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ORIGINAL PAPER

Adapting Meaning-Centered Psychotherapy in Advanced Cancer for the Chinese Immigrant Population

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Abstract The Chinese immigrant community faces multiple barriers to quality cancer care and cancer survivorship. Meaning-centered psychotherapy (MCP) is an empirically-based treatment shown to significantly reduce psychological distress while increasing spiritual well-being and a sense of meaning and purpose in life in advanced cancer patients. However, it has not yet been adapted for racial and ethnic minority populations for whom the concept of "meaning" may likely differ from that of westernized White populations. In this study, we conducted a community needs assessment to inform the cultural adaptation of MCP for Chinese patients with advanced cancer, in accordance with Bernal et al. ecological validity model and the cultural adaptation process model of Domenech-Rodriquez and Weiling. We conducted interviews until saturation with 11 key Chinese-serving community leaders and health professionals with a range of areas of expertise (i.e. oncology, psychology, palliative care, cancer support services), to examine community needs, priorities, and preferences within the context of the MCP intervention. Sessions were audio recorded and transcribed. The research team analyzed the transcripts using Atlas.ti. Six frequently occurring themes were identified. Interviewees described the role of the family, traditional Chinese values, cancer stigma, and social norms (e.g. saving face) in adapting MCP. Researchers and clinicians should consider the role of the family in treatment, as well as specific social and cultural values and beliefs in adapting and delivering MCP for Chinese patients with advanced cancer.

Keywords Chinese immigrants · Advanced cancer · Psycho-oncology · Meaning-centered psychotherapy · Cultural adaptation · Spiritual well-being

Background

Stark inequalities exist in quality of life (QOL) for minority cancer survivors [1]. Chinese immigrants are a poor, medically underserved population with numerous barriers to good QOL in survivorship [1]. This group is particularly vulnerable because of cancer stigma [2], limited cancer knowledge [1, 2], lack of health care navigation knowledge [3], poor access to culturally and linguistically responsive support [3–5] and financial barriers [6]. In the U.S., 50% of the Chinese population speaks English less than "very well" [7]. In New York City, 45% report speaking English "not well" or "not at all" [8]. Language and communication are crucial in effective cancer support, with its complexity and emotional nuance [9, 10], yet cultural and language barriers often exist [11]. Chinese patients may be passive in the health care system. Traditionally the doctor is not to be challenged [2], leading to reduced care participation [12].

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Cultural differences between Western health care workers and Chinese patients can add difficulty to end-of-life care [13].

There are few studies that have specifically focused on existential or spiritual domains in treatment or measured the impact of meaning-making psychotherapeutic treatment on QOL in patients with advanced cancer [14]. In response to the paucity of such literature, Breitbart et al. developed Meaning-centered psychotherapy (MCP) [14, 15]. Based on the principle that humans are motivated by a "will to meaning," drawn from Victor Frankl's work with Holocaust survivors, MCP is designed to help patients with advanced cancer sustain or enhance a sense of meaning as they approach the end-of-life [15]. A small but growing body of research has demonstrated that MCP significantly reduces psychological distress (e.g. depression, hopelessness, anxiety, and desire for hastened death) and significantly increases spiritual well-being and a sense of meaning and purpose in life in patients with advanced cancer [14, 16, 17]. Breitbart's MCP intervention consists of seven (individual) or eight (group) 90 min sesssions [16] (Table 1).

The efficacy of MCP was tested in a randomized controlled clinical trial to assess its impact on reducing psychological distress and improving spiritual well-being with an English speaking, predominantly White (71.2%) sample in which Asian-Americans were not included as a demographic category [17]. MCP has not yet been adapted for racial-ethnic minorities who may hold different cultural, spiritual, and religious values, attitudes, and beliefs and for whom the concept of "meaning" may differ from their White counterparts [13]. The present study describes a qualitative community needs assesment to inform the adaptation of MCP for Chinese cancer patients, a large, underserved, and understudied minority community.

In this study, we sought to determine the needs and issues that are important to Chinese cancer patients, to inform adaptation of the MCP intervention. Our study was informed by the ecological validity model (EVM) of Bernal et al. [18] and the cultural adaptation process (CAP) model of Domenech-Rodriquez and Weiling [19]. The EVM focuses on cultural adaptations to the content of evidence-based treatments. The EVM consists of eight dimensions of treatment interventions that serve as a framework for adapting psychosocial interventions for minority populations: Language, Persons, Metaphors, Content, Concepts, Goals, Methods, and Context [18]. The CAP was developed to be used together with the EVM [19]. The CAP has three phases: (1) Meetings with community leaders to explore interest and needs and gathering information to inform intervention adaptation; (2) Measurement issues and selection of the specific intervention itself, including initial pilot-testing of the intervention; (3) Adaptation iterations, to be made as needed [19]. This study corresponds to Phase 1 of the CAP model.

Methods

Study staff worked closely with partners in the Chinese community to identify key Chinese-serving community leaders and health professionals with a range of areas of expertise (i.e. oncology, psychology, palliative care, cancer support services), to examine community needs, priorities, and preferences within the context of the MCP intervention.

Potential interviewees were recruited by referral from the above mentioned partners in the Chinese community, and then approached by telephone to assess interest in participation. The PI (JL) conducted the interviews (in English) with interested parties in person, describing the MCP

Table 1 Meaning-centered psychotherapy sessions

Session no.	Topics	Description of session
1	Concepts and sources of meaning	Participants first share their cancer stories, then share what "meaning" means to them, i.e., what is important in life—their beliefs, values, hopes for the future
2	Cancer and meaning	Participants explore how cancer has affected their sense of identity
3	Historical sources of meaning	Participants are asked, "When you look back on your life and upbringing, what are the most significant memories, relationships, traditions, etc. that have made the greatest impact on who you are today? As you reflect upon who you are today, what are the meaningful activities, roles, or accomplishments that you are most proud of? As you look toward the future, what are some of the life-lessons you have learned along the way that you would want to pass on to others?"
4	Attitudinal sources of meaning	Participants are asked, "Since your diagnosis, are you still able to find meaning in your daily life despite your awareness of the finiteness of life?"
5	Creative sources of meaning	Participants explore meaning derived from creativity and responsibility
6	Experiential sources of meaning	Participants are asked to list three ways in which they "connect with life" and feel the most alive through the experiential sources of love, beauty, and humor
7	Transitions	Goodbyes, and hopes for the future: participants give their feedback on the program

intervention, the purpose of the intervention, and the proposed adaptation process. Interviews were conducted to data saturation. An interview guide outlined the following primary areas of inquiry: (1) patients' goals for the adapted intervention (relates to Goals dimension of the EVM); (2) relevance and adaptability of the MCP session themes (relates to Metaphors, Concept, and Content dimensions of the EVM); (3) relevance of key themes from literature and preliminary work (relates to Metaphors, Concept, and Content dimensions of the EVM); (4) preference for intervention methods (relates to Methods dimension of the EVM); and (5) potential impact of contextual barriers on delivery and effectiveness of the intervention (relates to Context dimension of the EVM).

Interviews were transcribed and analyzed using Atlas.ti, a software package that has been used extensively for qualitative data analysis [20]. The analysis was conducted by the PI (JL) and two of the authors (FL, AC), using inductive analysis techniques. Inductive analysis requires that categories, patterns, and themes come from the data; this iterative process results in a coding scheme. Once the coding scheme was developed, the transcripts of the interviews were reread and coded (JL, FL, AC). The process of coding permitted reviewers to closely examine the prominent issues raised in the interviews and to identify specific themes, subthemes, and subtopics. Results were discussed (JL, FL, AC), disagreements on coding were resolved, and key themes were elucidated. Reviewers also agreed on selected quotations to illustrate the key themes.

Results

Eleven potential interviewees were approached and all agreed to participate. Of the 11 interviewees, nine were female and two were male. Six interviewees worked in an urban hospital setting, two in the hospice setting, two in community-based organizations, and one in a community-based private practice. Seven interviewees provided direct care to patients, while the other four held advocacy/program development roles in the Chinese community. Five of the interviewees were physicians. Eight of the community leaders (72.7%) were ethnically Chinese and seven (63.6%) spoke Chinese. All had direct experience with Chinese patients.

Inductive analysis of the transcripts yielded thirty-eight codes (subtopics) within six key themes: (1) family; (2) culture; (3) immigration; (4) end of life; (5) distress, suicide, and symptom control; and (6) other specific adaptations to MCP (Table 2).

The majority of interviewees felt Chinese cancer patients and their families would endorse the following preferences for intervention methods (relating to Methods dimension of the EVM): family participation in sessions; experiential exercises and discussion (i.e. "life review") rather than didactics; session locations at hospitals, clinics, or where existing support groups are held; in-person versus phone sessions; and individual versus group sessions.

Family

All interviewees raised the issue of family in adapting MCP for the Chinese population. Many interviewees (n = 5) emphasized the cultural value of filial piety, i.e., a Confucian virtue of respect for one's parents, elders, and ancestors. "They have this sense of duty to take care of their parents and to respect them. If you don't emphasize those values, it will be very hard for [MCP] to be culturally relevant and to get buy-in."

Several interviewees (n = 4) described their treatment of Chinese cancer patients as characterized by a family-centered decision-making model rather than a Westernized model of patient autonomy. This was described as complicating clinicians' disclosure of medical information to patients, some of whom elected to have a family member, often an eldest son, receive information and make decisions about their care: "The first son is the decision maker … but [is not] the primary caregiver … So there's a lot of disjointed, fragmented communication."

All (n = 11) recommended family participation in the MCP intervention, given the cultural norms around family involvement in medical care.

Culture

All interviewees (n = 11) described the unique role of culture in adapting MCP for the Chinese community. Interviewees (n = 5) described traditional views of Chinese patients, e.g. past-time orientation; guilt, fear of punishment, failure, and fatalism; and beliefs around superstition and luck. One interviewee described how these views might negatively impact spiritual well-being in a hypothetical Chinese cancer patient: "Why me? … Okay, that's because I'm not a good person; this is punishment from God … a lot of concern, regret, and guilt."

Social norms in Chinese culture were also discussed. One interviewee explained that differences between collectivistic Chinese culture and individualistic Western norms might contribute to Chinese patients' devaluation of interventions like MCP that focus on the internal psychological processes of the individual: "We're not individualistic … Most people, their responsibility is to their family, not really to themselves." While most interviewees (n = 8) warned that cultural norms of face-saving and privacy could impede treatment, one interviewee suggested that this norm might not apply to everyone. "A

Table 2 Key themes, subthemes, and subtopics

Theme	Subtheme	Subtopic
Family	Family expectations	Patient as family burden
		Importance of being honored by family across generations
		Filial piety
	Family relationships	Patient autonomy vs. family-centered decision-making model
		Disclosure of medical information
		Brokering family dynamics, tensions and conflicts
		Generational differences
		Role of family in end of life care
		Forgiveness and closure
		Family participation in MCP intervention
Culture	Traditional views	Past-time orientation
		Guilt, fear of punishment, failure, fatalism
		Superstition and luck
	Social norms	Collectivist versus individualist
		Face-saving and privacy
		Lack of expressivity
		Show love by feeding
	Cancer stigma	Fear of contagiousness and contamination
		Indirect references to cancer (e.g. angry tumor)
		Belief that cancer occurred due to misdeeds in past life
	Chinese proverbs	Chinese proverbs/terms
	Religion	Provide opportunities to include religion
Immigration		Immigration status as a barrier to care
		Desire to return to country of origin
		Hetereogeneity within Chinese population
		Reframing immigration experience
End of life (EOL)		Not wanting to die at home
		Desire for good death
		Reframing attitudes towards EOL
Distress, suicide, symptom control		Underreporting of pain
		Denial/refusal of medication
		Distress and depression
		Suicidal ideation
Other specific adaptations to MCP		Build trust with patients and their communities trust
		Emphasize the practicality of MCP in context of family
		Provide resources on cancer and navigating the healthcare system
		Use more specific/concrete examples
		Address barriers to participation

lot of people make assumptions that … Chinese patients don't want therapy. As long as you establish a good relationship with the patient and show a genuine desire to help them, they're gonna buy into it".

Interviewees suggested incorporating cancer-related education in the adapted intervention to combat culturally-influenced superstitions related to cancer. Interviewees (n = 5) discussed how cancer stigma related to fears of contagiousness and contamination. Some (n = 3) described employing indirect references to cancer (e.g. "angry tumor") when treating Chinese cancer patients: "We don't use the word 'cancer' in any of our materials … because of the stigma and the taboo around it". Others (n = 2) described the cultural belief some patients held that cancer occurred because of misdeeds the patient had committed in a past life.

Several interviewees suggested the adapted MCP intervention incorporate Chinese proverbs and terms. The majority of interviewees (n = 7) also endorsed addressing religion in MCP. One observed parallels between Eastern religions and the goals of MCP: "[Many] pay homage to their ancestors, and tradition is really important, [so] in meaning-making it would be good to incorporate that."

Immigration

Interviewees (n = 8) described the significance of Chinese cancer patients' immigration experiences in

adapting MCP. Participants discussed Chinese patients' desire to return to their country of origin at the end of life as a common phenomenon.

Interviewees advised that researchers be aware of the range of immigration histories patients may have experienced in adapting the intervention instead of adopting a one-size fits all approach. This heterogeneity extended to religious beliefs ("Older generations or people from Taiwan have more of a religious base. People from China, because of the Cultural Revolution, that's all gone"); language, generational status, and education ("The San Francisco area is more Cantonese-speaking, and older. In South Bay it's all tech, highly educated, very analytical"); and ethnicity ("Fujianese, Cantonese, Mandarin").

End of Life (EOL)

Interviewees (n = 3) stressed dying in the household was a serious cultural taboo that could cause anxiety and negatively impact spiritual well-being. One interviewee recounted an incident in which a patient committed suicide to avoid inadvertently dying at home and bringing her family bad luck. "She didn't want to leave the family with this guilt of dying at home."

Most participants (n = 9) recognized the Chinese cultural emphasis on a good death, where familial and financial responsibilities have been met and conflicts resolved, and suggested incorporating it into the MCP adaptation. One interviewee provided an example of a community-based workshop focusing on end-of-life issues that could be incorporated into MCP: "We call it 'Celebrating Life's Journey,' processing end-of-life, a life review".

Interviewees recommended the adapted intervention reframe patients' immigration experiences in discussions about meaning at the end-of-life. One interviewee suggested encouraging patients to speak freely by referring to the variety of cultural norms available to them as immigrants: "You're in America, you don't have to be restricted to these Chinese ways." Another described adopting a strengths-based approach building upon patients' immigration histories: "It's a survivor culture. Chinese patients have gone through lots of wars, lost lots of things. We try to frame [end-of-life preparation] as hoping for the best, planning for the worst."

The majority of interviewees (n = 10) were optimistic that MCP presented a valuable opportunity for Chinese patients to reframe their attitudes towards end of life, citing "fulfillment" and discovering "meaning" as potential benefits.

Distress, Suicide, and Symptom Control

Interviewees (n = 3) expressed significant concerns over Chinese patients' tendency to underreport pain, which would need to be addressed before spiritual well-being could be achieved. One bemoaned "neglect" of the interrelated issues of symptom control, suicidal ideation, and pain, observing that the most "demoralized" patients worry about being "burdensome" (to their families) even when in "incredible physical, emotional pain." Denial and refusal of medication was discussed (n = 3): "[Denying medication] is a badge of honor that 'I'm tough' … But it's really common."

Other Specific Adaptations to MCP

In addition to recommending adaptations related to the five themes described above, interviewees made additional general suggestions to improve the reception and outcome of MCP in the target population.

An interviewee emphasized meeting patients where they are: "Instead of respecting our goals, we have to respect their goals." For instance, the intervention could highlight "the value in the end of life stage, that there are still achievable ways that they're helping their family, contextualized in the family unit." Interviewees recommended that MCP adapted for the Chinese population must be "easy to adopt" and show results "right away." It was suggested that the MCP adaptation reframe and redefine study goals, definitions, and approaches to highlight their practical relevance, i.e. how MCP could help patients become happier, more functional, less of a burden on their families, and better communicators with the people in their lives.

All interviewees (n = 11) recommended the use of more specific examples to guide some of the more abstract topics that are included in the MCP intervention. Most interviewees (n = 6) expressed concerns regarding the session on experiential sources of meaning, when patients are asked to list three ways in which they connect with life and feel the most alive through the experiential sources of love, beauty, and humor. One respondent explained, "Culturally, it's not so practical. [Patients] may not think a sense of humor can help [him or her] get out of this." Suggestions included: [Modifying] the initial questions in each session [to be more concrete] or experiential and. .. to give examples or categories when introducing topics for discussion.

Conclusions

This study highlights the needs, priorities, and preferences of immigrant Chinese patients with advanced cancer in the context of adapting the MCP intervention for

this population. Community leaders described how the role of the family, cultural values, cancer stigma, immigration histories, and attitudes toward end-of-life may impact the reception, processes, and outcomes of MCP in Chinese immigrants with cancer. They expressed the need for enhancing spiritual well-being in Chinese immigrant patients with advanced cancer and described several barriers to quality psychotherapy treatment for this population.

Interviewees voiced the central role of family in Chinese cancer patients' illness, including fear of becoming a burden to family members and the common practice of designating a family member to make medical decisions for the cancer patient. This is consistent with prior research describing Chinese cancer patients' anxiety about becoming a burden on the family compounding their own distress [21]. Interviewees described how filial piety can represent an additional concern in the lives of Chinese cancer patients. In adapting MCP for this population, researchers and clinicians should be cognizant of the role of filial piety in the care arrangements for Chinese cancer patients and should be inclusive of family members.

Chinese cancer patients' unique, culturally-influenced needs and priorities should be incorporated in adapting MCP for this population. Interviewees explained how traditional views, collectivistic norms, and cancer stigma might present barriers to delivering mental health care to Chinese immigrant patients with advanced cancer. These themes echo findings that ethnic-specific programs are associated with lower premature dropout and increased length of treatment [22, 23]. Practitioners delivering MCP to Chinese immigrants should be required to complete "cultural competency/responsiveness" training to gain the specific knowledge, attitudes, awareness, and clinical skills necessary for effective cross-cultural communication in the clinical setting [24–26].

Our findings underscore the importance of the therapeutic alliance in the context of the MCP intervention. The therapeutic alliance, defined as the quality of involvement between therapist and patient, has been identified as one of the most important factors in therapeutic effectiveness [27, 28]. Yet numerous threats to the alliance exist for ethnic minorities, possibly due to cultural misunderstandings, miscommunications, and race-related biases [29]. Establishing agreement on goals, tasks, and processes builds the therapeutic alliance and is positively related to outcomes [30]. Because Chinese immigrant patients may have culturally-influenced preferences regarding treatment approaches (e.g. preferring directive to nondirective approaches [31, 32]), therapists should consider which would best suit the individual's needs.

Interviewees also highlighted the cultural relevance of, and need for, spiritual well-being for this population. They observed the overlap between philosophies held in Eastern religions such as Buddhism and the meaning-enhancing goals of MCP as embodied in the Chinese cultural emphasis on a good death at the end-of-life. Their observations mirror related findings in the literature: the concept of mindfulness, which emphasizes deliberate non-judgmental attention to present moment experiences, has roots in Buddhism and Asian philosophies, and has been gaining support among mental health professionals as a viable component of mental health care [33]. Mindfulness has been judged to contribute to the development of qualities such as transcendence and interconnectedness that are components of spiritual well-being [34].

The study's limitations include a small sample size and sampling bias inherent in the selection of community leaders serving the target population. Future research should include interviews with patients and their families to assess their perspectives directly. However, the results present valuable information on the needs of this underserved group and parallel and expand upon findings reported in the limited number of other studies that address the challenges involved in developing a culturally-sensitive empirically-based treatment (EBT) for this population [3, 12, 23, 30, 32, 33, 35, 36]. These previous studies, in addition to our study, suggest that applying an overarching framework of cultural sensitivity, with particular attention to Chinese cultural norms, values, philosophies, and the central role of family, would contribute to the effective adaptation of MCP for this community. Results of this study provide further groundwork for future research and the development of linguistically and culturally tailored EBTs for this vulnerable population.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval The study was granted exempt status by MSKCC's Institutional Review Board. All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This article does not contain any studies with animals performed by any of the authors.

Informed Consent Informed consent was obtained from all individual participants included in the study.

References

1. Guidry JJ, Torrence W, Herbelin S. Closing the divide: diverse populations and cancer survivorship. Cancer. 2005;104(11 Suppl):2577–83. doi:10.1002/cncr.21251.
2. Lam WW, Fielding R. The evolving experience of illness for Chinese women with breast cancer: a qualitative study. Psychooncology. 2003;12(2):127–40. doi:10.1002/pon.621.
3. Ngo-Metzger Q, Massagli MP, Clarridge BR, et al. Linguistic and cultural barriers to care. J Gen Intern Med. 2003;18(1):44–52.
4. Liang W, Wang JH, Chen MY, et al. Developing and validating a measure of Chinese cultural views of health and cancer. Health Educ Behav. 2008;35(3):361–75. doi:10.1177/1090198106294893.
5. Mui AC, Kang SY, Kang D, et al. English language proficiency and health-related quality of life among Chinese and Korean immigrant elders. Health Soc Work. 2007;32(2):119–27.
6. Yu MY, Hong OS, Seetoo AD. Uncovering factors contributing to under-utilization of breast cancer screening by Chinese and Korean women living in the United States. Ethn Dis. 2003;13(2):213–9.
7. Reeves T, Bennett CE. We the people: Asians in the United States: US Department of Commerce, Economic and Statistics Administration, US Census Bureau; 2004.
8. MLA Language Map Data Center. Data Center Results. 2008.
9. Surbone A. Cultural aspects of communication in cancer care. Support Care Cancer. 2008;16(3):235–40. doi:10.1007/s00520-007-0366-0.
10. Thorne SE, Hislop TG, Armstrong EA, et al. Cancer care communication: the power to harm and the power to heal? Patient Educ Couns. 2008;71(1):34–40. doi:10.1016/j.pec.2007.11.010.
11. Green CR, Anderson KO, Baker TA, et al. The unequal burden of pain: confronting racial and ethnic disparities in pain. Pain Med. 2003;4(3):277–94.
12. Lin JS, Finlay A, Tu A, et al. Understanding immigrant Chinese Americans' participation in cancer screening and clinical trials. J Community Health. 2005;30(6):451–66.
13. Hsiao SM, Gau ML, Ingleton C, et al. An exploration of spiritual needs of Taiwanese patients with advanced cancer during the therapeutic processes. J Clin Nurs. 2011;20(7–8):950–9. doi:10.1111/j.1365-2702.2010.03278.x.
14. Breitbart W, Rosenfeld B, Gibson C, et al. Meaning-centered group psychotherapy for patients with advanced cancer: a pilot randomized controlled trial. Psychooncology. 2010;19(1):21–8. doi:10.1002/pon.1556.
15. Breitbart W. Spirituality and meaning in supportive care: spirituality- and meaning-centered group psychotherapy interventions in advanced cancer. Support Care Cancer. 2002;10(4):272–80. doi:10.1007/s005200100289.
16. Breitbart W, Poppito S, Rosenfeld B, et al. Pilot randomized controlled trial of individual meaning-centered psychotherapy for patients with advanced cancer. J Clin Oncol. 2012;30(12):1304–9. doi:10.1200/jco.2011.36.2517.
17. Breitbart W, Rosenfeld B, Pessin H, et al. Meaning-centered group psychotherapy: an effective intervention for improving psychological well-being in patients with advanced cancer. J Clin Oncol. 2015;33(7):749–54. doi:10.1200/jco.2014.57.2198.
18. Bernal G, Bonilla J, Bellido C. Ecological validity and cultural sensitivity for outcome research: issues for the cultural adaptation and development of psychosocial treatments with Hispanics. J Abnorm Child Psychol. 1995;23(1):67–82.
19. Domenech Rodriguez MM, Baumann AA, Schwartz AL. Cultural adaptation of an evidence based intervention: from theory to practice in a Latino/a community context. Am J Community Psychol. 2011;47(1–2):170–86. doi:10.1007/s10464-010-9371-4.
20. Development AtSS. ATLAS.ti: The Qualitative Data Analysis & Research Software. 2012. Available from http://www.atlasti.com/index.html.
21. Lee J, Bell K. The impact of cancer on family relationships among Chinese patients. J Transcult Nurs. 2011;22(3):225–34. doi:10.1177/1043659611405531.
22. Takeuchi DT, Sue S, Yeh M. Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. Am J Public Health. 1995;85(5):638–43.
23. Yeh M, Takeuchi DT, Sue S. Asian-American children treated in the mental health system: A comparison of parallel and mainstream outpatient service centers. J Clin Child Psychol. 1994;23(1):5–12.
24. Betancourt JR. Cross-cultural medical education: conceptual approaches and frameworks for evaluation. Acad Med. 2003;78(6):560–9.
25. Betancourt JR, Green AR, Carrillo JE, et al. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public Health Rep. 2003;118(4):293–302.
26. Kagawa-Singer M, Kassim-Lakha S. A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes. Acad Med. 2003;78(6):577–87.
27. Williams EN, Hill CE. Evolving connections: research that is relevant to clinical practice. Am J Psychother. 2001;55(3):336–43.
28. Warwar S, Greenberg LS. Advances in theories of change and counseling. In: Brown SD, Lent RW, editors. Handbook of counseling and psychology, 3rd ed. Hoboken, NJ: Wiley; 2000. p. 571–600.
29. Comas Diaz L. The present and future of clinical psychology in private practice. Clin Psychol Sci Pract. 2006;13(3):273–7.
30. Vasquez MJ. Cultural difference and the therapeutic alliance: an evidence-based analysis. Am Psychol. 2007;62(8):875–85. doi:10.1037/0003-066x.62.8.878.
31. Lin YN. The application of cognitive-behavioral therapy to counseling Chinese. Am J Psychother. 2002;56(1):46–58.
32. Chen SW-H, Davenport DS. Cognitive-behavioral therapy with Chinese American clients: cautions and modifications. Psychother Theor Res Pract Train. 2005;42(1):101.
33. Nagayama Hall GC, Hong JJ, Zane NW, et al. Culturally-competent treatments for Asian Americans: the relevance of mindfulness and acceptance-based psychotherapies. Clin Psychol. 2011;18(3):215–31. doi:10.1111/j.1468-2850.2011.01253.x.
34. Falb MD, Pargament KI. Relational mindfulness, spirituality, and the therapeutic bond. Asian J Psychiatry. 2012;5(4):351–4. doi:10.1016/j.ajp.2012.07.008.
35. Lorence DP, Park H, Fox S. Racial disparities in health information access: resilience of the digital divide. J Med Syst. 2006;30(4):241–9.
36. Thomas SB, Fine MJ, Ibrahim SA. Health disparities: the importance of culture and health communication. Am J Public Health. 2004;94(12):2050.