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Problem-Solving and Solution-Focused Therapy for Chinese: Recent Developments

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This article examines the recent developments of Problem-Solving (Strategic) Family Therapy and Solution-Focused Therapy for Chinese in the United States. These developments include: an integration of the aforementioned approaches; an integration of Psychoeducational Family Treatment with Interactional Supportive Group Therapy for families who have a family member suffering from severe and persistent mental disorders; and an increase in group work for clients with severe and persistent mental disorders, and teamwork and group supervision among Chinese counselors. Specific cultural and clinical issues related to these developments are discussed.

Kim (1985) proposed that a Strategic-Structural Family Therapy framework is a viable model for working with Asian-American families because the framework represents a good cultural fit. In the framework, he identified therapeutic elements that are more compatible with Asian-American cultural values, family structure, and communication patterns. For instance, there is a cultural expectation that one respects authority figures

The case illustration used in this article is based on actual case scenarios, but personal identification information has been modified to ensure anonymity and confidentiality. Correspondence concerning this article should be addressed to Stephen Cheung, Asian Pacific Counseling & Treatment Centers and Asian Pacific Consultation Services, 520 S. Lafayette Park Place, Los Angeles, CA 90057, U.S. Email: Sfcheung@aol.com

(e.g., doctors, teachers, mentors/counselors, etc.) and expects to receive advice or directives from these figures since they are considered to be capable of knowing what is wrong with their clients and giving advice. Asians are also practical; if they seek help from a counselor, they expect their problems be solved. The directive approach of Strategic (Problem-Solving) Family Therapy that focuses on the client's presenting problems, sets specific treatment goals, and initiates a particular approach for each problem is therefore compatible with Asian cultural values.

In the past decades, there emerged different thoughts and ideas which have become part of the center stage of the evolution of family therapy in the United States. For example, in the early 1980s, Postmodernism came to the scene as a reaction to Modernism. Modernism began around the turn of the twentieth century and believed that truth could be known and that universal principles could be discovered to explain human behavior (Nichols & Schwartz, 2001). Problem-Solving (Strategic) Family Therapy was originated in the thought of Modernism and benefits Chinese clients because Chinese defer to authority, believe more or less in absolute truth, and value principles of parsimony.

Postmodernism started an era of skepticism and reexamination of what was believed to be the truth or authority in Modernism (Anderson, 1990). With Postmodernism came the ideas of Constructivism and Social Constructionism. Constructivism postulates that reality does not exist as a world out there, but is a mental construction of the observer. The implications for counseling of the constructivist position are that counselors should not regard what they see in a family as existing in the family, but should realize that what they see is the product of their own assumptions about people, families, and problems, as well as their interaction with the family (Hoffman, 1985, 1988; Nichols & Schwartz, 2001; Watzlawick, 1984). Social Constructionism further asserts that we are unable to perceive an absolute and objective reality. This position argues that the realities we construct are

anchored in the language systems in our social environment (Gergen, 1985, 1991, 1994). Rooted in Social Constructionism, Solution-Focused Therapy focuses on helping people shift from dwelling on their problems to identifying solutions, while emphasizing strengths and possibilities. The treatment goal is to get clients to shift from "problem talk" (i.e., trying to understand or analyze their problems) to "solution talk" (i.e., focusing on what is working or could work in the future) as quickly as possible. This therapy approach has developed a set of techniques (e.g., exception questions, coping questions, miracle questions, the formula first session task, and giving compliments) for changing "problem talk " to "solution talk" (Berg & Miller, 1992; O'Hanlon & Weiner-Davis, 1989). This apparent simple treatment procedure coupled with the emphasis on finding successful solutions can be attractive to Chinese American clients.

In the United States, the debate between the Modern School and Postmodern School of Family Therapy continues: Should therapy consist of nonhierarchical conversation? Where is the place for professionalism and expertise? Is it possible to balance warmth, respect, and collaboration with expert understanding and skillful intervention? At the same time, one would scrutinize the utility of Problem-Solving (Strategic) Family Therapy and Solution-Focused Therapy for Chinese in the United States.

With the aforementioned debate and scrutiny still going on in the background, this article discusses some of the author's observations of the recent developments in family therapy with Chinese American clients and what we can learn from this evolution.

Context of Observation

Before proceeding, I would like to describe in what context my observations are based on. For ten years as a program director and clinical psychologist at Asian Pacific Counseling & Treatment Centers (APCTC) and Asian Pacific Consultation Services (APCS) in Los Angeles, California,

I have been providing and supervising family, couples, group, and individual therapy with adults, children, and adolescents. APCTC is a private non-profit-making community mental health center with funding from both the public (e.g., the Los Angeles County Department of Mental Health) and private sectors. The majority of our adult clients at APCTC suffer from severe and persistent mental disorders such as schizophrenia, bipolar disorders, and chronic major depressive disorder, and are monolingual in one of the Asian languages and dialects. In addition to contending with their mental disorders, our clients have to struggle with cultural shock; language and cultural barriers; lack of support system, transportation, and knowledge of resources; unemployment; discrimination; acculturative stress, and so forth. APCS provides fee-for-service consultation for clients with disorders that are not covered by the Los Angeles County Department of Mental Health targeted disorders. That is, it serves clients with milder problems such as adjustment disorders, relational problems, and so on.

Three Recent Developments in Therapy With Chinese Americans

While working with Chinese Americans, I have noticed three recent developments: (1) the integration of Problem-Solving (Strategic) Family Therapy with Solution-Focused Therapy; (2) the integration of Psychoeducational Family Treatment with Interactional Supportive Group Therapy for families that have a family member suffering from severe and persistent mental disorders; and (3) the increase in group work for clients with severe and persistent mental disorders, as well as teamwork and group supervision among Chinese American counselors.

Integration of Problem-Solving (Strategic) Family Therapy With Solution-Focused Therapy

First, there is an integration of Problem-Solving (Strategic) Family Therapy (Haley, 1973, 1987; Ho, 1997; Hong & Ham, 2001; Lee, 1982, 1996, 1997; Madanes, 1990, 1991) with Solution-Focused Therapy (Berg & Miller, 1992; O'Hanlon & Weiner-Davis, 1989) for Chinese Americans.

Problem-Solving (Strategic) Family Therapy is congruent with Chinese cultural values, family structure, and communication patterns in that it is problem-solving and symptom-relieving, it respects the authority of family hierarchy (i.e., the power inherent in the parental subsystem over the sibling subsystem), and it offers indirect as well as direct interventions to effect change. However, the counselor does not attempt to engender insight/ awareness in the individuals or the family during the planned change effort because the responsibility for change rests with the counselor rather than the client. This can collude with the clients' dependency. Neither does the counselor try to empower the family to the point of maintaining an egalitarian relationship with them, which would be the ideal at least toward the end of counseling. On the other hand, the brief (short-term) solution-oriented aspect of Solution-Focused Therapy is definitely appealing to the pragmatic nature of the Chinese culture. Its empowering treatment process and outcome (i.e., finding their successful solutions) are also therapeutically desirable. Nonetheless, its emphasis on an egalitarian and collaborative relationship between the client and the counselor goes counter to the Chinese cultural expectations of treatment and the hierarchical arrangement between the counselor and the client.

The two approaches can be harmoniously applied to the Chinese if we carefully select and integrate the therapeutic elements of the approaches that are consonant with the Chinese culture. To further guide the integration, the Ericksonian hypnotic principle of Pacing and Leading was employed (Zeig & Gilligan, 1990; Zeig & Lankton, 1988). Pacing refers to a therapeutic stance of fully respecting and accepting what the client brings to the session and mirroring the client's thinking and behavior (including the client's treatment resistance) so as to join the client at exactly where the client is. Leading, which comes only after Pacing has resulted in establishing a strong counseling relationship, refers to introducing intervention that is beneficial at least in the counselor's perspective, and eliciting the client's full cooperation and collaboration in following the intervention. To pace with

the Chinese family's cultural expectation of the counselor and treatment, the counselor employs a Problem-Solving (Strategic) approach that focuses on the family's presenting problems in the very beginning of forming a therapeutic relationship with the identified patient and the family. The counselor helps the family set objectively measurable and realistic goals, while empathizing with and validating the family's feelings and attempted solutions. Then the counselor paces by giving directives or assignments that will help alleviate the presenting problems and at the same time alter the less adaptive interactional patterns and family hierarchical structure. When the family is less demoralized and more hopeful about change, the counselor will further lead by employing a Solution-Focused orientation and will begin to help the family discover, recognize, expand, and amplify their successful solutions. In doing so, a positive spiral will start and the family will feel empowered and continue to increase their confidence in solving their problems.

Case Illustration

Alice, a 35-year-old Chinese American single female from Hong Kong who recently made a serious suicidal attempt with overdose of anti-depressants, was brought up in the clinical team conference at APCTC. She came to APCTC for treatment of major depressive disorder symptoms: depressive mood, suicidal attempts, loss of interest and pleasure in her favorite activities, insomnia, and fatigue for two years, after she had broken up with her Caucasian boyfriend. Aside from that, she had experienced increasing dissatisfaction with her job and intensified conflict with her father. She reported that she did not choose business as her career, but her father, a successful businessman, insisted that she and her elder sister follow his footsteps. Both she and her sister begrudgingly did. She had been primarily seen in individual therapy for two years. Initially she responded positively to pharmacological and psychotherapeutic interventions and was able to manage some part-time work. Nevertheless, in the past year or so, she has become more and more withdrawn, missed her appointments, discontinued

medications on her own, and quit her work. She also complained of her loss of interest in all daily activities and loss of sensations and feelings. She was particularly concerned about "not feeling anything … including hunger, or any other sensations and emotions." According to her physician, there was no physiological basis for her "not feeling." In this context, Alice made her most serious suicidal attempt; fortunately her mother discovered her lying unconscious and got help.

Alice immigrated to the United States with her family at the age of eight and has been adjusted well to the mainstream culture. She further reported that she has had a very conflictual relationship with her father because he is "very Chinese" and is very strict with her and her sister but is much more permissive with her oldest brother. Moreover, she reported that she had witnessed a lot of verbal and physical fights between her parents as she was growing up. The fights have reportedly decreased in the past twenty years as both of her parents have mellowed.

It was concluded that Alice had serious suicidal potential and that family therapy should be the mode of treatment to deal with some of the family conflict and mobilize family resources to reduce her suicidal behavior. Since her primary counselor, Dr. B., a licenced psychologist, had not had a lot of family therapy experience, I agreed to be her co-therapist.

A conjoint family therapy session was arranged. In the outset of the first session, the purpose and the structure of the assessment sessions as well as the limits of confidentiality were outlined so as to inform the family about what to expect and thus abate anxiety. In view of the complexity of this case, three assessment sessions were suggested with some recommendations promised at the end of the third session. Then we started to greet the father and mother and then the rest of the family with small talks. The purpose was to establish connections with each individual in the family. Then each family member was asked about their number one concern

in the family followed by some interactions among family members about each of their concerns. Lastly, some specific concrete and measurable goals were set. In this case, a reduction of Alice's depression was the agreed-upon goal. The family's feelings, efforts, and attempted solutions were positively validated, a brief explanation of the existing condition was offered, realistic hope was instilled, and the assignment of recording Alice's mood if possible three times a day was given to the family.

In the second and third sessions, how the family interacted around Alice's depression and lack of sensations and feelings, how these problems impacted each of the family members, and what they attempted to do to solve the problems were further explored. Owing to the increasing gravity of Alice's suicidal attempts and the lack of connectedness among family members, the following paradoxical (indirect) intervention was made at the end of the third session. We noted that Alice's "not feeling" seems to serve several functions: by not feeling, she appears to be able to ward off her father's imposition of his expectations on her; her father can have less conflict with her and approaches her in a more gingerly manner; her mother seems to have some one to care for; her elder sister goes home more because of her; she and her oldest brother can talk with each other more and be closer; at the same time she can afford not to pressure herself too much to be an independent adult. Because her "not feeling" serves these functions for her and her family, we recommended that they think twice before getting rid of the symptoms.

Alice and her family returned two weeks later and reported that she had interacted more with them and had started cooking two meals for them in the two weeks. The family's ratings indicated that she had shown much improvement in her depression and daily functioning. She looked brighter: her affect was more reactive, although she still maintained that she did not feel. When queried about her suicidal risk, she denied any suicidal thoughts, intention, or plans.

Their beginning change was met with surprise; they were asked in detail about what they did to result in changes. At the end of the session, they were reminded of the functions of the symptoms and were recommended to "go slow" in getting rid of the symptoms. In the following sessions, time and efforts were spent on detailing the successful solutions they had employed to result in the positive changes in Alice (e.g., beginning some of her artistic and horticultural pursuits such as painting, sketches, planting flowers, etc.; going to the gym again; cooking more for, and interacting more with, all of them). The sessions were then spaced out from two weeks to four weeks, then to six weeks, and eventually to eight weeks. Within four sessions after the initial three assessment sessions, Alice found a job and began to talk more about how to deal with the people at work. Dr. B., her primary counselor, continued to see her individually to help her deal with her adjustment to work and her self-esteem and relationship issues with her father and mother until she terminated counseling about a year ago.

As illustrated above, we made use of certain elements of Problem-Solving Family Therapy and Solution-Focused Therapy that are congruent with the Chinese culture. To begin with, we employed the more authoritative and directive therapeutic stance of Problem-Solving (Strategic) Therapy to facilitate the building of faith in us as counselors and receptivity of treatment. We took charge of the sessions and explained the purpose and structure of the sessions in the outset so as to increase the "credibility" of our knowledge and expertise, minimize ambiguity, and thus alleviate anxiety (Lee, 1997; Sue & Sue, 1999). We greeted the father and mother first to show our respect for the Chinese family hierarchy. To be culturally competent, we focused on the family's presenting problem, set mutually agreed-upon concrete and measurable treatment goals, started "giving" the family psychological/ emotional "gifts" (e.g., empathy, validation, instillation of hope, and some explanation of their problem) and gave the family a direct action-oriented assignment (Ho, 1997; Hong & Ham, 2001; Lee, 1997; Sue & Sue, 1999). When we offered the paradoxical (indirect) intervention, we targeted it at

the presenting problem (i.e., reduction of the identified patient's depression) on the one hand, and the family dynamics that seemed to predispose/ precipitate/perpetuate the problem on the other. Prescribing no change or slow change in the context of change (i.e., in family therapy) resulted in the positive changes in the identified patient's behavior and the family interactions (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978; Weeks & L'Abate, 1982). Only until the family was more hopeful and trusted counseling did we employ the Solution-Focused approach to empower the family to search for, identify, and amplify their successful solutions (Berg & Miller, 1992; O'Hanlon & Weiner-Davis, 1989). The effect of providing solution-focused interventions was to help the family tap into their own resources, identify what they were doing right, and attribute their successes to themselves. We focused on more long-standing emotional and relational issues, after the presenting problem was resolved.

Integration of Psychoeducational Family Treatment With Interactional Supportive Group Therapy

The integrated Problem-Solving and Solution-Focused Therapy model for Chinese Americans appears to be effective for families with a wide array of problems, but it has its own limitation. That is, it does not seem to be as effective with severe and persistent mental disorders (e.g., schizophrenia and bipolar disorder). For families that have a family member suffering from the aforementioned disorders, an integration of Psychoeducational Family Treatment (McFarlane, 1991; Torrey, 1994; Woolis, 1992) with Interactional Supportive Group Therapy (Yalom, 1983, 1995) is indicated. In the past decades, there has been literature support of the efficacy of Psychoeducational Family Treatment for families that have a family member with severe and persistent mental disorders (Hong & Ham, 2001; McFarlane, 1991; Torrey, 1994; Woolis, 1992). The emphasis of family treatment has been placed not on changing the family dynamics of clients suffering from these mental disorders, but on family psychoeducation. Family psychoeducation includes didactic lectures on such topics as the nature of

schizophrenia and its impact on the patient and the family, what to expect from the identified patient, how to manage the patient's symptoms, and so forth. Providing lectures definitely meet the cultural expectation of receiving some education or instruction from experts. The integration of the two approaches can achieve at least two things: first, it allows the counselor to "join" the family via family psychoeducation (Hong & Ham, 2001; Minuchin, 1974; Minuchin & Fishman, 1981); second, it can maximize mutual support, encouragement, and information sharing among different families facing similar challenges via Interactional Supportive Group Therapy (Hong & Ham, 2001; Yalom, 1983, 1995).

At APCTC, Family Support Groups in Chinese, Japanese, and Korean languages — an culturally congruent integration of the aforementioned approaches — are a vibrant part of treatment for individuals with schizophrenia and bipolar disorders. In the Chinese Family Support Group, group members meet only once a month due to transportation problems of family members. A little refreshments including Chinese tea is served in each monthly session. Each session lasts about two hours. The first 30 minutes is devoted to family psychoeducation on such topics as crisis intervention, the management of family members' symptoms and problems, and how to take care of the caregivers, while the remaining 90 minutes is open for family members' reactions and discussion of issues pertinent to them. In short, there is some structured presentation followed by some supportive group processes. The effects of such integration are very positive: the families feel that they have learned something practical and useful from the experts to cope with their problems; they also experience support not only from the experts, but also from other people, who are "in the same boat" as they are. In other words, the didactic presentation component of the session meets the cultural expectation of learning from the experts in treatment; the Interactional Supportive Group Therapy utilizing different therapeutic factors such as universality, instillation of hope,

altruism, imparting of information, group cohesiveness, and so on provides enormously more powerful support and guidance for the families than Psychoeducational Family Treatment alone.

Increase in Group Work, Teamwork, and Group Supervision

In the midst of the aforementioned developments, there is an increase in group work for clients with severe and persistent mental disorders, as well as teamwork and group supervision among Chinese American counselors. Apart from providing Family Support Groups for families with a member suffering from severe and persistent mental disorders, there is an upsurge of group work for such a Chinese American individual. The reason for this is that there is literature support for group treatment for individual clients with severe and persistent mental disorders on the one hand and for culturally competent adaptation of Western group psychotherapeutic techniques to running groups for Chinese American clients on the other (Hong & Ham, 2001; Lee, 1997). The group process is typically more structured and directive at least in the beginning of the group to meet the expectations of Chinese Americans. In illustrating how to incorporate Chinese cultural practices into group treatment, Hong and Ham (2001) described some of the groups at APCTC. The group they discussed more in length was a therapy group designed to engage some Chinese American clients with severe and persistent mental disorders who are resistant to treatment. The goal of the group was to engage these clients in treatment, to provide them with some therapeutic routine (i.e., coming to see their psychiatrist, counselor, and group members at least once a month), to improve socialization, and to combat social isolation. In order to promote treatment compliance, it was arranged for the clients' convenience that they see their psychiatrist and participate in the group in one visit rather than in two. The clients went to a group, which would begin with a simple lunch, after their appointments with the psychiatrist. The counselors would then lead the group in *Liu Tong Quan*, a form of Chinese aerobic exercise/Kung Fu for about 15 minutes. After that the group would sit in a circle to have tea and discuss

their clinical problems. The group attendance has been good and the clients reported receiving support from other group members and making some improvement in their symptoms.

Finally, as a parallel process, teamwork and supervision groups burgeon as well because counselors continue to recognize the strength and support in collaborative efforts and group dynamics. Most Chinese counselors admit that it is very emotionally draining to work with clients who are suffering from severe and persistent mental disorders and are also negatively impacted by their immigration experience and subsequent acculturative stress in the United States. Working in teams of at least two or three appears necessary. There is more comprehensive, efficient, and creative case conceptualization and treatment planning when two or three people collaborate. Besides, there is more emotional support among team members. Much is to be gained with the increase of the activities discussed above, and yet it also comes with difficulties and challenges such as time management, sometimes conflictual communication between team members, and personality clash, and so on. Therefore the team leader or group supervisor needs to be astute and skilled in the following areas: time management; selection, creation, maintenance, facilitation, and management of the team or supervision group; and isomorphism/parallel process within the client-counselor-supervisor-administrator/agency system in an agency setting (Bernard & Goodyear, 1998; Liddle, Breunlin, & Schwartz, 1988; Todd & Storm, 1997; Watkins, 1997).

Conclusion

As discussed above, there is an integration of Problem-Solving (Strategic) Family Therapy with Solution-Focused Therapy for Chinese American clients with most clinical problems except for severe and persistent mental disorders. For families with a member suffering from the latter, there are Family Support Groups that provide Psychoeducational Family Treatment on the one hand, and process-oriented group support on the other.

Furthermore, there is an increase of therapy groups for Chinese Americans with severe and persistent mental disorders, while Chinese American counselors are engaged more in teamwork and group supervision.

There are several things we can learn from these recent developments. First, there is an emerging comprehensive system of providing family counseling for Chinese Americans. That is, a beginning integrated model of Problem-Solving and Solution-Focused Family Counseling can be employed for Chinese American clients with most clinical issues and an integrated Family Support Group model utilizing the culturally compatible therapeutic elements of Psychoeducational Family Treatment and Interactional Supportive Group Therapy particularly for families with members suffering from severe and persistent mental disorders. Moreover, to maximize effective and efficient case conceptualization and treatment planning, and minimize professional burnout, teamwork and group supervision among Chinese American counselors are warranted. The complicated, confusing, and sometimes even conflictual demands on team members and team leaders in teamwork and group supervision are acknowledged. In addition, it is recommended that team leaders should deepen and sharpen their knowledge and skills in selecting, forming, facilitating, and managing the team, and monitor regularly the relationships among all the players (including clients, counselors, supervisors, administrators, funding and referral sources, and other community agencies) in the complex counseling service delivery system.

Second, to have a supportive and creative teamwork and group supervision, not only the team leader/group supervisor, but also all team/group members have to do their part. On the one hand, the leader/supervisor needs to set a good example (i.e., being open and not defensive, supportive, and eager to learn, etc.) for the team/group, and create a supportive and intellectually stimulating environment for collaboration and learning. On the other hand, to seek support, consultation, and collaboration in team/

group meetings, members need to acknowledge their limitations including their vulnerabilities when appropriate. These acts of humility and openness can promote more fruitful mutual sharing and support, mitigate professional isolation and burnout, galvanize creative teamwork, and consequently improve our effectiveness with clients.

Third, other than being humble and honest with ourselves and our team members about our professional needs, it is expedient that we should be open about the limitations of our favorite counseling models in order to learn from other models, and incorporate them in our practice.

Finally, to provide culturally competent counseling with Chinese clients, we should identify and utilize counseling approaches that are culturally congruent and clinically effective with our clients. As we respect and accept our clients' worldview and cultural values, we can join them at where they are, and help them tap into and actualize their potential.

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應用策略性家庭治療法及問題解決治療法輔導美國華人的新近發展

本文探討近年美國在輔導華人上應用「策略性家庭治療法」及「問題解決治療法」的發展情況，當中包括：（1）上述兩種治療法的綜合運用；（2）向長期精神病患者的家庭提供有關精神病資訊的教育及互助小組輔導；（3）加強對長期精神病患者的小組治療，並鞏固華人治療師的團體合作和小組督導訓練。此外，本文亦會討論美國華人專業輔導界在這些發展上所面對的文化及輔導方面的重要事項。