Adlerian Brief Therapy for Hmong Clients

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Abstract

After the Vietnam War tens of thousands of Hmong refugees left their homeland, Laos, to immigrate to many countries such as America, France, Canada, and Australia. Those who came to America brought with them specific challenges to the healthcare system of the United States: As these immigrants attempted to preserve their cultural identities while adapting to the American traditions of mental health care. Professionals such as family care physicians, social workers, and mental health professionals could improve their communication with these patients by looking for ways to appreciate their ways of life and their treatment practices. Through expanding, such familiarity would make it possible for physicians in all encounters with Hmong patients or clients to improve communication and care. Specifically, western perspectives and the Hmong approach to dealing with physical and mental illnesses are discussed in this literature review. This project was intended to help Western healthcare professionals make their treatment of Hmong patients or clients more successful. It was written from the point of view of an author with a Hmong background. An ethical concept was also discussed in this project: the duty to inform all parties of potential harm by clients, which is required of mental health practitioners or counselors in general. A case scenario of a Hmong client was presented to help mental health therapists carry out the procedure to inform various parties when dealing with the bizarre behavior of Hmong clients.
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Adlerian Brief Therapy for Hmong Clients

Introduction

The primary content of this master’s project was to articulate the application of Adlerian Brief Therapy (ABT) to Hmong clients. Secondly, this research project covered an ethical aspect, which was about the duty to inform all parties in regard to potential harm from Hmong clients with negative behavior. This concept of duty to inform is mandated by law in most states in the United States, as well the code of ethics of mental health professionals. The overarching purpose of part one in this master’s project was to present research related to serving Hmong clients who need mental health services. The objective, significance, scope, and terms were discussed first. An overview of Hmong history and the unique cultural characteristics based on a literature review of different sources was presented, as well as the Hmong transition to America specifically. Third, a literature review of articles on Hmong mental health issues written by both Hmong and non-Hmong authors is included. Fourth, the literature review focused on ABT and other therapies such as Solution-Focused Therapy (SFT) and Strategic Therapy (ST). The discussion, recommendations, questions, and conclusion were also presented. Overall, it was intended that this research would help current mental health professionals to identify new perspectives in serving potential Hmong clients who are not open to mental health diagnoses or treatment, as well as to retain their current clients.

The literature review explains the concept of duty to inform, the actions that are applicable to mental therapists to inform in an ethical and legal manner, and to prevent harm. Finally, a case scenario was presented to demonstrate the application of duty to inform, and the best option for the therapist in the scenario was presented. Objective

The objective of this master’s project was to present literature reviews related to serving Hmong clients who needed assistance in solving their mental health problems. These clients
were primarily elders in an urban Hmong community in the Midwest. In the Hmong tradition, mental health is a term that has negative connotations such as brain damaged or crazy. Because of this negative perception, Hmong individuals are reluctant to seek mental health care.

**Significance**

The Hmong population in the United States is growing, but countless are facing mental health issues daily. Without proper mental health solutions to their problems, the Hmong will have a hard time finding a meaningful life living in America, pursuing happiness and prosperity. The Hmong community is suffering from a lack of services as they attempt to change and integrate into the new American culture. Mental health professionals who have contact with the Hmong people can gain more perspectives about their mental health problems and how to treat their mental health illnesses.

**Scope**

The scope of this literature review has been drawn from mental health journals written by Hmong and non-Hmong researchers, as well as from books and articles on Brief Adlerian Therapy. Other theoretical approaches such as SFT and ST were reviewed to better help mental health professionals as they treat Hmong clients. The literature review was limited to Hmong clients in the United States (Midwest) only.

**Terms**

Hmong refers to an ethnic group of tribal people from Laos. This group is often referred to as “mountain people” by many Western researchers. After the Vietnam War, the Hmong began to settle in different parts of the world. The United States has the most concentrated Hmong population (Lor & George, 2014).
Overview of Hmong Population Worldwide and in the US

Lor and George (2014) reported, “The term ‘Hmong’ means free men” (p. 337). This seems to be true because today the Hmong are found in most countries around the globe. Worldwide, the Hmong population is about 12 million; the Hmong population in America is about 260,000 based on the 2010 US population census. The breakdowns of different aspects about the Hmong in America are as follows:

- Hmong growth rate: 37%
- Hmong speaking their language at home: 92.7%
- Hmong speaking English less than perfectly: 44%
- Average of Hmong family: 5
- Hmong per-capita income: Less than $12,000 (Collier, Munger, & Moua, 2012; Lee & Chang, 2011).

Vang (2014) and Tatman (2004) explained that there were no records indicating specifically where the Hmong originally came from. For years, they were people without a country. The Hmong have shared their lives with other people in China, northern Laos, and Vietnam. The Hmong’s homes were made of bamboo or logs and thatched dwellings built just below mountain peaks. Other researchers also described that the Hmong once lived in China, where millions are still living today, but they started to move to Southeast Asian countries during the early part of the 19th century, specifically Laos, Vietnam, and Thailand (Tapp, 2016).

Thao (2006) reported after the Vietnam War ended in 1975, thousands of Hmong in Laos had resettled or migrated to many countries in the West, particularly America. She summarized various specific characteristics pertinent to the Hmong as follows:

Mong[sic]-Americans brought their oral culture from the mountains of Laos and carried their traditions to the United States. They did not give up their values, but maintained
strong roots in their cultural traditions. Yet, for hundreds of years the Mong[sic]s' determination to preserve their cultural practices has been viewed by non-Mong[sic] as foreign and unacceptable behavior. In China, the government perceived them as the enemy who resisted Chinese culture and political power. The Chinese viewed the Mong[sic]'s strong kinship and cultural practices as a form of resistance against their government and culture (QUINCY 1988, i-ii). The author found similarly that Mong[sic] cultural practice was also viewed negatively by Americans on the California North Coast (see THAO Y. J., 1999, 2003). The Mong[sic] have long maintained a self-governing structure that has protected them and served as their own legal justice system in Laos, Thailand and, eventually, the United States. In the United States, the majority of Mong[sic] elders still favor this traditional system. Operating through respect for traditions, it protects families, religion, culture, values, and employs mediation by Mong[sic] elders of the community. In many cases, family disputes are resolved within the community by the traditional system and never reach the American, Lao, or Thai courts. (p. 251)

In addition, Thao (2006) explained that the Hmong way of life has been passed from one generation to the next by oral communication, usually through storytelling by Hmong elders. The Hmong had no written language until 1950 when missionaries went to Laos. Today, Hmong elders have difficulties living in America because they cannot master the lifestyles that depend mostly on written communication.

**Other Aspects of Hmong Life**

In the Hmong culture, the home is the main social unit that provides security and identity for all members in the family. Traditionally, married Hmong males are always assigned the position of power, and they are found to be higher on the scale of power among men, women, and children. The fathers hold the most power in the family. Mothers and children have other specific roles which are not equal to the roles of the leaders of the home (Hsu, Davies, & Hansen, 2004).

**Hmong Values**

According to Carteret (2012), it is not an acceptable behavior for Hmong people to compete against one another for personal benefit. The only exception of this rule is when they
are competing in a sport activity. Children are encouraged to compete against themselves to improve their skills versus trying to be better than their siblings. If they do compete against one another, they are asked to teach the child who has fewer skills to improve. When members of a Hmong family work against one another, the family system is broken and no longer works to achieve mutual success for the family members. The individuals who are working against one another are brought to the attention of the elders by one of the individuals who is having the conflict or by another concerned family member. The elders will meet with the individuals who are working against one another and give them instruction on how they are to change their behaviors. The elders will continue to work with these individuals until they have learned to work together. If one or both of the individuals are not willing to work toward a solution, they are excluded from the family and the clan. Some of the younger generation are okay with being excluded and continue their lives without the support of their families. It is possible for persons who have been excluded to return to their families if they change their behaviors (Carteret, 2012).

Cobb (2010) and Carteret (2012) reported further that contributions are expected by all members in the family and the clan. Most members within the family honor this expectation. It is expected that family members contribute their time and money equally to the other members for the common good, especially when there is a crisis. When a member chooses not to honor the expectation to contribute for the benefit of another family member and then later in their life they are in a crisis situation, their family members are not required to help them. Because of their personal values, some family members may still contribute to them and encourage the person to change.
Traditionally, equality or power is not distributed equally among men, women, and children. Elders and Hmong men have more advantages than women and younger people. Within a family, the parents will have more power over the household affairs. Regardless, children will have to ask for their parents’ permission to engage in activities with their peers. If parents are not available, the oldest person in the family will have to make the decision. It is difficult to maintain equality among members in the same family (Carteret, 2012).

**Hmong Language**

According to Cobb (2010) the language that the Hmong speak today is called “Hmoob” (p. 80). This language is used by about four million people around the world. Compared to English, Hmoob is viewed as a minor and an unpopular language with different dialects; however, the Hmong Americans speak either white or green Hmong dialects. Research indicated that the origin of the Hmong languages came from the colors of Hmong women’s dresses; White Hmong tended to wear the traditional white dress and speak the language spoken by White Hmong. The same is true for Green Hmong. The differences between the two dialects are the sounds of the words, which is similar to American English and British English. Both dialects are equally valued; lately the White Hmong dialect tends to be spoken by both Green and White Hmong. There is no implication when choosing one language over the other. There are fewer White Hmong who speak the language of the Green Hmong correctly. When this is the case, it is embarrassing for the speaker, as well as causing miscommunication between the speaker and listener (Carteret, 2012; Center for Disease Control and Prevention, 2008).

**Hmong Culture**

Historically, the Hmong have been living in a collective society. The interest of the group is more important than individual interests. The arrangement of Hmong life starts as an
individual forms family, and connects to his or her clan. There are only 18 clans in the Hmong world. Yang, Vue, and Xiong are some examples of Hmong clan names. People who share the same clan names treat each other as relatives even though there is no biological connection. People are members of the clans’ system by birth, adoption, or marriage. Intermarriage within the clan is not allowed. For the Hmong, like other Asian groups, the family structure has always been patriarchal. Males carry most of the major decision-making whereas women and children are subordinated to men who are the heads of the households (Tapp, 2016).

Relationships. Individuals’ willingness to participate and cooperate for the common benefit of the group has been necessary for survival within the Hmong society for centuries. Due to the importance of social interest for the continuation of the Hmong people, the elders have set this as a priority to be taught to all generations. If a member of the family is not living by the social interest standards set by the elders, he or she will be brought to the attention of the elders and will be given instruction on how to change their behavior in order to stay a member of the family and contribute to the common good. If they are unwilling to work with the elders to change their behavior, they are then excluded from the family membership and will need to survive on their own and will be labeled as someone who is untrustworthy (Carteret, 2012).

Someone seen as being inferior in a specific area that the culture expects that person to be an expert in, is looked upon with shame by themselves and others within the family. Because of this, a person will pretend knowing how to complete the task thereby learning the task. In the end, this person will demonstrate his or her expertise, and then will be honored by the family and the larger Hmong community (Carteret, 2012).

In order to live with honor in the Hmong culture, individuals must belong to a family and to a specific clan. This is achieved by being born into a family and clan or through marriage or
adoption. Every role with a family has specific ways in which a person can gain significance. One obvious way that Hmong elder males are significantly respected is that most elders can handle complex activities such as performing religious ceremonies to honor ancestors, weddings, and funeral rituals. Hmong women earn respect through their bravery and capacity to raise many children and manage the internal family affairs (Pfeifer, Lai, & Arguelles, 2003).

**Religion.** The Hmong have a long tradition of believing in animism and ancestry. They strongly believe that streams, trees, rocks, hills, and so on have their own specific spirits. Maintaining good relationships with these natural things is vital for the Hmong. Additionally, Hmong believe that disease, death, and misfortune are caused by the supernatural. When personal or household issues occur, the Hmong tend to blame various types of spirits. These include ancestors, nature, evil, and property placement. A good example of their belief system is illness. When someone becomes sick, the Hmong often feel that a spirit has chased the soul away from the body. They believe that in order for the sick person to recover, they have to practice some type of ritual to settle the conflict between the angered spirit and the sick person. Today, the Hmong still continue to practice traditional rituals to cure sick people or prevent illness from happening. They have faith in practicing traditional rituals, and it is a positive linking between their world and the world of the spirits (Carteret, 2012; Tatman, 2004).

**Hmong and Chinese Culture**

Literature on Chinese culture will help to better understand Hmong culture and Adlerian therapy since there is scant research associated with Hmong people in this area of mental health (Vang, 2014). Like the Hmong culture, the Chinese culture also believes in being respectful to family members, hard work, and collectivism over individualism, responsibility, and privacy in life. In Chinese society, the interest of community and the world are more important than
individual and family matters. Chinese parents are supposed to nurture their sons or daughters to carry the family name and honor the ancestors. Most importantly, parents must ensure that their children become good and productive citizens. Parents and elderly people are considered more experienced, and their words always count more or are viewed as superior over young peoples. Women and children are always subordinate to men or the head of the households (Carteret, 2012; Tapp, 2016; Tatman, 2004).

**Hmong Transition to America**

Based on articles written by Tsai (2001) and Hsu et al. (2004), the Hmong are part of the Southeast Asian Refugees (SEAR). These are refugees from Laos, Cambodia, and South Vietnam. Their arrival in America is different from the Chinese, Japanese, and Filipinos. They came for political reasons because they helped the United States during the Vietnam War. Chang (2007) summarized the Hmong experience specifically as follows:

Originally from China, the Hmong are a mountain people of eastern Laos who allied with the U.S. Central Intelligence Agency in its secret war in Laos against the leftist Pathet Lao insurgency and North Vietnamese Army. This war overlapped with the larger Vietnam conflict. When the U.S.-backed governments in South Vietnam, Cambodia, and Laos collapsed in 1975, pro-U.S. elites from all of these countries escaped via Thailand to the United States. Other Hmong fled to refugee camps in Thailand before moving, over time, to the United States. Partly because of the activities of Roman Catholic and Lutheran organizations, many Hmong went to Minnesota and Wisconsin. Migration of new Hmong Americans from other U.S. areas to the Twin Cities beefed up the metropolitan area’s Hmong American population (up to 42,000 in Census 2000). This is so much so that St. Paul has essentially become the capital of the global Hmong diaspora. This is a community of at least several million spread across China, Laos, Thailand, the United States, Canada, Australia, and other countries. The shift in the center of gravity of the Hmong universe towards the Twin Cities was pronounced enough that it frequently brought to the metro area the most prominent of all Hmong leaders, Vang Pao. Vang Pao is a one-time Royal Laotian Army general and CIA ally who has continued to exercise influence and raise funds for anti-Communist resistance in Laos since his 1975 move to the United States. (p. 4)

Similarly, Lee and Chang (2011), as well as the CDC (2008) reported that after the United States withdrew from the Vietnam War, hundreds of thousands of Hmong refugees
sought safety in other countries through various resettlement programs. Many Hmong individuals and families are still chronically facing various mental health issues resulting from social, educational, and cultural situations as a result of various accounts after the Vietnam War was over. These include struggling to reach Thailand via jungle routes, being captured by the Laos Communist government, crossing the Mekong River, living in crowded conditions in Thailand refugee camps, and adjusting to their new lives in their final destinations (Vang & Flores, 1999).

**Cultural Perspectives of Mental Health**

**American Perspective of Mental Health**

According to Okazaki, Kassem, and Tu (2014), millions of Americans suffer from psychological illness in some ways. Because mental health impacts a huge number of people, it causes a public concern for American citizens, public officials, and other parties in American society. Researchers indicate that the gap between whites and people of color who are facing mental health issues is very wide. This makes minority psychological researchers feel concerned about those who are facing mental health issues, who need adequate treatments and other support. As early as 1977, mental health researchers discovered that people of Asian backgrounds had the tendency not to seek mental health services. Those who were treated for mental health issues left treatment centers early, leading to unsuccessful recovery from the disorder. What concerned Asian American mental health specialists the most was how Asian Americans utilized mental health services. Studies showed that with the growth of technology since the 1970s, the numbers of mental health clinics designed to serve Asian Americans in cities were increased. At the same time, the steps that Asian Americans took to seek help from those clinics fell. Okazaki et al. (2014) wrote that the gap between mental health services and
minorities not seeking them will continue to increase. Refugees and new immigrants are among the groups least likely to seek mental health services even though they are suffering from mental health illnesses, leaving the gap constantly unfilled.

Additionally, researchers described that after leaving from their homelands to their host countries, the Hmong ended up with many challenges. In other words, the resettlement process for the Hmong people produces various concerns. Education, depression, acculturation, physical illnesses, and language barriers are some of the top issues faced by new Hmong-Americans (Collier et al., 2012).

**Hmong Perspective of Mental Health**

According to researchers, the concept of mental health is new to the Hmong community. The words “mental health” never existed in Hmong society. Mental health means brain damage to the Hmong (Her, 2012). Clinically, the terms sadness and depressed mood are often used by Hmong interpreters during their visits with Hmong clients to mental health clinics (Postert, 2012). The clinical terminology of the mental health field does not exist in the Hmong language or culture; therefore, Hmong individuals who do seek mental health counseling with translators have the additional difficulty of a lack of language, words, or concepts in their own language and culture that the translators can utilize when interpreting and translating from English into Hmong. Because the Hmong view mental health as a negative health aspect, they hardly ever seek Western counselors for help or treatment anyway. Instead, their priority is turning to their own healers such as shamans, ritual healers, and herbal specialists (Carteret, 2012).

In the Hmong world, when someone is depressed, it is considered that a mad evil spirit has entered the body. In this case, a traditional healer like the shaman or the spirit healer is
Incense fills the air of a living room in St. Paul where 10 relatives of a 17-year old girl have gathered. The girl is suffering hallucinations. The family believes she has been taken over by the Spirit of Death and may soon die. A Hmong shaman wears a black hood and clutches hand cymbals. He gyrates and chants before the group. A slaughtered pig is offered as a sacrifice to the evil spirit. A goat, representing the seriousness of the illness, was sacrificed earlier.

Chanting in Hmong, the shaman says he’s traveling on horseback into the spirit world to reclaim the spirits of the young woman. The shaman warns the evil spirits he is ready to do battle. He stomps his feet to get their attention. The chanting could last for hours.

Following the ceremony, the family will eat a meal consisting of the sacrificial meat and by doing so, believe they will eat away the evil.

Since this ritual, her father reports his daughter has been cured. But if the hallucinations return, the family will likely not turn to a doctor, but instead try another shaman. Hmong leaders say while not all immigrants utilize shaman, the practice is still used by the majority of Hmong living in Minnesota to address both physical and mental ailments. (para. 3-6)

Additionally, the Hmong consider that mental illness is caused by somatic problems. The Hmong still do not accept medicine as a solution for their ailments. Many Hmong are adjusting to Western health perspective. Because in many cases, the Hmong shaman could not provide explanations of why some people were not healthy mentally. Seeking American counselors is the last option when all healing sources of Hmong traditional health practices fail (Goetz, 2001).

In America, there are two contrasting views of mental health for the Hmong. It is vital that Western counselors consider revising their perspectives in helping the Hmong people when necessary. Researchers have recommended strategies for therapists or other healthcare professionals who work with Hmong clients including overcoming language barriers, paying attention to clients’ expectations, and developing tactics to improve psychological measures (Cobb, 2010).
Language Barriers

Cobb (2010) explained that language is the biggest issue between Western healthcare professionals and Hmong patients. Not all Hmong families have members who can communicate in English well. Additionally, Hmong never had a written language until the 1950s, making many Hmong elders illiterate in their own language, and written materials are useless for Hmong elders. Researchers also found that not all medical terminologies are translated into the Hmong language.

Healthcare professionals must consider communication barriers as their priority. Studies showed that patients with less communication support appear to receive poorer quality of care. It is important for health care providers to understand the language needs of their Hmong clients. To prevent insufficient health care service to Hmong patients, health care professionals must turn to appropriate sources such as interpreter agencies that employ professional Hmong interpreters (Carteret, 2012; Cobb, 2010).

Expectation from Hmong Clients

Many providers failed to ask their Hmong patients questions like, “What do you expect from the care I provide?” (Cobb, 2010, p. 82). Their answers included: “Holistic, practical and positive education, trust that is earned though cultural awareness and contextual features and the incorporation of alternative remedies and spiritual healing to their care” (Cobb, 2010, p. 82).

Factors Affecting Hmong Mental Health

Before the Vietnam War, there was no record of mental health in the Hmong society. After the Hmong lost their country, Laos, they began to encounter various difficulties in their lives. According to many researchers, the Vietnam War, living in a new environment, the US
Refugee Policy, and changing family dynamics were responsible for Hmong mental health issues (Vang, 2014).

**Vietnam War**

According to Vang (2014) the Vietnam War greatly impacted the mental health status of Hmong settlers. Anxiety, depression, and post-traumatic stress disorder were their major mental health problems. They faced these issues as soon as the war was over. Their mental health sufferings were not known to many researchers because not many writers were interested in their issues. Those who are familiar with the Hmong population agreed that the Vietnam War marked the first heavy burden for the Hmong in regard to mental health issues. After the US withdrew from Vietnam, the Hmong suffered the most.

Cerhan (1990) and Collier et al. (2012) contended that the Hmong were one of the Asian American groups who supported the US policy in the Vietnam War. After the United States left Southeast Asian countries, the Hmong faced countless casualties. Tatman (2004) wrote that about 20% of Hmong men died or became victims of the Vietnam War. After the Lao communists took power in Laos after the Vietnam War, the Hmong faced severe retaliation by the North Vietnamese and Lao Communists for their siding with the United States. As a consequence, more than half of the Hmong in Laos then made every effort to escape to Thailand and other parts of the world in the West. The United States was the priority destination for the Hmong. Their casualties were huge as the Hmong attempted to leave Laos between 1975 and the late 1980s. Many researchers claimed that only half of them reached safety. The rest were either killed, starved, or drowned in the Mekong River while crossing to Thailand. Every single Hmong family lost at least one loved one on their way to refugee camps in Thailand (Cerhan, 1990; Collier et al., 2012; Tatman, 2004).
According to Tatman (2004), the Vietnam War led the Hmong to face different aspects of mental health. For example, about 118 Hmong individuals were asked to identify their most stressful event since coming to the United States. All of them reported that being isolated from their family members was very stressful. In addition, moving from their settlement locations to different localities led to psychological issues for them. Refugee officials reported that many Hmong families who chose to move closer to areas such as Minnesota, Wisconsin, and California ended up facing more mental health issues than those who chose to begin life where they first came to the United States. These places have larger Hmong communities, and people moved to these areas with hope to join one or more of their family members, relatives, or the Hmong in general, but not all who moved gained positive outcomes. Studies showed that moving resulted in more unemployment and lack of housing, increasing mental health issues.

**Acculturation**

According to Vang (2014), 30 years have passed by, but the Hmong still continue to experience mental health symptoms. There is not much difference when comparing the first Hmong generation to the second Hmong generation. Based on research findings, depressive mental health symptoms appear similar among Hmong populations in the US regardless of their age, socioeconomic status, acculturation, and generational status. As a result, it is vital for health professionals and researchers to conduct more studies on the Hmong mental health as they do to others groups of Americans.

Vang (2014) and Lee (2013) made clear that as Hmong attempted to decrease their traditional lifestyles so they could increase their acculturation process in American society, they continued to carry with them issues of war related trauma, grief, loss, and adjustment disorders. These negative experiences have been passed on to younger Hmong children who were born in
America and have never seen or been involved in the war and resettlement process. Hmong believe in their culture very strongly. It is very difficult for both the first and second generation of Hmong people to let go of their mental health issues even though they are better off with education and income status. It is difficult for health professionals to treat Hmong when professionals lack knowledge of Hmong culture and belief systems.

Cerhan (1990) found that adjusting to life in America is very difficult for older Hmong as compared to younger Hmong. Older Hmong did not learn English and American culture as fast as their children. This seemed to be the case that Hmong children received more support from schools to socialize in American ways. At the same time, Hmong parents or older adults continued in isolation from the general public. With this isolation, they became homesick, faced physical illness, and experienced traumatic recollections.

Collier et al. (2012) and Hsu et al. (2004) reported that reversing roles between Hmong men and women led to stressful life for Hmong older men, especially Hmong men who had status positions prior to their arrival in America. Hmong women assimilated more easily because they had more chances to earn a living through their sewing skills, child care experiences, and housekeeping skills. Hmong men took menial work, less valuable than the farming and hunting, skills which was part of their status in Laos. Sometimes, it was very difficult or impossible for Hmong men to find employment of their choice. This created tension between husbands and wives.

US Refugee Policy

Tatman (2004) explained that the United States’ refugee policy was enacted for regulating Indochinese refugees who came to the United States between 1975 and 1980. The provision of this policy was to split refugee families to settle evenly in both urban and rural areas.
of the United States with the hope that they would learn and adapt to the new culture as fast as possible. This splitting of Hmong people into urban and rural areas impacted the Hmong families severely. This new law limited each refugee family to a maximum of eight people. This meant that refugee families that had more than eight members in the family had to split their families, or they were prohibited to settle in the United States. This made many Hmong families with extended members, separate from the nuclear portion. Upon arrival, they were immediately sent to various regions across the country. With this splitting up of various family members, the Hmong elders suffered the most. The fact was that these elders depended on their children for survival. They wanted to be near their beloved and highly valued family and clan leaders. The value placed by the Hmong on family and sense of community represented the most important part within their culture.

According to researchers such as Cerhan (1990) and Tatman (2004), the individualistic perspective is not tolerated by Hmong. The Hmong values a collectivistic worldview. A person is seen as a product of all the generations of the family, and the welfare of the family and community has priority over individual wants or needs. The Western perspectives of individualism have a tremendous effect on many areas of life for the Hmong. Such impact can be seen in the marriage context. For example, Hmong marriage is treated as an addition or extension to the family, rather than serving as a method to be independent of the family. It is also normal to have a family that includes both nuclear and extended members. Gender roles also play a big part in Hmong tradition. This can be seen clearly in problem solving. Hmong major events such as weddings, funerals, and conflicts of interest between individuals are handled in different ways by Hmong men. Throughout history, the Hmong have lived in a male dominated system. Under the clan system, wives and subsequent children become subordinates.
of the husband's clan, and they are expected to show respect to the elder males. Interestingly, inter marriage between two individuals within the same clan is not allowed. The clan is identified as a collective group of people who share a common heritage. Those who break the custom to marry each other with the same last name are labeled as outcasts, which implies that they are abnormal or against Hmong clan values.

**Changing Family Dynamics in the Hmong Community**

Collier et al. (2012) reported that Hmong Americans face a number of specific family issues or social problems that are associated with mental disorders. The most prominent ones are intergenerational communication barriers, marital discord, domestic violence, child abuse, issues related to mental illness, severe stigma associated with mental illness, psychiatric symptoms, elder status and mental well-being, developmental disability, and medical problems.

**Theoretical Approaches**

**History of Adler**

Before discussing ABT, it is wise to know about Alfred Adler and the key concepts of his theory. Adler was born on February 7, 1870, into a Jewish family; he had five other siblings, one sibling was older and four others were younger than Adler. While he was a child, Adler was a sickly boy who almost lost his life from physical illnesses and car accidents. He did not do well at school while he struggled with his illnesses. In spite of his experience with his health and early life struggles, Adler became a good student later on in his life. He studied and graduated from medical school at the University of Vienna, Austria. Upon getting his doctoral education in medicine, Adler was interested in private practice. While seeing patients from different backgrounds, he learned that their social conditions and where they lived and worked were the sources of their sickness. For this reason, Adler became interested in psychology and began to
help his clients by applying his psychological perspective. As Adler’s psychological approach to help people become more popular, Sigmund Freud decided to invite Adler to join him. Sigmund Freud and Alfred Adler jointly formed their first psychology center, Psychoanalytic Society, in 1902. Adler worked with Freud for a number of years. He later resigned from their joined practices due to differences in how they viewed clients who needed psychiatric care. After leaving the Psychoanalytic Society, Adler built his own team and developed his own concept of psychology, which today is called Adlerian therapy; ABT is one of his concepts (Carlson, Watts, & Maniacci, 2006).

Alfred Adler not only liked helping people solve their social and mental health problems, he also liked politics. While practicing medicine, he joined many political meetings where he met his wife, Raissa Timofevna Adler. His wife was a Russian Jewish woman and a pro-communist figure. They married and began to work on their goals. As Hitler came to power in Europe, they lost their dreams. Alfred Adler and his family ended up leaving his practices behind and moved to the United States. He settled in New York in 1935 and worked as the head of the psychiatric department at Long Island College. He also gave lectures internationally. He died in 1937 while he was on a lecture tour in Scotland, England (Mosak & Maniacci, 1999; Dinkmeyer, Dinkmeyer, & Sperry, 1987).

**Adlerian Brief Therapy (ABT) in General**

Brief therapy is usually defined as distinct from long term therapy. The terms themselves remain vague and ill-defined. In a managed care world, cultural, political, and financial considerations tend to favor brief therapy models over the more open-ended long term therapy. There is no question that the third-party insurance providers and managed care health providers have influenced the promotion of brief therapy as a preferred method of psychological treatment.
Cost-effectiveness is as important a consideration in the mental health field as is therapeutic benefit for a client. It is difficult to assess the relative benefit of particular kinds of therapy for clients without taking into account the financial and political demands of the mental health system (Carlson et al., 2006).

**Relevance of Adlerian Therapy**

ABT is universally applicable to work with clients of all backgrounds. Today, managed care organizations or third parties want therapists to offer shorter sessions and treatment for their clients. It is possible that ABT or a shorter version of therapy would reach many more Hmong clients (Carlson et al., 2006).

**Key Concepts Adlerian Theory**

According to Bitter (2014), Mosak and Maniaci (1999), and Corey (2005), people are social animals. They need others in order for survival. The social system or a family unit is unique. A social system is a primary point for children to learn various skills from their parents so they can deal with life tasks in reality. Social interest, community feeling, appreciation, inferiority feeling, fiction finalism, lifestyle, and self-determination are some vital key aspects that Adlerian therapists rely on when evaluating and applying Adlerian principles to people who need help to overcome their psychiatric issues. Additionally, Adler’s theory is about people’s opinions, feelings, responsibilities, interpretations, and what they use instead of what they possess. He “focused on reeducating individuals and reshaping society” (Corey, 2005, p. 95).

Adler viewed people from a subjective perspective, meaning that people are the experts of their beings. According to Adlerian theory, people analyze their internal and external aspects through perceptions, judgments, emotions, philosophies, faiths, and choices (Corey, 2005).
Adlerian Perception of Brief Therapy

While there is a strong association between Alfred Adler and brief therapy models, Adler’s approach is conducive to brief therapy but was not necessarily designed for it. Adler’s genius was that his ideas were flexible, adaptive, eclectic, and human centered. That is, Adlerian therapists try to focus on the unique needs and situations of their clients. Adlerian principles are adaptable to more long term therapy, when that is indicated. Adler emphasized the importance of interpersonal interactions as necessary and important in understanding intra-psychic processes. ABT takes account of the social interest of the individual which includes family, occupational, and social relationships. The focus on the social interests of each individual inevitably places clients in the context of their social, cultural, historical, and religious contexts. Adler’s approach was humanistic and emphasized that human beings are not passive recipients of social or external influences (Carlson et al., 2006).

According to Adlerian scholars, human beings are social animals, and to fully understand a human’s problems, therapists must consider the person’s social unit. In order to thrive, people must form attachments with others. Under the Adlerian perspective, human beings are gregarious. They cannot thrive on their own. People would be isolated and suffer if they lack social interests and connections with others, which leads to developing a wide range of mental and physical health problems (Carlson et al., 2006).

Adler viewed clients as persons rather than as recipients of psychiatric categories. People do not want to be defined their ailment. Adler challenged the medical model of mental health that viewed symptoms as the result of incomplete character and behavior. In his wisdom, Adler viewed therapists and clients as equals. In addition, Adler contended that clients are more knowledgeable about their problems than the therapists are. In other words, Adler viewed clients
as the experts. He rejected the hierarchy that was entrenched in the biomedical model that placed the client in a one down position. The Adlerian approach focuses on the disappointment, issues, and frustrations that naturally arise from the conflict between social circumstances and social interests. The successful therapeutic outcomes should conform to the dignity, respect, and interest of therapists and clients (Carlson et al., 2006).

In therapy, Adlerian counselors assist clients to define their circumstances, concerns, stresses, and hopes. The primary roles of the therapists are as consultants. To make the therapy session productive, counselors need to pay attention to their clients’ stories. Listening to the clients’ accounts would enable the therapists to evaluate the clients’ concerns, strengths, and weaknesses. It would also help the therapists to detect ineffective or inconsistent problem solving skills that clients previously employed (Carlson et al., 2006).

Carlson et al. (2006) explained that the unique feature of ABT is its focus on specific goals and clear outcomes. Clients who often encounter mental health issues are those who lack realistic and specific goals. For instance, a person might want to achieve fame for having a unique patent, but that person was not a scientist or an engineer. Such people lack the necessary skills and knowledge to reach their goals. Moreover, some people mistakenly feel and think that they can reach their goals if they attempted hard enough. When this is the case, clients may believe that they failed because they did not work as hard as possible toward their goals. Clients need to be educated that they do not have to be superior so they can feel comfortable. In order for clients to gain hope, they need to learn and adapt to reality that goals are different for everyone (Carlson et al., 2006).

According to Carlson et al. (2006), the first few seconds of contact with clients are the most important in therapy counseling. Scientists contended that human beings make their first
impression within seconds of their first encounter with one another. From the clients’ perspective, therapists must show a positive attitude toward clients. In other words, clients want therapists to treat them as people by showing kindness, interest, and care for them. Clients are sensitive to actions or expressions that they feel are insulting or irrelevant to their issues. Therapists who consider clients’ stories not genuine and unbelievable would make their clients terminate from therapy sessions prematurely. To help therapists win their clients, therapists must practice positively by being patient, showing respect to their clients as people, and committing to help them from start to finish (Carlson et al., 2006).

**Adlerian Psychological Superstructure**

Adlerian therapy, as does any other therapeutic approach, relies on particular assumptions and beliefs that structure the therapist’s understanding of the client. ABT is a combination or a product of Adler’s principle of psychology and systems approach. From Adlerian therapists’ point of view, it is difficult to assess clients’ problems unless all aspects that are applicable to clients are included. The clients’ interpersonal context, their family units, and their places of work are crucial factors that contribute to the accuracy of assessing their mental health problems (Carlson et al., 2006).

**Characteristics of Adlerian Brief Therapy**

- Time-limited focus on presenting problems will structure the type of intervention a therapist will make. Therapists might be directive but within the needs and desires of the client.
- Symptoms or problems are viewed as opportunities for personal development and growth rather than as signs of pathology.
- Therapy is solution-focused rather than understanding the etiology of the problem.
Motivation modification includes reconsidering past problem-solving solutions that were not effective (Carlson et al., 2006).

**Socratic Questions**

To facilitate a client-centered approach, the therapist relies on their curiosity about the client to know more about the client. Adlerian therapists use Socratic questions to solicit information and affective responses from the client. Asking clients various questions such as “How do you feel when ____ occurred?” or “What would your life be if such things did not happen to you?” Assessing clients’ issues by using the questioning approach can help clients realize what things happen accordingly, as well as enable clients to predict future outcomes of their behaviors. Additionally, the questioning strategy helps therapists connect to the reality of their clients’ needs and stories. To fully gain an insight to clients’ accounts, therapists need good listening and communication skills. The non-verbal communication is as important as the verbal one. Thus, it is essential for therapists to consider the differences between verbal and non-verbal interaction when dealing with clients. The key factors for therapists to be effective are good listening skills and being able to ask follow up questions (Bitter, 2014).

**The Miracle Question**

The goal of the miracle question is to request that the clients articulate a possible solution to their problems. A key element of Adlerian therapy is to encourage a hopeful, optimistic attitude, and challenges the client to think in positive ways about solutions. The therapist encourages clients to seek positive outcome as they view their future. Some clients have more resources and know how to solve their own problems more than what they can understand. Clients are optimistic for changes if their therapists are supporting them openly. Clients who are experiencing depression or anxiety often feel guilty because they feel weak and lack courage to
thrive. Because of this, the Adlerian therapists’ role is to help clients understand the differences between what causes anxiety and fear, as well as what maintains resilience and courage (Carlson et al., 2006).

**Framework of Adlerian Brief Therapy**

Watts and Carlson (1999) explained that the conceptual framework of Adlerian Brief Therapy rests on three levels. The goals of the framework are to provide ABT professionals with a system for comprehending the client’s acting manner and the brief therapy system. The first level of the framework involves “action and emotion”; at this level the therapist would ask the client, “How”, and the client would reply by saying “I/we do… and feel”. Exchanging conversation this way allows the therapist to assess precisely what the client does and how the client feels as he or she engages in choosing the behavior. Level two relates to determination (purpose) and meaning (function). When in discussion, the therapist asks the client “What for?”, and the client would normally respond like “In order to.” This level prompts the therapist to move deeper in the process. The therapist wants to know what is the purpose and function of the client’s behavior. Level three deals with the guidelines (rules) of contact (interaction). When intermingling with the client, the therapist would ask the client “Why?” and the client would respond by saying “Because.” Level three is the deepest level which allows the therapist to assess why the client chooses a certain approach to handle his or her life. These three levels are useful for designing therapeutic strategies to help the client change for better. Among these, the third level serves as the starting point for intervention to take place (Watts & Carlson, 1999, p. 20).
Four Stages of Adlerian Brief Therapy

Adlerian Brief Therapy translates the three levels above into a four-level process via the abbreviation “BURP: Behavioral description of the presenting problem, Underlying rules of interaction assessment, Reorientation of the client’s rules of interaction, and Prescribing new behavioral rituals” (Watts & Carlson, 1999, p. 22). These four stages of ABT are set up for best delivery of mental health services to clients, although it is not necessary to follow the sequence as it is portrayed (Watts & Carlson, 1999).

Behavioral assessment – phase one. Carlson et al., (2006) explained that it is critical for the Adlerian Brief Therapy practitioner to form a strong relationship with the client in order to gain precise information about issues that impact the client’s daily living condition. At this stage, it is best for the therapist to listen actively to the client’s story that put the client in an adversarial position. It is best to learn the client’s problem from an action and emotion perspective rather than from a medical standpoint. Asking the client to indicate specific situations and times when the client is experiencing difficulties is essential under ABT. Some of the good questions that would help the therapist to engage clients in sharing their concerns with the therapist are:

- The last time that you feel depressed or sad, what did you do to make you feel better?
- Was your depressed feeling impacting other people in your family?
- If so, what kind of response or action did you receive from them?
- When they were concerned about your depressed mood, how did you reply to them?

(Carlson et al., 2006).

According to Carlson et al. (2006), the above questions will enable the therapist to assist the client later on in the treatment process. In addition, using “action-oriented and terminology”
(Carlson et al., 2006, p. 167) will increase the client’s level of self-esteem to make change from negative thinking to positive thinking. In other words, doing so will prompt the client to make effort to solve the problem instead of focusing on the problem itself. In order to have a clear picture of the client’s total system, it is essential that the therapist focus on how the client reacts emotionally at certain times and places when the client experienced the bad mood (Carlson et al., 2006).

**Underlying rules of interaction – phase two.** At this stage of the Adlerian Brief Therapy process, the therapist evaluates an understanding of the client’s presenting problems, including all factors that stimulate the problems and “the purpose of the client behavior symptoms” (Carlson et al., 2006, p. 167). Having a clear picture of the problem as a whole, the therapist can imagine intelligently the client’s behavior. With this perspective, the therapist can best position a match to the client’s stance. Once the therapist and client are allied, the client will begin to engage with the therapist and move in the direction that will promote differences. Early recollection, genogram information derived from the client’s family, and magical questions are beneficial for the therapist to apply at this phase of the counseling process. Doing so will help the therapist and client move to the next level or third stage (Carlson, et al., 2006).

**Reorientation process – phase three.** Watts and Carlson (1999) explained that the main fundamental concern in the reorientation phase is to carefully talk the client through both behavioral aspects and rules of interactions that contribute to the client’s presenting complaint from as many angles as possible. Doing so will enable ABT professionals to facilitate and carefully direct the change process. This is the initial point for change to begin (Carlson et al., 2006).
To benefit clients, researchers encouraged mental health practitioners to utilize various techniques such as those that are found in solution-focused and narrative therapies as he or she is helping the clients to clearly understand their problems. Some examples of the techniques in solution-focused therapy are “reframing, relabeling, humor, and confrontation” (Carlson et al., 2006, p. 168). Those found in narrative therapy relate to uttering the problem, searching for exceptions, and supposing a one-down or unknown view. The decision to apply appropriate techniques to the client’s presenting problem rests on the judgment of the therapist who can justify the uniqueness of the client (Carlson et al., 2006).

**Prescribing new behavioral rituals – phase four.** Watts and Carlson (1999) reported that in prescribing new behavioral rituals phase four, is the foundation point for ABT therapists to develop new activities for clients to do between therapeutic sessions. It is essential that clients vigorously participate “in the change process outside of the therapy” (p. 168). In this final phase of ABT, practitioners position their understandings of the client’s problems into practice. To bring positive outcome, clients need help from therapists in searching for better and more purposeful options. Thus, it is the therapist’s responsibility for inspiring and challenging clients to take risk for positive change to occur (Corey, 2005).

**Limitation of Adlerian Therapy**

Culturally, Adlerian principles are not universally applied to treating mental illness, due to the fact that Adlerian principles focus primarily on the self or individuation. Besides, it might be difficult for one to look at his or her early memories or childhood experiences within his or her family. Some people might block the insights of their personal lives that they feel are not applicable to the cause of their problems. In addition, people of many cultures are not open to sharing personal information with others. It is hard for clients to work with the therapist unless
the latter can prove to the client that the therapist is culturally receptive of the client’s background. Researchers have found that even though therapists are well-trained to solve mental health issues, they may not know enough information about different issues of people from differing cultural backgrounds. In some cultures, the clients would perceive the therapist as an expert, and they would expect the therapist to prescribe solutions to their problems. For these people, Adlerian therapists would run into this main issue (Corey, 2005).

Another limitation regarding the Adlerian approach is the loose ideas. For example, critics have mentioned that Adler’s ideas were too simplistic and not effective when working with clients. Major parts of Adlerian approach are still in question due to lack of empirical support. Finally, another critique about the limitation of Adlerian approach was in regard to solutions. The Adlerian approach would not be effective for someone who would seek an immediate solution to their presenting problem since the approach explores many childhood and early life experiences, which requires much time and deep exploration (Corey, 2005).

**Solution-Focused Therapy, Principles, and Techniques**

Researchers explained that there are multiple concepts and techniques that are applicable within the framework of Solution-Focused Therapy (SFT). For example, one of the main concepts of solution-focused therapy is focusing on the future and not the previous experiences of individuals. In addition, problems are best handled by emphasizing what the clients are already capable of (Bitter, 2014). Other principles within the SFT that are relevant to help the clients in this case are focusing on positive change, focusing on resources, clients as the expert, and building a collaboration (Burwell & Chen, 2006).

Focusing on positive change allows the therapist to focus less on problem stories, and do more on developing solutions based on the client’s needs. Applying this concept reality helps
the clients change their negative form of communication to a positive one without putting judgment on the past. Also focusing on resources refers to the strengths of the clients instead of their limitations. Burwell and Chen (2006) suggested that it is best that the clients understand their capabilities and are able to solve their own problems. For example, the clients can refocus on how to re-construct their communication pattern by using their own resources like “exception to the dysfunctional behavior, past success, and the clients’ ability to imagine a future” (p. 192).

The client as the expert is another component in SFT that is critical for the success of therapeutic process. In SFT, the clients know their problems more than the therapist. According to Burwell and Chen (2006) it is necessary that therapists work cooperatively with the clients to define the main objective of therapy. This joint effort enables the therapist and client to work on what they perceive their problem is as it is. In reality, therapists work to encourage their clients to develop solutions to their problems based on the clients’ knowledge of the issues. To make the therapeutic process productive, therapists must remain judgment free and not insert their own opinions to the solutions of their clients’ choices.

In SFT, building collaborative alliance is essential for the success of the therapeutic process. It is necessary that the therapist and clients deal with each other cooperatively and collaboratively in order to initiate change for the clients. This relationship should be developed as early as their first meeting; therefore, it is essential that therapists establish their relationships with each of their clients by getting to know them at a personal level. As the therapists and clients are getting to feel more confident with one another, the therapists can encourage the clients to briefly discuss their issues and collaboratively emphasize the solutions that would satisfy their goals (Burwell & Chen, 2006).
Key Techniques of Solution-Focused Therapy

The key interventions that researchers describe as the best for the group dynamics would include the use of scaling question, compliments, and inviting clients to do more of what is working. These key techniques are mainly used to make future goals and solutions more concrete, small, and measureable for the client. The problem does not seem as daunting and instills more confidence, hope, and motivation in the client. The scaling questions can also be used to track the client’s performance over sessions, along with what will be the next steps in therapy. In therapy, the therapist could use a scaling question such as: “On a scale of one to ten (one is the worst and ten is the best), where do you see your communication skills being effective with others?” In addition, one could ask “What would it take for you to move up the next number (ex: 3, 4, etc.) on the scale?” Overall, scaling questions would be effective in any case because it helps the clients to see their capable of improvements (Bitter, 2014).

Nichols (2009) reported that compliments often work well in solution focused therapy. Recognizing what the clients are capable of doing and accepting how challenging their problems can be is a form of motivation for the clients to change. The therapist would simultaneously show to the clients that he or she is actively listening to the clients’ stories. This concept also assists the clients and specifies what they are doing well at a certain time. For example, compliments can be used to show appreciation and empathy in the form of questioning the clients like “Wow how did you manage to do that before?” This type of question would prompt the clients to realize that they already have the tools to solve their issue or problem. For example, therapist would insert a compliment when they were willing to meet in group to develop solutions to their problems or describing an exception to the case. It is best for solution-focused therapists to develop an optimistic attitude using the technique of compliments and
discovering there are exceptions to the problem. Next the therapist would kindly ask the client to repeat what has worked in the past. Burwell and Chen (2006) explained that the therapist can encourage the client to try new things that often are called experiments. When providing therapy for group, the therapists would encourage all the members to act as a guest to one another in a professional setting. For example, each of them would be as polite as possible and respect each other’s views. An ideal communication would include directness, calmness, and lack of criticism.

**Effectiveness of Solution Focused Therapy**

Studies showed that there were positive and negative aspects of SFT in reality. Positively, therapists can introduce a new problem solving approach to help clients learn modern ways of dealing with issues that is different from their traditional life. For example, clients of other culture sometimes would put someone at fault when a problem exists; this would lead to someone being labeled as a loser in the conflict. When this is the case, the SFT therapist could help to balance the issues by saving individuals from being labeled and instead show them they have the capabilities to change their situation (Corey, 2005).

**Limitation of Solution-Focused Therapy**

There are some limitations. These include less of a focus on the problems and more attention on the solutions. For example, this therapy does not explore past childhood experience. Researchers found that part of the puzzle is missing when the client does not look at the past. There were suggestions that the past is important in one’s life. In addition, SFT is not multicultural sensitive. For example, in Asian cultures, past tradition is highly emphasized. When solving problems, people always attempt to find the root cause of the problems before generating solutions; therefore, this traditional message would contradict and not fit well for
cross cultural cases because there is a strong future orientation. Another negative feature of SFT is that it is a type of therapy that focuses on equality among members in the client system. This aspect violates clients who respect hierarchy and generation differences (Burwell & Chen, 2006; Nichols, 2009).

**Strategic Therapy**

According to Haley (1987), ST is a different kind of therapy approach that the therapist is in charge of what is best for the client. The therapist is responsible for creating a blueprint and setting precise, not suggested, goals to help the client change or solve his or her current problem. Setting clear goals will not only allow the therapist to see whether or not the client will carry his or her task accordingly, but goals will also help the therapist determine how to direct the client. In a therapy session, the strategies that the therapist designs for clients communicates that the therapist can be either direct and straightforward or indirect and paradoxical, instructional in nature, as well as prescribing tasks as homework (Gardner, Burr, & Wiedower, 2006). ST styles of therapy take into account the familial and social contexts that clients live within. Specifically, family members are enlisted in the process and contribute to solving the problem. ST recognizes that individuals are never solitary beings but always live in social environments and when one person changes, the change impacts his or her whole family (Haley, 1963). In addition, ST focused on “the analytical way in which it conceptualizes a problem” (Madas, 1981, p. 21). Under ST, depression is considered as a form of communication. For example, when a child or a man is depressed, he or she is communicating to others in his or her social context (Madas, 1981).
History of Strategic Therapy

Madanes (1981) and Gardner et al. (2006) explained that the foundation that led to the development of ST is communication theory. ST is one of the family counseling approaches that originated at the Mental Health Research Institute (MRI) in Palo Alto, California during the 1950s. The first main leading figures who developed this family therapy concept were Don Jackson and Gregory Bateson, who were later joined by Jay Haley and many others. However, SFT advanced into two different models including MRI brief therapy and Haley and Madanes’ Strategic Therapy. The core focus of the MRI brief therapy model “is grounded in the identification and change of problem-maintaining family interactional processes and patterns” (Gardner et al., 2006, p. 339). In 1967, Jay Haley moved out from the MRI brief therapy project and relocated to Philadelphia to join Salvador Manuchin and Cloe Madanes to create Strategic Family Therapy (SFT). The emphasis of SFT under Jay Haley and his team was based on hierarchy and power for (Haley, 1987).

A fundamental idea of ST is that an individual’s problems are best solved by taking into account how the problem and its symptomology is an expression of the dynamics of the family system. Under SFT, the therapist is responsible for developing precise tactics that will improve the functioning of the family by mapping the relationships among various family members. With a clear policy created by the therapist, clients can examine both the visible and invisible rules of their family. The basic goal is to unsettle and change dysfunctional familial relationships to a healthier position. ST therapists focus more on the family, rather than the individual as the source of the problem. Thus, the therapeutic approach designed by the strategic therapist is to interrupt dysfunctional family patterns by attending to how power is used to
maintain unnecessary inequalities. Overall, modifying the distribution of power and its expression has the effect of changing communication patterns (Haley, 1987).

**Strategic Therapy and Change**

Under ST, there are countless ways for change to take place including hopefulness, conversation, analysis of motivations, and communication (Garnder, et al., 2006). The core function of ST is that the responsibility for change is rested on the counselor. Change will not occur unless the therapist and client work collaboratively, according to the blueprint designed to respond to the problems of the clients. Since problems or clients are dynamic and evolve, therapists must be flexible and creative in developing specific strategies to solve various issues encountered by clients (Madanes, 1981).

In addition, researchers reported that ST is extremely directive. It requires the mental health practitioner to play a powerful role in a very vigorous manner. It is beneficial for the therapist to give a specific roadmap that highly predicts change will happen and that will allow the family to function differently. Concurrently, the therapist must form a friendly and trusting relationship with the client and the family so that the client is confident in carrying out the instruction that the therapist proposes (Haley, 1963).

**Strengths, Limitations, and Contradictions**

The strengths or values of the ST approach are that it is a direct and clear way of communicating with clients. In addition, this approach provides the therapist with a flexible opportunity to modify the treatment process to meet the needs of the clients. This flexibility is applicable for clients who expect the therapist to tell them what to do. These types of clients feel powerless. Additionally, ST can be applied to people of different cultural backgrounds to reach their goals (Garnder et al., 2006). Soo-Hoo (1999) and Haley (1987) reported that strategic
family therapy is applicable to mental issues of people with different cultural backgrounds such as Chinese, of South Americans, and even the Japanese. The emphasis on family structure and brief therapy sessions are the ingredients that fit well into the individual family’s exceptional practices and arrangements.

However, the biggest limitation of SFT is that the client may feel the therapist is pushing too hard without fully understanding the client’s perspective. The therapist will not be effective if applying SFT in an inappropriate manner or with the client who is not able to tolerate this approach. Some clients who may not like the position of the therapist because they feel the therapist has too much control of their life. The therapist’s failure to give clear advice or failure to understand the client’s problem clearly can also be issues (Gardner et al., 2006).

Discussion

As indicated by various literature research, the Hmong are experiencing mental health issues differently and in different contexts. It is fundamental for Adlerian therapists to pay close attention to Hmong’s mental health needs as the therapists exercise the application of ABT to initiate changes for Hmong clients or patients. From the literature review, utilizing ABT alone might not be sufficient to solve the mental health challenges of the Hmong.

The question is, Is ABT applicable to solving Hmong mental health issues? The answer to this is yes only if Adlerian therapists blend their practice to include other theoretical orientations of counseling therapies and cultural perspectives. So far, the writer found no single article that articulated cases involving Hmong people under the Adlerian concept. It is possible that ABT can benefit the Hmong if mental health practitioners are willing to include other therapy orientations in their therapy process when seeing Hmong clients. First, it is advisable for mental health therapists to view how ABT is applicable to the Chinese people. By looking at this
perspective, it is likely that ABT is effective to solve Hmong mental problems. Research showed that both Hmong and Chinese share similar cultures and values. Thus, it is assumed that the Hmong would benefit from the ABT as the Chinese do. Research indicated that Chinese people have adapted Adlerian models in China and other regions in Asia. Adlerian therapists favor peace to Asian families, community, and the world (Bitter & Sun, 2012; Carlson, Carlson, & Emavardhana, 2011).

The down side for Adlerian therapists and Hmong clients would rest on the worldview between the two parties. Like the Chinese, the Hmong will not accept the concept of equality among men, women, and children as proposed by Adlerian therapists. In Hmong as well as Chinese culture, the values of hierarchy and elderly respect are highly prized. The focus on the Adlerian model is likely to conflict with the Hmong value of power differences between genders, ages, and generations (Carteret, 2012; Tapp, 2016; Tatman, 2004).

To solve the adversarial aspect of power differences, Adlerian therapists might consider adapting techniques in strategic family therapy to overcome this issue. Since the Hmong perceive therapists as experts, it is to their advantage to exercise the directive approach in SFT to motivate Hmong clients to engage in the change process. As stated, the core function of strategic family therapy is that the responsibility for change rests on the counselors. It is the therapist who develops the blueprints and provides precise direction for clients to initiate change. The directive technique is useful for the therapist when he or she uses it during the final stage of ABT, prescribing new behavioral rituals.

Another useful perspective that would make an Adlerian therapist’s job easier when dealing with Hmong clients is to include various techniques in solution-focused therapy in the practices. This is relevant during the third level of ABT framework structure. When applying
solution-focused therapy concepts, the counselor can help the Hmong learn to broaden their perspectives of mental health. It is also a chance for therapists to open the clients’ minds to learn from their therapists that they can think and act differently when encountering mental health problems. By using this approach, therapists can encourage their Hmong clients “to modify repetitive, unhelpful patterns on their own by shifting from problem-centric to solution-center language” (Epstein et al., 2012, p. 225).

Again, the Hmong and the Chinese are identical in nature in terms of culture and values. Thus, there is no doubt that what benefits the Chinese will be effective with Hmong people. It is advisable that when therapists have doubts, they should turn to therapists who use solution-focused therapists to treat Chinese clients. The time limits in solution-focused therapy, its intention to deal with issues, and therapists’ use of complimentary strategy are other key aspects to be compatible with Hmong clients as they fit well in Chinese culture. By this account, it is predictable that solution-focused therapy will bring benefits to both sides: therapists and Hmong clients (Epstein et al., 2012).

Lor and George (2014) reported that from the scientific community’s point of view, appreciative inquiry (AI) is another chosen framework to work with minority groups of people such as the Hmong. AI is a change driven approach designed to solve human and organizational systems. It was developed by David Cooperride, a professor at Case Western Reserve University, in the 1980s. AI is comparable to the four stages process of ABT, the “4-D Cycle” (Lor & George, 2014, p. 339). According to the Center for Appreciative Inquiry (2016), Figure 1 displays the connection among the 4-D Cycle. This visual image will provide logical steps for mental health practitioners to follow.
Phase one is the innovation or “discovery” step, and it is similar to the first stage or behavioral assessment part in ABT. This is where therapists build rapport, include others from the client’s system in the therapy, and determine what the best values of the topic being discussed are. Without this phase, therapists cannot engage clients in conversations that would result in positive perspective. The vision of “dream” stage is equal to the underlying rules of interaction. The strategy or “design” step relates to the reorientation process, and intention or “destiny” point corresponds to the prescribing new behavioral rituals part respectively. Due to the time constraint in this project, AI is not fully explained here (Whitney & Bloom, 2003, p. 6).
Conclusion and Recommendation

Tactics to Improve Psychological Measures

Cobb (2010) reported that when patients were provided with easy access to health services or resources, their mental health seemed to improve positively. For example, when a group of Hmong health care professionals visited Hmong patients with Type II diabetes, the patients’ level of chronic depression and anxiety decreased. This made the patients more willing to accept treatment provided to them. In addition, researchers “found that providing cultural exchange and one-on-one learning opportunities, as well as focused advocacy skills resulted in improved quality of life, decreases psychological distress, increase English proficiency and increase satisfaction with resources” (Cobb, 2010, p. 82). Based on this account, it is useful for policy makers to shift their attention to Hmong patients from helping perspectives to mutual learning (Cobb, 2010).

Suggestion for Providers

Cobb (2010), the Centers for Disease Control (2008), Chang, Feller, and Nimmagadda (2009), and Carteret (2012) described that in order to work best with Hmong patients, the following aspects need to be considered by health care professionals:

- Show respect and optimistic attitude toward patients.
- Show interest toward culture exchange between patients and doctors.
- Take time to address the needs for diagnosis, treatment methods, and outcome of treatment.
- Provide quality translation services or visual aid to so patients can understand visually.
- Involve family members or clan leaders in patient care system, as well as asking who should be involved in the treatment plan.
• Respect patients’ decisions and avoid negative prediction and ignore stereotyping.
• Use trained interpreters and same gender providers, cooperate with shamans, avoid drawing too much blood, be neutral and supportive to patients.
• Encourage bringing Hmong food to hospitals.
• Avoid weakening a father’s influence and allow a mixture of Western medicine with Hmong herbal or healing practices.
• Rephrase or reflect the question in simple terms to make sure patients understand what is being communicated to them. Do not force patients to respond, and check for Yes answers; sometimes Yes means NO.
• Because Hmong’s voices are soft, avoid speaking to them too loudly
• Avoid praising Hmong children due to spiritual purposes.
• Avoid making direct eye contact with Hmong patients, avoid hugging and shaking hands with Hmong women.
• Respect second opinions because when making medical decisions, Hmong tend to seek advice from relatives or someone who they believe is more knowledgeable or sensitive to their concerns (Her & Culhane-Pera, 2004).

Duty to Inform with Hmong Clients

The ‘duty to inform concept’ is applicable to mental health professionals regardless of their clients’ cultural backgrounds. When the therapist discovers that a Hmong client is intending to harm a specifically named person, it is required that the therapist must act accordingly under the law. A case scenario is presented to demonstrate the application of duty to inform involving a Hmong client and the best option will articulated for the therapist in the scenario.
Duty to Inform

In regard to mental health, Woody and Woody (2001) defined duty to inform as “the ethical and/or legal obligation to notify an identified potential victim, or group of victims of possible danger. In some situations, the duty to warn also involves a duty to report potential dangerousness to law enforcement authorities or government agencies” (p. 126). Remley and Herlihy (2016) explained that the Tarasoff Case was adapted as a “Code of Ethics” (p. 196) by all counselors in the United States’ jurisdictions, except those in Texas. Specifically, the application of the Tarasoff Case was summarized as follows:

When a psychotherapist determines, or pursuant to the standards of his profession should determine, that a patient presents a serious danger or violence to others, the therapist incurs an obligation to use reasonable care to protect the foreseeable victim from such danger. (Remley & Herlihy, 2016, p. 196)

Today most states follow the Tarasoff Case as a guideline to regulate their practice because it presents a clear interpretation of actions and protocol that are applicable to health care professionals. Different jurisdictions in the United States, however, interpret and apply the Tarasoff Case differently with regard to ethical and legal decision-making.

Options to Inform

Counselors have to perform multiple tasks to ensure ethical and legal requirements of duty to inform are met in therapy. These include discussing the issue more with the client to determine the possibility of harm that the client plans to carry out. It may prove appropriate for the therapist to contact an immediate family member of the client to come and take the client from the therapist’s office if the risk-level is assessed and this step is deemed appropriate. If a minor, the parents of the client should be the first to be contacted if the client is not an immediate danger requiring police intervention. The third option for counselors is to contact a local law enforcement to assess the level of risk. Finally, the therapist must contact the potential victim as
soon as the client leaves the therapist’s office. As such, it is mandatory to document in detail what transpires. Ultimately, the law and ethical professional standards allow counselors or therapists to break confidentiality when there is a threat of harm to others by the client or if the client is threatening to harm him or herself (Ivers & Perry, 2014).

**Case Scenario**

The case scenario that is used for the discussion of this paper was derived from Remley and Herlihy (2016). These authors summarized the following case scenario that is applicable to the discussion about the duty to inform:

Todd is a counselor in a community mental health center. For the last weeks he has been seeing a client named Bill who is a junior in high school. Bill comes to the center one day each week walking from school to his sessions and then walking home afterward. This afternoon Bill tells Todd that after thinking about it for quite some time he has decided to shoot the assistant principal at his school. Bill says that his father has a rifle collection in their home and he has access to the guns and ammunition. Bill explains that he plans to wait outside the assistant principal’s home until he walks out in the morning and shoot him as he walks to his car. Because Bill is so calm as he relates all of this information Todd asks Bill if he is serious. Bill smiles, laughs, and then says, ‘No, I was only kidding. I would never do anything like that.’ Because Todd does not know Bill very well he is not sure what to do next. Todd asks Bill to excuse him for a minute and leaves his office to look for his supervisor. He discovers that his supervisor and all the other staff have left for the day. Todd returns to his office and finds Bill standing by a window looking out with tears in his eyes. (Remley & Herlihy, 2016, p. 194)

Under the law-and codes of ethics, mental health practitioners are obligated to take specific actions in order to prevent negative consequences that adversely impact the community at large (Remley & Herlihy, 2016). Similarly, Appelbaum (2013) wrote that mental health professionals have duties to report to authorities as soon as they discover that a child is being abused or an adult is making a deadly threat to hurt others.

**Discussion**

When considering issues with Todd’s client, Bill, it is important for this therapist to conceptualize the case from different perspectives. To help make a better decision, the therapist
needs to determine the best option utilizing moral, ethical, and legal principles, as well as getting more information from the client. It is vital; therefore, for the therapist to answer the following questions at the beginning:

1. Which moral principle or principles are applicable in dealing with this case?
2. Which ethical decision-making process will be most suitable to solve this dilemma?
3. Are there any court decisions or legal principles applicable to this case?

The therapist would need to be familiar with all the relevant moral principles.

Ivers and Perry (2014) explained that the different moral principles are:

- Beneficence (promote client welfare),
- non-maleficence (do no harm),
- autonomy (protect the freedom and independence of clients),
- justice (treat clients equitably),
- and fidelity (fulfill commitments and obligations).
- A sixth principle, veracity (being truthful to clients), was later added to the model.

(p. 72)

According to Remley and Herlihy (2016), taking time to study the above moral principles will help this therapist handle his case productively. The therapist must evaluate each of them individually in order to determine which concepts are most applicable to the case.

Apart from the moral principles, it is necessary that the therapist employs an ethical decision making model. A common ethical decision making method that is often used by therapists involves a seven step process. Remley and Herlihy (2016) and Woody and Woody (2001) discussed this seven step process of as follows:
1. Study the problems or problem analysis. In the above case scenario, the therapist can talk more with the client about his motivation to pursue his plan. When talking to Bill it is important to be direct and documented. Talking more with the client also enables the therapist to determine if a legal question exists. If so, the therapist can seek legal advice. It will also prompt the therapist to self-question: Is the issue in the case related to me? What should I do, or should I not do? And what about the client and his significant others? (Miller & David, 1996).

2. Consult the code of ethics. To help the therapist make effective and ethically sound decisions, it is beneficial for the therapist to review the American Counseling Association Codes of Ethics or other professional code, as well as consulting the professional association board that monitors the field (Remley & Herlihy, 2016).

3. Define the nature and scope of the situation. The therapist can turn to step four and discuss the issue with a co-worker in the field (Miller & David, 1996). Seeking advice from colleagues in the field for further advice can change the perspectives and outcomes of the case (Remley & Herlihy, 2014).

4. Assess “the rights, responsibilities, and vulnerability of all affected parties (Woody & Woody, 2001, p. 7). At this stage, it is vital that the therapist makes decisions based on information that was collected, and chooses to weigh each of them according to their merits while ignoring useless information. (Miller & David, 1996).

5. Calculate the course of action. At this stage of the process, the therapist must evaluate the options that he or she selected and determine if there are any issues related to ethical consideration. Three questions the therapist must ask are: Is it fair
and can others treat me this way? What do I want the press to say about me? Can I suggest my actions to others in the same field?

6. After consulting with law enforcement a decision must be made regarding the level of risk the client poses to his stated target. His parents must be informed. The school and the Assistant Principle must also be informed of the threat.

7. It is critical that prior to any appointment with a client they read and understand the informed consent which should stipulate clearly what the therapists’ legal reporting obligation is in situations like this. This informed consent should be verbally reviewed at the time of the initial intake appointment and periodically after that during the course of treatment.

Regardless of clients’ cultural backgrounds, it is essential for therapists to consider following the above decision making model and moral analysis in their everyday practice so they can produce sound ethical decisions. In addition, solving complex situations requires advanced competence and integrity on the part of the therapists. Thus, it is vital that counselors continue to enhance their capacities through ongoing learning (Woody & Woody, 2001).

**Conclusion**

This master’s project allowed the author to learn about all aspects that are applicable to therapists with a dilemma situation. It is recommended that therapists take the factors previously listed into consideration when facing a situation that elicits ethical, moral, and legal questions. The best options for therapists are to be knowledgeable about ethical, moral, and legal dimensions. There are different approaches for therapists when dealing with issues that relate to the duty to inform. The sources to help the therapists are their supervisors if employed, and the American Counseling Association Code of Ethics, moral principles, and ethical decision making
approaches. The law in the state where therapists practice should be given first and primary consideration, because compliance with the law regarding a duty to warn, takes precedence over any association’s code of ethics, or cultural considerations.

Questions

There are some questions that need to be raised as a result of this project. These questions are varied depending on who is raising the questions. This project may or may not fulfill the needs of mental health practitioners who have limited knowledge of the Hmong people as a whole. How can this project be made attractive to other non-Hmong mental health professionals? How can this project be improved to cover current relevant information?

Some readers may consider other ways that can help professionals to address the issues of Hmong mental health. Still, other readers will question whether or not this research project is applicable to the current issues that impact the Hmong locally and nationally. Overall, it is intended that this research project will help current mental health specialists modify their current practices to better serve Hmong clients who are often not open to mental health diagnoses or treatment, as well as to retain their current clients.
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