Faculty of Health Sciences
School of Psychology

Towards a Culturally Adapted Cognitive Behavioural Therapy for Depression in Chinese Migrants living in Australia

Alice-Viviana Bercean

This thesis is presented for the Degree of
Doctor of Philosophy
of
Curtin University

January 2019

DECLARATION

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number # HR190/2015

Signature:  …….

Date: 25 January 2019

ABSTRACT

In a world where migration is becoming an increasing global reality, migrants' mental health is a cause of concern as they may face dual vulnerabilities due to cultural (e.g., stigma attached to mental disorder) and structural barriers to treatment (e.g., navigating the medical system). In Australia, Chinese migrants represent the third largest group of overseas-born residents and the largest group from non-English speaking backgrounds. Concerningly, studies conducted in Australia have found that this migrant group reports a lower use of mental health services compared to the locally born people and a tendency to delay treatment until their mental health problems become severe, which significantly increases the personal, social, and economical costs of treatment. Depression is a common mental disorder among Chinese migrants living in multicultural countries including Australia. Given that cognitive behavioural therapy (CBT) is one of the most efficacious and cost-effective treatments for depression, the compatibility between CBT and Chinese values, and the promising evidence for the efficacy of CBT for depression in Chinese migrants and nationals, the overarching aim of this research program was to investigate cultural adaptations of CBT for depression symptoms in Chinese migrants living in Australia. The present research sought to contribute, through three interrelated studies, to the development of culturally adapted psychological treatments, which may help to improve client engagement and treatment outcomes in populations that are underrepresented in psychological services.

Study One comprised a scoping review of the current literature on CBT for depression and anxiety in Chinese nationals and migrants, with a particular focus on cultural adaptation frameworks, cultural modifications to therapy, consultations with health providers and consumers, and clients' experiences of undergoing therapy. Included studies ($N = 21$) were reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) Statement. This scoping review makes an important contribution to the literature by mapping the available evidence on CBT for depression with or without comorbid anxiety in Chinese nationals and migrants. Although there is favourable evidence to support the efficacy of CBT in this population, there are important gaps in the literature, including limited use of cultural adaptation frameworks for adapting CBT for depression in Chinese migrants internationally, no cultural adaptation frameworks used in adapting CBT for depression in

Chinese migrants to Australia in particular, and a high degree of variability in involving clinicians and consumers in the cultural adaptation of CBT.

Study Two was a qualitative study that aimed to use the Formative Method for Adapting Psychotherapy (Hwang, 2009) and the Generic Cognitive Model (GCM, Beck & Haigh, 2014) to guide the cultural adaptation of CBT for depression in Chinese migrants. The objective was to document clinicians' and community members' perspectives on the cultural adaptation of CBT to Chinese migrants in Australia, with an emphasis on the specific and non-specific factors of CBT. The qualitative study included two stages to document clinicians' and community members' perspective on the specific factors (stage one) and non-specific factors (stage two) of CBT. Thirty-four participants recruited using snowballing and purposive sampling, participated in twelve individual semi-structured interviews and five focus groups. Thematic analysis and a modified consensual qualitative research approach were used for data analysis. The interviews and the focus groups were audiotaped, transcribed and structured in a database using NVivo 11. The main findings of stage one were that it is equally important to use cognitive, behavioural, and mindfulness techniques in a culturally sensitive manner with Chinese clients, and to cultivate cultural humility, to ultimately improve treatment outcomes. Stage two identified unique aspects of the non-specific factors including clinicians' self-disclosure, providing a treatment rationale that participants can connect with at an intellectual and emotional level, and using culturally appropriate terminology for depression to facilitate client engagement.

Study Three comprised a quantitative study. The findings of Study Two informed the integration of migration stress (i.e., trigger for depression) and ethnic identity (i.e., potentially negative impact on mental health of losing one's own identity after migration or being stereotyped because of one's identity) with aspects of the GCM, including brooding, mindful attention, automatic thoughts, activation, and avoidance, to predict depression in Chinese migrants. The first hypothesis was that the relationships between migration stress and brooding, and migration stress and mindful attention, would be moderated by ethnic identity, such that at higher levels of ethnic identity (i.e., a sense of belonging to a group and learning about one's group) the relationships will be weaker than at lower levels of ethnic identity. Higher brooding and lower mindful attention were expected to predict higher automatic thoughts and avoidance, and lower activation, which ultimately would predict the severity of depression symptoms. The second hypothesis was that indirect effects between migration stress and depression symptoms

(H2a), and between ethnic identity and depression symptoms (H2b), would be significant. A convenience sample of 399 Chinese migrants across Australia completed a battery of questionnaires uploaded on Qualtrics survey software. Structural equation modelling was used to test a series of models investigating relationships between aspects of migration stress, ethnic identity, components of the GCM, and depression symptoms. SPSS 23.0 and Mplus version 8 (Muthén & Muthén, 1998-2017) were used for data analysis. The main results of the quantitative study are that only two aspects of migration stress (i.e., loss and not feeling at home) were associated with higher brooding and lower mindful attention, which in turn were associated with higher automatic thoughts and avoidance, which were ultimately associated with depression symptoms.

The findings of these three interrelated studies contribute to the fidelity-adaptation debate and favour the need for adaptations to evidence-based treatments to reduce disparities among culturally and linguistically diverse groups in accessing mental health services. Additionally, the present results underscore the need for testing a culturally sensitive version of CBT informed by the findings of this thesis. A focus on cultural sensitivity has the potential to improve access, clinical engagement, and treatment outcomes of psychological interventions for clients from diverse ethnic groups, which is critical in an increasingly globalised world.

ACKNOWLEDGEMENT

First, I would like to thank the participants and clinicians who participated in my studies. Without your willingness to assist me with recruitment and asking your family, friends, and friends of friends to participate in my studies, completing this research program would have been impossible. I am grateful to each and every one of you for sharing your personal and clinical experiences with me. From you I learned as much about the importance of considering culture in providing psychotherapy as I did about the similarities and differences between us as human beings. Regardless of what the future holds for me, this PhD made me a better clinician.

To my supervisory team, Professor Peter McEvoy, Associate Professor Rosie Rooney, Associate Professor Lauren Breen, and Dr. Robert Kane, for agreeing to supervise and journey with me. I have never imagined I would do a PhD in Australia, so thank you for giving me this opportunity. To Pete, for his endless guidance and constant encouragement through these years. You helped me understand that the biggest lesson from this journey is perseverance despite self-doubt. To Rosie, for always having to say something positive and for seeing the positive in what I was doing. To Lauren, for making me feel understood and supported. I will remember to hope for the best, but at the same time to wear a helmet. To Bob, for his guidance on statistics, which seemed a different language at the beginning of my PhD. I am grateful and privileged for being able to call you my supervisors.

I am thankful to SiewHo Yeak for being my informal supervisor. Your guidance in better understanding the Chinese culture and support with recruitment was invaluable. To Chun (Sophia) Yau Man and Amber Mengyi Li, your dedication in helping me with recruitment made a huge difference. Words cannot thank you all enough.

To my friends from the HDR HUB, you know who you are. I am truly happy I had the chance to meet you and journey with you. The laughs, the hugs, the happiness dance, and the little victories we shared will always be cherished. Because of you, I will remember in a more positive light the time spent at Curtin.

Finally, I wish to thank my family and close friends from Romania and Perth for their unconditional support. Special thanks to my parents Mariana and Geza for supporting me when I decided to embark on this journey, which seemed to be at the end of the world, for your love, and

for being amazing role-models. Hope you are proud of me. To my friends, I feel fortunate for receiving encouragement both in my native language and English and for celebrating twice my little victories. Lastly, to Marius, my husband, for taking me on a big jet plane to come to Australia and encouraging me to fulfil my dream of doing a PhD. I cannot express my gratitude enough for being there for me during my ups and downs. I cannot wait for our next adventure together.

LIST OF CONFERENCE PRESENTATIONS

Bercean, A. (née Farcas), McEvoy, P., Rooney, R., Breen, L., & P., Kane, B. (July, 2018). *Towards a culturally adapted cognitive behavioural therapy for depression in Chinese migrants living in Australia: Findings from two studies.* Paper presentation at Denis Glencross Memorial Student Seminar, Perth, Australia

Bercean, A. (née Farcas), McEvoy, P., Kane, R., Breen, L., & Rooney, R. (July, 2018). *The generic cognitive model for depressive symptoms and its specificity in Chinese migrants: A structural equation model.* Paper presentation at the 24th Congress of the Cross-Cultural Psychology, Guelph, Canada

Farcas, A., Breen, L., McEvoy, P., Rooney, R, Kane, R., & Yeak, S. (June, 2017). *Culturally adapting cognitive behavioural therapy for depression in Chinese Australians*. Paper Presentation at the 9th International Congress of Cognitive Psychotherapy, Cluj-Napoca, Romania

Farcas, A., Rooney, R, McEvoy, P**.,** Rooney, R., Breen, L., & Kane, R. (September, 2015*). Non-specific factors of culturally adapted cognitive behavioural therapy for depression in Chinese Australians*. Paper presentation at the Mark Liveris Health Sciences Research Student Seminar, Perth, Australia

Farcas, A., McEvoy, P**.,** Rooney, R., & Breen, L., Kane, R., & Yeak, S. (June, 2016). *Adapting Cognitive Behavioural Therapy for Depression in Chinese Australians: Health providers' perspectives*. Rapid Oral presentation at the 8th World Congress of Behavioural and Cognitive Therapies, Melbourne, Australia

Farcas, A., Rooney, R, McEvoy, P**.,** Rooney, R., Breen, L., & Kane, R. (September, 2015*). A scoping review of cognitive behavioural therapies for depression and anxiety in a North-East Asian population*. Poster presented at the Mark Liveris Health Sciences Research Student Seminar, Perth, Australia

Farcas, A., McEvoy, P**.,** & Rooney, R. (October, 2014). *Cognitive-behavioural therapies for depression in Asian populations: A literature review and proposed guidelines*. Poster presented at the Australian Association of Cognitive Behaviour Therapy's 37th National Conference "Uniting Research and Practice in Mental Health Care", Perth, Australia

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

ABS	Australian Bureau of Statistics
AIC	Akaike information criterion
APA	American Psychiatric Association
APA	American Psychological Association
ATQ-N	Negative Automatic Thoughts Questionnaire
BADS	Behavioural Activation for Depression Scale
BIC	Bayes information criterion
CBT	Cognitive behavioural therapy
CFI	Comparative Fit Index
CI	Confidence interval
DI	Demand of Immigration Stress
DSM	Diagnostic and Statistical Manual of Mental Disorders
FMAP	The Formative Method of Adapting Psychotherapy
GCM	Generic Cognitive Model
iCBT	Internet-delivered CBT
M	Mean
MAAS	Mindful Attention Awareness Scale-6 item scale
MCM	Members of the Chinese Community
MDD	Major depressive disorder
MEIM-R	Multigroup Ethnic Identity Measure - Revised
MI	Modification indices
MLR	Robust Maximum Likelihood
n	Subsample
N	Full sample
PAMF	The Psychotherapy Adaptation and Modification Framework
PHQ-9	Patient Health Questionnaire-9
PRISMA	The Preferred Reporting of Items for Systematic Reviews and Meta-Analysis
RCT	Randomised control trial
RMSEA	Root Mean Square Error of Approximation
SD	Standard deviation

SE	Standard errors of the parameter estimates
SEM	Structural equation modelling
SRMR	Standardised Root Mean Square Residual
TLI	Tucker-Lewis Index

"…humans evolved to respond to psychotherapy—or better put, psychotherapy evolved as a culturally imbedded healing practice because of human traits."

(Wampold, 2012, p. 445)

Chapter 1: Depression and Culture

1.1. World Prevalence of Major Depressive Disorder

Major depressive disorder (MDD) is a highly debilitating mental disorder that is associated with substantial personal, interpersonal, societal, and economical costs (Ferrari et al., 2013; Richards, 2011). The quality of life of individuals with MDD and their relatives is significantly impacted (Saarni et al., 2018). Further, the ability of individuals with MDD to participate in the labour force is considerably reduced, which can lead to social and economic marginalisation (Schofield et al., 2011). MDD is predicted to rank first in disease burden in high-income countries and second worldwide by 2030 (Mathers & Loncar, 2006), which indicates that MDD is an urgent global public health issue.

The science of MDD has greatly evolved from the first (i.e., conceived as organic or reactive) to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM; i.e., dimensional approach; American Psychiatric Association, 2013; Richards, 2011). In the DSM-5, MDD is characterised by discrete episodes of at least two weeks' duration involving significant changes at emotional, cognitive, and behavioural levels. Five or more of the following symptoms need to be present for a diagnosis: (1) depressed mood; (2) markedly diminished interest or pleasure; (3) significant weight loss when not dieting or weight gain; (4) insomnia or hypersomnia; (5) psychomotor agitation or retardation; (6) fatigue or loss of energy; (7) feelings of worthlessness or excessive or inappropriate guilt; (8) diminished ability to think or concentrate or indecisiveness; (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. Depression symptoms must be present nearly every day and at least one of the symptoms must be depressed mood or markedly diminished interest or pleasure. In this thesis, MDD is used to refer specifically to the DSM disorder, whereas depression is used to describe the dimension from mild to severe symptoms.

Lim et al. (2018) conducted the most recent meta-analysis of the prevalence of MDD among adults. Data from 1 million participants from 30 countries across all continents, over a

period of 20 years (1994-2014), were analysed. The findings showed that the aggregate point prevalence was 12.9%, one-year prevalence was 7.2%, and the lifetime prevalence was 10.8%. The use of self-report measures yielded significantly higher prevalence data compared to clinical interviews (i.e., 17.3% versus 8.5%). The studies published between 2004 and 2014 had a significantly higher prevalence of depression than the studies published between 1994 and 2003 (i.e., 15.4% versus 9.8%). The authors suggested that the increase was due to the development of Internet and online health programs, which appear to have improved depression awareness, and the increasing acceptability of depression among both patients and clinicians. Though the prevalence of depressive disorders (i.e., MDD and dysthymia) varies by region, globally they are the third leading contributor to the disease burden for both sexes combined and all age ranges (Vos et al., 2016). The economic burden of MDD and the indirect costs, including lower quality of life, absenteeism, decreased productivity, and increased mortality (e.g., suicide), call for an ongoing effort to improve diagnosis and treatment (Donohue & Pincus, 2007).

1.2. Cultural Influences on Depression

Culture has a major influence on MDD expression, interpretation of symptoms, coping strategies, social response to distress, and help seeking (Kirmayer, 2001). Awareness of the importance of culture on illness experience and diagnosis has been reflected in the fourth and fifth edition of the DSM. Culture was defined in DSM-IV as a set of values, beliefs, and practices that apply to a given ethnocultural group. This definition has the advantage of acknowledging inter-individual differences and emphasising the value system of individuals, but also the disadvantage of depicting culture as a static phenomenon rather than a process (López & Guarnaccia, 2000). A static definition may hinder our understanding of how migrants navigate between different cultural environments, which is important in this era of globalisation and increased mobility. Importantly, there has been substantial progress in the operationalisation of culture between DSM-IV and DSM-5, with the latter moving towards a more dynamic and comprehensive definition. In the DSM-5, culture is defined as:

> …systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems. Cultures are open, dynamic systems that undergo continuous change over time (APA, 2013, p. 749).

The advantage of a dynamic definition of culture is the emphasis on the link between culture and social context, which highlights the importance of inter and intra individual differences (Bredström, 2017) and not harming clients by stereotyping them (Kleinman, 2004). Therefore, more careful consideration of inter and intra individual differences in regard to symptom expression of MDD across cultures is critical to improve the diagnostic accuracy of MDD and treatment. For instance, *kufungisisa* (i.e., thinking too much) is an idiom of distress and a cultural explanation among the Shona of Zimbabwe. Kufungisisa involves rumination and is linked with depression and other mental disorders. *Shenjing shuairuo* (i.e., weakness of the nervous system) is a cultural syndrome that integrates traditional Chinese medicine with neurasthenia, a Western diagnosis. This syndrome had been documented in China, India, and Japan (APA, 2013). As such, it is critical for clinicians to be aware of how culture influences the expression of depression, in addition to how cultures are changing as a result of migration and globalisation (Ventriglio, Ayonrinde, & Bhugra, 2016).

1.3. Cultural characteristics of Chinese migrants

Because Chinese migrants represent one of the largest ethnic groups in Australia, Canada, and the UK (Australian Bureau of Statistics, 2017; Office for National Statistics, 2018; Statistics Canada, 2016), it is important to gain a deeper understanding of the cultural characteristics of this ethnic group to improve access and equity to mental health treatments in multicultural countries. The cultural characteristics of Chinese migrants are strongly influenced by the traditional Chinese culture (Kulich & Zhang, 2010). Confucianism is one of the major school of thoughts in traditional China, which still has a major influence on Chinese individuals' philosophy of life, values, and behaviours (Baoyun, 1998). Confucian principles strongly emphasise the value of education (i.e., self-cultivation), harmony between people, society, and nature, hierarchical relationships (e.g., a son should obey and be devoted to his farther and senior family members), and family as the foundation of social organisation (Bogart, 1998). An individual is seen as a relational being and is defined in dyadic relationships (e.g., father-son; Kolstad & Gjesvik, 2014).

Interestingly, these traditional cultural characteristics correspond to key cultural dimensions such as vertical collectivism, and psychological concepts such as interdependent self. The collectivism-individualism dimension is one of the most important cultural dimensions used to describe the role of the individual versus the role of the group from both a historical and cross-

cultural perspective (Hofstede, Hofstede, & Minkov, 2010; Triandis, 2001). Collectivism has been defined as the opposite of individualism and as a social pattern of closely connected individuals who are willing to give priority to the goals of their in-group (e.g., family, co-workers, nation; Triandis, 1995). Individuals in collectivist societies are especially concerned with relationships and learn to think of themselves in terms of in-group or "we" group and are interdependent in their in-group (Hofstede et al., 2010; Triandis, 2001). The "we" group represents a major source of one's identity and secure protection against the hardships of life. Another key concept that characterises collectivist cultures is face. This concept entered the English language from Chinese and refers to the sense of honour or prestige. The importance of saving face or avoiding loosing face (i.e., being humiliated) in collectivist societies is a reflection of the importance of social relationships (Hofstede et al., 2010). This fundamental connectedness between individuals considerably influences the experience of self and translates into an interdependent self. An interdependent self is reflected in thoughts, feelings, actions, and autobiographical memories oriented towards significant others (H. R. Markus & Kitayama, 2010; Zhu & Han, 2008). In sum, collectivist societies are inclined to encourage conformity, obedience, loyalty, and reliability (Triandis, 2001).

In contrast, individualism is a social pattern of loosely connected individuals who are inclined to give priority to their personal goals over the goals of their in-group. One is motivated by their own preferences, needs, rights, and contracts with the others (Triandis, 1995). Individuals in individualistic societies learn to think of themselves in terms of "I", are independent from their in-groups, and maintain their independence by focusing on the self and by exploring and expressing their unique qualities. As a result, the sense of self of individuals in individualist societies has been described as independent (Hofstede et al., 2010). Distinctive cognitive features of an independent self are analytic and rational thinking. The self is seen as stable and the social environment changeable, and therefore one is inclined to adjust the social environment to fit their personality (Triandis, 2001). Self-respect is a key concept that characterises people in individualist societies and is considered the equivalent to face (Hofstede et al., 2010). In sum, individualist societies are inclined to encourage autonomy, exploration, creativity, and self-reliance (Triandis, 2001).

Triandis (1995, 2001) proposed the horizontal and vertical concepts to further refine the collectivism-individualism dimension for describing cultural differences. Horizontal societies

have been described as valuing equality, while vertical societies as valuing hierarchy. As a result, four types of cultures can be identified (a) horizontal individualist societies (e.g., Australia, Sweden) were one values equality, self-reliance, and focuses on expressing their uniqueness; in other words people want to be "unique and do their own thing"; (b) vertical individualist societies (e.g., the UK, the USA) were one is focused on competition, achievement, and power; people want to "do their own thing and also be the best"; (c) horizontal collectivist societies (e.g., Israeli kibbutzim) emphasise honesty, directness, and cooperation in the context of assumed equality; and (d) vertical collectivist societies (e.g., China, Japan) emphasise respect to the authority of the in-group and in the context of hierarchical relationships (Shavitt, Lalwani, Zhang, & Torelli, 2006; Triandis, 2001).

Importantly, Confucian influenced countries or East Asian countries, including China, Hong Kong, Japan, South Korea, Taiwan, Thailand, are the cultural regions with the highest score on hierarchy (Schwartz, 2009). Further, this cultural region reported moderate to high scores on power distance (i.e., handling inequality in society; people in societies with high power distance accept hierarchical orders), and high scores on collectivism (Hofstede et al., 2010). Within societies there are inter-individual differences and heterogeneous subcultures due to differences related to various factors such as socioeconomic status, geography, education, political, and historical context (Kulich & Zhang, 2010). However, to provide a cultural context to this thesis, when evidence on depression or other mental health aspects in Chinese migrants was not available, studies comprising East Asian participants were summarised.

1.4. Depression in Chinese Migrants

1.4.1. Depression prevalence among Chinese migrants.

There are no representative epidemiological studies *focusing on depression* in Chinese migrants to Australia, despite Chinese migrants representing the largest non-English speaking group (ABS, 2017). Available epidemiological data about the prevalence of mental disorders in general among immigrant communities in Australia varies according to the country of birth and disorder (Anikeeva et al., 2010; Leach, Olesen, Butterworth, & Poyser, 2014; McEvoy, Grove, & Slade, 2011). Although the available epidemiological data suggests that the prevalence of mental disorders among Australian adult migrants is lower than the prevalence of Australian-born adults, no firm conclusions can be drawn because of the small sample sizes of migrants and

refugees included in national surveys and the aggregation of overseas-born people into categories such as region of birth (e.g., aggregating individuals from China, Hong Kong, Macau, Mongolia, Taiwan, Japan, and North and South Korea under North-East Asia category; ABS, 2016; Minas et al., 2013). The disadvantage of aggregating participants into categories is that it might mask important cultural differences and historical and economic influences, which might affect the detection of symptoms in the most vulnerable populations (Bhopal, 2009; Jimenez, Alegría, Chen, Chan, & Laderman, 2010).

One recent epidemiological study revealed that first generation migrants from non-English speaking backgrounds (e.g., China, India, Vietnam) in Australia reported lower prevalence rates of affective disorders (i.e., collapsed across major or minor depression, dysthymia, bipolar disorder) than the Australian-born group. Despite this, first generation migrants from non-English speaking backgrounds with an affective disorder reported higher levels of disability and impairment than Australian-born individuals with an affective disorder (Liddell, Nickerson, Sartor, Ivancic, & Bryant, 2016). In this context, it is particularly important to discuss the implications of the healthy migrant hypothesis, which states that migrants are granted visas due to being physically and mentally healthier, wealthier, and better educated than the general population in their country of origin (Renzaho, 2016). One of the implications of this positive selection is better health outcomes of migrants compared to the Australian-born population (e.g., lower hospitalisation rates). However, the health advantage was found to decline with increased length of residency and adoption of the lifestyle of the new country of residence (Anikeeva et al., 2010). Importantly, Liddell et al.'s (2016) findings challenge the healthy migrant hypothesis by indicating that first generation migrants from non-English speaking backgrounds were not generally heathier regarding functioning (Liddell et al., 2016).

Several studies have examined depression and anxiety symptoms or psychological distress in Chinese migrants or Asian migrants to Australia. One primary care study demonstrated that approximately half of the Chinese participants residing in Sydney, Australia had a moderate or high risk of anxiety and/or depression and 30.8% of the participants were experiencing a high level of distress (Tang, Dennis, Comino, & Zwar, 2009). The prevalence rate reported in this study was higher than the prevalence rate among the Australian born group reported in 2006 in New South Wales (i.e., 10.7%; Centre for Epidemiology and Research, 2007). Consistent with these results, another study found that 18.87% of the Chinese participants

residing in five different states in Australia (i.e., Queensland, New South Wales, South Australia, Victoria, Western Australia) were at risk of moderate to high psychological distress and 6.3% of the participants reported a high level of distress (J. Hu & Wang, 2016). These findings indicate slightly higher rates of high psychological distress among Chinese migrants living in Australia than among Australian-born participants (i.e., 2.6% were at risk of high psychological distress; Sanjay Sharma, 2012). Similarly, in a nationwide representative study in Australia elderly Asian migrants (e.g., China, Japan, Korea) reported higher level of distress compared to migrants from Western and developed countries, in spite of receiving greater formal and informal support (Chou, 2007). Because of the lack of representative epidemiological studies on depression in Chinese migrants to Australia, the following section examines epidemiological studies comprising Chinese migrants in other multicultural countries.

The most recent epidemiological study of mental health issues in Chinese migrants was conducted in Ontario, Canada (Chiu, Amartey, Wang, & Kurdyak, 2018), and indicated low prevalence of diagnosed mood and anxiety disorders and lifetime suicidal ideation. These findings are consistent with those of Tiwari and Wang (2008) who found a lower prevalence of MDD among Chinese participants compared to their Western counterparts. However, Chinese participants in Chiu et al.'s (2018) study reported the lowest self-rated mental health, the weakest sense of belonging, the lowest use of mental health services, and the highest level of unmet needs compared to other ethnic groups (e.g., South Asian). Among those who sought treatment, Chinese participants were the only group included in this large population-based study that had a significantly higher prevalence of mental health care visits compared to their Western counterparts. A possible explanation may be that the Chinese participants' mental health conditions were severe when seeking treatment and therefore a higher number of visits to health professional was required. The findings regarding the lowest self-rated mental health were unexpected, especially because a large percentage of Chinese migrants in Ontario live in ethnic neighbourhoods. It appears that living in ethnic neighbourhoods is not a protective factor against mental disorders. However, multiple factors need to be considered to explain these unexpected findings (e.g., cultural and structural barriers to mental health services).

Only one study was located in the literature examining the mental health of Chinese migrants living in the UK (Huang & Spurgeon, 2006). Overall, prevalence of caseness in Birmingham (i.e., elevated anxiety or depression symptoms) was 61.4% among the Chinese

participants, which was significantly higher than the prevalence of the general population in the UK (i.e., 14% for men and 20% for women). However, the findings of this study need to be interpreted carefully given the sampling strategy (i.e., convenience) and the low response rate (39%).

Several epidemiological and primary care studies have been conducted in the USA to examine the prevalence of MDD in Chinese migrants. González, Tarraf, Whitfield, and Vega (2010) used the National Institute of Mental Health's Collaborative Psychiatric Epidemiology Survey to report the epidemiology of MDD among major ethnic and native groups. The 12-month prevalence was 3.7% among the overseas-born Chinese participants and 8.8% among the US-born Chinese participants, while the lifetime prevalence of MDD was 7.7% among the overseas-born Chinese participants and 21.5% among the US-born Chinese participants. It appears that the prevalence of 12-month and lifetime MDD of the US-born Chinese participants was approximately twice that of the overseas-born Chinese participants. The Chinese subgroup who met the MDD criteria reported lower role impairment compared to their "White" counterparts. Interestingly, the prevalence rates among the overseas-born Chinese participants exceeded that of the US-born Chinese participants in old age. A possible explanation could be that the health advantage of first generation Chinese migrants deteriorates over time and their vulnerability to develop mental disorders increases due to the various demands of immigration, which is consistent with the previous findings examining the healthy migrant hypothesis in Australia (Anikeeva et al., 2010). Yeung et al. (2004) examined the prevalence of MDD among Chinese American patients in a primary care clinic in Boston, USA. The prevalence of MDD was 19.6%, which was comparable or higher than the prevalence rates reported in previous studies with "White" participants conducted in primary care. In contrast, G. Hsu et al.'s (2005) findings indicate a lower prevalence rate of MDD among Chinese patients in a primary care clinic in Boston, USA (i.e., 10%).

Acculturation is an important factor that affects the prevalence rate of depression. Although several definitions of acculturation have been proposed, the located studies defined acculturation as a unidimensional construct reflecting changes that occur among migrants after coming into contact with the culture of the country of destination (Hwang & Myers, 2007; Parker, Chan, & Tully, 2006; Parker, Chan, Tully, & Eisenbruch, 2005). Parker et al. (2005) found that differences in lifetime depression rates between Chinese migrants to Australia and

their Western counterparts were diminished by acculturation. Further, Parker et al. (2006) did not find substantial differences between Chinese migrants to Australia and their Western counterparts on lifetime depression measures. Hwang and Myers (2007) found that acculturation had a moderating effect in the relationship between negative life events and depression and increased the risk for depression, but only for the highly acculturated Chinese migrants to the USA. In other words, more acculturated Chinese Americans were at higher risk of depression in stressful conditions than the less acculturated Chinese Americans. It is important to note that changes in risk for depression do not simply occur because of migrating to a new country, but rather as a consequence of cultural, environmental, language, and occupational changes associated with migration (Aroian & Norris, 2003; Hwang & Myers, 2007). As such, conceptualising acculturation as a unidimensional construct raises concerns about capturing the complexity of acculturation. Berry's (2005) multidimensional conceptualisation of acculturation as a dual process of cultural and psychological change that occurs as a results of two or more cultural groups coming into contact, which results in multiple acculturation strategies (e.g., integration, assimilation), could be a better alternative.

The current prevalence data of diagnosed MDD among Chinese migrants in Western countries reveals paradoxical findings. Although lower prevalence rates of diagnosed MDD have been found among Chinese migrants, they were not generally healthier regarding functioning than the Australian born group (Liddell et al., 2016), they indicated the lowest self-rated mental health in a large population-based study undertaken in Ontario, Canada (Chiu et al., 2018), and the prevalence rates of diagnosed MDD changed among first generation Chinese migrants in the USA in old age to the point of exceeding the rates of US-born Chinese participants (González et al., 2010). Further, Chinese migrants in Australia, Canada, the UK, and the USA, report low rates of service utilisation and an inclination to delay services until their mental health problems become acute (Chiu et al., 2018; J. Hu & Wang, 2016; Jim & Pistrang, 2007; S. Sue, Yan Cheng, Saad, & Chu, 2012). It appears that this help-seeking pattern occurs in Chinese migrants regardless of the Western country in which they live, suggesting that there are common barriers in Western countries to mental health services. As such, these findings suggest that prevalence rates of diagnosed MDD do not provide a comprehensive overview of mental ill-health in Chinese migrants. Mental health related disability, help-seeking behaviours, delay in accessing

mental health services, and barriers to mental health services also need to be considered for effective policy and service planning.

1.4.2. Depression expression in Chinese culture.

The tendency to somatise psychological distress in Chinese societies, including China, Hong Kong, Taiwan, and Chinese migrants living in Western countries, has been discussed over the last three decades and confirmed in cross-national studies (Dere et al., 2013; Parker, Cheah, & Roy, 2001; Ryder et al., 2008; X. Zhou et al., 2016). Two important perspectives of somatisation have been described by Ryder and Chentsova-Dutton (2012) including the experience and expression of distress and the conceptualisation and communication of distress. According to the first perspective, the subjective experience of depression in Chinese people is dominated by somatic symptoms.

Neurasthenia or *shenjing shuairuo* is a cultural syndrome related to depression that includes weakness symptoms (e.g., mental fatigue), emotional symptoms (e.g., feeling vexed), excitement (e.g., increased recollections), nervous pain (e.g., headache), and sleep disturbance (e.g., insomnia; S. Lee, 1994). The two important differences between neurasthenia and MDD are that (a) the key symptom of neurasthenia is low energy, which is congruent with the traditional Chinese medicine preoccupation for low *qi* (i.e., "life force") and society's preoccupation for economic productivity, and (b) emotional symptoms of neurasthenia were thought to be a consequence of fatigue (Chentsova-Dutton, Ryder, & Tsai, 2014). Between 1950 and 1990, neurasthenia was a common diagnosis among psychiatric outpatients in China (Kleinman, 1982; T.-Y. Lin, 1989). Kleinman (1982) conducted the first study that used both anthropological and psychiatric methods to examine MDD according to DSM-III (APA, 1980) in Chinese patients with neurasthenia. This study showed that 87% of the Chinese patients could have been diagnosed with MDD according to DSM III (APA, 1980). Kleinman's (1982) findings were supported by a subsequent study conducted in China showing that most of the Chinese patients with neurasthenia were diagnosed with anxiety and depression neurosis according to Western diagnosis manuals (M. Y. Zhang, 1989). Later cross-national comparisons (Dere et al., 2013; Parker et al., 2001; Ryder et al., 2008) found that Chinese patients from China still emphasised somatic symptoms compared to Euro-Canadians and Euro-Australian patients, but their symptom expression did not meet the diagnostic criteria for neurasthenia. Parker et al. (2001) found that 60% of Chinese patients from Malaysia diagnosed with MDD nominated a

somatic symptom as their main complaint compared with 13% of their Euro-Australian counterparts. Ryder et al. (2008) found that Chinese patients reported more somatic symptoms on spontaneous problem report in structured clinical interviews than their Euro-Canadians, who reported more psychological symptoms. Dere et al. (2013) found that Chinese patients reported significantly higher levels of supressed emotions and depressed mood relative to their overall symptomatology, despite emphasising more the somatic symptoms than their Euro-Canadian counterparts. These relatively recent findings suggest that the expression of depression in Chinese nationals changed considerably over the last decades; in particular, the prevalence of neurasthenia appeared to decline considerably while depression became a more common diagnosis, possibly because of globalisation, increased competition, and changing roles in increasingly complex environments (Ryder, Sun, Zhu, Yao, & Chentsova-Dutton, 2012). Additionally, the passing of the Cultural Revolution (1966-1975), when depression was thought to be an expression of wrong political thinking and psychology was considered to be "90% useless" (Bond, 1991; D. Zhang, 1995), had a tremendous impact on decreasing the stigma attached to mental disorders.

In contrast, the conceptualisation of communication of distress perspective emphasises that Chinese people hold a set of particular beliefs about their symptomatology and consciously choose to highlight somatic symptoms when communicating with others (Ryder & Chentsova-Dutton, 2012). Ryder et al. (2008) found that, because Chinese patients from China reported externally oriented thinking, they did not focus on their emotional experience, despite being able to experience and express emotions. In addition, participants in this study reported more somatic symptoms than their Euro-Canadian counterparts when questioned directly by an unfamiliar clinician. A possible explanation could be that Chinese patients, when directly questioned by a clinician with whom they did not previously build rapport, might report somatic symptoms due to their less stigmatising nature. The Chinese patients in this study reported higher perceived stigma than their Euro-Canadian counterparts, suggesting that talking about physical symptoms might be more acceptable than talking about psychological symptoms. In addition, it appears that acculturation influences the conceptualisation and communication of distress. Studies involving Chinese migrants to Australia showed that the tendency to assign a somatic explanation to a psychological symptom decreased as acculturation increased (Parker et al., 2006; Parker et al., 2005). Similar results have been found in a sample of Asian migrants to the USA comprising

Chinese and Japanese first generation migrants (H. Chen, Guarnaccia, & Chung, 2003). Importantly, X. Zhou et al. (2016) found that the experience and expression of distress and conceptualisation and communication of distress were correlated (i.e., moderate correlation in the clinical sample and strong correlation in the student sample), but only the experience and expression of distress was directly associated with somatic depressive symptoms in both samples. As such, clinicians' ability to contextualise depression expression is critical in a world of constant change.

1.4.3. Barriers to depression treatment among Chinese migrants.

Chinese migrants are one of the most underrepresented migrant groups in counselling and therapy services compared to their Western counterparts. Researchers from Australia, Canada, the UK, and the USA have repeatedly reported low rates of mental health services use (Blignault, Ponzio, Ye, & Eisenbruch, 2008; Chiu et al., 2018; J. Hu & Wang, 2016; Jim & Pistrang, 2007; S. Sue et al., 2012; Wynaden et al., 2005), high drop-out rates (Akutsu, Tsuru, & Chu, 2004), and higher involuntary admissions to hospitals among Chinese migrants compared to the locally born people (Blignault et al., 2008; J. Hu & Wang, 2016). Cultural, structural, and attitudinal barriers may explain this pattern of underutilisation of mental health services. It is important to note that these barriers to mental health services are not unique to Chinese migrants; however, this thesis is focusing on detailing cultural, structural, and attitudinal barriers to mental health services among Chinese migrants.

Cultural barriers refer to shame attached to mental illness and loss of face for the extended family (Blignault et al., 2008; Wynaden et al., 2005), low mental health literacy (Blignault et al., 2008; Choi, Andrews, Sharpe, & Hunt, 2015; Parker et al., 2006; D. F. K. Wong, Lam, & Poon, 2010), and cultural views of mental illness that differ considerably from those of Western cultures (Na, Ryder, & Kirmayer, 2016; Y. J. Wong, Tran, Kim, Van Horn Kerne, & Calfa, 2010). Y. J. Wong et al. (2010) found that cultural beliefs such as naïve dialectical principles of change (i.e., positive and negative experiences are viewed as relatively short-term and transient) and collectivistic worldviews (i.e., beliefs in personal failure and impersonal issues as causes of mental disorders) influence whether Chinese migrants will seek professional help for mental disorders. For example, Asian Americans (e.g., Chinese, Koreans) who believed that depression would last for a short period of time were less likely to seek professional help than those who believed that their depression would last a longer period of time

(Y. J. Wong et al., 2010). The authors also found that the enculturation level, which refers to the process of retaining or adhering to the cultural norms and values of the group of origin (B. Kim & Abreu, 2001), was another important factor that, in combination with particular beliefs about health (e.g., depression is cause by personal failure), inhibited seeking professional help. A possible explanation may be that a strong adherence to Asian cultural values may amplify shame of personal failure and losing face when experiencing a mental disorder.

Structural barriers include limited knowledge of navigating the health system, costs of treatment varying according to visa (i.e., only permanent residents have access to Medicare subsidised services; Australian Institute of Health and Welfare, 2018), low English proficiency (Blignault et al., 2008; Wynaden et al., 2005), few treatment options and poorly coordinated services (Cross & Singh, 2012), difficulties in diagnosis due to cultural differences (Minas et al., 2013), and lack of culturally appropriate services (Minas, Klimidis, & Kokanovic, 2007).

Attitudinal barriers have been found to play an essential role in help-seeking. Chinese individuals' preference for handling problems independently is one of the most frequently reported help-seeking behaviours (Yu et al., 2015). The preference for dealing with problems independently might be explained by stoicism, which is a fundamental value about self-conduct linked with enduring both emotional and physical pain (Parker, Gladstone, & Chee, 2001; Tung & Li, 2014). Chinese individuals with stoic beliefs might be inclined to endure emotional problems until they become severe, which may explain the delay in mental health services and the higher involuntary admissions to hospitals (Blignault et al., 2008; J. Hu & Wang, 2016). As such, it is understandable that attitudinal barriers have been found to be a stronger obstacle to initiating and continuing treatment than structural barriers (Mojtabai et al., 2011). In sum, cultural, structural, and attitudinal barriers provide a complex overview of obstacles of help-seeking behaviour among Chinese migrants.

1.5. Would Chinese Migrants Benefit From Cognitive Behavioural Therapy?

1.5.1. Cognitive behavioural therapy for depression.

One of the most researched, efficacious, and cost-effective treatments for MDD is cognitive behavioural therapy (CBT; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; National Institute for Health and Care Excellence, 2016). CBT is an active, structured, and problem-oriented psychotherapy based on the cognitive model of depression, which was specifically developed in response to the need to treat depression (A. T. Beck, 2008; A. T. Beck, Rush,

Shaw, & Emery, 1979). The core premise of the cognitive model is that changes in beliefs lead to changes in behaviours and emotions. The central tenet of the CBT model is that negative life events activate the cognitive triad, which includes negative views of one's self, the future, and the external world. Recently, A. T. Beck and Haigh (2014) updated the cognitive model and proposed the Generic Cognitive Model (GCM). This recent model involves the postulation that "psychopathology is initiated and maintained when the schema-activated components (e.g., beliefs, focus, and maladaptive behaviour) are triggered by stimuli and interact" (A. T. Beck & Haigh, 2014, p. 14). Although focus is a new component in the GCM, the role of attentional focus, including self-focused attention, in psychopathology has been long documented (Ingram, 1990). Self-focused attention has been linked with a variety of mental disorders, including depression, and more self-focus has been associated with more severe psychopathology (Woodruff-Borden, Brothers, & Lister, 2001). Because the GCM includes focus along with the belief and behaviour components, A. T. Beck and Haigh (2014) suggested that the therapeutic approach deriving from the updated cognitive model may include mindfulness, cognitive, and behavioural techniques.

The evidence-base for CBT for depression has increased considerably over the last 20 years (Butler, Chapman, Forman, & Beck, 2006; Cuijpers et al., 2013; Gloaguen, Cottraux, Cucherat, & Ivy-Marie Blackburn, 1998; Hofmann et al., 2012). There is level I evidence (i.e., systematic reviews of randomised controlled trials, RCTs; National Health and Medical Research Council, 2009) for CBT for depression in adults (Australian Psychological Society, 2018). Therefore, it is not surprising that CBT is the mainstream treatment for depression in Western countries. Because CBT is congruent with the social and cultural factors characterising Western countries (i.e., individualism, independence, personal choice), it "has become a very suitable type of psychological treatment for this time in our history" (Dobson & Dobson, 2017, p. 15). As such, a key challenge for clinicians is to investigate the suitability and efficacy of CBT for clients from culturally and linguistically diverse backgrounds.

1.5.2. Cognitive behavioural therapy and Chinese culture: Theoretical compatibility and evidence.

Cultures are dynamic systems that change over time. Therefore, it is important to examine traditional and philosophical thoughts of a particular culture, which provide a general philosophy of life, and their application over time. Confucianism is the core of the traditional

thought shared by individuals of Chinese descent for centuries. Confucian thought provides guidance for improving one's human qualities, developing harmonious interpersonal relationships, and cultivating a scholarly manner (Hequin, 2005). Thus, this school of thought describes ideal situations that people strive for and therefore may not reflect the real lives of common people. Is it thought that "Chinese realise from experience that life is full of harshness and difficulties, mixed with hate and love, greed and generosity, deception and honesty" (Hequin, 2005, p. 139), which may clash with the straightforward principles of Confucianism. When the Confucianism philosophy of life is not sufficient to assist individuals to deal with the complexity of daily problems, psychotherapies may be a more pragmatic solution.

As discussed in the previous section, CBT is clearly one of the most researched, efficacious, and cost-effective treatments for depression. Considering its effectiveness, CBT seems to be a good treatment option for depression in Chinese people. Thus, questioning CBT's compatibility with the Chinese culture is of critical importance and has the potential to extend the application of CBT for clients with a different cultural profile than those for whom it was developed. Hodges and Oei (2007) examined the conceptual compatibility between CBT and the common values of Chinese culture. Six distinctive processes of CBT that were compatible with Chinese culture have been described: (a) direction of session activity, (b) teaching of skills, (c) emphasis on homework, (d) focus on present and future experiences, (e) psychoeducation, and (f) cognitive processes. Direction of session activity is thought to be compatible with the hierarchical nature of society and relationships and respect for authority. The educational aspect of CBT responds to the expectation of learning practical and useful ways to deal with problems. The emphasis on homework, as a CBT technique, corresponds with the Confucian work ethic, achievement orientation, and discipline. The focus on present and future experiences fits with Confucian pragmatism and tendency to deal with problems in the present, but considering the future at the same time. Importantly, cognitive processes appear to be the only problematic aspect of CBT. One of the main obstacle in identifying and challenging irrational or automatic thoughts is the tendency to accept rules and norms without scrutiny. As such, challenging irrational or automatic thoughts involves questioning fundamental cultural beliefs, which may be confronting.

Consistent with Hodges and Oei (2007), several researchers have argued in favour of the compatibility of CBT with Chinese culture (S. W.-H. Chen & Davenport, 2005; Guo & Hanley,

2015; Hwang, 2006; Y.-N. Lin, 2002). There is a consensus over the advantages and challenges of CBT for Chinese people. The key advantages of CBT are the correspondence with Chinese people's preference for short-term, pragmatic and solution-focused, unambiguous, structured, and clinician-led therapies. However, the main challenge of using CBT with Chinese clients is that the cognitive restructuring process involves modifying core beliefs that are deeply rooted in the collective identities of Chinese individuals (Guo & Hanley, 2015). Cognitive restructuring may result in identity crisis, anxiety, and ruptures of the therapeutic alliance (S. W.-H. Chen & Davenport, 2005; Shen, Alden, Söchting, & Tsang, 2006). Therefore, Y.-N. Lin (2002) proposed a more gentle approach that emphasises external locus of control and responsibility and adapting individualistic therapeutic skills (i.e., assertiveness training, confrontation, exploration of personal problems too early in therapy), while Guo and Hanley (2015) suggested challenging the tendency of accepting rules and norms without scrutiny by encouraging the client to take an open stance to questioning core beliefs. Further, Hwang (2006) proposed 18 therapeutic principles that build on cultural competency to improve the cultural sensitivity of CBT for Asian Americans.

The evidence of CBT for depression in Chinese nationals and migrants suggests that CBT is a promising therapy in this ethnic group (Choi et al., 2012; Chu, Huynh, & Areán, 2012; Dai et al., 1999; Hwang et al., 2015; Shen et al., 2006; D. F. K. Wong, 2008a, 2008b). However, there are some notable gaps in the literature. First, most of these studies were conducted in the USA (Chu et al., 2012; Dai et al., 1999; Hwang et al., 2015), and only one study was conducted in Australia (Choi et al., 2012). Chinese migrants in Australia and the USA may encounter different demands of immigration due to differences in terms of cultural profile. Although both Australia and the USA are individualist countries, Australia is characterised by horizontal individualism, which implicates valuing equality and expressing one's uniqueness and capabilities to be self-reliant, while the USA is characterised by vertical individualism, which implicates distinguishing oneself via competition, achievement, and power (X.-P. Chen & Li, 2005; Triandis, Bontempo, Villareal, Asai, & Lucca, 1988). Therefore, Chinese migrants may encounter stressors related to migration, which may have a detrimental impact on their mental health (e.g., increase their vulnerability of developing depression). Second, only two studies used a cultural adaptation framework (i.e., the Formative Method of Adapting Psychotherapy; Hwang, 2009) to guide the cultural adaptation process of CBT in Chinese migrants, which limits the generalisability of the current literature (Chu et al., 2012; Hwang et al., 2015). Lastly, there is a high degree of

variability in the extent to which clients or consumers were involved in the cultural adaptation process of CBT (Choi et al., 2012; Chu et al., 2012; Hwang, 2009). Therefore, more studies investigating the cultural adaptation process of CBT for depression, particularly involving consumers from ethnic groups that engage ineffectively with mental health services (i.e., Chinese migrants to Australia), is required. A comprehensive overview of the evidence of CBT for depression among Chinese migrants and nationals is provided in Chapter Two.

1.5.3. Concepts of culture applied in psychotherapy.

Including mental health on the global health agenda challenges clinicians to develop culturally appropriate skills in clinical and other applied psychological practices (American Psychological Association, 2002). Clients are likely to participate in several different cultural groups, which creates a unique constellation of cultural aspects to each individual. As such, several key concepts including cultural competency, cultural humility, cultural sensitivity, and cultural adaptation have been developed to facilitate "tuning into clients' individualised experience as cultural beings" (Ridley, Mendoza, Kanitz, Angermeier, & Zenk, 1994, p. 128), to ultimately reduce mental health disparities in multicultural societies.

Cultural competency is the most influential concept in the literature proposed to improve clinicians' capability in working with culturally diverse clients. Cultural competency can be approached at multiple levels—clinicians, treatments, institutions, and systems (S. Sue, Zane, Hall, & Berger, 2009). However, the focus of the present research program is on the clinician level. The most widely recognised framework of cultural competency emphasises three components (a) cultural awareness and beliefs, involving clinicians' own sensitivity to personal values and biases to reduce ethnocentrism; (b) cultural knowledge, involving gaining knowledge about the clients' cultures, perspectives, and expectations for the therapeutic relationship; and (c) cultural skills, involving the ability to intervene in a relevant and culturally sensitive manner (D. W. Sue, Arredondo, & McDavis, 1992; D. W. Sue et al., 1982). This model informed the development of the multicultural guidelines by APA (2003) on education, training, research, and practice, and the Society of Counselling Psychology (Division 17). Although there is a consensus over the importance of acquiring knowledge of clients' worldviews and cultural background as well as developing culture-specific expertise (Chu, Leino, Pflum, & Sue, 2016), the different ways of defining cultural competency have generated considerable controversy over their assumptions, effects, and necessity (S. Sue et al., 2009).

Importantly, a shift towards a multicultural orientation conceptualised as "a way of being" (i.e., cultural humility) versus "a way of doing" (i.e., cultural competency) in therapy with clients from diverse culturally and linguistically backgrounds has been suggested (Chu et al., 2016; Owen, Tao, Leach, & Rodolfa, 2011). Cultural humility requires a lifelong commitment to self-reflection and self-critique, and explicitly acknowledges the power imbalance between clinicians and their clients (Tervalon & Murray-García, 1998). Culturally humble clinicians learn not to assume competency, but rather approach their clients with respectful openness and explore clients' cultural identities through a collaborative therapeutic process (Owen et al., 2015). Although cultural humility is not as widely investigated as cultural competency, recent research found several key advantages in clinical practice. Clients' perceptions of therapists' cultural humility were positively associated with both working alliance and better therapy outcomes in student and community samples (Hook, Davis, Owen, Worthington, & Utsey, 2013; Owen et al., 2015). Counsellors perceived as culturally humble were less likely to commit racial microaggressions such as denial of cultural stereotypes and avoidance of discussion of cultural issues. Furthermore, when culturally humble counsellors committed racial microaggressions, their mistakes had a lower impact on the therapeutic relationship. A possible explanation could be that culturally humble therapists are more likely to initiate cultural conversations and acknowledge their limitations and mistakes, which helps to repair possible ruptures in the therapeutic relationship (Hook et al., 2016).

Cultural sensitivity is another important concept related to "a way of being" when working with clients from culturally and linguistically diverse backgrounds. Culturally sensitive clinicians are required to not only acknowledge differences, but also to genuinely value, respect, and appreciate them (Parham, 2001). In therapy, this would involve welcoming rather than simply tolerating diversity (Collins & Arthur, 2007). As such, one of the key advantages of cultivating cultural sensitivity is that it encourages the consideration of both similarities and differences without assigning value judgements (i.e., positive or negative, Bennett, 1993) when providing the best available psychological treatments.

Cultural adaptation in another key concept in the literature which is considered to serve as an important bridge between cultural competency and cultural sensitivity (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). Cultural adaptations are defined as systematic modifications of evidence-based treatments regarding clients' language, culture, and context to

enhance its compatibility with clients' cultural patterns, meaning, and values (Bernal et al., 2009). Cultural adaptations may be necessary when clients' engagement with an evidence-based treatment is below standards established with the dominant ethnic groups. Further, Lau (2006) suggested a data-driven approach to cultural adaptations when an ethnic group faces unique clinical problems and exhibits poor treatment outcomes. In other words, cultural adaptations are required for specific areas of evidence-based treatments that prove to be problematic (i.e., poor client engagement and treatment outcomes) in particular ethnic groups. Therefore, developing culturally adapted interventions may be a solution for ensuring a complex psychotherapeutic approach and equity in culturally and linguistically diverse populations underrepresented in mental health services (Minas et al., 2013).

1.5.4. Cultural adaptation frameworks: A way forward?

Several cultural adaptation frameworks have been developed in an effort to introduce mainstream evidence-based interventions to culturally and linguistically diverse groups in multicultural countries (Castro, Barrera, & Holleran Steiker, 2010; Chu & Leino, 2017). Existing systematic reviews and meta-analyses (Benish, Quintana, & Wampold, 2011; Chowdhary et al., 2014; Chu & Leino, 2017; Kalibatseva & Leong, 2014) provide support for the efficacy of cultural adaptations to psychotherapies in culturally and linguistically diverse groups. Most cultural adaptation frameworks involve qualitative methods to allow potential consumers to inform the proposed intervention, development of a culturally adapted intervention, pilot testing, and further refinement (Castro et al., 2010). In other words, most of the cultural adaptation frameworks involve a theory-driven and data-driven approach to guide the cultural adaptation process.

One of the most common approaches includes the differentiation between surface versus deep structure adaptations (Resnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000). Surface structure involves matching the materials and messages used in intervention to the ethnic group's culture, experience, and behavioural patterns. Surface structure is similar to face validity and is achieved through expert, community, and ethnic group review. In contrast, deep structure involves consideration of the cultural, social, psychological, environmental, and historical factors that might explain the ethnic groups' perception of the cause, course, and treatment of a mental disorder. Deep structure can be achieved by incorporating core cultural values. While surface structure might improve feasibility, deep structure might improve treatment outcomes.

The Cultural Treatment Adaptation Framework (Chu & Leino, 2017), was developed to identify and synthesise patterns of cultural adaptations published in the last 20 years. Similar to surface versus deep structure adaptations (Resnicow et al., 2000), Chu and Leino's (2017) framework consists of two first order categories—peripheral and core treatment components. Peripheral components are used to increase the accessibility of a treatment to a particular population. Therefore, peripheral components include engagement (i.e., psychoeducation) and treatment delivery (i.e., materials and semantics). Core components are primary therapeutic ingredients responsible for mediating symptom change. A continuum of low to high levels of adaptation was described, including (a) no change; (b) core modifications (i.e., core component not suitable and needs to be changed or removed); (c) core addition (i.e., adding components deemed appropriate and necessary for a particular ethnic group); (d) complete change (i.e., significant change to a traditional evidence-based intervention required to the extent of an entirely different intervention). Interestingly, Chu and Leino's (2017) systematic review showed that the most frequently identified cultural adaptations were to peripheral components (i.e., engagement and delivery), while most frequent cultural adaptations to core components involved core modifications and core additions. No studies reported a complete change of core components.

The Psychotherapy Adaptation and Modification Framework (PAMF, Hwang, 2006) is a conceptual framework developed for adapting therapies for ethnic minorities and improving the cultural competency of clinicians in providing evidence-based treatments. This is a complex model comprising six therapeutic domains and 25 therapeutic principles. The domains include (a) dynamic issues and cultural complexities; (b) orienting clients to psychotherapy and improving mental health awareness; (c) understanding cultural beliefs about mental disorders, its causes, and appropriate treatment; (d) improving the client-therapist relationship; (e) understanding cultural differences in the expression and communication of distress; and (f) addressing cultural issues that are specific to the population. The therapeutic principles were described for assisting clinicians in providing therapy to less acculturated Asian Americans.

The Formative Method of Adapting Psychotherapy (FMAP, Hwang, 2009) is a community-based, bottom-up approach involving a comprehensive, multistep process. The FMAP was developed to culturally adapt CBT for depression in Chinese migrants to the USA. The FMAP comprises five stages: (a) generating knowledge and collaborating with stakeholders

(e.g., community members, clinicians); (b) integrating generated information with theory, empirical, and clinical knowledge; (c) reviewing and revising the proposed culturally adapted intervention; (d) testing the culturally adapted intervention, and (e) finalising the culturally adapted intervention. Hwang et al. (2015) conducted the RCT comparing the effectiveness of culturally adapted CBT, developed by using PAMF and FMAP, with non-culturally adapted CBT in Chinese migrants to the USA with MDD. Results showed that clients receiving the culturally adapted CBT reported approximately twice the reduction in depressive symptoms compared to those receiving standard CBT. Further, the drop-out rates in the culturally adapted CBT (i.e., 7%) were lower than in standard CBT (i.e., 26%), indicating that systematic cultural adaptations may improve client engagement as well as rates of symptom reduction. Despite these favourable results, most patients in both treatment conditions presented depressive symptomatology after treatment. A possible explanation could be that patients in this study were more severely depressed (i.e., total score of 23 on Hamilton Depression Rating Scale for standard CBT and a total score of 26 for culturally adapted CBT) that those in other studies (i.e., total score of 19.2 on the Hamilton Depression Rating Scale in Elkin et al., 1989; total score of 14.2 in Miranda, Azocar, Organista, Dwyer, & Areane, 2003). Further, Chu et al. (2012) used the FMAP to develop and pilot test a culturally adapted problem-solving intervention for depression in Chinese elderly. The intervention was acceptable and effective in reducing depression symptoms. Importantly, other overlapping frameworks have been developed for designing, implementing, and evaluating culturally adapted interventions (Barrera & Castro, 2006; Cardemil, 2010). Overall, existing effort for systematically guiding the cultural adaptation of evidence-based interventions indicate that substantial advancement has been made in this developing science (Castro et al., 2010; Chu & Leino, 2017).

1.6. Thesis Overview

1.6.1. Rationale of the present thesis.

Australia is one of the most culturally and linguistically diverse countries in the world, with more than a quarter of the population being born overseas (ABS, 2017). More people than ever before in human history are migrating in search of better job opportunities and lifestyle (Foo et al., 2018). Migration is a significant life event accompanied by both positive and negative emotions depending on one's reframing skills. Stress associated with migration can be reframed in positive terms such as rebuilding personal identity in spite of demands of immigration,

personal development and making a fresh start (Adler, 1987; Bobowik, Basabe, & Páez, 2015; O'Reilly & Benson, 2009). However, the stress associated with migration might be reframed in negative terms such as the loss of one's social structure, culture, language, values, and support network (Bhugra et al., 2011). Additionally, demand aspects of immigration (e.g., loss, not feeling at home) have been found to play a key role in the development, maintenance, and resolution of depression (Aroian & Norris, 2003).

Chinese migrants to Australia represent the third largest group of overseas-born residents and the largest group from non-English speaking backgrounds (ABS, 2017). Despite this, there are no representative epidemiological studies focusing on depression in Chinese migrants to Australia. The available data from one study assessing the prevalence of affective disorders in large sample of immigrants (e.g., China, India) reported lower prevalence rates of affective disorder among first generation migrants from non-English speaking backgrounds than among the Australian-born group (Liddell et al., 2016). However, this finding needs to be interpreted carefully because the first generation migrants from non-English speaking backgrounds reported higher levels of disability and impairment than Australian-born individuals with affective disorder. Interestingly, Tang et al.'s (2009) study indicated slightly higher rates of depression and anxiety among Chinese migrants than among Australian-born participants. It is important to note that data collection in this study was undertaken at a family practice located in a suburb where the majority of patients were Chinese migrants seeking help for health issues. Therefore, the higher prevalence rates could be explained by the compounded effect of migration stress (e.g., highly educated patients not being able to find an equivalent job to their occupation in their country of origin) and their anxiety about physical illness. Consistent with these findings, J. Hu and Wang (2016) reported a slightly higher level of high psychological distress among Chinese migrants living in Australia than among Australian-born participants. Participants in this study were recruited via Chinese social websites. Several risk factors for higher level of psychological distress have been identified including younger age, single, lower education level, being a student, residing in Australia for less than five years, lower English proficiency, and having a chronic illness. Further, Chou (2007) reported that elderly Asian migrants (e.g., China, Japan, Korea) displayed a higher level of distress compared to migrants from Western countries. Data from the Longitudinal Survey of Immigrants to Australia conducted in 2000 and 2001 by the Department of Immigration and Multicultural Affair was used for analysis. Risk factors for

psychological distress consistent with J. Hu and Wang (2016) have been identified (e.g., language barriers, low education), as well as new risk factors such as the visa type (e.g., family union visa, skill labour visa). In sum, it appears that studies conducted in environments (i.e., family practice and online) with less structural and cultural barriers to mental health and longitudinal studies clearly highlight that depression and anxiety or psychological distress is common among Chinese migrants. These findings, along with the evidence showing that Chinese migrants in Australia delay seeking treatment until emotional problems become severe, which leads to frequent involuntary admission to hospitals (Blignault et al., 2008; J. Hu & Wang, 2016; Wynaden et al., 2005), indicate that mental disorders in Chinese migrants represent a serious cause of concern.

Developing culturally adapted interventions for depression might be a solution to address some of the cultural (e.g., shame attached to mental disorders) and attitudinal (e.g., stoicism) barriers to mental health services, which in turn might improve clinical engagement, and ultimately treatment outcomes. CBT is one of the most researched, efficacious, and cost-effective treatments for depressive disorder (Hofmann et al., 2012). There is evidence supporting (a) the compatibility between CBT and the Chinese culture (S. W.-H. Chen & Davenport, 2005; Guo & Hanley, 2015; Hodges & Oei, 2007; Hwang, 2009; Y.-N. Lin, 2002); and (b) the efficacy of CBT for depression in Chinese nationals and migrants (Choi et al., 2012; Chu et al., 2012; Dai et al., 1999; Hwang et al., 2015; Shen et al., 2006; D. F. K. Wong, 2008a, 2008b). It is important to note that most of these studies were conducted in the USA and only one study was conducted in Australia (Choi et al., 2012). As discussed in detail earlier in this chapter, both Australia and the USA are individualist countries. However, Australia is characterised by horizontal individualism, wherein equality and expressing one's uniqueness and capabilities to be self-reliant are valued, while the USA is characterised by vertical individualism, wherein one distinguishing oneself via competition, achievement, and power (X.-P. Chen & Li, 2005; Triandis et al., 1988). Thus, Chinese migrants in Australia and the USA might face different stressors (e.g., expressing their uniqueness in Australia versus the pressure of being the best in the USA), which might add to the general stress caused by moving into a new country and securing basic needs such as housing, a job, schooling for children. Additionally, there are important differences in terms of accessing mental health services. In Australia, only permanent residents have access to Medicare subsidised mental health services, while the USA is lacking in

universal health insurance coverage and, even with private insurance, the out-of-pocket cost are significant (Schneider, Sarnak, Squires, Shah, & Doty, 2017). More studies are required to investigate cultural adaptations to CBT for depression in Chinese migrants in the Australian context.

To date, (a) no scoping reviews have been conducted to map the existing CBT literature for depression symptomatology or MDD in Chinese nationals and migrants, (b) no studies have been conducted in Australia to investigate cultural adaptations of CBT to treat depression in Chinese migrants, and (c) no studies have involved the investigation of specific vulnerability factors associated with depression in Chinese migrants to Australia. As such, the present research program adopted a mixed-method research design conducted across three studies to address these gaps in the CBT literature for depression in Chinese migrants to Australia. The present research program has important implications for developing a culturally adapted CBT version for depression in Chinese migrants living in Australia, which has the potential to reduce the disease burden of depression in a migrant population underrepresented in counselling and therapy services.

1.6.2. Research aim, objectives, and studies.

The overall aim of this research program was to investigate cultural adaptations of CBT for depression symptoms in Chinese migrants living in Australia. The research objectives were to:

- Review the current literature on CBT for depression and comorbid anxiety in Chinese nationals and migrants, with a particular focus on cultural adaptation frameworks, cultural modifications to therapy, consultations with clinicians and consumers, and clients' experience undergoing therapy;
- Document clinicians' and Chinese community members' perspectives on the cultural adaptation of CBT for depression in Chinese migrants, with an emphasis on the specific and non-specific factors of CBT; and
- Integrate migration stress and ethnic identity with aspects of the GCM, including brooding, mindful attention, automatic thoughts, activation, and avoidance, to predict depression in Chinese migrants.

The present research program added to the growing body of cross-cultural research by adopting a mixed-method research design conducted across three studies. Each study informed the development of the subsequent study. The research commenced with the scoping review, which informed the development of the qualitative study, which in turn informed the quantitative study. Each study comprised an independent methodology and analysis, which was followed by an integration of the findings, with an emphasis on clinical implications, to address the overall research aim.

1.6.3. Structure of the thesis.

This thesis is presented in the manuscript format and includes four chapters written as standalone publishable articles, as well as a background and general discussion chapter. Each chapter begins with a meaningful quote relevant to the content of that chapter. A master reference list and appendices are presented after the discussion chapter.

The first study comprised a scoping review to address the first objective. The necessity of conducting a scoping review was highlighted in the early stage of this research program as, at that time, there were no reviews focusing explicitly on CBT for depression and comorbid anxiety in a Chinese context. A scoping review was considered for the key advantage of mapping the existing literature and therefore establishing a solid theoretical foundation for the entire research program. A comprehensive account of this study is provided in Chapter Two.

Based on the findings of the scoping review, the second study was designed as a qualitative study to address some of the gaps in the literature regarding the high variability in involving consumers and clinicians in the cultural adaptation of CBT. This study used the FMAP (Hwang, 2009)and the GCM (A. T. Beck & Haigh, 2014) to guide the cultural adaptation of CBT for depression in Chinese migrants and address the second objective of the thesis. A qualitative approach involving focus groups and individual semi-structured interviews with community members and clinicians was considered the most efficient and appropriate approach. A comprehensive account of this study is included in Chapters Three (specific factors) and Four (non-specific factors).

The third study was a quantitative study designed to address the third objective of the thesis. Study Two informed the development of a structural model based on the GCM (A. T. Beck & Haigh, 2014) for depression in Chinese migrants. Structural equation modelling was used to test a series of models investigating relationships between aspects of migration stress,

ethnic identity, components of the GCM, and depressive symptoms. A comprehensive account of this study is included in Chapter Five.

The thesis begins with Chapter One, which presents the background to the research by providing a literature review regarding depression prevalence worldwide and in Chinese migrants living in Western countries, depression expression in Chinese culture, and barriers to depression treatments. Key concepts of culture and cultural adaptations frameworks are discussed. A summary of the cognitive model, the evidence for CBT, and the compatibility between CBT and Chinese values is presented. The chapter concludes with the rationale of the thesis, the research aim, studies, and ethical considerations.

Chapter Two details a scoping review undertaken to review the existing CBT literature for depression and comorbid anxiety in Chinese nationals and migrants. This chapter highlights the gaps in the current literature, presents the methods employed, key findings, and recommendations for future research. The scoping review calls for studies using cultural adaptations frameworks to guide the cultural adaptation of CBT for depression in Chinese migrants living in Australia.

Chapter Three describes the first stage of the qualitative study, involving the specific factors of CBT. This chapter documents the clinicians' and community members' perspectives on the specific factors of CBT, the rationale of the study informed by Study One, the methods, outlines themes and subthemes derived from the data, and key findings. This study provides recommendations for developing a culturally sensitive version of CBT and emphasises that a clients' interdependent self needs to be considered in future versions of CBT for Chinese migrants.

Chapter Four presents the second stage of the qualitative study, involving the non-specific factors of CBT. This chapter presents the clinicians' and community members' perspectives on the non-specific factors of CBT, the rationale of the study, outlines themes and subthemes derived from the data, and key findings. Because the same methodology as the previous chapter was used, only different methodology aspects were described. This study suggests that careful consideration of both specific and non-specific factors is required to culturally adapt CBT for depression in Chinese migrants.

Chapter Five outlines the quantitative study, which involves testing a series of structural equation models investigating relationships between aspects of migration stress, ethnic identity,

components of the GCM, and depressive symptoms. This chapter presents the rationale of Study Three, which was informed by Study Two, the methodology, and key findings. This study described the aspects of migration stress associated with depression and clinical implications of addressing these aspects in CBT.

These chapters are followed by a comprehensive general discussion (Chapter Six). The General Discussion Chapter summarises major findings of each study, integrates the clinical implications, and offers recommendations for future research. The thesis concludes with overall limitations and strengths and final conclusions.

1.6.4. Ethical considerations.

Prior to commencing the research, ethics approval was granted by Curtin University's Human Research Ethics Committee (approval number HR 190/2015, see Appendix A). The National Statement on Ethical Conduct in Human research (2007, –updated 2014) was considered in the design, data collection, and reporting. Study Two and Three involved data collection from human participants, therefore attention was given to informing participants about the purpose of the studies, potential risks and benefits, and it was made clear that participation in the studies was voluntary and that the participants had the right to withdraw at any time, without any consequences.

The data collected for the present research program was stored with no identifying information. Only the researcher and supervisory team had access to confidential information. Hard copy data were stored in a locked cupboard at Curtin University. All electronic data was stored on a password-protected computer provided by the university and on the university's research drive. Data will remain stored for a period of seven years in accordance with university's data storage policy.

"As therapists, we must retain not only our humanity (McWilliams, 2005), but also our humility and curiosity regarding various elements of cognitive behavioural therapy."

(Dobson & Dobson, 2017, p. 15).

Chapter 2: Cognitive Behavioural Therapy for Depression and Comorbid Anxiety in Chinese Nationals and Migrants: A Scoping Review

2.1. Introduction

MDD is one of the common mental disorders (Kalibatseva & Leong, 2014; Vos et al., 2016) identified in all countries and among all ethnic groups. Anxiety is the most common comorbid disorder with MDD and it appears to be the rule and not the exception in primary care both in the Western (Kessler, Merikangas, & Wang, 2007; Lamers et al., 2011) and Chinese contexts (Phillips et al., 2009; Wu et al., 2018). Clients with depression and comorbid anxiety are inclined to have higher severity of illness, higher chronicity, lower quality of life, and reduced psychosocial functioning than those without comorbidity (Hirschfeld, 2001; Wu et al., 2018). As discussed in Chapter One, CBT is one of the most researched and efficacious therapies for depression (Bauer, Wilansky-Traynor, & Rector, 2012; Hofmann et al., 2012). Systematic reviews and meta-analyses provide support for the efficacy of CBT for depression in culturally and linguistically diverse populations (Chowdhary et al., 2014; Kalibatseva & Leong, 2014).

Only two meta-analyses have reviewed the efficacy of CBT in a Chinese context (T. K. Ng & Wong, 2018; Xu & Tracey, 2016), but the findings were mixed. Xu and Tracey (2016) conducted a network meta-analysis to examine the efficacy of CBT, psychodynamic therapy, humanistic-experiential therapy, and indigenous therapy (e.g., Taoism cognitive therapy) in Chinese individuals. The search strategy included published and unpublished RCTs comparing one psychotherapy treatment with a control group or another psychotherapy. The China Knowledge Resource Integrated Database, which includes studies written in Chinese, was searched. A total number of 235 studies was included in this meta-analysis of which 180 were CBT studies. Interestingly, T. K. Ng and Wong (2018) conducted a meta-analysis with a different aim and methodology. The authors focused only on examining the efficacy of CBT for Chinese individuals and the efficacy of culturally adapted CBT for Chinese individuals. The search strategy included published RCTs or non-RCTs involving at least one CBT condition and one control condition. Web of Science, PsycINFO, and PubMed were searched. A total number

of 55 studies published in English was included in this meta-analysis. Xu and Tracey's (2016) findings indicate that indigenous therapies (e.g., Naikan therapy developed in Japan, Taoism cognitive therapy developed in China) and humanistic-experiential therapy were more effective than CBT, whereas T. K. Ng and Wong (2018) found that CBT was most efficacious for depression and anxiety in Chinese people and culturally adapted CBT was more effective than unadapted CBT, which is consistent with previous literature (Benish et al., 2011; Chowdhary et al., 2014; Kalibatseva & Leong, 2014). A possible explanation for these differences in findings is that the meta-analyses used different methodologies, including different search strategies, databases, and inclusion and exclusion criteria. The operationalisation of Chinese participants was different as well. In Xu and Tracey's (2016) study, Chinese participants were defined as originating from China, while in T. K. Ng and Wong's (2018) study, Chinese participants were defined as residing in Australia, China, Hong Kong, Taiwan, and the USA. Additionally, Xu and Tracey (2016) did not describe cultural adaptations to CBT, and therefore it is not clear if the studies included in their meta-analysis were culturally adapted.

Despite preliminary evidence for the efficacy of CBT and culturally adapted CBT in Chinese people, there are several gaps in the existing literature. Four out of six systematic reviews and meta-analyses (Benish et al., 2011; Chowdhary et al., 2014; Chu & Leino, 2017; Kalibatseva & Leong, 2014; T. K. Ng & Wong, 2018; Xu & Tracey, 2016) included only RCTs, and therefore a substantial body of evidence (e.g., open trials, qualitative studies, follow-up studies) may have been neglected. The systematic reviews and meta-analyses reviewing the efficacy of CBT in culturally and linguistically diverse populations included a relative small number of studies with Chinese participants. Benish et al. (2011) reported that 14.3% participants self-identified as Asian Americans, while the other systematic reviews reported between two and ten studies involving Asian Americans or Chinese people (Chowdhary et al., 2014; Chu & Leino, 2017; Kalibatseva & Leong, 2014). Cultural adaptations to a variety of age groups (e.g., adolescents, adults, elderly), mental disorders (e.g., drug addition, psychotic disorders), and comorbid conditions (e.g., depression in patients with breast cancer) have been reported. These findings indicate that more studies are required to review the CBT literature for depression and comorbid anxiety in Chinese people. In this case, a scoping review was preferred to capture wider types of evidence (i.e., case studies, qualitative studies), which is of critical importance because the literature on cultural adaptations is still in the early stages. Conducting a

scoping review has the advantage of providing an in-depth coverage of qualitative and quantitative studies on culturally adapted CBT, with an emphasis on common and unique adaptations (Arksey & O'Malley, 2005). Gaining a comprehensive overview of the existing cultural adaptations is essential to improve client engagement and treatment outcomes in Chinese migrants who are underrepresented in counselling services in Western countries (Akutsu et al., 2004; J. Hu & Wang, 2016; Jim & Pistrang, 2007; Lau, 2006), but also to improve the efficacy of CBT provided in primary care for Chinese nationals (Wu et al., 2018). Therefore, the aim of this scoping review was to review the current literature on CBT for depression with or without comorbid anxiety in Chinese nationals and migrants, with a particular focus on cultural adaptation frameworks, cultural modifications to therapy, consultations with clinicians and consumers, and clients' experience undergoing therapy.

2.2. Methodology

A scoping review, using Arksey and O'Malley's (2005) methodological framework, was undertaken to map the current literature on CBT for depression with or without comorbid anxiety in Chinese nationals and migrants, with a particular focus on cultural adaptation frameworks, cultural modifications to therapy, consultations with clinicians and consumers, and clients' experiences while undergoing therapy. This framework comprised five stages: (a) identifying initial research questions, (b) identifying relevant studies, (c) study selection, (d) charting the data, and (e) collating, summarising, and reporting the results.

Stage 1: Identifying the Research Question

To ensure that a substantial body of evidence was captured, the following research questions were formulated: (a) What is known from the existing literature about the efficacy of CBT for depression and comorbid anxiety in Chinese nationals and migrants? (b) What is known from the existing literature about the experience of clients with a Chinese ethnic background undergoing CBT for depression or comorbid depression and anxiety? (c) What is known from the existing literature about the cultural modifications to CBT for depression and comorbid anxiety in Chinese nationals and migrants? Types of evidence including RCTs, follow-up studies, qualitative studies, and case studies were systematically summarised.

Stage 2: Identifying Relevant Studies

A literature search was conducted between August and October 2014, with an update undertaken between October and November 2018, to capture articles written in English on CBT for depression and comorbid anxiety in Chinese nationals and migrants. PsycINFO, ProQuest, and Medline were searched using Boolean operators to narrow and combine potentially relevant articles. Several terms for Chinese ethnicity were used to ensure a comprehensive search of studies with Chinese nationals and migrants. The following keywords were used: cognitive behavio?r therapy AND depression OR major depression AND Chinese OR Chinese immigrants OR Cantonese immigrants OR Hong Kong Chinese OR Hong Kong Chinese immigrants OR Mandarin OR Han Chinese. Additional articles were identified by consulting reference lists of the final articles included in this scoping review. RCTs, single group studies, qualitative studies, and case studies investigating CBT for depression in the targeted population were considered for inclusion. Articles deemed relevant after screening the title and the abstract were downloaded into Endnote X7. Studies with anxiety as the primary diagnosis, studies solely with children and adolescents, comorbid psychotic disorders, bipolar disorder, eating disorders, drug and alcohol addiction, health conditions such as heart conditions, cancer, and HIV, discussion papers, expert opinion, study protocols, and reviews were deemed ineligible.

Stage 3: Study Selection

Using the key search terms, 1266 articles were identified. Articles that were duplicated in the three databases selected for this scoping review were removed. Further, the articles deemed irrelevant after screening the title and the abstract were excluded. In accordance with the inclusion and exclusion criteria detailed in Stage 2, 31 studies were identified as being potentially relevant. Full-text versions of the articles were reviewed. Ten articles were excluded for being written in Chinese (n = 4), including participants with other mental disorders than depression comorbid with anxiety disorder (n = 1), investigating depression in dementia caregivers (n = 4), and having less than five percent Chinese participants (n = 1). The articles were assigned to subgroups of relevant, excluded, and duplicates of articles in Endnote X7. A total of 21 articles were included in this scoping review. The Preferred Reporting of Items for Systematic Reviews and Meta-Analysis (PRISMA) Statement (Moher, Liberati, Tetzlaff, Altman, & The, 2009) was used to report the article selection process (see Figure 1 for a flowchart describing included studies).

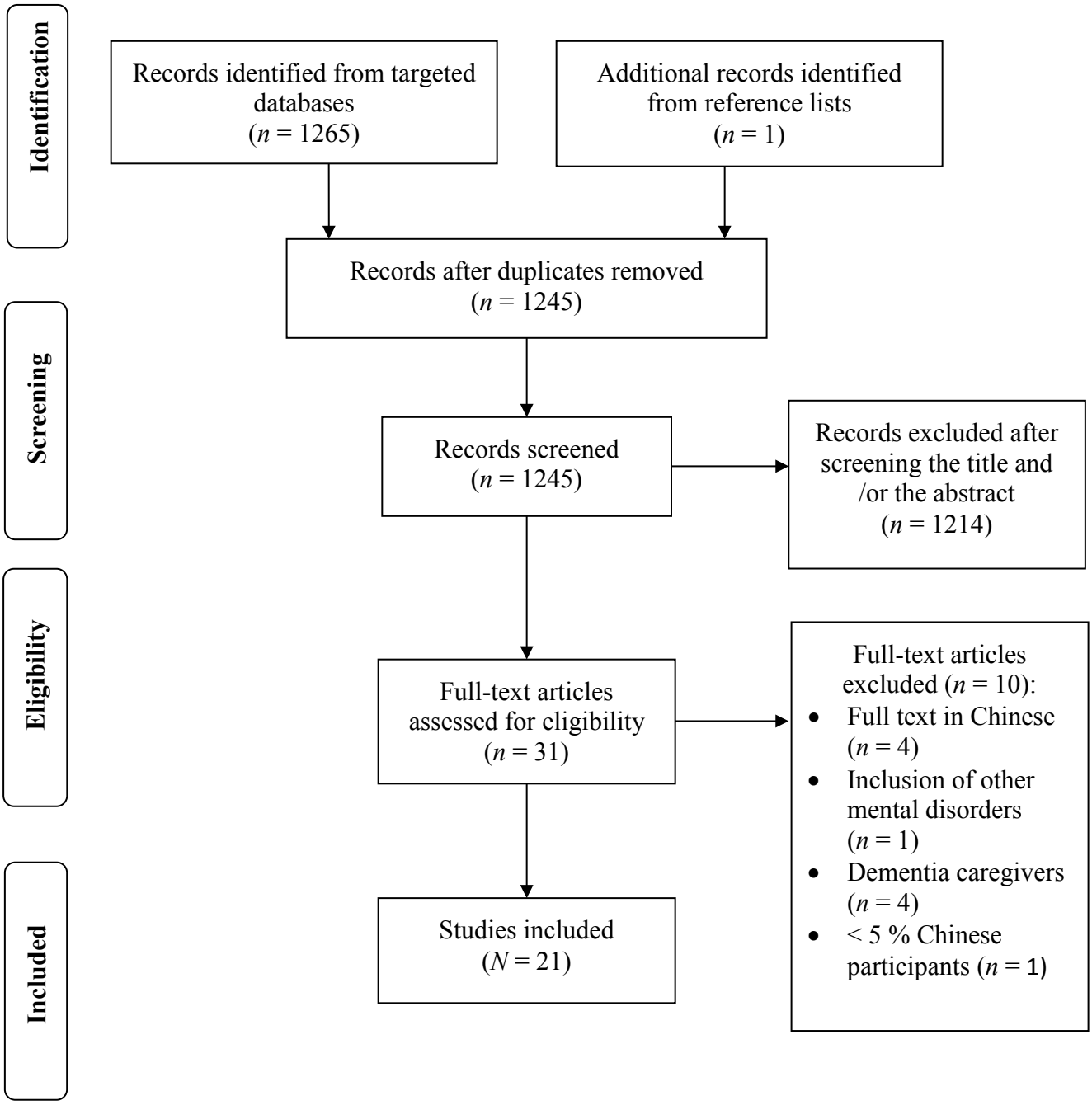

FIGURE 1. PRISMA FLOWCHART DESCRIBING INCLUDED STUDIES.

Stage 4: Charting the Data

The relevant articles ($N = 21$) were recorded on a spreadsheet listing information about the author, year of publication, region, condition, treatment format, inclusion criteria, outcome measures, and cultural adaptations (see Table 1 for a summary of the studies on CBT for depression and comorbid anxiety in Chinese nationals and migrants).

Stage 5: Collating, Summarising, and Reporting Results

An analysis of the methodological and conceptual aspects of the selected studies was conducted. The methodological analysis focused on describing participants' status (i.e., nationals or migrants), intervention type, research methods, and cultural modifications. The conceptual analysis involved identifying common and unique cultural modifications.

2.3. Results

2.3.1. The efficacy of CBT for depression and comorbid anxiety.

The efficacy of CBT for depression in Chinese participants originating from China, Hong Kong, and Taiwan was examined in 10 RCTs and one case study, and the efficacy of CBT for depression in Chinese migrants to Australia, Canada, and the USA was examined in four RCTs and two case studies. Most of the studies involving Chinese migrants were conducted in the USA (n = 4). A wide range of intervention types were identified, including cognitive bibliotherapy (n = 1), internet-delivered CBT (iCBT; n = 1), telephone-based CBT (n = 1), RCTs involving individual sessions (n = 2), RCTs involving group sessions (n = 9), and case studies involving individual sessions (n = 3). In terms of treatment format, it is clear that group therapy featured predominantly. CBT interventions were compared with waitlist control (n = 8), standard treatment (n = 31), supportive intervention (n = 1), medication (n = 1), culturally adapted CBT (n = 1), and an intervention based on traditional Shaolin Chan practice and Dan Tian abdomen breathing (n = 1). Two studies conducted in China compared CBT along with medication versus medication. CBT interventions as well as interventions incorporating medication have been found effective in reducing depression and anxiety symptoms, except for the culturally adapted CBT and an intervention based on traditional Chinese practices, which led to superior results.

2.3.2. Use of cultural adaptation frameworks.

Interestingly, no cultural adaptation frameworks were reported in the RCTs involving Chinese participants originating from China, Hong Kong, and Taiwan. Cultural adaptation frameworks were used only in studies involving Chinese migrants, the FMAP being the most frequently used framework (n = 4). A qualitative study was conducted based of the FMAP to develop a manualised culturally adapted CBT intervention for Chinese Americans with depression (Hwang, 2009).

TABLE 1

STUDIES ON CBT FOR DEPRESSION AND COMORBID ANXIETY IN CHINESE NATIONALS AND MIGRANTS

Author	Region	Condition	Treatment format	Inclusion criteria	Outcome measures	Cultural adaptations
			RCTs involving Chinese nationals			
Chan et al. (2012)	Taiwan	1. DMBI (*n* = 20) 2. GCBT (*n* = 20)	Group: 4 weekly sessions of 90 mins	Depression symptoms	C-BDI; EEG	No
Cui et al. (2016)	China	1. GCBT (*n* = 60) 2. SG (*n* = 60) 3. WLC (*n* = 60)	Group: 8 weekly sessions of 2 h	SDS ≥ 5	SDS; SAS; CCSAS	No
C. T. Hsu et al. (2010)	Taiwan	1. GCBT (*n* = 10) 2. WLC (*n* = 10)	Group: 8 weekly sessions of 2 h	Depression symptoms	CES-D; PSQI; SF-36	No
(Leung et al., 2013)	Hong Kong	1. GCBT (*n* = 47) 2. Control group (*n* = 50)	Group: 6 weekly sessions of 2 h	EPDS ≥ 10	Chinese EPDS; HAD; PSS; DAS; Family APGAR	Yes; based on D. F. K. Wong (2008) and literature on pregnant and postnatal women
E. T.-H. Liu et al. (2009)	Taiwan	1. Cognitive bibliotherapy (*n* = 27)	Bibliotherapy, reading the self-	10 > C-BDI < 47	Chinese- BDI; The Self-	No

		2. WLC (*n* = 25)	help book in 4 weeks		Control Schedule	
Ngai et al. (2015)	Hong Kong	1. Telephone-based CBT (*n* = 197) 2. ST (*n* = 200)	5 weekly telephone sessions of 20 to 30 min	EPDS score ≥ 10	Chinese version of EPDS; BDI; GHQ	Yes; cultural modifications based on (Ngai et al., 2009)
D. F. K. Wong (2008a)	Hong Kong	1. GCBT (*n* = 163) 2. WLC (*n* = 159)	Group: 10 sessions of 3 h	MDD; mild to severe depression symptoms on C-BDI	C-BDI; APS-R; Q-LES-Q-18; DAS	Yes
D. F. K. Wong (2008b)	Hong Kong	1. GCBT (*n* = 48) 2. WLC (*n* = 48)	Group: 10 sessions of 2.5 h	MDD; mild to severe depression symptoms on C-BDI	C-BDI; The Emotion Checklist; COPE; DAS	Yes, same as D. F. K. Wong (2008a)
B. Zhang et al. (2016)	China	1. GCBT + MED (*n* = 32) 2. MED (*n* = 30)	Group: 12 weekly sessions of 2 h	Unipolar depression 7 > HDRS < 17	HDRS; HAM-A; SDSS, LSS; MSPSS, SF-36	No
Zu et al. (2014)	China	1. MED (*n* = 25) 2. CBT (*n* = 12) 3. COMB (*n* = 43) 4. ST (*n* = 16)	Individual: 24 weekly sessions of 1 h	MDD; Chinese HDRS ≥ 17	Chinese version of HDRS; QIDS-SR; WSAS	No

RCTs involving Chinese migrants						
Choi et al. (2012)	Australia	1. iCBT (*n* = 25) 2. WLC (*n* = 30)	6 online lessons & homework	MDD; CB-PHQ-9 > 19 or Q 9 (suicidal ideation) > 1	C- BDI, CB-PHQ-9, DASS-21, K-10, SDS	Yes; cultural modifications based on Shen et al. (2006) and D. F. K. Wong (2008a, 2008b)
Dai et al. (1999)	USA	1. GCBT (*n* = 23) 2. WLC (*n* = 7)	Group: 8 weeks session; duration not reported	Depressive symptoms	Chinese version of HDRS & HAM-A	Yes; based on Munoz and Ying (1993)
Hwang et al. (2015)	USA	1. Standard CBT (*n* = 23) 2. CA-CBT (*n* = 27)	Individual: 12 sessions; duration not reported	MDD; HDRS ≥ 14	Chinese version of SCID & HDRS	Yes; PAMF (Hwang, 2006) and FMAP (Hwang, 2009)
Shen et al. (2006)	Canada	1.GCBT 2. TAU (*n* not reported)	Group:10 weekly sessions of 2 h; duration not reported	Mild to moderate depression	Cantonese version of SCID; VIA	Yes
Follow-up studies						
Choi et al. (2015)	Australia	self-reported questionnaire	Not applicable	MDD; Chinese-speaking participants in Choi et al., (2012):	CB-PHQ9; PHQ-9; C-BDI;	Not applicable

				4 > CB-PHQ-9 < 20 & Q 9 ≤ 1; English-speaking participants in Titov et al. (2010): 10 > PHQ-9 < 22 & Q 9 ≤ 2	BDI; K-10; SDS;	
D. F. K. Wong (2009)	Hong Kong	6 months follow-up study	Not applicable	MDD; participants in D. F. K. Wong (2008b)	C-BDI; The Emotions Checklist; COPE, DAS	Not applicable
Qualitative studies						
Hwang (2009)	USA	14 focus groups; individual interviews	Not applicable	Therapists with experience in Asia-American groups; traditional healers & spiritual masters; lay community members	Not applicable	Yes; FMAP used to create a manualised intervention
D. F. K. Wong (2011)	Hong Kong	Retrospective individual semi-structured interviews	Not applicable	MDD; participants in D. F. K. Wong (2008b)	Not applicable	Not applicable

Case studies						
Chu et al. (2012)	USA	Focus groups and interviews with	Pilot study: 12 individual weekly sessions; duration not reported	Community providers; client with MDD	SCID; PHQ-9	Yes; FMAP (Hwang, 2009)
E. T.-H. Liu (2007)	USA	Case study	41 individual sessions; duration not reported	MDD & GAD	Burns Anxiety Measure; Burns depression measure	Yes; PAMF (Hwang, 2006)
P. Ng, Tsun, Su, and Young (2013)	Hong Kong	Case study	13 individual sessions; duration not reported	Depression symptoms; BDI = 27	None reported	Yes; PLAY model

Note. ***Key to intervention*** (alphabetical order): Antidepressant only (MED); Combined treatment of CBT and MED (COMB); Dejian Mind-Body Intervention (DMBI); Group Cognitive Behaviour Therapy (GCBT); Internet delivered CBT (iCBT); Standard treatment (ST); Supportive group (SG); Treatment-as-Usual (TAU); Wait-list control condition (WLC); ***Key to measures:*** The Almost Perfect Scale Revised Version (APS-R); Chinese version of Beck Depression Inventory (C-BDI); Centre of Epidemiologic Studies Depression (CES-D); Coping Orientations to Problems Experienced (COPE); Chinese College Student Adjustment Scale (CCSAS); Depression Anxiety Stress Scales 21 (DASS-21); Dysfunctional Attitude Scale (DAS); Electroencephalography (EEG); Edinburgh Postnatal Depression Scale (EPDS) Hamilton Depression Rating Scale (HDRS); Hamilton Anxiety Rating Scale (HAM-A); General Health Questionnaire (GHQ); Kessler 10 Psychological Distress Scale (K-10); Life Satisfaction scale (LSS); Multidimensional Scale of Perceived Social Support (MSPSS); Patient Health Questionnaire (PHQ-9); Chinese Bilingual PHQ-9 (CB-PHQ-9); Perceived Stress Scale (PSS); Pittsburgh Sleep Quality Index-Chinese Version (PSQI); Psychiatric Symptom Rating Scale (PSRS); Quick Inventory of Depressive Symptomatology-Self-Report (QIDS-SR); The Sheehan disability scales (SDS); Short Form-36 Health Survey-Taiwan Version (SF-36); Social Disability Screening Schedule (SDSS); Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I); Vancouver Index of Acculturation (VIA); Work and Social Adjustment Scale (WSAS); Zung Self-Rating Anxiety Scale (SAS); Zung Self-Rating Depression Scale (SDS); ***Key to disorders***: Generalised Anxiety Disorder (GAD).

The efficacy of a manualised culturally adapted CBT that used two cultural adaptation frameworks (i.e., FMAP and PAMF) versus standard CBT was investigated in one RCT (Hwang et al., 2015). Further, FMAP was used to develop a culturally adapted problem solving intervention for Chinese Americans with depression, which was documented in a case study (Chu et al., 2012) The PAMF was used to inform the development of a culturally adapted intervention for one Chinese American client with MDD and GAD, which was documented in a case study (E. T.-H. Liu, 2007).

2.3.3. Consumer and clinician consultation regarding cultural adaptations.

Overall, there is a high degree of variability in the involvement of consumers and clinicians in the cultural adaptation process of CBT. Focus groups with community providers were reported in two studies involving Chinese Americans (Chu et al., 2012; Hwang, 2009). Interviews with traditional healers, spiritual masters, and lay community members were conducted in Hwang's (2009) study. Consumers and health professionals reviewed all the materials designed for iCBT in one RCT involving Chinese Australians (Choi et al., 2012). In addition, consumers were consulted about the efficacy and acceptability of CBT in one case study (Chu et al., 2012), two RCTs including Chinese migrants to Australia and Canada (Choi et al., 2012; Shen et al., 2006), and one RCT including Hong Kong Chinese women (Leung et al., 2013). Further, one qualitative study retrospectively investigated Hong Kong Chinese participants' experience of undergoing CBT for depression (D. F. K. Wong, 2011), a 6-month follow-up study was conducted with Hong Kong Chinese participants undergoing CBT for depression (D. F. K. Wong, 2008b), and another follow-up study compared the symptom severity and previous help-seeking patterns of Chinese Australians who accessed the iCBT program (Choi et al., 2012) and English-speaking participants in the Sadness program (Titov et al., 2010). Unexpectedly, no consultations with consumers and clinicians were reported in the RCTs involving Chinese participants originating from China, Hong Kong, and Taiwan.

2.3.4. Common adaptation to semantics, treatment delivery, and client engagement.

The most common cultural adaptations included culturally sensitive titles of CBT programs to avoid the stigma and shame attached to depression (i.e., Brighten Your Mood Program, Choi et al., 2012; A Course on Diligent Practice of New Thoughts, Shen et al., 2006), delivery by bilingual therapists (Dai et al., 1999; Hwang et al., 2015; Shen et al., 2006), and conducting the intervention in a familiar environment such as the participants'

church (Dai et al., 1999) or at a hospital outpatient psychology clinic located in a predominantly Chinese community (Shen et al., 2006). A translated self-help book (Liu et al., 2009), translated worksheets and handouts for participants (Choi et al., 2012; Dai et al., 1999; Leung et al., 2013; Shen et al., 2006; D. F. K. Wong et al., 2008a, 2008b), and culturally sensitive videotapes (Dai et al., 1999) were reported. When the translated materials did not include conceptually equivalent terms, participants reported difficulties in identifying with the main characters and their personal conflicts due to having a different cultural background and experience (E. T.-H. Liu et al., 2009). More careful consideration of CBT and depression terminology was given in several studies (n = 5). Regarding depression terminology, using de-stigmatising language (Chu et al., 2012) and concepts consistent with Chinese culture (e.g., using the term "closed heart" to describe depression; Choi et al., 2012) were reported. Regarding CBT terminology, technical terms have been translated into colloquial expressions (e.g., automatic thoughts renamed as thought traps; D. F. K. Wong, 2008a, 2008b). Moreover, the manualised culturally adapted CBT intervention has been back-translated to ensure linguistic, semantic, and conceptual equivalence (Hwang et al., 2015). Comprehensive psychoeducation was reported in two studies (Chu et al., 2012; Hwang et al., 2015). Although the importance of adopting a directive approach to meet the hierarchical provider-client expectations (i.e., therapist is the authority figure while the client is the learner) was reported in several studies (Chu et al., 2012; Hwang, 2009; D. F. K. Wong, 2008a, 2008b), other studies highlighted that members in group therapy assisted each other in identifying automatic thoughts and alternative views (Leung et al., 2013; B. Zhang et al., 2016).

2.3.5. Common and unique cultural adaptations to CBT techniques.

Common adaptations to CBT were identified including (a) the use of the 5 senses approach (i.e., recognising one's physiological responses, thought stopping, self-disputing questions, distraction, and the use of cue cards; Leung et al., 2013; D. F. K. Wong, 2011); (b) approaching interpersonal conflict (Leung et al., 2013; Ngai et al., 2015; Shen et al., 2006; D.F.K. Wong, 2008a, 2008b); (c) cognitive restructuring of misconceptions about motherhood (Leung et al., 2013; Ngai et al., 2015); and (d) an explicit focus on participants' strengths (E. T.-H. Liu, 2007; Ngai et al., 2015). Importantly, participants reported a preference for behavioural techniques over cognitive techniques (E. T.-H. Liu, 2007; Shen et al., 2006) or the 5 senses approach over self-disputing alone (D. F. K. Wong, 2011). Although the incorporation of relaxation techniques into CBT for depression is not common (A. T. Beck et al., 1979; Freeman & Oster, 1998), two studies incorporated relaxation

techniques into the CBT intervention (Cui et al., 2016; C. T. Hsu et al., 2010), 10% of participants in an RCT suggested the incorporation of a relaxation component (Shen et al., 2006), and the Dejian Mind-Body Intervention (DMBI) intervention that involves breathing techniques was more effective than CBT in reducing depressive symptoms (Chan et al., 2012).

Unique cultural adaptations to CBT were also described (n = 7). Regarding the intervention content, common stressful events among Chinese pregnant and postnatal women were addressed (Leung et al., 2013) and cultural metaphors and philosophical teachings were used (Hwang et al., 2015). Regarding communication skills, assertiveness skills were reframed in accordance with Chinese cultural values (e.g., promoting interpersonal harmony) and bilingual resources were provided (Choi et al., 2012). In addition, illustrations reflecting Asian features were included to improve treatment adherence (Choi et al., 2012). Regarding the cognitive component, a variety of cognitive techniques were used to stimulate cognitive flexibility (i.e., contrasting a list of maladaptive beliefs shared by depressed people both in Western and Asian cultures; Shen et al., 2006); linking CBT concepts (i.e., mental filter) to Chinese cultural values (i.e., the value of seeing the "whole" rather than just the "parts"), and therapist orientation towards cultural competency (i.e., acquiring knowledge) and cultural humility (i.e., not making assumptions despite sharing similar cultural backgrounds; Liu, 2007) was described; and the PLAY model (i.e., Predestination - I am not in control of my life, Losing face, Avoiding conflict, Yin and Yang balance) describing Chinese cultural characteristics was incorporated to assisted with cognitive restructuring (P. Ng et al., 2013). Lastly, acculturation processes were considered in therapy (i.e., education about behaviours that are not acceptable in Western countries such as physical violence to solve marital problems; Chu et al., 2012).

2.4. Discussion

The aim of the present scoping review was to review the current literature on CBT for depression with or without comorbid anxiety in Chinese nationals and migrants, with a particular focus on cultural adaptation frameworks, cultural modifications to therapy, consultations with clinicians and consumers, and clients' experiences while undergoing therapy. This study is unique in that it is the first to review wider types of evidence (i.e., case studies, qualitative studies) in this population. The key advantage of conducting a scoping review was capturing a substantial range of literature not included in previous systematic reviews and meta-analyses (a) six additional RCTs than those reviewed in previous meta-

analyses and systematic reviews (Chowdhary et al., 2014; Kalibatseva & Leong, 2014; T. K. Ng & Wong, 2018); one of these RCTs is the first to compare the effectiveness of cultural adapted CBT versus standard CBT (Hwang et al., 2015); (b) a qualitative study documenting the use of FMAP to develop a culturally adapted intervention for Chinese Americans with depression; (c) a qualitative study documenting Hong Kong Chinese participants' experience undergoing CBT for depression; (d) two follow-up studies including Hong Kong Chinese and Chinese Australian participants in RCTs investigating the efficacy of CBT; and (e) two case studies. Gaining a comprehensive overview of cultural adaptations of CBT is critical considering that there is no empirical validation of culturally adapted CBT interventions.

The current findings provide support for the efficacy of CBT for depression with or without comorbid anxiety in Chinese nationals and migrants, which is consistent with previous meta-analyses and systematic reviews (Chowdhary et al., 2014; Chu & Leino, 2017; Kalibatseva & Leong, 2014; T. K. Ng & Wong, 2018). Cultural adaptation frameworks and/or consultation with clinicians and Chinese migrants from Australia, Canada, and the USA were reported in less than a quarter of the studies included in this scoping review. It is clear that more studies using the same cultural adaptation framework (i.e., FMAP) are required in different cultural context, including Australia.

The cultural adaptations reviewed in the present scoping review are consistent with the continuum of low to high levels of adaptations to peripheral and core components described by Chu and Leino (2017). See Table 2 for a comparison of cultural adaptations from the present study and Chu and Leino's (2017) framework. D. F .K. Wong (2008a, 2008b) and Shen et al.'s (2006) interventions appear to be some of the most influential studies in this research area. Despite this, no direct replications have been undertaken. It is important to note that D. F. K. Wong (2008a, 2008b) and Shen et al. (2006) did not use a cultural adaptation framework. Therefore, it is not clear to what extent an intervention needs to be culturally adapted to improve client engagement and treatment outcomes. In regard to studies that used cultural adaptation frameworks, the lack of direct replications might be explained by the extensive and time-consuming consultation with clinicians and consumers required so that interventions can be tailored to consumers' needs. Interestingly, there was a consensus between Chu et al. (2012) and Hwang et al.'s (2015) findings about approaches to increasing client engagement (i.e., comprehensive psychoeducation, directive approach). The key advantage of using a culturally adapted framework is that the clinicians and consumers will indicate the required level of cultural adaptation. As such, the present study calls for using cultural adaptation frameworks to develop personalised interventions for Chinese

migrants in different contexts than the USA and to replicate some of the existing manualised interventions to enhance the reliability and generalisability of their outcomes. The use of cultural adaptation frameworks may contribute to the debate between treatment fidelity and cultural adaptation (i.e., fidelity in delivering evidence-based treatments versus adaptations to reconcile incongruences between interventions and ethnic groups; Castro et al., 2010), while replication and extension to other countries may contribute to progressing towards evidence based psychotherapies via empirically validating manualised intervention in at least two rigorous studies conducted by two independent research teams (David & Montgomery, 2011).

TABLE 2

COMPARISON OF CULTURAL ADAPTATIONS FROM THE SCOPING REVIEW AND CHU AND LEINO'S (2017) FRAMEWORK

The cultural treatment adaptation framework	**Findings from present study**
Peripheral component modification: engagement and treatment delivery	Comprehensive psychoeducation, a directive approach, consideration of terminology for depression and CBT, translated materials, cultural metaphors and philosophical teachings, bilingual therapists, culturally sensitive videotapes, delivering the intervention in accessible environment
Core treatment component: core addition	Adding techniques: 5 sense approach, relaxation, assertive communication Adding topics: interpersonal conflict, common stressful events among Chinese pregnant and postnatal women, acculturation processes
Core treatment component: core modification	Adjustments to cognitive restructuring (e.g., contrasting a list of maladaptive beliefs shared by depressed people both in Western and Asian cultures)

2.4.1. Limitations and directions for future research.

Although a systematic approach to the search strategies and study selection was used, the present study has several limitations. Because the aim of this scoping review was to review the CBT literature on depression with or without comorbid anxiety in Chinese nationals and migrants broadly, the methodological quality of the studies was not assessed. Peer review was an inclusion criterion that is an indicator of quality and, as a result, the grey literature, including unpublished masters and doctoral dissertations and conference abstracts, was not included. Potentially important studies may have therefore been neglected. Future research might include the grey literature to address this limitation. Further, future research is required to investigate the efficacy of individual CBT. More studies using cultural adaptation frameworks are required in an Australian context given that Chinese migrants are the largest non-English speaking group and this population is underrepresented in counselling and therapy services. Identifying similarities and differences between cultural adaptations to Chinese communities from different countries is essential as their migration experience may be significantly influenced by the cultural characteristics of the country of destination, and they may face unique issues and barriers to mental health services.

Despite these limitations, the current study makes an important contribution to the literature by mapping the available evidence on CBT for depression with or without comorbid anxiety in Chinese nationals and migrants. There is favourable evidence to support culturally adapted CBT in this population, but this literature is still in the early stages. These findings have potentially important implications for enhancing the cultural sensitivity of CBT for depression in Chinese migrants living in multicultural countries. The following two chapters report on an investigation of adaptations that may be required for Chinese migrants within the Australian context.

"The therapist needs to tread the line between being overly concrete and overly abstract; atomistic vs. global. Cognitive therapy is a holistic approach but it is applied in a sequence of discrete, readily understandable steps."

(A. T. Beck et al., 1979, p. 29)

Chapter 3: Improving the Cultural Sensitivity of CBT: Community Members' and Clinicians' Perspectives on Specific Factors

3.1. Introduction

Disparities between cultural sub-groups in accessing mental health treatments have been documented in high-income countries, low- and middle-income countries, and migrant communities (Atdjian & Vega, 2005; Cuijpers, 2017). As discussed in Chapter One, evidence from Australia, the UK, and the USA showed that Chinese migrants underutilise mental health services (Blignault et al., 2008; Jim & Pistrang, 2007; Wynaden et al., 2005). Possible reasons for this pattern of underutilisation may include inadequate and poorly coordinated services (Cross & Singh, 2012); barriers to service access, including lack of awareness of services, low English proficiency, shame attached to mental illness, loss of face for the extended family (Blignault et al., 2008; Wynaden et al., 2005); and difficulties in diagnosis due to cultural differences (Minas et al., 2013). Low rates of service utilisation might explain the delay in seeking treatment until emotional problems become acute, which leads to more frequent involuntary admissions to hospitals among Chinese migrants (Blignault et al., 2008; J. Hu & Wang, 2016).

Developing culturally appropriate services, especially culturally adapted interventions for depression, may benefit from more careful consideration of cross-cultural issues for several reasons. First, in 2015 around 4.4 % of the global population was diagnosed with depressive disorders (World Health Organisation, 2017). Though the prevalence of depressive disorders varies by region, globally it is the third leading contributor to the disease burden for both sexes combined and all age ranges (Vos et al., 2016). Second, as detailed in Chapter One, prevalence data of diagnosed MDD among Chinese migrants in Western countries reveals paradoxical findings. The current evidence challenges the healthy migrant hypothesis (Liddell et al., 2016) and shows that depression is common among Chinese migrants living in multicultural countries (Chiu et al., 2018; González et al., 2010; Tang et al., 2009; Yeung et al., 2004). Therefore, developing culturally adapted interventions for depression could be a solution for improving access and equity in underrepresented populations in counselling services (Minas et al., 2013).

Several cultural adaptation frameworks have been developed, with most involving qualitative methods to allow potential mental health service consumers to inform the development, pilot testing, and further refinement of a culturally adapted intervention (Castro, Barrera, & Holleran Steiker, 2010). Most cultural adaptation frameworks therefore involve theory-driven and data-driven approaches to guide the cultural adaptation process. The present study was guided by the FMAP (Hwang, 2009), which is a community-based bottom-up approach developed to culturally adapt CBT for depression in Chinese migrants to the USA. A comprehensive description of FMAP is provided in Chapter One. The first two stages of the FMAP— generating knowledge and collaborating with stakeholders (e.g., community members, clinicians), and integrating generated information with theory, empirical, and clinical knowledge have been followed. The results of this qualitative study will inform the development of the next steps of the FMAP in Chinese migrants to Australia. Existing systematic reviews offer support for the effectiveness of culturally adapted evidence-based interventions for depressive disorders in Chinese migrant (Chowdhary et al., 2014; Kalibatseva & Leong, 2014; T. K. Ng & Wong, 2018).

One of the most researched, efficacious, and cost-effective treatments for depressive disorder is cognitive behavioural therapy (Hofmann et al., 2012). A comprehensive description of the updated cognitive model, the GCM, and CBT efficacy for depression is provided in Chapter One and Two. It is important to note that a CBT intervention derived from the updated cognitive model may include techniques specifically designed to target focus along with the classic components, cognitive restructuring, and behavioural interventions (A. T. Beck & Haigh, 2014).

As discused in Chapter Two, there is evidence to support for the efficacy of culturally adapted CBT for depression in Chinese migrants (Choi et al., 2012; Chu et al., 2012; Dai et al., 1999; Hwang et al., 2015; Shen et al., 2006); however, there are some notable limitations. First, most of these studies were conducted in the USA (Chu et al., 2012; Dai et al., 1999; Hwang et al., 2015), and only one study was conducted in Australia (Choi et al., 2012). Although both Australia and the USA are individualistic countries, they are characterised by a different type of individualism (i.e., horizontal versus vertical). As a result, Chinese migrants in Australia and the USA may encounter different stressors (e.g., expressing their uniqueness in Australia versus the pressure of being the best in the USA) due to the differences regarding the cultural profile of the countries and different structural barriers to mental health services (e.g., access to Medicare subsidised services in Australia versus using private insurance for accessing mental health services in the USA), which may feature

different migration and help-seeking experiences. Second, the use of cultural adaptation frameworks is very limited. Only two studies used the FMAP (Hwang, 2009) to guide the cultural adaptation process of CBT in Chinese migrants, which limits the generalisability of the current literature (Chu et al., 2012; Hwang et al., 2015). Lastly, there is a high degree of variability in the extent to which clients or consumers have been consulted in regard to documenting cultural adaptations to CBT (Choi et al., 2012; Chu et al., 2012; Hwang, 2009).

The present study adds to the current literature on culturally adapted psychological interventions by using one of the existing cultural adaptation frameworks, along with a theory-based model that explains the intervention's core components, to guide the cultural adaptation of CBT; explicitly documenting the cultural adaptation to the cognitive, behavioural, and focus techniques for depression; and consulting members of the Chinese migrant community. Documenting community members' perspectives ensures that the psychological treatment is more closely connected to the lived experiences of the Chinese clients (Castro, Barrera, & Martinez, 2004; Kulich & Zhang, 2010) and increased ecological validity of the culturally adapted intervention. Documenting clinicians' perspectives is equally important to identify the common cultural adaptations to CBT and their insights about culturally adapting CBT techniques. The aim of this study was to use the FMAP (Hwang, 2009) and GCM (Beck & Haigh, 2014) to document the clinicians' and community members' perspectives on the cultural adaptation of CBT to Chinese migrants in Australia, with an emphasis on the specific factors of CBT based on the GCM for Chinese migrants with depression.

3.2. Methodology

3.2.1. Participants.

Members of the Chinese Community. Fourteen members of the Chinese community participated in the study (female $n = 8$; age range = 25-68, $M = 44.64$, $SD = 16.47$). Eight participants had higher education degrees, while five participants completed high school. Four participants were students, four were employed, three were unemployed, and three were retired. The country of birth were China ($n = 5$), Hong Kong ($n = 2$), Malaysia ($n = 3$), Singapore ($n = 2$), and Taiwan ($n = 2$). Seven were Christians, four were Buddhists, two reported no religion, and one participant did not respond. Years living in Australia ranged from two months to 27 years ($M = 9.73$ years, $SD = 8.63$ years).

Clinicians. Twenty clinicians who self-identified as having experience and expertise in working with Chinese migrants agreed to participate in the study (female $n = 13$, age range

= 19-67, *M* = 46.95, *SD* = 12.67). In this sample, 11 participants identified themselves as Chinese, while nine of the participants reported different ethnic backgrounds: Australian (*n* = 4), English (*n* = 1), Polish (*n* = 1), Scottish (*n* = 1), Croatian (*n* = 1), and South African (*n* = 1). In terms of occupation, the clinicians were Clinical Psychologists (n = 5), Social Workers (*n* = 5), Counsellors (*n* = 2), Registered Nurses (*n* = 3), and one each of Occupational Therapist, Cardiologist, Physiotherapist, Sociologist, and Health Science student.

3.2.2. Interview and focus group protocol.

A semi-structured interview and focus group protocol was developed to document both the perspectives of Chinese community members and clinicians on culturally adapting CBT for depression. Questions to document methods to culturally adapt the belief, behaviour, and focus components were included. Only the clinicians were asked to share their perspectives on the cultural appropriateness of cognitive restructuring due to their clinical experience and familiarity with the strengths and limitations of cognitive restructuring with Chinese clients. Both the clinicians and the community members were asked to share their perspectives on the behavioural and focus components.

3.2.3. Procedure.

Purposive and snowball sampling techniques to recruit both members of the Chinese community and clinicians were used. Community members were recruited by distributing the study to the University's research hub, two local migrant agencies, and a Chinese Christian church. Clinicians working in the public, private, and not-for-profit sectors were recruited by distributing the study via email. The inclusion criteria for recruiting clinicians were clinicians (e.g., Psychologists, Counsellor) who self-identified as having experience and expertise in working with Chinese clients. The inclusion criteria for recruiting community members were age 18 and above, and first or second generation Chinese migrants or Chinese international students. Data collection and analysis of the individual interviews and focus groups were simultaneously conducted until no new themes emerged, and thus saturation was achieved (Guest, Bunce, & Johnson, 2006).

The literature on conducting focus groups with people from culturally and linguistically diverse backgrounds was consulted. Because there is evidence that focus groups may not be a culturally appropriate research method in Chinese participants (Halcomb, Gholizadeh, Digiacomo, Phillips, & Davidson, 2007), the initial protocol involved

conducting individual interviews with the Chinese members of a not-for-profit organisation. Interestingly, these participants expressed a preference to organise one focus group instead of conducting five individual interviews. A possible explanation for their preference is that they attended English classes together and therefore felt comfortable to have a conversation about depression in a group. In this study, it was pivotal to adopt a culturally sensitive approach to conducting individual semi-structured interviews, while also respecting participants' preferences. Therefore, participants' suggestion to conduct one focus group was accommodated. The first author was assisted by a certified interpreter in conducting this focus group (see Appendix B for the information sheet in both English and simplified Chinese and the interview schedule for consulting community members in regard to the specific factor of CBT).

Focus groups with the clinicians were considered the most appropriate approach for several reasons. Focus groups have the advantage of helping participants to share their views and experiences as well as their comments and disagreement (Stewart, Shamdasani, & Rook, 2007), and therefore might yield deeper insights into the cultural adaptation process of CBT for Chinese migrants with depression. Although there is a consensus that three to four focus groups with minimum four experts might be sufficient to achieve data saturation (Krueger & Casey, 2009), additional information was revealed after each of the four focus groups with clinicians. Despite the initial plan to conduct only focus groups with the clinicians, one face-to-face individual interview, and two Skype interviews with Clinical Psychologists were conducted to achieve data saturation. These clinicians were unable to attend one additional focus group due to distance and convenience reasons (see Appendix C for the information sheet and interview schedule for consulting clinicians in regard to the specific factor of CBT).

Some changes to the initial protocol in conducting the interviews and focus groups were made to ensure a culturally sensitive approach, while also respecting participant preferences. It is important to note that no changes to the initial interview schedules were made. In total, we conducted five focus groups and 12 individual semi-structured interviews: nine individual interviews and one focus group with the community members, and four focus groups and three individual semi-structured interviews with the clinicians. The interviews ranged between 61 and 93 minutes, whereas the focus groups ranged between 90 and 105 minutes. Between four to five clinicians participated in each focus group, while five community members participant in one focus group. All participants provided informed written consent prior to their participation. The members of the Chinese community had the option to receive an information sheet and consent form translated in simplified Chinese.

Each member of the Chinese community received a $10 voucher for their time, and the clinicians received refreshments during the focus group but no payment.

3.2.4. Data analysis.

Thematic analysis was used to analyse the data because it allows interpretation of participants' meanings; integration of theory and clinical knowledge with the community members' unanticipated insights; and highlights similarities and differences between the clinicians' and community members' perspectives (Braun & Clarke, 2006). The interviews and the focus groups were audiotaped and transcribed verbatim by professional transcribers. The first author checked the accuracy of transcription and excluded identifying information. After reading and rereading the transcripts, the first author used NVivo11 to generate initial codes and search for themes. The coding process involved a hybrid approach of data-driven and theory-driven codes. The data-driven codes were constructed from the raw information provided by the clinicians and community members, whereas the theory-driven codes were constructed from the GCM (A. T. Beck & Haigh, 2014). The co-authors each participated in reviewing, defining, and labelling the themes.

A modified consensual qualitative research analysis (C. E. Hill, Thompson, & Williams, 1997) was used to determine the more prevalent themes and sub-themes. Via a process of consensus, the team examined the representativeness of the results by indicating whether the themes were general (applied to every case), typical (applied to half or more cases), or variant (applied to fewer than half of the cases but more than two cases). Themes that reflected cultural adaptations to CBT that appeared even once were captured in the final list of themes and subthemes. However, sub-themes that were not reflecting cultural adaptations to CBT or that applied to only one case were removed from the overall results as they were not representative of the sample.

3.2.5. Trustworthiness.

Because it was important to document both the clinicians' and community members' perspectives on the specific factors of CBT based on the GCM (A. T. Beck & Haigh, 2014), we used methodological triangulation (interviews and focus groups) and participant triangulation (Chinese community and clinicians) to ensure comprehensive data collection (Jones & Bugge, 2006). In addition, the first author kept a reflexive journal (Ortlipp, 2008) throughout the research process to reduce any potential bias. Lastly, we followed the Consolidated Criteria for Reporting Qualitative Research (COREQ, Tong, Sainsbury, & Craig, 2007).

3.3. Results

The participants suggested cultural adaptations to CBT and core strategies for developing a culturally sensitive intervention for depression. Documenting both clinicians' and community members' perspectives was critical to gain a comprehensive overview of strategies that may improve clinical engagement and treatment outcomes. Five major themes were identified: (a) mixed attitudes and perspectives towards CBT, (b) improving the cultural sensitivity of cognitive restructuring, (c) applications of behavioural strategies, (d) attitudes towards mindfulness meditation, and (e) the importance of incorporating core culturally sensitive strategies (see Table 3).

3.3.1. Mixed attitudes and perspectives towards CBT.

The clinicians in this study reported providing a wide range of services for Chinese migrants including CBT (e.g., migrant resource centres, public hospitals, university counselling service). Mixed attitudes towards CBT among clinicians, including a strong commitment to using CBT and a reluctance to use CBT due to doubting its cultural appropriateness have been identified. A variant number of the CBT therapists asserted their commitment to using CBT with their clients. For instance, one Clinical Psychologist expressed her strong commitment towards CBT by stating, "I just knew that I'm doing my CBT, my problem solving, and I knew they would love it because it's so structured." Further, some of these clinicians indicated that they conducted clinical research to investigate different aspects of CBT among Chinese individuals.

Clinicians who had a strong commitment towards CBT reported confidence in using cognitive techniques. These CBT therapists reported that no major cultural adaptations to the belief and behaviour component were required in working with Chinese clients. They variably explained that changing culturally defined core beliefs is necessary if those beliefs "are out of proportion" and generate distress. One Clinical Psychologist explained that she would assist her Chinese clients in analysing if their thoughts are not "helpful, logical, and rational and question accordingly" and will not change this Socratic questioning process for her Chinese clients.

TABLE 3

SUMMARY OF THEMES AND SUBTHEMES REFLECTING CULTURAL ADAPTATIONS TO SPECIFIC FACTORS OF CBT

Themes and subthemes	Clinicians' frequency	MCMs' frequency
Theme 1: Mixed attitudes and perspectives towards CBT		
a) A strong commitment towards using CBT is associated with confidence in using cognitive and behavioural techniques	Variant	
b) Doubting the cultural appropriateness of CBT is associated with a reluctance to use CBT	Typical	
Theme 2: Improving the cultural sensitivity of cognitive restructuring		
a) Level of belief is a central consideration (intermediate rather than core beliefs)	Typical	
b) Specific cognitive factors to consider:		
i. Explore if migration is perceived as a loss	Variant	
ii. Negative views of ones' self in relation to significant others		Variant
iii. Target rumination		Variant
Theme 3: Applications of behavioural strategies		
1. Incorporate sleep hygiene techniques	Variant	Typical
2. Greater emphasis on behavioural experiments to facilitate perspective change through new experiences	Variant	
3. Behavioural activation might address the Chinese client's need for achievement	Variant	

4. Attending cultural events (e.g., festivals, concerts) with other communities might facilitate integration into the wider society, while doing activities with their own ethnic group might be culturally appropriate activities for behavioural activation	Typical	Typical
Theme 4: Attitudes towards mindfulness meditation		
1. Mindfulness is useful to increase metacognitive awareness	Variant	
2. Mindfulness meditation may not be a culturally bridging technique	Variant	Typical
3. Open to learning short mindfulness meditation		Typical
Theme 5: The importance of incorporating core culturally sensitive strategies		
1. Cultivate cultural humility (e.g., self-reflection, learn from clients about their culture, values, and beliefs)	Typical	
2. Due to the importance of physical health and stigma attached to mental illness, emphasise health and wellbeing to facilitate clinical engagement	Variant	Variant

Note: Members of the Chinese Community (MCM); We identified a theme or a subtheme as general if it applied to 20 clinicians and 14 MCM, typical if it applied to 10-19 clinicians and 7-13 MCM, and variant if it applied to 2-9 clinicians and 2-6 MCM.

Furthermore, one Clinical Psychologist suggested that if the cultural beliefs are true, clients might tend to catastrophise the consequences and be concerned about losing face, but then "it is probably more important that you are healthy rather than just making sure or pretending everything is ok." The same Clinical Psychologist disclosed that she might consider minor adaptations including:

> Is this thought true? And is it really going to be that bad? And is it helpful to have this sort of thoughts? I think you might push a bit less with Chinese clients if they are really resistant of that, of changing that thought. Probably leave it just there, but I think, it is still, I think there are things you can still challenge.

In contrast, a typical number of clinicians expressed their reluctance to use CBT as a possible therapeutic approach because they doubted its cultural appropriateness. They explained that they preferred to use other therapeutic approaches (e.g., narrative therapy, mindfulness therapies) instead of culturally adapting CBT for their Chinese clients. The clinicians' arguments for their reluctance to use cognitive restructuring were varied and included rational and irrational beliefs might have different meaning for different cultural groups; challenging people's irrational beliefs might be perceived as confronting; and that adaptation will not allow the engagement required for therapeutic shift. For example, one Social Worker stated "I actually find CBT very confronting, because what do you mean that doesn't make sense? Like, it might not make sense to you, but it makes perfect sense to me with my history and my story." It seems that the clinicians' view on cognitive restructuring as less culturally appropriate was the most commonly described obstacle to using CBT.

3.3.2. Improving the cultural sensitive of cognitive restructuring.

Despite expressing a reluctance to use CBT with Chinese clients, some clinicians typically acknowledged the potential of a culturally adapted CBT to be effective for this population. Several strategies for enhancing the cultural sensitivity of cognitive restructuring were suggested. First, the clinicians underlined the importance of the level of beliefs addressed in cognitive restructuring. They variably reported that attempts of relaxing the client's automatic thoughts including "shoulds" might reinforce the client's helplessness core beliefs. Chinese peoples' shoulds might include life principles taught by family such as "do your best" and "work hard", and relaxing these principles might be perceived as an acknowledgement of failure. Both the clinicians and the community members variably emphasised that do your best and work hard are fundamental Chinese values. One Social

Worker further explained: “My Chinese clients, and actually other East Asian, they can’t parse that [not worrying about doing perfect and instead doing good enough]. It’s like I’m giving them permission to fail.” Furthermore, the clinicians variably suggested modifying the outcome of a cultural perspective “because it’s not so closely linked with family relationship,” and the expectations derived from the core beliefs. Modifying the expectations resulting from their core beliefs will not involve modifying the life principles and core values learned from their family. In CBT terminology, we interpreted this recommendation as modifying intermediate beliefs including rules, attitudes, and assumptions (J. S. Beck, 2011). For instance, one Mental Health Nurse stated:

> … But if we were to challenge, say, the outcome of [cultural perspective], or the expectation of that, maybe you can challenge that thinking …I think the clients will be more comfortable with that, rather than you're challenging what they've been taught, or what they've been told.

Second, clinicians typically reported that attempts to modify culturally defined core beliefs might interfere with Chinese people’s interdependent self. Clinicians explained the interdependent self as a) “for a collective culture, after the immediate core of me is my link with my family” which implies a deep connection between self and family, and b) “Chinese people tend to be a bit more community based, rather than being ‘me’ based, ‘me first, I’m important’. It’s about considering the family, considering the community.” Therefore, the clinicians suggested that changing culturally defined core beliefs might affect clients’ sense of identity and relationship with family. Additionally, they variably proposed to adopt an approach consistent with the interdependent self of Chinese clients. Such an approach was described as not making any judgmental comments towards family members and facilitating a values-based understanding. For instance, one Clinical Psychologist explained that when working with a young Chinese girl pressured by her father to achieve more academically, she used reframing to facilitate a values-based understanding by stating “I have a lot of admiration for your father, you want to please him, that is your love for him, so I congratulate you for your love for him, it is from the heart.”

Third, the clinicians variably suggested to explore if migration is perceived as a loss. The clinicians variably explained that changes due to settling into the new country of residence might be perceived as a loss, especially in the early post-migration phase. For instance, one Social Worker explained “The problem with being a migrant, and I speak from personal experience, is that often, integration means giving up a little bit about who you

were." In other words, the clinicians suggested that the cultural integration after migration in some cases might lead to loss of identity, grief and ultimately to depression.

Lastly, the community members in this study typically identified negative views of one's self and the future, and variably identified negative views of one's self in relation to significant others, as important depressive symptoms. In CBT terminology, the community members' perspective is consistent with the cognitive triad (Beck et al., 1979), but added a different nuance by emphasising "worth to family and society," and being equally concerned about self and family (e.g., "I am failing myself, I am failing my family"). Furthermore, the community members variably identified rumination as a symptom of depression and revealed that the depressed people they knew keep repeating themselves. For instance, one community member stated "I think they are quite repetitive. They will talk about the same incident that makes them very sad, like repeat and repeat again."

3.3.3. Applications of behavioural strategies.

Several strategies to enhance the cultural sensitivity of the behavioural component were described. First, more careful consideration of sleeping issues was suggested by both the clinicians and community members. The community members typically identified sleeping issues as an important symptom of depression, while the clinicians variably suggested that Chinese clients may complain about sleeping issues and seek help. The clinicians variably suggested incorporating sleeping hygiene techniques very early in treatment. For instance, one Clinical Psychologist described the clinical application of incorporating sleeping hygiene techniques:

> Start them off with sleep hygiene techniques pretty early in the treatment, so that is one of the first techniques I give them. Because a lot of the Chinese people come in with a lot of complaints about their sleep or you know, their energy levels, and I think to engage them, it's best to give them strategies so they can use straight away, that they can see some difference, and then they would be more inclined to continue the treatment.

Behavioural experiments were considered an important technique to facilitate perspective change through new experiences. The CBT therapists variably reported that behavioural experiments can capitalise on Chinese clients' pragmatic and problem-solving approach and therefore might produce cognitive change. For instance, one Clinical Psychologist explained that when working with an elderly Chinese woman who was in her

70s, who had the belief that no one loves her and was worried that if she dies no one will wrap her body, he asked her to do a behavioural experiment which involved asking one of her nieces what she would do if she died. Further, this Clinical Psychologist stated "…by her performing this act and having new experience or different thoughts as an experience, not just challenging her thought, then she realised that "OK! Someone does care".

Behavioural activation was perceived as a culturally appropriate technique. The clinicians variably reported that Chinese clients might respond well to behavioural activation because of their competitiveness and need for achievement in "any aspect of life, academic competition, sporting competition, wealth claim, and power." One Social Worker who identified herself as Chinese disclosed a personal conversation with her parents to further explain the need for achievement in Chinese culture. Her parents advised her "Do whatever you want. […] If you're going to be at Burger King, be the best damn burger flipper there is."

We further documented the opinion of the clinicians and community members on developing a culturally appropriate catalogue of pleasant activities. Both the clinicians and the community members typically reported that sharing traditional food (e.g., dim sum) and attending Chinese cultural activities (e.g., Chinese festivals) are culturally appropriate activities to be included in a catalogue of activities. In addition, we explored the potential of culturally appropriate activities to facilitate integration into the wider society. The community members typically reported that attending cultural events with other communities such as festivals and concerts might facilitate their integration in the wider society. A variant number of the clinicians complemented this perspective (see Table 4 for the catalogue of activities).

TABLE 4

CATALOGUE OF ACTIVITIES

BBQ	Soccer
Attend a cooking class	Basketball
Share lunch or dinner (steamboat/hot pot, dim sum)	Badminton
Have a picnic	Ping Pong
Drinking tea	Table tennis
Celebrate Chinese festivals	Take a walk
Celebrate multicultural festivals	Hiking
Attend a concert that you like	Calligraphy

Volunteer (to improve your English or to gain some work experience)	Drawing
Check the available activities at your local community centre	Join a Chinese community group
Watch a Chinese TV show /movie/ listen to Chinese radio	Look for a Chinese literature club
Watch an English movie	Reading
Singing karaoke	Mah-jong
Dancing	Chinese chess
Listen to Chinese music	Practice Tai chi
Listen to the music you like	Drumming

3.3.4. Attitudes towards mindfulness meditation.

Both the clinicians and the community members suggested that mindfulness meditation might be perceived as a culturally sensitive bridging technique for Chinese migrants. A variant number of the clinicians suggested that their Chinese clients were not familiar with mindfulness meditation. Despite this, they acknowledged the psychological benefits of this technique for clients regardless their ethnic background. Regardless the country of origin, religion, and age, the community members did not report practicing mindfulness meditation in their daily life. Interestingly, they typically stated that although they did not practice meditation, they were open and willing to learn short meditation. The emphasis on short meditation might reflect Chinese participants' pragmatic mindset. For example, one Chinese participant stated "Yes, they're open [to learn short meditation]. Such as me. I'm interested in that, but I never done that before."

3.3.5. The importance of incorporating core culturally sensitive strategies.

The clinicians typically emphasised that developing a culturally sensitive approach is foundational in working with Chinese clients. Two core strategies, including cultivating cultural humility and more emphasis on well-being and health, were described. The use of these core strategies might play a significant role in improving clinical engagement and treatment outcomes.

Cultural humility was described involving three elements. First, engaging in self-reflection was variably identified as an essential skill. For instance, one Clinical Psychologist disclosed that when she started working with Chinese clients the dropout rate was very high.

By reflecting on the techniques and language she used, she realised that "as soon I used psychological jargon... I never see them again." Furthermore, she asked herself if she "is not sensitive or competent enough" and through self-critique she identified several areas of improvement such as adopting a family focus:

> First of all, I changed my focus on the individual person and then I imagined that I am talking to the whole family. I have learnt …that family harmony is mental health… So the way I conducted the session, asked questions, interpreted, summarised or rephrased, I made sure I never offended anyone in the family… I would never be judgmental or critical towards father or mother, even if they were not here, but I know for this person they are very important and valuable part of him.

Second, the clinicians typically reported that it was important to learn from clients about their culture and values and allow them to guide the therapy. The clinicians' key message was to not make any assumptions about the Chinese culture and not assume expertise. One Clinical Psychologist explained that "she takes her own lead" from the client and explored how strongly her client identified with the Chinese culture and how important it was for the client to "stay connected to that culture." Similarly, one Social Worker suggested:

> Take a position of ignorance. Like, don't assume, you know, what they call basic work with people from culturally and linguistically diverse background. Be open to, just put on culturally open lenses, and let them advise you. Let them tell you what it's like for them to be this Chinese person, in this part of Australia, at this age, and this time.

Lastly, clinicians typically recommended that clients' ethnic identity be explicitly explored because of the potentially important implications for psychotherapy. The clinicians described that, despite Chinese migrants sharing core values such as family wellbeing, they are not a homogenous group. One Clinical Psychologist explained that mainland Chinese people might be more traditional, might hold "stronger cultural beliefs that are harder to shake," and might have a dichotomous thinking style, which might impact the sequencing of treatment. Other clinicians emphasised the importance of exploring the impact of migration on ethnic identity, especially the detrimental effect when individuals might be stereotypes because of their ethnic identity. For instance, some Chinese migrants might be stereotyped after migration by their own ethnic group (e.g., "banana yellow inside out") and by the dominant culture (e.g., "smart Asian"), which might become important sources of distress.

Therefore, a possible interpretation is that exploring ethnic identity might become a bridging technique by facilitating an open conversation and co-learning.

Greater emphasis on health and wellbeing to improve clinical engagement was another important suggestions. Clinicians variably recommended more emphasis on health because it seems that in the Chinese culture it is more culturally appropriate to talk and complain about physical pain than about emotional problems. For instance, one community member explained that Chinese people will find it easier to complain about back pain or headache than disclosing "I have an unhappy life or–I have an unhappy day." Greater emphasis on wellbeing was suggested for several reasons. Approaching wellbeing might be consistent with the stoic beliefs of Chinese people. For instance, one community member stated: "They want to be strong because it's a cultural thing to be strong." Therefore, addressing more positive topics, that do not imply mental illness, might increase engagement with mental health services as a result of not challenging their stoic beliefs. In addition, talking about well-being might prevent stigma and loss of face attached to mental illness.

3.4. Discussion

This study contributes to a deeper understanding of the cultural adaptation of CBT for Chinese migrants with depression by documenting both clinicians' and community members' perspectives. The findings provide valuable insights into a culturally informed version of CBT, which involves adopting a culturally sensitive approach when using cognitive, behavioural, and focus techniques. This study is unique in that it is the first qualitative study using two theoretical frameworks, including the FMAP (Hwang, 2009) and the GCM (A. T. Beck & Haigh, 2014), to guide the cultural adaptation of CBT for depression in a migrant population (see Figure 2).

Cognitive restructuring was the most debated CBT technique. Clinicians mixed attitudes towards cognitive restructuring are consistent with the mixed findings in the literature suggesting that the absoluteness of maladaptive core beliefs be challenged (J. S. Beck, 2011; Guo & Hanley, 2015), and that modifying culturally defined core beliefs might be perceived as disrespectful (Hays, 2009), might cause a clash of values (e.g., betrayal of the Chinese culture or being corrupted by Western values; Shen et al., 2006), and might destabilise clients' identities and relationships with significant others (Kirmayer, 2007).

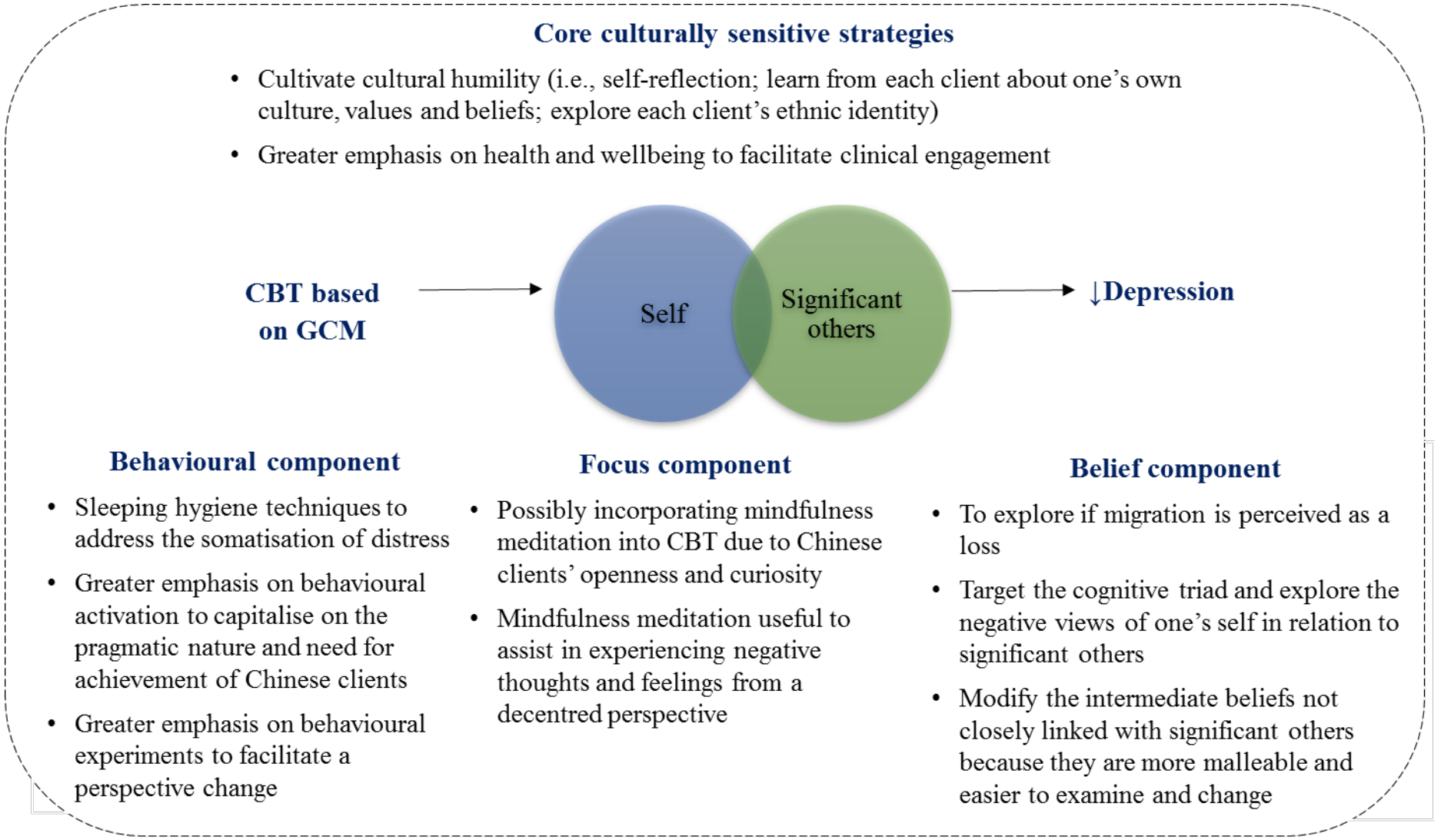

FIGURE 2. SUMMARY OF THE STEPS FOR IMPROVING THE CULTURAL SENSITIVITY OF THE SPECIFIC FACTORS OF CBT.

The self-identified therapists who clearly expressed their commitment to practicing CBT proposed no major cultural adaptations to CBT, while the clinicians who doubted the cultural appropriateness of cognitive restructuring suggested that developing a culturally sensitive CBT approach needs to be a central concern in working with people from culturally and linguistically diverse backgrounds. The latter group of clinicians stressed the importance of the level of beliefs targeted during cognitive restructuring. They suggested that attempts to relax automatic thoughts including "shoulds" might reinforce helplessness core beliefs. In Chinese culture, self-worth and self-identity are related to family achievement, and personal success of a family member reflects on the entire family (B. S. K. Kim, Atkinson, & Umemoto, 2001).

Therefore, it is important for clinicians to consider that challenging the "shoulds" of people with a Chinese heritage might be in opposition to fundamental values such as filial piety, importance of family, and educational and academic achievements (B. S. K. Kim et al., 2001). Furthermore, challenging Chinese clients' "shoulds" might be interpreted as evidence that they are not able to work hard and make the required effort to make a living in the new country, which in turn might reinforce helpless core beliefs such as "I am incompetent" and "I can't do anything right" (J. S. Beck, 2011). Instead, modifying intermediate beliefs including rules, attitudes, and assumptions may be more culturally appropriate. Intermediate beliefs have the key advantage of being more malleable than core beliefs (J. S. Beck, 2011). Thus, it is reasonable to assume that dysfunctional rules, attitudes and assumptions can be unlearned and more functional rules, attitudes, and assumptions can be developed through therapy (J. S. Beck, 2011).

Additionally, it was suggested that attempts to modify culturally-defined core beliefs might interfere with Chinese people's interdependent self, which, in turn may adversely impact on relationships with significant others. There are significant differences in cognition and self between East Asia and Westerns cultures (e.g., North America; Markus & Kitayama, 2010). An interdependent self is often reflected in thoughts, feelings, actions, and autobiographical memories being oriented towards their significant others, shaping psychological functioning in general (H. R. Markus & Kitayama, 2010; Zhu & Han, 2008). These effects may then be reflected in the cognitive triad by negative thoughts about the self, others, and future (A. T. Beck et al., 1979). The community members in this study reported negative views of one's self in relation to their significant others. Therefore, culturally sensitive CBT would be required to formulate the self *in relation to* significant others rather than independent from them. An explicit emphasis on exploring the dysfunctional beliefs of

one's self in relation to significant others is consistent with D. F. K. Wong's (2008a, 2008b) CBT intervention for depression in Chinese clients from Hong Kong. Consequently, these findings show that an interdependent self needs to be a central consideration in therapy when applying therapeutic techniques developed in Western countries to clients from non-Western countries. The efficacy and acceptability of the belief and behaviour components of CBT might increase with the awareness and incorporation of techniques that are addressing thought processes associated with an interdependent self.

Explicitly exploring clients' perceptions of migration and the impact of migration on ethnic identity is consistent with a previous investigation showing that the experience of migration involves various forms of loss, including identity, language, values, and social networks, which can have significant influences on mental health (Casado, Hong, & Harrington, 2010). Experience of loss can trigger overgeneralisation and de-evaluation of the self, which may lead to social withdrawal and ultimately to depression (A. T. Beck & Haigh, 2014). These findings informed the development of the third study and the incorporation of migration stress and ethnic identity in a structural model (see Chapter Five).

Behavioural activation was considered a culturally appropriate technique for increasing experiences of pleasure and a sense of mastery (J. S. Beck, 2011), and to facilitate integration in the new country of residence. Although there is strong evidence to support the efficacy of behavioural activation as a component of a CBT intervention (Hoffman et al., 2012) and as a standalone intervention (Ekers et al., 2014), this study provides a different perspective on the rationale for using behavioural activation with Chinese migrants. Behavioural activation might capitalise on Chinese clients' pragmatic and problem-solving mindset and need for achievement. Interestingly, the present findings are consistent with previous investigations conducted in the USA (Hwang, 2009) and Canada (Shen et al., 2006), suggesting that the use behavioural techniques is less problematic and is more congruent with the problem-solving focus and holistic thinking study of Asian people (Hwang, 2009). This study explored for the first time the possibility of using behavioural activation as a tool to facilitate integration of migrants in the new country. The suggested activities by participants might be culturally appropriate for people with a Chinese heritage, but also for people with another Asian heritage (see Table 4). Additionally, these findings suggest that using behavioural techniques early in the treatment to address sleeping issues might be particularly beneficial as Chinese clients tend to complain and seek help for sleeping issues. These findings are consistent with an ethnographic study conducted in China revealing the centrality of sleeplessness, which might be related to neurasthenia, a psychiatric diagnosis perceived as

less stigmatising, or might reflect cultural differences in experiencing symptoms of depression (D. T. S. Lee, Kleinman, & Kleinman, 2007).

A. T. Beck and Haigh (2014) suggested that the most elegant and durable therapeutic approach is to incorporate cognitive and behavioural interventions along with a focus intervention (e.g., mindfulness meditation). Interestingly, community members expressed a positive attitude towards mindfulness meditation and clearly stated that they are open and willing to learn short mindfulness meditation. Cultivating mindfulness may play an essential role in cross-cultural adaptation. In one study, higher mindfulness was associated with better sociocultural adjustment and positive affect during cross-cultural transitions (Kashima et al., 2017). Therefore, incorporating mindfulness into CBT holds great promise for improving treatment outcomes.

The findings in this study suggest that cultivating cultural humility and greater emphasis on health and wellbeing in using the CBT techniques are foundational in providing a culturally sensitive version of CBT. Surprisingly, clinicians did not emphasise developing cultural competency, involving acquiring knowledge and developing culture-specific expertise, which is the dominant approach in the cultural adaptation literature (Chu et al., 2016). Instead, clinicians described cultural humility as involving self-reflection, learning from clients about their culture, values, beliefs, and ethnic identity not making assumptions about clients' cultures, and not assuming expertise, which are all consistent with previous literature on cultural humility (Hook et al., 2013; Tervalon & Murray-García, 1998; Yeager & Bauer-Wu, 2013). Cultural humility requires a shift in therapist attitude and thinking about clients, diagnoses, and intervention (Owen et al., 2015). Clinicians may reflect cultural humility in their clinical practice by adopting a balanced approach between their expertise and collaboratively establishing goals for therapy on a continuum between collectivist and individualist goals, case formulation, and ultimately develop a culturally sensitive intervention. Additionally, greater emphasis on health and wellbeing is consistent with the tradition of considering physical symptoms more distressing than the psychological ones (Parker, Gladstone, et al., 2001), and orientation towards physical health, wellness and productivity in Chinese culture (Chu et al., 2012). Applying cognitive, behavioural, and mindfulness techniques with a focus on health and wellbeing might help to avoid family shame, which is one of the fundamental responsibilities in Asian cultures (B. S. K. Kim et al., 2001) and a culturally-specific psychopathological process (W.-S. Liu & Leung, 2010).

3.4.1. Limitations and directions for future research.

The present study has several limitations. Because of the sample size and sampling strategies, the findings of this study might not be transferable to other Chinese communities, and therefore more research is required in other contexts. The familiarity between the community members who attended one focus group may have influenced the level of self-disclosure of the participants, although this format was used due to the participants' preference. They might have shared more information due to feeling comfortable and confident, or shared less due to concerns that the other members of the group might be judgmental. Another limitation is the recruitment of community members who did not necessarily have a diagnosis of depression or past experience of CBT or other psychotherapies.

Several recommendations for future research are provided. First, conducting qualitative research to document the lived experiences of Chinese migrants with depression, their treatment experience, and possible barriers associated with the treatment is suggested. Second, further research is required on negative core beliefs of one's self in relation to significant others in Chinese communities (e.g., *My self-worth is defined by my family unit*, rather than independent from them (e.g., *I am worthy*). Lastly, pilot testing and examining the efficacy and acceptability of an intervention informed by the cultural adaptations identified in the present study, and finalising the culturally adapted intervention, is recommended.

This study provides a comprehensive overview of clinicians' and community members' perspectives on the cultural adaptation of CBT for Chinese migrants with depression. The present results indicate that it is equally important to using cognitive, behavioural, and mindfulness techniques in a culturally sensitive manner with Chinese clients and to cultivate cultural humility. As such, a key challenge for clinicians is to shift their clinical perspective from one of cultural competency to cultural humility to better understand each individual client's cultural mindset and specific vulnerability factors. A focus on cultural sensitivity has the potential to improve access, clinical engagement, and treatment outcomes of psychological interventions, which is critical in an increasingly globalised world.

"The therapist, whether one is a humanistic, psychodynamic, interpersonal, or cognitive–behavioural therapist, needs to appreciate that psychotherapy is a deeply humanistic experience—two humans in a room, in an intense interpersonal interaction."

(Wampold, 2012, p. 447)

Chapter 4: Non-specific Factors of Culturally Adapted CBT for Depression in Chinese Migrants: Community Members' and Clinicians' Perspectives

4.1. Introduction

CBT is grounded in a cultural and social context that provides a perspective for understanding and interpreting individuals' cognitive, emotional, and behavioural patterns and their interrelations (J. S. Beck, 2011). In CBT, therapists and clients work together to ameliorate depression through focusing on the cognitive formulation of depression, information about clients' problems, the therapeutic relationship, and use of a variety of techniques to change thinking, mood, and behaviour associated with depression (J. S. Beck, 2011). Both therapists and clients with diverse cultural backgrounds may face unique challenges during the therapeutic process as their beliefs about oneself, the others, and the world will be shaped by their sociocultural contexts (Kitayama & Cohen, 2007). As such, it is essential "to establish a starting point to bridge the gap of communication in the therapy sessions" (Thomas, 2006, p. 209).

Over the last decades, there has been a movement towards attributing the efficacy of empirically supported psychological treatments to specific factors, which are usually presented in treatment manuals (Ahn & Wampold, 2001). Another important movement has been the one towards common factors or non-specific factors originating with Rosenzweig's (1936) work on common factors that apply across different psychotherapeutic approaches (cited in Lambert & Ogles, 2014). Common factors have been defined as ingredients of therapies that are efficacious despite not being unique to any therapeutic approach (Lambert, 2005). Several classifications of non-specific factors have been developed based on different conceptual models, with most involving the therapeutic relationship, expectations for improvement, a rationale that provides a plausible explanation for the clients' symptoms, and a set of procedures or rituals (Frank & Frank, 1991; Imel & Wampold, 2008; Laska, Gurman, & Wampold, 2014; Wampold, 2015).

Determining whether specific or non-specific factors are responsible for psychotherapy efficacy is a complex process but both are thought to be essential to the efficacy of psychological interventions (David & Montgomery, 2011). The three-phase model

of outcome developed by Howard, Lueger, Maling, and Martinovich (1993) is a general model of psychotherapy suggesting that both factors are critical to different phases of therapy, and ultimately to the overall effectiveness. The model has been described as involving a sequential improvement in subjective well-being, reduction in symptomatology, and improvements in life functioning. The model involves the tenets that the early stage of therapy is characterised by an increase of hopefulness due to the non-specific factors such as therapeutic relationship, treatment rationale, and therapeutic procedures that assist clients in clarifying their own symptomatology and generate positive expectations of treatment. The middle and the last stages of therapy are characterised by the use of specific techniques that facilitate a reduction of symptomatology, raise awareness about possible maladaptive longstanding patterns, establish new and healthier ways to deal with life problems, and prevent future relapses, which in turn may lead to improvements across several domains of life functioning.

In CBT, specific factors include techniques prescribed by the cognitive model of depression (e.g., cognitive restructuring, A. T. Beck et al., 1979; A. T. Beck & Haigh, 2014; see Chapter Two for a comprehensive description of the specific factors), while the non-specific factors include the therapeutic relationship, treatment rationale, homework, and treatment procedure (Ilardi & Craighead, 1994). The therapeutic relationship has been regarded as essential to treatment but not sufficient to produce symptom change in CBT (A. T. Beck et al., 1979). Despite this, the importance of building trust and rapport with clients from the initial contact has been clearly emphasised (J. S. Beck, 2011). Microcounselling skills have been found to contribute to better relationships between therapists and clients (Gillespie, Smith, Meaden, Jones, & Wane, 2004). However, collaboration and active participation have been regarded as CBT specific elements (J. S. Beck, 2011). Clients' perceptions of the quality of the therapeutic relationship has been related to outcome (Martin, Garske, & Davis, 2000), and better therapeutic relationships have been found to precede better outcomes (Klein et al., 2003). An expert panel emphasised that therapeutic relationship can be a powerful tool in helping clients to re-evaluate their beliefs and expectations of therapy (Kazantzis et al., 2018). Therefore, it is reasonable to assume that improving the therapeutic relationship may contribute to better treatment outcomes (Leahy, 2008).

Treatment rationale has been considered to be an essential component of CBT interventions (J. S. Beck, 2011). Providing a treatment rationale involves describing "a model of aetiology (Why is this person having this problem?) and treatment (What should we do to change it?"; Addis & Carpenter, 2000, p. 147). Presenting the treatment rationale may

generate both hopes and fears about the treatment (Addis & Carpenter, 2000). However, when it was emphasised that the treatment was based on scientific research, the treatment rationale had a significant effect on generating positive expectations for therapeutic change and hopefulness about the benefits of therapy (Ilardi & Craighead, 1994; Kazdin & Krouse, 1983). Acceptance of the CBT treatment rationale has been associated with positive treatment outcomes (Addis & Jacobson, 1996; Addis & Jacobson, 2000). Further, acceptance of the treatment rationale during the first three sessions predicted change midway through treatment and treatment outcome (Addis & Jacobson, 2000). It appears that providing a credible treatment rationale may be a critical skill for facilitating client engagement.

Although homework assignments have been identified as a common process to a various psychotherapies, they are a fundamental feature of CBT (J. S. Beck, 2011). Homework provides opportunities to clients to educate themselves further; monitor, test, and modify their thoughts, emotions, and behaviours, to ultimately facilitate the transference of cognitive and behavioural skills from the therapy room to everyday life (J. S. Beck, 2011). There is evidence for a robust homework-quantity relationship and evidence of superiority of CBT versions including homework when compared with CBT versions without homework for anxiety and depression (Kazantzis, Deane, & Ronan, 2000; Kazantzis, Whittington, & Dattilio, 2010). Further, clients who have completed homework had better progress than those who did not, suggesting that greater compliance with homework is associated with enhanced therapy outcomes for various symptoms (Kazantzis et al., 2010; Mausbach, Moore, Roesch, Cardenas, & Patterson, 2010). Homework compliance has been associated with a significant reduction of depression symptoms following treatment (Addis & Jacobson, 2000).

A set of therapeutic procedures or healing rituals has been a central component of the common factor approach (Frank & Frank, 1991; Wampold, 2001). The therapeutic procedure of CBT for the initial sessions is likely to capitalise on non-specific factors to promote clinical improvement (Ilardi & Craighead, 1994). As with any psychotherapy, the CBT therapeutic procedure works only when clients engage in the therapeutic process (Kazantzis, Brownfield, Mosely, Usatoff, & Flighty, 2017). As a result, careful consideration of client engagement factors is required when providing therapy to Chinese migrants, especially because of the cultural and attitudinal barriers to mental health services and help-seeking behaviours (see Chapter One for a detailed discussion).

The literature on culturally adapting the non-specific factors of CBT for Chinese migrants is limited (Benish et al., 2011; Chu et al., 2012; Hwang, 2009). As discussed in Chapter Two, two studies underpinned by a cultural adaptation framework have been

conducted to culturally adapt CBT and problem solving therapy for Chinese Americans with depression (Chu et al., 2012; Hwang, 2009), while two meta-analyses that have been conducted with the overall aim of reviewing or assessing the efficacy of culturally adapted psychotherapies for a wide range of ethnic groups also examined cultural adaptations to non-specific factors (Benish et al., 2011; Chowdhary et al., 2014). Chu et al. (2012) and Hwang (2009) developed comprehensive guidelines for culturally adapting non-specific factors including the therapeutic relationship, providing a treatment rationale involving an aetiological model for depression and rationale for treatment, and providing homework via consultation with therapists, clients, and community stakeholders. Chowdhary et al. (2014) reported that ten authors out of the 19 studies selected for a systematic review described that aspects of the therapeutic relationship did not require cultural adaptation, but no justification was provided. Benish et al. (2011) investigated the moderating role of several variables including age, language match, language match upon request, matched race/ethnicity, myth adaptation, severity of disorder, treatment modality, and volunteer status, and found that only adaptation of the illness myth (i.e., explanation of illness) was the only moderator of superior treatment outcomes. As discussed in Chapter One, Chu and Leino (2017) proposed a cultural adaptation framework that synthesises patterns of cultural adaptations in the existing literature. This framework consists of two first order categories—peripheral and core treatment components. The peripheral components, which refer to engagement and treatment delivery, appear to be equivalent to non-specific factors. Interestingly, adaptations to peripheral components have been reported in all studies captured in Chu and Leino's (2017) systematic review, highlighting the importance of increasing the accessibility of evidence-based treatments for ethnic groups.

Based on previous literature and the scoping review presented in Chapter Two, there are several important gaps in the current literature. The non-specific factors of CBT for depression in Chinese migrants may benefit from more careful consideration because of the lower rates of mental health service use, high drop-out rate, and higher involuntary admissions to hospitals compared to the locally born people (Akutsu et al., 2004; Blignault et al., 2008; J. Hu & Wang, 2016; Jim & Pistrang, 2007; Wynaden et al., 2005). Additionally, as detailed in Chapter One, Chinese migrants might face important cultural and structural barriers to mental health services such as low familiarity with Western psychotherapies due to their relative new history in Asian countries (C. W. Wong, 2013), low mental health literacy (Parker et al., 2006; Y. J. Wong et al., 2010), and stigma attached to mental illness (Wynaden et al., 2005). It is reasonable to assume that therapists may need to spend more

time building rapport and trust, adopt a keen sensitivity to connect with the clients at a more personal level (C. W. Wong, 2013), and provide a cultural context for learning and facilitate understanding of mental disorders as defined in Western countries (Hwang, 2009). Second, investigating the non-specific factors of CBT in an Australian context may reveal similarities and/or differences between the cultural adaptations of non-specific factors deemed most helpful in previous investigations undertaken in the USA. Lastly, investigating the cultural adaptation of non-specific factors contributes to gaining a deeper understanding of the factors that may facilitate clinical engagement and assist clinicians in connecting with clients' experience of the therapeutic process (Robinson, 2009). Therefore, the aim of this study was to document both the clinicians' and community members' perspectives on non-specific factors of a culturally sensitive version of CBT. The present chapter complements the study of specific factors reported in Chapter Three.

4.2. Methodology

4.2.1. Interview and focus group protocol.

The methodology of the present study is briefly reviewed because a full description is provided in Chapter Three. An interview schedule was developed for conducting semi-structured interviews and focus groups to document both the community members and clinicians' perspectives on the non-specific factors of a culturally sensitive version of CBT for depression. The common topics were expectations, treatment rationale, therapeutic relationship, miscounselling skills culturally acceptable terminology for depression and homework, provision of translated information, and therapy format (e.g., group versus individual). The clients' expectations of a Psychologist and the clinicians' expectations of Chinese clients was documented to identity possible gaps in the service provision. In addition, only the clinicians were asked to describe the importance of the therapeutic relationship and ways to develop a strong therapeutic relationship because the community members did not necessarily have a past experience of CBT or other psychotherapies (see Appendix B and C for the information sheet and interview schedules for documenting the non-specific factors of CBT).

4.2.2. Data analysis.

Thematic analysis was used to analyse the data (Braun & Clarke, 2006) because of the unique advantage of emphasising the similarities and differences between the community members and clinicians perspectives on the non-specific factors of a culturally sensitive

version of CBT. A hybrid approach of data-driven and theory-driven codes was used for coding. The data-driven codes were constructed from the raw information provided by the clinicians and community members, whereas the theory-driven codes were constructed from CBT theory (J. S. Beck, 2011) and non-specific factors in CBT for depression (Ilardi & Craighead, 1994). In addition, a modified consensual qualitative research analysis (C. E. Hill et al., 1997) was used to determine the more predominant themes and sub-themes. The research team examined the representativeness of the results by indicating whether the themes were general (applied to every case), typical (applied to half or more cases), or variant (applied to fewer than half of the cases but more than two cases).

4.3. Results

Documenting both clinicians' and community members' perspectives was critical to gain a comprehensive overview of the non-specific factors of a culturally sensitive version of CBT for depression. The participants in this study suggested cultural modifications that may improve clinical engagement and ultimately treatment outcomes. Four major themes were identified: (a) community members and clinicians' mixed expectations; (b) the importance of microcounselling skills in developing a strong collaborative alliance; (c) promoting clinical engagement through providing extended psychoeducation and a treatment rationale that may normalise depression; and (d) preferences for individual therapy or individual therapy with a support person (see Table 5 for a summary of themes and subthemes).

4.3.1. Community members' and clinicians' mixed expectations.

The community members typically reported mixed expectations of Psychologists and therapy. Regardless of their age, years of living in Australia, and English skills, some community members reported limited knowledge of service provision and psychological treatments for depression, which appeared to influence their expectations of Psychologists. Some of the elderly community members stated that psychological services are relatively new to them and therefore they did not have clear expectations of Psychologists. Despite this, they described a Psychologist as someone they can talk to when they are sad or unhappy. For instance, one community member stated:

TABLE 5

SUMMARY OF THEMES AND SUBTHEMES REFLECTING CULTURAL ADAPTATIONS TO NON-SPECIFIC FACTORS OF CBT

Themes and subthemes	Clinicians frequency	MCM frequency
Theme 1: Community members and clinicians' mixed expectations		
a) Community members mixed expectations of Psychologists and therapy		Typical
b) Clinicians mixed expectations of clients with a Chinese ethnic background	General	
Theme 2: The importance of microcounselling skills in developing a strong therapeutic relationship		
a) A more directive approach involving teaching and using fewer open-ended questions may correspond to Chinese people' cultural expectation of a hierarchical relationship	Variant	Typical
b) Use the Rogerian skills and be genuine to connect with the clients at a more personal level	Variant	Variant
c) Emphasis of the collaborative nature of therapy and learning new skills	Variant	
d) Clinicians' self-disclosure may reveal their humanness	Variant	General
Theme 3: Promoting clinical engagement through extended psychoeducation and a treatment rationale that may normalise depression		
a) Extended psychoeducation may be needed because:		
i. Depression might be associated with psychotic disorders, suicide, self-harm	Variant	Typical

ii.	Chinese clients tend to access mental health services when their condition is severe (e.g. psychotic symptoms, suicidal attempt, domestic violence)	Typical	
b)	Consideration to depression and homework terminology		
i.	Use clients' language for depression as they will indicate culturally acceptable terms	Typical	
ii.	Mixed perspective on the advantages and disadvantages of using the term depression in therapy	Variant	
iii.	Mixed perspectives on the advantages and disadvantages of using the term homework in therapy	Variant	Variant
c)	Provide a treatment rationale that clients may connect with at an intellectual and emotional level		
i.	Use case studies and statistics about CBT effectiveness	Variant	Typical
ii.	Show that people from the same ethnic group, but also from other cultural backgrounds, experience mental health problems to reduce stigma		Variant
Theme 4: Preferences for individual therapy or individual therapy with a support person			
a)	Strong preference for individual therapy	Typical	General
b)	Individual therapy with a support person as an alternative therapeutic format	Variant	Variant

Note: Members of the Chinese Community (MCM); We identified a theme or a subtheme as general if it applied to 20 clinicians and 14 MCM, typical if it applied to 10-19 clinicians and 7-13 MCM, and variant if it applied to 2-9 clinicians and 2-6 MC.

> If I am a depressed person and if you say to me 'I am a Psychologist' I would probably think that's a good opportunity. I can have a chat, I can communicate with you, and then you maybe guide me to some bright light.

Other community members reported that they would expect Psychologists to be experts, but "humble enough to connect" or have a good understanding of Chinese values and culture. Furthermore, community members suggested that Chinese migrants might not know the benefits of seeing a Psychologist because of not having had a personal experience of attending psychotherapy session and not knowing other community members undergoing psychotherapy. Interestingly, community members variably suggested greater trust in psychological services endorsed by community members. Other community members reported high and unrealistic expectations to be "completely cured after several sessions" as they would after treatment for health problems. For instance, one community members stated:

> …we are very, let's just say, bio-medically focused, we expect that depression should be treated like heart attack, with a pill or get injection and stuff. This – and a bit more passive treatment – do things on me. Okay. Don't ask me to write down my feelings; don't ask me to do this. So it's a bit more passive, high expectations, expect you to work wonders.

The clinicians in this study generally reported mixed expectations of clients with a Chinese ethnic background, with more than half reporting no expectations. One Counsellor explained "It's not our journey. It's theirs. It's not our expectations. It's their expectations." Some clinicians suggested that Chinese clients might expect other modes of assistance such as traditional Chinese medicine, religious or cultural assistance, while others suggested that Chinese clients might want a pragmatic approach, solutions "to get on with their lives", and quick results. Others clinicians suggested that Chinese clients are expected to comply with the Western model of health services:

> …conscious or unconscious, we do apply the Western model to them. Our expectation then, that they comply with the Western model and either they come to the service to be seen or comply, otherwise, you are discharged….Otherwise, you are not … you do not fit in to the system.

4.3.2. The importance of microcounselling skills in developing a strong therapeutic relationship.

Both the community members and the clinicians suggested that a more directive approach involving teaching may correspond to Chinese individuals' cultural expectation of hierarchical relationships. The community members typically stated that Chinese clients may benefit from a more directive approach because "they might struggle with open-ended questions", "they are not taught to be freely speaking", "Chinese people may not work so well with a lack of direction", and they might have difficulties in expressing themselves. Consistent with this view, the clinicians variably reported using a more directive and didactic approach to establish a sense of authority and knowledge and be perceived as experts. One Clinical Psychologist explained that she prefers to use teaching mainly in the early stage of therapy and then she gradually transitions towards a more Socratic style. Another Clinical Psychologist emphasised that although in Western cultures a more directive approach might be perceived as "dependence and control", Chinese clients might respond much better to such an approach because "if they have decided you are the authority, they would like you to tell them what to do and that is normal."

The clinicians variably suggested to use the Rogerian skills (e.g., summarising, paraphrasing, active listening) to connect with the Chinese clients at a more personal level. Some clinicians believed that summarising is especially important in working with clients who may speak English as a second language, although one Mental Health Nurse stressed the importance of adopting a sensitive approach in using the microcounselling skills to prevent clients from doubting their English skills. Consistent with this view, community members variably suggested that asking open-ended questions might help to "get a lot more from the patient" and might create an opportunity to express their opinions, although some community members doubted the utility of asking open-ended questions.

In addition, both the community members and the clinicians variably suggested that Chinese clients appreciate clinicians showing a genuine interest in them. One community member stated "I need to feel you genuinely care about me", which reflects the importance of being genuine in building an authentic therapeutic relationship. A Mental Health Nurse compared being genuine with being empathetic and stated:

> How do you demonstrate empathy? Because it's difficult to demonstrate that. It has to come from within. So we have to train ourselves really mentally, physically. If you are not ready to see someone, I don't think you should see anyone because you have to believe in yourself to achieve treating the person, or looking after the person. That should come from within. Once you have that from within, it will come up.

CBT therapists variably believed it is critical to explain that CBT involves a collaborative process and learning new skills. It was suggested that this may assist clients in improving their problem solving skills and gaining different perspectives. In CBT terminology this can be interpreted as assisting clients to develop self-efficacy and become their own therapist (J.S. Beck, 2011). For instance, one Clinical Psychologist reported using a metaphor with clients to illustrate the collaborative work in CBT:

> If a son is hungry and goes out to the father, if the father would just give the son a fish, he will only feed him one dinner. But if the father taught his son how to fish, then he will never go hungry for life.

Unexpectedly, clinicians' self-disclosure was one of the few general themes applied to community members. Some community members believed that clinicians' self-disclosure about their own struggles may help to build rapport by reinforcing clinicians' capacity to understand clients' struggles in life and at the same time might normalise the fact that "everybody has problems". In other words, clinicians' self-disclosure may reveal their humanness. Consistent with this view, one Clinical Psychologist stated: "Meaningful self-disclosure. As I said, Chinese people love to hear stories and they also love to hear stories from someone seemingly high in authority but they also struggles in life." Another important aspect that both the community members and the clinicians agreed upon is if the clinicians are migrants, using their own ethnic background might be beneficial in building a strong therapeutic relationship because of sharing the migration status. For instance, one of community members stated "Yes, it will help [therapists sharing information about their ethnic background]. Yeah, because we're all migrants."

4.3.3. Promoting clinical engagement through providing extended psychoeducation and a treatment rationale that may normalise depression.

Extended psychoeducation may be needed for several reasons. The community members typically associated depression with a psychotic disorder, suicide, self-harm, or being weak. Community members shared six stories about Chinese people with depression who suicided. It appears that the community members' view on depression might reflect an awareness mainly about severe depression, while the awareness about mild and moderate depression is lacking. For instance one community member stated "when you say that a person is depressed, the first impression is you're really in the pit." In addition, another community member stated "They think it's something that only weak people will experience, that they are too strong to experience things like this. That will only happen to her. She's different and I'm special. Depression won't happen to me," which clearly reflects the stigma attached to depression and low mental health literacy. These misconceptions about depression might explain the utilisation of mental health services only when clients' problems become acute. More precisely, clinicians typically reported that their clients with a Chinese ethnic background sought mental health services when experiencing psychotic symptoms, suicidality among adults and children "of high-achieving migrants", domestic violence, and difficulty coping with their family members' symptoms. Three of the clinicians stated that most of their Chinese patients came from the emergency, inpatient unit or had an involuntary patient order. The clinicians variably reported spending more time on psychoeducation to build rapport and to facilitate engagement with CBT. It was highlighted that clinical engagement and building rapport is "a more complicated process" because Chinese clients are less prepared to engage in therapy services compared to Western populations.

Additionally, it was suggested that clinical engagement might be affected if clients access services when they have severe depression and if they have language barriers and need an interpreter. Some community members suggested clearly explaining the therapeutic process (i.e., "don't take it for granted that they know how it works"), along with the benefits and possible outcomes of doing therapy, as this will assist with developing more realistic expectations of therapy and may reduce the uncertainty associated with therapy. Consistent with this view, one Clinical Psychologist described her approach in doing CBT with Chinese clients with depression:

> … so I will still start off with an assessment, lots of psychoeducation, I tend to focus a bit more on psychoeducation with Chinese clients than with the other clients and then spending a lot of time talking about the ABC model, about their thoughts and their feelings and the situation and all that.

Depression and homework terminology may benefit from more careful consideration in therapy. The clinicians typically suggested using clients' language for depression as they will indicate culturally acceptable terms. For instance, one Clinical Psychologist explained that two of her clients expressed depression by "I am idle" and "I don't sweat". The cultural meaning was that they were not able to work and they were inactive as a result of depression. This Clinical Psychologist further explained that using clients' language might improve clinical engagement by not making a "judgement, which they might not be ready to accept." Consistent with this view, the community members identified a wide range of culturally acceptable terms for depression, including "unhappy", "feeling down", "sad", "upset", and having a "low mood". Interestingly, only the community members with low English skills preferred the term "a closed heart" to describe depression.

However, clinicians had mixed perspectives on the advantages and disadvantages of using the term depression in therapy. They variably suggested that using the term depression might assist in explaining that depression is an illness, which may help to treat depression as any other physical illness, and consequently avoid stigma attached to the term. Furthermore, one clinician believed that using the term depression helps to emphasise that this is a "universal problem" and "depression is in every race". In contrast, other clinicians variably stated that using the term depression is labelling and stigmatising. One Social Worker explained that she prefers to ask clients "How does your depression look like?" to get a more descriptive explanation.

Both the community members and the clinicians had mixed perspectives on the advantages and disadvantages of using the term homework in therapy. The community members variably stated that the term homework is acceptable because they will associate the term with education. Moreover, one community member explained that "homework is the way of Chinese culture" and therefore may increase the sense of responsibility in doing the homework. In line with this view, the self-identified CBT therapists explained that they were using the term homework, and they were providing homework to their clients, and explaining the benefits of practicing skills outside the therapy sessions. In contrast, other community members and

clinicians variably recommended not using the term homework because it sounds mandatory. Alternative terms suggested by the community members were home practice, home experience, or worksheets, while the clinicians suggested to explain the benefits of practicing skills outside the therapy sessions at an individual and family level (e.g., "if you are better the family is better, it is not about you getting stronger it is about the whole family getting stronger") without using the word homework.

Providing a strong treatment rationale was considered important for several reasons. Community members typically suggested that the combination of case studies and statistics in explaining the treatment rationale may be particularly useful because some community members might connect at a personal level with the case studies and examples, while others might better relate at an intellectual level to statistics about CBT effectiveness. A variant number of clinicians supported this view. For instance, on community member stated:

> But if your stories are [about] people who let's say fall into depression, where to get help, how to get help, and how they recover from it, I will find that it'd be more effective, I think, because it's a real life situation. …Statistics is good. …I'm not one in a million, I'm actually not so afraid to express that 'Oh, I'm also depressed,' but I would just wanna know more than that.

Other identified advantages might be assisting clients in better understanding and remembering information and building up the clinicians' credibility. In addition, a variant number of community members believed that showing that people from the same ethnic group, but also from other cultural backgrounds, experience mental health problems, may reduce stigma and normalise depression. One interesting suggestion was to use interviews with people from different cultural backgrounds talking about their experience with depression to normalise depression.

4.3.4. Preferences for individual therapy or individual therapy with a support person

Both community members and clinicians expressed their preferences for therapy format (i.e., individual or group therapy). Surprisingly, all the community members expressed their preference for individual therapy. A typical number of clinicians considered that Chinese clients may respond better to individual therapy. Essential advantages of individual therapy have been described including keeping their problems private as this will not generate "face" issues, and it

is less stigmatising and confronting. Moreover, a variant number of community members and clinicians suggested attending therapy with a family member as an alternative therapeutic format to individual therapy. Some community members suggested that attending a psychotherapy session with a support person, who is someone they trust and they feel comfortable with, will assist with their motivation for therapy and engagement. Some clinicians explained that they were allowing their Chinese clients to attend assessment and therapy sessions with a support person if they expressed their need to be accompanied by someone.

4.4. Discussion

This chapter contributes to a deeper understanding of the cultural adaptation of the non-specific factors of CBT for Chinese migrants with depression by documenting both clinicians' and community members' perspectives. Careful consideration of non-specific factors when providing CBT to Chinese migrants with depression is critical considering barriers to accessing mental health services such as unfamiliarity with psychotherapy as an alternative option to medical treatment for depression. These findings provide valuable insights into (a) developing a strong therapeutic relationship; (b) providing a treatment rationale that clients' may connect with at both intellectual and emotional levels; (c) addressing clients' expectations of the therapeutic process, and (d) considering clients' preferences for therapeutic format, which may ultimately improve clinical engagement.

Both clinicians and community members in this study reported mixed expectations of the therapeutic process. Specifically, clinicians reported no particular expectations, other modes of assistance than psychological treatment (e.g., traditional Chinese medicine), and clients wanting a pragmatic approach or complying with the Western model of health services. It is important to note that no negative expectations of Chinese clients were identified. Overall, community members expressed positive outcome expectations, which has important clinical implications. Previous research has found that positive expectations are associated with favourable treatment outcomes (Visla, Fluckiger, Constantino, Krieger, & Grosse Holtforth, 2018; Wampold, 2015). However, researchers have shown high dropout rates among Asian clients (e.g., Chinese, Korean) accessing mental health services and premature termination (Akutsu et al., 2004). Possible explanations for the high dropout rates may be that Chinese clients' high expectations of psychological treatment are not met, attending therapy sessions may enhance self-stigma associated with mental illness, or they may not be supported by their family to undergo therapy.

As discussed in Chapter One, there may be a significant discrepancy between the Chinese tendency to somatise psychological distress and the Western emphasis on psychological aspects of distress (Ryder et al., 2008). As such, more research is required to investigate aspects related to clients' expectations and to examine the relationship between outcome expectations and clinical engagement.

The participants in this study described several important aspects to developing a strong therapeutic relationship. Consistent with previous studies conducted in the USA and the UK (Chu et al., 2012; Hwang, 2009; Jim & Pistrang, 2007; Kim-Goh, Choi, & Yoon, 2015), the present findings suggest that a directive approach involving teaching and fewer open-ended questions may be perceived as culturally appropriate due to Chinese persons' cultural expectation of a hierarchical relationship. Surprisingly, community members had mixed opinions about the importance of asking open-ended questions. It appears that both a directive and a collaborative approach may be necessary to facilitate client engagement, which is consistent with previous literature (Chu et al., 2012; Jim & Pistrang, 2007).

Although the recommendation to provide extended psychoeducation about the therapeutic process and the course of treatment is consistent with previous studies (Chu et al., 2012; Guo & Hanley, 2015; Hwang, 2009; Kim-Goh et al., 2015), participants in this study suggested that extended psychoeducation is important because of misconceptions about depression (e.g., association of depression with psychotic disorders). This finding indicates that the community members gained some knowledge about mental disorders as defined in Western countries, and indeed depression may be associated with psychotic disorders or suicide, but their perspective appears to reflect a dichotomous conceptualisation of mental illness and mental health with no intermediary concepts between wellbeing and major depression.

It is important to note that psychoeducation might be considered both a specific and a non-specific factor. More precisely, psychoeducation might be viewed as a specific factor in CBT because (a) it involves educating the client about depression and the cognitive model of depression (i.e., explaining the relationship between triggering situations, beliefs, emotions, and behaviours; and (b) it is used in every step of the therapeutic process (J. S. Beck, 2011). However, psychoeducation might be considered a non-specific factor in the sense that is likely to be an important component of other therapeutic modalities (i.e., educating clients about the theoretical model of a particular therapeutic modality for depression).

Providing a treatment rationale that clients may connect with at an intellectual and emotional level appears to be critical to reinforce each client's understanding of the aetiology of depression and the course of treatment. Using case studies may be particularly important to help Chinese clients relate to the experiences of other individuals undergoing therapy at an emotional level (Hwang, 2009), while presenting statistics about CBT effectiveness of CBT may improve the credibility of the treatment. Additionally, community members highlighted that showing that people from the same ethnic group, but also from other cultural backgrounds, experience mental health problems may reduce stigma and normalise depression.

Importantly, all the community members in the present study expressed their preference for individual therapy. A possible explanation may be that the individual format corresponds to cultural values such as interpersonal harmony and avoiding family shame (B. S. K. Kim et al., 2001). Consistent with previous studies (Chu et al., 2012; Kim-Goh et al., 2015), the present findings revealed that individual therapy with a support person may be an alternative therapeutic format. This alternative therapeutic format may correspond better to an interdependent self (Kim-Goh et al., 2015) and therefore may facilitate clinical engagement (Chu et al., 2012). As such, a unique challenge for clinicians may be to work in a culturally sensitive manner with a client seeking treatment accompanied by significant others without providing family therapy.

This study identified unique non-specific factors deemed important in providing CBT to Chinese clients with depression. Clinicians' self-disclosure was one of the few general themes applied to community members. There was a consensus among community members that clinicians' self-disclosure may reveal the humanness of authority figures, which may be essential in determining whether clinicians are able to understand clients' cultures and inner worlds. Clinicians emphasised that using meaningful self-disclosure, involving success stories, and sharing information about their own ethnic background, if relevant, may assist in building a strong therapeutic relationship. These findings are consistent with (a) the theoretical perspective that self-disclosure may reveal humanness and may assist in modelling modifying negative core beliefs and reinforcing alternative views (J. S. Beck, 2011; Goldfried, Burckell, & Eubanks-Carter, 2003), and (b) previous studies showing that clinicians' self-disclosure was seen as appropriate by both clients and clinicians (Audet, 2011; Miller & McNaught, 2018), and a useful tool for building rapport (Jim & Pistrang, 2007; Miller & McNaught, 2018). Modelling coping skills may be especially important considering that CBT may be a new form of treatment for

some Chinese clients, which may not correspond to their cultural expectations of a treatment for depression. Despite the beneficial role of self-disclosure in CBT, clinicians need to be aware of the risks linked with using this technique, including diminishing role differentiation between clinicians and clients, and compromising clinicians' competency and credibility (Audet, 2011; Simi & Mahalik, 1997). A suggested rule of thumb to using self-disclosure might be to act in the best interest of the client and answer the following questions "Why do I want to say what I am about to say?" and "What will be the likely impact on the client?" (Goldfried et al., 2003, p. 567).

Previous investigations revealed that the Chinese lexical construction of emotions contain the word heart in combination with other symbols (D. T. S. Lee et al., 2007; Pritzker, 2007), illustrating the importance of heart metaphors for feelings. Further, Chinese migrants participating in an RCT investigating the efficacy of an online CBT program for depression, resonated with the term "a closed heart", a metaphor of the heart equivalent to depression (Choi et al., 2012). Unexpectedly, only the community members with low English skills preferred the term "a closed heart" to describe depression. The linguistic repertoire of the participants with a stronger command of English included Western terms for depression symptoms (e.g., unhappy, feeling down). A possible explanation may be that the participants with better English skills were more acculturated and developed an English vocabulary for emotions that did not include literal translations of Chinese terms. Consistent with previous studies (Chu et al., 2012; Hwang, 2009), it appears that using clients' language for depression may help to ensure the use of culturally sensitive and de-stigmatising terminology. Regarding the use of the term homework in therapy, some of the community members' and clinicians' perspectives are consistent with previous research, which suggested that the term homework may be interpreted as mandatory and therefore it may be counterproductive in therapy (Hwang, 2009).

4.4.1. Limitations and directions for future research.

The present study has several limitations (see Chapter Three for a full description of the limitations of this study). Community members who had not necessarily experienced CBT for depression were consulted in this study, so more research is required to document outcome expectations of Chinese clients with depression in-between sessions and over treatment, and facilitators to and barriers to attending CBT sessions. Further, research is required to investigate clients' and clinicians' perceptions of clinicians' self-disclosure and the impact on clinicians'

credibility, engagement with CBT, and overall efficacy of CBT. Clinicians' self-disclosure may have both positive and negative implications. A possible negative implication may be that boundaries between a professional relationship and a friendship could be slightly blurred. In addition, clinicians' self-disclosure may create confusion for clients who are not familiar with psychotherapy and may expected a hierarchical relationship. Because the majority of the community members and clinicians was female, future research may investigate gender differences in regard to the nonspecific factors of CBT.

Despite these limitations, the present study documented the potentially beneficial role of non-specific factors for improving client engagement. There is a consensus between the findings from this study and studies conducted in the USA and the UK regarding the cultural appropriateness of using a directive approach, providing extended education, and providing individual therapy with a support person. Further, this study identified unique aspects regarding clinicians' self-disclosure, providing a treatment rationale that participants can connect with at an intellectual and emotional level, and culturally appropriate terminology for depression. Careful consideration of the non-specific factors of CBT is required to facilitate clinical engagement, which is critical to ensure that clients attend therapy sessions long enough to experience the benefits of one of the most effective treatments of depression (Cuijpers et al., 2013), which is still the gold-standard of psychological treatment (David, Cristea, & Hofmann, 2018).

"The role of cognitions in depression is often misinterpreted to be one of simple linear causality: negative cognitions cause depression. If this were true, the implications for treatment would be further simple linear reasoning: positive thinking cures depression."

(Freeman & Oster, 1998, p. 515)

Chapter 5: The Generic Cognitive Model for Depression Symptoms and its Specificity in Chinese Migrants: A Structural Equation Model

5.1. Introduction

Depression is one of the world's most disabling illnesses (Vos et al., 2016), and is characterised by prominent and prolonged disturbance of mood, cognition, and behaviour, which appear to be universal (D. W. Black & Grant, 2014; Freeman & Oster, 1998). Depression may arise from a complex interaction between external stressors and individuals' characteristic patterns of thinking, feeling, and behaving (Freeman & Oster, 1998). In this era of migration and globalisation, it is extremely important to study depression as "an idiom of distress that influences illness experience, help-seeking, and adaptation" (Kirmayer, Gomez-Carrillo, & Veissière, 2017, p. 167) as migrants may face dual vulnerabilities because of the stigma attached to mental illness and obstacles in accessing and utilising services (Cross & Singh, 2012). A migrant group with one of the lowest rates of mental health services use compared to the locally born people is Chinese migrants (J. Hu & Wang, 2016; Jim & Pistrang, 2007; Minas et al., 2013). Possible explanations for this could include poor treatment options, lack of culturally appropriate treatment models (Cross & Singh, 2012), lack of culturally appropriate services (Minas et al., 2007), and low mental health literacy (Blignault et al., 2008; Parker et al., 2006; D. F. K. Wong et al., 2010). As such, it is critical to improve theoretical models and include specific vulnerability factors for migrants to develop culturally appropriate treatments for depression.

The cognitive model of depression was developed specifically in response to the need to treat depression (A. T. Beck, 2008; A. T. Beck et al., 1979). The cognitive perspective is a diathesis-stress model highlighting the complex relationships between life events, thoughts, behaviour, and mood. The model involved the proposition that severe life events (e.g., loss of a job) are precipitants of depression, but more recent research has suggested that milder stressful events may trigger depression in vulnerable individuals (A. T. Beck, 2008). Research findings have provided support for the cognitive diathesis-stress vulnerability to depression and show that

negative schemas emerge under stress (Scher, Ingram, & Segal, 2005; Segal & Ingram, 1994). As discussed in detail in Chapter One, A. T. Beck and Haigh (2014) updated the cognitive model and proposed the GCM. Consistent with the GCM, depression is initiated and maintained when beliefs (i.e., automatic thoughts), attentional focus (i.e., brooding and mindful attention), and behaviours (i.e., avoidance and activation) are triggered by stimuli (i.e., migration stress) and interact. As an extension in a Chinese migrant sample, the model investigates the possibility that migration stress and ethnic identity (along with their interaction) are associated with higher levels of brooding and lower levels of mindful attention.

Migration is a significant life event associated with both positive and negative emotions. Stress associated with migration can be framed in positive terms such as rebuilding personal identity in spite of demands of immigration, personal development, and making a fresh start (Adler, 1987; Bobowik et al., 2015; O'Reilly & Benson, 2009). However, stress associated with migration could be framed in negative terms such as the loss of one's social structure, culture, language, values, and support network (Bhugra et al., 2011). Consistent with the GCM, loss or rejection are typically activating stimuli of depression and focusing on losses and other demands of immigration might trigger maladaptive beliefs and behaviours associated with depression (A. T. Beck & Haigh, 2014). Importantly, loss along with other demanding aspects of immigration, including not feeling at home, novelty, occupation, language, and discrimination have been identified as aspects that play a key role in the development, maintenance, and resolution of depression (Aroian & Norris, 2003).

Investigating the interaction between migration stress and ethnic identity may provide new insights into improving the cultural sensitivity of depression treatments. Ethnic identity involves a sense of belonging to a group and learning about one's group, which is associated with cultural behaviours, values, and attitudes towards one's own group (Phinney & Ong, 2007). There are two lines of evidence investigating the protective and the exacerbating role of ethnic identity in the relationship between discrimination, an essential aspect of migration stress, and mental health. A strong ethnic identity has been shown to contribute positively to migrants' well-being (Nesdale, Rooney, & Smith, 1997; Phinney, Horenczyk, Liebkind, & Vedder, 2001), and to buffer migrants against the stress generated by perceived discrimination (Mossakowski, 2003). It appears that a stronger ethnic identity may reflect a stronger connection to one's ethnic group, which may play a protective role in the relationship between discrimination and depression by

preventing negative stereotypes from being internalised (Ai, Nicdao, Appel, & Lee, 2015; Mossakowski, 2003; Pascoe & Richman, 2009). In contrast, other studies showed that a strong ethnic identity intensified the effect of discrimination on mental health (Noh, Beiser, Kaspar, Hou, & Rummens, 1999; Yip, Gee, & Takeuchi, 2008). Ethnic identity intensified the negative effect of discrimination on mental health for the individuals aged between 31 and 40 years, and 51 and 75 year in an US born group with Asian descent (e.g., Chinese, Japanese; Yip et al., 2008). Surprisingly, ethnic identity has been found to play a protective role in the relationship between discrimination and mental health for the individuals aged between 41 and 50 years in the same sample, indicating that the effect of discrimination varied by age. Further, ethnic identity did not mediate the relationship between discrimination and depression in an Asian refugees sample in Canada (e.g., Chinese, Vietnamese), although the use of a passive acceptance coping reduced the strength of the association between discrimination and depression (Noh et al., 1999). In other words, a strong ethnic identity has been found to exacerbate the experience of discrimination among the individuals who failed to use passive acceptance as a coping mechanism. Consistent with these findings, ethnic identity has been found in another study comprising Asian refugees in Canada (e.g., Chinese, Vietnamese) to intensify the negative effects of resettlement stressors, including perceived discrimination and unemployment, although ethnic identity had no direct effect on the risk of depression (Beiser & Hou, 2006). Considering the mixed evidence about the protective and the exacerbating role of ethnic identity in the relationship between discrimination and depression in different populations, further research is required among Chinese migrants in an Australian context.

Attentional focus (i.e., brooding and mindful attention) and cognitive factors (i.e., automatic thoughts) have been found to be pivotal in the development of depression. Brooding reflects a passive comparison of one's current situation with some unmet standard (Treynor, Gonzalez, & Nolen-Hoeksema, 2003) and has been found to be associated with more depression both concurrently and longitudinally over one year (Joormann, Dkane, & Gotlib, 2006; Treynor et al., 2003). Though brooding and mindful self-focused attention both involve attention to one's own internal experience, mindful self-focus is adaptive, while brooding is maladaptive (Sauer & Baer, 2012). Mindful self-focused attention has been defined as a non-evaluative awareness and attention associated with wellbeing (Brown & Ryan, 2003). A significant negative correlation has been found between mindfulness and depression symptoms, and between mindfulness and

brooding, in a nonclinical sample (Burg & Michalak, 2011). Acting with awareness has been found to be associated with lower negative affect in a sample of Asian international students (e.g., Chinese, Japanese), while higher mindfulness skills have been found to be associated with better sociocultural outcomes during cross-cultural transition (Kashima et al., 2017). Consequently, investigating the relationship between brooding and mindful attention in predicting depression symptoms might contribute to exploring specific vulnerability factors for migrants. Automatic thoughts have been found to be highly correlated with depression symptoms in a clinically depressed sample (C. Hill, Oei, & Hill, 1989) and closely related to cognitive and somatic change in depression (Furlong & Oei, 2002). In addition, automatic thoughts have been found to mediate the relationship between negative life events, conceptualised as migration stress, and depression in Korean migrants (Oei & Kwon, 2007), as well as the relationship between negative life events encountered by adolescents and depression in a nonclinical sample of Chinese adolescents (Cui, Shi, & Oei, 2013).

Avoidance behaviour and lower activation towards one's own goals and present events have been found to be essential behavioural aspects associated with depression (Manos, Kanter, & Busch, 2010). A moderate to strong negative correlation has been found between activation and depression and automatic thoughts, respectively, while a moderate to strong positive correlation has been found between avoidance and depression and automatic thoughts, respectively, in a non-clinical student and community sample (Kanter, Mulick, Busch, Berlin, & Martell, 2007; Manos, Kanter, & Luo, 2011). However, stronger correlations have been found between avoidance and depression than between activation and depression in a student sample in China (Li, Ding, Kanter, Zeng, & Yang, 2014) and Japan (Shudo, Yamamoto, & Sakai, 2017), indicating that avoidance may be a more important behavioural aspect associated with depression than activation. Thus, avoidance appears to be a potential risk factor that contributes to the onset, relapse, or maintenance of depression (Ottenbreit & Dobson, 2008), and therefore may benefit from more careful consideration within the Chinese migrant population.

This study extends the previous literature by investigating (a) the GCM for depression in individuals from a collectivistic culture, such as the Chinese culture (B. S. K. Kim et al., 2001), and thus the cross-cultural applicability of the model; and (b) the integration of migration stress and ethnic identity with the GCM in predicting depression in a migrant population (as identified in Chapter Three). Examining potential vulnerability factors for migrants, which might be

targeted in CBT using attentional focus, belief, and behavioural change techniques (A. T. Beck & Haigh, 2014), might provide critical insight into improving the cultural sensitivity of depression treatments among a population that tends to underutilise mental health services and delay treatment until mental health problems become severe (Blignault et al., 2008; Jim & Pistrang, 2007; Wynaden et al., 2005). Based on the reviewed literature, we proposed a comprehensive model of depression building on the GCM (see Figure 3). The aim of the present study was to integrate migration stress and ethnic identity with aspects of the GCM, including brooding, mindful attention, automatic thoughts, activation, and avoidance, to predict depression in Chinese migrants. The first hypothesis was that the relationships between migration stress and brooding, and migration stress and mindful attention, would be moderated by ethnic identity, such that at higher levels of ethnic identity the relationships will be weaker than at lower levels of ethnic identity. Higher brooding and lower mindful attention were expected to predict higher automatic thoughts and avoidance, and lower activation, which ultimately would predict the severity of depression symptoms. The second hypothesis was that indirect effects between migration stress and depression symptoms (H2a), and between ethnic identity and depression symptoms (H2b), would be significant.

5.2. Method

5.2.1. Participants.

The sample comprised 429 participants with a Chinese ethnic background aged between 18 and 70 years (M = 27.8; SD = 10.10). The majority was female, single, had a university degree, and identified as being Chinese. On average, length of residence in Australia was 6.90 years (SD = 8.15 years). Inclusion criteria were: adults aged 18 years or over who were first- or second-generation Chinese migrants or Chinese international students living in Australia. Participants were excluded for not meeting the age and ethnicity criteria (n = 14), and for not completing more than one questionnaire (n = 16), resulting in a final sample size of 399 participants (see Table 6 for demographic information).

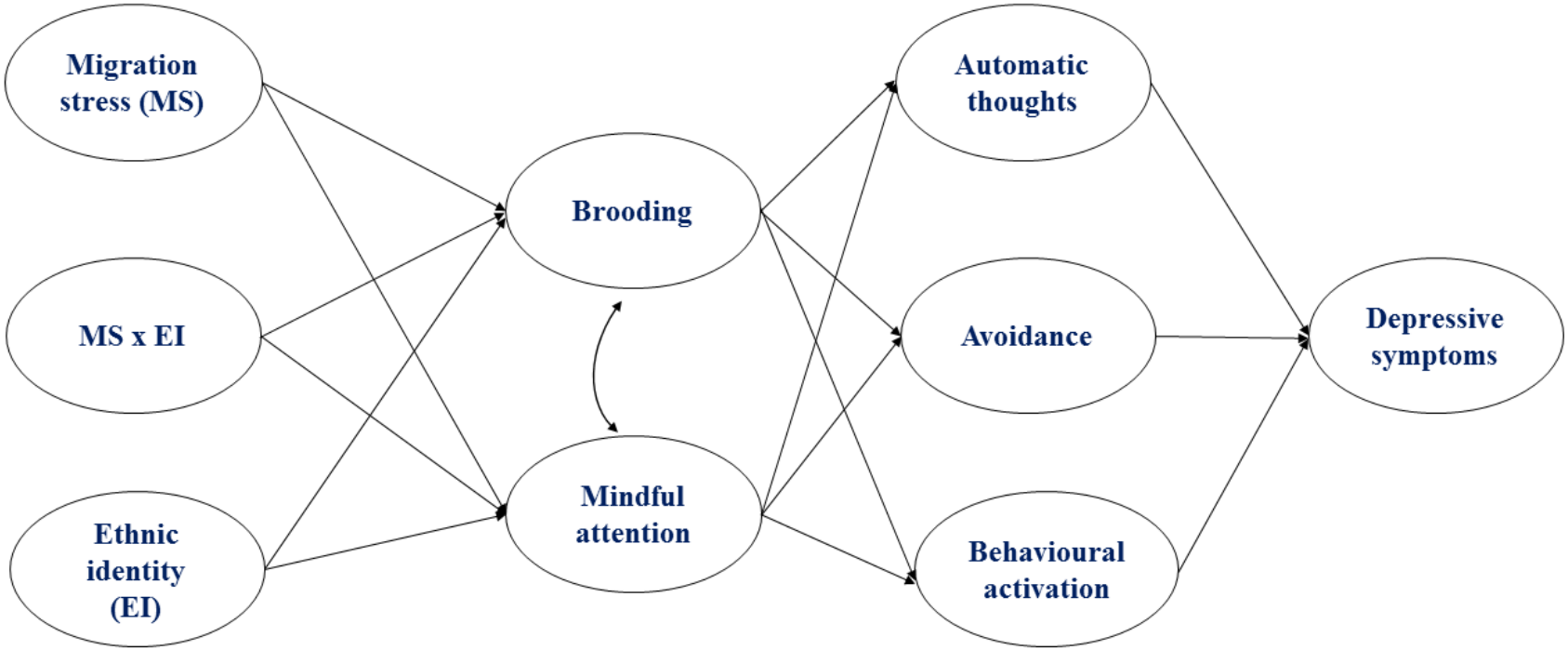

Figure 3. Hypothesised model showing the relationships between migration stress, ethnic identity, brooding, mindful attention, automatic thoughts, behavioural activation, avoidance, and depressive symptoms.

TABLE 6

DEMOGRAPHIC INFORMATION (N = 399)

		N	%
Gender	Male	134	33.6
	Female	264	66.2
	Another gender	1	0.3
Employment	Students	242	60.7
	Employed	156	39.1
	Unemployed	1	0.1
Education	Some high school	92	23.1
	Vocational education	22	5.5
	Bachelor degree	161	40.4
	Post-graduate degree	89	22.3
	Other	35	8.8
Marital status	Married	108	27.1
	Living with partner	30	7.5
	Divorced	4	1.0
	Separated	1	0.3
	Widowed	2	0.5
	Single	254	63.7
Ethnic identity	Chinese	251	62.9
	Chinese-Australian	42	10.5
	Chinese-Malaysian	36	9
	Other*	43	10.8
	No response	27	6.8

*e.g., Asian, Cantonese, Chinese-Singaporean

5.2.2. Measures.

Behavioural Activation for Depression Scale-9 item version (BADS, Manos et al., 2011). The 25-item BADS (Kanter et al., 2007) measures changes in activation and avoidance consistent with behavioural activation theory. The 9-item version (Manos et al., 2011) that

measures two factors, avoidance (e.g., "Most of what I did was to escape from or avoid something unpleasant") and activation (e.g., "I engaged in many different activities"), was used. Responses are recorded on a 7-point Likert scale, ranging from 0 (*not at all*) to 6 (*completely*). Participants responded to each statement indicating how much the statement was true during the past week including the day when the questionnaire was completed. The scale has demonstrated a good internal consistency (Cronbach's α = .81; Kanter et al., 2007). Internal consistency of all measures in the current study are described in the Results section and are reported in Table 7.

Brooding Subscale (Treynor et al., 2003). The 5-item Brooding Subscale of the Ruminative Responses Scale is a self-report measure of repetitive negative thinking associated with depression (e.g., Think "What am I doing to deserve this?"). Responses are recorded on a 4-point Likert-type scale, ranging from 1 (*almost never*) to 4 (*almost always*). Treynor et al.'s (2003) findings suggest that brooding is maladaptive, with higher scores related to higher levels of depression symptoms cross-sectionally and prospectively after one year. The brooding scale has demonstrated good internal consistency (Cronbach's α = .77) and the test retest reliability over two years was adequate (r = .62, Treynor et al., 2003).

Demand of Immigration Stress (DI; Aroian, Norris, Tran, & Schappler-Morris, 1998). The 23-item DI measures the level of distress in the past three months associated with demands of immigration and has six factors (1) loss; (2) novelty; (3) occupational adjustment; (4) language accommodation; (5) discrimination, and (6) not feeling at home in the receiving country. Responses are recorded on a 6-point Likert scale, ranging from 1 (*not at all*) to 6 (*very much*). High scores indicate high level of migration stress. J. H. C. Tsai (2002) evaluated the readability and psychometric properties of the Chinese version of the DI. The Chinese DI has demonstrated a good internal consistency (Cronbach's α = .92 for the total scale, and .68 to .90 for the subscales), and test-retest reliability assessed in two weeks (r = .89 for the total scale, range of r = .71 - .91 for subscales). J. H. C.Tsai's (2002) findings suggested that the scale may be used as a generic measure of migration stress. Despite this, the novelty subscale had the lowest Cronbach's α (.68) and the occupational adjustment subscale had the lowest response rate (33%) due to its low applicability to the participants' situation including migration pathway and work credentials. Consequently, we excluded these two subscales. We made minor changes to reflect the demand of immigrations in the Australian context (e.g., "Australians have a hard time understanding my accent" and "Australians don't think I really belong in their country").

Mindful Attention Awareness Scale-6 item scale (MAAS; D. S. Black, Sussman, Johnson, & Milam, 2012). The 15-item MAAS (Brown & Ryan, 2003) measures self-focused attention and present awareness (e.g. "It seems I am "running on automatic", without much awareness of what I'm doing"). Responses are recorded on a 6-point Likert scale, ranging from 1 (*almost always*) to 6 (*almost never*). Higher scores indicate higher levels of mindful attention. We used the 6-item version, which is a unidimensional measure (D. S. Black et al., 2012). D. S. Black et al. (2012) evaluated the psychometric properties of the MAAS among Chinese adolescents. The selected six items had the highest factor loadings based on confirmatory factor analysis of the 15-item version over three months. The MAAS-6 item version demonstrated excellent internal consistency among this population (Cronbach's α = .89 - .93) and moderate test-retest reliability over 13 months (r = .35 - .52). Five of these six items emerged from Osman, Lamis, Bagge, Freedenthal, and Barnes (2015) investigation of the MAAS psychometric properties in a multiethnic group showing that this short version maintained the structure, score reliability, and the pattern correlates of the original version.

Multigroup Ethnic Identity Measure –Revised (MEIM-R; Phinney & Ong, 2007). The 6-item MEIM-R measures ethnic identity with two factors, exploration (e.g., "I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs") and commitment (e.g., "I feel a strong attachment towards my own ethnic group"). Responses are recorded on a 5-point Likert scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). An open question was included to ask the participants to indicate the ethnic group with which they identify. Herrington, Smith, Feinauer, & Griner's (2016) findings showed that Cronbach's α averaged .88 across 37 studies. The 6-item MEIM-R had a significantly greater internal consistency than the original 15-item scale. The reliability coefficients did not differ across study (e.g., number of variables measures in the study, survey length, gender, or ethnicity).

Negative Automatic Thoughts Questionnaire-8 item version (ATQ-N; Netemeyer et al., 2002). The ATQ-N (Hollon & Kendall, 1980) is a sensitive and specific 30-item measure of cognitions associated with depression. The 8-item version (Netemeyer et al., 2002), which is a unidimensional measure (e.g., "I'm worthless"), was used. Responses are recorded on a 6-point Likert scale, ranging from 1 (*not at all*) to 6 (*all the time*). Participants responded to each statement indicating how frequently, in the last week, those thoughts occurred. The reduced-item

version demonstrates excellent internal consistency (Cronbach's α = .85 - .92; Netemeyer et al., 2002).

Patient Health Questionnaire-9 (PHQ-9; Spitzer, Kroenke, & Williams, 1999). The PHQ-9 is a 9-item self-report measure of major depression symptoms (e.g., "Little pleasure or little interest in doing things"). Responses are recorded on a 4-point Likert scale, ranging from 0 (*not at all*) to 3 (*nearly every day*). Participants responded to each symptom statement indicating how often, in the last two weeks, they felt bothered by such symptoms. Total scores of 5, 10, 15, and 20 represent cut-off scores for mild, moderate, moderately severe and severe depression symptoms, respectively. The PHQ-9 has demonstrated excellent internal consistency (Cronbach's α = .86 - .89), sensitivity (.77 to .88), and specificity (.88 to .94; Kroenke, Spitzer, Williams, & Löwe, 2010). The PHQ-9 performed similarly across sex, age, and ethnicity. Yeung et al. (2008) validated the Chinese Bilingual version of the PHQ-9. Their findings indicated that the Chinese Bilingual version may be a useful screening instrument of depression among Chinese Americans in primary care.

5.2.3. Procedure.

Participants were recruited from social media, social network websites, migrant resource centres, and the university research pool. The participant information sheet, consent form, demographic questions (see Appendix D) and the standardised self-report questionnaires were provided in English (see Appendix E). Informed consent was obtained from all individual participants included in the study. The questionnaires along with the other materials were accessible online via Qualtrics survey software, but the option to complete the hard copies was offered to participants who did not have access to internet or preferred to complete the hard copy (n = 30). The demographic questions were presented first and thereafter the measures were randomised to control for potential order effects. The university students were granted coursework credit for participation and the community members had the option to enter a draw to win one of five $50 vouchers (see Appendix G for the flyer used to recruit community member; Appendix H for the advert used to recruit participants via the university research pool; and Appendix F for the terms and conditions of the draw).

5.2.4. Data analysis.

Prior to data analysis, SPSS 23.0 was used to screen for missing values and normality, and to calculate descriptive statistics, correlations, and internal reliability. The measurement models for each scale, and the hypothesised structural models, were tested using Mplus version 8 (Muthén & Muthén, 1998-2017). Robust Maximum Likelihood (MLR; Muthén & Muthén, 1998-2017), which accounts for non-normality in the data, was used as the estimator for all models. To determine model fit for the measurement and structural models goodness-of-fit indices, factor loadings, and modification indices were inspected. Goodness-of-fit indices included the chi-square statistics and degrees of freedom, which is highly sensitive to sample size and less useful as a measure of fit (Tabachnick & Fidell, 2007), Comparative Fit Index (CFI; values greater than .90 and .95 indicate an acceptable and excellent fit), Tucker-Lewis Index (TLI; values greater than .90 and .95 indicate an acceptable and excellent fit, Root Mean Square Error of Approximation (RMSEA; values close to .06 indicate an acceptable fit), and Standardised Root Mean Square Residual (SRMR; values close to .08 indicate an acceptable fit; L. T. Hu & Bentler, 1999). The Akaike's information criterion (AIC), the Bayesian information criterion (BIC), and the sample size adjusted BIC, were also considered when choosing the optimal structural equation model, particularly for models with interactions effects which do not yield absolute fit indices in Mplus, with smaller values indicative of superior fit (L.-C. Lin, Huang, & Weng, 2017).

5.3. Results

5.3.1. Preliminary analysis.

Data screening indicated only a slightly non-normal distribution as evidenced by skewness (i.e., <2) and kurtosis (i.e., < 7) values and examination of histograms. The missing data was 37 data points (i.e., 9.7% was the maximum proportion of missing data for any particular variable). The MLR was used to account for missing data. Importantly, MLR has been shown to be fairly robust if continuous variables are slightly non-normal (Finney & DiStefano, 2006). Cronbach's alphas for all measures were adequate (.71) to high (.81-.92) and participants in this study reported moderate depression symptoms (Table 7). Pearson's bivariate correlations between all study variables are reported in Table 8. Inspection of Pearson's bivariate correlations indicated moderate to large significant relations between automatic thoughts, brooding,

migration stress, mindful attention, activation, avoidance, and depression symptoms. Interestingly, there were no significant correlations between ethnic identity and the other scales, except for a small significant correlation with activation, avoidance, brooding, and loss, respectively.

TABLE 7

MEANS, STANDARD DEVIATIONS, AND CRONBACH'S ALPHAS (A)

Measure	*M*	*SD*	α
ATQ-8 items	1.89	.84	.92
Activation	4.21	1.16	.83
Avoidance	3.76	1.09	.78
Brooding Scale	2.10	.63	.81
DI	2.73	.90	.89
Loss	9.42	3.5	.82
Language	5.92	2.84	.85
Discrimination	8.46	3.93	.89
Not feeling at home	6.76	3.36	.90
MAAS-6 items	4.26	.97	.87
MEIM-R	3.41	.68	.83
Commitment	3.61	.76	.83
Exploration	3.21	.81	.77
PHQ-9	1.66*	.59	.89

*moderate depression symptoms

TABLE 8

PEARSON'S BIVARIATE CORRELATIONS BETWEEN ALL VARIABLES

	1	2	3	4	5	6	7	8	9	10	11	12
ATQ	-											
Activation	-.30**	-										
Avoidance	.41**	.18**	-									
Brooding	.60**	-.15**	.43**	-								
Discrimination	.23**	-.13**	.05	.13**	-							
Language	.23**	-.09	.10*	.24**	.39**	-						
Loss	.31**	-.08	.20**	.36**	.27**	.37**	-					
Not feeling at home	.35**	-.19**	.19**	.29**	.55**	.43**	.47**	-				
DI	.38**	-.17**	.19**	.34**	.75**	.69**	.70**	.82**	-			
MAAS	-.49**	.18**	-.42**	-.53**	-.14**	-.18**	-.28**	-.23**	-.29**	-		
MEIM	.04	.11*	.15**	.13**	-.03	-.03	.19**	.08	.08	-.08	-	
PHQ	.75**	-.24**	.44**	.56**	.30**	.27**	.37**	.41**	.46**	-.50**	.08	-

*$p < .05$; **$p < .01$.

5.3.2. Measurement models.

Structural equation modelling (SEM) is a statistical technique used to test the viability of causal models. SEM consists of two models, a measurement model and a structural model (Tabachnick & Fidell, 2007). Prior to testing the structural model, a confirmatory factor analysis was conducted in Mplus version 8 (Muthén & Muthén, 1998-2017) to test if the measurement model for each individual measure fits the data.

BADS (Manos et al., 2011). The measurement model of the BADS was evaluated and the two factor model included avoidance and activation, which was indicated by items within the respective subscales. The model displayed an excellent fit to the data χ^2 (27) = 71.16, $p < .001$, CFI = .96, TLI = .95, SRMR = .05, and RMSEA = .06 (90% CI [.05 to .08]). The standardised factor loadings were statistically significant (all *p*s < .001) and were moderate to high, ranging from .45 to .84. The latent variable explained between 21% and 71 % of the variance in the items.

Brooding Subscale (Treynor et al., 2003). The measurement model of the brooding scale demonstrated a poor fit to data, χ 2 (5) = 56.09, $p < .001$, CFI = .92, TLI = .84, SRMR = .05, and RMSEA = .16 (90% CI [.12 to .20]). The standardised factor loadings were statistically significant (all *p*s < .001) and were moderate to high (.59 to .77). The latent variable explained between 35% and 59 % of the variance in the items. Inspection of the modification indices (MI) showed that item 4 *("Why do I have problems other people don't have?"*) and 5 *("Why can't I handle things better*?") had a strong covariance (MI = 43.51). It is not clear why these items covaried strongly or if this will replicate in other sample. Considering that the aim of this study was to investigate the relationship between brooding, migration stress, mindful attention, automatic thoughts and avoidance in predicting depression symptoms, the covariance between items 4 and 5 was freed. The revised model displayed an adequate fit, χ 2 (4) = 16.96, $p < .001$, CFI = .98, TLI = .95, SRMR = .02, and RMSEA = .09 (90% CI [.05 to .14]). The standardised factor loadings were moderate to high, ranged from .57 to .72, and were statistically significant (all *p*s < .001). The latent variable explained 33% to 53% of the variance in the items.

DI (Aroian et al., 1998). The measurement model of the DI was evaluated and items within the four subscales were used as indicators of first-order latent variables labelled loss, language accommodation, discrimination, and not feeling at home in the receiving country. The four latent variables were then used as indicators of a second-order general migration stress

latent variable. The model displayed an adequate fit to the data χ 2 (2) = 14.22, p < .001, CFI = .97, TLI = .90, SRMR = .03, and RMSEA = .12 (90% CI [.07 to .19]). Although the RMSEA is higher than .06, no modifications were deemed theoretically defensible. The standardised factor loadings were statistically significant (all *ps* < .001) and were moderate to high, ranging from .55 to .83. The latent variable explained between 30% and 69 % of the variance in the items.

*MAAS (D. S. Black et al., 2012)***.** The measurement model of the MAAS scale demonstrated a good fit to data, χ 2 (9) = 29.81, p < .001, CFI = .98, TLI = .97, SRMR = .02, and RMSEA = .08 (90% CI [.05 to .11]). No further modifications were deemed theoretically defensible. The standardised factor loadings were statistically significant (all *p*s < .001) and strong, ranging from .67 to .79. The latent variable explained between 45% and 63% of the variance in the items.

*MEIM-R (Phinney & Ong, 2007).*The measurement model of the MEIM-R was evaluated and items within the two subscales were used as indicators of first-order latent variables labelled commitment and exploration. The commitment and exploration latent variables were then used as indicator of a second-order general ethnic identity latent variable. The model displayed a good fit to the data χ 2 (8) = 29.09, p < .001, CFI = .98, TLI = .96, SRMR = .04, and RMSEA = .08 (90% CI [.05 to .11]). Although the RMSEA is higher than .06, no modifications were deemed theoretically defensible. The standardised factor loadings were statistically significant (all *p*s < .001) and were moderate to high, ranging from .52 to .94. The latent variable explained between 27% and 79 % of the variance in the items.

ATQ-N-8 item version (ATQ-N; Netemeyer et al., 2002). The measurement model of the ATQ-N demonstrated an adequate fit to data, χ2 (20) = 131.56, p < .001, CFI = .95, TLI = .93, SRMR = .03, and RMSEA = .12 (90% CI [.10 to .14]), although the RMSEA was somewhat elevated. The standardised factor loadings were statistically significant (all *p*s < .001) and strong, ranging from .61 to .87. The latent variable explained between 38% and 76 % of the variance in the items. Inspection of the modification indices did not reveal any theoretically defensible covariances, therefore no further changes were made.

PHQ-9 (Spitzer et al., 1999). The measurement model of the PHQ-9 demonstrated an adequate fit to data, χ 2 (27) = 112.17, p < .001, CFI = .95, TLI = .93, SRMR = .04, and RMSEA = .09 (90% CI [.07 to .11]). The modification indices were inspected, however, no modifications were deemed to be theoretically defensible. The standardised factor loadings were statistically

significant (all *p*s < .001) and were moderate to high, ranging from .58 to .83. The latent variable explained between 34% and 70 % of the variance in the items. To summarise, the measurement model for BADS provided an excellent fit to the data, the models for MEIM-R and MASS were good, and the models for DI, PHQ-9, Brooding Scale, and ATQ-N were adequate (see Table 9 for goodness-of-fit statistics for each model). These measures appeared to be reliably assessing the underlying construct of interest, therefore were deemed appropriate to use in the structural equation model. The factor loadings within the models were moderate to high, ranging from .52 to .89.

TABLE 9

MODEL FIT INDICES FOR EACH SCALE INCLUDED IN THE MEASUREMENT MODEL

Scale	Chi-square test	df	CFI	TLI	RMSEA [90% CI]	SRMR
BADS	71.16*	27	.96	.95	.06[.05-.08]	.05
Brooding	16.96*	4	.98	.95	.09[.05-.14]	.02
DI	14.22*	2	.97	.90	.12 [.07-.19]	.03
MAAS	29.81*	9	.98	.97	.08[.05-.11]	.02
MEIM-R	29.09*	8	.98	.96	.08[.05-.11]	.04
ATQ	131.56*	20	.95	.93	.12[.10-.14]	.04
PHQ-9	112.17*	27	.95	.93	.09[.07-.11]	.04

Note. *p < .001.

5.3.3. Structural model.

The first structural model tested the hypothesis that the interaction between migration stress and ethnic identity would predict brooding and mindful attention, which in turn would predict automatic thoughts, activation, and avoidance, which ultimately would predict severity of depression symptoms (see Figure 3). First, the model was run without the migration stress by ethnic identity interaction, which yielded an AIC of 46683.00 and a BIC of 47261.40. The model was then re-run with the interaction as an additional predictor, which resulted in an increase in

the AIC (46685.79) and BIC (47272.17), suggesting a slightly poorer fit and no advantage of including the interaction. The absolute fit statistics for this model indicated an adequate fit to data and the more parsimonious model without the interaction was preferred χ^2 (844) = 1434.07, $p < .001$, CFI = .92, TLI = .91, SRMR = .06, and RMSEA = .04 (90% CI [.04 to .05]). The relationships between ethnic identity and brooding (β = .12, SE = .16, $p > .05$), and ethnic identity and mindful attention (β = - .07, SE = .09, $p > .05$) were not significant. The relationships between brooding and activation (β = - .13, SE = .10, $p > .05$), mindful attention and activation (β = .17, SE = .09, $p > .05$), and activation and depression symptoms (β = -.04, SE = .04, $p > .05$), respectively, were also non-significant. The relationship between mindful attention and automatic thoughts was also not significant (β = - .13, SE = .08, $p > .05$). Therefore, post hoc model modifications were performed to increase parsimony and ethnic identity and activation were removed from the hypothesised model. The non-significant pathway between mindful attention and automatic thoughts was also removed. The revised model (see Figure 4) provided an adequate fit to the data, χ^2 (595) = 1040.01, $p < .001$, CFI = .93, TLI = .92, SRMR = .06, and RMSEA = .04 (90% CI [.04 to .05]).

To investigate which components of migration stress were associated with brooding and mindful attention awareness, a model was then run with all components as separate predictors (discrimination, language, loss, not feeling at home) instead of the global migration stress variable. The goodness of fit indices indicated an acceptable fit to data χ^2 (968) = 1626.43, $p < .001$, CFI = .93, TLI = .92, SRMR = .06, and RMSEA = .04 (90% CI [.04 to .05]). However, the relationships between language and brooding (β = .10, SE = .07, $p > .05$), and discrimination and brooding (β = - .06, SE = .07, $p > .05$), were not significant. The relationships between language and mindful attention (β = - .02, SE = .07, $p > .05$), discrimination and mindful attention (β < - .01, SE = .07, $p > .05$), and not feeling at home and mindful attention (β = - .08, SE = .09, $p > .05$), were also not significant. Therefore, language and discrimination were removed along with the non-significant pathway between not feeling at home and mindful attention, and the model was run again. The final model (see Figure 5) displayed a good fit to the data, χ^2 (691) = 1191.05, $p < .001$, CFI = .93, TLI = .93, SRMR = .06, and RMSEA = .04 (90% CI [.04 to .05]).

The standardised parameters for the indirect effects were then calculated for the first part of the second hypothesis (H2a). The total indirect effect of loss to depression was significant (β = .31, SE = .05, $p < .05$, 95% CI [.10 to .27]). The indirect effect of loss, to brooding, to automatic

thoughts, to depression was significant (β = .24, SE = .04, $p < .05$, 95% CI [.08 to .22]), as was the effect from loss, to brooding, to avoidance, to depression (β = .05, SE = .02, $p < .05$, 95% CI [.01-.06]). However, the indirect effect of loss, to mindful attention, to avoidance, to depression was not significant (β = .02, SE = .01, $p > .05$, 95% CI [.00 to .03]). The total indirect effect of not feeling at home to depression was significant (β = .09, SE = .04, $p < .05$, 95% CI [- .00-.07]). The indirect effect of not feeling at home, to brooding, to automatic thoughts, to depression was significant (β = .07, SE = .03, $p < .05$, 95% CI [- .00-.06]), but the effect of not feeling at home, to brooding, to avoidance, to depression was not (β = .01, SE = .00, $p > .05$, 95% CI [.00-.02]*).* The standardised parameters for the indirect effects were not calculated for the second part of the second hypothesis (H2b) due to removing ethnic identity from the hypothesised model to increase parsimony.

5.4. Discussion

The aim of the present study was to examine the relationships between migration stress, ethnic identity, brooding, mindful attention, automatic thoughts, activation, avoidance, and depression symptoms in Chinese migrants. This study is unique in that it is the first to integrate migration stress and ethnic identity with the generic cognitive model in predicting depression in a migrant sample from a collectivistic culture. Better understanding the vulnerability factors for migrants associated with depression has critical implications for improving clinical engagement and treatment outcomes in a population underrepresented in counselling and therapy services (Blignault et al., 2008; Jim & Pistrang, 2007; Wynaden et al., 2005).

The first hypothesis was partially supported. A model comprising migration stress, brooding, mindful attention, automatic thoughts, avoidance, and depression was more parsimonious and better-fitting than the hypothesised model that also included behavioural activation and an interaction between migration stress and ethnic identity. The role of negative life events, conceptualised as migration stress in the current study, as an indirect predictor of depression symptoms is consistent with the GCM (A. T. Beck & Haigh, 2014; A. T. Beck et al., 1979), empirical evidence supporting the cognitive model (A. T. Beck, 2008; Scher et al., 2005), and the cross-cultural applicability of the model (Cui et al., 2013; Oei & Kwon, 2007).

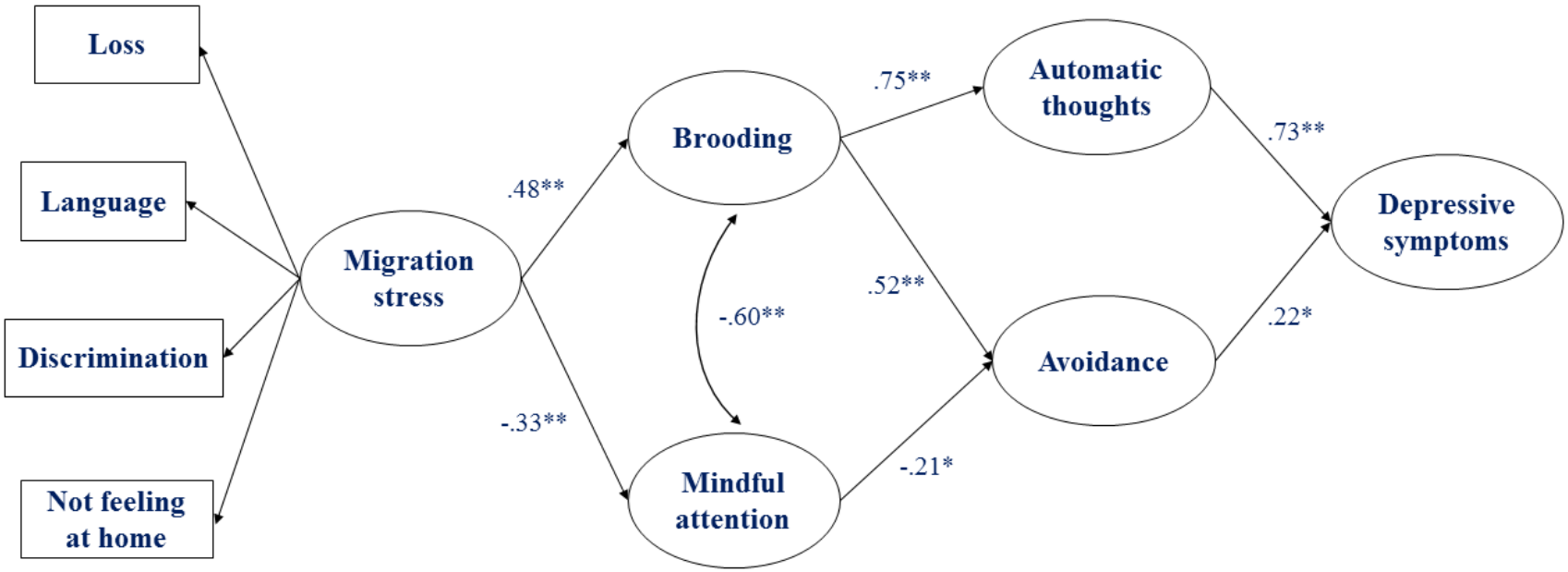

FIGURE 4. MODEL SHOWING THE RELATIONSHIPS BETWEEN THE COMPONENTS OF MIGRATION STRESS, BROODING, MINDFUL ATTENTION, AUTOMATIC THOUGHTS, AVOIDANCE, AND DEPRESSIVE SYMPTOMS; *P < .05; **P < .01.

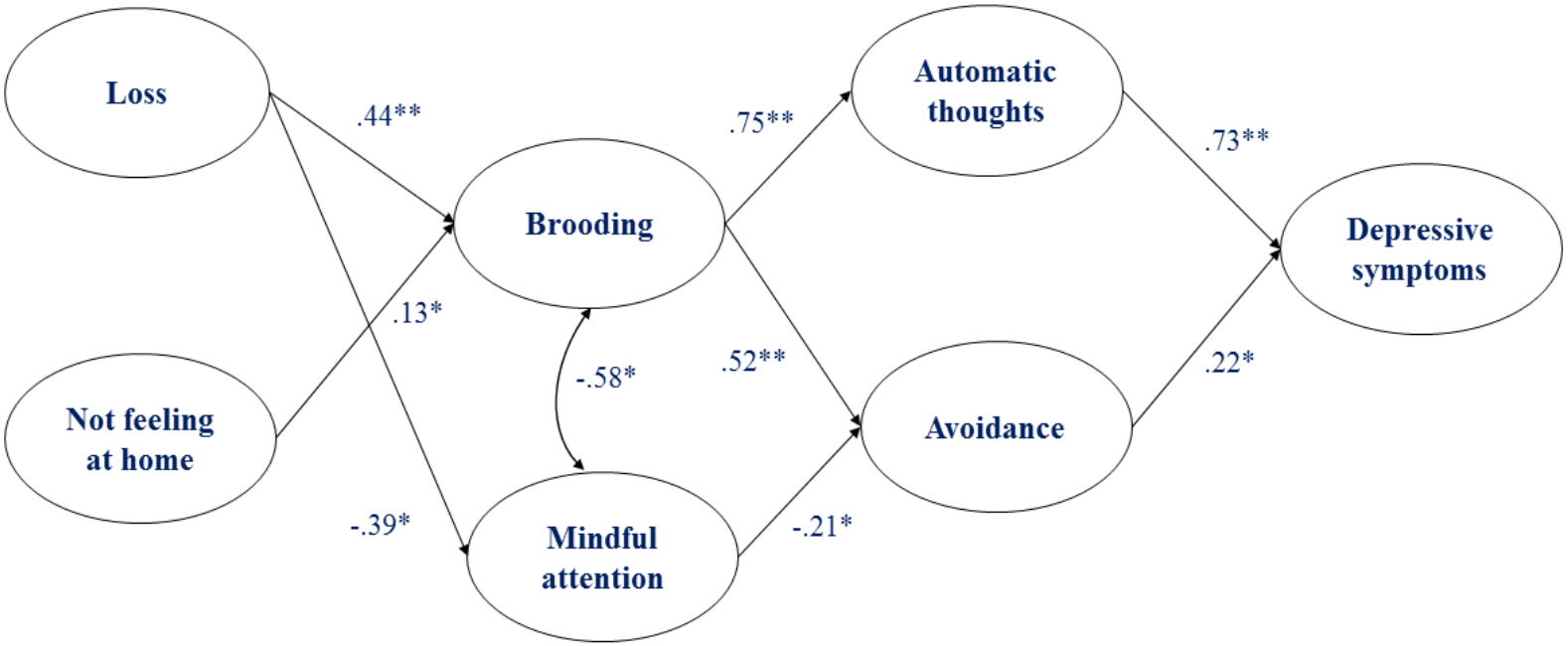

FIGURE 5. FINAL MODEL SHOWING THE RELATIONSHIPS BETWEEN COMPONENTS OF MIGRATION STRESS, INCLUDING LOSS AND NOT FEELING AT HOME, BROODING, MINDFUL ATTENTION, AUTOMATIC THOUGHTS, AVOIDANCE, AND DEPRESSION SYMPTOMS; *$P < .05$; **$P < .01$.

Only two aspects of migration stress (i.e., loss and not feeling at home) were associated with higher brooding and lower mindful attention, which in turn were associated with higher automatic thoughts and avoidance, which were ultimately associated with depression symptoms. The association between not feeling at home and depression aligns with prior work showing that wishing to return to the home country was associated with a significantly greater likelihood of experiencing distress and lower likelihood of experiencing flourishing, which is a central component of mental health (du Plooy, Lyons, & Kashima, 2018). Regarding the association between loss and depression, the present findings are consistent with previous research associating loss and grief with migration (Aroian & Norris, 2003; Casado et al., 2010; Casado & Leung, 2002; Wang, Wei, Zhao, Chuang, & Li, 2015). Specifically, loss-related scales among migrants have shown a strong significant correlation with depression symptoms (Casado et al., 2010; Casado & Leung, 2002) and a moderate significant correlation with negative affect (Wang et al., 2015). The grieving experience related to migration might be interpreted as disenfranchised grief, which occurs when a loss is not appropriately acknowledged in society (Doka, 1989). Casado et al. (2010) suggested that "the expectation that immigrants are supposed to adjust to their new host country proscribes societal dismissal of grief expressions over cultural and personal losses associated with immigration" (p. 612). Consequently, the experience of loss and not feeling at home might benefit from more careful consideration in psychotherapy, as well as the broader community.

Unexpectedly, language and discrimination were not associated with depression in this study. These findings are inconsistent with previous research showing that a lower level of English proficiency was associated with higher levels of depression (Sumer, Poyrazli, & Grahame, 2008; Yeh & Inose, 2003), and perceived discrimination was associated with greater odds of having depression within the past 12 months among Asian Americans (e.g., Chinese, Vietnamese; Gee, Spencer, Chen, Yip, & Takeuchi, 2007) and negative health and mental health outcomes (Pascoe & Richman, 2009). The new country of residence, in this case Australia, might have a significant influence on migrants' experiences. There are several aspects of the country of residence that might contribute to a unique migration experience. First, Australia is one of the most culturally and linguistically diverse countries in the world, with Chinese migrants being the third largest group of overseas-born residents (ABS, 2017). Second, research conducted in Australia has shown a positive attitude towards multiculturalism (Dandy & Pe-Pua, 2010; Kamp,

Alam, Blair, & Dunn, 2017; A. Markus, 2017). More precisely, 80.4% of the participants in one survey agreed that "it is a good thing for a society to be made up of different cultures" (Kamp et al., 2017, p. 66), while 75% of respondents to another survey endorsed the view that "multiculturalism has been good for Australia" (A. Markus, 2017, p. 64). Some of the positive aspects of cultural diversity that have been identified include enriching the Australian culture, the economy, and broadening people's perspectives and views about the world by making them more accepting of others and less biased (Dandy & Pe-Pua, 2010). Lastly, Australia has been characterised by a horizontal individualism, which involves an emphasis on equality, a tendency to reject hierarchy and power differentiation among individuals based on social rank and role, and a tendency towards cooperative decisions (X.-P. Chen & Li, 2005; Triandis et al., 1988). The current results might be explained by the compounded effect of the positive attitude towards multiculturalism and horizontal individualism, although further research is required. Another possible explanation might be related to sampling bias. Because the majority of the participants were highly educated and reported being students, it is reasonable to assume that they had a strong command of English and were less likely to be discriminated against in a university context.

Consistent with previous research, we found a strong negative correlation between brooding and mindful attention (Burg & Michalak, 2011). Brooding was also associated with higher levels of automatic thoughts, while higher brooding and lower mindful attention were both associated with more avoidance. The findings about the role of automatic thoughts is consistent with the more broader literature on the strong association with depression symptoms (C. Hill et al., 1989; Lamberton & Oei, 2008) and with studies highlighting a mediating role in the relationship between migration stress and depression symptoms (Cui et al., 2013; Oei & Kwon, 2007). It appears that avoidance was a much better predictor of depression than activation in the present sample. These findings are consistent with previous studies showing that avoidance holds a stronger link to depression (Li et al., 2014; Manos et al., 2010; Shudo et al., 2017).

Contrary to the first hypothesis, the relationships between migration stress and brooding, and migration stress and mindful attention, were not moderated by ethnic identity. The present findings are consistent with the line of evidence showing that ethnic identity had no direct effect on the risk of depression (Beiser & Hou, 2006; Noh et al., 1999; Yip et al., 2008). The way

individuals feel about their ethnic group may influence their migration stress experience and their response to cultural incongruities (Lantrip et al., 2015). Around 30% of the participants in this study described hyphenated identities (e.g., Chinese-Australian, Chinese-Malaysian), which suggests that they held multiple, flexible, and context dependent identities related to nationality and ethnicity (Sala, Dandy, & Rapley, 2010). It is possible that the participants developed cross-cultural boundaries and the ability to navigate through cultural environments without feeling disoriented (S. Liu, 2015). Another possible explanation is the fact that the participants live in a cultural environment that favours multiculturalism (Dandy & Pe-Pua, 2010; Kamp et al., 2017; A. Markus, 2017) and therefore their ethnic identity is not affected. In other studies, ethnic identity buffered against perceived discrimination (Huynh, Devos, & Goldberg, 2014; Lantrip et al., 2015; Mossakowski, 2003), but in this study stress related to discrimination was not associated with depression. As such, it is possible that ethnic identity plays a protective or exacerbating role when individuals are more likely to experience discrimination and therefore it is not so surprising that automatic thoughts and avoidance are more proximal variables to depression than ethnic identity. The moderating role of hyphenated identities in the relationship between migration stress and depression requires further exploration.

The second hypothesis that indirect effects between migration stress and depression symptoms (H2a), would be significant, was partially supported. When investigating individual components of migration stress, the indirect effect of loss to depression was significant, as was the effect of not feeling at home to depression. The experience of loss may increase the risk of depression symptoms by increasing the frequency of brooding, which in turn increases the frequency of automatic thoughts and avoidance. The pathway from loss to mindful attention, to avoidance, to depression was not significant. These findings were unexpected because theory (A. T. Beck & Haigh, 2014) and existing empirical evidence (Brown & Ryan, 2003; Burg & Michalak, 2011; Sauer & Baer, 2012; Watkins & Teasdale, 2004) suggest that mindful self-focus is adaptive, and therefore loss and mindful attention, and mindful attention and avoidance, are expected to be significantly inversely related. It is possible that higher levels of mindful attention were not associated with less avoidance because avoidant emotional coping has been found one of the preferred coping strategies of Chinese individuals (Mortenson, 2006) regardless of their level of mindfulness. More research is required to investigate this unexpected result. In addition, not feeling at home may increase the risk of depression symptoms by increasing the frequency of

brooding, which in turn may increase the frequency of automatic thoughts. The pathway from not feeling at home to brooding, to avoidance, to depression was not significant. It appears that avoidance plays only a weak and non-significant role in the indirect relationship between not feeling at home and depression, although avoidance was significantly associated with brooding, mindful attention, and depression symptoms. The second part of the hypothesis that indirect effects between ethnic identity and depression symptoms (H2b), would be significant, was not supported. Ethnic identity was removed from the hypothesised model to increase parsimony, and therefore the indirect effect was not calculated.

5.4.1. Clinical implications.

Globalisation involves an interaction between cultures, which may influence how people think about the world and themselves (Sagar Sharma & Sharma, 2010). Therefore, a therapeutic approach deriving from the cognitive model has the potential to be an agent for positive cultural change by facilitating the exploration of different perspectives and discourse style (Hodges & Oei, 2007). The current findings have important clinical implications for developing a culturally sensitive version of CBT for Chinese migrants with depression. Cognitive restructuring could be used with the aim of examining and reframing the experience of loss and not feeling at home. There are two types of loss that need to be considered—physical loss, which refers to tangible losses (e.g., loss of extended family), and symbolic loss which refers to intangible or abstract losses (e.g., loss of status; Casado et al., 2010). When the gains after migration are perceived as outweighing the losses, migration is considered a worthwhile effort, which has a positive impact on the motivation to integrate in the new country of residence (Cerdin, Diné, & Brewster, 2014). Acknowledging, validating, and normalising the feelings towards their home country (Casado et al., 2010), exploring and redefining the meaning of home, and exploring the advantages for self and significant other of living in the country might be of benefit. Consequently, cognitive techniques might also be used to identify the benefits of migration at an intellectual level, while behavioural activation might be used as an experiential technique to explore the new country of residence, engage in the activities that were part of their routine before migration, and explore new activities, and therefore increase the strength of new core beliefs about one's own migration experience (J. S. Beck, 2011).

Mindfulness techniques may be incorporated into CBT interventions with the aim of helping the clients to be in the present moment, which might reduce brooding and the tendency

to perseverate on negative cognitive content, which in turn, might reduce the frequency of automatic thoughts. Additionally, including mindfulness techniques may reduce avoidance behaviours associated with depression. Considering that avoidance was more strongly associated with depression than activation in this study, incorporating behavioural experiments and situation exposure hierarchies might address a potential vulnerability factor in Chinese migrants.

Although ethnic identity did not moderate the relationship between migration stress and depression, small significant correlations with activation, avoidance, brooding, and loss, respectively were found. As such, exploring the meaning of ethnic identity and the impact of migration on ethnic identity might reveal new useful insights for therapy. Individuals may demonstrate multiple positioning in their identity construction and negotiation, despite shared language, birthplace, and social practices (Sala et al., 2010). For instance, American-born Asians are inclined to have a bidimensional model of cultural orientation, while overseas-born Asian are inclined to have a unidimensional model, showing that culture might not have the same meaning across ethnic groups (J. L. Tsai, Ying, & Lee, 2000). The focus, belief and behaviour techniques might facilitate the cognitive change required to reduce depression symptoms and assist individuals to produce and create their own adaptation (Anderson, 1994).

5.4.2. Limitations and directions for future research.

The cross-sectional design of the study prevents causal inferences about the directional influence of migration stress on depression symptoms, so future prospective studies are required. The English version of the questionnaires was used in this study, which might have hampered individuals with low English skills participation. Therefore, future research is required to provide the Chinese and/or the English version of the questionnaires. The ethnic identity scale (Phinney & Ong, 2007) used in this study did not measure hyphenated identities or sense of belonging to the new country of residence (i.e., Australia). Further, changes in the circumstances in which individuals leave their country of origin (e.g., push such as war or persecution, versus pull factors such as work or lifestyle opportunities) were not investigated. Therefore, future research is required to consider these factors and possible implications for ethnic identity. Using another ethnic identity scale that measures multiple identities that are not part of the same continuum (e.g., measuring the multiple identity of an individual with a Chinese-Singaporean background and belonging to Australia) might yield new insights into the relationship between multiple ethnic identities and mental health. As such, research is required to replicate these findings and

examine whether the current results generalise to other Chinese communities. The participants in this study did not necessarily have a diagnosis of depression, so replicating the study in a sample with Chinese participants with clinical depression might contribute to a deeper understanding of the specific vulnerability factors.

Despite these limitations, the current study makes an important contribution to the literature by examining important factors associated with depression vulnerability within a migrant population. The results of this study indicate that only two aspects of migration stress (i.e., loss and not feeling at home) were associated with higher brooding and lower mindful attention, which in turn were associated with higher automatic thoughts and avoidance, which were ultimately associated with depression symptoms. Loss and not feeling at home may be targeted with cognitive, behavioural, and mindfulness techniques. As such, these findings have potentially important clinical implications for enhancing the cultural sensitivity of CBT for depression within a migrant population that is underrepresented in counselling and therapy services.

"Research in cultural–clinical psychology should tell us something new about the cultural contexts under study, not just the pathologies."

(Ryder, Ban, & Chentsova-Dutton, 2011, p. 962)

Chapter 6: General Discussion

6.1. Review of Thesis Objectives

In this era of globalisation and increased mobility, migrants' mental health represents a cause of concern as they may face dual vulnerabilities due to cultural and structural barriers to treatment. Chinese migrants are the largest non-English speaking group in Australia, yet studies have found that they report low use of mental health services and are inclined to delay treatment until their mental health problems become severe, which significantly increases the personal, social, and economical costs of treatment. Depression is a common mental disorder among Chinese migrants in multicultural societies including Australia. Given the promising evidence in the current literature (reviewed in Chapter One), for the efficacy of CBT for depression and the compatibility between CBT and Chinese values, the overarching aim of this research program was to investigate cultural adaptations of CBT for depression symptoms in Chinese migrants living in Australia. The present research sought to contribute to the development of culturally adapted psychological treatments, which is thought to be a possible solution to improve client engagement and treatment outcomes in populations that are underrepresent in psychological services.

Using a mixed-method research design, this research program comprised: (1) a scoping review mapping the current literature on CBT for depression and comorbid anxiety in Chinese nationals and migrants, with a particular focus on cultural adaptation frameworks, cultural modifications to therapy, consultations with clinicians and consumers, and clients' experience undergoing therapy; (2) a qualitative study documenting clinicians' and community members' perspectives on the cultural adaptation of CBT to Chinese migrants to Australia, with an emphasis on the specific and non-specific factors of CBT; and (3) a quantitative study integrating migration stress and ethnic identity with the GCM, including brooding, mindful attention, automatic thoughts, activation, and avoidance, to predict depression in Chinese migrants. Each study informed the next study and contributed to addressing the overall research aim.

6.2. Summary of Major Findings

This research program contributes to the fidelity-adaptation debate by employing a three-study research program. Researchers have long questioned whether evidence-based treatments should be provided to culturally and linguistically diverse groups with fidelity to original treatments or whether an intervention-consumer mismatch requires cultural adaptation (Castro et al., 2010; Chu & Leino, 2017). The present findings favour the need for adaptations to evidence-based treatments to reduce disparities between culturally and linguistically diverse groups in accessing mental health services and provide more relevant and engaging treatments (see Figure 6 for a summary of non-specific and specific factors of a culturally sensitive version of CBT).

6.2.1. Study one.

Study One sought to provide a comprehensive and in-depth review of studies of CBT for depression and comorbid anxiety in Chinese nationals and migrants by capturing a wider range of evidence than previous reviews (e.g., case studies, qualitative studies). Consistent with previous meta-analyses and systematic reviews (Chowdhary et al., 2014; Chu & Leino, 2017; Kalibatseva & Leong, 2014; T. K. Ng & Wong, 2018), the findings of the scoping review provide support for the efficacy of CBT with or without comorbid anxiety in Chinese nationals and migrants. Cultural adaptations to peripheral (e.g., directive approach, cultural metaphors) and core components (e.g., 5 senses approach, adjustments to cognitive restructuring) of CBT have been identified. These peripheral and core adaptations appear to be grounded in Chinese cultural values such as interpersonal harmony, conforming to familial and societal norms, respect for authority figures, and a strong sense of attachment to the group of origin (B. S. K. Kim et al., 2001). The incorporation of relaxation techniques into CBT interventions for depression, which is not common, may target depression expression in Chinese people (i.e., tendency to somatise distress).

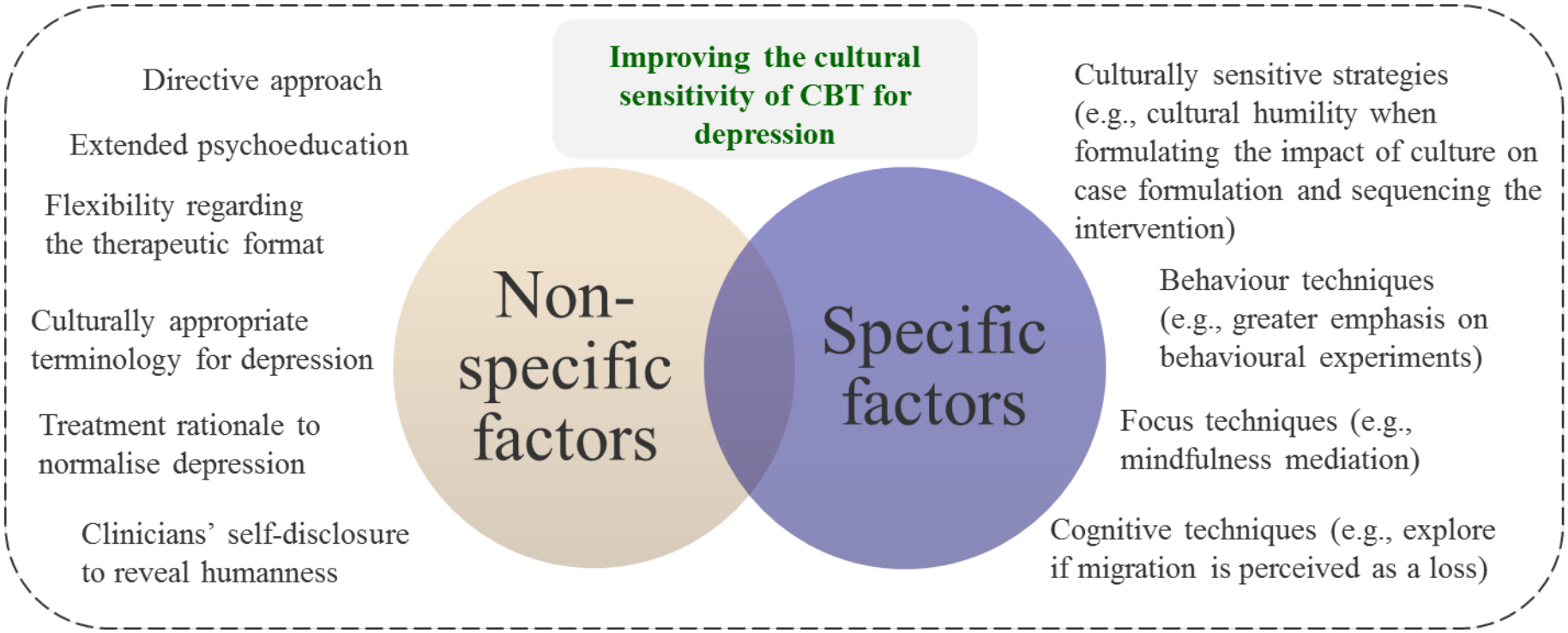

FIGURE 6. SUMMARY OF NON-SPECIFIC AND SPECIFIC FACTORS FOR IMPROVING THE CULTURAL SENSITIVITY OF CBT FOR DEPRESSION IN CHINESE MIGRANTS LIVING IN AUSTRALIA.

This scoping review highlighted a number of gaps in the existing literature, including limited use of cultural adaptation frameworks (i.e., FMAP, Hwang, 2009) for adapting CBT for depression in Chinese migrants internationally, and no cultural adaptation frameworks used in adapting CBT for depression in Chinese migrants to Australia, in particular. There is a high degree of variability in involving clinicians and consumers in the cultural adaptation process of CBT (e.g., focus groups with clinicians; interviews with lay community members; consumers and health providers reviewing treatment materials). The extent to which a CBT intervention needs to be culturally adapted to improve client engagement and treatment outcomes is not clear. As a result, Study Two aimed to address these gaps by using the FMAP to document both clinicians and Chinese community members' perspectives on cultural adaptations of CBT. The key advantage of using cultural adaptations frameworks is the emphasis on consultations with clinicians and consumers to inform the entire process of development, pilot testing, and refinement of culturally adapted treatments (Castro et al., 2010). Clinicians are responsible for delivering psychological treatments, while consumers are recipients of treatments and are directly affected by clinicians' decisions regarding treatment. Therefore, documenting and corroborating both perspectives offers a solid base for Study Two and is critical for ensuring the development and delivery of relevant and engaging treatments for Chinese migrants who are the largest non-English speaking group in Australia.

6.2.2. Study two.

Study Two built upon the findings of Study One through consulting both clinicians and Chinese community members on cultural adaptations to CBT for depression symptoms in Chinese migrants. This study contributed to a deeper understanding of the cultural adaptation to the specific and non-specific factors of CBT and it is unique in that it is the first qualitative study building on two theoretical frameworks, including FMAP (Hwang, 2009) and the GCM (A. T. Beck & Haigh, 2014). The findings of this study revealed unique cultural adaptations to Chinese migrants to Australia, but also common cultural adaptations to those from Canada (Shen et al., 2006), Hong Kong (P. Ng et al., 2013; D. F. K. Wong, 2008a, 2008b), the UK (Jim & Pistrang, 2007), and the USA (Chu et al., 2012; Hwang, 2006, 2009; Hwang et al., 2015; Kim-Goh et al., 2015).

6.2.2.1. Main findings on specific factors of CBT.

One of the unique findings regarding cultural adaptations to specific factors of CBT was that at the centre of psychotherapy with Chinese clients is an interdependent self. People with an interdependent self are likely to have a sense of self that incorporates social relationships and therefore the self may include the significant others (Hequin, 2005). Considering this line of evidence, it is sensible to question the transportability of cognitive techniques. The findings of this study indicated that using cognitive restructuring may have a detrimental effect in therapy because modifying culturally-defined core beliefs may be inappropriate (Hays, 2009; E. T.-H. Liu, 2007; Shen et al., 2006), and might destabilise clients' identities and relationships with significant others (Kirmayer, 2007). Although clinicians in this study had diverging views about the level of beliefs that needs to be targeted in cognitive restructuring, the majority suggested the examination and modification of automatic thoughts and intermediate beliefs not related to an interdependent self. Another important aim of using cognitive techniques was to explore if migration is perceived as a loss, which is consistent with Hwang's (2006) findings emphasising the importance of being aware of life experiences that may represent additional stressors or may increase clients' risk of developing mental disorders.

The transportability of behavioural techniques was not questioned by the participants in this study. Overall, it was thought that behavioural activation might be compatible with fundamental Chinese values and might capitalise on Chinese clients' pragmatic and problem-solving mindset (Hwang, 2009; Shen et al., 2006). Additionally, it was suggested that behavioural experiments might facilitate perspective change through new experiences, which is another key findings of this study. Further, it was emphasised that sleeping hygiene techniques might be used to address somatic issues such as sleeping problems early in the treatment, which might be particularly beneficial as Chinese clients tend to somatise distress.

Despite not practicing mindfulness meditation, a positive attitude towards mindfulness meditation was documented among the community members in this study. Although A. T. Beck and Haigh (2014) suggested the incorporation of mindfulness meditation into CBT, no clear guidelines have been published in peer reviewed articles on how this might be translated in terms of therapy. Given the community members' curiosity and openness to practice mindfulness meditation, the evidence that mindfulness meditation might play an essential role in cross-cultural adaptation (Kashima et al., 2017), and A. T. Beck and Haigh's (2014) recommendations,

an important challenge for clinicians is to incorporate mindfulness meditation without changing CBT's core tenets.

Another critical and unique finding of this study is incorporating core culturally sensitive strategies into CBT. Cultural humility and a greater emphasis on health and wellbeing appear to be fundamental to a culturally sensitive version of CBT techniques. Cultural humility seems to be consistent with the dynamic definition of culture according to DSM-5 and might be particularly useful in better understanding clients' cultural heritage and capturing possible changes over time of values, beliefs, and practices without making any assumptions. Additionally, understanding the social and historical context of clients and their families might shed light on their perspectives on psychological treatments. For instance, it might be particularly useful to detect possible misconceptions about psychology that were common during the Cultural Revolution, when psychology was perceived as being "90% useless" (Bond, 1991; D. Zhang, 1995), to assist clients in reducing stigma, and possibly self-stigma, attached to mental disorders. Another core culturally sensitive strategy identified in this study was greater emphasis on health and well-being, which may better address depression expression in Chinese culture. There is evidence that acculturation reduces the tendency to assign a somatic explanation to a psychological symptom (H. Chen et al., 2003; Parker et al., 2006; Parker et al., 2005), and therefore changes in the conceptualisation and communication of distress may be expected among the more acculturated Chinese migrants.

6.2.2.2. Main findings on non-specific factors of CBT.

Both the specific and non-specific factors of CBT are needed to reduce the disease burden of depressive disorders (Ilardi & Craighead, 1994). With respect to non-specific factors, the findings from the present study and those from studies conducted in Hong Kong, the UK, and the USA provide compelling evidence for using a directive approach (Chu et al., 2012; Hwang, 2009; Jim & Pistrang, 2007; Kim-Goh et al., 2015; P. Ng et al., 2013; D. F. K. Wong, 2008a), providing extended psychoeducation (Chu et al., 2012; Hwang et al., 2015; Kim-Goh et al., 2015), considering therapy with a support person (Chu et al., 2012; Kim-Goh et al., 2015), using culturally appropriate terminology (e.g., using client's language; Choi et al., 2012; Chu et al., 2012; Hwang, 2009; D. F. K. Wong, 2008a), and clinicians' self-disclosure to reveal their humanness (Jim & Pistrang, 2007). These findings are interesting given that these studies have been conducted in countries with a different cultural profile, including Australia (i.e., horizontal

individualism), Hong Kong (i.e., vertical collectivism), the UK and the USA (i.e., both have been characterised by vertical individualism; Shavitt, Torelli, & Riemer, 2011). A possible explanation for these results may be that the common non-specific factors identified across studies reflect fundamental values (e.g., harmony, family) that are well preserved by Chinese communities, and consequently less influenced by the cultural profile of the countries of residence. Providing extended psychoeducation and using culturally appropriate terminology is understandable given that social and political factors have significantly affected the practice and general perception of psychotherapy in China (Tseng, Lee, & Qiuyun, 2005). Interestingly, clinicians' self-disclosure was considered important only by the Chinese community members in the present study and Chinese participants in a study conducted in the UK (Huang & Spurgeon, 2006). A possible explanation may be that Australia has a British colonial past, which had a major influence on social norms and interpersonal communication (Australian Institute of Family Studies, 1995). Further, a study that examined language and communication in various countries clustered English spoken in Australia and the UK. It was found that self-disclosure in personal communication was preferred only by Australians and British individuals (Zander, 2005).

Several distinctive cultural adaptations to the non-specific factors were documented in my Australian sample. First, participants emphasised the importance of using a directive approach and clinicians self-disclosure at the same time, which seems counterintuitive. It seems that Chinese community members in this study expected a hierarchical psychologist-client relationship, but at the same time they stated that would value the humanness of a psychologist who is perceived as the authority figure. Further, it is important to note that clinicians' self-disclosure to reveal humanness is one of the few general themes in the present study. While adjusting to the new country of residence, migrants are likely to both "give to and take from their environments" (Anderson, 1994, p. 301). Their interpersonal communication model might be influenced by the Australian model, which might influence their views on hierarchical relationships.

Although there is a consensus on using a culturally sensitive and de-stigmatising language in the literature, the present findings revealed that only the community members with low English skills preferred the term "a closed heart" to describe depression, which is inconsistent with Choi et al.'s (2012) findings. Though the importance of heart metaphors for feelings has been documented in previous studies (D. T. S. Lee et al., 2007; Pritzker, 2007), one

cannot assume that Chinese clients will resonate with these metaphors. Unexpectedly, the linguistic repertoire of the community members with a stronger command of English included Western terms for depression symptoms (e.g., unhappy, feeling down). As such, cultural humility may be a critical tool in identifying each client's own terminology for depression and may ultimately assist with clinical engagement. Another distinctive cultural adaptation to non-specific factors to Chinese migrants to Australia is the emphasis on providing a treatment rationale that participants can connect with at an intellectual and emotional level. This finding may be interpreted as a holistic approach that incorporates both the mind and the heart, which are fundamental concepts in the traditional Chinese medico-philosophical theory (Pritzker, 2007).

It is important to note that diverging views regarding cultural adaptations to CBT have been documented among self-identified CBT therapists and non-CBT therapists. Overall, CBT therapists proposed no major cultural adaptations to cognitive and behavioural techniques, they reported using the term homework in therapy, and they were providing homework to their Chinese clients. In contrast, non-CBT clinicians suggested modifications to cognitive techniques and stressed the importance of the level of beliefs targeted during cognitive restructuring. Additionally, the non-CBT therapists considered that the term homework sounds mandatory and preferred to not use it in therapy. The benefit of documenting diverging perspectives is questioning the efficacy and acceptability of CBT for Chinese migrants to ultimately improve clinicians' capability to provide CBT to Chinese clients. Overall, it appears that the efficacy and acceptability of CBT might increase with the awareness of cultivating cultural humility and incorporation of techniques that are addressing an interdependent self.

6.2.3. Study three.

Study Three evolved from the findings of Study Two that highlighted the important roles of migration stress (i.e., trigger for depression) and ethnic identity (i.e., potentially negative impact on mental health of losing one's own identity after migration or being stereotyped because of one's identity) in developing depression. Study Three added to the cross-cultural literature by integrating migration stress and ethnic identity with the GCM in predicting depression in Chinese migrants. Only two aspects of migration stress (i.e., loss and not feeling at home) were associated with higher brooding and lower mindful attention, which in turn were associated with higher automatic thoughts and avoidance, which were ultimately associated with depression symptoms. These findings are consistent with (a) a previous study

showing that wishing to return to the home country was associated with a significantly greater likelihood of experiencing distress (du Plooy et al., 2018), and (b) the literature associating loss and grief with migration (Aroian & Norris, 2003; Casado et al., 2010; Casado & Leung, 2002; Wang et al., 2015). Unexpectedly, the findings of this study indicate that language and discrimination were not associated with depression. Living in a culturally and linguistically diverse country with a positive attitude towards multiculturalism might explain the present findings (ABS, 2017; Dandy & Pe-Pua, 2010; Kamp et al., 2017; A. Markus, 2017). As such, the attitude of the residents of Australia towards culturally and linguistically diverse groups might play a critical role in reducing the negative impact of language and discrimination on mental health. Importantly, loss and not feeling at home might be less influenced by the attitudes of the residents of the new country of destination and by the cultural profile of the new country of destination. In this study, these two aspects of migration stress may be related to Chinese participants' cognitive triad (i.e., views of themselves, their significant others, and the world), their migration experience, and their reframing of migration (i.e., a gain or a loss). Given that loss and not feeling at home appear to be specific vulnerability factors for migrants, it would be sensible to explicitly target them in therapy.

6.3. Clinical Implications

The findings of this research program provide in-depth insights into "a way of doing" and "a way of being" in therapy with clients from culturally and linguistically backgrounds, to ultimately benefit both the clinicians and the consumers. One of the unique findings regarding cultural adaptations to CBT was that at the centre of psychotherapy with Chinese clients is an interdependent self. As a result, cognitive, behavioural, and attentional focus techniques need to be culturally adapted to ensure compatibility with an interdependent self's idiosyncratic pattern of thinking, feeling, and behaving (H. R. Markus & Kitayama, 2010). Because loss and not feeling at home have been associated with depression in this thesis, it is critical to examine each client's perspective on these important demands of immigration and address these factors with cognitive, behavioural, and attentional focus techniques. Cognitive restructuring might be used to explore alternative perspectives and give new meaning to what was lost and what is gained for the self and significant others. Additionally, cognitive techniques might need to be modified in the sense of examining and modifying automatic thoughts and intermediate beliefs not related to an interdependent self to prevent a clash of values generated by challenging teachings from

clients' parents (e.g., do your best) and misinterpreting relaxing their "shoulds" as evidence of not being able to work hard and make the required effort to make a living in a new country, which might reinforce helplessness core beliefs. Behavioural experiments might be especially useful to facilitate change through new experiences and could reinforce new healthy core beliefs. Behavioural activation may be used with multiple aims. For instance, behavioural activation may be used as an experiential technique to explore the new country of residence, engage in the activities that were part of their routine before migration, and explore new activities. In this sense, behavioural activation might be used as a tool for facilitating integration into new the country of residence. Integration has been found to be a more effective acculturation strategy compared to other strategies (e.g., assimilation, separation; Berry, 2005). Additionally, being active in community could increase the client's sense of pleasure and mastery, which might reduce isolation. Mindfulness techniques might be incorporated into CBT by teaching clients an adaptive self-focus via mindfulness meditation. By practicing mindfulness meditation, clients could learn to be in the present moment, which might reduce brooding over losses and not feeling at home, which in turn might reduce the frequency of automatic thoughts specific to depression. Further, clients could learn to refocus their attention on the positive aspects of their new life after migration and the possible positive implications for the life of their significant others. In other words, clients could learn to see the glass half full, which might prevent the interaction between the brooding, automatic thoughts, and avoidance, which according to the GCM initiates psychopathology. Importantly, cognitive, behavioural, and attentional focus technique may be used to provide more complex interventions to ensure symptom change and strengthening a healthy pattern of thinking, feeling, and behaving.

Cultivating cultural humility is the most important finding from this research program related to "a way of being" a therapist. As discussed in Chapter One, cultural humility requires a shift in therapist attitude and thinking from developing culture-specific expertise to learning from clients about their culture and worldviews (Owen et al., 2015). The distinctive features of cultural humility are allowing clinicians to learn from clients about their social and historical context, current fundamental values, and inner world without the risks of stereotyping. Importantly, cultural humility might play a pivotal role in collecting, contextualising symptom expression, integrating, and formulating information into a set of hypotheses about the

mechanisms that are causing and maintaining the client's condition (Dobson & Dobson, 2017). Developing a culturally sensitive case formulation has crucial implications for planning and sequencing a culturally sensitive intervention.

The following example is presented to illustrate the incorporation of cultural humility and facilitating a values-based understanding. Anne is a 25-year-old Singaporean Chinese woman who migrated to Australia. She accessed a university counselling service after experiencing depressive symptoms including insomnia, feeling sad and crying most of the time, and social withdrawal. The CBT therapist is a 32-year-old European-Australian woman.

Therapist: What brings you here today?

Client: My friends encouraged me to see a Psychologist. They are worried about me, but I don't really understand why.

Therapist: What do you think made them encourage you to see a Psychologist?

Client: They are worried because I'm not getting enough sleep. My housemate knew that I barely slept four hours. They say I look unhappy but I don't agree, I'm fine.

Therapist: Where there any times when you were getting enough sleep after moving to Australia?

Client: Perhaps I was sleeping more in the first months after moving here, but I always had issues in falling asleep.

Therapist: We'll come back to your issues in falling asleep, but now I'm wondering what made your friends worry about you only recently.

Client: Hmmmm …they say I look very tired and unhappy all the time and I pretty much always talk about Singapore.

Therapist: Are you feeling unhappy?

Client: I don't know…. I feel homesick…

Therapist: What do you miss the most?

Client: I miss my mum, the food and the places…

Therapist: That is understandable. Moving to another country is a life changing experience. Feeling homesick is very common for people who move to another country. You said you miss your mum. Are there any other family members you miss?

Client: Hmm…I'm not a family person, but don't get me wrong, family it's still important for me, but I want to make my own decisions…. I guess I miss my mum the most.

Therapist: "I'm not a family person" is a strong statement. What does this mean to you?

Client: Hmm people expect me to be a family person because I'm Chinese, but I'm not. They are important for me but I won't make sacrifices for my family like my mum did…I want to be free to do whatever I want…travel the word and be adventurous…

Therapist: Ok, let me check if I got this right…So being a family person means to be concerned for your family wellbeing and do everything for them, including sacrifices… Their needs come first and yours second… Am I getting this right?

Client: Yes, I learned respect for parents and elders and this is still important for me but I also learned freedom and independence from the Western culture…I want to do things that my mum couldn't.

Therapists: It seems that you are stuck between two worlds with slightly different value systems and finding a balance between these value systems is a big challenge that makes you feel uneasy. Also, it seems to me that you want to travel the world and be adventurous but at the same time you miss your mum, food, and places from Singapore which means that you may experience an internal conflict.

Client: Yes…it's very strange…I was so happy to come here and I didn't expect to miss anyone, not even my mum …I don't know what to do…

In this dialogue, cultural humility and facilitating a values-based understanding is reflected by not making any assumptions about the fundamental values in the Chinese culture. Asking open-ended questions, being curious, and pointing out the conflict between core values are essential components that contribute to cultural humility. Additionally, this approach is consistent with the dynamic definition of culture and assists in capturing changing values and beliefs between generations.

Despite the awareness of providing evidence-based treatments to people from culturally and linguistically diverse backgrounds, it appears that the CBT curriculum for community mental health clinicians does not address the cross-cultural application of CBT (Stirman et al., 2013; Waltman, Hall, McFarr, Beck, & Creed, 2017). CBT books (J. S. Beck, 2011; Dobson & Dobson, 2017) that are likely to greatly influence the practice of CBT do not provide insight into the "way of doing" CBT with client from culturally and linguistically diverse backgrounds. Further, there is a discrepancy between clinicians' global sense of multicultural competency and the frequency of practicing multicultural skills, which suggests that clinicians do not really practice what they preached (Hansen et al., 2006; Sehgal et al., 2011). As such, the findings of

this research program have important implications for improving the CBT curriculum to address the issues and unique needs of individuals from culturally and linguistically diverse backgrounds by describing the application of CBT for depression in Chinese migrants. CBT is "more than a bag of tricks" (Waltman et al., 2017, p. 10) and just learning to use the CBT techniques is not sufficient to produce symptom change. The insights from this thesis into "a way of doing" CBT (i.e., knowledge and skills) along with "a way of being" a therapist (i.e., cultural humility) contribute to improving clinicians' capability to artfully provide CBT to clients underrepresented in counselling and therapy services.

6.4. Strengths, Limitations, and Future Research

A detailed description of limitations and directions for future research of the three studies included in this research program is provided in Chapter Two, Three, Four, and Five. This section offers overall strengths and limitations. One of the strengths of Study One was reviewing a broader array of literature on CBT for depression with or without comorbid anxiety not reviewed by previous systematic reviews and meta-analyses. However, an important limitation of this study was not reviewing the literature written in Chinese. It is important to note that this was not possible due to the Chinese language barrier of the researcher and the supervisory team.

The main strengths of Study Two were the sample size, which exceeded the minimum sample size recommendations (Guest et al., 2006), achievement of data saturation, and participant diversity in terms of age, education, occupation, country of origin, and length of residence in Australia. Recruiting a diverse group of clinicians was critical to reduce agency specific biases (Hwang, 2009) and groupthink. Interviewing only CBT therapists might have hampered questioning the cultural appropriateness of CBT techniques and examining cultural adaptations to CBT. Recruiting a diverse group of Chinese community members assisted in identifying variations between Chinese individuals from various countries and capturing fundamental but also changing values and beliefs between generations. Additionally, multiple procedures were used to ensure trustworthiness such as triangulation, reflexivity, and adherence to the COREQ guidelines (Tong et al., 2007). Important limitations of Study Two are not recruiting Chinese individuals diagnosed with MDD and not consulting the community members about online therapy and their preference for therapist's ethnic background (i.e., Australian versus Chinese).

Important strengths of Study Three were the solid theoretical foundation, evolving from the findings of the qualitative study, and the sample size ($N = 399$). The structural model tested in this study has 45 free parameters. There are more than five participants for each parameter, which meets Kline's (2005) recommendation of having between five and 20 participant for each free parameter in the model. One of the main limitations of this study was including first or second generation Chinese migrants to Australia or Chinese international students. First and second generation Chinese migrants and Chinese international students might experience different aspects of migration stress (e.g., language barriers might be stronger for first generation migrants), and in terms of ethnic identity, there might be variations in their exploration and commitment to their ethnic groups (e.g., first generation migrants might have a higher commitment towards their ethnic group than second generation). Another limitation was the use of the English version of the questionnaires, which possibly hampered the participation of individuals with low English skills in this study. Moreover, due to time and funding constraints, it was not possible to recruit a large sample of Chinese participants diagnosed with MDD and use random sampling. Using a cross-sectional design limits causal inferences about the directional influence of migration stress on depression symptoms.

Several recommendations for future research, underpinned by the integration of the three studies included in this research program, are provided. Conducting a scoping review to map the literature written in Chinese and English is recommended to provide a more refined overview of CBT for depression. It is recommended that research extends beyond studies that are consulting community members on cultural adaptations to CBT to studies with a higher level of consumers and community engagement in the entire research endeavour. According to the spectrum of public participation developed by the International Association for Public Participation (2014), collaborating with consumers and community members would translate into partnering with them in developing future research from initial conceptualisation through to implementation. In other words, this would involve a shift from conducting research *on* Chinese migrants to conducting research *with* Chinese migrants. As such, collaboratively developing (a) a qualitative study to document the lived experience of Chinese migrants diagnosed with MDD and their experience of undergoing CBT, and (b) a structural model to predict MDD, would be an innovative approach to

advance this literature. Future research is required to use the Chinese version of the questionnaires to ensure the participation of individuals with low English skills.

An important next step for advancing the cross-cultural applicability of CBT would be pilot testing a culturally sensitive version of CBT informed by the findings of this research program. This would contribute to refining the culturally sensitive version of CBT and implementing the last stage of the FMAP. The key advantage of a manualised intervention is describing the intervention in sufficient detail to facilitate understanding of the core components of the intervention (Castro et al., 2010), whilst allowing clinicians to cultivate cultural humility and use their clinical judgement in response to clients' unique needs. A possible sequencing of CBT techniques might be (a) behavioural activation to increase the client's sense of pleasure and mastery, possibly reducing isolation, and facilitating integration in the new country of residence, (b) mindfulness meditation to assist them to be in the present moment, and reduce brooding and the tendency to perseverate on negative cognitive content, (c) incorporating relaxation or sleep hygiene techniques to address somatisation of distress, and (d) cognitive techniques to target the cognitive triad with more emphasis on exploring negative views of one's self in relation to significant others (e.g., "my self-worth is defined by my family unit", rather than independent from them "I am worthy"), examine and modify automatic thoughts and intermediate beliefs, and examine and reframe the experience of loss and not feeling at home.

Given that the Chinese community members suggested individual intervention with a support person as an alternative format to individual therapy, it would be important to examine the impact of attending therapy in dyads (i.e., the client with a support person) on clinical engagement and treatment outcomes. One study showed that Chinese dyads were more likely to provide problem-focused support than Euro-Canadian dyads who were more likely to provide emotion-focused support (B. Zhou, Heather, Cesare, & Ryder, 2017). There were no differences in regard to asking for help directly or indirectly between the participants in this study. As such, dyadic members might positively influence each other's emotions, cognitions, and behaviours (B. Zhou et al., 2017), which might significantly benefit the member of the dyad attending therapy. Researchers might use a similar research program to identify relevant cultural adaptations for CBT (and other therapies) for depression (and other issues) for other ethnic groups.

6.5. Concluding Remarks

Migration has become more frequent than ever before in human history. The freedom of relocating to another country in search of better job opportunities and lifestyle has tremendous advantages, but this also comes with demands of immigration. Migration might be perceived as a positive and negative experience, and therefore the type of reframe used for interpreting the migration experience (e.g., loss and/or gain) might have a significant influence on mental health. Chinese migrants represent an increasing group in many Western countries, yet studies conducted in Australia, Canada, and the USA have found low rates of mental health services use and delay of treatment until their mental health problems become severe. Developing culturally adapted interventions to treat depression is thought to be one way of improving client engagement and treatment outcomes for this (and other) vulnerable communities. Therefore, the aim of this research program was to investigate cultural adaptations of CBT for depression symptoms in Chinese migrants living in Australia. Across three interrelated studies, this research has built upon a growing body of literature that supports the compatibility between CBT and fundamental Chinese values, the efficacy of CBT for depression in Chinese nationals and migrants, and the use of FMAP for culturally adapting CBT for Chinese migrants.

This thesis has made a substantial contribution to cultural adaptations to CBT for depression in Chinese migrants through questioning, strengthening, and offering new insights into the use of specific and non-specific factors of CBT. To summarise, the present findings indicated that (a) behavioural techniques might be used to address depression expression in Chinese culture, facilitate perspective change, and assist with integration in the new country of residence; (b) cognitive restructuring could be used to examine and reframe the experience of loss and not feeling at home and target automatic thoughts and intermediate beliefs without destabilising the sense of an interdependent self; and (c) mindfulness meditation could assist in shifting from a maladaptive to an adaptive self-focused attention. Clinicians may motivate change among Chinese clients by sequencing the CBT techniques around an interdependent self and emphasising that to contribute to the wellbeing and welfare of their families they need to start with cultivating their own wellbeing (Hequin, 2005).

It is hoped that this thesis will contribute to improving CBT curriculum and practice with culturally diverse groups. An ongoing effort is required to improve clinicians' capability to

provide culturally sensitive CBT interventions for depression in Chinese migrants and equity in mental health services. Doing so would reduce the personal, interpersonal, societal, and economical effects of this highly debilitating mental disorder and promote the quality of life of this migrant group.

> Finally, difficulties with one patient provides an opportunity for you to refine your own skills, to promote your flexibility and creativity, and to gain new understandings and expertise in helping other patients, as problems can arise not just because of the patient's characteristics but also because of the therapist's relative weaknesses.
>
> (J. S. Beck, 2011, p. 346)

References

Addis, M. E., & Carpenter, K. M. (2000). The treatment rationale in cognitive behavioral therapy: Psychological mechanisms and clinical guidelines. *Cognitive and Behavioral Practice, 7*, 147-156. http://dx.doi.org/10.1016/S1077-7229(00)80025-5

Addis, M. E., & Jacobson, N. S. (1996). Reasons for depression and the process and outcome of cognitive-behavioral psychotherapies. *Journal of Consulting and Clinical Psychology, 64*, 1417-1424.

Addis, M. E., & Jacobson, N. S. (2000). A closer look at the treatment rationale and homework compliance in cognitive-behavioral therapy for depression. *Cognitive Therapy and Research, 24*, 313-326. http://dx.doi.org/10.1023/a:1005563304265

Adler, P. S. (1987). Culture shock and the cross-cultural learning experience. In L. F. Luce & E. C. Smith (Eds.), *Toward internationalism* (pp. 24–35). Cambridge, MA: Newbury House.

Ahn, H.-N., & Wampold, B. E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *Journal of Counseling Psychology, 48*, 251-257. http://dx.doi.org/10.1037/0022-0167.48.3.251

Ai, A. L., Nicdao, E. G., Appel, H. B., & Lee, D. H. J. (2015). Ethnic identity and major depression in Asian American subgroups nationwide: Differential findings in relation to subcultural contexts. *Journal of Clinical Psychology, 71*, 1225-1244. http://dx.doi.org/10.1002/jclp.22214

Akutsu, P. D., Tsuru, G. K., & Chu, J. P. (2004). Predictors of nonattendance of intake appointments among five Asian American client groups. *Journal of Consulting and Clinical Psychology, 72*, 891-896. http://dx.doi.org/10.1037/0022-006X.72.5.891

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3d ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed.). Arlington, VA: American Psychiatric Association.

American Psychological Association. (2002). Criteria for evaluating treatment guidelines. *American Psychologist, 57*, 1052-1059. http://dx.doi.org/10.1037//0003-066X.57.12.1052

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*, 377-402. http://dx.doi.org/10.1037/0003-066X.58.5.377

Anderson, L. E. (1994). A new look at an old construct: Cross-cultural adaptation. *International Journal of Intercultural Relations, 18*, 293-328. http://dx.doi.org/10.1016/0147-1767(94)90035-3

Anikeeva, O., Bi, P., Hiller, J. E., Ryan, P., Roder, D., & Han, G. S. (2010). The health status of migrants in Australia: A review. *Asia-Pacific Journal of Public Health, 22*, 159-193. http://dx.doi.org/10.1177/1010539509358193

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology, 8*, 19-32. http://dx.doi.org/10.1080/1364557032000119616

Aroian, K. J., & Norris, A. E. (2003). Depression trajectories in relatively recent immigrants. *Comprehensive Psychiatry, 44*, 420-427. http://dx.doi.org/10.1016/S0010-440X(03)00103-2

Aroian, K. J., Norris, A. E., Tran, T. V., & Schappler-Morris, N. (1998). Development and psychometric evaluation of the Demands of Immigration Scale. *Journal of Nursing Measurement 6*, 175-194.

Atdjian, S., & Vega, W. A. (2005). Disparities in mental health treatment in U.S. racial and ethnic minority groups: Implications for psychiatrists. *Psychiatric Services, 56*, 1600-1602. http://dx.doi.org/10.1176/appi.ps.56.12.1600

Audet, C. T. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers? *Counselling Psychology Quarterly, 24*, 85-100. http://dx.doi.org/10.1080/09515070.2011.589602

Australian Bureau of Statistics. (2016). *Standard Australian Classification of Countries (SACC), 2016* (1269.0). Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/mf/1269.0

Australian Bureau of Statistics. (2017). *Over 28 per cent of Australians born overseas* (3412.0). Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/lookup/3412.0Media%20Release12015-16

Australian Institute of Family Studies. (1995). *Families and cultural diversity in Australia*. Retrieved from https://aifs.gov.au/publications/families-and-cultural-diversity-australia/1-families-values-and-change-setting-scene

Australian Institute of Health and Welfare. (2018). *Mental health services: In brief 2018 provides an overview of data about the national response of the health and welfare system to the mental health care needs of Australians*. Retrieved from

https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia-in-brief-2018/contents/table-of-contents

Australian Psychological Society. (2018). *Evidence-based psychological interventions in the treament of mental disorders: A review of the literature*. Retrieved from https://www.psychology.org.au/getmedia/23c6a11b-2600-4e19-9a1d-6ff9c2f26fae/Evidence-based-psych-interventions.pdf

Baoyun, Y. (1998). The relevance of Confucianism today. In J. Cauquelin, P. Lim & B. Mayer-König (Eds.), *Asian values: Encounter with diversity*. London, UK: Routledge. Retrieved from http://ebookcentral.proquest.com/lib/curtin/detail.action?docID=1596510

Barrera, M., & Castro, F. G. (2006). A heuristic framework for the cultural adaptation of interventions. *Clinical Psychology: Science and Practice, 13*, 311-316. http://dx.doi.org/10.1111/j.1468-2850.2006.00043.x

Bauer, I., Wilansky-Traynor, P., & Rector, N. A. (2012). Cognitive-behavioral therapy for anxiety disorders with comorbid depression: A review. *International Journal of Cognitive Therapy, 5*, 118-156.

Beck, A. T. (2008). The evolution of the cognitive model of depression and its neurobiological correlates. *American Journal of Psychiatry, 165*, 969-977. http://dx.doi.org/10.1176/appi.ajp.2008.08050721

Beck, A. T., & Haigh, E. A. P. (2014). Advances in cognitive theory and therapy: The generic cognitive model. *Annual Review of Clinical Psychology, 10*, 1-24. http://dx.doi.org/10.1146/annurev-clinpsy-032813-153734

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York, NY: Guilford Press.

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). New York, NY: Guilford Press.

Beiser, M. N. M. N., & Hou, F. (2006). Ethnic identity, resettlement stress and depressive affect among Southeast Asian refugees in Canada. *Social Science & Medicine, 63*, 137-150. http://dx.doi.org/10.1016/j.socscimed.2005.12.002

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counseling Psychology, 58*, 279-289. http://dx.doi.org/10.1037/a0023626

Bennett, M. (1993). Towards ethnorelativism: A developmental model of intercultural sensitivity. In M. Paige (Ed.), *Education for the intercultural experience* (pp. 179-196). Yarmouth, ME: Intercultural Press.

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice, 40*, 361-368. http://dx.doi.org/10.1037/a0016401

Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations, 29*, 697-712. http://dx.doi.org/https://doi.org/10.1016/j.ijintrel.2005.07.013

Bhopal, R. (2009). Medicine and public health in a multiethnic world. *Journal of Public Health, 31*, 315-321. http://dx.doi.org/10.1093/pubmed/fdp069

Bhugra, D., Gupta, S., Bhui, K., Craig, T., Dogra, N., Ingleby, J. D., . . . Tribe, R. (2011). WPA guidance on mental health and mental health care in migrants. *World Psychiatry, 10*, 2-10. http://dx.doi.org/10.1002/j.2051-5545.2011.tb00002.x

Black, D. S., Sussman, S., Johnson, C. A., & Milam, J. (2012). Psychometric assessment of the Mindful Attention Awareness Scale (MAAS) among Chinese adolescents. *Assessment, 19*, 42-52. http://dx.doi.org/10.1177/1073191111415365

Black, D. W., & Grant, J. E. (2014). *DSM-5^{tm} guidebook : The essential companion to the diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Blignault, I., Ponzio, V., Ye, R., & Eisenbruch, M. (2008). A qualitative study of barriers to mental health services utilisation among migrants from Mainland China in South-East Sydney. *International Journal of Social Psychiatry, 54*, 180-190. http://dx.doi.org/10.1177/0020764007085872

Bobowik, M., Basabe, N., & Páez, D. (2015). The bright side of migration: Hedonic, psychological, and social well-being in immigrants in Spain. *Social Science Research, 51*, 189-204. http://dx.doi.org/10.1016/j.ssresearch.2014.09.011

Bogart, K. (1998). Asian values and their impact of business practices. In J. Cauquelin, P. Lim & B. Mayer-König (Eds.), *Asian values: Encounter with diversity* (pp. 139-163). Retrieved from http://ebookcentral.proquest.com/lib/curtin/detail.action?docID=1596510

Bond, M. H. (1991). *Beyond the Chinese face: Insights from psychology*. Oxford, England: Oxford University Press.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101. http://dx.doi.org/10.1191/1478088706qp063oa

Bredström, A. (2017). Culture and context in mental health diagnosing: Scrutinizing the DSM-5 revision. *The Journal of Medical Humanities,* http://dx.doi.org/10.1007/s10912-017-9501-1

Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: Mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology, 84*, 822-848. http://dx.doi.org/10.1037/0022-3514.84.4.822

Burg, J., & Michalak, J. (2011). The healthy quality of mindful breathing: Associations with rumination and depression. *Cognitive Therapy and Research, 35*, 179-185. http://dx.doi.org/10.1007/s10608-010-9343-x

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26*, 17-31. http://dx.doi.org/10.1016/j.cpr.2005.07.003

Cardemil, E. V. (2010). Cultural adaptations to empirically supported treatments: A research agenda. *The Scientific Review of Mental Health Practice, 7*, 8-21.

Casado, B. L., Hong, M., & Harrington, D. (2010). Measuring migratory grief and loss associated with the experience of immigration. *Research on Social Work Practice, 20*, 611-620. http://dx.doi.org/10.1177/1049731509360840

Casado, B. L., & Leung, P. (2002). Migratory grief and depression among elderly Chinese American immigrants. *Journal of Gerontological Social Work, 36*, 5-26. http://dx.doi.org/10.1300/J083v36n01_02

Castro, F. G., Barrera, M., & Holleran Steiker, L. K. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual Review of Clinical Psychology, 6*, 213-239. http://dx.doi.org/10.1146/annurev-clinpsy-033109-132032

Castro, F. G., Barrera, M., & Martinez, C. (2004). The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. *Prevention Science, 5*, 41-45. http://dx.doi.org/10.1023/B:PREV.0000013980.12412.cd

Centre for Epidemiology and Research. (2007). *New South Wales Population Health Survey 2006. Report on adult health*. Retrieved from https://www.health.nsw.gov.au/surveys/adult/Publications/adults-06.pdf

Cerdin, J.-L., Diné, M. A., & Brewster, C. (2014). Qualified immigrants' success: Exploring the motivation to migrate and to integrate. *Journal of International Business Studies, 45*, 151-168. http://dx.doi.org/10.1057/jibs.2013.45

Chan, A. S., Wong, Q. Y., Sze, S. L., Kwong, P. P. K., Han, Y. M. Y., & Cheung, M.-C. (2012). A Chinese Chan-based mind–body intervention for patients with depression. *Journal of Affective Disorders, 142*, 283-289. http://dx.doi.org/https://doi.org/10.1016/j.jad.2012.05.018

Chen, H., Guarnaccia, P. J., & Chung, H. (2003). Self-attention as a mediator of cultural influences on depression. *The International Journal of Social Psychiatry, 49*, 192-203. http://dx.doi.org/10.1177/00207640030493005

Chen, S. W.-H., & Davenport, D. S. (2005). Cognitive-behavioral therapy with Chinese American clients: Cautions and modifications. *Psychotherapy: Theory, Research, Practice, Training, 42*, 101-110. http://dx.doi.org/10.1037/0033-3204.42.1.101

Chen, X.-P., & Li, S. (2005). Cross-national differences in cooperative decision-making in mixed-motive business contexts: The mediating effect of vertical and horizontal individualism. *Journal of International Business Studies, 36*, 622-636. http://dx.doi.org/10.1057/palgrave.jibs.8400169

Chentsova-Dutton, Y. E., Ryder, A. G., & Tsai, J. (2014). Understanding depression across cultural contexts. In I. H. Gotlib & C. L. Hammen (Eds.), *Handbook of Depression* (3rd ed., pp. 337–354). New York, NY: Guilford Press.

Chiu, M., Amartey, A., Wang, X., & Kurdyak, P. (2018). Ethnic differences in mental health status and service utilization: A population-based study in Ontario, Canada. *Canadian Journal of Psychiatry/Revue Canadienne de Psychiatrie, 63*, 481-491. http://dx.doi.org/10.1177/0706743717741061

Choi, I., Andrews, G., Sharpe, L., & Hunt, C. (2015). Help-seeking characteristics of Chinese- and English-speaking Australians accessing Internet-delivered cognitive behavioural therapy for depression. *Social Psychiatry and Psychiatric Epidemiology, 50*, 89-97. http://dx.doi.org/10.1007/s00127-014-0956-3

Choi, I., Zou, J., Titov, N., Dear, B. F., Li, S., Johnston, L., . . . Hunt, C. (2012). Culturally attuned internet treatment for depression amongst Chinese Australians: A randomised controlled trial. *Journal of Affective Disorders, 136*, 459-468. http://dx.doi.org/10.1016/j.jad.2011.11.003

Chou, K.-L. (2007). Psychological distress in migrants in Australia over 50 years old: A longitudinal investigation. *Journal of Affective Disorders, 98*, 99-108. http://dx.doi.org/10.1016/j.jad.2006.07.002

Chowdhary, N., Jotheeswaran, A. T., Nadkarni, A., Hollon, S. D., King, M., Jordans, M. J. D., . . . Patel, V. (2014). The methods and outcomes of cultural adaptations of

psychological treatments for depressive disorders: A systematic review. *Psychological Medicine, 44*, 1131-1146. http://dx.doi.org/10.1017/S0033291713001785

Chu, J., Huynh, L., & Areán, P. (2012). Cultural adaptation of evidence-based practice utilizing an iterative stakeholder process and theoretical framework: Problem solving therapy for Chinese older adults. *International Journal of Geriatric Psychiatry, 27*, 97-106. http://dx.doi.org/10.1002/gps.2698

Chu, J., & Leino, A. (2017). Advancement in the maturing science of cultural adaptations of evidence-based interventions. *Journal of Consulting and Clinical Psychology, 85*, 45-57. http://dx.doi.org/10.1037/ccp0000145

Chu, J., Leino, A., Pflum, S., & Sue, S. (2016). A model for the theoretical basis of cultural competency to guide psychotherapy. *Professional Psychology: Research and Practice, 47*, 18–29. http://dx.doi.org/10.1037/pro0000055

Collins, S., & Arthur, N. (2007). A framework for enhancing multicultural counselling competence. *Canadian Journal of Counselling, 41*, 31-49.

Cross, W., & Singh, C. (2012). Dual vulnerabilities: Mental illness in a culturally and linguistically diverse society. *Contemporary Nurse, 42*, 156-166. http://dx.doi.org/10.5172/conu.2012.42.2.156

Cui, L., He, F., Han, Z., Yang, R., Xiao, J., & Oei, T. P. S. (2016). A brief group cognitive-behavioral program for the prevention of depressive symptoms in Chinese college students. *International Journal of Group Psychotherapy, 66*, 291-307. http://dx.doi.org/10.1080/00207284.2015.1111098

Cui, L., Shi, G., & Oei, T. P. S. (2013). A study of cognitive vulnerability–stress model of depressive symptoms among Chinese adolescents. *Stress and Health, 29*, 383-391. http://dx.doi.org/10.1002/smi.2484

Cuijpers, P. (2017). Four decades of outcome research on psychotherapies for adult depression: An overview of a series of meta-analyses. *Canadian Psychology/Psychologie Canadienne, 58*, 7-19. http://dx.doi.org/10.1037/cap0000096

Cuijpers, P., Berking, M., Andersson, G., Quigley, L., Kleiboer, A., & Dobson, K. S. (2013). A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison with other treatments. *The Canadian Journal of Psychiatry, 58*, 376-385. http://dx.doi.org/10.1177/070674371305800702

Dai, Y., Zhang, S., Yamamoto, J., Ao, M., Belin, T., Cheung, F., & Hifumi, S. (1999). Cognitive behavioral therapy of minor depressive symptoms in elderly Chinese Americans: A pilot study. *Community Mental Health Journal, 35*, 537-542. http://dx.doi.org/10.1023/A:1018763302198

Dandy, J., & Pe-Pua, R. (2010). Attitudes to multiculturalism, immigration and cultural diversity: Comparison of dominant and non-dominant groups in three Australian states. *International Journal of Intercultural Relations 34*, 34-46. http://dx.doi.org/10.1016/j.ijintrel.2009.10.003

David, D., Cristea, I., & Hofmann, S. G. (2018). Why cognitive behavioral therapy is the current gold standard of psychotherapy. *Frontiers in psychiatry, 9*, 4. http://dx.doi.org/10.3389/fpsyt.2018.00004

David, D., & Montgomery, G. H. (2011). The scientific status of psychotherapies: A new evaluative framework for evidence-based psychosocial interventions. *Clinical Psychology: Science and Practice, 18*, 89-99. http://dx.doi.org/10.1111/j.1468-2850.2011.01239.x

Dere, J., Sun, J., Zhao, Y., Persson, T. J., Zhu, X., Yao, S., . . . Ryder, A. G. (2013). Beyond "somatization" and "psychologization": Symptom-level variation in depressed Han Chinese and Euro-Canadian outpatients. *Frontiers in Psychology, 4*, 377. http://dx.doi.org/10.3389/fpsyg.2013.00377

Dobson, D., & Dobson, K. (2017). *Evidence-based practice of cognitive-behavioral therapy* (2nd ed.). New York, NY: The Guilford Press.

Doka, K. J. (1989). *Disenfranchised grief: Recognizing hidden sorrow*. Lexington, England: Lexington Books.

Donohue, J., & Pincus, H. (2007). Reducing the societal burden of depression. *Pharmacoeconomics, 25*, 7-24. http://dx.doi.org/10.2165/00019053-200725010-00003

du Plooy, D. R., Lyons, A., & Kashima, E. S. (2018). Predictors of flourishing and psychological distress among migrants to Australia: A dual continuum approach. *Journal of Happiness Studies*, 1-18. http://dx.doi.org/10.1007/s10902-018-9961-7

Ekers, D., Webster, L., Van Straten, A., Cuijpers, P., Richards, D., & Gilbody, S. (2014). Behavioural activation for depression; An update of meta-analysis of effectiveness and sub group analysis. *PLOS ONE, 9*, e100100. http://dx.doi.org/10.1371/journal.pone.0100100

Elkin, I., Shea, M. T., Watkins, J. T., Imber, S. D., Sotsky, S. M., Collins, J. F., . . . et al. (1989). National institute of mental health treatment of depression collaborative research program. General effectiveness of treatments. *Archives of General Psychiatry, 46*, 971-982.

Ferrari, A. J., Charlson, F. J., Norman, R. E., Patten, S. B., Freedman, G., Murray, C. J. L., . . . Whiteford, H. A. (2013). Burden of depressive disorders by country, sex, age, and year: Findings from the global burden of disease study 2010. *PLOS Medicine, 10*, e1001547. http://dx.doi.org/10.1371/journal.pmed.1001547

Finney, S. J., & DiStefano, C. (2006). Non-normal and categorical data in structural equation modeling. In G. R. Hancock & R. O. Mueller (Eds.), *Structural equation modeling: A second course* (pp. 269-314). Greenwich, CT: Information Age Publisching.

Foo, S. Q., Tam, W. W., Ho, C. S., Tran, B. X., Nguyen, L. H., McIntyre, R. S., & Ho, R. C. (2018). Prevalence of depression among migrants: A systematic review and meta-analysis. *International Journal of Environmental Research and Public Health, 15*, 1986. http://dx.doi.org/10.3390/ijerph15091986

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.

Freeman, A., & Oster, C., L. (1998). Cognitive therapy and depression. In V. E. Caballo (Ed.), *International handbook of cognitive and behavioural treatments for psychological disorders* (pp. 489-520). Oxford, England: Elsevier.

Furlong, M., & Oei, T. P. S. (2002). Changes to automatic thoughts and dysfuntional attitudes in group CBT for depression. *Behavioural and Cognitive Psychotherapy, 30*, 351-360. http://dx.doi.org/10.1017/S1352465802003107

Gee, G. C., Spencer, M., Chen, J., Yip, T., & Takeuchi, D. T. (2007). The association between self-reported racial discrimination and 12-month DSM-IV mental disorders among Asian Americans nationwide. *Social Science & Medicine, 64*, 1984-1996. http://dx.doi.org/10.1016/j.socscimed.2007.02.013

Gillespie, M., Smith, J., Meaden, A., Jones, C., & Wane, J. (2004). Clients' engagement with assertive outreach services: A comparison of client and staff perceptions of engagement and its impact on later engagement. *Journal of Mental Health, 13*, 439-452. http://dx.doi.org/10.1080/09638230400006767

Gloaguen, V., Cottraux, J., Cucherat, M., & Ivy-Marie Blackburn, M. (1998). A meta-analysis of the effects of cognitive therapy in depressed patients. *Journal of Affective Disorders, 49*, 59-72. http://dx.doi.org/10.1016/S0165-0327(97)00199-7

Goldfried, M. R., Burckell, L. A., & Eubanks-Carter, C. (2003). Therapist self-disclosure in cognitive-behavior therapy. *Journal of Clinical Psychology, 59*, 555-568. http://dx.doi.org/10.1002/jclp.10159

González, H. M., Tarraf, W., Whitfield, K. E., & Vega, W. A. (2010). The epidemiology of major depression and ethnicity in the United States. *Journal of Psychiatric Research, 44*, 1043-1051. http://dx.doi.org/10.1016/j.jpsychires.2010.03.017

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? *Field Methods, 18*, 59-82. http://dx.doi.org/10.1177/1525822X05279903

Guo, F., & Hanley, T. (2015). Adapting cognitive behavioral therapy to meet the needs of Chinese clients: Opportunities and challenges. *PsyCh Journal, 4*, 55-65. http://dx.doi.org/10.1002/pchj.75

Halcomb, E. J., Gholizadeh, L., Digiacomo, M., Phillips, J., & Davidson, P. M. (2007). Literature review: Considerations in undertaking focus group research with culturally and linguistically diverse groups. *Journal of Clinical Nursing, 16*, 1000-1011. http://dx.doi.org/10.1111/j.1365-2702.2006.01760.x

Hansen, N. D., Randazzo, K. V., Schwartz, A., Marshall, M., Kalis, D., Frazier, R., . . . Norvig, G. (2006). Do we practice what we preach? An exploratory survey of multicultural psychotherapy competencies. *Professional Psychology: Research and Practice, 37*, 66-74. http://dx.doi.org/10.1037/0735-7028.37.1.66

Hays, P. A. (2009). Integrating evidence-based practice, cognitive–behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. *Professional Psychology: Research and Practice, 40*, 354-360. http://dx.doi.org/10.1037/a0016250

Hequin, Y. (2005). Confucian thought: Implications for Psychotherapy. In W.-S. Tseng, S. C. Chang & M. Nishizono (Eds.), *Asian culture and psychotherapy: Implications for East and West* (pp. 129-141). Honolulu: University of Hawai'i Press.

Herrington, H. M., Smith, T. B., Feinauer, E., & Griner, D. (2016). Reliability generalization of the Multigroup Ethnic Identity Measure-Revised (MEIM-R). *Journal of Counseling Psychology, 63*, 586-593. http://dx.doi.org/10.1037/cou0000148

Hill, C., Oei, T., & Hill, M. (1989). An empirical investigation of the specificity and sensitivity of the Automatic Thoughts Questionnaire and Dysfunctional Attitudes Scale. *Journal of Psychopathology and Behavioral Assessment, 11*, 291-311. http://dx.doi.org/10.1007/BF00961529

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist, 25*, 517-572. http://dx.doi.org/10.1177/0011000097254001

Hirschfeld, R. M. A. (2001). The comorbidity of major depression and anxiety disorders: Recognition and management in primary care. *Primary Care Companion Journal of Clinical Psychiatry, 3*, 244-254.

Hodges, J., & Oei, T. P. S. (2007). Would Confucius benefit from psychotherapy? The compatibility of cognitive behaviour therapy and Chinese values. *Behaviour Research and Therapy, 45*, 901-914. http://dx.doi.org/10.1016/j.brat.2006.08.015

Hofmann, S., Asnaani, A., Vonk, I., Sawyer, A., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research, 36*, 427-440. http://dx.doi.org/10.1007/s10608-012-9476-1

Hofstede, G., Hofstede, G. J., & Minkov, M. (2010). *Cultures and organizations. Software of the mind. Intercultural cooperation and its importance for survival* (3rd ed.). New York, NY: McGraw-Hill.

Hollon, S. D., & Kendall, P. C. (1980). Cognitive self-statements in depression: Development of an Automatic Thoughts Questionnaire. *Cognitive Therapy and Research, 4*, 383-395. http://dx.doi.org/10.1007/bf01178214

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60*, 353-366. http://dx.doi.org/10.1037/a0032595

Hook, J. N., Farrell, J. E., Davis, D. E., Deblaere, C., Van Tongeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. *Journal of Counseling Psychology, 63*, 269-277. http://dx.doi.org/10.1037/cou0000114

Howard, K. I., Lueger, R. J., Maling, M. S., & Martinovich, Z. (1993). A phase model of psychotherapy outcome: Causal mediation of change. *Journal of consulting and clinical psychology, 61*, 678-685.

Hsu, C. T., Weng, C. Y., Kuo, C. S., Lin, C. L., Jong, M. C., Kuo, S. Y., & Chen, P. F. (2010). Effects of a cognitive-behavioral group program for community-dwelling elderly with minor depression. *International Journal of Geriatric Psychiatry, 25*, 654-655. http://dx.doi.org/10.1002/gps.2371

Hsu, G., Wan, Y., Adler, D., Rand, W., Choi, E., & Tsang, B. (2005). Detection of major depressive disorder in Chinese Americans in primary care. *Hong Kong Journal of Psychiatry, 15*, 71-76.

Hu, J., & Wang, Z. (2016). Exploring the associated factors of elevated psychological distress in a community residing sample of Australian Chinese migrants. *Australian Journal of Psychology, 68*, 116-122. http://dx.doi.org/10.1111/ajpy.12099

Hu, L. T., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling: A Multidisciplinary Journal, 6*, 1-55. http://dx.doi.org/10.1080/10705519909540118

Huang, S.-L., & Spurgeon, A. (2006). The mental health of Chinese immigrants in Birmingham, UK. *Ethnicity & Health, 11*, 365-387. http://dx.doi.org/10.1080/13557850600824161

Huynh, Q.-L., Devos, T., & Goldberg, R. (2014). The role of ethnic and national identifications in perceived discrimination for Asian Americans: Toward a better understanding of the buffering effect of group identifications on psychological distress. *Asian American Journal of Psychology, 5*, 161-171. http://dx.doi.org/10.1037/a0031601

Hwang, W.-C. (2006). The psychotherapy adaptation and modification framework: Application to Asian Americans. *American Psychologist, 61*, 702-715. http://dx.doi.org/10.1037/0003-066X.61.7.702

Hwang, W.-C. (2009). The formative method for adapting psychotherapy (FMAP): A community-based developmental approach to culturally adapting therapy. *Professional Psychology: Research and Practice, 40*, 369-377. http://dx.doi.org/10.1037/a0016240

Hwang, W.-C., & Myers, H. (2007). Major depression in Chinese Americans. *The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services, 42*, 189-197. http://dx.doi.org/10.1007/s00127-006-0152-1

Hwang, W.-C., Myers, H. F., Chiu, E., Mak, E., Butner, J. E., Fujimoto, K., . . . Miranda, J. (2015). Culturally adapted cognitive-behavioral therapy for Chinese Americans with depression: A randomized controlled trial. *Psychiatry Services, 66*, 1035-1042. http://dx.doi.org/10.1176/appi.ps.201400358

Ilardi, S. S., & Craighead, W. E. (1994). The role of nonspecific factors in cognitive-behavior therapy for depression. *Clinical Psychology: Science and Practice, 1*, 138-155. http://dx.doi.org/doi:10.1111/j.1468-2850.1994.tb00016.x

Imel, Z. E., & Wampold, B. E. (2008). The importance of treatment and the science of common factors in psychotherapy. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (4th ed., pp. 249-266). Hoboken, NJ: John Wiley & Sons Inc.

Ingram, R. E. (1990). Self-focused attention in clinical disorders: Review and a conceptual model. *Psychological Bulletin, 107*, 156-176. http://dx.doi.org/10.1037/0033-2909.107.2.156

International Association for Public Participation. (2014). *IAP2's public participation spectrum*. Retrieved from https://www.iap2.org.au/Tenant/C0000004/00000001/files/IAP2_Public_Participation_Spectrum.pdf

Jim, J., & Pistrang, N. (2007). Culture and the therapeutic relationship: Perspectives from Chinese clients. *Psychotherapy Research, 17*, 461-473. http://dx.doi.org/10.1080/10503300600812775

Jimenez, D. E., Alegría, M., Chen, C.-n., Chan, D., & Laderman, M. (2010). Prevalence of psychiatric illnesses in older ethnic minority adults. *Journal of the American Geriatrics Society, 58*, 256-264. http://dx.doi.org/doi:10.1111/j.1532-5415.2009.02685.x

Jones, A., & Bugge, C. (2006). Improving understanding and rigour through triangulation: An exemplar based on patient participation in interaction. *Journal of Advanced Nursing, 55*, 612-621. http://dx.doi.org/10.1111/j.1365-2648.2006.03953.x

Joormann, J., Dkane, M., & Gotlib, I. H. (2006). Adaptive and maladaptive components of rumination? Diagnostic specificity and relation to depressive biases. *Behavior therapy, 37*, 269-280.

Kalibatseva, Z., & Leong, F. T. L. (2014). A critical review of culturally sensitive treatments for depression: Recommendations for intervention and research. *Psychological Services, 11*, 433-450. http://dx.doi.org/10.1037/a0036047

Kamp, A., Alam, O., Blair, K., & Dunn, K. (2017). Australians' views on cultural diversity, nation and migration, 2015-16. *Cosmopolitan Civil Societies, 9*, 61-84. http://dx.doi.org/10.5130/ccs.v9i3.5635

Kanter, J., Mulick, P., Busch, A., Berlin, K., & Martell, C. (2007). The Behavioral Activation for Depression Scale (BADS): Psychometric properties and factor structure. *Journal of Psychopathology and Behavioral Assessment, 29*, 191-202. http://dx.doi.org/10.1007/s10862-006-9038-5

Kashima, E. S., Greiner, T., Sadewo, G., Ampuni, S., Helou, L., Nguyen, V. A., . . . Kaspar, K. (2017). Open- and closed-mindedness in cross-cultural adaptation: The roles of mindfulness and need for cognitive closure. *International Journal of Intercultural Relations, 59*, 31-42. http://dx.doi.org/https://doi.org/10.1016/j.ijintrel.2017.05.001

Kazantzis, N., Brownfield, N. R., Mosely, L., Usatoff, A. S., & Flighty, A. J. (2017). Homework in cognitive behavioral therapy: A systematic review of adherence assessment in anxiety and depression (2011-2016). *The Psychiatric Clinics of North America, 40*, 625-639. http://dx.doi.org/10.1016/j.psc.2017.08.001

Kazantzis, N., Dattilio, F. M., McGinn, L. K., Newman, C. F., Persons, J. B., & Radomsky, A. S. (2018). Defining the role and function of the therapeutic relationship in cognitive behavioral therapy: A modified Delphi panel. *International Journal of Cognitive Therapy, 11*, 158-183. http://dx.doi.org/10.1007/s41811-018-0014-0

Kazantzis, N., Deane, F. P., & Ronan, K. R. (2000). Homework assignments in cognitive and behavioral therapy: A meta-analysis. *Clinical Psychology: Science and Practice, 7*, 189-202. http://dx.doi.org/doi:10.1093/clipsy.7.2.189

Kazantzis, N., Whittington, C., & Dattilio, F. (2010). Meta-analysis of homework effects in cognitive and behavioral therapy: A replication and extension. *Clinical Psychology: Science and Practice, 17*, 144-156. http://dx.doi.org/doi:10.1111/j.1468-2850.2010.01204.x

Kazdin, A. E., & Krouse, R. (1983). The impact of variations in treatment rationales on expectancies for therapeutic change. *Behavior Therapy, 14*, 657-671. http://dx.doi.org/10.1016/S0005-7894(83)80058-6

Kessler, R. C., Merikangas, K. R., & Wang, P. S. (2007). Prevalence, comorbidity, and service utilization for mood disorders in the United States at the beginning of the twenty-first century. *Annual Review of Clinical Psychology 3*, 137-158. http://dx.doi.org/10.1146/annurev.clinpsy.3.022806.091444

Kim-Goh, M., Choi, H., & Yoon, M. S. (2015). Culturally responsive counseling for Asian Americans: Clinician perspectives. *International Journal for the Advancement of Counselling, 37*, 63-76. http://dx.doi.org/10.1007/s10447-014-9226-z

Kim, B., & Abreu, M. J. (2001). Acculturation measurement: Theory, current instruments, and future directions. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 394-424). Thousand Oaks, CA: Sage.

Kim, B. S. K., Atkinson, D. R., & Umemoto, D. (2001). Asian cultural values and the counseling process: Current knowledge and directions for future research. *The Counseling Psychologist, 29*, 570-603. http://dx.doi.org/10.1177/0011000001294006

Kirmayer, L. J. (2007). Psychotherapy and the cultural concept of the person. *Transcultural Psychiatry, 44*, 232-257. http://dx.doi.org/10.1177/1363461506070794

Kirmayer, L. J., Gomez-Carrillo, A., & Veissière, S. (2017). Culture and depression in global mental health: An ecosocial approach to the phenomenology of psychiatric disorders. *Social Science & Medicine, 183*, 163-168. http://dx.doi.org/https://doi.org/10.1016/j.socscimed.2017.04.034

Kitayama, S., & Cohen, D. (2007). *Handbook of cultural psychology*. New York, NY: Guilford Press.

Klein, D. N., Schwartz, J. E., Santiago, N. J., Vivian, D., Vocisano, C., Castonguay, L. G., . . . Keller, M. B. (2003). Therapeutic alliance in depression treatment: Controlling for prior change and patient characteristics. *Journal of Consulting and Clinical Psychology, 71*, 997-1006. http://dx.doi.org/10.1037/0022-006X.71.6.997

Kleinman, A. (1982). Neurasthenia and depression: A study of somatization and culture in China. *Culture, Medicine, and Psychiatry, 6*, 117-190. http://dx.doi.org/10.1007/BF00051427

Kleinman, A. (2004). Culture and depression. *The New England Journal of Medicine, 351*, 951-953. http://dx.doi.org/10.1056/NEJMp048078

Kline, R. B. (2005). *Principles and practice of structural equation modeling* (2nd ed.). New York, NY: Guilford Press.

Kolstad, A., & Gjesvik, N. (2014). Collectivism, individualism, and pragmatism in China: Implications for perceptions of mental health. *Transcultural Psychiatry, 51*, 264-285. http://dx.doi.org/10.1177/1363461514525220

Kroenke, K., Spitzer, R. L., Williams, J. B. W., & Löwe, B. (2010). The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: A systematic review. *General Hospital Psychiatry, 32*, 345-359. http://dx.doi.org/10.1016/j.genhosppsych.2010.03.006

Krueger, R. A., & Casey, M. A. (2009). *Focus groups: A practical guide for applied research* (4th ed.). Thousand Oaks, CA: Sage Publications.

Kulich, S. J., & Zhang, R. (2010). The multiple frames of "Chinese" values: From tradition to modernity and beyond. In M. H. Bond (Ed.), *The Oxford Handbook of Chinese Psychology* (pp. 241-278). New York, NY: Oxford University Press.

Lambert, M. J. (2005). Early response in psychotherapy: Further evidence for the importance of common factors rather than "placebo effects". *Journal of Clinical Psychology, 61*, 855-869. http://dx.doi.org/10.1002/jclp.20130

Lambert, M. J., & Ogles, B. M. (2014). Common factors: Post hoc explanation or empirically based therapy approach? *Psychotherapy 51*, 500-504. http://dx.doi.org/10.1037/a0036580

Lamberton, A., & Oei, T. P. S. (2008). A test of the cognitive content specificity hypothesis in depression and anxiety. *Journal of Behavior Therapy and Experimental Psychiatry, 39*, 23-31. http://dx.doi.org/10.1016/j.jbtep.2006.11.001

Lamers, F., van Oppen, P., Comijs, H. C., Smit, J. H., Spinhoven, P., van Balkom, A. J., . . . Penninx, B. W. (2011). Comorbidity patterns of anxiety and depressive disorders in a large cohort study: The Netherlands Study of depression and anxiety (NESDA). *The Journal of Clinical Psychiatry, 72*, 341-348. http://dx.doi.org/10.4088/JCP.10m06176blu

Lantrip, C., Mazzetti, F., Grasso, J., Gill, S., Miller, J., Haner, M., . . . Awad, G. (2015). Ethnic identity and acculturative stress as mediators of depression in students of Asian descent. *Journal of College Counseling, 18*, 144-159. http://dx.doi.org/10.1002/jocc.12011

Laska, K. M., Gurman, A. S., & Wampold, B. E. (2014). Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective. *Psychotherapy 51*, 467-481. http://dx.doi.org/10.1037/a0034332

Lau, A. S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical psychology: Science and practice, 13*, 295-310. http://dx.doi.org/10.1111/j.1468-2850.2006.00042.x

Leach, L. S., Olesen, S. C., Butterworth, P., & Poyser, C. (2014). New fatherhood and psychological distress: A longitudinal study of Australian men. *American Journal of Epidemiology, 180*, 582-589. http://dx.doi.org/10.1093/aje/kwu177

Leahy, R. L. (2008). The therapeutic relationship in cognitive-behavioral therapy. *Behavioural and Cognitive Psychotherapy, 36*, 769-777. http://dx.doi.org/10.1017/S1352465808004852

Lee, D. T. S., Kleinman, J., & Kleinman, A. (2007). Rethinking depression: An ethnographic study of the experiences of depression among Chinese. *Harvard Review of Psychiatry, 15*, 1-8. http://dx.doi.org/10.1080/10673220601183915

Lee, S. (1994). Neurasthenia and Chinese psychiatry in the 1990s. *Journal of Psychosomatic Research, 38*, 487-491. http://dx.doi.org/10.1016/0022-3999(94)90045-0

Leung, S. S., Lee, A. M., Chiang, V. C., Lam, S., Kuen, Y. W., & Wong, D. F. (2013). Culturally sensitive, preventive antenatal group cognitive–behavioural therapy for Chinese women with depression. *International Journal of Nursing Practice, 19*(Supplement S1), 28-37. http://dx.doi.org/10.1111/ijn.12021

Li, M., Ding, C., Kanter, J. W., Zeng, Q., & Yang, D. (2014). Further evaluation of the psychometric properties of the Behavioral Activation for Depression Scale. *International Journal of Psychology and Psychological Therapy, 14*, 45-57.

Liddell, B. J., Nickerson, A., Sartor, L., Ivancic, L., & Bryant, R. A. (2016). The generational gap: Mental disorder prevalence and disability amongst first and second generation immigrants in Australia. *Journal of Psychiatric Research, 83*, 103-111. http://dx.doi.org/10.1016/j.jpsychires.2016.08.011

Lim, G., Tam, W., Lu, Y., Ho, C., Zhang, M., & Ho, R. (2018). Prevalence of depression in the community from 30 Countries between 1994 and 2014. *Scientific Reports, 8*, 2861-2861. http://dx.doi.org/10.1038/s41598-018-21243-x

Lin, L.-C., Huang, P.-H., & Weng, L.-J. (2017). Selecting path models in SEM: A comparison of model selection criteria. *Structural Equation Modeling: A Multidisciplinary Journal, 24*, 855-869. http://dx.doi.org/10.1080/10705511.2017.1363652

Lin, T.-Y. (1989). Neurasthenia revisited: Its place in modern psychiatry. *Culture, Medicine, and Psychiatry: An International Journal of Cross-Cultural Health Research, 13*, 105-129. http://dx.doi.org/10.1007/BF02220656

Lin, Y.-N. (2002). The application of cognitive-behavioral therapy to counseling Chinese. *American Journal of Psychotherapy, 56*, 46-58. http://dx.doi.org/10.1176/appi.psychotherapy.2002.56.1.46

Liu, E. T.-H. (2007). Integrating cognitive-behavioral and cognitive-interpersonal case formulations: A case study of a Chinese American male. *Pragmatic Case Studies in Psychotherapy, 3*, 1-33. http://dx.doi.org/10.14713/pcsp.v3i3.903

Liu, E. T.-H., Chen, W.-L., Li, Y.-H., Wang, C. H., Mok, T. J., & Huang, H. S. (2009). Exploring the efficacy of cognitive bibliotherapy and a potential mechanism of change in the treatment of depressive symptoms among the Chinese: A randomized controlled trial. *Cognitive Therapy and Research, 33*, 449-461. http://dx.doi.org/10.1007/s10608-008-9228-4

Liu, S. (2015). Searching for a sense of place: Identity negotiation of Chinese immigrants. *International Journal of Intercultural Relations, 46*, 26-35. http://dx.doi.org/10.1016/j.ijintrel.2015.03.020

Liu, W.-S., & Leung, P. W.-L. (2010). Psychotherapy with the Chinese: An update of the work in the last decade. In M. H. Bond (Ed.), *The Oxford Handbook of Chinese Psychology* (pp. 457-478). New York, NY: Oxford University Press.

López, S. R., & Guarnaccia, P. J. (2000). Cultural psychopathology: Uncovering the social world of mental illness. *Annual Review of Psychology, 51*, 571-598. http://dx.doi.org/10.1146/annurev.psych.51.1.571

Manos, R. C., Kanter, J. W., & Busch, A. M. (2010). A critical review of assessment strategies to measure the behavioral activation model of depression. *Clinical Psychology Review, 30*, 547-561. http://dx.doi.org/10.1016/j.cpr.2010.03.008

Manos, R. C., Kanter, J. W., & Luo, W. (2011). The Behavioral Activation for Depression Scale-Short Form: Development and validation. *Behavior Therapy, 42*, 726-739. http://dx.doi.org/10.1016/j.beth.2011.04.004

Markus, A. (2017). *Mapping Social Cohesion The Scanlon Foundation survey 2017*. Retrieved from http://scanlonfoundation.org.au/wp-content/uploads/2014/05/ScanlonFoundation_MappingSocialCohesion_2017.pdf

Markus, H. R., & Kitayama, S. (2010). Cultures and selves: A cycle of mutual constitution. *Perspectives on Psychological Science, 5*, 420-430. http://dx.doi.org/10.1177/1745691610375557

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450.

Mathers, C. D., & Loncar, D. (2006). Projections of global mortality and burden of disease from 2002 to 2030. *PLOS Medicine, 3*, e442. http://dx.doi.org/10.1371/journal.pmed.0030442

Mausbach, B. T., Moore, R., Roesch, S., Cardenas, V., & Patterson, T. L. (2010). The relationship between homework compliance and therapy outcomes: An updated meta-analysis. *Cognitive Therapy and Research, 34*, 429-438. http://dx.doi.org/10.1007/s10608-010-9297-z

McEvoy, P. M., Grove, R., & Slade, T. (2011). Epidemiology of anxiety disorders in the Australian general population: Findings of the 2007 Australian National Survey of

Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry, 45*, 957-967. http://dx.doi.org/10.3109/00048674.2011.624083

Miller, E., & McNaught, A. (2018). Exploring decision making around therapist self-disclosure in cognitive behavioural therapy. *Australian Psychologist, 53*, 33-39. http://dx.doi.org/doi:10.1111/ap.12260

Minas, H., Klimidis, S., & Kokanovic, R. (2007). Depression in multicultural Australia: Policies, research and services. *Australia and New Zealand Health Policy, 4*, 16. http://dx.doi.org/10.1186/1743-8462-4-16

Minas, H., Ritsuko, K., Too, L. S., Vayani, H., Orapeleng, S., Prasad-Ildes, R., . . . Oehm, D. (2013). Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion. *International Journal of Mental Health Systems, 7*, 1-25. http://dx.doi.org/10.1186/1752-4458-7-23

Miranda, J., Azocar, F., Organista, K. C., Dwyer, E., & Areane, P. (2003). Treatment of depression among impoverished primary care patients from ethnic minority groups. *Psychiatric Services, 54*, 219-225. http://dx.doi.org/10.1176/appi.ps.54.2.219

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & The, P. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLOS Medicine, 6*, e1000097. http://dx.doi.org/10.1371/journal.pmed.1000097

Mojtabai, R., Olfson, M., Sampson, N. A., Jin, R., Druss, B., Wang, P. S., . . . Kessler, R. C. (2011). Barriers to mental health treatment: Results from the National Comorbidity Survey Replication. *Psychological Medicine, 41*, 1751-1761. http://dx.doi.org/10.1017/S0033291710002291

Mortenson, S. (2006). Cultural differences and similarities in seeking social support as a response to academic failure: A comparison of American and Chinese college students. *Communication Education, 55*, 127-146. http://dx.doi.org/10.1080/03634520600565811

Mossakowski, K. N. (2003). Coping with perceived discrimination: Does ethnic identity protect mental health? *Journal of Health and Social Behavior, 44*, 318-331. http://dx.doi.org/10.2307/1519782

Muthén, L. K., & Muthén, B. O. (1998-2017). *Mplus User's Guide* (8th ed.). Los Angeles, CA: Muthén & Muthén.

Na, S., Ryder, A. G., & Kirmayer, L. J. (2016). Toward a culturally responsive model of mental health literacy: Facilitating help-seeking among East Asian immigrants to

North America. *American Journal of Community Psychology, 58*, 211-225. http://dx.doi.org/10.1002/ajcp.12085

National Health and Medical Research Council. (2009). *NHMRC Additional Levels of Evidence and Grades for Recommendations for Developers of Guidelines*. Melbourne, Vic: NHMRC.

National Institute for Health and Care Excellence. (2016). *Depression in adults: Recognition and management*. Retrieved from https://www.nice.org.uk/guidance/cg90/chapter/Key-priorities-for-implementation

Nesdale, D., Rooney, R., & Smith, L. (1997). Migrant ethnic identity and psychological distress. *Journal of Cross-Cultural Psychology, 28*, 569-588. http://dx.doi.org/10.1177/0022022197285004

Netemeyer, R. G., Williamson, D. A., Burton, S., Biswas, D., Jindal, S., Landreth, S., . . . Primeaux, S. (2002). Psychometric properties of shortened versions of the Automatic Thoughts Questionnaire. *Educational and Psychological Measurement, 62*, 111-129. http://dx.doi.org/10.1177/0013164402062001008

Ng, P., Tsun, A., Su, S., & Young, D. (2013). Cognitive behavioral intervention in the Chinese cultural context: A case report. *Asia-Pacific Psychiatry, 5*, 205-211. http://dx.doi.org/doi:10.1111/appy.12092

Ng, T. K., & Wong, D. F. K. (2018). The efficacy of cognitive behavioral therapy for Chinese people: A meta-analysis. *Australian & New Zealand Journal of Psychiatry, 52*, 620-637. http://dx.doi.org/10.1177/0004867417741555

Ngai, F. W., Wong, P. W. C., Leung, K. Y., Chau, P. H., & Chung, K. F. (2015). The effect of telephone-based cognitive-behavioral therapy on postnatal depression: A randomized controlled trial. *Psychotherapy and Psychosomatics, 84*, 294-303. http://dx.doi.org/10.1159/000430449

Noh, S., Beiser, M., Kaspar, V., Hou, F., & Rummens, J. (1999). Perceived racial discrimination, depression, and coping: A study of Southeast Asian refugees in Canada. *Journal of Health and Social Behavior, 40*, 193-207. http://dx.doi.org/10.2307/2676348

O'Reilly, K., & Benson, M. (2009). Likestyle migration: Escaping to the good life? In M. Benson & K. O'Reilly (Eds.), *Lifestyle migration: Expectations, aspirations and experiences* (pp. 1-13). Farnham, England: Ashgate.

Oei, T. P. S., & Kwon, S. M. (2007). Evaluation of the integrated cognitive model of depression and its specificity in a migrant population. *Depression and Anxiety, 24*, 112-123. http://dx.doi.org/10.1002/da.20225

Office for National Statistics. (2018). *Population of England and Wales*. Retrieved from https://www.ethnicity-facts-figures.service.gov.uk/british-population/national-and-regional-populations/population-of-england-and-wales/latest

Ortlipp, M. (2008). Keeping and using reflective journals in the qualitative research process. *Qualitative Report, 13*, 695-705. Retrieved from www.nova.edu/ssss/QR/QR13-4/ortlipp.pdf

Osman, A., Lamis, D. A., Bagge, C. L., Freedenthal, S., & Barnes, S. M. (2015). The Mindful Attention Awareness Scale: Further examination of dimensionality, reliability, and concurrent validity estimates. *Journal of Personality Assessment, 98*, 1-11. http://dx.doi.org/10.1080/00223891.2015.1095761

Ottenbreit, N. D., & Dobson, K. S. (2008). Avoidance. In K. S. Dobson & D. J. A. Dozois (Eds.), *Risk factors in depression* (pp. 447-470). San Diego, CA: Elsevier Academic Press. http://dx.doi.org/:1016/B978-0-08-045078-0.00020-4

Owen, J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy, 48*, 274-282. http://dx.doi.org/10.1037/a0022065

Owen, J., Tao, K. W., Drinane, J. M., Hook, J., Davis, D. E., & Kune, N. F. (2015). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *Professional Psychology: Research and Practice, 47*, 30–37. http://dx.doi.org/10.1037/pro0000046

Parham, T. A. (2001). Afterword: Beyond tolerance—Bridging the gap between imposition and acceptance. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 871–881). Thousand Oaks, CA: Sage.

Parker, G., Chan, B., & Tully, L. (2006). Depression and help-seeking in a western sample of 'highly acculturated' Chinese and controls. *Journal of Affective Disorders, 94*, 239-242. http://dx.doi.org/10.1016/j.jad.2006.03.012

Parker, G., Chan, B., Tully, L., & Eisenbruch, M. (2005). Depression in the Chinese: The impact of acculturation. *Psychological Medicine, 35*, 1475-1483. http://dx.doi.org/10.1017/S0033291705005623

Parker, G., Cheah, Y. C., & Roy, K. (2001). Do the Chinese somatize depression? A cross-cultural study. *Social Psychiatry and Psychiatric Epidemiology, 36*, 287-293. http://dx.doi.org/10.1007/s001270170046

Parker, G., Gladstone, G., & Chee, K. T. (2001). Depression in the planet's largest ethnic group: The Chinese. *American Journal of Psychiatry, 158*, 857-864. http://dx.doi.org/10.1176/appi.ajp.158.6.857

Pascoe, E. A., & Richman, L. S. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin, 135*, 531-554. http://dx.doi.org/10.1037/a0016059

Phillips, M. R., Zhang, J., Shi, Q., Song, Z., Ding, Z., Pang, S., . . . Wang, Z. (2009). Prevalence, treatment, and associated disability of mental disorders in four provinces in China during 2001–05: An epidemiological survey. *The Lancet, 373*(9680), 2041-2053. http://dx.doi.org/10.1016/S0140-6736(09)60660-7

Phinney, J. S., Horenczyk, G., Liebkind, K., & Vedder, P. (2001). Ethnic identity, immigration, and well-being: An interactional perspective. *Journal of Social Issues, 57*, 493-510. http://dx.doi.org/10.1111/0022-4537.00225

Phinney, J. S., & Ong, A. D. (2007). Conceptualization and measurement of ethnic identity: Current status and future directions. *Journal of Counseling Psychology, 54*, 271-281. http://dx.doi.org/10.1037/0022-0167.54.3.271

Pritzker, S. (2007). Thinking hearts, feeling brains: Metaphor, culture, and the self in Chinese narratives of depression. *Metaphor and Symbol, 22*, 251-274. http://dx.doi.org/10.1080/10926480701357679

Renzaho, A. M. N. (2016). Migration and the healthy migrant effect in Australia: Current knowledge, gaps and opportunity for future research. In A. M. N. Renzaho (Ed.), *Globalisation, Migration and Health: Challenges and Opportunities* (pp. 363-389). http://dx.doi.org/:10.1142/9781783268894_0011

Resnicow, K., Soler, R., Braithwaite, R. L., Ahluwalia, J. S., & Butler, J. (2000). Cultural sensitivity in substance use prevention. *Journal of Community Psychology, 28*, 271-290. http://dx.doi.org/10.1002/(SICI)1520-6629(200005)28:3<271::AID-JCOP4>3.0.CO;2-I

Richards, D. (2011). Prevalence and clinical course of depression: A review. *Clinical Psychology Review, 31*, 1117-1125. http://dx.doi.org/10.1016/j.cpr.2011.07.004

Ridley, C. R., Mendoza, D. W., Kanitz, B. E., Angermeier, L., & Zenk, R. (1994). Cultural sensitivity in multicultural counseling: A perceptual schema model. *Journal of Counseling Psychology, 41*, 125-136. http://dx.doi.org/10.1037/0022-0167.41.2.125

Robinson, B. (2009). When therapist variables and the client's theory of change meet. *Psychotherapy in Australia, 15*, 60-65.

Ryder, A. G., Ban, L. M., & Chentsova-Dutton, Y. E. (2011). Towards a cultural–clinical psychology. *Social and Personality Psychology Compass, 5*, 960-975. http://dx.doi.org/doi:10.1111/j.1751-9004.2011.00404.x

Ryder, A. G., & Chentsova-Dutton, Y. E. (2012). Depression in cultural context: "Chinese somatization," revisited. *The Psychiatric Clinics of North America, 35*, 15-36. http://dx.doi.org/10.1016/j.psc.2011.11.006

Ryder, A. G., Sun, J., Zhu, X., Yao, S., & Chentsova-Dutton, Y. E. (2012). Depression in China: Integrating developmental psychopathology and cultural-clinical psychology. *Journal of Clinical Child & Adolescent Psychology, 41*, 682-694. http://dx.doi.org/10.1080/15374416.2012.710163

Ryder, A. G., Yang, J., Zhu, X., Yao, S., Yi, J., Heine, S. J., & Bagby, R. M. (2008). The cultural shaping of depression: Somatic symptoms in China, psychological symptoms in North America? *Journal of Abnormal Psychology, 117*, 300-313. http://dx.doi.org/10.1037/0021-843x.117.2.300

Saarni, S. I., Suvisaari, J., Sintonen, H., Pirkola, S., Koskinen, S., Aromaa, A., & Lönnqvist, J. (2018). Impact of psychiatric disorders on health-related quality of life: General population survey. *British Journal of Psychiatry, 190*, 326-332. http://dx.doi.org/10.1192/bjp.bp.106.025106

Sala, E., Dandy, J., & Rapley, M. (2010). 'Real Italians and wogs': The discursive construction of Italian identity among first generation Italian immigrants in Western Australia. *Journal of Community & Applied Social Psychology, 20*, 110-124. http://dx.doi.org/10.1002/casp.1023

Sauer, S. E., & Baer, R. A. (2012). Ruminative and mindful self-focused attention in borderline personality disorder. *Personality Disorders: Theory, Research, and Treatment, 3*, 433-441. http://dx.doi.org/10.1037/a0025465

Scher, C. D., Ingram, R. E., & Segal, Z. V. (2005). Cognitive reactivity and vulnerability: Empirical evaluation of construct activation and cognitive diatheses in unipolar depression. *Clinical Psychology Review, 25*, 487-510. http://dx.doi.org/10.1016/j.cpr.2005.01.005

Schneider, E. C., Sarnak, D. O., Squires, D., Shah, A., & Doty, M. M. (2017). *Mirror, mirror 2017: International comparison reflects flaws and opportunities for better U.S. health care*. Retrieved from https://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-2017-international-comparison-reflects-flaws-and

Schofield, D. J., Shrestha, R. N., Percival, R., Passey, M. E., Callander, E. J., & Kelly, S. J. (2011). The personal and national costs of mental health conditions: Impacts on income, taxes, government support payments due to lost labour force participation. *BMC Psychiatry, 11*, 72. http://dx.doi.org/10.1186/1471-244x-11-72

Schwartz, S. H. (2009). Culture matters: National value cultures, sources, and consequences. In R. S. Wyer, C. Y. Chiu & Y. Y. Hong (Eds.), *Understanding culture: Theory, research, and application* (pp. 127-150). New York, NY: Psychology Press.

Segal, Z. V., & Ingram, R. E. (1994). Mood priming and construct activation in tests of cognitive vulnerability to unipolar depression. *Clinical Psychology Review, 14*, 663-695. http://dx.doi.org/10.1016/0272-7358(94)90003-5

Sehgal, R., Saules, K., Young, A., Grey, M. J., Gillem, A. R., Nabors, N. A., . . . Jefferson, S. (2011). Practicing what we know: Multicultural counseling competence among clinical psychology trainees and experienced multicultural psychologists. *Cultural Diversity and Ethnic Minority Psychology, 17*, 1-10. http://dx.doi.org/10.1037/a0021667

Sharma, S. (2012). Psychological distress among Australians and immigrants: Findings from the 2007 National Survey of Mental Health and Wellbeing. *Advances in Mental Health, 10*, 106-116. http://dx.doi.org/10.5172/jamh.2011.10.2.106

Sharma, S., & Sharma, M. (2010). Globalization, Threatened Identities, Coping and Well-Being. *Psychological Studies, 55*(4), 313-322. http://dx.doi.org/10.1007/s12646-010-0048-8

Shavitt, S., Lalwani, A. K., Zhang, J., & Torelli, C. J. (2006). The horizontal/vertical distinction in cross-cultural consumer research. *Journal of Consumer Psychology, 16*, 325-342. http://dx.doi.org/10.1207/s15327663jcp1604_3

Shavitt, S., Torelli, C. J., & Riemer, H. (2011). Horizontal and vertical individualism and collectivism: Implications for understanding psychological processes. In M. J. Gelfand, C.-y. Chiu & Y.-y. Hong (Eds.), *Advances in culture and psychology* (Vol. 1, pp. 309-350). New York, NY: Oxford University Press.

Shen, E. K., Alden, L. E., Söchting, I., & Tsang, P. (2006). Clinical observations of a Cantonese cognitive-behavioral treatment program for Chinese immigrants.

Psychotherapy: Theory, Research, Practice, Training, 43, 518-530. http://dx.doi.org/10.1037/0033-3204.43.4.518

Shudo, Y., Yamamoto, T., & Sakai, M. (2017). Longitudinal predictions of depression symptoms using the activation and avoidance subscales of the Japanese Behavioral Activation for Depression Scale-Short Form. *Psychological Reports, 120*, 130-140. http://dx.doi.org/10.1177/0033294116680794

Simi, N. L., & Mahalik, J. R. (1997). Comparison of feminist versus psychoanalytic/dynamic and other therapists on self-disclosure *Psychology of Women Quarterly, 21*, 465-483. http://dx.doi.org/doi:10.1111/j.1471-6402.1997.tb00125.x

Spitzer, R. L., Kroenke, K., & Williams, J. B. (1999). Validation and utility of a self-report version of PRIME-MD: The PHQ primary care study. Primary Care Evaluation of Mental Disorders. Patient Health Questionnaire. *Jama, 282*, 1737-1744. http://dx.doi.org/10.1001/jama.282.18.1737

Statistics Canada. (2016). *Ethnic and cultural origins of Canadians: Portrait of a rich heritage*. Retrieved from https://www12.statcan.gc.ca/census-recensement/2016/as-sa/98-200-x/2016016/98-200-x2016016-eng.cfm

Stewart, D., Shamdasani, P., & Rook, D. (2007). *Focus groups: Theory and practice* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Stirman, S. W., Gutiérrez-Colina, A., Toder, K., Esposito, G., Barg, F., Castro, F., . . . Crits-Christoph, P. (2013). Clinicians' perspectives on cognitive therapy in community mental health settings: Implications for training and implementation. *Administration and Policy in Mental Health, 40*, 274-285. http://dx.doi.org/10.1007/s10488-012-0418-8

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*, 477-486. http://dx.doi.org/10.1002/j.1556-6676.1992.tb01642.x

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist, 10*, 45-52. http://dx.doi.org/10.1177/0011000082102008

Sue, S., Yan Cheng, J. K., Saad, C. S., & Chu, J. P. (2012). Asian American mental health: A call to action. *American Psychologist, 67*, 532-544. http://dx.doi.org/10.1037/a0028900

Sue, S., Zane, N., Hall, G. C. N., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525-548. http://dx.doi.org/10.1146/annurev.psych.60.110707.163651

Sumer, S., Poyrazli, S., & Grahame, K. (2008). Predictors of depression and anxiety among international students. *Journal of Counseling & Development, 86*, 429-437. http://dx.doi.org/10.1002/j.1556-6678.2008.tb00531.x

Tabachnick, B. G., & Fidell, L. S. (2007). *Using multivariate statistics* (5th ed.). Boston, MA: Pearson/Allyn & Bacon.

Tang, G., Dennis, S., Comino, E., & Zwar, N. (2009). Anxiety and depression in Chinese patients attending an Australian GP clinic. *Australian Family Physician, 38*, 552-555.

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*, 117-125. http://dx.doi.org/10.1377/hlthaff.2014.0564

Thomas, M. (2006). The contributing factors of change in a therapeutic process. *Contemporary Family Therapy, 28*, 201-210. http://dx.doi.org/10.1007/s10591-006-9000-4

Titov, N., Andrews, G., Davies, M., McIntyre, K., Robinson, E., & Solley, K. (2010). Internet treatment for depression: A randomized controlled trial comparing clinician vs. technician assistance. *PLoS One, 5*, e10939. http://dx.doi.org/10.1371/journal.pone.0010939

Tiwari, S., & Wang, J. (2008). Ethnic differences in mental health service use among White, Chinese, South Asian and South East Asian populations living in Canada. *The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services, 43*, 866-871. http://dx.doi.org/10.1007/s00127-008-0373-6

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*, 349-357. http://dx.doi.org/10.1093/intqhc/mzm042

Treynor, W., Gonzalez, R., & Nolen-Hoeksema, S. (2003). Rumination reconsidered: A psychometric analysis. *Cognitive Therapy and Research, 27*, 247-259. http://dx.doi.org/10.1023/A:1023910315561

Triandis, H. C. (1995). *Individualism & collectivism*. Boulder, CO: Westview Press.

Triandis, H. C. (2001). Individualism-collectivism and personality. *Journal of Personality, 69*, 907-924. http://dx.doi.org/doi:10.1111/1467-6494.696169

Triandis, H. C., Bontempo, R., Villareal, M. J., Asai, M., & Lucca, N. (1988). Individualism and collectivism: Cross-cultural perspectives on self-ingroup relationships. *Journal of personality and Social Psychology, 54*, 323-338.

Tsai, J. H. C. (2002). Psychometric evaluation of the Demands of Immigration Scale with Taiwanese–Chinese immigrants: A pilot study. *Journal of Advanced Nursing, 39*, 274-280. http://dx.doi.org/10.1046/j.1365-2648.2000.02274.x

Tsai, J. L., Ying, Y.-W., & Lee, P. A. (2000). The meaning of "being Chinese" and "being American": Variation among Chinese American young adults. *Journal of Cross-Cultural Psychology, 31*, 302-332. http://dx.doi.org/10.1177/0022022100031003002

Tseng, W.-S., Lee, S., & Qiuyun, L. (2005). The historical trends of psychotherapy in China. In W.-S. Tseng, S. C. Chang & M. Nishizono (Eds.), *Asian culture and psychotherapy: Implications for East and West* (pp. 249-264). Honolulu: University of Hawai'i Press.

Tung, W.-C., & Li, Z. (2014). Pain beliefs and behaviors among Chinese. *Home Health Care Management & Practice, 27*, 95-97. http://dx.doi.org/10.1177/1084822314547962

Ventriglio, A., Ayonrinde, O., & Bhugra, D. (2016). Relevance of culture-bound syndromes in the 21st century. *Psychiatry and Clinical Neurosciences, 70*, 3-6. http://dx.doi.org/10.1111/pcn.12359

Visla, A., Fluckiger, C., Constantino, M. J., Krieger, T., & Grosse Holtforth, M. (2018). Patient characteristics and the therapist as predictors of depressed patients' outcome expectation over time: A multilevel analysis. *Psychotherapy Research*, 1-14. http://dx.doi.org/10.1080/10503307.2018.1428379

Vos, T., Allen, C., Arora, M., Barber, R. M., Bhutta, Z. A., Brown, A., . . . Chen, A. Z. (2016). Global, regional, and national incidence, prevalence, and years lived with disability for 310 diseases and injuries, 1990–2015: A systematic analysis for the Global Burden of Disease Study 2015. *The Lancet, 388*, 1545-1602. http://dx.doi.org/10.1016/S0140-6736(16)31678-6

Waltman, S., Hall, B. C., McFarr, L. M., Beck, A. T., & Creed, T. A. (2017). In-session stuck points and pitfalls of community clinicians learning CBT: Qualitative investigation. *Cognitive and Behavioral Practice, 24*, 256-267. http://dx.doi.org/https://doi.org/10.1016/j.cbpra.2016.04.002

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

Wampold, B. E. (2012). Humanism as a common factor in psychotherapy. *Psychotherapy, 49*, 445-449. http://dx.doi.org/10.1037/a0027113

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*, 270-277. http://dx.doi.org/10.1002/wps.20238

Wang, K. T., Wei, M., Zhao, R., Chuang, C.-C., & Li, F. (2015). The Cross-Cultural Loss Scale: Development and psychometric evaluation. *Psychological Assessment, 27*, 42-53. http://dx.doi.org/10.1037/pas0000027

Watkins, E., & Teasdale, J. D. (2004). Adaptive and maladaptive self-focus in depression. *Journal of Affective Disorders, 82*, 1-8. http://dx.doi.org/10.1016/j.jad.2003.10.006

Wong, C. W. (2013). Collaborative empiricism in culturally sensitive cognitive behavior therapy. *Cognitive and Behavioral Practice, 20*, 390-398. http://dx.doi.org/https://doi.org/10.1016/j.cbpra.2012.08.005

Wong, D. F. K. (2008a). Cognitive and health-related outcomes of group cognitive behavioural treatment for people with depressive symptoms in Hong Kong: Randomized wait-list control study. *Australia and New Zealand Journal of Psychiatry, 42*, 702-711. http://dx.doi.org/10.1080/00048670802203418

Wong, D. F. K. (2008b). Cognitive behavioral treatment groups for people with chronic depression in Hong Kong: A randomized wait-list control design. *Depression and Anxiety, 25*, 142-148. http://dx.doi.org/doi:10.1002/da.20286

Wong, D. F. K. (2009). A six-month follow-up study of cognitive–behavioural treatment groups for Chinese people with depression in Hong Kong. *Behaviour Change, 26*, 130-140. http://dx.doi.org/10.1375/bech.26.2.130

Wong, D. F. K. (2011). Cognitive behavioral group treatment for Chinese people with depressive symptoms in Hong Kong: Participants' perspectives. *International Journal of Group Psychotherapy, 61*, 438-459. http://dx.doi.org/10.1521/ijgp.2011.61.3.438

Wong, D. F. K., Lam, Y. K. A., & Poon, A. (2010). Depression literacy among Australians of Chinese-speaking background in Melbourne, Australia. *BMC Psychiatry, 10*, 7. http://dx.doi.org/10.1186/1471-244X-10-7

Wong, Y. J., Tran, K. K., Kim, S. H., Van Horn Kerne, V., & Calfa, N. A. (2010). Asian Americans' lay beliefs about depression and professional help seeking. *Journal of Clinical Psychology, 66*, 317-332. http://dx.doi.org/10.1002/jclp.20653

Woodruff-Borden, J., Brothers, A. J., & Lister, S. C. (2001). Self-focused attention: Commonalities across psychopathologies and predictors. *Behavioural and Cognitive Psychotherapy, 29*, 169–178. http://dx.doi.org/ 10.1017/S1352465801002041

World Health Organisation. (2017). *Depression and other common mental disorders: Global health estimates*. Retrieved from http://apps.who.int/iris/bitstream/10665/254610/1/WHO-MSD-MER-2017.2-eng.pdf?ua=1

Wu, Z., Cao, L., Peng, D., Mellor, D., Zhang, C., Li, H., . . . Fang, Y. (2018). The clinical correlates of comorbid anxiety symptoms and syndromal anxiety in patients with major depressive disorder. *Psychiatry Research, 269*, 251-257. http://dx.doi.org/https://doi.org/10.1016/j.psychres.2018.07.019

Wynaden, D., Chapman, R., Orb, A., McGowan, S., Zeeman, Z., & Yeak, S. (2005). Factors that influence Asian communities' access to mental health care. *International Journal of Mental Health Nursing, 14*, 88-95. http://dx.doi.org/10.1111/j.1440-0979.2005.00364.x

Xu, H., & Tracey, T. J. G. (2016). Cultural congruence with psychotherapy efficacy: A network meta-analytic examination in China. *Journal of Counseling Psychology, 63*, 359-365. http://dx.doi.org/10.1037/cou0000145

Yeager, K. A., & Bauer-Wu, S. (2013). Cultural humility: Essential foundation for clinical researchers. *Applied Nursing Research, 26*, 251-256. http://dx.doi.org/10.1016/j.apnr.2013.06.008

Yeh, C. J., & Inose, M. (2003). International students' reported English fluency, social support satisfaction, and social connectedness as predictors of acculturative stress. *Counselling Psychology Quarterly, 16*, 15-28. http://dx.doi.org/10.1080/0951507031000114058

Yeung, A., Chan, R., Mischoulon, D., Sonawalla, S., Wong, E., Nierenberg, A. A., & Fava, M. (2004). Prevalence of major depressive disorder among Chinese-Americans in primary care. *General Hospital Psychiatry, 26*, 24-30. http://dx.doi.org/10.1016/j.genhosppsych.2003.08.006

Yeung, A., Fung, F., Yu, S.-C., Vorono, S., Ly, M., Wu, S., & Fava, M. (2008). Validation of the Patient Health Questionnaire-9 for depression screening among Chinese Americans. *Comprehensive Psychiatry, 49*, 211-217. http://dx.doi.org/10.1016/j.comppsych.2006.06.002

Yip, T., Gee, G. C., & Takeuchi, D. T. (2008). Racial discrimination and psychological distress: The impact of ethnic identity and age among immigrant and United States–born Asian adults. *Developmental Psychology, 44*, 787-800. http://dx.doi.org/10.1037/0012-1649.44.3.787

Yu, Y., Liu, Z.-w., Hu, M., Liu, H.-m., Yang, J. P., Zhou, L., & Xiao, S.-y. (2015). Mental health help-seeking intentions and preferences of rural Chinese adults. *PLOS ONE, 10*, e0141889. http://dx.doi.org/10.1371/journal.pone.0141889

Zander, L. (2005). Communication and country clusters: A study of language and leadership preferences. *International Studies of Management & Organization, 35*, 83-103. http://dx.doi.org/10.1080/00208825.2005.11043727

Zhang, B., Xuefan, D., Weihong, L., Jing, Z., Qinyu, L., Zhenghui, Y., . . . Yindi, C. (2016). Effect of group cognitive-behavioral therapy on the quality of life and social functioning of patients with mild depression. *Shanghai Archives of Psychiatry, 28*, 18-27. http://dx.doi.org/10.11919/j.issn.1002-0829.215116

Zhang, D. (1995). Depression and culture-A Chinese perspective. *Canadian Journal of Counselling, 29*, 227-233.

Zhang, M. Y. (1989). The diagnosis and phenomenology of neurasthenia. A Shanghai study. *Culture, Medicine and Psychiatry, 13*, 147-161.

Zhou, B., Heather, D., Cesare, A. D., & Ryder, A. G. (2017). Ask and you might receive: The actor–partner interdependence model approach to estimating cultural and gender variations in social support. *European Journal of Social Psychology, 47*, 412-428. http://dx.doi.org/doi:10.1002/ejsp.2251

Zhou, X., Peng, Y., Zhu, X., Yao, S., Dere, J., Chentsova-Dutton, Y. E., & Ryder, A. G. (2016). From culture to symptom: Testing a structural model of "Chinese somatization". *Transcultural Psychiatry, 53*, 3-23. http://dx.doi.org/10.1177/1363461515589708

Zhu, Y., & Han, S. (2008). Cultural differences in the self: From philosophy to psychology and neuroscience. *Social and Personality Psychology Compass, 2*, 1799-1811. http://dx.doi.org/10.1111/j.1751-9004.2008.00133.x

Zu, S., Xiang, Y.-T., Liu, J., Zhang, L., Wang, G., Ma, X., . . . Li, Z.-J. (2014). A comparison of cognitive-behavioral therapy, antidepressants, their combination and standard treatment for Chinese patients with moderate–severe major depressive disorders. *Journal of Affective Disorders, 152-154*, 262-267. http://dx.doi.org/https://doi.org/10.1016/j.jad.2013.09.022

List of Appendices

Appendix A: HREC Approval

MEMORANDUM

Curtin University

To:	A/Prof Rosanna Rooney School of Psychology and Speech Pathology
CC:	Alice Viviana Farcas
From	Professor Peter O'Leary, Chair HREC
Subject	Ethics approval Approval number: HR190/2015
Date	02-Oct-15

Office of Research and Development
Human Research Ethics Office

TELEPHONE 9266 2784
FACSIMILE 9266 3793
EMAIL hrec@curtin.edu.au

Thank you for your application submitted to the Human Research Ethics Office for the project: 5231
Culturally Adapted Cognitive Behavioural Therapy for Depression in Chinese Migrants

Your application was reviewed by Human Research Ethics Committee at Curtin University at their meeting on the 4/08/2015

Thankyou for providing the additional information requested by the Human Research Ethics Committee. The information you provided was satisfactory and your proposal is now approved.

Please note the following conditions of approval:

1. Approval is granted for a period of four years from **05-Oct-15** to **05-Oct-19**
2. Research must be conducted as stated in the approved protocol.
3. Any amendments to the approved protocol must be approved by the Ethics Office.
4. An annual progress report must be submitted to the Ethics Office annually, on the anniversary of approval.
5. All adverse events must be reported to the Ethics Office.
6. A completion report must be submitted to the Ethics Office on completion of the project.
7. Data must be stored in accordance with WAUSDA and Curtin University policy.
8. The Ethics Office may conduct a randomly identified audit of a proportion of research projects approved by the HREC.

Should you have any queries about the consideration of your project please contact the Ethics Support Officer for your faculty, or the Ethics Office at hrec@curtin.edu.au or on 9266 2784. All human research ethics forms and guidelines are available on the ethics website.

Yours sincerely,

pp. Professor Peter O'Leary
Chair, Human Research Ethics Committee

Appendix B: Information Sheet in English and Simplified Chinese and Interview Schedule for Consulting Community Members

Curtin University

Cultural competence Version 3 14th September 2015

Participant Information Sheet

School of Psychology and Speech Pathology, Curtin University

Project title	Cultural competence in working with Chinese migrants to Australia
Principal investigator	A/Prof Rosanna Rooney
Co-investigator	A/Prof Peter McEvoy
Co-investigator	Alice Bercean (née Farcas)
Co-investigator	Dr Lauren Breen
Co-investigator	Dr Robert Kane

What is the study about?

Research suggests that Chinese migrants under-utilise mental health services. One of the main reasons is that migrants may believe that mental health services do not consider their culture. We would like to understand Chinese culture, beliefs and needs and how to provide a psychological treatment to Chinese migrants to help them feel understood and comfortable. We will use this information to develop a culturally appropriate treatment to Chinese migrants with depression. This treatment will be tested on a small number of people in another study.

Who is doing the Research?

The study is being conducted by Alice Bercean, in the capacity of a research student. The results of this research project will be used by Alice to obtain a Doctor of Philosophy at Curtin University and is funded by the University.

Who can participate?

You have been invited to take part in the study because you are a first generation Chinese migrant (you moved in Australia from another country), or a second generation Chinese migrant (you were born in Australia and at least one of your parents were born overseas) or a Chinese international student.

What will the study involve?

You are being invited to attend an interview. You will be asked questions that will help us understand how to provide a culturally appropriate treatment e.g. activities you enjoy, if drinking a tea with the therapist might help a Chinese person feel more comfortable, if asking open-ended questions might help a Chinese person to open one's heart. The duration of the interview is up to 90 min. The interview will take place at a location that is convenient for you. An interpreter will be provided for you if you would like one.We will make a digital audio recording which will be transcribed either by Alice or a professional transcriptionist who will be bound by confidentiality.

Are there any benefits' to being in the research project?

We will recompense you with a $10 Coles/Myers gift voucher for your time.

We hope that with your help we will better understand Chinese people's culture, beliefs and needs. This will allow us to develop a new treatment for Chinese migrants that will make them feel more comfortable, understood and confident to open their heart.

Curtin University

Cultural competence Version 3 14th September 2015

Are there any risks, side-effects, discomforts or inconveniences from being in the research project?

We have been careful to make sure that the questions in the interview do not cause you any distress. However, if you feel uncomfortable about any of the questions, you do not need to answer them. If the questions cause any concerns or upset you, we can refer you to a counsellor. In addition, you can receive immediate confidential psychological assistance by contacting Free Translating and Interpreting Service on 13 14 50 to talk to Lifeline on 13 11 14 in the required language.

Confidentiality

The information collected in this research will be re-identifiable (coded). This means that we will remove identifying information on any data and replace it with a code. Any information we collect will be treated as confidential and used only in this project unless otherwise specified. The following people will have access to the information we collect in this research: the supervisors, the student researcher, the transcriptionist and the interpreter.

Electronic data including digital audio recordings will be password-protected and hard copies including consent forms and field notes will be in locked storage. The information we collect in this study will be kept under secure conditions at Curtin University for 7 years after the research has ended and then it will be destroyed. If you require an interpreter we will ask the interpreter to sign a confidentiality agreement before the interview.

Do I have to take part in the research project?

Taking part in a research project is voluntary. It is your choice to take part or not. You do not have to agree if you do not want to. If you decide to take part and then change your mind, that is okay, you can withdraw from the project. You do not have to give us a reason; just tell us that you want to stop. Please let us know you want to stop so we can make sure you are aware of anything that needs to be done so you can withdraw safely. If you choose not to take part or start and then stop the study, it will not affect your relationship with the University, staff or colleagues. If you choose to leave the study we will use any information collected unless you tell us not to.

What happens next and who can I contact about the research?

If you decide to take part in this research we will ask you to sign the consent form. By signing it is telling us that you understand what you have read and what has been discussed. Signing the consent indicates that you agree to be in the research project and have your health information used as described. Please take your time and ask any questions you have before you decide what to do. You will be given a copy of this information sheet and the consent form to keep. If you require further details about the study, please contact:

Alice Bercean (co-investigator) at alice.farcas@postgrad.curtin.edu.au

A/Prof Rosanna Rooney at R.Rooney@curtin.edu.au

A/Prof Peter McEvoy at peter.mcevoy@curtin.edu.au

Dr Lauren Breen at Lauren Breen Lauren.Breen@curtin.edu.au

Dr Robert Kane at R.T.Kane@curtin.edu.au

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HR190/2015). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Curtin University

Cultural competence Version 3 14th September 2015

CONSENT FORM

Project title	Cultural competence in working with Chinese migrants to Australia
Principal investigator	Associate Professor Rosanna Rooney
Co-investigator	Associate Professor Peter McEvoy
Co-investigator	Alice Bercean (née Farcas)

Thank you for your interest in this project. Just to remind you, the data you provide in the course of this project will be treated in the strictest confidence and will be used for research purposes only. Furthermore, as a participant in this research you will never be identified in any outputs (e.g., research articles) that arise from this project and your data will never be identifiable or viewed by any other party outside the supervisors and the student researcher.

Please tick boxes

1. I confirm that I have read and understand the information sheet for the above study and I understand its contents. ☐
2. I have had the opportunity to ask questions and I am satisfied with the answers I have received. ☐
3. I voluntarily consent to take part in this study. ☐
4. I do consent to being audio-recorded. ☐
5. I do consent to use the selected interpreter. ☐
6. I do consent the interpreter to be present. ☐
7. I agree to take part in the above study. ☐
8. I would like to receive the results from this research. ☐

My email address is_____

_____	_____	_____
Participant Name	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HR190/2015). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

文化能力 版本 2 2015 年 9 九月 23 日

参与者信息表

科廷大学心理学及言语疾病学院

项目名称：与澳洲的中国移民工作时显示的文化能力
首席研究员：罗珊娜·鲁尼副教授（A/Prof Rosanna Rooney）
联合调查员：彼得·麦克沃伊副教授（A/Prof Peter McEvoy）
联合调查员：爱丽丝·法克斯（Alice Bercean née Farcas）
联合调查员：劳伦·布林博士(Dr Lauren Breen)
联合调查员：罗伯特· 凯恩博士 (Dr Robert Kane)

该项目研究的是什么？
研究表明，中国移民很少使用心理健康服务。其中一个主要的原因是，移民可能认为心理健康服务没有考虑他们的文化。我们想了解中国文化、信仰和需求，以及如何为中国移民提供心理治疗，帮助他们受到理解，并感到舒适。我们将利用这一信息来为患有抑郁症的中国移民制定一个文化上适当的治疗方案。该治疗方案将在另一项研究中针对少数人进行测试。

谁在做这项研究？
这项研究由爱丽丝·法克斯（Alice Farcas）进行，她是一位在读的研究生。这一研究项目的结果将由爱丽丝·法克斯（Alice Farcas）用于获得其在科廷大学的哲学博士学位。该研究项目由科廷大学资助。

谁可以参加这项研究？
我们邀请你参加此研究是因为您是第一代中国来的移民（您从另外一个国家来到澳大利亚），或者您是第二代中国来的移民（您在澳大利亚出生并且您的父母至少有一方是在海外出生），或您是留学生。

该研究的内容是什么？
你被邀请参加面试。面试将在一个方便的地方。您将会回答一些问题，这些问题将帮助我们理解如何可以提供符合不同文化背景的治疗措施:例如，您喜欢做的事情；如果在看理疗师的时候喝杯茶是否能让中国客户感到更加自在；如果问一些开放式问题是否可以帮助中国客户敞开自己的心扉等等。
访谈将持续 90 分钟。如果您需要翻译，我们可以为您提供。我们将进行数码录音，然后将由 Alice 或是专业文字录入员对于录音进行文字录入。文字录入人员都将受到隐私保护条例的约束。

参与该研究项目有什么好处？
我们将送给您一张$10 的 Coles 或 Myers 的消费券作为报酬，感谢您付出的时间。我们希望通过您的帮助，我们将更好地了解中国人的文化、信仰和需求。这将允许我们为中国移民制定新的治疗方案，使他们感到更舒适，受到他人理解并自信地敞开心扉。

科廷大学人类研究道德委员会（HREC）已批准这一研究（HREC 批准号 HR 190/2015。如果您想要与未参与此项研究的人讨论该研究，具体来说就是讨论涉及该研究的任何事务或者您作为参与者的权利，或者您想要提出保密的投诉，您可以联系道德委员会的工作人员，电话 (08) 9266 9223，或者联系研究诚信委员会主任，电话 (08) 9266 7093，或者发送电子邮件至 hrec@curtin.edu.au。

文化能力 版本 2 2015 年 9 九月 23 日

参与该研究项目是否有任何风险、副作用、不适或不便？

我们一直非常小心，以确保在面试中的问题不会给您带来任何困扰。但是，如果您对任何问题有顾虑或担心，您可以不需要回答。如果这些问题造成任何疑问或使您不安，我们可以向您推荐一个顾问。另外，您可以通过拨打免费的翻译服务热线 13 14 50，告知他们您的语言是中文，并且您希望联系生命热线 13 11 14，以此可以立即获得完全保密的心理帮助。

保密性

该研究收集的信息将被重新识别（编码）。这意味着我们将除去任何具有识别性质的数据信息或样本，并用一个代码替换。我们收集的任何信息都将被视为机密，除非另有规定用于此项目。下列人员可以看到我们在此研究中收集到的信息：负责人、学生研究员、文字录入人员和翻译。

电子版数据(包括数码录音)，都将有密码保护。纸质文件(包括同意表、现场笔记等) 将会上锁存档。 我们在该研究中收集的信息将被保存在科廷大学安全的地方，保存时间为该研究结束后 7 年，然后将被销毁。如果您需要口译员，我们会要求口译员在采访前签署保密协议。

我必须参与该研究项目吗？

参与改研究项目是自愿的。您可以选择是否参与。如果您不想参与，你不必同意。如果您决定参与，然后改变了您的想法，那也没关系，您可以退出该研究项目。你不必给出理由，只需要告诉我们您希望停止参与。请让我们知道您想停止，这样我们可以确保您知道任何相关信息及有待解决的事务，然后您可以放心地退出。如果您选择不参与该研究，或者开始参与后又决定停止参与，这不会影响到您与科廷大学、员工或同事的关系。如果你选择离开该研究，除非您告诉我们不要这么做，否则我们将使用收集的任何信息。

接下来会发生什么？我能和谁联系？

如果您决定参与这项研究，我们将要求您签署同意书。签署后就意味着您告诉我们您已理解本同意书的内容以及相关讨论话题。签署同意书表明您同意参与该研究项目，并同意我们使用您的健康信息。请在决定下一步之前仔细考虑，有任何问题可以现在提出。最后，您将获得该信息表及同意书的副本。

如果您需要有关该研究的进一步详情，请联系：

爱丽丝·法克斯 研究员（Alice Bercean née Farcas)，电子邮箱 alice.farcas@postgrad.curtin.edu.au

罗珊娜·鲁尼副教授（A/Prof Rosanna Rooney)，电子邮箱：R.Rooney@curtin.edu.au

彼得·麦克沃伊副教授（A/Prof Peter McEvoy)，电子邮箱： peter.mcevoy@curtin.edu.au

劳伦·布林博士 (Dr Lauren Breen)， 电子邮箱： Lauren.Breen@curtin.edu.au

罗伯特· 凯恩博士(Dr Robert Kane), 电子邮箱：R.T.Kane@curtin.edu.au

文化能力 版本 2 2015 年 9 九月 23 日

同意书

HREC 研究项目编号： XX
项目名称： 与澳洲的中国移民工作时显示的文化能力
首席研究员： 罗珊娜·鲁尼副教授（Associate Professor Rosanna Rooney）
研究员： 彼得·麦克沃伊副教授（Associate Professor Peter McEvoy）
研究员： 爱丽丝·法克斯（Alice Bercean née Farcas）

感谢您对这个研究项目的兴趣。只是提醒您，您在这个研究项目进行过程中提供的数据将严格保密，并仅用于研究目的。此外，作为这项研究的参与者，您的信息将永远不会在源自该项目的任何输出文件（如报告、研究文章等）中显示，识别您的信息将永远不会显示，也不会提供给研究团队之外的任何其他方。

	请勾选框
1.我确认已阅读并理解该研究信息表中的内容。	☐
2.我有机会提问，并且我很满意我得到的答案。	☐
3.我自愿同意参与这项研究。	☐
4.我同意进行录音记录。	☐
5.我同意使用选定的口译员。	☐
6.我同意翻译员在场。	☐
7.我同意参与上述研究。	☐
8. 我希望得到此研究的结果。	☐

我的电子邮件地址是_____

_____	_____	_____
参与者姓名	日期	签名
_____	_____	_____
研究员姓名	日期	签名

科廷大学人类研究道德委员会（HREC）已批准这一研究（HREC 批准号 HR 190/2015。如果您想要与未参与此项研究的人讨论该研究，具体来说就是讨论涉及该研究的任何事务或者您作为参与者的权利，或者您想要提出保密的投诉，您可以联系道德委员会的工作人员，电话 (08) 9266 9223，或者联系研究诚信委员会主任，电话 (08) 9266 7093，或者发送电子邮件至 hrec@curtin.edu.au。

Interview protocol for semi-structured interview

Script for the beginning of interview

Good evening/Good morning and welcome. Thanks for taking the time to discuss culturally appropriate mental health services for Chinese migrants. My name is Alice Bercean and I will serve as the interviewer. Assisting me is ..who is a professional interpreter. He/she will translate my questions for you. I'm a Psychology PhD Student at Curtin University. I'm from Romania and I've been here for 2 years. Being a migrant, I'm interested in the mental health of other migrants. I'm particularly interested in understanding how Chinese migrants experience depression and how to improve psychological interventions for them. Your opinions are very important to me because they will help me to develop an appropriate intervention for Chinese migrants.

Please feel free to share your point of view. I am here to ask questions and to listen. The interview will take up to 1 h 30 min. You've probably noticed the microphone. We're tape recording the session because I can't write fast enough to write down everything you say and I don't want to miss any of your comments. You are assured of complete confidentiality. I won't write your name in any reports. So this discussion is only between you and me.

Please tell me if you have any questions before we start. You can contact me later by email alice.farcas@postgrad.curtin.edu.au. Well, let's begin. First, I'd like to find out a bit more about you:

- Gender □ Male □ Female
- Age_____
- Are you a student □ Yes (please specify course) _____ □ No
- Occupation/employment (please specify) _____
- Which culture do you identify with most? Please specify _____
- Do you identify with any other culture? Please specify _____
- What is your country of birth? Please specify _____
- How long have you been here? _____

1. Do you live here with your family? How has your experience in Perth been so far?

2. We would like to understand Chinese culture, beliefs and needs in order to develop a psychological treatment for Chinese migrants with depression. Depression is a term that we use to refer to the situation when someone's heart is closed and one's body and mind is affected. How would you describe depression in your own words? What are the usual signs of depression?

3. We know that Chinese migrants under-utilise the mental health services and one of the reasons is the shame and "loss of face". How could we reduce the shame associated with depression? Do you think discussing the fact that people all over the world, regardless of their gender, age, nationality, experience depression might be useful?

4. A psychological treatment is provided over a number of sessions. In the first session the psychologist will discuss why a problem exists, what to do about it and how effective the treatment is (stats or stories about people who got better). What information might be more impactful? How can this information be presented in an attractive way?

5. What expectations might a Chinese migrant have of a psychologist?

6. Would you attend a group treatment with other Chinese migrants with depression or would you prefer a session with a therapist on your own?

7. Do you think considering some customs, such as drinking tea, might help the Chinese migrants to feel more comfortable during the treatment? Are there other customs? What do you think about decorating a therapy room with a few Chinese objects? What objects would you choose?

8. A psychological treatment aims to develop new skills. Therefore, a psychologist will give some homework to a client. Is homework an appropriate word? How could a psychologist increase a Chinese person's motivation to do the homework?

9. What technique might help a Chinese person to open one's heart eventually: asking open-ended questions, providing mini lectures, sharing similar experiences, providing translated materials in Simplified Chinese? Are there any other approaches that would be particularly helpful?

10. Do you think proving personalised bilingual worksheets might be beneficial? What kind of images, symbols and quotes could we use?

11. What leisure activities do you enjoy?

12. Would you engage in activities with the broader Australian community, for example go to concerts, festivals, local community art centre, local leisure park and sport competition? What activities would you prefer?

13. Do you think Chinese migrants practice meditation nowadays? What is the possible effect of meditation?

14. What is the best way to advertise a psychological treatment? What do you think about these flyers?

15. Is there anything that you came wanting to say that you didn't get a chance to say?

Appendix C: Information Sheet and Interview Schedule for Consulting Clinicians

Curtin University

Cultural competence Version 3 14th September 2015

Participant Information Sheet

School of Psychology and Speech Pathology, Curtin University

Project title	Cultural competence in working with Chinese migrants to Australia
Principal investigator	Associate Professor Rosanna Rooney
Co-investigator	Associate Professor Peter McEvoy
Co-investigator	Alice Bercean (née Farcas)
Co-investigator	Dr Lauren Breen
Co-investigator	Dr Robert Kane

What is the study about?
Research suggests that Chinese migrants report a low rate of mental health services and one of the main reasons is limited access to culturally appropriate services. We would like to understand how to provide a culturally appropriate psychological intervention to Chinese migrants. We will use this information to develop a culturally appropriate cognitive-behavioural therapy for depression in Chinese migrants that will be pilot tested in a further study.

Who is doing the Research?
The study is being conducted by Alice Bercean, in the capacity of a research student. The results of this research project will be used by Alice to obtain a Doctor of Philosophy at Curtin University and is funded by the University.

Who can participate?
You have been invited to take part in the study due to your expertise in working with Chinese migrants.

What will the study involve?
You are being invited to attend two focus groups. We will use the information from the first focus group to develop a culturally adapted individual cognitive behavioural protocol for depression in Chinese migrants. Then, we will run a second focus group to review and revise the intervention protocol. The duration of the first focus group is up to 2 hours and the second focus group will take up to 1 h and 15 min. The focus groups will take place at a location that is convenient for you. We will make a digital audio recording, which will be transcribed either by Alice Farcas or a professional transcriptionist who will be bound by confidentiality. An assistant moderator will assist the student researcher in conducting the focus groups and will take notes.

Are there any benefits' to being in the research project?
By participating in this study you will have the satisfaction knowing that you have helped us to develop a culturally sensitive intervention for depression in Chinese migrants. If effective, the intervention might be used by other mental health providers. We will have a few refreshments as a thank you for giving us your time and ideas.

Curtin University

Cultural competence Version 3 14th September 2015

Are there any risks, side-effects, discomforts or inconveniences from being in the research project?

Apart from giving up your time, we do not expect that there will be any risks or inconveniences associated with taking part in this study.

Confidentiality

The information collected in this research will be re-identifiable (coded). This means that we will remove identifying information on any data and replace it with a code. The quotes that will be used in further publications will be de-identified. The following people will have access to the information we collect in this research: the supervisors, the student researcher, the transcriptionist and the assistant moderator.

Electronic data including digital audio recordings will be password-protected and hard copies including consent forms and field notes will be in locked storage. The information we collect in this study will be kept under secure conditions at Curtin University for 7 years after the research has ended and then it will be destroyed. Whilst all care will be taken to maintain privacy and confidentiality of any information shared at a focus group or group discussion, you should be aware that you may feel embarrassed or upset if one of the group members repeats things said in a confidential group meeting.

Do I have to take part in the research project?

Taking part in a research project is voluntary. It is your choice to take part or not. You do not have to agree if you do not want to. If you decide to take part and then change your mind, that is okay, you can withdraw from the project. You do not have to give us a reason; just tell us that you want to stop. Please let us know you want to stop so we can make sure you are aware of anything that needs to be done so you can withdraw safely. If you choose to leave the study we will use any information collected unless you tell us not to.

What happens next and who can I contact about the research?

If you decide to take part in this research we will ask you to sign the consent form. By signing it is telling us that you understand what you have read and what has been discussed. Signing the consent indicates that you agree to be in the research project and have your health information used as described. Please take your time and ask any questions you have before you decide what to do. You will be given a copy of this information sheet and the consent form to keep.

If you require further details about the study, please contact:

Alice Bercean (co-investigator) at alice.farcas@postgrad.curtin.edu.au

A/Prof Rosanna Rooney at R.Rooney@curtin.edu.au

A/Prof Peter McEvoy at peter.mcevoy@curtin.edu.au

Dr Lauren Breen at Lauren Breen Lauren.Breen@curtin.edu.au

Dr Robert Kane at R.T.Kane@curtin.edu.au

Curtin University

Cultural competence Version 3 14th September 2015

CONSENT FORM

Project title	Cultural competence in working with Chinese migrants to Australia
Principal investigator	Associate Professor Rosanna Rooney
Co-investigator	Associate Professor Peter McEvoy
Co-investigator	Alice Bercean (née Farcas)

Please tick boxes

1. I confirm that I have read and understand the information sheet for the above study and I understand its contents. ☐
2. I have had the opportunity to ask questions and I am satisfied with the answers I have received. ☐
3. I voluntarily consent to take part in this study. ☐
4. I do consent to being audio-recorded. ☐
5. I agree to take part in the above study. ☐
6. I would like to receive the results from this research. ☐
   My email address is_____

_____	_____	_____
Participant Name	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HR 190/2015). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Interview Schedules for Consulting Clinicians

Script for the beginning of interview

Good evening/Good morning and welcome. Thanks for taking the time to join our discussion about adapting cognitive behavioural therapy for depression (CBT) in Chinese migrants. My name is Alice Bercean, and I will serve as moderator facilitator for today's focus group discussion. Assisting me is.... The purpose of today's discussion is for us to learn how to adapt CBT for depression in Chinese migrants, to make it more relevant and engaging and therefore more effective and likely to be used. Cognitive therapy is an active, structured and problem-oriented psychotherapy, which posits that people's emotions, behaviours, and physiology are influenced by their perception of events. The therapy has three major components, namely, the cognitive intervention, the behaviour intervention and meditation. You were invited because of your experience in working with Chinese migrants.

Please feel free to share your point of view but please don't feel like you have to respond to me if you don't feel like it. Also please feel free to have a conversation with one another about these questions. I am here to ask questions, listen and make sure everyone has a chance to share. We're interested in hearing from each of you.

You've probably noticed the microphone. We're audio recording the session because we don't want to miss any of your comments. People often say very helpful things in these discussions and we can't write fast enough to get them all down. We will be on a first name basis today, and we won't use any names in our reports. You may be assured of complete confidentiality.

If you have any questions you can contact me by email alice.farcas@postgrad.curtin.edu.au. Well, let's begin. We've placed name cards on the table in front of you to help us remember each other's names. Let's find out more about each other by going around the table.

1. Think back to your Chinese patients and tell us about your experience with them. What went particularly well?

2. What therapeutic approach and psychological techniques do you use with Chinese migrants?

3. What are your expectations of a Chinese patient?

4. What are the Chinese subgroups that are likely to access mental health services?

5. Are there any differences between the Chinese subgroups that might be relevant in providing a psychological treatment?

6. We would like to know your opinion about the specific and non-specific factors of a treatment. Let's discuss the non-specific factors first (treatment rationale, therapeutic relationship, therapeutic setting, and homework).

a) How important is to provide a treatment rationale to a Chinese patient in the first session?

b) We could present the basic description of CBT, stats about the efficacy of CBT for depression in an accessible language, case studies, or we could include all these pieces of information in a handout. What option might address Chinese migrants' needs best?

c) How important is the therapeutic relationship in working with a Chinese migrant?

d) What techniques might be useful to develop a good therapeutic relationship? What about microcounselling skills e.g. paraphrasing, summarising, open-ended questions, reflection,

empathy? What do you think about considering some customs such as drinking a Chinese tea during the session? Are there any other customs that we should be aware of?

e) How important is the therapeutic setting in working with a Chinese person? What might be the impact of decorating the therapy room with some Chinese objects?

f) Homework is an important component of CBT. Is the word 'homework' appropriate for the Chinese migrants? Do you think we could increase their motivation to do the homework if we explain it in English and then we ask them to do the homework in their native language?

Now let's discuss the specific factors of CBT.

a) In one study Chinese migrants to Canada reported difficulties in challenging and reframing the culture–specific core beliefs (e.g. "I must take care of others before myself"; "If I say no, I am a selfish person"). Any attempt to relax such beliefs was considered a betrayal of their culture. However, other studies showed that cognitive restructuring was possible with Chinese people. What do you think? Is it appropriate to challenge and reframe the automatic thoughts of Chinese people?

b) We plan to develop a catalogue of culturally appropriate activities as a tool for behavioural activation. What kind of activities might be relevant to Chinese migrants?

c) Do you think the Chinese migrants will engage in activities with the broader Australian community, for example go concerts, festivals, local community art centre, local leisure park and sport competitions? What kind of activities that would involve the broader community could be relevant for them?

d) A researcher proposed that mindfulness meditation might be a cultural bridging technique in Chinese community because of their familiarity with meditation. What do you think? How can we use meditation in an effective and appropriate way?

7. What therapeutic format (group or individual) might be more appropriate and beneficial for Chinese migrants?

8. What is a more culturally appropriate word for depression?

9. Are there any aspects related to verbal and non-verbal communications that we need to consider?

10. We are aware that for Chinese people relationships with family members and the community are very important. How could we involve family members in the therapeutic process?

11. A researcher recommended conducting interviews with Traditional Chinese Medicine practitioners, Buddhist monks or religious Taoist masters because of their experience in providing a traditional treatment for depression. What do you think? What might be more feasible and beneficial for developing an intervention protocol: to conduct interviews with cultural healers or with Chinese migrants living in Perth?

12. We need your help to adapt cognitive behavioural therapy to be more culturally appropriate for Chinese migrants. Is there anything we missed? Is there anything that you came wanting to say that you didn't get a chance to say?

Appendix D: Information Sheet for the Online Survey

Curtin University

Impact of migration Version 4 12th May 2016

Participant Information Sheet

School of Psychology and Speech Pathology, Curtin University

Project title	Impact of migration on Chinese living in Australia
Principal investigator	A/Prof Rosanna Rooney
Co-investigator	A/Prof Peter McEvoy
Co-investigator	Alice Bercean (née Farcas)

What is the study about?

My name is Alice Bercean and I am a PhD student enrolled in School of Psychology and Speech Pathology at Curtin University, WA. This study constitutes a part of my research project and aims to explore how migration might influence Chinese migrants' well-being and how their thoughts, feelings, and behaviours might be affected. This information will benefit the Chinese community by developing and providing a more relevant and culturally appropriate well-being program. Some of the benefits of the program may be feeling happier, adjusting more easily to the new culture, better problems solving and decision making skills.

Who can participate?

To take part in the study you need to be **aged 18 +.** Also you need to be a **first generation Chinese migrant** (you moved in Australia from another country), or a **second generation Chinese migrant** (you were born in Australia and at least one of your parents were born overseas) **or a Chinese international student.**

What will the study involve?

If you choose to take part in this study, you will be asked to follow the link to an online survey which should take maximum 20 min to complete. The survey includes questions about your ethnic background, some situations commonly faced by migrants, thoughts, feelings and behaviors people might have. The questions included in the survey are in English.

Are there any benefits' to being in the research project?

If you are a student enrolled in School of Psychology and Speech Pathology, at Curtin University, and you have registered for this study on SONA website, you will be awarded 2 credit points if you complete at least 90% of the survey (57 questions). After completing the survey, you will be asked to provide your Student ID and email address. This information will not be linked to your responses that you provide in the survey.

If you are not a Psychology student at Curtin University you will have the option of entering a draw to win one of five $50 prizes after completing at least 90% of the survey (57 questions). The email address provided will not be linked to your survey responses and will be stored in a separate location.

Are there any risks or inconveniences from being in the research project?

We do not expect any potential risk/ harm for any participant involved in this study. However, if the questions cause any concerns or upset you, please do not hesitate to contact us and we will assist you with it or even guide you through the process of seeking

Curtin University

Impact of migration Version 4 12th May 2016

professional advice. In addition you can receive immediate confidential psychological assistance by contacting Lifeline on 13 11 14, Samaritans on 13 52 47 and Men's Line Australia on 1300 789 978.

Confidentiality

All data obtained from participants will be treated as confidential and used only in this project unless otherwise specified. The supervisors and the student researcher will have access to this information. Electronic data will be password-protected. The information we collect in this study will be kept under secure conditions at Curtin University for 7 years after the research has ended and then it will be destroyed.

Who can I contact about the research?

It is your choice to take part in this study. You can withdraw from the study anytime.

If you require further details about the study, feel free to contact me at alice.farcas@postgrad.curtin.edu.au , or you may contact my supervisors Associate Professor Rosanna Rooney at R.Rooney@curtin.edu.au and Associate Professor Peter McEvoy at peter.mcevoy@curtin.edu.au .

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HR 190/2015). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Appendix E: Questionnaires included in the Online Survey

Consent form
I have read, understood and printed a copy of the foregoing participant information sheet. I am also aware that I have the choice to withdraw from the study at any-time during the process, if I change my mind. I consent voluntarily to be a participant in this study.

- ○ Yes
- ○ No

I do consent to be contacted about future research projects that are related to this study.

- ○ Yes
- ○ No

I would like to receive the results from this research.

- ☐ Yes
- ☐ Please provide your email address
- ☐ No

Block 1

I am interested in entering a draw to win one of five $50 Coles/Myer vouchers.
Click here to read the competition terms and conditions.

Yes

- ☐ Please provide your full name
- ☐ Please provide your email address. We need a valid email address to be able to contact you if you win one of the five $50 Coles/Myer vouchers.
- ☐ No

Demographic information

What is your age?

What is your gender?

- ○ Male
- ○ Female
- ○ Another gender

Are you a student?

- ○ Yes, please specify your course or major
- ○ No, please specify your occupation

What is the highest level of education you have completed?

- Year 10
- Year 12
- Certificate I-V (TAFE)
- Bachelor degree
- Post-graduate degree
- Other

What is your current marital status?

- Married
- Living with partner
- Divorced
- Separated
- Widowed
- Single

What is your country of birth?

- Please specify

How long have you been living in Australia?

- Please specify

DI

Instructions: Below are a series of statements expressing the difficulties confronted by immigrants and international students. Evaluate each statement as it applies to your recent (within the last 3 months) personal experience and tick the answer that best describes your experience.

	Not at all	Rarely	Occasionally	Sometime	Frequently	Very much
1. I miss the people I left behind in my original country.						
2. When I think of my past life, I feel emotional and sentimental.						
3. When I think of my original country, I get teary.						
4. I feel sad when I think of special places back home.						
5. Australians have a hard time understanding my accent.						
6. I have difficulty doing ordinary things because of a language barrier.						
7. Talking in English takes a lot of effort.						
8. As an immigrant, I am treated as a second-class citizen.						
9. Australians don't think I really belong in their country.						
10. Australians treat me as an outsider.						
11. People with foreign accents are treated with less respect.						
12. I do not feel at home.						
13. Even though I live here, it does not feel like my country.						
14. I do not feel that this is my true home.						

Meim-R

	Not at all	Several days	More than half of the two week period	Nearly every day

In this country, people come from many different countries and cultures, and there are many different words to describe the different backgrounds or ethnic groups that people come from. Some examples of the names of ethnic groups are Chinese, Chinese-Australian, Australian, German, African, American and many others. These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.

○ Please fill in: In terms of ethnic group, I consider myself to be

These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.	○	○	○	○	○
2. I have a strong sense of belonging to my own ethnic group.	○	○	○	○	○
3. I understand pretty well what my ethnic group membership means to me.	○	○	○	○	○
4. I have often done things that will help me understand my ethnic background better.	○	○	○	○	○
5. I have often talked to other people in order to learn more about my ethnic group.	○	○	○	○	○
6. I feel a strong attachment towards my own ethnic group.	○	○	○	○	○

PHQ

Over the previous 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half of the two week period	Nearly every day
1. Little pleasure or little interest in doing things.	○	○	○	○
2. Feeling down, depressed, or hopeless.	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much.	○	○	○	○
4. Having little energy or feeling tired.	○	○	○	○
5. Poor appetite or overeating.	○	○	○	○
6. Feeling negative about yourself or that you are a failure or have let yourself or your family down.	○	○	○	○
7.Trouble concentrating on things, such as reading the newspaper or watching television.	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.	○	○	○	○
9. Thoughts that you would be better off dead or of hurting yourself in some way.	○	○	○	○

RRS

Please read each of the statements below and indicate whether you never, sometimes, often or always think each one when you feel sad, down or unhappy. Please indicate what you generally think or do, not what you think you should think or do.

	Almost Never	Sometimes	Often	Almost Always
1. Think "What am I doing to deserve this?"	○	○	○	○
2. Think "Why do I always react this way?"	○	○	○	○
3. Think about a recent situation, wishing it had gone better.	○	○	○	○
4. Think "Why do I have problems other people don't have?"	○	○	○	○
5. Think "Why can't I handle things better?"	○	○	○	○

	Not at all	Not at all Almost Never	Somewhat Infrequently	A little Infrequently	Moderately Somewhat Frequently	A lot Often	Mostly Very Frequently	Completely All the time Almost Always

ATQ

Listed below are a variety of thoughts that pop into people's heads. Please read each thought and indicate how frequently, if at all, the thought occurred to you over the last week. Please read each item carefully and tick the appropriate answers.

	Not at all	Sometimes	Moderately often	Often	All the time
1. I'm no good.	○	○	○	○	○
2. I'm so disappointed in myself.	○	○	○	○	○
3. What's wrong with me?	○	○	○	○	○
4. I'm worthless.	○	○	○	○	○
5. I feel so helpless.	○	○	○	○	○
6. Something has to change.	○	○	○	○	○
7. My future is bleak.	○	○	○	○	○
8. I can't finish anything.	○	○	○	○	○

MAAS

Below is a collection of statements about your everyday experience. Using the 1-6 scale below, please indicate how frequently or infrequently you currently have each experience. Please answer according to what really reflects your experience rather than what you think your experience should be. Please treat each item separately from every other item.

	Almost Never	Very Infrequently	Somewhat Infrequently	Somewhat Frequently	Very Frequently	Almost Always
1. It seems I am "running on automatic", without much awareness of what I'm doing.	○	○	○	○	○	○
2. I rush through activities without being really attentive to them.	○	○	○	○	○	○
3. I get so focused on the goal I want to achieve that I lose touch with what I'm doing right now to get there.	○	○	○	○	○	○
4. I do jobs or tasks automatically, without being aware of what I'm doing.	○	○	○	○	○	○
5. I find myself preoccupied with the future or the past.	○	○	○	○	○	○
6. I find myself doing things without paying attention.	○	○	○	○	○	○

BADS

Please read each statement carefully and the statement which best describes what was true for you during the past week including today.

	Not at all	Somewhat	A little	Moderately	A lot	Mostly	Completely
1. There were certain things I needed to do that I didn't do.	○	○	○	○	○	○	○
2. I am content with the amount and types of things I did.	○	○	○	○	○	○	○
3. I engaged in many different activities.	○	○	○	○	○	○	○
4. I made good decisions about what type of activities and/or situations I put myself in.	○	○	○	○	○	○	○
5. I was an active person and accomplished the goals I set out to do.	○	○	○	○	○	○	○
6. Most of what I did was to escape from or avoid something unpleasant.	○	○	○	○	○	○	○
7. I spent a long time thinking over and over about my problems.	○	○	○	○	○	○	○
8. I engaged in activities that would distract me from feeling bad.	○	○	○	○	○	○	○
9. I did things that were enjoyable.	○	○	○	○	○	○	○

Block 10

Thank you for your time. It is most appreciated !

If the questions cause any concerns or upset you, please contact:
1. Phone Support services available 24 hours/7 days a week
Lifeline line 1311 14
Samaritans 13 52 47
MEN'S LINE AUSTRALIA 1300 789 978

Free Translating and Interpreting Service on 131 450 to talk to Lifeline
-MEN'S LINE AUSTRALIA 1300 789 978
2. Mental Health Services
Counselling services for on-campus students at Curtin University
Tel: +61 8 9266 7850 or 1800 651 878 (Freecall)
South Metropolitan Mental Health Services available during business hours 8.30 am-4.15 pm
- Armadale Mental Health Services: +61 8 9391 2300
- Bentley: +61 8 9416 3666
- Fremantle: +61 8 9431 3555
- Rockingham: +61 8 9528 0600

North Metropolitan Mental Health Services available during business hours 8.30 am-4.15 pm
- City: +61 (08) 9224 1720
- Joondalup: +61 (08) 9400 9599
- Stirling: +61 (08) 9344 5400

Appendix F: Impact of Migration Competition – Terms and Conditions

1. Instructions on how to enter and other details contained within promotional advertisements for this competition form part of the conditions of entry.
2. By entering the competition, entrants agree to abide by these Terms and Conditions.
3. The Terms and Conditions of this competition are governed by the laws of the State of Western Australia.
4. The competition is being run by Curtin University of Technology, GPO Box U1987, Perth, Western Australia, 6845 ("Curtin").
5. The Impact of migration Competition commences at 16 June 2016 Australian Western Standard Time (AWST)
6. The competition will close after finalising the data collection or by 18 months from the start of the competition whichever comes first.
7. Entry to the competition is limited to first and second generation Chinese migrants and Chinese International Students.
8. To enter the competition, the entrant must complete 90% of the online survey.
9. Entry to the competition is free. Entrants will be responsible for all costs associated with entering the competition, which may include costs associated with accessing the internet.
10. Entrants may only enter the competition once.
11. There will be five (5) prizes. A prize will be $50 Coles/Myers voucher.
12. The draw will be by random number generator from all eligible entries received and five (5) participants who are chosen randomly will the prize winners.
13. The prize winner will be contacted within seven (7) days of the draw by the email address provided to register for completing the online survey.
14. If the prize winner does not respond to claim the prize within <twenty-one (21) days> of the draw, a re-draw will be conducted within <thirty (30) days> of the original draw date, in the same location, and with the same method. Redraws will continue in the same manner until all prizes have been claimed by prize winners.
15. The prize may be collected in person by the prize winner or may be mailed/couriered.
16. If a prize winner who has been contacted and been made aware of their prize winning, and has agreed to collect the prize and does not collect the prize within <twenty-one (21) days> of this contact, a re-draw will be conducted within <thirty (30) days> of the original draw date, in the same location, and with the same method.
17. The prize winners may be required to provide evidence of their identity (such as photographic ID, birth certificate or current passport) when receiving the prize.
18. The prize winner will be responsible for all costs associated with collecting and using the prize.
19. By entering the competition the entrant agrees that they are over the age of 18 years.
20. The prize is not redeemable for cash or an alternative prize.
21. The prize is not transferrable.

22. The prize winner's name will be published on the Impact of Migration Facebook Community Page. By entering the competition, entrants grant permission to use their full name for up to six months from the date of the draw.
23. Curtin is not responsible in any manner whatsoever for any problems or any financial costs incurred, or any combination thereof, including any injury or damage to participants or any other persons related to or resulting from participation in this competition.
24. Curtin accepts no responsibility and shall not be held legally liable or responsible for any accident, loss, injury or damage to any individual or property whether direct or indirect, whether in contract, tort, negligence or otherwise arising out of or in connection with the competition or the prize, either during or after the competition.
25. Entry into the competition signifies acceptance of all conditions. Entrants are required to abide by the Terms and Conditions as presented.
26. Curtin's decision will be final and no correspondence will be entered into.
27. Personal information provided by an entrant to Curtin for the purpose of entering the Competition will be collected, used and disclosed in accordance with Curtin's Privacy Statement. A copy of the privacy statement is available at http://global.curtin.edu.au/legal/privacy.cfm. Personal information collected will be kept strictly confidential and will not be sold, reused, rented, loaned or otherwise disclosed to any third party otherwise than in accordance with the Curtin privacy statement and these Terms and Conditions.

Appendix G: Flyer for Recruiting Participants

VOLUNTEERS NEEDED:
SURVEY FOR WELL-BEING PROGRAM
FOR PEOPLE WITH A CHINESE BACKGROUND

If you are someone with a Chinese background and you are living, working or studying in Australia we are keen to hear from you. We are conducting a survey to understand how people with a Chinese background can achieve a better well-being in the Western context.

Completing the survey takes less than 20 minutes. In appreciation of your time you can enter a draw to win 1 of the 5 Coles/Myer vouchers.

Survey: curtin.au1.qualtrics.com/jfe/form/SV_bEDqQn5bPiBjSkd

MORE INFORMATION

If you would like more information, please contact Alice Farcas (爱丽丝)
alice.farcas@postgrad.curtin.edu.au
or https://www.facebook.com/researchCurtinUniversity

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HR190/2015).

Make tomorrow better.

Appendix H: SONA Advertisement for the online survey

Study name: Impact of migration on Chinese people living in Australia

Study type: Web Study. This is an online study.

Duration: 30 min

Points: 2

Description: Adjusting in a new country can be a challenging experience for migrants, including Chinese migrants. We do not know what adaptation strategies are most helpful. We would like to understand how stress and adaptation strategies influence the Chinese migrant's well-being and how their thoughts, feelings and behaviours might be affected.

Eligibility requirements: aged 18, Chinese ethnicity, first* and/or second** generation migrants to Australia and Chinese international students

*first generation migrants: you moved in Australia from another country

**second generation migrants: you were born in Australia and at least one of your parents were born overseas

Preparation: Please use a computer-based browser to complete this online survey.

Researchers: Alice Bercean, A/Prof Rooney, A/Prof McEvoy

Principal investigator: A/Prof Rooney

HREC number HR 190/2015