Evidence-Based Practices and Asian Pacific American Diversity:

Can Western Practices and Eastern Philosophies Integrate in Client Care?

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IN THE LAST DECADE, THE DEVELOPMENT AND USE OF evidence-based practices (EBP) in the treatment of behavioral health disorders has been steadily growing. This increase is attributable to more stringent funding requirements, public policy demands and a general expectation for treatment providers to demonstrate favorable outcomes (Steenrod, 2009). The evidence-based practices in use today are typically developed and normed for the population at large. Although developers attempt to design interventions appropriate to a broad spectrum of American society, literature suggests that behavioral health does not yet have a totally "culture-free" evidence-based protocol, one devoid of all possible cultural bias (Flaherty et al., 1988). Noted in the August 2011 and February 2012 issues of *Counselor* (Stevens & Titus), the trend toward wider utilization of EBP has given rise to questions about the effectiveness of EBP with people of diverse racial, ethnic, regional and cultural distinctions (Sue & Zane, 2006).

The question of cultural sensitivity with EBP was brought to subject experts, trainers and treatment providers from diverse backgrounds who came together for a three-day summit to share and discuss cultural adaptations and implications when using the GAIN (Global Appraisal of Individual Needs). The GAIN is an evidence-based family of assessments used widely in the substance abuse treatment field in both the United States and Canada. Participants in the GAIN Cultural Sensitivity Summit, sponsored by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment and Chestnut Health Systems, worked together to answer the following question: "How can an evidence-based assessment like the GAIN most effectively address the various dimensions of diversity of clients with substance use disorders?"

In part 3 of this six-part series on lessons learned from the GAIN Cultural Sensitivity Summit, we continue our discussion on the effective utilization of EBP with diverse clients. This article focuses on clinical service provision with Asian Pacific Americans who may have substance use or mental health disorders. Given the differences between Western thought and the philosophies of many Eastern nations, questions arise among practitioners about the applicability of Western-developed EBP for use with clients of Asian Pacific descent.

How Can EBP Effectively Address the Various Dimensions of Asian Pacific American Diversity?

If EBPs are going to meaningfully contribute to positive outcomes in the treatment of substance abuse and mental health disorders, treatment providers must be willing to take individual differences into account and make reasonable adaptations in their implementations. In "Understanding Evidence-Based Practice in Behavioral Health" David Surface cites the work of Dr. Joan Levy Zlotnik, executive director of the Institute for the Advancement of Social Work Research:

> *Zlotnik points out that a progressive, inclusive approach to EBP should combine the evidence provided in EBP protocols; the practitioner's knowledge, wisdom and ethics; along with the client's culture, individual interests and needs. "Those interventions that are drawn from systematic reviews of research studies around a particular intervention are all based on averages, and it doesn't take into account the 'outlier,' or the person for whom that intervention doesn't work," says Zlotnik. "So you have to have a system where you can adopt and adapt things to people's individual needs" (Surface, 2009, "Looking Forward," para. 2).*

The importance of adaptation when providing assessment and treatment services to members of Asian Pacific American populations is underscored by the great degree of diversity among people of Asian descent. The term Asian American is commonly used to collectively describe all individuals with ethnic roots in the regions of China, Hong Kong, Indonesia, Japan, Korea, Thailand, Vietnam and other Eastern countries. The term actually applies to at least 43 distinct ethnic groups, including 28 Asian and 15 Pacific Islander groups. For the purpose of this article, all of the 43 groups will be broadly referred to as Asian Pacific American (APA). We are unable to cover every group within the limitations of this article, but we will provide examples from several groups throughout the article to illustrate the diversity of the APA groups.

These APA populations vary immensely in immigration history, language, level of acculturation, spirituality, exposure to war and trauma, beliefs about the acceptability of social ranking, orientation toward time, individualist versus collectivist approaches to life and numerous other factors that can impact service delivery, acceptance and effectiveness. With this high degree of intragroup diversity among APA clients, effective service providers will not only be aware of possible differences between the culture of the client and the provider, but they will also avoid the tendency to ascribe inaccurate or homogeneous assumptions that overlook the diversity across APA clients.

How Can EBP Be Used Effectively with Asian Pacific American Clients?

As described in the original article in this series, the summit participants identified the following five user competencies as being essential for using EBP with cultural sensitivity:

- Recognize the power of historical perspective
- Appreciate the impact of cultural explanations and stigmas
- Respect cultural variations, expectations and communication
- Create an atmosphere of cultural safety
- Show adaptability and flexibility

This series addresses each of these areas for the cultural groups under consideration. Using these five areas as a discussion framework, here are some implications for working with Asian Pacific Americans.

Recognize the power of historical perspective.

Asia is a continent rich in culture, and many of those cultures have found their way to America. Every story is unique, but the distinct historical perspective of each nationality that has immigrated to the United States is laden with implications for how those cultures interact with Western service providers.

- The Chinese were among the earliest Asian Pacific groups to come to America. They came during the Gold Rush (1848–1855) and many worked in low-paying jobs as laborers building the transcontinental railway system or as laborers in the mining industry. As the number of Chinese immigrants grew, Congress passed the 1882 Chinese Exclusion Act: the only U.S. law ever to prevent immigration and naturalization on the basis of race (Wei, n.d.).
- In 1942, in the wake of Japan's attack on Pearl Harbor, approximately 110,000 Japanese Americans and Japanese who lived on the West Coast of the United States were remanded to war relocation camps (Inada, 2000).
- In the mid-1970s, the end of the Vietnam War led to massive emigration from Vietnam to the

United States. Those Vietnamese who had worked closely with Americans during the War feared retaliation by the Communist party, so approximately 125,000 Vietnamese departed their native country and came to the United States. Those initial Vietnamese immigrants were largely unwelcomed by the general American populous (Povell, 2005).

In one way or another, most Asian Pacific Americans or their immigrant ancestors found it difficult to acculturate and assimilate. Summit participants noted that in some cases the effects of war, famine and discrimination have carried over through generations, causing posttraumatic stress disorder–like symptoms even in generations that do not have firsthand experience with the traumatic events. Moreover, there are many APA groups such as Mien, Cambodian, Laotian and Hmong who still struggle for jobs and self-sufficiency and rely heavily on government assistance to survive.

It is nearly impossible to discuss a single collective experience of APA communities in the United States because of the diversity in their respective cultures. When working with

Asian Pacific Americans, clinicians are advised to consider how their clients and their families came to the United States and whether the client represents the family's first-generation Asian Pacific Americans. The degree of acculturation and assimilation can shape the client's view on his or her problem and the idea of treatment.

Appreciate the impact of cultural explanations and stigmas.

Cultural norms and values play a large role in the way APA clients think about treatment and treatment providers. Many of those values become barriers to Western models of treatment. For example, maintaining family dignity is of paramount importance. As a result, issues related to shame, stigma and loss of face are often the most significant barriers to increasing awareness and providing treatment for nearly all behavioral health problems in APA communities. Asian Pacific Americans often respond to behavioral health problems by trying to isolate, avoid or deny the problem (Ja, 1991), resulting in underreporting by clients and their loved ones. If the clinician has collateral information strong enough to suggest underreporting, or if responses to an assessment like the GAIN suggest the presence of symptoms that the client does not report, clinicians should use their clinical judgment in making a diagnosis or providing appropriate referrals.

Searching for help outside of one's family or outside one's culture can be seen as dishonoring to the family. Because of this, individuals and families tend to look for help within the community rather than go to a clinician on the outside. In many Asian Pacific American communities, symptoms will be viewed as spiritual issues rather than as mental health issues. Disorders are frequently attributed to the person being either "crazy" or affected by ancestral spirits from the past because there are no words in many Asian cultures for disorders such as depression, posttraumatic stress disorder or schizophrenia. In those cases, religious ceremonies or a traditional healer such as a shaman may take the place of a counselor, an assessment or an intervention in the Western sense. Treatment professionals who take the time to understand the spiritual perspective of clients and their families are likely to be more effective at culturally contextualizing their evidence-based practices for APA clients.

It is a common Western myth that people of Asian descent do not use or abuse alcohol, but David Powell (2007) notes that Korea, Japan and China have the highest alcohol consumption rates worldwide. Speaking specifically of Chinese culture, he notes that alcohol is viewed as "a representation of happiness and auspiciousness" (Powell, 2007). Drinking is not only socially acceptable in APA cultures, but commonly plays a significant part in weddings, festivals, birthdays and other celebrations where alcohol consumption may go on for extended periods of time. But despite high rates of alcohol and drug use, terms for alcoholic or drug abuser or drug dependence do not typically exist in Asian languages. The community members may know about people who get angry when they drink, or people who get DUIs or have car accidents because of substance use, but they will not likely use the term alcoholic. Families with children who are involved in abusing substances do not generally seek treatment because they do not have an understanding of what treatment is and what they can expect. Many APA parents find "treatment" a hard concept to grasp, while others look for a "cure" for their children's issue or believe the problem is a matter of "will power" because they have no theoretical base for understanding recovery as an ongoing process.

Culture-based methods for dealing with trauma may be another barrier to accessing substance abuse treatment.

D'Avanzo's (1997) study indicates that it is not uncommon for Southeast Asian refugees to use drugs or alcohol to self-medicate problems with insomnia, pain and emotional stress associated with traumatic experiences. Furthermore, many traditional medicines are alcohol-based, which increases opportunities for alcohol abuse. Limited access to culturally competent medical care, education and services compounds this problem.

Respect cultural variations in communication, expectations, and norms and values.

Using Geert Hofstede's international research on cultural values in the workplace (2001; Hofstede, Hofstede, & Minkov, 2010) to inform this discussion, one can appreciate how values differ between Asian Pacific countries. By recognizing how those cultural distinctions may be present in treatment scenarios, we can apply greater cultural sensitivity to the administration of evidence-based assessments and interventions.

One of the most important cultural dimensions in Hofstede's research is the degree of individualism that is accepted in a particular culture. The United States tends to be a highly individualistic society, where people's self-image is defined in terms of "I" rather than "we." Western thought suggests that people must be self-reliant and look out for themselves and their direct family only. In collectivist societies, people tend to belong to "in groups" where the collective well-being preempts individual benefit. This may create conflict in treatment or assessment where recovery communities typically emphasize self-care and "doing what you need to do for you." This can be inconsistent with the cultural values of APA and can result in confusion, family conflicts, lack of treatment engagement, failure to follow through and poor treatment outcomes by Western standards. For example, when using the GAIN or other assessments to explore the client's reasons for change, a treatment provider can expect an APA's responses to be more related to community than to individual motivations. Treatment planning should reflect these collective motivations rather than focusing on individual benefits. On the other hand, clinicians must also be aware that substance abusers can take advantage of these collectivistic values and the norms of interdependence to promote codependence and sustain enabling behaviors (Ja, 1991).

Another area of distinction is the acceptance of power differential. This is defined in Hofstede's work as "the extent to which the less powerful members of institutions and organizations within a country expect and accept that power is distributed unequally" (Hofstede, 2001, p. 94). The American premise of liberty and justice for all suggests that it would be unethical for clinicians to discriminate against clients for any reason. Compare those values with those of China, Hong Kong or Vietnam, for example. These are societies that believe that social inequalities among people are acceptable and that people should not have aspirations beyond their rank. This has implications for the therapeutic relationship, particularly if clients see themselves as being less socially, financially or educationally empowered than the clinician. It may also impact the types of long-term goals that clients are willing to set if they see certain goals as being beyond their current social status. The power differential within Asian Pacific American families may cause younger family members of lower hierarchy to withhold or underreport substance use or mental illness out of fear of bringing shame to the elder family members of higher hierarchy. Treatment outcomes with EBP are likely to be better if the service provider can keep all of these concepts in mind.

Some EBP and treatment expectations in higher levels of care can be very regimented. This can pose challenges for clients whose cultures have very fluid expectations. In China, for instance, adherence to laws and rules tends to be flexible to suit specific situations. Hofstede (2001) and colleagues (Hofstede, Hofstede, & Minkov, 2010) suggest that the Chinese are highly adaptable and comfortable with ambiguity, traits that can be difficult for Western people to accept. Japan, on the other hand, is a country where life is highly ritualized and prescribed for maximum predictability. In Japan, risk factors must be weighed, contingencies assessed and uncertainties avoided whenever possible. As such, changes are difficult to realize in Japan. In treatment settings, the implications for working with clients of Chinese descent, compared to working with clients of Japanese descent, are quite different. For example, a Chinese American client in a highly-structured residential EBP treatment program may have grown up with the understanding that there are exceptions to every rule; they may be perceived as resistant to treatment for exercising their cultural norm of flexibility. In the same program, a Japanese American client may expect even more structure and have little tolerance for anything ambiguous. These examples highlight the need to understand cultural nuances when administering EBP to support desired outcomes.

A fourth area for consideration is how an APA culture defines success. American society is typically driven by comparative achievement where success is defined by an objective, competitive measure and the winner is considered to be the "best" contender. Hofstede notes that this value system starts in school and continues throughout life—in both work and leisure pursuits. Most Asian countries, including China, India, Japan and Vietnam, strongly share this value.

Compare this value system to that in Thailand or Indonesia, where the dominant values in society are more nurturing and society is less assertive or competitive. Standing out as the best at the expense of others is not highly regarded. Recognizing the differences in these culturally driven values can help clinicians develop or select EBPs with motivational enhancement interventions that are congruent with client values. Recognizing cultural differences can also help treatment professionals who interpret clinical assessments like the GAIN to consider the values that inform client attitudes about quality of life and environment satisfaction.

Create an atmosphere of cultural safety.

APA families and youth in recovery with limited English proficiency and unfamiliarity with resources often face a unique set of challenges. An individual's addiction can strain an already stressed family whose members, because of their cultural background, may not fully understand how to cope with the health problems related to substance abuse or how to communicate with the individual struggling with addiction. The convergence of substance abuse and related health problems results in impaired community and family relations. APA immigrants and refugees who struggle with substance abuse face the very real prospect of a life of isolation. Because of stigma and shame, APAs in recovery may not seek support from social systems such as the family, church and mutual assistance groups in the way that Westerners seek support. At the same time, because of language and cultural barriers, they may not be able to access mainstream recovery support services. They are truly left to face this struggle on their own. These issues make it imperative for clinicians to create an atmosphere of cultural safety and conduct themselves in a way that encourages trust. Trust may not be immediately gained, but it can be strengthened as the practitioner demonstrates sensitivity to the client's unique needs.

Show adaptability and flexibility.

Some APAs face not only the complex issues of addiction but the added barriers of navigating American culture and its unfamiliar systems, the inability to speak English proficiently, legal problems and low income. For many adult immigrants, their greatest source of stress lies in the overwhelming priority placed on basic survival needs (Ponterotto, Casas, Suzuki, & Alexander, 1995). There is a desperate lack of basic community resources for the influx of immigrants and refugees in the Pacific Northwest and a lack of training in how to manage the complicated aspects of multiple systems' expectations. Mainstream treatment programs are ill-equipped to provide culturally competent and linguistically accessible substance abuse services for this diverse population. The APA recovery community, and especially the family members of people in recovery, often lack support services, including drug- and alcohol-free structured activities, education in coping strategies and stress management, and language-accessible support groups that are relevant and meaningful to their cultural backgrounds.

Treatment providers who serve clients of Asian and Pacific Island descent will be wise to use EBPs in a manner that allows for adaptability and cultural sensitivity in every aspect of EBP implementation. Use flexibility in identifying needed resources and work with the clients and their families to identify and close service gaps that alienate APA clients or cause them to lose their unique identities. Keep in mind that some Western medical and behavioral health concepts or clinical jargon may be unfamiliar or meaningless to Asian Pacific Americans, and whenever possible, engage in linguistic research so that clinicians who serve APA clients can use words that enhance the client's understanding. Most important, remember that EBPs should serve the client, and not vice versa. Management must be committed to training staff to be culturally competent with APA clients rather than fostering a homogenous "one size fits all" approach that preserves the protocol at the expense of client care.

Conclusion

A well-trained clinician recognizes that APA clients are part of a diverse population. Concepts of shame and loss of face have been identified as the most significant barriers to increasing awareness and providing treatment for nearly all social and health problems that affect APA communities. APAs face not only the complex issues of addiction but the added barriers of navigating American culture and its unfamiliar systems, the inability to speak English proficiently, legal problems and low income. It is critical to understand the various needs for specific services for APA clients while developing and using EBP. Treatment professionals should not expect to find a huge number of EBP that will meet APAs' needs without adaptations, but with an understanding of possible client perceptions and needs, counselors will be better able to adapt the protocols to deliver services in a culturally and linguistically competent manner.

To recognize and appreciate the great diversity among APA clients is to honor their individual and community distinctions. With APAs and any other racial, ethnic, regional or cultural groups, the implementation of evidence-based practices will be only as effective as the degree of sensitivity with which the protocol is selected, administered and interpreted. Whether within the ranks of research, clinical practice or program management, those who develop, train and utilize EBP have an obligation to balance program fidelity with cultural sensitivity for Asian and Pacific Islander groups and for all people.

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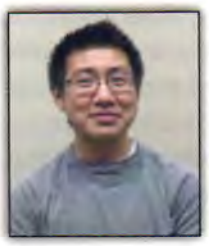

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