| Some information about the nature and causes of mental illness [52] | Conveying that illnesses are common and many have a biological basis may help to reduce feelings of shame and stigma. |
| Boundaries around the talking therapies process, their role in deciding goals and communicating concerns about the process[52] | Many Asian people may expect practitioners to take a directive role. However, apply caution when using this therapeutic style. See page 31 for further discussion. |
| What talking therapy is | It may be useful to develop trust and rapport before embarking on detail about Western therapeutic approaches. When these approaches are discussed, care should be taken to emphasise how these processes can work, and whether they have been used by people from the person's home culture previously. |

**Resources:**
- Information sheets
  - Cognitive behavioural therapy information sheet available in Chinese www.rcpsych.ac.uk/PDF/cpif2.pdf.
  - What is talking therapy? information sheet available in Chinese www.mentalhealth.org.nz/kaixinxingdong/file/downloads/pdf/file_271.pdf.
- **Kai Xin Xing Dong website**
  This website contains culturally appropriate mental health resources for service users and community members. It also includes a literature review entitled *Chinese Attitudes to Mental Illness* and information on organisations, help lines, free workshops, and Chinese support groups to inform therapists' referrals.
  See www.mentalhealth.org.nz/kaixinxingdong/page/5-Home.

### Information to support effective termination of therapy

Termination of therapy may lead to a sense of fear and abandonment for the service user. Some New Zealand therapists suggest that Asian service users may develop reliance on, or familial-like perceptions of, therapists. However, a fear of abandonment can occur for people from any culture. Providing information about the nature of the therapeutic process and establishing alternative support can increase the service user's readiness to end a course of therapy. The New Zealand consultation panel recommended the following techniques:

- discuss the limits on therapy sessions early on, to give the service user time to prepare
- increase the interval between follow-up sessions towards the end of the therapy course, particularly for long-term therapy relationships
- assure service users about their ability to access therapy again
- some therapists do allow email communication following therapy termination, however there are confidentiality issues in doing so
- refer the service user to another source of support, for example general practitioners and telephone services such as Lifeline
- arrange booster sessions if possible to consolidate the learning from therapy and confirm the therapy's success in achieving long-term change
- therapists may need to negotiate with their organisation the provision of a longer course of therapy to achieve positive outcomes and independence from the therapist.

## Engagement – assessment issues

Each Asian service user brings a unique set of values, beliefs and service needs to the therapy session. These in turn influence the type of communication, goals, recommendations and talking therapy models that are likely to be most effective for that individual. Therapists consulted reported that assessment should go beyond a focus on symptoms to explore some or all of the following:

- symptoms of mental illness as the service user experiences them (mental and physical)
- the service user's perception of the cause of their symptoms
- migration history[9]
- views and knowledge about traditional and clinical therapy
- views about appropriate help-seeking behaviour
- family and other social support network
- current family and social functioning
- goals for therapy
- past trauma and grief
- cultural values[10]
- religious values[10].

It is important to explore a service user's own perceptions of their symptoms. Subjective understandings and contextual information is useful for developing treatment strategies that service users will be motivated to engage with. Due to the collectivist orientations of many Asian people, asking about family may be useful for building rapport and understanding a service user's way of life.

The New Zealand consultation panel recommend that a semi-structured approach to assessment may be most appropriate to balance the need for comprehensive assessment with the service user's freedom to discuss issues that are most important to them. Some Asian people are not experienced in talking about emotional states and may find it difficult to label and discuss these[67]. A preference for avoiding shame can also limit willingness to self-disclose symptoms of mental illness, addiction or problem gambling. Thus careful use of direct questioning may be helpful to uncover further symptoms[7].

Enquiring about cultural and religious values is important[10]. Research from the United Kingdom notes that South Asian men were seldom questioned about their cultural or religious views as part of assessment. However, they felt that this would have aided therapist understanding of their experience and symptoms[10]. For some Asian people the spiritual realm is seen as critically intertwined with the mind and body (compared with other Asian world views that focus on the mind–body duality).

Therapists consulted indicated that Asian service users may be unlikely to raise sexual issues, due to feelings of shame and embarrassment. Nonetheless, there are correlations between mental health issues and experiences of sexual or other forms of abuse. Sexual issues may need to be explored with care and sensitivity. Service users may not feel ready to raise these issues until later sessions, once rapport has been firmly established.

### Assessment and outcome measures

Service users are likely to report positive change and satisfaction with therapy, as a mark of respect for a therapist. As a result, consulted therapists indicated that employing concurrent outcomes can be useful for assessing the reliability of a service user's assessment. Nonetheless, in many instances it may be possible to undertake assessments and outcome evaluations without using these formal tests.

Some work has been done to adapt models of assessment, and translate assessment tests developed in the West, so that they are sensitive to the experience of mental illness in Asian communities. Assessment tests commonly used with Asian service users include the General Health Questionnaire (GHQ), Social Functioning Health Questionnaire (SF-36), Beck Depression Inventory and the Beck Anxiety Inventory. These tests may carry limitations in their ability to pick up symptoms of distress with Asian service users. However, they may be necessary and useful for particular presentations or service users, or for gaining access to services.

# Involving families

### Importance of family involvement

For many Asian people, family plays a key role in help-seeking behaviours and mental well-being. In both East Asian and South Asian cultures, families are central to a person's self-concept and can be highly influential in decision-making and life choices[8, 52]. Asian people are more likely to live and operate as a family unit. For example, research from the United States indicates that Asian mental health service users are more likely to live with their family compared with Caucasian family members[53]. In Indian cultures, formal and hierarchical family structures are common, as are strict gender roles in which females often defer to their husband's wishes[8]. Parents may use guilt and shame to influence their children's behaviour[8].

Japanese people may have a preference to address the parent–child relationship, before addressing conflict in marital relationships or other relationships[34]. Fathers and authority figures may have a strong role in help-seeking decisions, particularly in cultures that value hierarchical family interactions. Despite these generalisations, every Asian family is different and it is important to work and adapt therapy in line with the unique needs of each family.

Where possible, therapists should develop a positive working relationship with the service user's family. Many Asian people expect family members to be involved in their interactions with health providers[7]. However, once again it should not be assumed that family involvement is preferred by all service users.

## Recommendations for working with families

When working with Asian people it is often useful to convey possible therapeutic benefits to the family decision-makers, as well as the service user[9]. With the service user's permission, involving and considering family members in treatment planning can help to get family buy-in for the treatment process and avoid premature termination of therapy[9].

It is important to get a sense of family dynamics, beliefs and goals for therapy prior to full family engagement. Therapists should ask the service user if they would like the family member to be involved and explore whether family members have similar ideas about what they perceive as important outcomes for therapy. The New Zealand consultation panel recommended that if the goals of the service user and family member are similar, then family members can be engaged. Where goals are different, mediation between family members or gaining involvement from extended family members may be useful. Inadequate preparation increases the likelihood of direct confrontation, damaging the therapeutic process and risking termination of treatment.

In delivering therapy to Asian people, therapists need to be aware of and work sensitively with the dynamics and values associated with family concepts in Asian cultures. Therapists should be careful to demonstrate respect for family members in communications with them. Respectful engagement includes addressing adult family members in formal terms and, if present, addressing the head of the family first. The New Zealand consultation panel recommend that elder family members or heads of family should not be challenged without adequate preparation. It is also important to be cautious in challenging beliefs about gender roles, particularly in Indian communities. This may be interpreted as a lack of understanding or a direct challenge to religious beliefs and can lead to service user disengagement from the therapist and treatment[8].

Family ties and obligations can be used as a mechanism and motivator for change. Goals of therapy can include improving family functioning, or improving the ability of the service user to contribute to their family. The value placed on children and good parenting can also be a key motivator. For example, therapy for couple issues can be reframed as improving parenting. Role plays, or using examples of a service user's situation in third party terms and asking family members how they would respond, may be useful techniques for exploring and resolving disagreements.

*Let's get real* emphasises the importance of involving family. The Working with Families skill states that (p. 4), "every person working in a mental health and addiction treatment service encourages and supports families/whānau to participate in the recovery of service users and ensures that families/whānau, including the children of service users, have access to information, education and support."[69]

# Support of community

## Importance of social support

Social support is known to be an important protective factor in mental well-being across cultures. For example, research indicates that a Chinese person will often choose to seek help from their social network, and engage in self-help strategies[7]. The therapists consulted indicated that where an Asian person chooses to engage in Western or traditional therapies, they will often choose a therapy based on word of mouth, either that a particular therapist is good or that a type of therapy is useful.

## Types of social support

Asian people may have vastly different levels of social support depending on their ethnicity, location, employment, education, transport and language resources. For Asian people from a refugee or migrant background, social networks may be limited when family members are overseas, or if they have limited transport options or English language skills. An absence of social support may be a particular issue for elderly people who may have limited social contact through education and employment activities.

Sources of social support in Asian communities include (but are not limited to):
- immediate family
- extended family
- colleagues and friends
- churches, mosques, temples
- community events
- community activities and education groups, for example night-classes.

Assessment of a person's functioning and treatment needs should include the support the person has available to them from family, church or temple, and community groups. Where there is limited support, therapists can work with service users to establish new connections[9].

## Spiritual activities as social support

Spiritual activities may be a particularly important form of social support for some people. Many Asian people perceive that spiritual beliefs and practices may help recovery, coping and prevention of mental illness by raising energy, supporting relaxation and achieving positive relationships with themselves and a higher power[56]. Some studies have also noted correlations between spiritual practices and lower rates of depression in Muslim people, following hospitalisation for self-harm, across a range of countries[56].

Drawing on community support is an example of applying one of the seven *Let's get real* skills: working within communities. This skill states that "every person working in a mental health and addiction treatment service recognises that service users and their families/whanau are part of a wider community[69] (p. 4).

# Stigma

## Origins of stigma

Mental illness carries with it a lot of stigma and discrimination in Asian cultures. Stigma and discrimination can be directed from others, or may be self-directed, as shame for not fulfilling family obligations or for bringing shame on other family members. Shame, stigma and discrimination are key aspects of the experience of mental illness for many Asian service users. For example, seeing a mental health professional may be seen to indicate the presence of serious mental illness and many Asian people are concerned that this may bring collective shame on the family. For some people simply admitting negative emotions can be seen as bringing shame on a family.

Shame, as well as stigma and discrimination can have a large impact on a person's well-being, and contribute to further feelings of isolation and hopelessness.

## Strategies for reducing shame

The consultation panel recommend that developing trust and confidence during the first session is important for reducing barriers that shame can cause in therapeutic engagement. A range of strategies for therapeutic engagement to reduce shame have been recommended, including:

- paying respect to the service user
- demonstrating acceptance for the service user by creating a warm, open and supportive atmosphere (verbally and non-verballing)
- avoiding intense personal questioning in the first session
- focusing on practical help that does not place emphasise on the mind (focussing on the mind may prime feelings of stigma or reluctance to engage in therapy)
- normalising the problems by sharing instances where others have been in the same situation (and emphasising others have recovered from these)
- reinforcing the confidentiality of therapy
- positively reframing circumstances, and providing feedback and compliments are important for dispelling embarrassment and shame, and facilitating continued interaction with therapy[9]
- focusing on the problem as an independent concept, rather than focusing on aspects of the service user as problematic
- providing service users with information about the biological basis of depression and other forms of mental illness[7].

Therapists consulted highlighted that it is important that therapists remain aware of their own opinions, in order to identify any points of over-identification with the service user, ignorance of the service users' perspective, or negative feelings towards the service user or their behaviours.

Acknowledging and addressing stigma and discrimination is as example one of the seven *Let's get real* skills: challenging stigma and discrimination. This skill states that "every person working in a mental health and addiction treatment service uses strategies to challenge stigma and discrimination and provides a valued place for service users[69] (p. 4).

**Resource:**

- ***Fighting shadows: Self-stigma and mental illness: Whawhai atu te whakama hihira***[62]
  This report includes information about self-stigma and includes a section on Chinese perspectives and experiences of self-stigma. See www.likeminds.org.nz/file/downloads/pdf/file_44.pdf.

# Medication

Clear and open communication between the therapist and the service user is important for facilitating effective use of medication. Therapists should clearly explain what the medication is, how it should be taken, and the importance of following the full course of medication. This should be explained to family members, as well as service users where possible. Some clinicians have noted some Asian service users may stop taking medications when symptoms begin to decrease. Thus therapists should convey the importance of sustaining a course of medication until consultation with a medical professional.

Therapists should be particularly attentive to monitoring signs of medication side-effects in Asian service users. Therapists consulted reported that some Asian people may not freely disclose whether they are experiencing side-effects. Therefore it is important for therapists to actively enquire about a service user's experience of medication, as they may discontinue medication if side effects are not addressed. Anecdotally therapists report that side-effects may be more severe for some Asian people, possibly due to the small body mass of a number of Asian people. Some New Zealand health professionals change the type of medications they prescribe to Asian service users in response to side-effects, while others may continue with the same medication at a lower dosage.

It is important for therapists to communicate to service users that medications may interact with traditional Chinese medicines and alternative medications. If medications are being prescribed, the use of alternative medications should be explored. Ultimately the choice of the therapy belongs to the service user and the role of a therapist is to enable the service user to make an informed choice.

# Relationship to *Let's get real*

Throughout engagement in any talking therapy it is important to remember the attitudes, skills and values of the Ministry of Health's *Let's get real* framework.

*Let's get real* describes the knowledge, skills and attitudes required to deliver effective mental health and addiction services. This knowledge, skills and attitudes are relevant and applicable to talking therapies work with Asian people. The seven Real Skills include working with service users, working with Maori, working with families/ whānau, working with communities, challenging stigma and discrimination, law, policy and practice, and professional and personal development. In particular, the skill of working with service users highlights the importance of culturally appropriate protocols and practices, and of having knowledge and understanding of the range of evidence-informed therapies and interventions that are available.

The engagement principles outlined in this section align closely with the *Let's get real* value of respecting the diversity of values of service users. This section also emphasises *Let's get real* attitudes, such as being supportive, understanding, open-minded and non-judgemental towards Asian service users and provides knowledge to facilitate the application of such attitudes in practice. For more information on *Let's get real* see www.tepou.co.nz/letsgetreal**.**

# Traditional and complementary therapies

Many Asian people see traditional therapies as valuable and legitimate treatments for the symptoms of mental illness. While there is limited scientific evidence for many of these therapies, there is a great deal of anecdotal evidence for their effectiveness. Furthermore, these traditional therapies can be based on cultural beliefs about the origins of mental illness.

Therapists consulted for this guide recommend the following approach to traditional therapies:

- enquire about any alternative forms of therapy being used by the service user
- display openness to discussing alternative therapies with the service user
- discuss potential risks in variations in quality of traditional therapists and gaps in research evidence
- explore whether advice from traditional therapists conflicts with other health information and the service user's feelings around this
- continue to explore potential for conflict over the course of therapy
- maintain the service user's right to informed choice in their selection of therapy.

Considering a service user's use of traditional medicine can help to avoid negative drug interactions with any herbal medicines, reduce service user confusion, and decrease conflicts in a service user's understanding of mental illness and treatment[81].

## What are traditional therapies?

A range of traditional therapies are used in most Asian countries and by Asian migrants. Typically, traditional medicines focus on prayers and rituals (spiritual healing), herbal plants, and massage or manipulation of bones and body tissues (relaxation techniques). Thus traditional therapies seek to address holistic or spiritual beliefs about the causes, symptoms and nature of mental health[81]. Many of these traditional therapies are widely used across the world as complementary therapies, for example yoga and meditation.

## What do we know about the extent of use?

- Many Asian people use multiple sources of therapies concurrently.
- Traditional medicines are used by some members of New Zealand's Asian communities, both as a means of achieving wellness on a daily basis, and as a response to symptoms associated with mental illness.
- Research from other countries suggests that traditional medicine is typically more popular with overseas-born Asian migrants[82] and the elderly[81], compared with young Asian people or Asian people born outside of Asia.
- Different traditional therapies are common in different cultures. For instance, herbal medicine is common in Chinese cultures, whereas yoga and meditation practices may be more common in Indian and other South Asian cultures.
- Many aspects of traditional therapies are increasingly being employed as stress relief in mainstream Western cultures. For example, mindfulness, guided imagery, yoga, tai chi, massage therapy, acupuncture and shiatsu.
- Homeopathy is an alternate treatment often used in Indian communities. Yoga, tai chi and other group wellbeing activities are particularly popular with a range of Asian ethnic groups.

## Research evidence

Therapists are often concerned that the use of traditional therapies may limit willingness and interest in seeking or complying with Western forms of therapy. However, there is research to suggest that Asian people who access traditional therapies are also more likely to access Western therapies[83].

It has also been noted that many Asian people may not typically disclose information about their use of traditional medicines[83], and thus therapists may need to specifically ask what other practices a service user is using to address their symptoms.

# Common types of traditional and alternative therapies in Asian communities

## Traditional Chinese herbal medicine

Traditional Chinese herbal medicine involves using herbs to balance extremes of heat, cold, bodily state and life energies. Traditional Chinese philosophies suggest that imbalances in heat and energy are related to the onset of mental and physical illness. Herbal medicines are used to treat both mental and physical symptoms, and in China herbal medicine is also often involved in drug detoxification practices[84].

## Shamanism

Shamanism involves using a spiritual healer to communicate with the spiritual world to aid healing[34]. The therapy is often sought when people perceive an illness to be associated with spirits, loss of soul or violation of taboos[34]. Practices include incantation and offerings, often working with a Shaman (spiritual healer) who transports themselves to the spiritual world. Shamanism has been observed in China, South Korea and Japan, and to a lesser extent Taiwan, Tibet and Vietnam. The number or availability of Shaman healers in New Zealand is unknown.

## Ayurveda

This is traditional form of therapy originating in India. Ayurveda translates to "the science of life" and focuses on achieving balances in bodily elements. It employs techniques of exercise, massage, herbal medicines, homeopathy, meditation and yoga to build a healthy metabolic and digestive system.

## Fortunetelling

Oracles (such as the *I Ching*) are used to predict the future, focusing on the balance of vital forces and harmony with the universe. It aims to create a state of harmony with the environment. It assumes that life is predetermined, with some room to adjust one's fate[34]. The fortuneteller engages in collecting information about the person, and interpreting this information to make predictions about the future.

## Morita therapy

Morita therapy is a form of therapy based on Eastern traditions and used as a therapy for treating anxiety. The therapy consists of seven days of isolated bed rest, followed by occupational therapy and then reintegration into a person's job and family. Morita therapy differs from Western forms of therapy in that it focuses on collective rather than individualistic well-being, and acceptance of reality and feelings as they are[85]. Its therapeutic basis and techniques are linked to Zen Buddhism[85]. At best, there is tentative evidence for its efficacy for improving concepts of well-being.

While originating in Asia, the following therapies are now commonly used in Western populations.

## Acupuncture

Acupuncture involves the insertion of filiform needles into targeted parts of a person's body. Acupuncture points are situated along what Chinese consider to be the meridians of body energy. Acupuncture is now widely adopted in a range of Western countries. It is a common part of traditional Chinese medicine and is increasingly used as part of Western alternative treatment approaches. There is some evidence for its usefulness in treating depression. However, many studies on it have not been well-designed. There is general agreement amongst practitioners that acupuncture is safe when undertaken by well-trained practitioners using sterile needles[54].

## Yoga

Yoga was originally developed by Indian monks, and is now increasingly used in other Asian and western countries. Yoga involves physical movement techniques, refocusing of energy, breathing, concentration and meditation techniques, and calming of the mind. There are many types of yoga. Traditional forms of yoga have a strong spiritual and meditation component. Yoga is considered particularly useful in reducing stress and anxiety, and improving self-awareness and self-control[34].

## Meditation

The aim of meditation is to take a person beyond a state of reflexive thinking into a sensation of relaxation or heightened awareness. Meditation aims to reduce stress and improve self-development. A variety of forms have arisen from different religious traditions, including yoga (above) and qigong (a Chinese form of meditation). Some evidence exists for its effectiveness at improving emotional well-being and reducing stress in people with physical illness[86]. A variety of forms of meditation are used in a range of Asian and Western countries.

Tai chi, feng shui and the I Ching divination guide are Eastern practices that may also be considered forms of traditional therapy.

**Resources:**

- ***Relaxation techniques for stress relief***[87]
  This guide provides examples of Asian traditional therapies applied in Western contexts as approaches for relieving stress. See http://helpguide.org/mental/stress_relief_meditation_yoga_relaxation.htm

- **Culture and psychotherapy: Review and practical guidelines**[34]
  This article provides further details on a range of traditional practices.

TALKING THERAPIES
FOR ASIAN PEOPLE
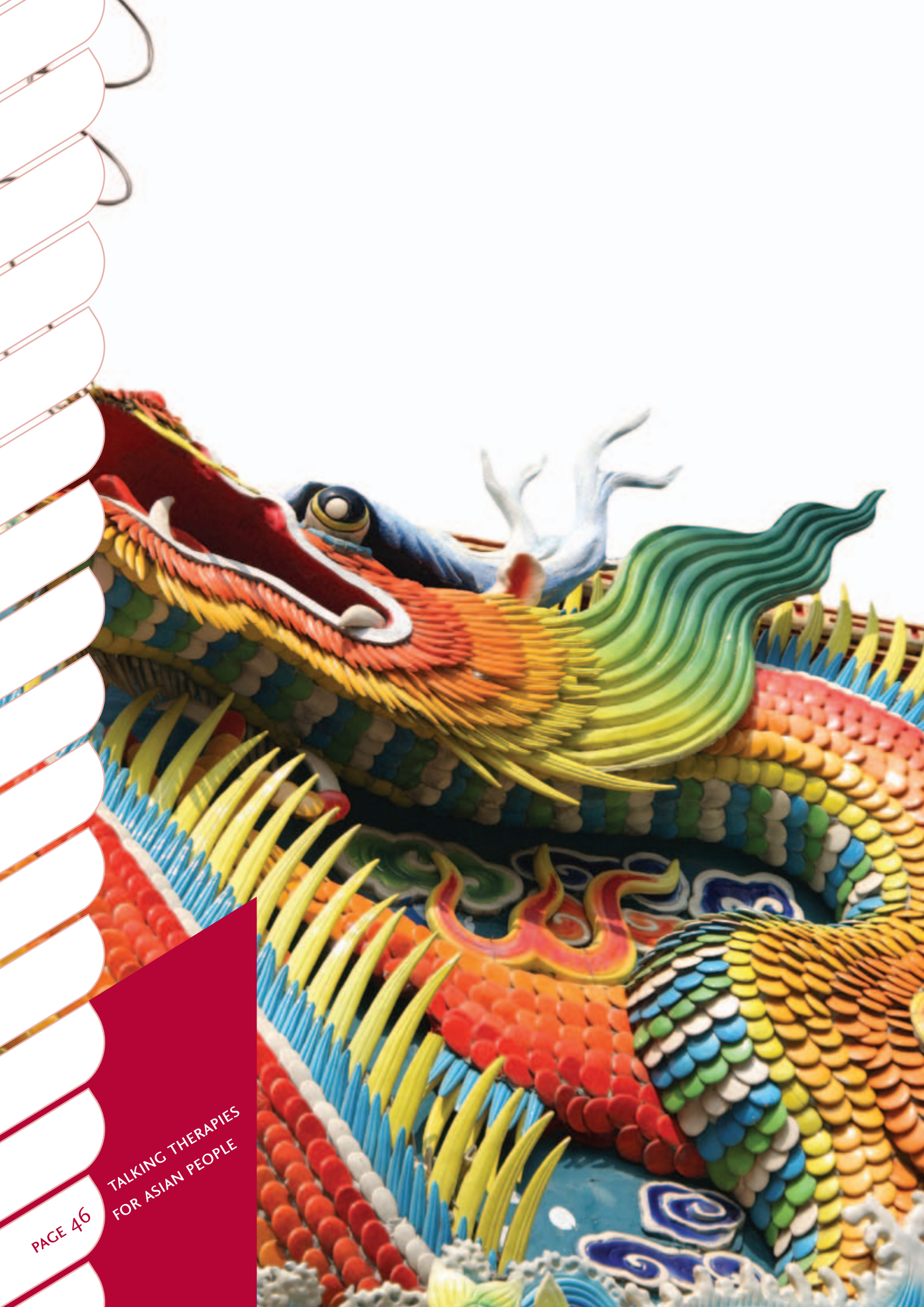
# 3. The therapies

A key challenge for therapists working with Asian communities is how to balance the role of evidence-based therapy with culturally competent practice[13]. Many experts argue that the content of a talking therapy session can be adapted to be more appropriate for particular ethnic groups, while maintaining the theory of change, basic procedures and key theoretical constructs of each type of therapy. It is important to remember that, as with any population, no one model will fit all service users. The cultural world views outlined on page 19 should be drawn upon when applying and adapting therapy for an individual Asian service user.

## How to choose what type of therapy is most appropriate

The effectiveness of most talking therapies have not been tested with Asian communities. Hence, the recommendations in this guide are based on expert opinion. When choosing a type of talking therapy, it is important to consider the following:

- the service user's symptoms, life situation and status
- what problem-solving strategies are familiar for the service user, for example practical approaches versus discussion of the problem
- the service user's psychological orientation and motivation
- willingness and readiness to change
- willingness of family members to take part
- language skills, as limited English language skills can make some types of therapy more difficult
- acculturation or level of identification with Western and Asian values.

It is crucial to build rapport before introducing a particular model of therapy. Therapists consulted report that, in many cases, an explicit explanation of the model being used is not necessary. Therapists must have flexibility to adjust the models as needed, and reframe explanations about the model using culturally relevant concepts. Flexible approaches may involve using several models according to the stage of the service user's progress. For example, using motivational interviewing to build commitment to goals, then using CBT to work on adapting thoughts to improve emotional and behavioral symptoms.

Therapists from the consultation panel have in some instances adapted Western talking therapies to be more appropriate for Asian service users by:

- integrating traditional faith and philosophies with the therapies, for example Taoism and CBT
- using mindfulness training
- flexibly moving between different models of therapy
- reframing therapeutic terms using culturally relevant concepts.

# Overview of therapies

## Table 4. Overview of the evidence for different therapies

| Therapy | For treatment of | Research evidence | Expert opinion |
|---|---|---|---|
| Acceptance and commitment therapy | Anxiety and depression | Tentative evidence in Western population | Occasionally used in New Zealand. Similarities between this therapy and some Asian philosophies may enhance applicability, particularly for Indian service users |
| Bibliotherapy | Mild levels of a range of disorders | Some evidence in Western populations. One programme demonstrated positive outcome in Taiwan | Seldom used in New Zealand. May be difficult to locate appropriate sources for working with Asian people who do not speak English, or who align strongly with traditional Asian world views |
| Cognitive behaviour therapy (CBT) | Depression, anxiety, addiction, eating disorders, problem gambling, post-traumatic stress disorder, trauma issues | A range of evidence in Western populations. Demonstrated improved outcomes relative to no treatment in a range of Asian communities | Very commonly used in New Zealand with Asian service users. Considered useful and acceptable. Adaptations may sometimes be useful |
| Computerised cognitive behaviour therapy (CCBT) | Mild anxiety and depression | Growing evidence in Western populations | No known culture-specific programmes |
| Counselling | Depression, anxiety, addiction, life issues | Some evidence in Western populations. No known research noted with Asian populations | Commonly used in New Zealand with Asian service users. Most therapists consider this useful and acceptable with Asian service users |
| Dialectical behaviour therapy | Self-harm behaviour, borderline personality disorder | There is initial evidence from controlled research in Western populations. No known research with Asian populations | Sometimes used in New Zealand. Moderate perceived acceptability and effectiveness for Asian service users |

| Therapy | For treatment of | Research evidence | Expert opinion |
|---|---|---|---|
| Family therapy | Depression, anxiety, addiction, anorexia nervosa, psychosis, life issues | A range of evidence in Western populations. Tentative evidence of improved treatment compliance and symptoms in Asian populations | Commonly used in New Zealand with Asian service users, and in Asian countries. Considered useful and acceptable by Asian therapists |
| Interpersonal psychotherapy | Depression, anxiety, bulimia and a range of other diagnoses and life issues | A range of evidence in Western populations | Occasionally used with Asian service users in New Zealand |
| Motivational interviewing | Addiction, problem gambling, also used in mental health | Some evidence for reducing addiction in Western populations | Widely used in New Zealand with Asian service users |
| Multi-systemic therapy | Problem behaviour in adolescence | Some evidence in Western populations | Rarely used in New Zealand with Asian service users |
| Problem-solving therapy | Depression, anxiety, addiction, life issues | Some evidence in Western populations | Commonly used with Asian service users in New Zealand |
| Psychotherapy | Life issues, depression, anxiety, addiction, post-traumatic stress disorder, abuse, eating disorders, problem gambling | Some evidence in Western populations | Sometimes used with Asian service users in New Zealand |
| Psychotherapy with children | A range of childhood emotional and behavioural disturbances | Some evidence in Western populations | Appears to be rarely used with Asian service users in New Zealand |

# Cognitive behaviour therapy (CBT)

CBT is a form of therapy that aims to adjust thought patterns to create more adaptive emotional and behavioural outcomes. Sessions are highly structured and focus on practical solutions to problems. These may be provided in a group or individual format[88].

## Why this therapy is used

Extensive research has been conducted on the effectiveness of CBT in the general population. Large effect sizes in meta-analyses confirm CBT's average effectiveness for:
- depression (uni-polar)
- generalised anxiety disorder
- panic disorder
- social phobia
- post-traumatic stress disorder
- childhood depressive disorder
- childhood anxiety disorder[89].

Moderate effect sizes have also been found for marital distress, anxiety, childhood somatic disorder and chronic pain[89].

Research suggests the effectiveness of CBT is likely to extend to Asian communities. Research in a variety of Asian communities has demonstrated significant improvements in symptoms of mental illness, including:
- post-natal depression in rural Pakistan[12]
- depression and self-esteem in China[90, 91]
- depression, particularly in combination with the use of anti-depressants, in Japan[92]
- social anxiety disorder in Japan[93]
- post-traumatic stress disorder symptoms in Vietnamese refugees[94].

The structured nature of CBT means that this type of therapy may be simpler to apply with Asian people who have limited English language skills than other types of therapy. Some authors and New Zealand therapists also argue that CBT is well-aligned with preferences some Asian people have for structured, problem-focused, time-limited, educational or skill-building, therapist-directed approaches[67]. However, other aspects of CBT, such as changing thoughts and behaviour may be incongruent with some Asian philosophies that promote tolerance and acceptance of hardship[95]. CBT is widely used in Asian countries including Taiwan, China, Hong Kong, India and Pakistan, as well as in Western countries in working with Asian service users. In New Zealand, according to the therapists consulted, CBT is one of the most common types of talking therapy applied with Asian service users. Therapists report it to be highly useful and acceptable with Asian service users.

### Group CBT

Some research suggests that group CBT is as effective with some Asian communities as it is with Western communities. A study of group therapy for Japanese people with social anxiety noted similar levels of improvement in self-reported and therapist-reported symptoms of anxiety, as have been noted in Western populations[93]. The

study also showed that group therapy was relatively acceptable with Japanese communities, with only a 12 per cent drop-out rate[93]. Research on the use of group CBT with Chinese migrants in Canada noted that Chinese service users may be cautious of group therapy sessions and be reluctant to disclose personal issues. However, overall the Chinese service users liked the groups sessions and wished for more sessions at the end of treatment[90].

## Possible adaptations for Asian people

A range of guidelines and recommendations have been developed for cross-cultural and Asian-specific adaptations of CBT[67, 96]. Cultural modifications of CBT include alterations in the terminology used to describe the CBT techniques and inclusion of cultural concepts in the therapeutic content[11]. Many of these recommendations are covered in the Section Two of this guide, as they are likely to be applicable across multiple types of therapy. Adaptations have been recommended to make CBT content more relevant to Asian values (see the section on possible adaptations for Asian people below). However, adaptations may remove aspects of the therapy that contribute to its effectiveness[13]. While there is evidence that adapted CBT can be effective, there is no research comparing the effectiveness of an adapted CBT with a non-adapted CBT approach[11].

Possible modifications for Asian service users include:
- incorporating Asian values and practices for example, Qi Gong, Tao philosophy and mindfulness
- using culturally appropriate terminology
- emphasising a practical focus, rather than an analytical focus in homework for CBT
- framing assertiveness as adaptive in particular situations (for example, Western contexts), even if it is not in others (traditional and family events)[67]
- recording the goals of therapy in the language of the family, to promote family engagement and understanding.

It is important to consider the values discussed in Table 1 (collectivism, family focus or duty, education and wealth focus, tolerance of hardship, and potential conflict avoidance and emotion regulation) in the delivery of CBT. In particular, a focus on changing behaviours to avoid negative life experiences may conflict with values that suffering is part of life and should be expected. Promotion and education in assertiveness skills may not be useful for some people, as these skills may not apply in traditional Asian relationships or communication situations. Furthermore, a focus on rational thinking and teaching people to seek objective evidence may not align with the spiritual faith of some Asian people.

Some overseas therapists[90] and therapists in New Zealand have also noticed a lack of adherence and negative attitudes towards the homework component of CBT. New Zealand therapists suggest that homework tasks may be more acceptable when they focus on practical goals rather than cognitive processes.

### Taoist cognitive therapy

Taoist cognitive therapy incorporates Taoist philosophies into Western models of cognitive psychotherapy. It incorporates Taoist philosophies of non-intervention (for example, benefit and not harm, strive and not fight, keep quiet and inaction, let nature take its course) into the selection of new behaviours. Taoist cognitive therapy has been widely practiced in China since 1995 for the treatment of anxiety, depression and other disorders. There is evidence for the effectiveness of this type of therapy in reducing symptoms of generalised anxiety disorder, particularly in combination with the use of benzodiazipines[97].

## Counselling

Counselling aims to improve a person's understanding of themselves and their relationships with others, and to identify methods of bringing about positive sustainable change in the person's life[88]. Counselling therapy can employ a range of techniques according to the therapist's training, but typically focuses on talking through issues and developing practical solutions to life stressors. Counselling may be undertaken for a single individual, couples, families or groups.

### Why this therapy is used

The Te Pou adult talking therapies guide reports that counselling can be useful for alcohol, drug, smoking and gambling issues, depression, anxiety, family violence, life changes, relationship issues, sexual abuse and personal development[88].

Limited research has been undertaken into the effectiveness of counselling with Asian communities. Group therapy delivered in a primary care setting generated positive feedback from service uses in China[98].

Counselling techniques are used relatively often with Asian service users in New Zealand's mental health, alcohol, drug and gambling services. Most therapists in the consultation reported that counselling was a highly useful and applicable form of therapy with Asian service users. Some therapists noted that this therapy may be less relevant for some service users, depending on their preferred communication method and problem-solving strategies.

### Possible adaptations for Asian people

Like other techniques, limited English language skills can make counselling difficult to apply. When language differences mean that it may be difficult to talk about an issue in depth, New Zealand therapists report using art, drawing, sand-trays and other tactile methods to explore problems, particularly grief.

Therapists consulted reported that some Asian people have a preference for immediate problem-focused strategies, rather than emotion-focused therapy. If a service user does indicate a preference for a problem-solving approach, then counselling techniques that aim for immediate solutions may be particularly useful.

To develop appropriate solutions and strategies in counselling sessions, exploring the user's preferred problem-solving approach and goals is important. It should not be assumed that a person's preferred problem-solving approach is the achievement of personal happiness, choice or independence. Asian people who hold collectivist world views may be more interested in goals related to harmony, achieving success and fulfilling family duties. Research investigating the value of ethnic-specific therapists

suggests that it is congruence between the service user's and therapist's goals for treatment that is important for making improvements in psychosocial functioning and limiting psychological distress in the therapy session[74].

To enhance counselling's acceptability with traditionally-oriented Asian service users, some therapists consulted suggested that a slight orientation towards directive, advice-giving approaches may be useful. Nonetheless, a directive approach carries a number of risks, and is often not advised as a style of communication in counselling approaches.

# Family therapy

Family therapy refers to therapy that focuses on the relationships and systems of the family. Other forms of talking therapy may involve families, but maintain a focus on the individual. Family therapy typically draws on methods from other therapies, with the aim of improving communication, supporting family strengths and using these as a mechanism for change[88].

## Why this therapy is used

Research with Western participants demonstrates that family therapy can be effective. For example, reviews have noted evidence for its effectiveness in reducing relapse and hospitalisation, improving drug adherence, and some evidence of improved family functioning for service users with schizophrenia[52].

Family therapy has been widely employed in Japanese, Chinese and Indian populations, both in their home countries and in migrant populations[8, 52, 60, 99, 100]. In migrant populations, family therapy may be particularly useful for discussing and addressing conflict in acculturation and values between migrant parents and their children. Therapists consulted reported that family-wide information about the health system and anti-stigma education is likely to be more effective than delivering information only to the service user. Family therapy is considered to be particularly useful for South Asian families, due to their heavy emphasis on the interconnectedness of family members[73] and has also been shown to be useful for families from a range of other Asian cultures.

Very few controlled research studies have investigated the effectiveness of family therapy for Asian service users. There is empirical evidence of family therapy for treating anorexia nervosa in Hong Kong[101], and for improving family knowledge and service user symptoms in China[102].

The New Zealand therapists consulted reported that family therapy is commonly used with Asian service users in New Zealand. It is generally considered to be relevant for Asian service users, as the central focus of many Asian people's lives is their family and interactions with these people. Some therapists have noted that family and couple therapy may not be acceptable for some Asian service users. Possible reasons for this lack of acceptability include family members perceiving that their behaviour is above scrutiny, family members not wanting to talk about their problems with a stranger, and service users wanting to be able to disclose their perspective to an independent person without opportunities for family members to contradict.

### Possible adaptations for Asian people

The strong Asian focus on family and family values means that family therapy can be particularly useful for Asian service users. However, the context of many Asian families means that family therapy needs to be sensitively applied to fit with family dynamics. In particular, therapists have noted that the Western values held by some Asian children and younger people may conflict with traditional views held by parents.

The New Zealand therapists consulted recommend the following possible modifications for Asian service users:

- additional time to build trust and rapport, particularly when challenging family values, hierarchies or gender status
- psycho-education can emphasise the importance of a structured and positive environment for recovery and relapse prevention, and emphasise that family members are not implicated in causing the person's illness[60]
- therapists maintain a neutral stance that does not involve taking sides[101]
- as with other types of therapy, problem-oriented approaches may fit well with the interests of some families. Problem-orientated approaches could include improving family member communication, problem-solving, encouraging service user's independence and social activities
- meeting with a person's family separately, prior to holding family-wide meetings can allow family members to voice their concerns and perspectives, and discuss these prior to the family and service user working with the therapist together[52]
- responding to acculturation differences, and differences in values between parents and children
- consideration of gender concepts and hierarchies. Some therapists have noted male partners may not always believe they have a problem, and it may take some time to work through this and build trust and rapport.

Recommendations for the use of family therapy suggest that honest communication and willingness to discuss and change behaviour is key to the utility of this form of therapy. Thus, family therapy may be most useful for family members who are relatively open to change, and see value in talking therapies as a form of support.

## Problem-solving therapy

Problem-solving therapy is a step-by-step brief psychological intervention, usually lasting four to eight sessions. Problem-solving therapy focuses on identifying issues, and developing approaches to solving these specific issues, as well as building long-term problem-solving skills[88].

### Why this therapy is used

Research with general populations shows that this form of therapy is useful for depression, anxiety, chronic illness, suicidal thoughts and behaviour, behaviour change and personal growth[88].

Few studies of problem-solving therapy appear to have been undertaken with Asian communities. A study with Chinese service users[103] failed to demonstrate improved outcomes from the use of problem-solving therapy, over and above that of usual care.

Despite the absence of research exploring the effectiveness of problem-solving therapy with Asian communities, a problem-solving approach is often advised in therapeutic work with Asian service users[9].

Problem-solving therapy is widely used with Asian service users in New Zealand and almost all therapists consulted rated it as highly acceptable and applicable. In particular, it is applicable for people who prefer to focus on tangible and immediate problems.

### Possible adaptations for Asian people

To deliver problem-solving therapy in a culturally relevant way it may be important to explore and acknowledge that service users may prefer goals such as improved family or collective functioning or the maintenance of family duty, rather than self-promoting goals or independence. As mentioned in Section Two, it is important to ensure and monitor service users' involvement in the problem-solving process.

## Motivational interviewing

Motivational interviewing is a brief counselling-style of therapy. It assists service users to realise and confront attitudes, beliefs and issues that are preventing behaviour change. It draws on a broad range of counselling techniques to assist service users to explore ambivalence, build commitment to change and plan steps to achieve the desired change[104]. Motivational interviewing is flexible for use alongside other forms of therapy. For instance, it can be used to build motivation to address emotional distress or engage in other forms of therapy.

### Why this therapy is used

Motivational interviewing is used to assist people to make health and life changes. It has traditionally been applied in alcohol, drug, smoking and gambling services, and is increasingly used in mental health and general health services in New Zealand. Research with general populations provides some evidence for the effectiveness of motivational interviewing in responding to addiction problems. A recent meta-analysis reported positive effects of motivational interviewing on alcohol, drug and tobacco use[104]. However, the meta-analysis did not report significantly improved outcomes in emotional well-being, eating problems and self-efficacy relative to other forms of treatment[104].

There appears to be no research on the effectiveness of motivational interviewing with Asian service users. A meta-analysis noted cultural differences in the effectiveness of motivational interviewing; samples that included a higher mix of other ethnic groups had better outcomes than studies with high African–American or European populations[104]. The authors of this study propose that motivational interviewing may be particularly useful with non-African–American ethnic groups. However, the meta-analysis did not specifically investigate effectiveness with people of Asian ethnicity.

Motivational interviewing is commonly used with Asian service users accessing addiction services and has also been applied in a range of primary care and mental health settings in New Zealand. Motivational interviewing may be particularly applicable for service users who want a short-term approach, or who are struggling to build commitment to engage in change.

## Possible adaptations for Asian people

Motivational interviewing may be useful for supporting Asian people to build motivation to engage in other forms of therapy. Particularly if a person is reluctant to change aspects of their life that are leading to distress or concern.

A key focus of motivational interviewing is to draw on the service user's intrinsic values and goals to motivate behaviour change. When working with Asian people, this may involve drawing on values and goals that are distinct from the therapist's own values. It is important to develop empathy towards the reasons that service users may be unwilling to make change. Willingness and ability to step into a person's cultural shoes may thus be a particularly important skill when applying motivational interviewing.

Motivational interviewing relies of a strong level of rapport between service users and their therapists[104]. Therefore, motivational interviewing may be a relatively slow process. Ensuring some immediate and tangible results occur may assist people who display a lack of confidence in the speed of therapy. A final point to consider is that motivational interviewing requires the service user to lead most of the discussion and this may not fit with people who expect a therapist-driven approach to problem-solving. If engagement is achieved, the service-user led focus of motivational interviewing may increase the likelihood that therapy will work towards culturally appropriate goals. The process may also help people to build useful problem-solving skills and self-confidence.

# Less commonly used talking therapies

## Dialectical behaviour therapy

Dialectical behaviour therapy aims to improve interpersonal, self-regulation and distress tolerance skills by integrating behaviour strategies and mindfulness practices[105]. The dialectical aspect of the therapy refers to its focus on validating the service user's acceptance of themselves as they are, whilst creating motivation for change[105]. Dialectical behaviour therapy is a relatively new form of therapy, designed for use with people diagnosed with borderline personality disorder for which other modes of therapy have had little success. Dialectical behaviour therapy delivered in outpatient settings typically involves individual psychotherapy, group skills training, and telephone counselling[105].

### Why this therapy is used

There are promising results for the effectiveness of dialectical behaviour therapy in reducing self-harming behaviours in people with borderline personality disorders[106]. However, this form of therapy is relatively new and there are only limited controlled studies of its effectiveness.

The highly structured nature of dialectical behaviour therapy, and its incorporation of mindfulness concepts and distress tolerance aligns with some traditional Asian meditation and faith practices. While aspects of the therapy may be particularly relevant for Asian service users, there appears to be no research testing the effectiveness of dialectical behaviour therapy with Asian people.

The consultation panel were less likely to use this form of therapy with Asian service users, relative to many other therapeutic models. This does not necessarily suggest that dialectical behaviour therapy is not appropriate for Asian service users, as it is likely that few of the consulted therapists were trained in the therapy. Anecdotally, the limited number of therapists trained in dialectical behaviour therapy and the high resource costs of the therapy are thought to be related to its infrequent use across a range of population groups in New Zealand.

### Possible adaptations for Asian people

This therapy may support Asian people to develop tolerance of hardship and regulate emotions, feelings and behaviour; skills that are valued in some Asian cultures. Mindfulness practices may be relatively familiar to Asian service users from a range of cultures, and thus this may help to increase the acceptability of this form of therapy with Asian service users. Trust and information about the value of group sessions may be useful to help dispel any fears around stigma and confidentiality.

## Acceptance and commitment therapy

Acceptance and commitment therapy uses strategies of mindfulness, acceptance, commitment and behavior change to increase cognitive flexibility. Acceptance and commitment therapy teaches people to notice their thoughts, feelings and sensations, and in this way differs from other forms of therapy that aim to change such thoughts and feelings. Service users are encouraged to use the knowledge gained from noticing thoughts, feelings and sensations to get more out of activities that they value.

### Why this therapy is used

There is promising evidence for the effectiveness of acceptance and commitment therapy. In a recent meta-analytic review, the therapy was found to be more useful than no treatment, or treatment as usual, for a variety of mental health conditions, such as psychosis, and physical conditions, such as chronic pain. Evidence was weakest for anxiety and depression, where it was not superior to control conditions. Overall, the meta-analysis concluded that acceptance and commitment therapy does not appear to be more effective than other established treatments, such as CBT, cognitive therapy, problem-solving and systematic de-sensitisation[107].

As with dialectical behaviour therapy, the inclusion of mindfulness may make this form of therapy particularly relevant for Asian service users. Furthermore, the philosophy behind acceptance and commitment therapy argues that human suffering is an inevitable part of existence and should be tolerated[108]. This fits well with Buddhist and Hindu faiths and other Asian traditions that value tolerance of distress (acceptance). Despite these predictions, no studies have been noted that specifically test the effectiveness of this type of therapy with Asian communities.

At least five therapists from the consultation panel have used this type of therapy with Asian service users in New Zealand. These therapists report that they have found it to be acceptable and applicable in most instances, with particular relevance noted for Indian communities.

### Possible adaptations for Asian people

Research investigating the impact of acceptance and commitment therapy on outcomes for Asian people is not available and the current evidence with general populations is tentative for anxiety and depression conditions.

Some Asian service users may not have much experience identifying and discussing strong emotions and feelings[67], and this part of the acceptance and commitment therapy programme may need additional time with some Asian service users.

## Psychotherapy

Psychotherapy refers to a range of techniques that can be used to treat emotional and mental health issues. Psychotherapy is sometimes used to refer to a wide range of talking therapies. However, in this discussion it refers primarily to psychodynamic psychotherapy, which typically involves analysis of the impact of previous life events and the influence of the unconscious on current behaviour and thoughts.

Psychotherapy techniques may include experiential relationship building, communication and behaviour change, and can be used in an individual or a group setting[88].

### Why this therapy is used

Psychotherapy is generally used to address emotional issues that have built up over many years. Therapeutic outcomes are enhanced by the quality of the therapeutic relationship. While there is some evidence for its effectiveness with Western communities, there is less research investigating its impact on outcomes for Asian service users.

This therapy is sometimes used with Asian service users in New Zealand. Therapists in the consultation panel for this guide considered it to have moderate applicability and acceptability with Asian communities. As with any population group, psychodynamic therapy is likely to fit well with the preferred coping strategies of some Asian service users, and less well with others. For example, some people want to focus on previous life events in responding to current issues, whereas other people may want to focus on problem-solving the immediate issue.

### Possible adaptations for Asian people

The New Zealand therapists consulted reported mixed views about whether this form of therapy was acceptable and applicable with Asian service users. Some therapists noted that psychodynamic psychotherapy has been well accepted by their clients, especially when integrated with other therapy approaches. Other therapists report that the majority of their Asian service users prefer pragmatic, problem-oriented and present-focused therapies.

As with all therapies, it is important to consider whether the service user's self-concept and goals may be highly interdependent with their family or community. Some Asian service users will place a high value on education, wealth, family duty and conflict avoidance, and this may differ from the therapist's own values.

## Interpersonal psychotherapy

Interpersonal psychotherapy focuses on interpersonal interactions and a person's symptoms of distress[88]. Interpersonal psychotherapy draws on psychodynamic psychotherapy models that focus on exploring expressions of emotion, recurring patterns of emotions, thoughts, behaviour and events, discussion of relationships and past experiences[109].

Interpersonal psychotherapy is considered most useful when relationships or social roles are central to the distress experienced by a service user. Interpersonal psychotherapy is typically a short-term approach and thus only one to two problem areas are targeted. The short-term nature of the therapy is one of the central features that distinguishes it from other forms of therapy.

### Why this therapy is used

The therapy aims to improve the relationships and social and interpersonal roles of the service user. There is evidence for its effectiveness in addressing depression, anxiety, anorexia nervosa and relationship issues in general populations[88]. There appears to be no research on the effectiveness of interpersonal psychotherapy with Asian service users. Consultation with a selection of New Zealand therapists suggests that it is rarely used with Asian service users in New Zealand. However, many Asian people may be open to the short-term nature of the therapy.

### Possible adaptations for Asian people

Interpersonal interactions may be particularly relevant for exploring distress with Asian service users. In doing so, it is important that therapists are open to exploring cultural family dynamics, such as family duty versus independence, structured and formal versus informal nature of relationships, value differences relating to acculturation and gender roles.

Research with general populations suggests that interpersonal psychotherapy is most useful when a service user is committed to the therapy before starting treatment. Confidence in the therapist has also been linked to better outcomes from interpersonal psychotherapy.

Interpersonal psychotherapy relies on the service user's ability to communicate about their feelings, relationships and experiences. Therapists in New Zealand report using art, drawing, sand-trays and other tactile methods to explore problems, particularly grief, when language difficulties may inhibit in-depth discussion of an issue.

## Bibliotherapy

Bibliotherapy involves the use of books, printed material, audio tapes, play scripts, pamphlets and other resources such as self-help materials for personal growth[88]. Therapists can prescribe the use of these tools, and service users and community members may also personally seek them out for purchase.

### Why this therapy is used

Evidence conducted in Western populations indicates that bibliotherapy is useful for mild to moderate depression[110]. There is also evidence to support the use of bibliotherapy with anxiety disorders, self-harm, panic disorder[111], obsessive compulsive behaviour, personal development, managing long-term illness, and helping children and young people with issues like bullying and divorce[88]. There is limited evidence of its effectiveness with alcoholism and few studies with more clinically severe populations[111].

Taiwanese research into the use of a self-help book has noted improvements in depression relative to wait-list control groups, with further symptom reduction at the three-month follow up[110]. The Chinese participants reported appreciating the convenience of the book, not having to talk to others who may not understand their perspectives, and the provision of well-organised information and multiple strategies for changing negative thoughts[110]. No further research relating to self-help resources for Asian service users was able to be located in the English language research literature.

Bibliotherapy may be useful for people who prefer to engage in self-help, rather than seeking support from others.

Bibliotherapy appears to be seldom used with Asian services users by the therapists consulted for this guide. These therapists rate it has having moderate applicability and acceptability for Asian service users.

### Possible adaptations for Asian people

Based on research with general population groups, bibliotherapy is not considered suitable for people with low self-motivation, or as a stand-alone therapy for people with moderate or severe mental illness. Therapists consulted for this guide also noted that there is often limited clinical oversight of bibliotherapy, or opportunities for checking the service user's understanding of the content of bibliotherapy resources.

English language bibliotherapy may be useful for Asian service users with mild disturbances and good English language skills, who are relatively acculturated to Western world views.

For Asian service users who do not speak English as a first language, books in their language of origin are recommended[110]. Furthermore, books should be relevant to the world views of Asian service users[110]. Asian-specific self-help or bibliotherapy resources do not appear to be widely available in New Zealand. While it may be possible to order these from overseas, it may require culturally-congruent therapists to be able to identify and work through Asian-specific resources with Asian service users.

## Computerised cognitive behaviour therapy

Computerised cognitive behaviour therapy (CCBT) is CBT provided using a website, CD or DVD format. A range of programmes for general populations have been developed in Western countries. However, a literature review and web search was unable to locate any CCBT programmes developed in Asian countries.

### Why this therapy is used

There is tentative evidence that some CCBT programmes are effective for treating mild anxiety and depression in general populations[112]. However, CCBT is only recommended as a stand-alone therapy for mild disturbances. None of the research on the effectiveness of CCBT appears to have focused on Asian communities.

In New Zealand there does not appear to be any specific online CBT programmes devoted to Asian service users. Western-based online tools may be useful for Asian service users with good English language skills, Westernised values, high levels of computer knowledge and a preference to engage in self-help therapies.

New Zealand therapists consulted reported that e-therapy has been used to a limited extent with Asian service users. However, it is unknown what programmes were used and whether the e-therapy was based on a CBT model.

### Possible adaptations for Asian people

CCBT may not be practical for Asian people with low levels of English, or who hold strongly traditional Asian values about mental illness or life. For example, many Western-designed CCBT programmes may not include a strong focus on collectivist and family goals. Service user engagement is most likely when the online CBT programme is in their first language (or a language they are very fluent in).

# Multi-systemic therapy

Multi-systemic therapy is a form of treatment aimed at addressing anti-social behaviour in adolescents through intensive family and community intervention. Multi-systemic therapy focuses on a young person as part of an inter-connected arrangement of self, family, peer, school and neighbour systems, and therapy may intervene by drawing on the existing strengths in one or more of these systems[88].

### Why this therapy is used

Positive outcomes from multi-systemic therapy have been noted in addressing substance abuse disorders in the general adolescent populations[113].

There does not appear to be any research on the use of multi-systemic therapy with Asian communities and, in general, rates of substance abuse appear to be relatively low in Asian youth. Multi-systemic therapy may be useful with Asian service users if it can be applied in a strengths-based manner to lever off positive community influences.

This form of therapy was rarely used by the consultation panel when working with Asian service users.

### Possible adaptations for Asian people

On a conceptual level, multi-systemic therapy may be considered a useful way to draw on the strengths of collectivist orientations. Additional time may be needed to work with Asian family members to counter any tendencies to hide emotional or behavioural challenges, associated with a fear of losing face and respect in the community. In some cases where loss of face is an insurmountable concern, multi-systemic therapy may not be appropriate.

# Psychotherapy with children

Psychotherapy with children often involves the use of play, drama and drawing to explore and analyse a child's symptoms, thoughts, feelings or behaviour[88]. During the first session, the therapist will usually see all the family members who live with the young person, to explore their concerns. Toys and art materials are provided for children to communicate their concerns, through the use of symbolic play and activities. Further sessions can vary: the therapist may meet with the parents alone, the whole family may be involved in sessions, and the child will spend time on their own with the therapist.

### Why this therapy is used

Psychotherapy can be adapted for child populations by integrating aspects of play to make therapy acceptable for children. There appears to be no research on the effectiveness of psychotherapy with young Asian service users and it is unknown to what extent psychotherapy has been used with Asian children in New Zealand or overseas.

### Possible adaptations for Asian people

When using psychotherapy with Asian children, it will be important for therapists to spend time explaining to families the potential for psychotherapy activities to address their child's concerns. Time may also need to be spent building trust with parents and explaining concepts around confidentiality.

It is also important to consider how best to work with children in ways that involve family. In some cases this may involve working within structured and formal family relationship boundaries, and accepting specific gender roles.

## Conclusion

Each Asian service user brings a unique set of values, beliefs and service needs to the therapy session. Widespread values in traditional Asian communities include collectivism, a family focus or duty, education and wealth focus, tolerance of hardship, and potential conflict avoidance and emotion regulation. A wide range of migration experiences, and differences in how closely an Asian service user identifies with Asian values or Western values, also means that individual assessments of these factors are critical. The diversity in Asian communities provides a strong argument for avoiding stereotypes when working with an individual.

The values, beliefs and service needs of each individual will in turn influence what type of communication, goals, recommendations and talking therapies models that are likely to be most effective for that individual. Having an ethnically-matched therapist is not critical to effective delivery of talking therapies. Therapists should demonstrate an interest, understanding and acceptance of a person's culture, and a willingness to learn about this, family dynamics and other aspects of the service user's reality[8]. Therapists can use therapy as a learning process, for example, by asking "Is this a value in your culture", discuss points of familiarity with the service user's country or culture, and identify areas of agreement in values. Models of talking therapy should be selected according to the values, preferred coping strategies, family dynamics, language and particular issues of each service user.

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# 4. Resources

## Health and community services

### Primary health organisations, mental health services and addiction services in New Zealand

Contact details for New Zealand's primary health organisations, and mental health and addiction services are available online.

- For primary health organisations see the Ministry of Health's website: www.moh.govt.nz/moh.nsf/indexmh/contact-us-pho
- For mental health services see the Healthpoint website: www.healthpoint.co.nz/findaservice.do?serviceType=108&branch=specialists
- For addiction services see the Addictions Treatment Directory: www.addictionshelp.org.nz.

### Asian-focused mental health services

There are a range of support services available specifically for Asian communities.

**Auckland District Health Board Asian Mental Health Service** provides clinical and cultural consultation support to Auckland District Health Board clinicians working with Asian service users. Staff of this service may sit in on consultations (for example assessments, consultations for clarifying diagnosis and brief psychological interventions), assist with family liaison, identify possible community support networks, provide indirect support for consultation, and undertake other activities to support and train clinicians who are working with Asian service users.

**Waitemata DHB Asian Mental Health Cultural Support Coordination Service** has a team of Asian clinical cultural advisors and cultural support coordinators who provide cultural assessments, communication support, assistance for service users to navigate the health system, psycho-education, and life skill counselling etc. See www.amhcs.org.nz.

**Supporting Families Auckland.** This service has an Asian-specific support worker, and an Asian-specific cultural advisor. See www.sfauckland.org.nz/support/asian.html.

**Community Alcohol and Drugs Service.** The Asian counselling arm of the Community Alcohol and Drugs Service provides information, face to face counselling, online counselling, home visits and referrals throughout Auckland. People with experience of alcohol, drug use or gambling problems, and their significant others, are eligible for these free of charge services. Online information about the service is available in Chinese, Japanese and Korean. See www.cads.org.nz/Asian.asp.

**Problem Gambling Services.** This service includes a specific Asian team that provides professional counselling and advice in Cantonese, Mandarin, Korean, Vietnamese, Khmer and Thai. All problem gambling services are available free of charge for gamblers, their family members, and others affected by a person's gambling. See www.pgfnz.org.nz/Our-story/0,2747,14732,00.html.

**Affinity Services.** Community support workers of Asian ethnicity provide services in the Counties Manukau and Auckland District Health Board region. Affinity services are free of charge to adults who are diagnosed with mental illness. The service accepts self-referrals, as well as referrals from family, friends, mental health professionals and other service providers. See www.affinityservices.co.nz/links/community-support-work-asian-service.html.

## Chinese-specific mental health services and groups

**Chinese Lifeline** 中文生命線. Chinese Lifeline supports the Chinese community through telephone and face-to-face counselling services. Chinese Lifeline works under the umbrella of Lifeline Auckland. See www.chineselifeline.org.nz.

**BoAiShe** is a mental health peer support organisation for Chinese people. The organisation supports mental well-being through sharing stories and increasing mental health knowledge at weekly meetings and regular events (physical fitness and recreational activities). Chinese people who use mental health services can self-refer themselves to these groups, or may be referred by family members. Referrals can also be made by social workers or mental health professionals. See http://sites.google.com/site/boaishechineseconsumer/home.

**Yai Oi Sei** provides psycho-education to communities from its base at Easthealth Trust in Howick, Auckland. The group arranges regular talks on topics such as recovery, combating stigma and discrimination, and mental well-being. See www.yanoisei.org.

**The Chinese Mental Health Consultation Services** provides clinical and educational services to support and promote the mental health needs of Chinese people in New Zealand. It consists of a team of accredited professionals from diverse Chinese backgrounds. The service provides direct services to service users, such as clinical assessment and interventions, training and education for health providers, individual and group supervision, advice on resources appropriate for Chinese service users, advocacy and research. See www.aucklandpsychology.co.nz/chinese.html.

## South-Asian-specific services

**Affinity services** provides cultural support, and community out-reach and support services, including group programmes and mental health promotion, for South-Asian communities. See www.affinityservices.co.nz/links/specific-cultural-support-service.html.

## Refugee services

**Refugees as Survivors in New Zealand** provides mental health support to refugee communities at the Mangere Refugee Resettlement Centre, and assessment and therapeutic services to refugees living in the Auckland region. It also provides community capacity building services and trains other therapists to work more effectively with culturally and linguistically diverse communities. See www.aucklandras.org.nz/aboutus/whatwedo.html.

**Refugees as Survivors Wellington.** The Wellington Refugees as Survivors service provides mental health support to refugee communities, and provides training to build capacity in other mental health services. See www.wnras.org.nz/about.html.

## Other Refugee community services

A list of further refugee services is available on the refugee resettlement website: www.refugeeservices.org.nz/resources_and_links/links.

# Further information

## Information resources for service users

**Information sheets**
- Cognitive behavioural therapy. Available in Chinese only at: www.rcpsych.ac.uk/PDF/cpif2.pdf.
- What is talking therapy? Produced by the Mental Health Foundation of New Zealand. Available in Chinese only at: www.mentalhealth.org.nz/kaixinxingdong/file/downloads/pdf/file_271.pdf.

**Kai Xin Xing Dong website**
The Mental Health Foundation has developed this website for the Chinese community. The site contains culturally appropriate mental health resources for service users and community members. It also includes a literature review entitled *Chinese Attitudes to Mental Illness* and information on organisations, help lines, free workshops, and Chinese support groups to inform practitioners' referrals. See www.mentalhealth.org.nz/kaixinxingdong/page/5-Home.

## Cultural competency tools for use in therapy

**STARTTS relaxation CDs and cassettes**[114]
Relaxation CD-ROMs in a variety of languages (Arabic, Bosnian, Dari, Khmer, Serbian, Tamil and Vietnamese) can be ordered from the New South Wales Service for the Treatment and Rehabilitation of Torture and Trauma Survivors. For more information, or to order, see www.startts.org.au/default.aspx?id=95.

**Translated mental health instruments**[115]
The Victorian Transcultural Psychiatry Unit website includes links to a number of translated and adapted mental health instruments, and to research about translating and validating assessment resources. See www.vtpu.org.au/resources/translated_instruments.

## Guidelines on working with Asian service users

***Fate, spirits and curses: Mental health and traditional beliefs in some refugee communities***[116]
This book provides insight into the traditional beliefs about the nature, causes and management of mental health held by some refugee communities from the Middle East and Africa. The final chapter discusses assessment and treatment issues, such as the impact of torture, concurrent physical ailments, somatisation and working with traditional healers. The book can be purchased from the Auckland Refugees as Survivors Centre. To order, email admin@aucklandras.org.nz or phone +64 9 270 0870. For more information see www.rasnz.co.nz/Publications/pub.html.

***Cultural awareness tool for mental health workers in primary care***[77]
This book provides guidance for primary care mental health workers about delivering culturally sensitive care. The book is designed to be a first step to developing cultural competence. It is available online at www.mmha.org.au/mmha-products/books-and-resources/cultural-awareness-tool-cat.

***Refugee health care: A handbook for health professionals***[22]
Chapter 5 of this book has information on mental health and refugee communities. The other chapters provide information on the experiences of refugee communities, communicating with refugee service users, working with interpreters and potential physical health needs. The book is available for download at www.moh.govt.nz/moh.nsf/49ba80c00757b8804c256673001d47d0/d85ce7cd090faaa4cc256b050007d7cb?OpenDocument.

## Working with interpreting services

Section 3 of ***Refugee health care: A handbook for health professionals***[22] has information about communicating effectively with refugee service users, including how, when and why trained interpreters should be involved in service delivery. It is available for download at www.moh.govt.nz/moh.nsf/49ba80c00757b8804c256673001d47d0/d85ce7cd090faaa4cc256b050007d7cb?OpenDocument

***Australian guidelines for the treatment of adults with acute stress disorder and post-traumatic stress disorder***[117]
These evidence-based guidelines for responding to post-traumatic stress disorder include specific considerations and assessment criteria for refugee and asylum seeker populations (pp.137–141). For more information see www.acpmh.unimelb.edu.au/resources/resources-guidelines.html.

***Guidelines for assessing and treating anxiety disorders***[118]
These evidence-based guidelines on assessing and treating anxiety disorders include short sections on working with Asian communities (pp. 37–38) and refugee communities (see pp.31-32). It is available as a PDF, see www.nzgg.org.nz/guidelines/0038/Anxiety_guideline.pdf.

***Assessment and management of people at risk of suicide***[119]
These evidence-based guidelines on assessing and managing people at risk of suicide include a short reference to working with refugee communities (p.p. 38–39). For more information see www.nzgg.org.nz/guidelines/dsp_guideline_popup.cfm?guidelineCatID=8&guidelineID=5.

***New Zealand's health and disability services (core) standards***[120]
These core standards include recommendations for working with refugee, migrant and ethnic service users, and all services should have a copy of them. They can be ordered at a cost through the Standards New Zealand website (use the catalogue search function): www.standards.co.nz.

## Workforce Training resources

**Cross-cultural resource for interpreters and mental health practitioners working together in mental health**[80].
This CD-ROM resource includes information about the need for interpreter training, common communication errors, and interpreting tips, as well as basic information on mental health, mental health interventions and cultural influences on symptoms. The information is presented as checklists, question and answer sets, and role plays. The CD-ROM is available for a small cost from Waitemata District Health Board. For more information see www.caldresources.org.nz/info/resources.php.

**Asian mental health training and development CD for Real Skills**[55]

This resource is made up of three modules: self-reflection, Asian philosophy and clinical issues. The modules include information on:

- Asian world views, beliefs and philosophies
- help-seeking behaviours
- special considerations for refugees
- considerations when providing therapy
- the experiences of Asian therapists
- references and links to other resources.

The resource can be purchased as a CD at minimal cost from the University of Auckland, contact Amritha Sobrun-Maharaj a.sobrun-maharaj@auckland.ac.nz, or can be used online on the university's website www.fmhs.auckland.ac.nz/soph/centres/cahre/amh/index.html.

**Cross-cultural resource kit – booklet and CD-ROM**[80]
This booklet and CD-ROM provide a practical, easy-to-use guide, including pre-interview checklists, interview questions and guidelines for working with interpreters. Greetings, communication guides and other information about working with people from 14 different cultures (Afghan, Burundian, Cambodian, Chinese, Iraqi, Iranian, Korean, Sudanese, Somali, Ethiopian, Iranian, Laotian, Indian, and Vietnamese) are provided. The CD-ROM and booklet can be purchased from Waitemata District Health Board or from Refugees As Survivors New Zealand. For more information see www.caldresources.org.nz/info/Home.php.

**Culturally and linguistically diverse (CALD) cross-cultural training course**[80]
This face-to-face CALD cross-cultural training is a practical course designed to improve cultural awareness, knowledge and skills for working with, and understanding, Asian, migrant and refugee service users from different cultural backgrounds. It also covers how to work effectively with interpreters in order to improve the communication process. An evaluation of the training showed that most participants (93 per cent) reported feeling more confident working with refugee and migrant service users after completing the training, and 97 per cent of participants would strongly recommend the programme to others[121]. This course was originally developed for face-to-face training, but is now also available as an interactive online course. For more information see www.caldresources.org.nz/info/Home.php

**Psychevisual – lectures about mental health therapy for refugee communities**[122]
This site includes a range of presentations about delivering care to refugee communities. Presentations cover topics from therapeutic considerations when working with refugee communities, to the use of specific approaches such as physiotherapy, neuro feedback, mindfulness, counselling, psycho-education and assessment. See www.startts.org.au/default.aspx?id=352 to find links to the relevant lectures.

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# Appendix A: Document development and consultation results

This guide brought together information from existing research and from expertise of New Zealand therapists to collate what is known about delivering talking therapies so that they are appropriate for service users of Asian ethnicity.

## Method

### Consultation with a panel of New Zealand therapists

Consultation for this guide was primarily managed by the Chinese Mental Health Consultation Services Trust. The trust arranged focus groups and interviews in order to accommodate as many people as possible in the consultation process.

Twenty five people were consulted in an initial round of focus groups and interviews. These 25 people included therapists with specialities in the adult mental health (15), child mental health (3), gambling (6), drug and alcohol (1), and marital and family (2) fields. The professional background of therapists included psychiatrists (7), clinical psychologists (2), counsellors (9), social work counsellors (2), nurses (2) and a psychotherapist (1). The ethnicity of those consulted included Chinese (17), Indian (3), Korean (2), Filipino (1), South-east Asian (1) and Japanese (1). Two service users of Chinese ethnicity were also directly involved in the consultation process. Prior to this consultation, a framework for the talking therapies document was drafted by the trust.

### Literature search

A literature search was undertaken to identify research articles and academic opinion papers that relate to the provision of talking therapies to Asian service users. Synonyms for the various Asian ethnic groups, talking therapy types and talking therapies skills were used to identify relevant articles. A Web of Science search focused on research published after 1995 and was limited to English language articles: 120 papers were identified. The Google search engine was then used to identify further unpublished reports and information, where published literature was unable to be identified. Many of the articles refer to expert-based opinion and service user feedback. Few studies demonstrating the impact of talking therapies for people with experience of mental illness have been undertaken.

### Further consultation, document development and review

To expand and explore the consistency of the information from the first round of consultation, a further set of reviews and checks was undertaken with other therapists. Three Pakeha clinicians who often deliver talking therapies to Asian communities were also interviewed, and the draft document was reviewed by five therapists, a service manager, a service user and four therapists from the Chinese Mental Health Consultation Services Trust.

The majority of this guide was drafted from the literature review, the New Zealand therapist recommendations was largely consistent with this information. In many cases, the most frequently used therapies reported by the consultation panel appeared to be the type of therapies most commonly researched. Furthermore, recommendations surrounding principles of engagement from the consulted therapists were also typically consistent with recommendations recorded in the research literature. Information from the focus groups, interviews and initial framework was integrated with information from the research literature. A draft guide was then sent out to the sector for feedback, before this document was reviewed, finalised and published by Te Pou.

## Consultation panel results

### Principles of engagement Feedback

Interviews and focus groups with the therapists in the consultation panel generated a range of recommendations relating to therapeutic engagement. These recommendations related to three phases: the initial phase of engagement, a middle phase involving therapy, and a final phase around termination. The majority of these recommendations have been included in the Principles of Engagement section of this guide. In particular, recommendations that are consistent with information from international experts found in the research literature have been included.

### Types of therapy used

The following table summarises information collected from the consultation panel about the types of therapies they commonly apply when working with Asian service users. At the end of the focus group or interviews, therapists were asked to comment on how frequently they applied each type of therapy with Asian service users, how applicable or useful and how acceptable they find the therapies in this context.

Although this guide provides some initial information about use of therapies with Asian service users in New Zealand, it should not be interpreted as a comprehensive

snapshot of New Zealand work in this area. In many cases, only a few people commented on particular therapy models.

The information collected suggests that the therapists on the consultation panel commonly use CBT, counselling, family therapy and motivational interviewing with Asian service users. Less commonly used therapies include psychodynamic psychotherapy, acceptance and commitment therapy, bibliotherapy, couple therapy and multi-systemic therapy. The frequency at which particular therapies are used may reflect the type of therapeutic models the panel members have been trained in. Therapists also commented that the existence of language barriers and the willingness of family members to be involved in therapy influenced the model of therapy that was used with each Asian service user. Therapists noted that no one model of therapy would be appropriate for all service users, and that a therapy model or mixture of therapy models should be selected according to the situation and status of the service user.

### Table A1. Feedback from the consultation panel on their frequency of use, perceived applicability and acceptability of different models of therapy for Asian service users (n=25)

| | Frequency of use (1=most, 3=least frequent) | | Applicability or usefulness 0–10 | | Acceptability 0–10 | |
|---|---|---|---|---|---|---|
| | *n* | *median* | *n* | *median* | *n* | *median* |
| Acceptance and commitment therapy | 7 | 2 | 4 | 8 | 3 | 6 |
| Bibliotherapy | 7 | 2.5 | 4 | 4 | 4 | 5.5 |
| CBT | 16 | 1 | 14 | 9 | 14 | 8 |
| Counselling | 10 | 2 | 9 | 8 | 8 | 7 |
| Couple therapy | 11 | 2 | 8 | 8 | 6 | 6 |
| DBT | 7 | 2 | 7 | 7 | 4 | 6.5 |
| Family therapy | 13 | 1 | 12 | 8 | 11 | 8 |
| Motivational interviewing | 12 | 1 | 11 | 7 | 10 | 8 |
| Multi-systemic therapy | 6 | 2 | 2 | 8.5 | 1 | 5 |
| Problem-solving therapy | 12 | 1 | 11 | 8 | 10 | 8 |
| Psychodynamic psychotherapy | 7 | 2 | 5 | 6 | 4 | 5.5 |
| Social supportive counselling | 12 | 1 | 11 | 8 | 9 | 8 |

[1]Due to the low number of responses, medians and ranges are used to demonstrate the average view and range of opinions across therapists in the panel.

Panel members also noted a range of other therapy models that they used in their work, including traditional therapies, narrative therapy, EMDR trauma therapy, person-centred therapy, pastoral counselling, and interactive drawing therapy. In some cases, therapists used videoconferencing and telephone counselling services to deliver therapy to Asian service users.

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# Appendix B: Cross-cultural competency information

The following list of competencies is sourced directly, with permission, from Lim, S., Camplin-Welch, V., Mannes, M., & Rowland, P. (2010). *CALD 1: CALD culture and cultural competency face-to-face and e-learning training course for health practitioners working with culturally and linguistically diverse (CALD) clients*. Auckland: University of Auckland, Goodfellow Unit, for Waitemata District Health Board. The text reproduced below is copyright Waitemata District Health Board.

The competencies in Lim et al., (2010) are adapted from Jackson, K. & Camplin-Welch, V. (2008). *Cross-cultural training programme for health practitioners working with culturally and linguistically diverse (CALD) clients*. Auckland: Waitemata District Health Board and Refugees as Survivors New Zealand.

## CALD Skills for interactions with service users

### Elements of cultural competency

**Cultural competency** refers to an ability to interact effectively with people of different cultures. Cultural competence comprises three components:
1. **Awareness** of one's own culture and attitude towards cultural differences.
2. **Sensitivity** and **knowledge** to different cultural practices.
3. Ability to use cross-cultural **Skills.**

**Cultural awareness** is the consciousness of one's personal reactions to people who are different. Awareness develops as the practitioner understands and appreciates a culture internally. This can result in greater flexibility and openness.

To interact appropriately with your CALD clients you need to adjust your attitudes and behaviours. To do this you need to recognise your own values and biases as well as the values and biases of your CALD patients and be consciously aware of your reaction and the reaction of your CALD patients.

**Cultural sensitivity and knowledge** in practice requires you to
- Show respect, compassion and empathy.
- Be genuine in your interaction with the client and/or family members to develop a therapeutic relationship (inclusive and holistic approach).
- Have non-judgemental and non-discriminating attitudes.
- Be aware of cultural differences and your own biases - try not to project your own biases (as long as the client's cultural practice is not a risk to the client or to others).
- Be flexible and accommodate the client's beliefs when you can.

## Skills for Preparation
- Do not assume English proficiency. Engage interpreters where there is low English proficiency and utilise their role as cultural advisors to assist the communication process.
- Be prepared to explain your role – different professional roles are not always understood by someone who has come from a different healthcare system.
- Respect others' beliefs and attitudes – do not be afraid to ask how things are done/seen/understood in the patient's culture.
- Find out what kind of physical touch and examination is expected and acceptable.
- Find out about other non-verbal communication such as rules around eye contact and personal space.
- Find out culturally appropriate modes of addressing your client – not all cultures regard first names as acceptable in a formal setting.

## Skills for Consultation
- Speak slowly and clearly without patronising. Use simple English and avoid using jargon and slang.
- Be aware of your patient's level of understanding. Do not assume they understand how the NZ healthcare system and treatments work.
- Pause and take time to explore any issues that need clarifying to ensure you are understood before continuing. The assumption that everything is understood could lead to non-compliance.
- Take note of non-verbal language remembering to interpret those non-verbal messages while taking into account cultural differences in meaning.
- Be aware of differences in meanings of words. (for example, Anglo Europeans use "Yes" as affirmative, whilst in other cultures it can be a form of acknowledgement without indicating consent. Saying "that is correct" or "I understand" may be clearer. Check what your client means).
- Periodically summarise what you have said.

## Skills for Establishing Care (Management)

- Take into account different faith-based practices and beliefs around health care and accommodate where possible.
- Take into account the possibility that your patient is taking alternative treatment and identify how you could accommodate it into the care management where possible or the possible impacts of this on their care.
- Check for client comprehension of consultation and the care management advised
- NZ healthcare system – ensure your patient understands how the system works. For example, the common system in Asia countries is that health service users are not required to enrol with general practice nor have to have a referral from a GP for specialist care, their preference is based on word of mouth recommendations or based on a need and the system is generally non-subsidised user-pay.
- Health systems in many Asian countries are still focussed on treatment rather than screening or preventative care.
- Depression is not considered as mental health in many Asian countries (there is no equivalent for translating this).
- Provide an appropriate indication that the consultation has come to a close.

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# Appendix C: CALD Recommendations for Working with Interpreters

The following text is sourced directly, with permission, from Lim, S., Camplin-Welch, V., Mannes, M., & Rowland, P. (2010). *CALD 4 Training: CALD culture and cultural competency face to face and e-learning training course for health practitioners working with culturally and linguistically diverse (CALD) clients*. Auckland: University of Auckland, Goodfellow Unit, for the Waitemata District Health Board.

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## Pre-session briefing

Aim: to get to know the interpreter to form an alliance, to establish the interpreting process and provide brief information about the session in order to work effectively together:

- Introduce yourself (your role)
- Identify a leader for the session (if more than one health professional)
- For face to face sessions, arrange an appropriate seating arrangement to facilitate the communication
- Brief interpreter the purpose and objectives of the session
- Obtain cultural background from the interpreter (if necessary or if you with to understand cultural etiquette)
- Establish mode of interpreting – consecutive or simultaneous mode
- Establish confidentiality protocol (this also includes not discussing with service user in the session)
- Briefly explain the therapeutic process or technique or issues that the session will be dealing with.

## Session Structuring

Aim: (especially important for the initial consultation sessions) to introduce the service user and / or family members to the interpreter, role, the interpreting and confidentiality protocols and work out appropriate seating arrangement to achieve good communication outcome.

Things for therapists to say to service user and /or family members before starting the session:

- Introduce interpreter and explain your and their role (include the fact that everything said in the session will be interpreted ie no private discussions between parties during the session)
- Confidentiality applies to both practitioner and interpreter
- Everything said during the sessions will be interpreted
- All parties to speak through the interpreter (ie not to)
- All parties to pause at regular intervals (three short sentences) for the interpreter to assimilate and interpret.

Things for therapists to remember during the session:

- For face to face sessions, maintain eye contact with your service user and / or family members (if eye contact is appropriate) and not to eye contact with the interpreter
- Direct questions/statements to the service user or family not directly to the interpreter
- Expect interpreters to use the 1st person singular when interpreting (eg if service users say "I am fine"; interpreters will interpret "I am fine"
- Do not enter into direct conversation with the interpreter
- Do not ask the interpreter for their opinion (only for cultural clarification) during the session
- Allow enough time for the interpreter to convey information (it may only take 3 words to explain but it may take more time for the interpreter to convey the information in their language)
- Use short sentences.
- Check with interpreter about any cultural contexts for information used by service users (only if necessary)
- If the response from the service user/family member does not seem to synchronise with the question asked, reframe the question to verify the accuracy of the interpretation of the questions or the possible misunderstanding from service user/family member (also remembering the possible misinterpretation of "open" to "closed" questions and vice versa)
- If responses from the service users are confusing – stop the session to clarify with the interpreter what's going on?
- Reminder:
  · Therapists are the driver of the interpreting session (the interpreters have no control over the running and management of the interpreting sessions)
  · Check with service users if they have any further questions before leaving or check for their understanding before closing the session
  · Avoid letting interpreters leave the session together with the service users to prevent further discussion (some service users who consider the therapists as the person with authority, and for fear of offending the therapists or because of shame of not understanding, may not want to ask the therapists but prefer to ask interpreters questions after the session).

## De-briefing after the session

Aim: (especially crucial if therapists felt lost in translation at some point during the session) to de-brief with the interpreter to clarify any areas of concern, misunderstanding and cultural issues/concepts.

- Summarise session and discuss whether objectives where met (there may be language or cultural reasons if objectives were not met)
- Clarify diagnostic /treatment issues where necessary
- Clarify any cultural issues, interpretation of words or concepts.

## General guidelines

- It is advisable that interpreters are not left alone with the service user/ family either before the session. This will prevent service users and /or family members.
- Forming a relationship with interpreters and affecting the therapeutic sessions because of the alliance and also impacting on interpreters' ability to maintain neutral (Service users tend to identify strongly with the interpreters for cultural and language reasons).
- Divulge information to interpreters before the session which they may not want to share with the therapists or repeat during the session. (This may leave the service users vulnerable and the interpreters holding the information that he/she may not be equipped to deal with).
- NB: organise interpreters to arrive earlier to meet for a pre-brief will avoid such a situation.
- It is advisable that interpreters are reminded during the pre-brief that they do not provide transport to service users for the same reasons.
- There may be times when interpreters may know service users from a social context given the small communities to which many migrant and refugee clients belong. This can be addressed in the pre-briefing session if necessary.
- Interpreters are expected to engage with the service users/family in a professional capacity only, for the purposes of the health intervention.

## Modes of interpreting

**Consecutive interpreting mode**: The interpreter speaks after the source-language speaker has finished speaking. When the source-language speaker pauses or finishes speaking, the interpreter then renders the entire message in the target language. This is the most common mode used by health professionals and most preferred by interpreters. This interpreting process will double the time required for consultation session.

**Simultaneous interpreting mode:** The interpreter renders the message in the target language as quickly as he or she can formulate it from the source language, while the SL speaker continuously speaks. This is useful for managing clients who are willing to use this mode (especially when clients ramble and do not pause for interpreters). The process takes up less time however it requires all parties to agree to this mode. It is not recommended for clients who are hearing voices or find it difficult to listen.

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