11 Working With a Chinese Immigrant With Severe Mental Illness

An Integrative Approach of Cognitive-Behavioral Therapy and Multicultural Case Conceptualization

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Introduction of the Authors

"How will (participants') acculturation levels influence the focus and delivery of your intervention?" The first author, Dr. Munyi Shea, was once asked this question about a research project she conducted with Asian immigrant youth. Several years later, the second author confronted her with a similar question, pertaining to a clinical context involving Asian immigrants. Both authors sensed the growing interest in integrating current psychotherapy models with a culturally responsive approach. Nevertheless, they found the literature on service delivery to Asian clients—especially to those with severe mental illnesses—lacking (Hwang, 2007; Hwang, Miranda, & Chung, 2007). Dr. Frederick Leong's question led to a discussion about how contextual factors could be consistently integrated in therapists' treatment formulation and how within-group, differences such as acculturation levels could be explored and explicitly addressed in the

clinical process. Since then, the two authors have collaborated to examine these subjects (see Shea, Yang, & Leong, 2010).

Dr. Munyi Shea is a counseling psychologist and currently a faculty member in the Department of Psychology at California State University, Los Angeles. She was born to ethnically Chinese parents and raised in Hong Kong and mainland China. She attended college as an international student in the United States and received her doctorate in counseling psychology from Teachers College, Columbia University. Her primary clinical training was in community mental health, working with individuals and families of diverse ethnic-cultural backgrounds and often low-income status. Her migration experience and professional training have significantly impacted her worldview and endeavors.

Dr. Frederick Leong is a leading scholar in multicultural psychology. He is a professor in the Department of Psychology at Michigan State University in both the Clinical and Organizational Psychology programs. He is also director of their Consortium for Multicultural Psychology Research. Having been trained in psychodynamic psychotherapy at the University of Maryland and Dartmouth-Hitchcock Medical Center, he has been involved in training graduate students in both psychodynamic and cross-cultural psychotherapy for the last 25 years. In 2008, he was invited to give a state-of-the-art lecture on his Cultural Accommodation Model of Psychotherapy (Leong & Lee, 2006) at the World Congress of Psychotherapy in Beijing.

The Practitioner

Dr. Shea

During my undergraduate orientation, a counselor spoke about potential challenges associated with cultural adjustment. At that time, these "potential challenges" did not worry me; my primary goal as an international student in the United States was to succeed in my academic studies. (I did not even realize until later that this orientation was separate from the one offered to U.S. nationals.) Jazzed by the variety of courses and the endless possibilities of social adventure, I felt well prepared to tackle any challenges. Over time, my contact with the mainstream culture intensified. Yet, I found it increasingly challenging to fully embrace the culture, or to be fully embraced by it. This realization was puzzling, paradoxical, and inconsistent with my learning experience. How could it be that over time I was becoming more accustomed, more assimilated to the dominant group, but felt more alienated? How could it be that I was becoming more fluent in the language but still stumbled in relationships and social processes? Simultaneously, I was slipping away from my culture of origin—its language, values, traditions, and customs. The experience of constantly navigating and negotiating both cultures was frustrating. The realization that I no longer had a strong footing in either culture was scary and painful.

The bewilderment, burdens, and tensions of operating across cultures cannot be easily resolved; however, they can be overcome. In my confusion and conflicts, I reached out to my friends, family, and mentors; found solace in reading and spirituality; and began a journey of seeking and authoring meaning. All these endeavors helped me reconnect with my work and my community and made me feel more grounded. The journey also steered me further in my quest for meaning and ultimately to studies in counseling psychology.

My graduate program emphasized multicultural psychology and a postmodernist perspective, both of which challenge the notion of "objective truth," including the definitions of psychological "normality" and "abnormality." Both perspectives advocate a collaborative stance between the therapist and the client: as the therapist takes a "not-knowing" or curious position, he or she becomes more attuned to the diversity of clients' voices and appreciates clients' subjective realities. Although I was clinically trained in the mainstream theoretical orientations and therapy models, such as psychodynamic therapy and cognitive-behavioral therapy (CBT), I attempt to integrate my academic background and philosophies with my clinical work. The training in psychodynamic and CBT approaches has given me a breadth and depth of knowledge, strategies, and techniques to apply during the treatment process. The multicultural and postmodernist perspectives challenge me to consider my position and relation to my clients and how my clients and I construct the meaning of therapy together. I have learned to allow room for clients to tell their stories so I can understand problems and challenges from their perspectives. Rather than merely applying diagnostic labels and implementing treatment without cultural accommodation, I believe that it is important to understand the deeper meaning of clients' psychological problems, distress, functioning (whether adaptive or maladaptive), and indigenous coping within their sociocultural contexts.

Theoretical Framework for Our Case

The theoretical framework that guides our conceptualization and discussion of this case is the cultural accommodation model (CAM) (Leong & Lee, 2006). The movement toward identifying and delivering evidence-based treatment or empirically supported therapies has gained footing in the field of psychology over the last two decades. Evidence-based practice or empirically supported therapies refer to those treatment modalities that have been demonstrated to be effective and superior to another treatment or a placebo during randomized controlled trials in experimental settings (Chambless & Hollon, 1998). Although research on the efficacy and effectiveness of empirically supported therapies (EST) and empirically validated therapies (EVT) for racial and ethnic minority groups remains limited (Chambless et al., 1996), scholars in multiculturalism have argued

that psychologists should not ignore or dismiss scientific evidence when conducting cross-cultural psychotherapy. Psychologists instead should examine the potential benefits of the mainstream (Western) psychotherapy model beyond the dominant racial-cultural group (i.e., White Americans in this case), while simultaneously attending to culturally specific elements of the mainstream model that may not be applicable to other racial-cultural groups (Leong & Lee, 2006).

To bridge the gap in applying mainstream theoretical models and implementing evidence-based treatment in culturally diverse groups, Leong and Lee (2006) proposed the CAM. This model provides a theoretically sound guide for conducting effective and culturally responsive therapy with racial-ethnic minority groups. The CAM process involves two major steps that are briefly summarized here: the first step seeks to identify and acknowledge cultural gaps and limitations of mainstream psychotherapy models with racial-ethnic minorities; the second step involves identifying constructs and variables that are culturally specific to the ethnic minority group (e.g., cultural values and beliefs, immigration experiences) and that need to be incorporated in the mainstream model and psychotherapy process. Further, the authors suggested that the process of identifying and accommodating culture-specific constructs and variables should be informed by current literature and scientific studies with racial-ethnic minorities; for instance, studies on acculturation, racism, and cultural values.

Against this backdrop, the authors of this chapter explore a case of a Chinese immigrant from Vietnam with prominent mood and psychotic symptoms, using an integrated approach of a mainstream, evidence-based treatment—cognitive-behavioral therapy—and a culturally responsive clinical perspective—multicultural case conceptualization. We demonstrate that cognitive-behavioral therapy can be an effective treatment approach with a Chinese immigrant with severe and persistent mental illness. Further, we describe how the client's contextual conditions and racial-cultural factors are taken into account when we formulate the treatment goals and intervention. The discussion focuses on a three-month clinical process during which Mr. P. was seen by Dr. Munyi Shea in a partial hospital program in the United States.

The Case

At the time of his referral to a partial hospital program, Mr. P. was a 47-year-old, single, heterosexual, Chinese American man from Vietnam, who lived in a group home and attended a rehabilitation day-treatment program. Mr. P. had been discharged from the psychiatric unit at a general hospital. Prior to his psychiatric admission, the group home staff had expressed concern that Mr. P.'s symptoms had worsened. These symptoms included increased agitation, arguments with staff over rule

infringement and medication regimen, and bizarre behaviors such as "chanting" and "dancing." He had—on one occasion—expressed suicidal thoughts: "Buddha tells me to kill myself."

Mr. P.'s primary language is Cantonese (a Chinese dialect); he speaks little English. Interview and therapy sessions were conducted with Dr. Shea (referred to in this chapter as *the therapist*) in his primary language. During the intake interview, Mr. P. was pleasant and cooperative. His speech and behavior were within the normal range. He did not display a dysphoric sad mood, nor did he appear elated. Occasionally he would giggle—an affect that appeared to be incongruent with the contents of the interview. He told the therapist that the "voices" in his head made him laugh. These voices were of his mother and friends, who told him to "study hard." However, Mr. P. was amenable to the therapist's redirection and able to focus throughout the interview. Mr. P.'s chief complaint at that time was "My nerves are all messed up. My thinking is confused." He could not elaborate what he was confused about, but stated that he suffered from a chronic headache. Mr. P. showed some insight into his conditions: He reported that the precipitating events leading to his recent hospitalization had been his "singing" and "dancing," which bothered other residents in the group home. But he stressed that there was no aggressive intent on his part. When asked about his suicidal ideation, Mr. P. adamantly denied it, saying, "I believe in Buddhism, and we are told to be good. We cannot hurt others or ourselves."

Personal History

Mr. P. was born and raised in an ethnically Chinese family in Ho Chi Minh City, formerly known as Saigon, Vietnam. He was the middle child of five children with one older brother, one older sister, and two younger sisters. Both of his parents were agricultural workers. Mr. P. described his father as "distant," and his mother as "warm" and "caring." He had a conflictual relationship with his older siblings; he recalled being physically abused by his older brother and verbally abused by his older sister. Mr. P. appeared fearful and reluctant to talk about his older siblings; he did not wish to elaborate on the abuses. According to Mr. P., there was no major medical or psychiatric history in his family.

Although his family struggled intensely with poverty and discrimination by the Vietnamese, Mr. P. did not report any other remarkable experiences during his childhood years. He attended Chinese-speaking elementary and middle schools until age 14 and then decided to drop out and find work. Mr. P. appeared proud of the fact that all his schooling was in Chinese and noted to the therapist, "I don't know or speak Vietnamese very well." After trying several odd jobs, he became involved in a smuggling business.

In the early 1980s, Mr. P. (then a teenager) and some friends fled Vietnam's new Communist regime in search of safety. He paid a "snakehead" (a person or a gang that is involved in human smuggling) to traffic him via boat to Hong Kong. Mr. P. remarked that his parents were ailing and his older siblings were married with children. "It would be too expensive to pay for the entire family to go." The rest of the family remained in Vietnam. They were later expelled to a southern province in China.

Clinical History

Mr. P. was first hospitalized in the early 1980s in Hong Kong. During this time, Mr. P. was under a great deal of stress arising from political, social, and economic situations. After arriving in Hong Kong from Vietnam, he was admitted to a refugee camp. To pass time and make money, Mr. P. started working "under the table" in several restaurants and factories. He reported drinking a lot of coffee and sleeping very little in order to work long hours. Over time, his supervisors and friends noted that he became increasingly irritable, incoherent, and uncooperative. Eventually, Mr. P. was taken by his friends to a local psychiatric hospital. There, he was diagnosed with bipolar disorder. Mr. P. did not seem to understand the diagnosis. As he said, "I just thought I had a lot of energy, and I needed to work a lot [to make money]. I did not sleep, and I collapsed. That is it."

Shortly after his discharge, Mr. P., along with other Vietnamese refugees, was admitted to the United States under the Humanitarian Operation. He settled in an urban city in the Northeast. Since then, he has had close to 20 psychiatric admissions due to recurrent manic and psychotic episodes. These are characterized by symptoms of persistently elevated mood, increased irritability, auditory hallucination, grandiose and control delusions, hyperactivity, and a substantially decreased need for sleep. Owning to his chronic mental health condition and limited English proficiency, he has not held steady jobs in the United States since his immigration. Mr. P. relies on government subsidies as his major source of income.

Mr. P. had been diagnosed with bipolar disorder and schizoaffective disorder by various therapists. Prior to the time discussed here, he had been receiving approximately once-a-month psychiatric care from a Cantonese-speaking outpatient psychiatrist in a general hospital, who described Mr. P.'s condition as "persistent" and "grim" in spite of continued antipsychotic medication treatment. "He believes he is powerful and able to communicate with people through extraterrestrial systems," the psychiatrist told the therapist. Mr. P. briefly saw a Cantonese-speaking social worker but terminated that therapy for unknown reasons. Additionally, Mr. P. had been referred to a rehabilitation program that consisted of primarily Vietnamese immigrants. According to Mr. P., he left the program because of "language and cultural mismatch." Mr. P. was a smoker, but he had no history of substance abuse or significant medical problems.

The Context

Considerable research has shown that the schizophrenia spectrum of mental illness is associated with genetic factors (Tsuang, Stone, & Faraone, 1999) and neurobiological vulnerabilities, such as alterations in brain structure (Belger & Dichter, 2006), an excess of the neurotransmitter dopamine, and dopamine's interaction with other neurotransmitters (Kapur & Lecrubier, 2003). Nevertheless, many researchers have suggested the significant role of environmental, psychological, and social factors; in particular, the effect of life stressors on the developmental trajectory of schizophrenia (Phillips, Francey, Edwards, & McMurray, 2007). In Mr. P.'s case, there were tremendous experiences in his history that embodied his identity as an immigrant and a refugee and multiple sociocultural factors that potentially instigated and became interwoven with the expression of his severe mental illness. In the following, we examine a few salient factors in Mr. P.'s migration and acculturative contexts that likely affected his psychological health and were important to consider in his treatment conceptualization and planning.

Migration History and Context

Mr. P. was born in Saigon in 1960 during the Vietnam War. Although he was unable to elaborate this part of his personal history, he alluded to disliking an environment that was combative and highly conflictual—one that was exemplified by his own family dynamics as well as the larger political climate. Mr. P. was a teenager when Saigon fell, and at that time, he became increasingly worried about the brutal rule of the new Communist government and the discrimination against ethnic Chinese. His fear of being persecuted or sent to a reeducation camp, coupled with a bleak future for job opportunities, led him to flee Vietnam to Hong Kong.

According to Mr. P., the refugee camp in Hong Kong was filthy; fights (verbal and physical) were frequent. He abhorred these tensions and rejected any association with the people there; instead, he sought solace in his Buddhist faith and focused on seeking jobs. One of the highlights Mr. P. recalled of this short stay was his ability to maintain several part-time jobs in restaurants and factories. Nonetheless, Mr. P. was constantly worried about being arrested for working illegally and deported back to Vietnam. "I worked a lot . . . to make a lot of money quick. I felt happy when I was working." Unfortunately, this abundance of energy, drive to succeed, elated mood, and unusual optimism signaled an impending manic episode, which eventually led to his first psychiatric hospitalization.

Acculturation Context

The term *acculturative stress* is used to describe the feeling of tension and anxiety caused by the demands of a new environment on a person to adapt

and change (Berry & Kim, 1988). Like many new immigrants (Rhee, 2009), Mr. P. struggled with economic hardship and significant acculturative stress associated with changes on individual (e.g., language spoken), structural (e.g., social network), and sociocultural (e.g., customs and norms) levels. Despite his high hopes for greater freedom and better job opportunities in the United States, Mr. P. was quickly plunged into an environment that was unfamiliar and challenging. At first, he tried to establish his footing by doing menial jobs (e.g., washing dishes in a restaurant) and making new friends. However, Mr. P.'s low educational level and limited English-language proficiency not only limited his vocational choices but also circumscribed his social network. Although he attended free English classes offered in the community, his ability to concentrate and retain information was impaired by his mental condition. Further, his life was punctuated by the chronicity and persistence of his mental illness. Mr. P. never quite returned to his premorbid level of functioning. Consequently, he could not maintain employment. Unable to make a living and care for himself, Mr. P. began to receive government subsidy and live in a group home.

After his multiple hospitalizations for mood and psychotic episodes, Mr. P.'s social network collapsed. Friends, especially those with families and children, became distant. He lived in a group home comprised predominantly of Whites and African Americans, with whom Mr. P. was cordial but had little in common. Although Mr. P. had been referred to ethnic specific rehabilitation centers, including a day treatment program with Cantonese-speaking social workers, he did not follow through and eventually terminated the service due to a long commute. Mr. P.'s experiences illustrate the paucity of culturally appropriate assessment and mental health services and the logistical challenges in delivering them (Sue & Sue, 2007). They also speak to a profound sense of sadness, loss, and resignation among recent immigrants as a result of social alienation and cultural marginalization.

The immigration process also brought upheaval and disruption to Mr. P.'s emotional support systems. Mr. P. was separated from his family for an extended period of time before he returned to China to visit them. During that visit, he learned that his father had passed away and his siblings had established their own lives in different towns. Mr. P. related to the therapist that he missed his mother but did not feel close to his siblings. That was his last and only visit to see his family.

Several studies have shown that stressful premigratory experiences can lead to severe mental health problems among Vietnamese immigrants or refugees, including elevated rates of depression, posttraumatic stress disorder (PTSD), and panic disorder (Abueg & Chun, 1996; Hinton et al., 2001; Kinzie et al., 1990; Tran, 1993). Postmigratory stressors such as language barrier, low socioeconomic status, disruption of family integration, and social isolation can exacerbate acculturative stress and increase the risk for mental health symptoms (Rhee, 2009; Shea, Yang, & Leong, 2010; Shen & Takeuchi, 2001). Mr. P.'s early exposure to war trauma and his experience

of living in highly unsettled and alienated environments may have resulted in his constant feelings of trepidation and uncontrollability and a lens tinted with distrust. All these factors affect the way he sees and interacts with the world (i.e., cognitive schemas), as well as his psychological experiences and symptom manifestation (discussed in the next section).

Other Racial Cultural Factors

Culture not only shapes immigrants' psychological experiences, but also orchestrates the expression of their psychological distress, such as *somatization*. As research has suggested, Asians and Asian Americans tend to express their distress and emotions through somatic metaphors (Cheung, 1995; Hwang, 2007; Shea et al., 2010) and emphasize somatic symptoms over psychological difficulties in assessment and treatment (Yang & Wonpat-Borja, 2006). When Mr. P. first arrived at the unit, he did not endorse any mood symptoms but complained about his perennial headache. This became a starting point of his work with the therapist.

Religious and spiritual beliefs also inform a client's worldview, conception of mental health, and coping mechanisms. Scholars and practitioners generally view religious and spiritual faith as a protective factor against psychological distress (Sanchez & Gaw, 2007) and a source of resilience and coping among Asian immigrants (Inman, Yeh, Madan-Bahel, & Nath, 2007). It is imperative to attend to the interaction of religious and cultural contexts. For instance, committing suicide is not explicitly forbidden by Buddhism and Hinduism (Leong, Leach, Yeh, & Chou 2007). However, the act of killing oneself may be regarded as selfish and disruptive to interpersonal harmony; hence, it is deplored in the Asian cultural context.

Beyond cultural factors, scholars have posited that race is a central organizing principle for our society as well as for our clinical work (Hardy & Laszloffy, 2008). It is not only important for therapists to recognize racial-ethnic differences but also important to understand differential meanings and values we attach to these differences. For instance, Mr. P., at one point, was referred by the inpatient clinicians (who are primarily White) to a rehabilitation day program that mainly served Vietnamese Americans following his discharge from an inpatient unit. He appeared particularly upset about this arrangement and said to the therapist, "I don't even speak Vietnamese." The misunderstanding and the misplacement should not simply be attributed to language barriers or carelessness. The confusion about Mr. P.'s ethnic background, cultural practice, and language preference might reflect clinicians' biases and assumptions of those who are racial-culturally different as well as their privileges of choosing not to see or understand group differences. Thus, it is critical for therapists to examine their daily operation as a racial-cultural being and its powerful implications for their interventions and interactions with clients (Constantine, Miville, Kindaichi, & Owens, 2010). In this case, the clinicians needed to learn to grasp the complexity of

Mr. P.'s sociocultural realities, become aware of widely varied within-group ethnic, linguistic, religious and cultural differences, and challenge their stereotypic views about racial-ethnic minority groups (Constantine et al., 2010; Hardy & Laszloffy, 2008; Sue & Sue, 2008).

Therapist's Role and Stature Relative to Mr. P.

The therapist was born outside the United States and shared with Mr. P. a similar ethnic background and the same spoken dialect. Nevertheless, her migration and acculturation experience was very different from Mr. P.'s. She first came to the United States as a student with financial and cultural resources. Unlike Mr. P., she never had to struggle with safety or survival issues, nor did she flee her home country and leave her family behind out of fear for her own life. She was accepted by her communities in the United States, and did not need to worry about where she would live and whom she could befriend because of stigma. She received advanced education that broadened her horizon of career opportunities and afforded her upward mobility and social class privileges in the dominant culture. Yet in some ways, she could relate to Mr. P., feeling at times the excruciating pain of being far from family and emotional support systems; challenged or misunderstood because of values, beliefs, and practices; or perceived as a perpetual foreigner.

These similarities and differences prompted the therapist to examine Mr. P.'s operation as an ethnic minority in the dominant culture as well as her own. Their shared language facilitated dialogue and contributed to a better understanding of Mr. P.'s distress and challenges. Yet the differences in their age, gender, social class, and life experiences reminded the therapist to be mindful of her values and assumptions of normality and privileges; to be humble and listen to Mr. P.'s story; and to explore meaning from his perspective, not hers.

The Treatment

Treatment Goals and Planning

When Mr. P. first arrived at the unit, he presented active delusions and hallucinations without prominent mood symptoms. He told the therapist and psychiatrist that his father was "Chairman Mao"; and, his mother, "Queen Elizabeth II." He also believed that he had the ability to maintain world peace by manipulating his thoughts. Additionally, he reported hearing voices—mostly his mother's voice telling him to "learn English" and "study hard." Mr. P. did not present significant negative symptoms.

Upon reviewing Mr. P.'s psychiatric history and course, the clinical team generally supported a diagnosis of schizoaffective disorder. There was a period of time when Mr. P.'s psychotic symptoms persisted without the

presence of mood symptoms. The key intervention recommended by the psychiatrist was medication. Mr. P. was treated with a combination of Depakote (Valproic acid), Lamictal (Lamotrigine), Clozaril (Clozapine), and Abilify (Aripiprazole) for his manic and psychotic symptoms. He was also prescribed Tylenol for his chronic headache and Ativan for his anxiety and instructed to take them as needed.

In addition to pharmacotherapy, CBT and multicultural case conceptualization (MCC) approaches were included in Mr. P.'s treatment plan. CBT (Beck, 1976) emphasizes helping clients examine maladaptive thought processes and recognize underlying cognitive schemas that trigger erroneous automatic thoughts and generate negative behavioral and emotional responses. Treatment often centers on modifying clients' faulty thinking patterns by substituting more realistic appraisals and enabling them to learn adaptive behavioral responses. Although it was once suggested that symptoms of schizophrenia would not respond to any form of individual therapy, recent treatment research has demonstrated that CBT can be an efficacious treatment for schizophrenia (see review by Turkington, Kingdon, & Weiden, 2006).

The MCC approach, on the other hand, focuses on mental health practitioners' ability to identify and integrate salient racial-cultural issues into their case conceptualizations of etiology and treatment formulation (Ladany, Inman, Constantine, & Hofheinez, 1997). Instead of attributing a client's symptoms and illness trajectory to a simple biological cause (e.g., imbalance of neurotransmitters) or psychosocial cause (e.g., homelessness, limited family support), this approach prompts therapists to engage in a closer examination of the sociopolitical and cultural contexts—such as race, ethnicity, gender, social class, and religion—that shape a client's identity, developmental experiences, and storytelling. Furthermore, MCC goes beyond understanding the intrapersonal factors on the client's part and stresses the importance of considering the practitioner's covert biases and assumptions in clinical assessment and diagnosis. MCC also emphasizes the racial-cultural dynamics between client and practitioner as well as the interpersonal processes within the treatment milieu (Constantine et al., 2010; Shea et al., 2010).

It has been suggested that MCC can augment mainstream theoretical orientations (e.g., psychodynamic, CBT, rational-emotive behavioral therapy, humanistic, and family systems) to promote comprehensive case conceptualizations and culturally responsive service delivery (Constantine et al., 2010). In Mr. P.'s case, the MCC approach fits well with the premises of CBT. First, both CBT and MCC promote client-practitioner collaboration, which generates shared formulations of problems through guided discovery (Kingdon & Turkington, 2005). Second, both methods value clients' subjective experiences. One of the central tenets of CBT for schizophrenia is to respect and understand the personal meaning of clients' experiences (Sullivan, 1962)—including their beliefs, feelings, and behaviors—without directly challenging the reality

basis of their experiences or colluding with their delusions (Turkington et al., 2006). Similarly, MCC encourages viewing clients' symptoms in the larger context and being interested in the specific narratives based on their racial and ethnic experiences. These strategies underemphasize preconceived ideas of normality and abnormality, help uncover culturally oriented conceptions and expressions of mental health problems, reduce Eurocentric biases in assessment and diagnosis, and facilitate understanding of how cognitions and behaviors may be adaptive from clients' perspectives (Constantine et al., 2010).

Informed by the CBT and MCC perspectives, the therapist took a collaborative stance in developing treatment goals with Mr. P. The first and foremost problem Mr. P. complained about was his chronic headache. He also stated that he would like to return to the English-speaking vocational-based rehabilitation center that he had previously attended. Prior to his recent hospitalization, Mr. P. had attended that center regularly and was engaged in some simple cleaning tasks.

Although it might seem that treating Mr. P.'s positive psychotic symptoms would be the paramount goal, it soon became clear to the therapist that his delusions and hallucinations were not particularly distressing to him or harmful to others. What piqued the curiosity of the therapist were the perseverative, ritualized, and almost soothing qualities in Mr. P.'s narratives of his delusional thoughts and voices, which led the therapist to explore the protective function of these symptom manifestations and their effect on Mr. P.'s mood.

The additional concern was Mr. P.'s history of erratic behaviors as described in consultation and liaison meetings. Specifically, group home staff members were troubled by Mr. P.'s "irritability" and "argumentative attitude." There were also the instances of "chanting" and "dancing," which he claimed were part of his religious rituals. Furthermore, therapists and staff at the partial hospital program noted that Mr. P. was "encroaching interpersonal boundaries" with some of the other clients. Mr. P. did not seem to agree with others' assessment of his behavior, insisting that he had no ill intention toward staff or other clients. Despite the dispute, Mr. P. agreed that it would be helpful to discuss different social norms and expectations that govern interpersonal processes to reduce misunderstanding between him and others.

After some discussion, the client and therapist generated three treatment goals: (1) understand Mr. P.'s positive symptoms and explore the effect on his mood and daily functioning, (2) enhance his interpersonal effectiveness, and 3) develop an integrative care plan that would address his physical and mental health concerns and promote his quality of life.

Course of Treatment

This section presents a brief summary of the work between Mr. P. and the therapist, which occurred during three months of meeting twice to three

times a week, for 30 to 45 minutes each time. The initial-estimated length of Mr. P.'s intervention was six to twelve weeks. The purpose of the partial hospital treatment is to provide transitional support and clinical care for clients who no longer need the intensive inpatient treatment, but who would benefit from more structured and frequent therapeutic encounters before they are discharged to outpatient facilities.

In the first few sessions, Mr. P. claimed that he was confused in his new surroundings and did not understand why he was attending the partial hospital day treatment program. In one moment he would repeatedly urge the therapist to let him "go home," and in the next, he would say to himself, "I need to study . . . I need to learn English." The initial sessions focused on developing empathy, respect, and unconditional positive regard for the client as well as fostering trust and honesty (Turkington et al., 2006). The therapist acknowledged Mr. P.'s confusion and encouraged him to discuss how the partial hospital program could be helpful and to explore what a home meant to him.

Within a week, Mr. P. felt more situated and became comfortable sharing his histories. Despite bitter complaints about his headache, Mr. P. began minimizing this problem and was reluctant to address it. He said, "I have been telling my doctors about my headache for almost thirty years, and they can do nothing about it. I just take Tylenol." The therapist, hoping to better understand Mr. P.'s vulnerabilities as well as stressors that trigger his headache, used *Yang Sheng* ("nourish life")—a Chinese concept related to cultivating a lifestyle that promotes inner balance and longevity—to stir Mr. P.'s interest in a dialogue about his health. Mr. P. became engaged and stated that Buddhism also encourages its believers to maintain physical health. These dialogues about inner balance and longevity seemed to help Mr. P. gain a new perspective on his health concerns and reduce the intensity of his headache symptoms.

Working with his attending psychiatrist, the therapist suggested that Mr. P. keep a log of his daily routines and dietary patterns, while simultaneously arranging a medical appointment for Mr. P. to undergo further examination. When Mr. P. returned with his log and observations, two vices appeared to be especially relevant to Mr. P.'s symptom of a headache: heavy smoking and caffeine consumption. He drank coffee continually throughout the day, which led to restlessness, difficulty falling and staying asleep at night, and chronic fatigue. Although the medical test revealed no organic causes for his headache, quite soon after the adjustments of his dietary habits (including increased hydration and decreased caffeine intake), Mr. P. appeared more physically comfortable. He reported improved sleep quality, higher levels of energy, and less frequent headache symptoms. Nevertheless, Mr. P. refused to give up smoking.

The therapist also noted that the onset of Mr. P.'s chronic headache coincided with a very stressful period of his life: living in the refugee camp in Hong Kong. Moreover, Mr. P. at times in therapy complained about

headaches when he was confused or anxious: "My nerves are all messed up. They hurt my brain." These complaints made the therapist mindful of how Mr. P. might express his emotional and psychological pain through somatic metaphors. The therapist then directed the session toward understanding Mr. P.'s fear and anxiety rather than reverting to simple medication intervention.

Mr. P.'s delusional thinking revolved around bizarre and grandiose themes, but he did not display systematic, elaborate, or well-organized delusions. He tended to focus on a few specific themes and talk about them in a ritualized manner. As stated earlier, he believed that his father was "Chairman Mao," his mother was "Elizabeth Queen II," and he could maintain world peace and stop the Iraq War by concentrating on his thoughts. (He could not elaborate what thoughts these were.) Mr. P. also appeared to experience persistent auditory hallucination. Mr. P. would often start giggling in the middle of the therapy and say, "It's my voices . . . so funny. My friends are talking to me now." Once during group therapy, he leaned toward the therapist and lowered his voice. "Can you hear that? The air conditioner is sending me messages, telling me to be good and to keep this group in peace. Now! Now! Hear it!"

Mr. P.'s delusions were refutable. There were multiple times when he clearly identified that his parents were agricultural workers in Vietnam, and his account of family and migration history was rather consistent. The therapist used a CBT technique known as "inference chaining" to examine personalized meaning underneath Mr. P.'s delusions (Kingdon & Turkington, 2005). An example follows:

Mr. P.: "I can control world peace. I just need to concentrate."

Therapist: "Could you please tell me what controlling world peace means to you?"

Mr. P.: "When I concentrate, the world will be safe. Everyone will be happy."

Therapist: "So it is important to you that the world is safe and everyone is happy. Could you please tell me why it is important?"

Mr. P.: "Yes. When it is not safe and people are unhappy, people argue."

Therapist: "Can you give me an example of a time when you felt that the world was not safe?"

Mr. P.: "Like when I was in the refugee camp in Hong Kong; people fight and argue all the time . . ."

Dialogue like this opened a well of revelations. In a sense, the delusion was bypassed and instead channeled to explore important feelings and

experiences in Mr. P.'s life. He subsequently related to the therapist how life had been challenging and chaotic for him as a refugee and immigrant. Even though Mr. P. had never verbally endorsed any feelings of loneliness or sadness, his responses at times suggested that he longed for connections and safety. For instance, when asked about what "Chairman Mao" and "Queen Elizabeth" would do for him if they were really his parents, Mr. P. sank into his deep thoughts; his eyes became moist. "I miss my mother," he said.

The details of Mr. P.'s hallucinations were explored to identify situations that increased the likelihood of his experiencing the sensation of hearing and becoming troubled by voices. It appeared that Mr. P. was most likely to hear voices when he was in a group setting or during an intense conversation that generated uneasiness or anxiety. The voices were mostly associated with familiar people: his mother and his friends, who encouraged him to study, learn English, and excel in the United States. They seemed to have a soothing effect. Instead of trying to convince Mr. P. that his auditory hallucination was a marker of schizophrenia, the therapist focused on uncovering stress factors that could exacerbate his symptom of anxiety and on enhancing his coping skills. For instance, the therapist suggested that Mr. P. excuse himself from the (therapy) room and go get a cup of water when he felt overstimulated. Mr. P. was also encouraged to keep to a regular routine of exercise, diet, and sleep that would help reduce stress.

Throughout his stay in the program, Mr. P. was cordial and made attempts to socialize with other clients. However, several therapists and staff expressed discomfort with Mr. P.'s insistence on shaking their hands every day and his habit of giving away cigarettes to other clients. Mr. P. argued, "I am just treating them like my brothers and sisters." The therapist and Mr. P. engaged in a constructive discussion about varying sociocultural norms and expectations for interpersonal boundaries and relationships in his country of origin and the United States as well as alternative ways of socializing besides offering cigarettes and smoking together. Mr. P. was quick to respond to the feedback and replaced handshakes with a simple wave and greeting; this change demonstrated Mr. P.'s ability to reason and to adapt to the demands of reality.

Evaluation of the Treatment

About eight weeks into the partial hospital treatment, Mr. P. was making steady progress and his condition was much improved and stabilized. Mr. P.'s physical and psychological symptoms had significantly reduced. His mood was stable, his affect was congruent, and his behaviors were appropriate. More importantly, he was engaged in the treatment and had not missed any individual or group therapy sessions.

As the clinical team began to discuss Mr. P.'s discharge plan, Mr. P. had a disagreement with a nurse about his medication regimen. During the

incident, he became angry and agitated, yelled and cursed at the nurse, and left the unit. When Mr. P. later returned, he was calmer but claimed that he was still irritated by the nurse's attitudes. Since irritability was one of the main concerns expressed by Mr. P.'s care workers and an emotional state that might underlie his suicidal thinking, Mr. P. and the therapist completed a functional analysis of this outburst. Functional analysis is a technique frequently used in behavioral therapy to understand factors that contribute to the development and maintenance of a behavior. Mr. P. was asked to identify (1) situations or emotions that triggered his outburst and (2) the pros and cons of his behavioral consequences. Both the therapist and Mr. P. were made aware that his outbursts were often triggered by specific emotional states and interpersonal exchanges. For instance, disagreements with people—especially authority figures—reminded him of prior physical and verbal abuse by his siblings, which then triggered feelings of fear, anxiety, and anger. Mr. P. equated the nurse with his sister and said, "Just like my older sister, [she is] so controlling." The therapist and Mr. P. then explored alternative explanations for the nurse's seemingly controlling behaviors. Mr. P. was able to better understand the nurse's intentions. Nevertheless, Mr. P. still felt disabled in his communication with people around him, as if he would not be heard or understood even if he screamed. After making an assessment based on the CAM, it struck the therapist that this profound sense of not being understood underlies Mr. P.'s struggle with loneliness and loss as an immigrant with severe mental illness. He remains alienated from the mainstream society due to linguistic and cultural difficulties and marginalized by his own ethnic cultural group due to the stigma attached to mental health problems.

It became clear to the therapist that she would need to be more proactive—not only as Mr. P.'s therapist but also as a cultural broker and advocate when formulating Mr. P.'s discharge plan. She began to contact community leaders and other bilingual therapists in the area and consulted with several community agencies and hospitals to discuss Mr. P.'s discharge plan and appropriate outpatient care. In addition to medication intervention from his psychiatrist, Mr. P. would receive continued care from a bilingual outpatient clinical team. A Cantonese-speaking case worker would visit Mr. P. in his group home on a weekly basis and act as a liaison, while a clinical social worker would conduct therapy. Furthermore, the therapist, together with the case worker, met with Mr. P.'s group home staff to discuss pertinent issues such as rule negotiations (e.g., religious rituals, medication regimen), diet, exercise, and financial management. The therapist also collaborated with the clinical social worker in that they would both provide treatment to Mr. P. during a 2-week period prior to his discharge. The parallel treatment aimed to provide a smooth transition for Mr. P. and an opportunity to address any potential issues.

Mr. P.'s input was also sought during the discharge planning. He specifically requested to go back to the vocational-based rehabilitation center where he could work. Instead of seeing his request as a futile attempt or a wild dream by an immigrant who had failed to succeed in the mainstream society, the therapist saw hope and resilience.

Conclusion

In this chapter, we illustrate how to integrate a mainstream, evidence-based treatment—cognitive behavioral therapy—with a culturally sensitive approach in case conceptualizations and interventions. Consistent with the CAM of psychotherapy (Leong & Lee, 2006), we believe that cultural factors can serve as major moderators of both the process and outcome of psychotherapy and need to be accommodated in order to provide culturally appropriate and responsive interventions. We hope this discussion will inspire therapists and trainees to (1) engage in a dialogue with colleagues and clients to understand how clinical discourse is intertwined with a client's personal narrative as a racial-cultural being; (2) uncover embedded sociocultural factors that may influence a client's idioms of distress, symptom manifestation, and coping strategies; (3) examine their own cultural imperatives, biases, and assumptions as well as resources and assets that can be powerful tools to shape case formulation and treatment course; and (4) become more proactive in their advocacy for infusing racial and cultural factors in clinical assessment, treatment planning, delivery of services, and practicum class and supervision discourse. As our society becomes increasingly diverse, we must challenge our conception of the traditional therapist's role in order to understand the broader context of our clients' experience, integrate social justice in our practice, and seek knowledge and collaborations from our local, national, and global communities.

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