Cross-Cultural Mental Health: The SSLD Approach

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Abstract

SSLD (Strategies and Skills Learning and Development) is a learning system that helps people to expand their repertoire of strategies and skills through systematic learning, so that they become more effective in meeting their own needs and achieving their goals in life. The system builds on earlier work in social skills training, and has been adapted and applied to a wide range of human service contexts in Canada and internationally. Applied to cross-cultural psychotherapy and counseling, the system provides a comprehensive framework for understanding human experience within its social context, including how culture affects our environment and social reality, body and biological processes, motivation and needs, cognition, emotion, and action. Based on multiple contingencies thinking, the SSLD system engages with the multiple forces at work in the cross-cultural clinical context, and emphasizes a personalized understanding of client needs and circumstances. It offers a systematic intervention procedure that enables more effective meeting of needs, associated with goal attainment, problem solving, improved self-efficacy, wellness, and quality of life.

Background

Strategies and Skills Learning and Development (SSLD) is a learning system that helps people to expand their repertoire of strategies and skills through systematic learning, so that they become more effective in meeting their own needs and achieving their goals in life. It is a practice system that has been applied to a wide range of clinical populations within mental health and community settings in Canada and internationally.

Development of SSLD

The development of SSLD can be traced back to my first application of Social Skills Training (SST) in Hong Kong back in the 1970s. Initially, I was primarily following the model developed by Michael Argyle and his colleagues (Argyle, 1969, 1972; Trower, Bryant, & Argyle, 1978). My very first experience of SST required me to negotiate cultural difference, as I had to adopt a system that was initially developed in the UK and apply it to a predominantly Chinese clientele in Hong Kong. I began using the system with a variety of mental health issues such as individual treatment for adults with schizophrenic disorder and helping them form a self-help group, social skills training for children with autism along with parallel training for their parents and caregivers, and skills training for people who wished to improve their self-confidence and interpersonal relationships.

Since the 1990s, I developed approaches and procedures that emphasized four elements: 1) a learner-centered design, 2) multiple contingencies thinking, addressing particular client circumstances and needs by taking into account multiple psychosocial factors that interact with each other, 3) empowerment and enhancement of self-efficacy, and 4) intersecting diversities. Apart from Argyle's (1969, 1972) pioneering work, I developed the programs with reference to the work by leaders in the field such as Singleton, Spurgeon, and Stammers (1979), Curran and

Monti (1982), Trower (1984), L'Abate and Milan (1985), Hollin and Trower (1986), and Liberman, DeRisi, and Mueser (1989). In the process, I tried to stay attuned to the performance of my clients and students, as well as the feedback they gave, much of which were conditioned by the cultural context we were in. This process led to ongoing modifications. For example, when applying the model to couples counseling, we had to take into account the actions and events that carried specific cultural meaning (Ma & Tsang, 1988). This process gradually transformed the content and structure of my programs, as well as the process and style of delivery. Thus in 2005, after reviewing features and characteristics of my practice model, I decided to distinguish it from the original SST model by naming it Strategies and Skills Learning and Development (SSLD). Over the years, I have applied the system to various mental health, social services and human development programs both in Canada and internationally, including the following:

- Counseling and psychotherapy
  - Individual
  - Couple and family
- Self-help groups
- Psycho-educational interventions: Education, learning, and training programs
- Corporate training and organizational development
- Mental health issues:
  - Schizophrenic disorder
  - Autistic spectrum disorder
  - Social phobia
  - Insomnia
  - Addiction and gambling
- Relationship and intimacy
  - Dating
  - Couples counseling
  - Interpersonal relationship
- Health promotion and management of chronic conditions
- Cross-cultural work
  - Counseling, psychotherapy, social work
  - International management
- Community development, community organizing
  - Advocacy, activism, AOP (Anti-Oppressive Practice)
  - grassroots leadership development
- Immigrant settlement services
- Human resource and organizational development
  - Recruitment and employment
  - Coaching and team building
  - Front desk reception

Basic Theoretical Premise of SSLD

SSLD integrates elements from a multidisciplinary knowledge base. Whereas a good part of the conceptual model is grounded in Social Cognitive Theory (Bandura, 1986), elements have been drawn from disciplines as diverse as critical discourse analysis, narrative analysis, social exchange theory, gerontology, and recent developments in neuroscience. A key premise of SSLD practice is that most problems experienced by our clients, including those experiencing mental health issues and challenges, are manifestations of unmet needs. The total bio-psycho-social organismic system is involved in the experience of needs and how they are met by individuals within their social contexts. Behaviors and responses that are seen as problematic, including psychiatric symptoms, are often the result of inappropriate or ineffective attempts to address those needs. The mastery of new strategies and skills that are effective in meeting those needs will lead to positive clinical change, in that ineffective or problematic coping will be replaced by more effective strategies and skills.

Most human behaviors are motivated or goal-oriented. In other words, human behaviors are functional; we do things because they do something for us. For example, we eat when we are hungry; we initiate contact with an attractive prospective partner because we need intimacy and interpersonal connection or because we have sexual needs. Human beings are conceived as active agents in constant pursuit of what they need. Although much of what we do can be considered functional, they may or may not be totally effective in meeting our needs. In mental health practice, we often see problematic behaviors that are ineffective or socially inappropriate in meeting people's needs. Or at times they could be effectively meeting some of their needs but at high costs to themselves or others. They could also meet certain needs but become a barrier to

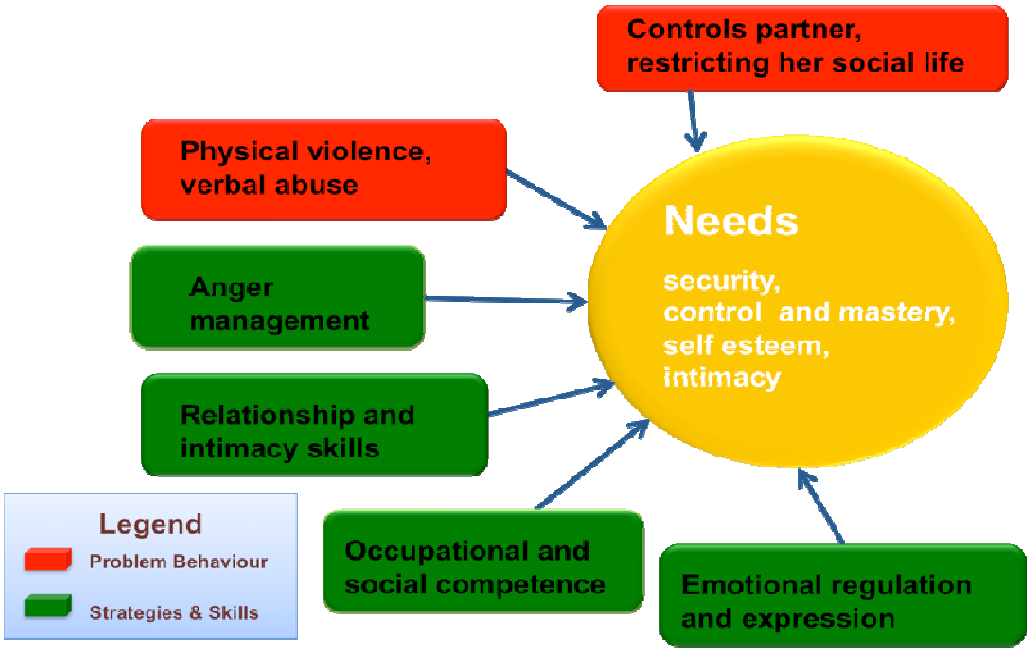
the gratification of other needs. Through SSLD clients can master effective strategies and skills to replace ineffective and inappropriate ones.

Case Illustration 1: Addiction

We will use a case of addiction as our first illustration. The individual attempts to address his/her needs of pleasure, excitement, pain reduction, and a sense of mastery through behaviors such as taking drugs or gambling, and avoiding challenges or difficulties in day-to-day life. These behaviors may be partially effective in meeting the individual's needs, such as reducing psychological pain through taking drugs. The problem is that the pain will re-emerge after the neurochemical effects of the drug wears off. Similarly, the quest for a subjective sense of pleasure and well-being is only partially successful. Moreover, when drug-use gradually becomes a more central part of one's life, other needs such as the need for social approval, connection with significant others, achievement through career advancement, and the like can no longer be effectively met. Addiction as a strategy is therefore not very effective in meeting the overall profile of needs. In SSLD, it can be replaced by new strategies and skills such as learning

stress management, interpersonal and problem-solving skills, and effective pleasure seeking behaviors.

Case Illustration 2: Partner Abuse



The second case illustration is a person who abuses his/her partner. The abuser attempts to fulfill his/her needs for security, control and mastery, self-esteem and intimacy by controlling his/her partner and restricting his/her social life through physical or verbal abuse. Such behaviors may sometimes meet the abuser's needs, again probably only partially; and will negatively impact the abuser's prospect of meeting other needs in life. In SSLD practice, the person will learn anger management, emotional regulation and expression, relationship and intimacy skills, and will develop occupational and social competence. When these strategies and skills are mastered well, they will effectively address the person's needs, and the original abusive behaviors will no longer be needed.

Human Experience and Action and the Environment

In practice, SSLD emphasizes the function of human action, and how effectively it addresses human needs and aspirations. This analysis is based upon a conceptual framework for understanding human experience and action within the context of our interaction with the environment.

Diagram 1: The Person and the Life-World

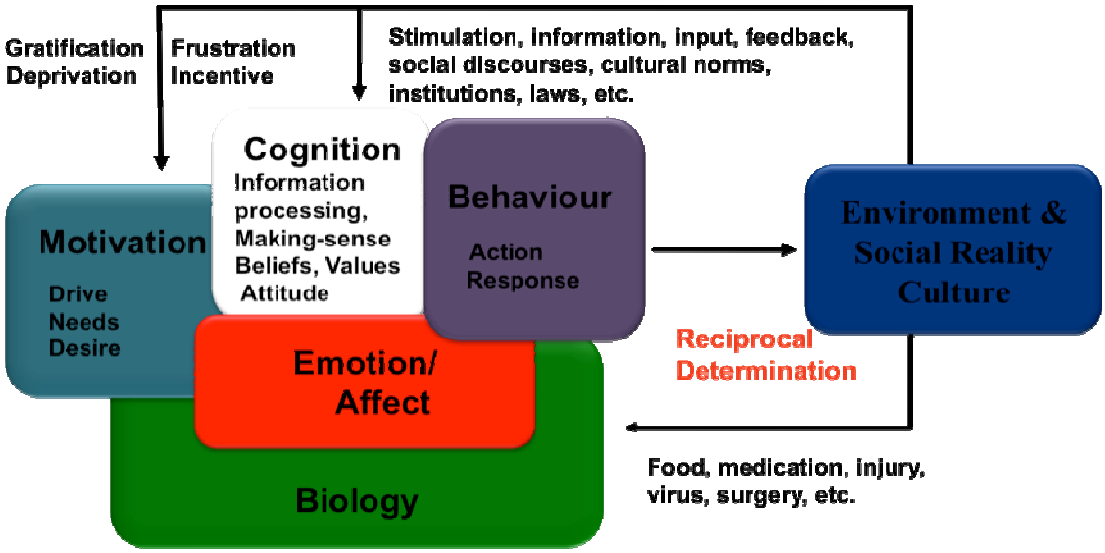


Diagram 1 illustrates the relationship between the person and the environment. In SSLD, we understand people's experience and circumstances with regard to six major domains. Five of them can be considered internal or organismic, and the sixth is external, which is the environment. The environment includes physical, material, economic, social, political, and cultural dimensions. A person's internal reality is made up of five domains: (1) biology, including genetic make-up, anatomy, physiology, metabolism, neurophysiology, disease, tissue damage, disability, and so on; (2) motivation, which refers to needs, wants, and desires; (3) cognition, including how we process information, our knowledge, belief systems, worldview, frameworks for making sense, and our value system; (4) emotion/affect, including how we

generate, experience, process, manage, and express emotions; and all these four domains work together to condition (5) behavior, which is what we say and do, including the way we say and do them.

All these five organism domains are simultaneously engaged in complex interactive processes with each other, while the person interacts with the environment through processes of mutual influence and transformation. To understand the environment, we need to bring together knowledge and analytic frames from multiple disciplines. Our world has changed rapidly over the last few decades, and the impact can be overwhelming even if we only track a few of the megatrends, such as globalization and the development of information technology. Our present inquiry into cross-cultural mental health practice, for example, is connected with the megatrend of globalization. The massive movement of people, capital, goods and services is intimately associated with the movement of ideas and practices that are constituents of different cultures. Whereas countries and cultures have different levels of openness and readiness to engage with people, ideas, and practices arriving on their land, it is probably fair to say that people in most parts of the world, especially for people living in big cities, have to deal with this phenomenon. Toronto, for example, is easily the most multicultural city in the world; and we have an explicit policy of multiculturalism in Canada. We have to take in a large number of immigrants each year to keep our population size stable and our economy sustainable. This reality helps to produce an imagination of national identity and citizenship which transcends simple ethnic categories.

The Role of Culture

A thorough discussion of the complex interaction between human action and culture is beyond the scope of this paper. Following the framework offered above, culture can be seen as an important process through which the environment conditions our lives. We can start with

motivation. While human beings share certain common needs such as food and shelter, security and relationship, pleasure and autonomy, and so on, cultural forces do shape our experience of such needs. Certain needs and drives, such as achievement and attaining wealth, are encouraged among men and discouraged among women in some cultures, while in others it is encouraged among both men and women but with different emphases and channels recommended. Some needs, such as sex, are often discouraged and heavily regulated, especially among children, women, and older people. In many cultures, same-sex attraction is heavily suppressed. In many cultures, sexual needs of the wealthy and powerful are given much more space and opportunity for expression than those who are poor and marginalized. Apart from motivation and needs, culture conditions the way we think by providing us with worldviews, ideologies, belief systems, religion, and the like. Religion, for example, can make people believe that the earth is flat, or that the universe was created only a few thousand years ago, or that there is a clear line between good and evil. Our feelings are also conditioned by culture, we learn to feel grief when a family member dies, to feel shame when we do something that contradicts the dominant value system, or to feel angry when someone steals our wallet but not to feel angry when women are asked to do a huge amount of unpaid housework. Culture regulates our behavior through rules, conventions, norms, and popularly accepted life scripts. In industrialized societies, for example, erotic experience is increasingly mediated by consumption behavior (Illouz, 1997). Examples include how Valentine's Day consumption patterns have been popularized in Asia, and how fine dining has become incorporated as a dating ritual. Through these multiple channels of influence on our motivation, cognition, emotion, and behavior, culture can even shape our bodies in significant ways. Our dietary habits, can directly influence our body build and constitution, our vulnerability to particular health risks, and our life expectancy. Culture can condition how our

bodies are to be seen, experienced, and used. Certain parts of the body, for example, are supposed to be covered, and the rules can be different for men and women. Culture enables or disallows certain things to be done to and with our bodies, such as cosmetic surgery, liposuction, tattoo, abortion, and the donation of organs and tissues, such as blood, sperm and eggs.

Although culture does play a key role in shaping people's lives, we have to remember the idea of reciprocal determination. Culture is what we make it, for it is a product of human action, including what we say, write, or produce as cultural products, such as film, art, music, and so on. Psychotherapy and professional mental health practices are also cultural products that are created and maintained by human action. To imagine problems and difficulties experienced by human beings as mental health issues is a particular cultural practice with only a very short history. The dominance of the Western medical model in explaining and handling human problems in life is the result of economic and political actions taken by generations of traders, colonizers, missionaries, scientists, teachers, health care professionals, and many other people. We are all caught in the web of complex interaction between the environmental and human experience and action. For example, when we consider how Korean culture has changed, we can ask ourselves what could have caused those changes, and how have those changes impacted the lives of people living in Korea? We will find ourselves dealing with all the intriguing forces and processes involved.

Critical Issues in Cross-Cultural Practice

The rapid changes and transformations in our environment can be overwhelming. When our familiar ways of thinking and coping are challenged, it is tempting for us to resort to simple analysis and solutions. In linear categorical thinking, reality is neatly organized into simple categories, and if we can put something into a category, then there is a simple linear logic that

will offer us a solution, or at least the comfort of apparently having a solution. Simple linear logical thinking follows a simple *if a, then b* structure. For example, if the client qualifies for the diagnosis of clinical depression, then prozac can be prescribed. Another example is if the client is Asian, then we can assume that he or she will comply with family expectations to excel academically. Such linear categorical thinking allows us to say that Americans are more individualistic than the Japanese, or that Chinese culture is Confucian.

The Cultural Literacy Approach

When such linear categorical thinking is applied to cross-cultural psychotherapy or mental health practice, we begin our inquiry by asking the wrong questions, such as what are Canadians like, or how should we talk to Indonesian clients? This approach is called the cultural literacy approach, which has been heavily criticized for its inadequacy (Dyche & Zayas, 1995; Tsang & George, 1998). The cultural literacy approach assumes that people within a broadly defined group, such as Indians or Filipinos, all share similar characteristics, beliefs, values, and cultural practices. Clinicians are then expected to become literate in these cultures by studying the presumably shared ideas and practices; and then come up with responses that are assumed to be appropriate for clients belonging to these groups. For example, if a client from the Philippines sought help from a clinician in Korea, the cultural literacy approach would dictate that the clinician would have to first educate him/herself about Filipino culture in order to understand the client. Once you have done so, you would be able to accurately interpret the client's verbalization and behavior because you are now literate in the client's culture.

The cultural literacy approach, employing linear categorical thinking, makes problematic assumptions and neglects significant aspects of cross-cultural reality: it assumes that cultures are

homogeneous, exaggerates intergroup differences, neglects internal diversity and ignores internalized culture as well as the reality of multiple cultural sources.

First, this approach is problematic as it assumes that individuals from the same ethnocultural group or category will share the same worldview, beliefs and values, as well as cultural practices. This is sometimes described as *essentialism*, or *homogeneity assumption*; and it leads to the production of stereotypic perceptions. Following this approach, the clinician will study the culture and become familiar with its rules and conventions, which will allow the clinician to perform effectively. In North America, a general stereotypical perception of Asians is that they put family interests or solidarity above individual needs and goals. This may be true in some or even most cases, but in clinical practice, we understand that many of the clients who come to see us are not the typical average members of their community, and to think that all Asians will value the same things to the same extent is a risky assumption. The relative significance attached to family solidarity, parental authority, and personal autonomy and freedom can be extremely different across individuals. Even within the same family, there can be major differences related to one's role, generation, age, gender, and unique personal experience. Therefore, the generalized statement that Koreans, Chinese, or Filipinos value family solidarity over individual autonomy and freedom is a generalization that does not hold in many cases.

Another associated limitation of the cultural literacy approach as a product of linear categorical thinking is that it can only deal with limited categories. In America, for example, people are put into five broad categories: White people or Caucasian Americans, African-Americans, Asian-American, Latino-Americans, and Native-Americans. This broad categorization, in my opinion, has very limited clinical value. For instance, Asian as a category will have to include Chinese, Indians, Pakistanis, Sri Lankans, Koreans, Thais, Vietnamese,

Singaporeans, Malays, Hmongs, Cambodians, and so on; and in some occasions it has to be extended to include the American Pacific Islanders. I find the fact that clinicians did actually use this for decades very intriguing.

Second, the cultural literacy approach tends to *exaggerate intergroup differences*. I would argue that amongst North American Caucasian families, there are also families that value family solidarity over individual autonomy and freedom. There may be differences depending on geographical distribution. This value may be more prevalent in rural areas as opposed to major metropolitan areas such as New York or Los Angeles. Even amongst highly urbanized centers, however, we are likely to find significant variations even within a given ethno-cultural group. The cultural literacy approach, therefore, exaggerate intergroup differences without paying enough attention to *intragroup* differences. In clinical practice, it is really important to emphasize that each individual client or patient that we see is a unique individual. If you try to understand that person primarily in terms of his or her ethnic group membership or culture, we are running the risk of misunderstanding the client and what I sometimes call unwarranted privileging of ethnocultural identity. What we are not familiar with in the clinical situation tends to stand out, be it culture, sexual orientation, unusual religious practices, or rare forms of disability. This unfamiliarity arouses anxiety and apprehension in the clinician, leading to focusing on this aspect of the client's reality. The reality is that this aspect of the client's overall situation, whether it is culture or something else, may be central to the client's clinical condition in some cases, but it can also be of very peripheral or minimal clinical significance. Linear categorical thinking in the form of *if the client is Korean, do this*, or applying it to someone who is Chinese, lesbian, or Muslim, for that matter, runs the risk of obscuring our clinical focus.

Third, within any social group, there is always *internal diversity.* We can immediately think of variables like gender, class, age, and sexual orientation; but if we throw in individual experience, history, and personality, then we will know that it is difficult to make any general assumptions about people belonging to a broadly defined category. To understand intragroup diversity, my experience is that the client is our best informant. For example, when working with a gay man from Pakistan who is skeptical of Islamic fundamentalism, we have to negotiate diversities arising from culture, gender, sexual orientation, and religion, on top of other personally relevant experiences and circumstances of the client, such as socioeconomic status and family dynamics.

Closely related to internal or intragroup diversity is the concept of *internalized culture* and the reality of multiple cultural sources (Ho, 1995). The cultural literacy approach attempts to understand culture categorically, and it mistakes objective social texts for subjective psychological reality. For example, a Chinese migrant worker living in Seoul may have internalized values and cultures from the Chinese heritage but the fact that this person is now living in Korea has to be taken into account. This person may be reading Korean newspapers, watching Korean television shows and Korean movies, and socializing with Korean friends. Through this interaction he/she may have internalized cultural components or elements from Korean culture. Another migrant worker who is also Chinese, but leads a more socially isolated and inward looking life, may have a very different internalized culture. The other thing that we cannot overlook within the current globalized context is the pervasive force of North American culture in the lives of those living outside of North America. I suspect that many individuals living in Korea, regardless of whether they are Korean or not, may have selectively internalized some mainstream American values, lifestyles, or preferences and copied specific behavioral

patterns that they saw represented in Hollywood movies, TV shows, and commercials. One can perhaps also trace similar Japanese and Chinese cultural influences in some cases. The complex dynamics of globalization and the reality of multicultural exposure render the simplistic categorical thinking assumed by the cultural literacy approach grossly inadequate. When I am working in Toronto, for example, I notice how fundamentalist or evangelical Christianity has become a very dominant cultural force among Korean immigrants, and it is quite influential among Chinese immigrants as well. The religious values, which represent a hybrid between conservative views propagated by missionaries and certain structures of Asian culture, such as patriarchism, can be studied as an interesting case of cultural production, transformation, and reproduction in a globalized context. Back to the idea of internalized culture that we are exploring, it must be added that such religious values are differentially internalized by members of these communities (Wong & Tsang, 2004).

When exposed to multiple cultural sources, people will go through a process of *selective assimilation*. People will selectively internalize cultural elements that are more relevant to their needs. For example, a man who grew up in a conservative Asian culture, which can be Chinese, Indian, Pakistani, or Korean, is more likely to internalize sexist and patriarchal values unquestioningly or uncritically than an oppressed daughter in the same family. It is possible for the daughter to end up internalizing similar values, but her process is probably different, more likely involving dynamics of resentment, confusion, and self-doubt.

Following this alternative approach to understanding culture, we see cultures not as stable and discrete categories, but as complex systems in constant transformation. In a globalized context, we also see the boundaries between cultures becoming increasing permeable, although for cultural groups who feel that their cultural heritage is being threatened, there is a higher

tendency to hold a more rigid and conservative orientation, often associated with xenophobic sentiments. To this dynamic understanding, we can also add a developmental perspective, which takes into account how cultures develop and change over time, and across generations. For example, we can compare a second generation Korean Canadian living in Toronto and a Korean of comparable age living in Seoul. Their overall cultural exposure may be quite different to start with, but to understand their respectively internalized cultures, we may be looking at multiple elements. Some of them may be very similar and some very different. The elements may have originated from Korea or other cultural roots. We can ask questions such as how Westernized a person is, or to what extent a person has internalized and maintained aspects of Korean culture. My sense is that we can get very different answers from different people, even when they live in the same place.

To take this analysis of internalized culture further, I will argue that ethnocultural differences are often not the most important aspect of a person's internalized set of beliefs and values. Sometimes it can be a political ideology or religion that overrides one's cultural identity. For a devout Muslim, or Buddhist or Christian for that matter, religious doctrines may have a stronger influence on the person's thought and action than the person's traditional culture. Another ideological system that is often left unexamined in cross-cultural clinical practice is capitalism, and the associated consumerism it engenders. I would argue that regardless of what our ethnic group membership is, our belief and value system, lifestyle, and behavior have been significantly conditioned by the pervasive logic of capitalism. So even when we say that a given culture is conditioned by Confucian tradition, the profiteering imperative and the emphasis on property and private ownership would probably override some of the more idealistic articulations in Confucian philosophy, such as benevolence, compassion, and fairness.

Intersecting Diversities

Engaging with multiple variables, which are conceived dynamically as changing and interacting with each other, is a more challenging intellectual task than thinking in a linear categorical manner. I am not surprised that people prefer to think in terms of categories as it may give them a sense of clarity or order. This kind of thinking probably meets the needs of the practitioner more than the needs of the client. Some clinicians have developed categorical responses to their clients by referring to their diagnostic label, such as schizophrenic disorder, obsessive compulsive disorder, or borderline personality disorder. I argue that clinical practice will be more productive if we pay more attention to the client's uniqueness, including the client's needs, circumstance, characteristics, and capacity. Our clinical response has to be contingent upon the varying realities of each clinical situation. If our response is dominated by attention to the client's membership of a particular social category, be it Korean, Chinese, Buddhist, lesbian, or mentally ill, we run the risk of neglecting the individuality of the client.

In clinical practice, we work with clients who are different from us in many ways, not just in culture but also gender, sexual orientation, religion, age, socio-economic status, and (dis)ability, just to name a few. These diversities intersect with each other, resulting in a valuable bio-diversity amongst human beings. Problematically, many theories or practice models assume that other variables are either constant or insignificant and choose to address only one of them. I propose an alternative approach which is based on *multiple contingencies thinking,* which can be applied to a wide range of client populations internationally because of its ability to handle intersecting diversities. The development of such an approach to clinical practice requires ongoing critical engagement with the dominant professional discourses so as to create and maintain a space for developing a more balanced global perspective.

Applying SSLD in Cross-Cultural Clinical Practice

SSLD is grounded in multiple contingencies thinking, which attempts to understand unique personal experience through considering the multiple domains of human functioning in a contingency-based manner. What is contingent is not fixed, but variable and changing. Something that is contingent changes in relation to factors and processes that condition it. Many aspects of human reality, which are assumed to be stable, are actually contingent. Many people, for example, take ideas such as national identity, family membership, and the socially scripted life course of birth, schooling, work, marriage, and parenthood for granted. These are considered stable and unchanging realities in their life-world. In reality, these structures are quite fluid and are constantly going through transformation. Their apparent stability is contingent upon a host of social structures and processes such as regional political situation, demographic structure, economic environment, and historical context, which themselves are contingent upon something else. In everyday life, the multiple contingencies interact with each other to produce complex situations, which often exceed the neat and tidy order created by linear categorical thinking.

Deciphering Culturally-Coded Messages

Applied to cross-cultural understanding, multiple contingencies thinking does not assume that any sign in the clinical situation will always carry the same meaning. One example that has been circulated in Western psychology is that when people from India shake their heads it means yes, and nodding means no. This is an assumption of a fixed relationship between a sign and what is being signified. Whereas we recognize the role of culture in the production of rules governing social and interpersonal communication, the rules are not always simple and straightforward. For example, when a client gives you a gift, it can have several meanings. It may mean a token of appreciation, a symptom of anxiety, a sign of lack of trust, or a strategy to

manipulate the relationship. In order to successfully decipher this action, one should look at the client's more nuanced internalized culture rather than the objective culture because each client will infuse personal meaning into a performed cultural act. As clinicians, we know that client presentation in the clinical context has to be considered with regard to key contingencies in the interaction. One suggestion that I often give is to consider the client's awareness of cultural difference, and the power dynamics between the client and the clinician. Many clients coming to see a clinician who is ethnoculturally different will take this difference into consideration when they present their issues and tell their stories. Some clients will be better able to adjust their presentation to the cross-cultural context than others.

This specific ability, which requires one to consider interpersonal difference, and to make appropriate adjustments, is an important skill that some people have learned and mastered better than others, be they clients or clinicians. SSLD is a learning system that helps people learn and master the skills they need, including interpersonal communication in a cross-cultural context. This ability is best developed through experiential learning involving actual or well-simulated cross-cultural interactions. This paper can only outline some of the practice principles, and it is hoped that colleagues will have the chance to pursue more systematic SSLD training in the future.

SSLD in Action

SSLD intervention usually involves four steps:

1. Engagement and problem translation
2. Formulation of strategies and skills to be mastered
3. Systematic learning and development of strategies and skills
4. Review and evaluation

Step 1: Engagement and Problem Translation

Psychotherapy research has shown that the most important therapeutic factor is the therapeutic alliance (Hubble, Duncan, and Miller, 1999; Lambert and Barley 2002). In SSLD practice, special emphasis is placed on engaging with the client right from the moment of first contact. The first step of problem translation reconstructs the client's presenting problems, issues, and concerns into needs that are unmet or ineffectively met. This translation facilitates initial engagement with the client in that it communicates recognition, acceptance, and empathic understanding of the client's needs and circumstances. The identified needs are then translated into learning goals and objectives. This helps to establish a common purpose, which is conducive to alliance building. It also sets up positive expectancy or hope. The entire procedure is carried out in a collaborative manner, maximizing client input and agency, with an associated aim of enhancing client self-efficacy right from the beginning.

Through a process-outcome study (Tsang, Bogo, Lee, 2010), my colleagues and I have found that well-engaged cross-cultural dyads are characterized by: (1) continuous efforts to communicate with each other; and (2) the practitioner's attention to small misalignments when they occur, and subsequently addressing them by communicating ongoing careful listening and understanding of the clients' struggles. Despite perceived cultural differences, a clinician can greatly increase the positive outcomes in cross-cultural clinical practice through (1) the practitioner's recognition of the client's major needs and concerns, and the communication of a cognitive understanding of them, leading to the negotiation of agreed upon purpose; and (2) the practitioner's emotional engagement with the client. When working with clients with diverse cultural backgrounds, it is important to focus on the clinical issue, which can be understood with

reference to the client's internalized culture. We access the client's internalized culture through careful listening, seeking clarification whenever appropriate. Perceived cultural differences should be explicitly addressed as to avoid misinterpretation and incorrect cultural transferences.

In actual clinical practice, we pay attention to the role culture plays in how the client's problem is produced, how it is understood and experienced, and what the client is doing about it. In the initial phase of the clinical encounter, clients will try to present to us what their issues are, mostly through verbalization. As clinicians, we know that the client's clinical presentation includes both verbalization and behavior. Clinically relevant behaviors are sometime directly observable in-session, sometimes we hear about them through the client's own accounts, and there are times when we learn about them through informants such as family members and friends. In order to gain an accurate understanding of the client's behavior, it may be helpful to ask ourselves the following questions:

- What does this (behavior, verbalization) mean?
- What function does it serve? SSLD takes symptoms as functional.
- What are the underlying needs?
- How does the client (and/or family and community members) make sense of this? For example, certain symptoms may be explained as demon possession or spiritual intervention.
- What is the client (and family and community) doing about it, other than seeking professional help? For example, preparing special food, herbal remedies, prayers.
- How is professional help (Western mental health service) understood? It can be seen as mysterious, more scientific, a bureaucratic requirement, the last resort, and so on.

The first contact with Western style mental health services can be daunting or intimidating to clients who do not have prior experience or knowledge. Since a client may not fully understand the newly formed relationship with a mental health professional and unfamiliar with its rules of interaction, it is imperative that the clinician be aware of the issues this can create. The client may need information and clarification about how an assessment is done or how psychotherapy works. Similarly clinicians can seek information and clarification from clients when in doubt. The most dangerous or potentially destructive thing to do is to allow ignorance, misinformation, and misunderstanding to drag on, as vividly portrayed by Fadiman (1997) in her tragic account of a Hmong girl with epilepsy, who eventually died without receiving effectively coordinated treatment. Our first task is to understand the meanings of clinically presented material from the client's perspective. For experienced clinicians, many of the meanings can be obtained through careful listening to the client's narrative, and we do not always have to ask the questions. When we are in doubt, however, we should try to seek clarification by raising prefaced questions like "I just want to make sure that I understand you correctly, when you said you had to do that, was it something you were expected to do by people around you?" or "When you say you all had dinner together after the seventh day of your father's death, was it something that people usually do?" If we are unable to obtain answers to some of these questions directly from the client, such as in the case of young children or clients with impaired capabilities, we can try to consult family members, members of the client's community or other individuals who may be more knowledgeable.

The N3C assessment

In SSLD, a clear focus is on addressing the needs of our clients. This focus allows us to gain knowledge and understanding that cut across the client's presenting issue, which is the true

meaning of the word diagnosis. *Dia* means across, and *gnosis* is knowledge. An N3C (needs, circumstances, characteristics, capacity) assessment enables a better and fuller understanding of the client's overall situation. The first part of the N3C assessment involves understanding the client's needs, and such needs may be culturally conditioned. For example, a new immigrant will want to take care of the basic survival needs, which will include an adequate income to provide for food, housing, clothing, and transportation. There is also a need for safety – the protection of self against external threats, real or imagined. The need for safety is related to information, mastery, and control, in that the more information one can access and the higher one's sense of mastery and control is, the safer one is likely to feel. Many newcomers to a country, however, have to take time to acquire the information, to establish mastery and to feel secure. When the need for information is not effectively met, the person is likely to experience insecurity, anxiety, fear, or anger. Such negative emotions can sometimes lead to behaviors that are considered problematic or symptomatic in mental health practice, such as eating disorder, anxiety disorder, addiction, or violence. SSLD sees clinical problems first and foremost as unmet needs, and considers the understanding of the dynamic and interconnected nature of human needs as an important component in any mental health assessment.

The second part of the N3C assessment concerns the client's circumstances, characteristics, and capacity as they relate to the clinical picture. *Circumstances* can include finance, business or employment, family relationship, housing condition, pregnancy, availability of support, and so on. It can also involve citizenship, residency, and minority status. *Characteristics* include personality, patterns of thought and action, and can also include aspects of the client's internalized culture. The individual may be introverted and passive, have an external locus of control, and prone to negative reframing. Physical characteristics such as

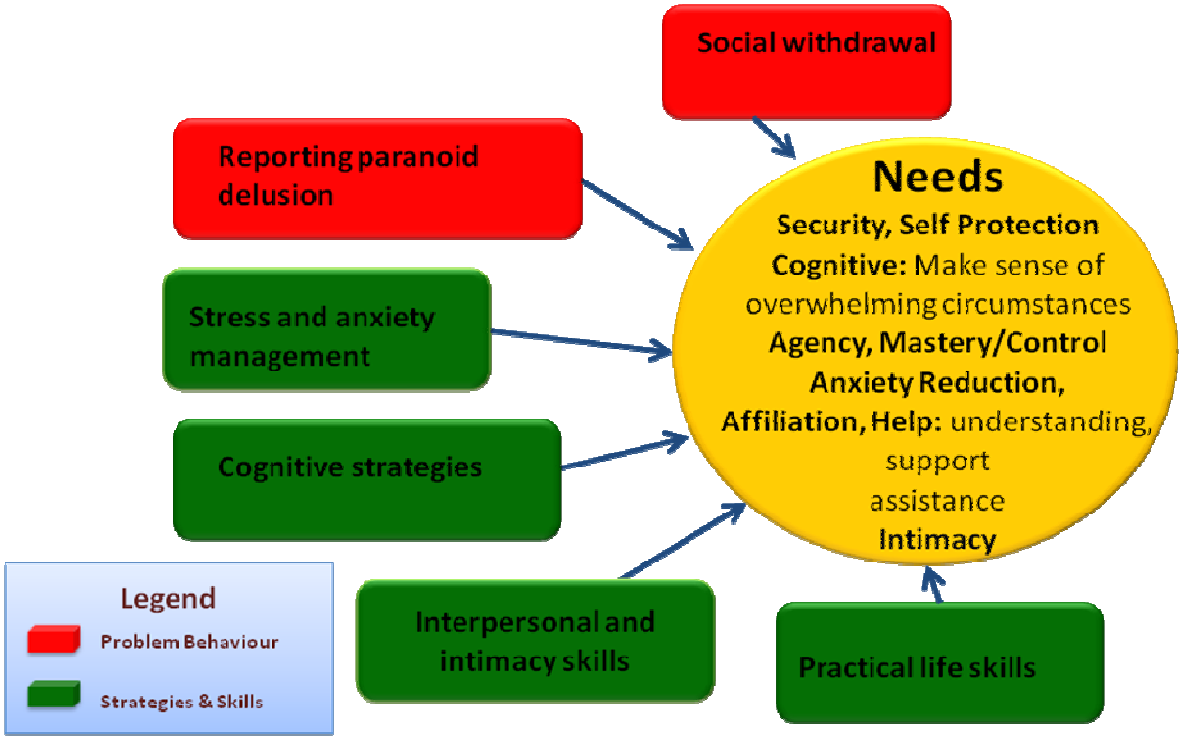
gender, age, appearance, body-build, skin color, chronic illness, HIV status, or disability are also part of this assessment. *Capacity* refers to the client's current capacity in managing their life, meeting needs and attaining goals. This includes their intellectual ability, social and interpersonal skills, emotional resilience, and other life skills such as vocational or professional competence. The ability to understand and manage cultural differences is also part of the capacity assessment. Individuals with an inadequate understanding of the host culture and a limited repertoire of culturally appropriate strategies and skills for meeting their personal needs, including the ability to use the local language effectively, are more likely to experience emotional and mental health difficulties.

Symptoms are functional, even paranoid delusion

The emphasis on functional analysis, claiming that problematic behaviors and symptoms are functional, in that they represent attempts to meet human needs, may come across as an extreme position to some clinicians. When I introduced this system to the psychiatrists at one of the most prestigious universities in China, the head of the department raised the example of a patient reporting paranoid delusions, and questioned how that could be functional. I responded by pointing out that (1) verbalization releases anxiety and addresses one's need for comfort and emotional equilibrium; (2) the construction of the delusion is a way of making sense (cognitive need) of threatening, overwhelming, or traumatic situations and can be a way of protecting oneself from psychological threat and damage (safety and self-esteem needs); and (3) when a client reports delusional thoughts, especially when knowingly communicating with a mental health professional, it can be interpreted as an encoded way to ask for help (need for understanding, help, or support).

We can apply this understanding to another case illustration. Imagine the client is a new immigrant woman reporting paranoid delusion and showing social withdrawal. If we follow a N3C assessment, we will come to the understanding that the client has the cognitive need for making sense, the emotional needs to feel safe and secure, and to reduce anxiety, or perhaps even an agentive need to feel that she is in control. The client needs to be understood and to feel supported and cared for, or being helped. It is possible that the client, upon coming to a new country, found her life *circumstances* too challenging, and exceeding her *capacity*. The production of the delusional system can also be understood with regard to certain personal *characteristics*, such as low self-efficacy, external locus of control, and a tendency of negative reframing.

Case Illustration 3: New Immigrant Reporting Paranoid Delusion



Step 2: Formulation of Strategies and Skills to Be Mastered

The N3C assessment allows us to translate the presenting clinical issue into specific strategies and skills that the client will have to learn in order to address her needs more effectively. The delusional system reveals immense anxiety, which is probably a result of experiencing life circumstances that are beyond one's control. It is not uncommon that such experience is associated with a sense of turmoil, helplessness, vulnerability, and panic. Reduction of such immobilizing emotions is usually a clinical priority. An effective strategy will involve learning active anxiety and stress management procedures, which can include the use of prescribed medication. In SSLD problem translation, the recognition of the client's needs provides a good starting point for cognitive reconstruction. Cognitive strategies will involve the adoption of a perspective that focuses on meeting one's own needs instead of feeling overwhelmed and helpless. Some form of positive reframing is usually involved as well. The client will need to improve on her current relationship with her husband and family, including seeking intimacy and support. Incremental steps toward a more active social life can be learned as well. As a new immigrant, the client may also need to learn more effective life skills, such as job-hunting strategies, job interview skills, and how to use public services (e.g., transportation, community centers and programs, libraries). These will enhance her self-efficacy, or her sense of agency, autonomy, control and mastery over the environment, on top of addressing her respective emotional, cognitive, and instrumental needs.

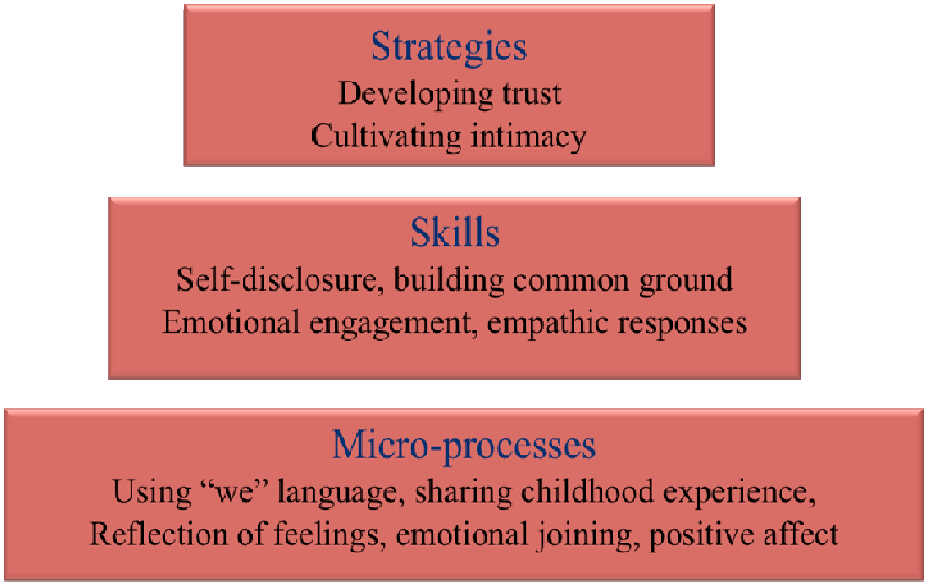
Step 3: Getting into Action: The Actual Learning Process

When the client is well-engaged and mutually agreed upon goals are set, we can move into the actual learning phase. A key learning principle is to foster client self-efficacy, so that the client will experience increasing mastery and control over his or her life. It is always important

to let the client have a positive learning experience right from the start, to avoid disappointment or disempowerment. Learning tasks have to be organized incrementally, so that the client can confidently try out the first steps. Whenever we encounter client reluctance, doubt, or resistance, the general principle is not to push beyond the client's comfort level, but to start with a manageable step. A successful first task, no matter how small, will strengthen the alliance and positive expectancy.

An associated feature in SSLD learning is collaboration. Instead of staging the practitioner as an authoritative expert, or an ideal model for the client to emulate, SSLD procedures emphasize collaboration by actively inviting client input and encouraging client initiative. A major mechanism is self-observation and review. Clients are encouraged to try out new behaviors and to observe them. Simulation and role-played scenarios that resemble real life situations are used for learning strategies and skills that can be easily transferred and applied. In individual psychotherapy, the procedure usually starts in the safety of the consultation room, where the client can receive feedback from the clinician. In couple, family, or group contexts, we will make active use of feedback from the other clients or participants. Video-recording and playback review is often used in SSLD for clients to establish reflective learning capacity. The process provides concrete, specific, and positively-framed feedback focusing on how the client can perform better in real life in order to achieve the desired outcome or goal. In SSLD, complex strategies can be broken down into composite skills to be learned, and the skills can be further specified in terms of micro-processes to help clients master them more reliably in an incremental manner. The diagram below illustrates how an attempt to learn and develop trust and intimacy can be further specified into composite skills and micro-processes.

Strategies, Composite Skills, and Micro-Processes



Another feature of SSLD practice is that of collaborative creation of new strategies and skills. Mental health practitioners do not always have ready solutions that will address the client's needs. When cultural difference is added to the formula, strategies and skills that have been used effectively with other clients may or may not be appropriate for the particular client we are working with. For example, learning assertive skills may be relevant for an immigrant man who feels that he is not taken seriously by people at work within the mainstream North American context. The same set of assertive behaviors may, however, be seen as insensitive and rude within some East Asian cultural contexts. Contingent upon the immediate social and cultural context and the client's characteristics and current capacity, new strategies may have to be developed. The collaborative creation process allows the practitioner to explore options together with the client, going through steps such as brainstorming, criteria setting, formulating and testing options, rehearsal, application and review. This procedure enables clients to expand

their repertoire of skills and strategies beyond the confines of the practitioner's knowledge and skills, making the intervention process creative, rewarding, and empowering for the client.

SSLD procedures emphasize real-life application, and do not assume an automatic knowledge-action transfer. The 4Rs (real-life practice, report back, review, and refinement) are steps that are often included in SSLD programs to help reinforce learning and transfer to real life. And as we are talking about skills, cognitive knowledge is a necessary but insufficient condition. To ensure proficiency and satisfactory performance in real life, the learning process will involve a lot of practice, practice, practice, and practice!

Step 4: Review and Evaluation

With successful SSLD intervention, clients will gradually learn and develop the relevant strategies and skills that will allow them to achieve their goals in life. The attainment of these goals also means that their needs are being met. With needs effectively addressed, clients will no longer need the problematic strategies that they previously employed to meet them. Behaviors such as aggression, substance use, or social withdrawal will be replaced by more functional and effective strategies and skills. When the goals are achieved, the client's needs will be met and the problem will be solved.

Successful completion of an SSLD intervention is always associated with enhanced client self-efficacy. Given the dynamic and changing nature of human needs and life circumstances, clients are likely to encounter new challenges later in life. The design of the SSLD intervention prepares the client for facing future challenges by establishing (1) awareness and acceptance of one's own needs, (2) mastery of a set of effective strategies and skills, (3) a positive orientation towards challenges in life, including an openness to explore and experiment new ways of dealing with issues, (4) enhanced capacity for future learning, and (5) enhanced self-efficacy and

positive expectancy. All these conditions are likely to contribute towards positive mental health and wellness. It is not unusual in SSLD practice to see clients moving beyond solving their problems, and attempt to use their new learning to manage their other needs or issues in life. As a result, many clients experience personal growth. In community and group practice contexts, we have also seen clients developing skills for mutual care or mutual help, and some of them can learn to become group leaders and offer support and assistance to other members.

As a practice system, SSLD can be applied in mental health either as the sole intervention method, or a supplementary or adjunct procedure. Given its multiple contingencies structure, SSLD can interface easily with other treatment approaches. It can also be applied to therapy groups, self-help groups, and various forms of psycho-educational and social work programs. We have used SSLD in community development and advocacy work as well. Interested readers can visit the SSLD website for more information: http://ssld.kttsang.com

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