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Therapeutic alliance through person-centered therapy:
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THERAPEUTIC ALLIANCE WITH ASIAN AMERICAN CLIENTS

Abstract

While the Asian population in the United States is growing vastly and there is an abundance of literature regarding barriers to utilization of psychological services for this population, there remains minimal research on positive or facilitative factors for those who do utilize services and do not prematurely terminate treatment. The purpose of this study was to explore possible factors that promote clients' utilization and commitment to mental health services, as reported by Asian clinicians working with an Asian American population. This study was performed through a descriptive qualitative approach consisting of semi-structured interviews with four clinicians providing mental health services in an integrative community mental health agency in Colorado. Results revealed that the therapeutic alliance and a person-centered therapeutic approach were meaningfully related to clients' long-term utilization of mental health services, despite barriers to engaging in mental health services including personal and cultural values, and beliefs and attitudes toward mental health and mental health services.
Introduction

From my recent training experience as an extern at a local community mental health center in Colorado, I experienced first-hand the challenges Asian clients faced when seeking mental health services. I observed barriers that limited successful attainment of services. I also learned about how my approach with clients impacted their experience of service utilization, as clients provided me with feedback during my training. These experiences sparked my interest to learn about facilitative factors that may be applied to optimize mental health services utilization among Asian clients.

For the purpose of clarifying the population of focus for this study, the following descriptions and distinctions will be provided. In a 2010 Census Brief (Hoeffel, Rastogi, Kim, & Shahid, 2012), published by the United States Census Bureau, the meaning of the Asian racial category for the purposes of the 2010 United States Census is as follows:

According to OMB [U.S. Office of Management and Budget], “Asian” refers to a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. The Asian population includes people who indicated their race(s) as “Asian” or reported entries such as “Asian Indian,” “Chinese,” “Filipino,” “Korean,” “Japanese,” and “Vietnamese” or provided other detailed Asian responses. (p. 2)

For clarification, this broad census category of an Asian racial group is comprised of diverse ethnic subgroups, each of which has distinguishing characteristics. For those who identified their race as solely Asian, their population growth rate between 2000 and 2010 was four times greater than the general U.S. population. In contrast, for those who identified as Asian combined with
another ethnicity, their population growth rate was higher than those of all other racial groups in the United States (Hoeffel, Rastogi, Kim, & Shahid, 2012).

According to the American Community Survey (ACS), which is an annual survey conducted by the United States Census Bureau (as cited by the Migration Policy Institute, 2017):

The term “foreign born” refers to people residing in the United States at the time of the population survey who were not U.S. citizens at birth. The foreign-born population includes naturalized U.S. citizens, lawful permanent immigrants (or green-card holders), refugees and asylees, certain legal nonimmigrants (including those on student, work, or some other temporary visas), and persons residing in the country without authorization.

Data collected through the ACS revealed that in 2015 there were approximately 43.3 million foreign-born individuals in the United States, among whom 26.6% were Asian Americans (as cited by the Migration Policy Institute, 2017).

A refugee is defined as an individual who is living outside of his or her native country and unable or unwilling to return home due to persecution or fear of persecution, and has applied to enter the United States under these circumstances prior to arrival (U.S. Citizenship and Immigration Services, 2017a). An asylee, an individual seeking asylum, is someone who has already entered the United States and has suffered persecution or fear of persecution, similar to refugees (U.S. Citizenship and Immigration Services, 2017b). A lawful permanent immigrant, or “permanent resident alien” according to the U.S. Department of Homeland Security (2016) is an individual who is “legally accorded the privilege of residing permanently in the United States” (Definition of Terms, Permanent Resident Alien Section, para 1).
For the purpose of this study, the term *Asian* will be used inclusively by referring to those who identify racially as Asian (with or without a particular ethnic group) residing in the United States, regardless of citizenship status. The term *Asian American* will encompass Asians who are U.S. citizens or permanent residents, regardless of country of birth. The term *refugee* will refer to Asians who have recently migrated to the U.S. and have the corresponding status as described by the U.S. Citizenship and Immigration Services. *Asylee* was included among these distinctions because the setting in which this study was conducted provides services to those seeking asylum. However, no asylee clients were discussed by the clinicians in this study. Accordingly, this study will explore the facilitative factors that promote the utilization and commitment to mental health services among Asians residing in the United States. These factors will be gathered from the appraisals of clinicians who work with an Asian population.

**Mental Health in the Asian Population**

There are various noteworthy aspects of mental health among the Asian population. They consistently have lower rates of reported mental illness, which contributes to the societal misperception that Asians are not in need of mental health services in comparison to their other racial counterparts (Hall & Yee, 2012; Kim-Goh, Choi, & Yoon, 2015; Sue, Cheng, Saad, & Chu, 2012). Asian Americans endorse a lower prevalence of mental disorders, which is related to cultural characteristics that specifically affect the reporting of symptomology and self-disclosure in general. Reflective of the diversity within this population, these dynamics differ across subgroups within the Asian population (Hall & Yee, 2012; Kim-Goh, Choi, & Yoon, 2015; Leong & Lau, 2001; Sue, Cheng, Saad, & Chu, 2012). Additionally, those who utilize mental health services tend to present with severe mental illness and symptomology, which may be related to delayed help seeking behavior based on cultural values and taboos. Consequently,
individuals tend to seek treatment not until their symptomology is severe enough to justify that treatment is regarded as necessary (Kim-Goh, Choi, & Yoon, 2015).

Asian refugees and Asian Americans often demonstrate poor functioning as a result of exposure to extensive trauma histories and significant migration adjustments (Leong & Lau, 2001; Rastogi et al., 2014; Sue, Cheng, Saad, & Chu, 2012). Asian Americans typically experience high rates of physical symptomology or somatization in comparison to other racial groups (Rastogi et al., 2014; Sue, Cheng, Saad, & Chu, 2012). The literature referred to culture-bound syndromes, which are a combination of mental and physical symptomology acknowledged by Asian American subgroups (Leong & Lau, 2001; Sue, Cheng, Saad, & Chu, 2012). Culture-bound syndromes often present challenges when diagnosing Asian American clients using the criteria in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (American Psychiatric Association, 2013), which in turn may be a possible contributing factor to low prevalence rates of mental health disorders among this population (Leong & Lau, 2001; Rastogi et al., 2014; Sue, Cheng, Saad, & Chu, 2012). Specifically, according to Small, Kim, Praetorius, and Mitschke (2016):

Refugee mental health is dependent on a number of factors related to the trauma experienced in one’s country of origin, refugee camp, and, in many cases, country of resettlement. Mental illness may manifest differently across culture, and Western-developed measures used to evaluate symptoms may lack authenticity for refugees from various backgrounds. (p. 343)

Upon the identification or report of mental health symptomology, the Asian American population additionally struggles with cultural implications that stifle disclosure of such experiences. The degree to which one feels comfortable to disclose distress is often negatively
impacted by feelings of shame and stigma, which are based on cultural beliefs regarding psychological difficulties (Leong & Lau, 2001; Kim-Goh, Choi, & Yoon, 2015). The notion of disclosing psychological distress requires an individual to engage in intimate communication and verbalize intense emotions (Leong & Lau, 2001). Disclosure is often contrary to a common cultural value of emotional regulation (Kim-Goh, Choi, & Yoon, 2015). Although there are exceptions, the common belief is that overtly expressing emotions can be disrespectful or potentially cause interpersonal conflict for the individual and elicit family discord (Kim-Goh, Choi, & Yoon, 2015). In addition to suppression of emotions and disclosure of mental distress, psychological difficulty is regarded as a sign of weakness, thus admittance to or reporting of mental distress is unlikely to occur (American Psychiatric Association, 2014).

Asian American subgroups report varying experiences and presentations of mental health. According to Masood et al. (as cited by S. Lee, Martins, & H. Lee, 2015, p. 153), “South Asians have generally had lower lifetime and past year prevalence of mood, anxiety, and substance use disorders when compared to the rest of the Asian Americans.” In S. Lee, Martins, and H. Lee’s (2015) study, they reported that Southeast Asians had a higher prevalence of psychiatric disorders in comparison to that of East Asians and South Asians. Asian refugees from politically conflicted countries such as Burma and Bhutan have extensive trauma histories often resulting in higher rates of psychiatric distress, with PTSD and major depression as the most common mental illnesses (S. Lee, Martins, & H. Lee, 2015; Shannon, Wieling, Simmelink-McCleary, & Becher, 2015; Shannon, Vinson, Cook, & Lennon, 2016). Similarly, foreign-born Asians often struggle with adjustment to unfamiliar, often unwelcoming circumstances, which results in a higher risk of developing mental health difficulties (Leong, Park, & Kalibatseva, 2013).
In summary, the Western concept of mental health among Asians is often unknown, disregarded or misunderstood. Mental illness or distress is considered stigmatizing and such stigma impedes help seeking behaviors. Long-standing histories of trauma among Asian subgroups further complicate the receptivity to mental health services, in addition to other barriers to treatment.

**Barriers to treatment.** Despite data reflecting growth in the Asian American population and various factors implicating low rates of mental illness, the literature noted that this population continues to maladaptively underutilize mental health services in the United States (Berger, Zane, & Hwang, 2014; Derr, 2016; Kim, Ng, & Ahn, 2005; Kim-Goh, Choi, & Yoon, 2015; Leong & Lau, 2001; Sue, Cheng, Saad, & Chu, 2012). Additionally, studies showed that when treatment is sought, Asian clients tend to prematurely terminate services at a higher rate compared to non-Asian clients (Kim-Goh, Choi, & Yoon, 2015; Leong & Lau, 2001). Parallel to the impact cultural beliefs and values have on the low prevalence rate of reported mental illness, shame, stigma, and pride in a collectivistic culture are also identified barriers to mental health service utilization (Kim-Goh, Choi, & Yoon, 2015; Leong & Lau, 2001; Wynaden, Chapman, Orb, McGowan, Zeeman, & Yeak, 2005). In addition to cultural barriers, structural barriers include transportation, unawareness of available services, high cost, culturally insensitive service delivery, and language (Kim-Goh, Choi, & Yoon, 2015; Leong & Lau, 2001; Wynaden, Chapman, Orb, McGowan, Zeeman, & Yeak, 2005).

In a systematic review of previous studies regarding service use among immigrants, or foreign-born Asian Americans (Derr, 2016), findings revealed that language barriers, high cost, lack of knowledge of services, and inaccessibility were the most common identified structural barriers to service utilization across 62 articles. Derr (2016) also identified previously noted
barriers including stigma and beliefs about mental illness. Furthermore, Saechao et al. (2012) identified additional factors including lower education, isolation, low rates of employment, trauma histories, and pain as heightened barriers to immigrants and refugees seeking mental health services. A participant in their study explained that concepts such as counseling and mental health were new and unknown, which speaks to the challenges that immigrants and refugees experience when adjusting to new cultural norms and a Westernized society (Saechao et al., 2012).

In particular, Asian refugees face distinct barriers that impact their utilization of services. In a study conducted by Shannon, Wieling, Simmelink-McCleary and Becher (2015), Karen and Bhutanese refugees expressed a fear of being “crazy.” Through their qualitative research, a Bhutanese participant explained that if others found out that he was mentally ill, it might result in his daughter not getting married. There is a great deal of stigma associated with mental health services, in that those who utilize such services are viewed as weak or mentally ill, thus reinforcing Asians’ fears of seeking treatment (Derr, 2016; Shannon, Wieting, Simmelink-McCleary, & Becher, 2015; Wynaden, Chapman, Orb, McGowan, Zeeman, & Yeak, 2005).

Language barriers and culturally insensitive treatment were cultural barriers identified by participants in a study that examined the outcomes of mental health referrals for Asian refugees in the United States (Shannon, Vinson, Cook, & Lennon, 2016). The literature frequently noted that Asians often refer to a lack of knowledge or awareness of mental health services as a significant barrier to seeking services (Kim-Goh, Choi, & Yoon, 2015; Leong & Lau, 2001; Shannon, Vinson, Cook, & Lennon, 2016; Wynaden, Chapman, Orb, McGowan, Zeeman, & Yeak, 2005). Therapy is often regarded as a new concept and a foreign practice for most (Kim-Goh, Choi, & Yoon, 2015; Leong & Lau, 2001; Shannon, Vinson, Cook, & Lennon, 2016;
Wynaden, Chapman, Orb, McGowan, Zeeman, & Yeak, 2005). Furthermore, accessibility to known mental health services in the community is another hurdle many Asians face (Leong & Lau, 2001; Shannon, Vinson, Cook, & Lennon, 2016). Navigating a transit system, learning how to utilize a taxi service, and traveling far distances to attain services, are all barriers that this population often struggles with (Leong & Lau, 2001; Shannon, Vinson, Cook, & Lennon, 2016).

Significantly noted in the literature, barriers to treatment utilization include cultural values and beliefs regarding mental health and mental illness. Pragmatic barriers such as transportation or time commitment are also impacted by cultural values and beliefs, such that one’s willingness to overcome these barriers is quite limited. Asians face many obstacles in seeking mental health services and successfully completing treatment, yet there are those who overcome barriers and are assisted by facilitative factors.

**Facilitative factors to treatment.** Given the foreign nature of various aspects of mental health, sharing information through psychoeducation in the community prior to the onset of treatment is a possible way to facilitate utilization of mental health services (Kim-Goh, Choi, & Yoon, 2015; Shannon, Vinson, Cook, & Lennon, 2016; Wynaden, Chapman, Orb, McGowan, Zeeman, & Yeak, 2005). Advertising available services and providing information about what these services entail to surrounding communities may help to reduce stigma, increase awareness, and strengthen the presence of mental health resources (Wynaden, Chapman, Orb, McGowan, Zeeman, & Yeak, 2005). Lack of a general understanding of what therapy is and what the therapeutic process might entail often results in hesitation, guardedness, and skepticism on the part of the person considering therapy (Kim-Goh, Choi, & Yoon, 2015; Shannon, Vinson, Cook, & Lennon, 2016). As such, psychoeducation during the initial stages of treatment can alleviate this barrier and allow for a stronger connection (Kim-Goh, Choi, & Yoon, 2015). Furthermore,
therapeutic interventions, such as psychoeducation, promote the collaborative effort of establishing a therapeutic working alliance between clinician and client (Bordin, 1979). Bordin (1979) emphasized the significance of a clinician’s role in creating a shared understanding of how coming to therapy is relevant to resolving their presenting problems, when establishing a therapeutic working alliance.

Facilitating access to services through coordination of transportation, education about public transportation, and accommodating clients’ work schedules are all common ways in which clinicians can reduce the practical barriers to treatment (Leong & Lau, 2001). More specifically, utilizing medical transportation services with drivers who speak the language of those served is more likely to be used in comparison to transportation services where communication is impacted by a language barrier (Shannon, Vinson, Cook, & Lennon, 2016). Once practical barriers are addressed and clients have access to services, it is paramount for interpreters and/or community navigators to be involved in the delivery of mental health services when a clinician who speaks the language is not available (Kim-Goh, Choi, & Yoon, 2015; Shannon, Vinson, Cook, & Lennon, 2016). It is also important for the interpreters and clinicians to be cognizant of not only the accurate interpretation of language, but also nonverbal cultural norms (Kim-Goh, Choi, & Yoon, 2015; Shannon, Vinson, Cook, & Lennon, 2016).

Although there are fewer facilitative factors in comparison to the many barriers mentioned previously, facilitative factors such as raising awareness of the Western notion of mental health and the services available to those experiencing mental distress appear to be beneficial to the Asian population. In summary, culturally responsive methods of transportation and providing services in clients’ native language were reported by several studies reviewed above to improve service utilization among Asians. In addition to these facilitative factors, a
significant contributing factor to the successful completion of treatment is creating a culturally responsive therapeutic alliance.

**Significance of therapeutic alliance.** As is universally the case, Bordin (1979) explained, “The effectiveness of a therapy is a function in part, if not entirely, of the strength of the working alliance.” (p. 253) Although this principle is applicable cross-culturally, particular considerations in establishing and strengthening a culturally sensitive therapeutic alliance are significant facilitative factors for long-term utilization of mental health services among Asians (Asnaani & Hofmann, 2012; Kim, Ng, & Ahn, 2005). Culturally sensitive services are especially pertinent when working with Asian clients given the plethora of distinct cultural factors (Asnaani & Hofmann, 2012; Kim, Ng, & Ahn, 2005; Tseng, 2004). According to Lo and Fung (as cited by Tseng, 2004, p. 152), **generic cultural competence** and **specific cultural competence** are two abilities necessary for clinicians to attain, and are defined as follows:

- **Generic cultural competence** includes the basic knowledge and skill set necessary to work effectively in any cross-cultural therapeutic encounter throughout different phases of therapy, while **specific cultural competence** refers to the knowledge and the techniques needed to work with patients of specific cultural backgrounds.

Tseng (2004) further noted particular adjustments culturally competent clinicians must be aware of and willing to address in the therapeutic relationship: technical adjustments, theoretical modifications, and philosophical reorientation. Technical adjustments refer to modifying the delivery of services to meet the cultural and demographic characteristics of the client including age, gender, presenting psychopathology, and all meaningful cultural factors identified by the client (Tseng, 2004). An example of such an adjustment, may entail altering one’s communication style when a client demonstrates difficulty engaging with an older or younger
clinician, in response to a correspondence between age and applicable cultural norms that emphasize an association between age and authority (i.e., greater age is associated with higher authority).

Theoretical modifications, when treating a culturally diverse client, requires taking into account a client’s cultural background, as it improves one’s understanding and conceptualization of a client’s presentation (Tseng, 2004). Gabbard (as cited by Tseng, 2004) notes:

For example, a “passive-aggressive” coping pattern is generally considered “immature” by contemporary Western psychiatrists (Gabbard, 1995), whereas this coping behavior may be considered “adaptive” in many non-Western societies. This is particularly true in relations with authority figures. Direct confrontation (especially with administrative authority figures) is viewed as “unwise” behavior. (p. 158)

Lastly, a culturally competent clinician may need to adjust one’s philosophical orientation or as Tseng (2004) described it, philosophical reorientation of one’s personal and professional beliefs as it informs the psychotherapeutic process or goal of therapy in working with Asian clients. An example of philosophical reorientation may be a clinician’s openness and ability to incorporate a client’s spiritual beliefs into the therapeutic process even if different than that of the clinician.

While these adjustments are necessary in cross-cultural relationships, it is evident that such adjustments are integral aspects of all working alliances. Of course, modifying the case conceptualization to account for a client’s unique history is an integral aspect of all working alliances, not just cross-cultural ones. Lastly, modifying one’s stance to include a client’s beliefs is also a key factor when working with clients cross-culturally.
Recipients of mental health services in past studies reported a preference for culturally competent clinicians and perceive those who are culturally sensitive as being more credible (Asnaani & Hofmann, 2012; Berger, Zane, & Hwang, 2014). Asnaani and Hofmann (2012) noted the significance of validating and respecting a client’s cultural values, as doing so influences their perspective on mental health treatment by enhancing trust and strengthening the therapeutic bond between clinician and client. They also emphasized the importance of building respect in the therapeutic alliance in order to achieve treatment goals collaboratively with the client by allowing the client to fully express their histories, and the extent to which their cultural beliefs play a part in their experiences. Similarly, clinicians in another study (Kim-Goh, Choi, & Yoon, 2015) explained that being purposeful in accommodating cultural values of clients and their families helped in the development of a therapeutic alliance.

Supporting clients with culture-bound syndromes creates an alignment with these clients, which further establishes trust necessary for clients to feel safe in discussing sensitive issues with the clinician moving forward (Asnaani & Hofmann, 2012; Shannon, Vinson, Cook, & Lennon, 2016). Trust was also the key underlying factor in successful mental health referrals amongst refugees in another study where “providers developed trust and rapport with clients, and used the alliance they developed to create opportunities for mental health care coordination” (Shannon, Vinson, Cook, & Lennon, 2016, p. 561). Furthermore, significant empathy is also essential in working with Asians, as it is with any population, but even more crucial in developing a therapeutic alliance and building trust with those often presenting with extensive trauma histories (Asnaani & Hofmann, 2012).

In summary, Asians in the United States commonly underutilize mental health services, despite being one of the fastest growing populations and having various factors contributing to
their actual need for mental health treatment. The facilitative factors discussed thus far include psychoeducation about mental health treatment and a strong emphasis on creating a therapeutic alliance with clients in particular culturally responsive ways. Other facilitative factors were simply noted as addressing known barriers to treatment including inaccessible services and language differences. Additional barriers include culturally insensitive service delivery, cultural perceptions of mental illness, stigma, and access to services as some of the more significant factors.

The predominant research literature has focused on barriers to treatment more readily than discussing facilitative factors, thereby focusing attention on challenges Asian clients may encounter and prepares clinicians to address such barriers in treatment. However, there is comparatively limited information as to what strengths or facilitative factors can positively contribute to the utilization and completion of treatment among the Asian population.

**Method**

**Setting**

This study was conducted in a community-based, nonprofit community mental health center in the state of Colorado. This organization serves Asian American and Pacific Islander communities by providing integrated behavioral, medical, and other related services through a culturally appropriate approach. Services are primarily provided to Asian Americans and Asian refugees, immigrants, and asylees through the use of native-language speaking clinicians or through the collaboration with, and use of, community navigators. Community navigators are professionals in the field who provide interpretation services within the agency, in addition to outreach in their native ethnic communities.
Participants

For practical reasons, a readily accessible sample of clinicians was utilized for this study. Participation was voluntary and confidential. Participants were recruited based on having a minimum of two years experience in providing mental health services to an Asian population. Four master’s level clinicians who self-identified as Asian American participated. They were two males and two females. Participants were bilingual and proficient in both their native language and English. For the purpose of easily discussing data in the results section and further de-identifying clients, the following pseudonyms will be used for participants: Ann, David, Emily, and John.

Procedure

Using a qualitative descriptive research approach, semi-structured interviews with open-ended questions were utilized. Clinicians were selected for this sample, instead of clients, to respect the privacy of this vulnerable population, many of whom recently migrated to the United States. Interview sessions were approximately 30 to 40 minutes in length. Participants were asked to share two different anecdotes regarding a clinical experience with a client. The first with someone who initially appeared invested in mental health treatment, or presented with a positive attitude towards the clinician early in the therapeutic relationship, yet who prematurely terminated therapy (based on the clinician’s judgment). Second, for comparison, I asked about a client who initially appeared resistant or uninterested in mental health treatment, yet who committed to therapy long-term. Additional open-ended, follow-up questions were asked of each participant (see Appendix A for actual questions). Upon completion of data collection, the content of each interview was transcribed verbatim, and transcripts were analyzed to identify major themes. Informed consent and permission to record were discussed with each participant.
and written consents were obtained. Participation was confidential throughout the course of this study, and clients’ confidentiality was upheld as clinicians were asked to provide only unidentifiable information. Given the nature of data collection, exempt status approval was obtained through the University of Denver Human Subjects Research Institutional Review Board (IRB).

**Results**

Although the focus of this study was to explore facilitative factors involved in clients’ utilization and commitment to mental health services, it would be negligent to dismiss the reported barriers to client’s utilization and commitment to mental health services. Two main themes were identified as barriers to treatment: values and mental health beliefs. Two main themes were identified as facilitative factors in treatment utilization: therapeutic alliance and family support. Lastly, identified as both positive factors and barriers, depending on the context of the clinical experience, were secondary gain and access to services.

**Facilitative Factors**

**Therapeutic alliance.** Participants referred to building the therapeutic alliance as paramount to engaging in meaningful work with clients. When asked what the participants appraised as facilitative factors in their clients’ commitment to therapy, they reported that establishing a therapeutic alliance was paramount. They further identified attributes necessary in developing and maintaining a strong therapeutic alliance. For instance, David expressed the importance of establishing a relationship with a 40-year-old Chinese immigrant female who migrated to the United States approximately 10 to 15 years ago:
I think the relationship is the key for me. The relationship, having trust, and having it be nonjudgmental and being empathetic in the relationship is the key. She didn’t feel she was judged and she could trust the relationship, and I think that was significant.

David also assessed that building the therapeutic alliance was an integral, positive factor in working with this client who expressed that she believed that merely talking in therapy would not change her life or solve her issues. David reported that, “Trust was a big thing, her ability to trust in the therapy.”

Participants explained the importance of the following qualities in establishing and building trust with their clients: empathy, positive regard, being nonjudgmental, genuineness and respect. Trust and empathy were identified as pivotal by all participating participants while positive regard, genuineness, respect and being nonjudgmental were described by at least three participants. Ann explained, “If they know that you are there to support them and that you are there with them, it is easier to build trust.” She endorsed that gaining the client’s trust is necessary to engage in meaningful work with the client.

Emily described a challenging case, where the client initially presented as resistant to mental health services, yet the client engaged in long-term therapy. She described the client as a 30-year-old Vietnamese immigrant female who had migrated to the United States as an adolescent. Emily reported that given this client’s skepticism and guardedness, in addition to wanting this clinician to assist with matters beyond this clinician’s role as a mental health professional, it was difficult to gain the client’s trust. When I reflected that despite the many obstacles the client faced she continued to engage in long-term therapy, Emily responded, “Yes, she told me she really trusted me.” She further explained that in building trust with this client, she placed great importance on showing respect:
I respected her opinion and attitude. I didn’t take it as offensive, you know, the way she treated me. And even though she told me I’m not helpful, I still showed her respect even though I know it was outside of the scope of my position.

Participants expressed notable significance of empathy on building rapport, establishing trust, and strengthening the therapeutic alliance. Conveying empathy to the client communicates that he or she is not alone and validates the client’s experience. Participants believed that in order to establish trust with a client, he or she must empathize with the client’s past and current experiences through demonstrating unconditional positive regard, which includes being present with the client in a nonjudgmental, genuine and respectful manner.

Ann explained that a consistent factor of a strong therapeutic alliance is “making sure the client knows you are there for them no matter what they are presenting with.” When asked if she was referring to unconditional positive regard, Ann responded:

Yes, that you are your client’s clinician no matter what they have done or what they are going through. A lot of them have a long trauma history and they feel trust in you when you are able to sit with them no matter the bad things they’ve witnessed or experienced in their life.

In describing the work with a 65-year-old Bhutanese refugee female, John highlighted the efficacy of easing into each session with a more casual conversational approach. He described asking the client about how their week or day had been so far, choosing a less threatening or intimate question to begin a session. John also noted that in doing so:

It helps them to know that you are really interested in how they are doing. You build trust through that and it shows them that you will listen about how their day or week was, regardless of what they share - having that positive regard I guess.
Similar to Emily’s experience with a resistant client mentioned previously, John noted an effort in continuing to be positive towards the client regardless of the client’s material coming up in session and the passive aggressive behaviors directed towards the clinician. John explained that it is important to address the behaviors with the client while still engaging in unconditional positive regard.

In referring to unconditional positive regard, participants also expressed the necessity of maintaining genuineness with clients and the importance of balancing both with professionalism. Participants described the importance of being genuine with clients while being nonjudgmental of clients’ material as a way to not only gain the trust of these clients, but also as a way of being present. Interacting with clients in a nonjudgmental approach was assessed as a means to maintain their utilization of services. They explained that it decreased the shame a client might experience for missing a session and not wanting to continue services as a result. In John’s work with the 65-year-old Bhutanese client noted previously, he explained the benefits of creating an effective therapeutic relationship:

Being myself, being genuine. Being able to ask about her histories, about her past, and just being able to carry that small conversation. I think over time allowed her to see me as a person and not someone there to judge her. And maybe lessen that fear, that if she didn’t show up that I would judge her.

Family support. Two of the participants emphasized the positive influence family support had on their clients’ utilization of mental health services and commitment to therapy. Ann discussed a case of a 48-year-old Bhutanese refugee female who migrated to the United States approximately nine years ago. She explained that this client was initially resistant to treatment, and yet she engaged in long-term therapy. Ann disclosed that the client’s “husband
was very open to seeking mental health services and her seeking mental health services,” which Ann believed was an influential factor in the client’s continued commitment to therapy despite her initial resistance.

Emily explained that her client, the 30-year-old Vietnamese female mentioned earlier, had family here in the United States. Emily reported that the client identified her family as a source of support, and that they all supported her initially even though it was difficult for her family to understand her mental distress. Nonetheless, the client expressed that her family was still very supportive of her even though she did not live with them: “She had family here, her sister and brother...Her family was still supportive even though she [did] not live with them.”

**Barriers**

**Values.** Participants reported that personal and cultural values and priorities were significant factors impacting their clients’ commitment to mental health services, and explained that these priorities often interfered with making time for therapy. After discussing facilitative factors regarding a 28-year-old Nepali refugee female, when asked about the barriers to treatment, Emily explained:

What she valued might have been a barrier. For example, I want to talk to someone about my problems, but only when I have time to talk. She did not think about the fact that she had an emotional challenge and that she needed help with it. And then culturally, other things were more important than mental health such as family, work. With that population, there is very little motivation for therapy and they do not think about themselves because they put family first.

John disclosed his similar appraisal in working with a 15-year-old Chinese American male. He reported that cultural values honored by this client’s family impeded his treatment:
So, when looking at his barriers to therapy I would look at the barriers as a family. First, mom’s schedule was very tight. A cultural part is that she thinks that work is the most important, and she will not sacrifice her time and work to get the kids to come here for therapy.

John also explained that sometimes clients’ value of personal pride is much stronger than their beliefs about the benefits of therapy.

**Mental health beliefs.** Participants identified mental health beliefs as deterrents of help-seeking behaviors, willingness to seek treatment, and utilization of mental health services. David, when talking about his work with a Bhutanese refugee, explained:

what I did learn is that mental health is bad, and that there’s not really a formal vocabulary to explain some of the signs and symptoms that we see here. So, a lot of it in the culture is described as “you’re crazy,” and it is very much looked down upon and nobody wants to talk about it. So, a lot of time is spent explaining what the purpose is.

Similarly, John expressed that the Chinese immigrant he worked with, “felt that counseling is for weak people and that it shows weakness.”

Participants endorsed that mental health related issues were stigmatized in the Asian community. David explained that therapy is very stigmatizing for many clients, and that services are only sought as a last resort, in desperation. David reported that a 30-year-old Korean immigrant that he worked with often reported that he was embarrassed about his anxiety when around his family and colleagues, because in his culture having an issue like anxiety was very shaming. David further noted that the client’s family often minimized the client’s experiences and symptoms, straying from any possibility of having a mental illness.
Both Facilitative and a Barrier

Secondary gain. Participants identified psychiatric services and assistance with services outside of the scope of mental health treatment (i.e. disability forms to be completed by medical professionals or citizenship forms that may require legal advice) as two motivating factors for clients to seek mental health services, therefore clients' investment in psychotherapy is actually secondary. Ann noted that many clients end up in long-term therapy primarily for medication to treat their symptoms, and that they are often not interested in therapy, thereby regarding this as a secondary gain. David discussed that a client attended therapy weekly until he acquired medications from the psychiatrist to address his anxiety, after which the client eventually terminated therapy once his symptoms dissipated. In addition to psychiatric services, assistance with completing disability forms were also noted by the four participants as a reason for seeking mental health services. For example, Ann described the following about a 52-year-old Laotian refugee female who had migrated to the United States approximately 20 years ago:

...she claimed she became disabled, and she came here claiming she could not work so she applied for benefits. She came here many times asking for help to complete the forms she needed. So, there was definitely secondary gain, which was [her] motivation. She often said nothing is changing, and I think she was often afraid to say that things were getting better. That's why she always said "same" when I asked her how things were, because if she admitted things were getting better then she wouldn't qualify for benefits. But, she also didn't want to talk about her personal issues.

Participants similarly noted that while it was still positive that clients were utilizing services regardless of their secondary gain, it was also a barrier that often resulted in premature
termination once those needs were addressed. Their secondary gain appeared to be both beneficial and detrimental, impacting clients’ perception as to what therapy entailed.

**Access to services.** Participants described clinical cases in which transportation, distance, and other aspects of access to services were deemed as both facilitators and barriers to treatment. Ann disclosed the consistency of a client’s attendance to therapy as a result of the client needing medical transportation, in the form of a taxi service. She explained that medical transportation was necessary due to the client’s anxiety impeding her ability to drive or utilize public transportation. Ann mentioned that utilizing transportation services positively influenced clients’ consistency with attendance, similar to those with personal vehicles.

Participants also described complications and preferences regarding transportation as potential barriers to clients’ utilization and commitment to services. As John reported, although his client was capable of utilizing public transportation such as the bus, he insisted that family members take him to therapy, which was not always possible. When asked about barriers to treatment, John responded:

> So first is the transportation. I would say he liked the easy way, which means he, like many of our clients here, live very close. But, he wanted someone to give him a ride because he either had to get a ride or catch the bus.

Despite John’s report of the client living nearby and still struggling to attend sessions, he also noted in a general statement that clients who resided close to services were unlikely to have difficulty attending treatment in comparison to those who were farther away. However, distance proximity was not quantified and it is important to note that what is determined as close in distance to one, may not be necessarily deemed close by another.
Discussion

Overall, this study further corroborated long-standing factors found to contribute to the mental health status of the Asian population in the United States, regarding both facilitative and obstructive factors. This study’s results confirmed well-known barriers to mental health service utilization and commitment amongst Asians, specifically personal and cultural values, and beliefs about mental health. Cultural norms in many Asian communities include suppression of emotions and abstaining from disclosure of psychological distress. Participants in this study confirmed that the beliefs about mental distress in the Asian population is essentially negative and stigmatizing. In particular, one participant specifically referred to the client’s perception of mental illness as a sign of weakness. Participants also discussed clients’ inabilities to balance values that include work, time, and family with their commitment to therapy, thus confirming cultural values as barriers to treatment and contributing factors of premature termination.

Secondary gain and access to services were both deemed as influential factors, positively and negatively. Secondary gain was described as a facilitative factor in that clients’ interest in seeking psychiatric medications and assistance with attaining disability benefits or other types of related services motivated clients to engage in mental health treatment. However, participants also identified secondary gain as a barrier, since clients prematurely terminated mental health services once their needs for medication or disability benefits were satisfied. When clients lived in close proximity to this mental health center and had means of transportation either via personal vehicle, medical transportation, or family support, access to therapy was considered a facilitative factor. In contrast, access to therapy was also regarded as a barrier when clients were unmotivated to utilize public transportation or walk when within reasonable distance, and when clients lived farther away and required additional supports to attend appointments. Such
behaviors are possibly related to a learned helplessness ethnic minorities, immigrants, and refugees face as a result of many barriers.

Specific to the aim of this study, results revealed the importance of the therapeutic alliance between clinician and client, which parallels existing literature. Similar to the findings of Asnaani and Hofmann (2012), where being respectful of a client’s cultural values and building trust enhances the therapeutic bond, this study found that the utilization of long-term therapy is positively influenced by the clinician’s ability to establish a strong therapeutic alliance. Literature that referred to trust as a key underlying factor in successful mental health referrals amongst refugees (Shannon, Vinson, Cook & Lennon, 2016) was also endorsed in this study regarding the significance of trust in mental health service utilization among Asian clients that were discussed.

Although not identified as a main theme, participants acknowledged clients’ particular cultural factors as potentially impacting the development of the therapeutic alliance. These factors include communication style, values and perspectives regarding privacy, and the hierarchical nature of a clinician-client relationship. A participant explained that his clients expressed feeling comfortable receiving help from a professional, and were more responsive when he clarified his role as their clinician. Tsui and Schultz (1985) suggests that clinicians should clearly inform clients of the nature and purpose of therapy and the therapeutic relationship. They explain that given the respect for authority figures in Asian cultures, Asian clients often willingly accept their clinician as a professional in a helping role, but that the degree to which a client engages may increase with a better understanding of what therapy entails (Tsui & Schultz, 1985).
Another participant reported, “They teach us in school not to self-disclose too much information, but you also have to be aware of the culture. In Asian culture, if you’re a stranger and I don’t know much about you, I’m not going to tell you about me.” Tsui and Schultz (1985) suggest that given the slow process of trust building outside of the familial system, it is advantageous for clinicians to ease into the gathering of information, which may involve adapting one’s communication style to a more conversational approach, at least initially. They further note, “To overcome the taboo that one should never discuss personal affairs with strangers, clients often attempt to incorporate the therapist into their family or clan network by inquiring about the therapist’s personal background.” (Tsui & Schultz, 1985, p. 568). It is suggested that clinicians refrain from avoiding such self-disclosure or responding defensively, and to instead, respond with appropriate self-disclosure to facilitate a therapeutic alliance (Tsui & Schultz, 1985).

Participants noted the significance of the therapeutic alliance, confirming findings from earlier studies, in addition to inadvertently identifying therapeutic concepts reflective of a humanistic theoretical approach as most effective. The results of this study were not merely consistent with previous findings, but rather, participants’ highlighted factors most influential in establishing relationships with their clients that were reflective of person-centered therapy created by Carl Rogers. According to Rogers (1951), an essential part of the therapeutic process is the relationship between clinician and client, and the client’s experience of that relationship. One of the fundamental aspects of the therapeutic relationship is building rapport with the client through warmth and responsiveness (Rogers, 1942).

Rogers (1967) identified three primary experiential conditions in the clinician as essential in establishing the therapeutic relationship and eliciting progress in the therapeutic process:
congruence, empathic understanding, and unconditional positive regard. Rogers (1967) defined congruence as the necessity of being genuine in the relationship through the counselor having awareness of the feelings he experiences in the room with the client, and communicating this experience appropriately. Empathic understanding refers to the counselor experiencing a true sense of the client’s private world and effectively communicating his understanding to the client (Rogers, 1967). Lastly, Rogers (1967) believed that the therapeutic process required the counselor to express a warm and positive attitude toward the client, which he described as unconditional positive regard. He defined this as the ability to convey a positive feeling without judgment or reservations towards the client (Rogers, 1967).

Although only one participant specifically referenced a humanistic approach and there was no specific mention of person-centered therapy, participants in this study placed an emphasis on the use of genuineness, empathy, and unconditional positive regard, thereby in effect endorsing a person-centered approach in their work with clients. In combination with being cognizant of a client’s cultural worldview and adapting their approach to be culturally sensitive, participants utilized the experiential conditions outlined in person-centered therapy to establish a therapeutic alliance and working relationship. Participants unanimously disclosed the importance of building trust as a foundation to an effective therapeutic relationship to which they described the use of genuineness, empathy, and unconditional positive regard as facilitating factors in doing so.

Person-centered conditions can also be a facilitative context for addressing and minimizing the impact barriers have on mental health services in the Asian population. Specific barriers such as stigma and shame associated with the utilization of mental health services can be weakened through the application of unconditional positive regard and empathy with Asian
clients. Previous research notes a significant impact of trauma histories and pain as heightened barriers amongst Asian immigrants and refugees. Accordingly, unconditional positive regard and empathy are approaches through which clinicians can begin to build trust and create an effective therapeutic alliance.

Furthermore, utilizing a person-centered approach aligns with Tseng’s (2004) previously noted cultural adjustments necessary in delivering culturally competent psychotherapy to Asian clients. Applying an unconditional positive regard while being genuine and empathic can be culturally universal and may minimize the need for technical adjustments, theoretical modifications, and philosophical reorientation. There may be few cultural and demographic considerations that would necessitate the adapting of one’s practice of genuineness, empathic understanding and unconditional positive regard. Such adjustments may be required in other aspects of a clinician’s presentation and application of psychotherapeutic skill; however, when focusing on the specific use of person-centered constructs, it would appear to be difficult to argue that one would view a clinician who is genuine, empathic and engages a client with unconditional positive regard as insensitive. This highlights a potential rational as to the effectiveness of person-centered therapy in working with Asian clients given the universal nature of its constructs, aligning with culturally competent psychotherapy.

Unique characteristics and histories within each Asian subgroup influence the effectiveness of applied therapeutic approaches in therapy, whether it be that a client resonates with a more directive approach in the service of a hierarchical culture, or that a client positively reacts to a systems approach given a more collectivistic culture (Kim-Goh, Choi, & Yoon, 2015). However, on a foundational level, using a person-centered therapeutic approach to establish a helping relationship may greatly improve the therapeutic process. Person-centered therapy may
also be used to facilitate a client's interest in services prior to the onset of treatment by establishing rapport through the application of person-centered principles. Additionally, in working with clients of Asian subgroups with trauma histories, establishing trust to even begin establishing a therapeutic relationship can be difficult when using modalities that do not necessarily have such emphasis. Although other therapeutic approaches may meet clients' needs, the notion behind a humanistic approach, such as person-centered therapy, is that all individuals have the need for and benefit from genuineness, empathy, and unconditional positive regard.

In summary, the findings and recommendations may be characterized as promoting a culturally responsive humanistic approach. At the detail level, Asians are to be treated specially in the service of being sensitive and responsive to particular (but not necessarily unique) cultural values and characteristics. At the broader level, Asian are to be treated just like everyone else, which is consistent with the tenets of humanistic psychology.

**Limitations and Future Research**

While this study provided new perspectives and confirmed earlier findings regarding various aspects of mental health among Asians (e.g., distress, illness, beliefs, and so forth), there were limitations in this study that should be noted and considered for future research. Specifically, the few participants and limited time with each participant are obvious notable limitations. Having few readily accessible participants limit the generalizability of these findings to the broader Asian population. It was challenging to recruit more participants due to the few number of clinicians meeting the criteria of a minimum of two years experience working with Asians. The current staff, already small in size, also consists of psychology interns from local and out of state universities. Given the smaller-sized staff with full caseloads and time constraints by clinician's schedules, the time allocated for interviews was considered reasonable.
in terms of the design of this study. However, these circumstances limited data collection to only two anecdotes and follow-up questions. Furthermore, the interviewer was often limited to asking prepared questions, and had limited opportunity to expand on material throughout the interview that may have led to additional themes or enriched those that were examined.

Colorado's demographic composition and diverse communities are also factors to consider. Specifically, according to the United States Census Bureau (as cited by the Migration Policy Institute, 2017), in 2015 Asian was the third largest race among the foreign born population in Colorado. In addition to numerical data, the prevalence and establishment of Asian communities in Colorado, which may positively impact the utilization of mental health services among the clients discussed. Furthermore, the presence of community navigators creating a positive association between community members and this mental health center may create a positive bias that is different from other agencies where this connection is not established. As a result of this facilitated relationship between the community and this mental health center, a positive reputation of the community mental health center may have had an impact on clients’ utilization of services, thus impacting the results of this study.

Future research should continue to explore facilitative and positive factors that influence Asian Americans success in attaining long-term mental health services in order to promote what is currently working in the mental health field and to explore the effectiveness of said factors to resolve the numerous barriers hindering Asian American’s well-being. With regard to the effectiveness of person-centered therapy as a facilitative factor in positive therapy outcomes, it would be beneficial to examine any possible correlations between the application of specific therapeutic approaches and treatment outcomes amongst Asian Americans, as it specifically relates to mental health services utilization and prevention of premature treatment termination.
Summary

The Asian population, in addition to being fast growing, is a diverse group including subgroups with various histories and migrations to the United States. This racial group struggles with many barriers to the utilization of mental health services, in turn affecting higher rates of premature termination of mental health services and underutilization. Some of these barriers may be alleviated through the application of person-centered therapy by clinicians being genuine, empathic, and expressing unconditional positive regard. Not surprisingly, the findings indicate that it is also be beneficial for clinicians to adjust their approach with Asian clients by being cognizant of cultural factors specific to this population and modifying their delivery of services accordingly. Finally, there are several notable facilitative factors to the utilization of mental health treatment among Asians, including the therapeutic alliance, which aligns with the importance of establishing this through a humanistic orientation, specifically person-centered.
References


Rogers, C. R. (1967). The interpersonal relationship: The core of guidance. In C. Rogers & B. Stevens (Eds.), *Person to person: The problem of being human, a new trend in psychology* (pp.89-103).


Appendix A

Interview Questions

Can you think of a client who you thought was not committed to therapy, yet the client continued therapy with you? Tell me about that experience.

Can you think of a client who you thought was committed to therapy, that terminated therapy early? Tell me about that experience.

What was the client’s familial beliefs about mental health?

a. ...about seeking mental health services?

b. what does his/her culture say or believe about mental health?

c. ...about seeking mental health services?

What is the client’s beliefs about mental health?

a. ...about seeking mental health services?

Were there any barriers to therapy?

Were there supportive factors in the client’s access and use of therapy?