1 Understanding the Skills Identification Stage Model in Context

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It shouldn't be theories that define the problems of our situation, but rather the problems that demand, and so to speak, select, their own theorization.

Martín-Baró (1994, p. 314)

Introduction and Overview

The Maligned Wolf

The forest was my home. I lived there, and I cared about it. I tried to keep it neat and clean. Then one sunny day, while I was cleaning up some garbage a camper had left behind, I heard footsteps. I leaped behind a tree and saw a little girl coming down the trail carrying a basket. I was suspicious of this little girl right away because she was dressed funny—all in red, and her head covered up as if she did not want people to know who she was. Naturally, I stopped to check her out. I asked who she was, where she was going, where she had come from, and all that. She gave me a song and dance about going

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to her grandmother's house with a basket of lunch. She appeared to be a basically honest person, but she was in my forest, and she certainly looked suspicious with that strange getup of hers. So, I decided to teach her just how serious it is to prance through the forest unannounced and dressed funny.

I let her go on her way, but I ran ahead of her to her grandmother's house. When I saw that nice old woman, I explained my problem and she agreed that her granddaughter needed to learn a lesson all right. The old woman agreed to stay out of sight until I called her. Actually, she hid under the bed. When the girl arrived, I invited her into the bedroom where I was in bed, dressed like the grandmother. The girl came in all rosy-cheeked and said something nasty about my big ears. I've been insulted before so I made the best of it by suggesting that my big ears would help me to hear better. Now, what I meant was that I liked her and wanted to pay close attention to what she was saying. But she made another insulting crack about my bulging eyes. Now, you can see how I was beginning to feel about this girl who put on such a nice front but was apparently a very nasty person. Still, I've made it a policy to turn the other cheek, so I told her that my big eyes helped me to see her better.

Her next insult really got to me. I've got this problem with having big teeth, and that little girl made an insulting crack about them. I know that I should have had better control, but I leaped up from that bed and growled that my teeth would help me to eat her better.

Now, let's face it, no wolf could ever eat a little girl; everyone knows that, but that crazy girl started running around the house screaming, me chasing her to calm her down. I'd taken off the grandmother's clothes, but that only seemed to make it worse. All of a sudden the door came crashing open, and a big lumberjack is standing there with his axe. I looked at him, and it became clear that I was in trouble. There was an open window behind me and out I went. I'd like to say that was the end of it. But that grandmother character never did tell my side of the story. Before long the word got around that I was a mean, nasty guy. Everybody started avoiding me. I don't know about that little girl with the funny red outfit, but I didn't live happily ever after (Fern, 1974).

The challenges of preparing for and providing counseling and clinical services that are culturally responsive are areas the helping professions are taking more seriously. In the United States, the ethnic demographics have changed, both nationally and at the state level (U.S. Census Bureau, 2009). Gone are the days when the norm was systemic resistance to engaging in discussions of multiculturalism and diversity. Currently, most professionals, institutions, and agencies seem intellectually committed to the idea of developing greater levels of multicultural responsiveness, yet seem caught in a state of uncertainty about how to best achieve those objectives.

"The Maligned Wolf," the story of Little Red Riding Hood from the Wolf's perspective, provides a template for the underpinnings of the multicultural movement. What the story shapes for us is a much-needed *paradigm shift* or *cultural shift* that appropriately redefines modes of assessing, diagnosing, and

intervening with clients (Ancis, 2004; Cardemil & Battle, 2003; D. W. Sue & Sue, 2003). It is clear that viewing therapy through a narrow, culturally encapsulated lens no longer meets the ethical standards as set forth by the counseling professions (American Counseling Association [ACA], 2005; American Psychological Association [APA], 2002, 2003). However, the professions' desire to prioritize clinical responsiveness over cultural responsiveness remains intact (Gallardo, Johnson, Parham, & Carter, 2009). Ultimately, it is still possible for graduate students in most training programs to graduate, complete an internship, and become licensed and not be adequately prepared to meet the needs of underserved and unserved communities. This illustrates the challenges we face in preparing future therapists/counselors to provide services that are culturally and contextually consistent with the lives of those they intend to serve. This also implies that we need to do a better job of assisting graduate training programs to understand the *what* and the *how*.

A continuing concern for us is *who* defines reality for ethnocultural communities as well as *how* it is defined. In essence, we are suggesting that the issue is one of power: The ability to define reality and make others respond to that definition as if it were their own (Nobles, 2010). Consequently, empowerment is a central component to working with ethnocultural communities (Aldarondo, 2007). Prilleltensky, Dokecki, Frieden, and Ota Wang (2007) would argue that "wellness cannot flourish in the absence of justice, and justice is devoid of meaning in the absence of wellness" (p. 19). Therefore, if you are a member of an ethnocultural community, we encourage you not to allow reality to be defined for you by those who do not share or embrace your cultural worldview. Simultaneously, we encourage those readers who may not identify with one of the five ethnocultural communities addressed in this book to avoid defining realities for others based on your own worldview and cultural lens. It is here that well-intentioned therapists can unintentionally violate those they intend to serve responsively.

It has become clear that as we shift our perspective to better understand ethnocultural communities, the need to become culturally responsive at least parallels, and in some cases supersedes, the desire to become clinically competent (D. W. Sue & Sue, 2003). Research addressing the development of cultural competence continues to permeate much of the current psychological and counseling literature (Aldarondo, 2007; Ancis, 2004; Arredondo, 1998; Gallardo et al., 2009; Hays & Iwamasa, 2006; McAuliffe, 2008; S. Sue, 1998; Toporek & Reza, 2001; Vera & Speight, 2003). In response to the growing body of literature in this area, *philosophical mandates* for service providers to develop culturally responsive interventions have emerged. We say "philosophical" simply because the translation from theory to practice has been missing from the literature, which has often personally and professionally challenged training programs and practitioners alike. What is often addressed in these "mandates" for cultural competence is a challenge for all service providers to make this *paradigmatic multicultural shift* when working with ethnocultural communities (APA, 2003). This shift in perspective forces us to reexamine the developmental changes that have occurred in ethical

mandates placed on service providers. We are not convinced that our ethical codes should be discarded entirely, but they should be viewed through a cultural lens first and foremost and should integrate culture-specific guidelines for various ethnocultural communities (Gallardo et al., 2009). More specifically, issues such as self-disclosure, multiple relationships, shifting the traditional therapeutic environment, and redefining the traditional therapeutic hour are issues that culturally responsive providers should address with some flexibility, based on the context and culture of their clients, without feeling like they are situating themselves in an unethical predicament. If we struggle in shifting our perspectives, is it because we believe in the universal application of traditional therapeutic techniques? Or, alternatively, does the system that calls for the mandates to make a multicultural shift limit, or present contradictory messages to, service providers and training programs? We argue that in shifting to a more culturally responsive paradigm (rather than making cultural responsiveness secondary or in addition to our clinical responsiveness), we actually broaden our clinical expertise and proficiency. The two should not be separated. In fact, for too long "clinical competence" has existed without the need to also be culturally responsive. Today, with the recent acceptance of the Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2002), we are challenged to redefine and continuously reevaluate our modes of practice and, at times, the restrictions that are placed on what is considered "ethical" practice.

Evidence-Based Practice in Psychology

A central premise of this book is the current Evidence-Based Practice in Psychology (EBPP) definition, as supported by the American Psychological Association Presidential Taskforce on Evidence-Based Practice (2006). The APA has defined EBPP as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). The EBPP begins with the client/community and asks what already existing research evidence, if any, will assist in achieving the best outcomes. We support this definition of EBPP because it allows for multiple sources of good "evidence" therapeutically, and it begins with a bottom-up perspective. That is, it begins with the client/community and then develops what might work, in what way, and with whom from this perspective. A top-down perspective assumes that what is good for the profession is also good for the communities we serve. There is currently more research being published with this bottom-up perspective in mind, including work with Haitians (Nicolas, Arntz, Hirsch, & Schmiedigen, 2009), cultural adaptations with adolescents (Bernal, Jimenez-Chafey, & Domenech Rodriguez, 2009), and with Chinese Americans (Hwang, 2009). While we are supportive of research to identify what works and with whom (Paul, 1967), we are also aware that an expansion of the "gold standard"—that is, treatments that have been empirically supported—is critical to continuing to advance therapeutic practice with

ethnocultural communities. The current EBPP definition allows both the therapist and client to decide what might be the most effective treatment for this person at this moment, based on culture and context. Additionally, the EBPP definition states that "culture is a multifaceted construct, and cultural factors cannot be understood in isolation from social class and personal characteristics that make each patient unique" (APA Presidential Taskforce, 2006, p. 278). The EBPP guidelines state that cultural factors influence not only the nature and expressions of psychopathology, but also clients' understanding of psychological and physical health (La Roche & Christopher, 2009). Griner and Smith (2006) found that interventions that were specifically designed for the cultural groups they were intended to serve were four times as effective as interventions that were implemented with individuals from a variety of cultural groups. Additionally, they found that interventions that were conducted in the client's native language, if other than English, were twice as effective as those conducted in English. For us, it is not an either/or discussion, but a both/and. We ultimately need to know what works best and for whom, but in keeping in sync with our proposed paradigm shift, we also need to employ an expanded perspective in our efforts to push the limits of narrowly defined practice standards. Moreover, Norcross (2002) found that empirically supported treatments fail to include the therapist as a person, the therapeutic relationship, and the client's nondiagnostic characteristics. He further noted that the following therapeutic factors account for variance in therapeutic outcome (the percentages of variance are in parentheses): treatment method (8%), individual therapist (7%), the therapy relationship (10%), patient contributions (25%), interaction (5%), and unexplained variance (45%). Also, a recent study examined the effects of cognitive-behavioral therapy (CBT) and person-centered therapy (PCT) in the treatment of posttraumatic stress disorder (PTSD) (McDonagh et al., 2005). The researchers specifically left out the "specific ingredient" thought to be essential for the treatment of PTSD from a cognitive-behavioral perspective—exposure—when implementing the PCT. They found that while both treatments were well received by patients, significantly fewer dropped out of the PCT than the CBT group, and the benefit to the patients was comparable in both treatment groups. This study further underscores the significance of expanding our perspective of what is good "evidence." This study also highlights the centrality of common factors in the therapeutic context.

Expanding Our Role

There have been several studies that have examined factors common to all healing approaches (Fischer, Jome, & Atkinson, 1998; Frank, 1961; Frank & Frank, 1991). From this body of work, Fischer et al. found support for four "universal healing conditions" that exist in all cultures: (1) The therapeutic relationship serves as a basis for all therapeutic intervention; (2) a shared worldview or conceptual schema or rationale for explaining symptoms provides the common framework within which the healer and client work

together; (3) the client has faith or hope in the process of healing; and (4) the therapeutic ritual or intervention is in the form of a procedure that requires the active participation of both the client and the therapist, and the procedure is believed by both to be the means of restoring the client's health. It is our belief that work with ethnocultural communities must focus on the four universal healing conditions, while incorporating any research evidence on the client's culture, context, and presenting concern, within the context of the therapist's clinical expertise and cultural knowledge.

This reexamination of practice with ethnocultural communities also calls for an expansion of our roles as service providers. The importance of shifting from one-on-one counseling to becoming cultural brokers (Stone, 2005), or social advocates (Parham, White, & Ajamu, 1999; D. W. Sue & Sue, 2003; White & Parham, 1990), or creating the good society (Nelson-Jones, 2002), is simply a must. At the foundation of what each of these terms implies is the growing need to further develop our roles as mentors, teachers, advisors, and consultants within the systems in which our clients live and work. Schank, Helbok, Haldeman, and Gallardo (2010) state that clients and community members often see an overlap between the roles of therapist and client as a strength, and so should we as therapists. In fact, clients may seek us out simply because we are a part of the community and seen as someone who understands the client's culture and context. We can no longer assume that helping an individual in the "therapy room" means that the healing process is complete (Vera, Buhin, Montgomery, & Shin, 2005). Failing to examine the social, political, and cultural contexts (La Roche, 2005) in which our clients live indicates that we have placed our desire to be clinically proficient before our desire to be culturally proficient. When we expand our lens into a therapeutic multicultural kaleidoscope, we then bring the systems and social structures that impact our clients in alignment with one another, and only then have we begun the healing process.

Initiating the Process

Outdated modes of thinking about what constitutes "good" practice are now serving as the unofficial "standards of practice." In comparing this tendency to a "low bar" approach, Parham (2002, 2004) has asked the pressing question, "How do we raise the bar of what passes for competence?" More specifically, how can we expand our existing repertoire of clinical skills to include more culturally sound and responsive modes of assessing, diagnosing, and intervening with ethnoculturally diverse clients? We believe that an effective therapist must combine clinical skills and knowledge with a more culturally expanded view of therapy.

Initiating this task has forced us to come to terms with a persistent predicament in the psychotherapy movement concerning cultural sensitivity and responsiveness. Specifically, therapists are more willing to engage in the

process of culturally responsive practice, but they may be unsure what specific skills would be useful to facilitate the desired therapeutic outcome. Upon further analysis, we find several culprits that seem to contribute to this state of inertia. One is the body of literature that summarizes demographic trends and population statistics. These writings do acknowledge the recent changes in ethnic demography, but knowing that information provides little help in planning a therapeutic intervention. A second culprit is literature about a cultural group's history, both its past glory and its confrontations with oppression and other negative social forces. This body of literature certainly increases our knowledge, but it still falls short of explaining how to incorporate that knowledge into specific interventions therapeutically. A third problem group is the body of literature that simply describes the limitations of traditional Eurocentric approaches to counseling and therapy in treating culturally diverse clients. This body of literature is very good at describing what doesn't work, but falls short of redirecting the reader to what does work. Each of these elements contributes to the sense of urgency in this book to improve cross-cultural sensitivity and responsiveness.

In distancing ourselves from the three limitations stated above, we have searched for a more crystallized and focused analysis and model that might help us to frame our work in counseling clients who are culturally diverse. The intent of this book is to shift from a top-down to a bottom-up perspective to understand ethnocultural communities. Accordingly, we have resurrected and expanded the Skills Identification Model proposed by Parham (2002). In his model, Parham sought to take the broad concepts of "multicultural counseling and therapy" and break them down into smaller component parts. He reasoned that doing so might enable practitioners and students alike to experience a greater level of confidence in learning and demonstrating specific skills that could be used to conceptualize and intervene. The model was originally designed as a way of deepening our understanding and enhancing our skills in working with African Americans (Parham, 2002). More recently, the model was adapted to working with the Latina/o population (Gallardo, 2004), given the belief in the therapeutic universality of the principles and concepts. This book is a further expansion of the original Skills Identification Model. We have extended the model's utility to include Asian, Latina/o, Native, and Middle Eastern American communities, with implications for other cultural groups as well (see Chapters 2, 5, 8, 11, and 14, this volume). The book contains specific skills therapists can use with all five groups and Case Illustrations as examples of the model's implementation.

Understanding Culture

Any discussion of multicultural skills must, by necessity, begin with both a definition and analysis of culture. The notion of culture is central to our work in this book, and we seek to move beyond simplistic, surface-level

manifestations of this concept. Although we have defined our respective cultural communities with "umbrella" terms, we also advocate that readers understand the immense diversity within each cultural community and begin to understand culture as more than race and ethnicity (Lakes, Lopez, & Garro, 2006; Warrier, 2008). In this regard, our profession cannot be so naïve as to assume that the most salient element of culture is the skin color and ethnic/racial background of therapy participants. Culture can include gender, religion and spirituality, sexual orientation, and class. Regardless of what element is most salient, the definition described below can help deepen our understanding of what "culture" means to an individual and/or community.

To help us to embrace this idea more thoroughly, Ani (1994) has provided us with a definition of culture at the deep structural level. Her work suggests that culture (1) unifies and orders our experience by providing a worldview that orients our experience and interpretation of reality; (2) provides collective group identification built on shared history, symbols, and meanings; and (3) institutionalizes and validates group beliefs, values, behaviors, and attitudes. Nobles (2010) reminds us that culture is a process representing the vast structure of behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies, and practices peculiar to a particular group of people that provides them with a "general design for living and patterns for interpreting reality."

As we seek to engage these constructs of culture, Grills (2002); Parham (2002, 2004; Parham, Ajamu, & White, 2011); and King, Dixon, and Nobles (1976) before them provide us with a more formalized structure through which to examine how culture is operationalized across various ethnocultural communities. Individually and collectively, they suggest that there are five domains of information that represent elements of culture at the deep structural level and that these domains are central to developing a better working knowledge of the construct. The five domains are ontology (the nature of reality), axiology (one's value orientation), cosmology (one's relationship to the Divine force in the universe), epistemology (systems of knowledge and discovering truth), and praxis (one's system of human interaction).

Examination of these five domains across the five ethnocultural communities referenced in this book allows us to develop a template that is useful in distinguishing areas of convergence and divergence between the various groups. Table 1.1 illustrates our comparison of cultural manifestations with each specific community.

The Skills Identification Stage Model (SISM)

Having now explored the necessity for more specificity in culturally responsive practice and the notion of culture at the deep structural level, it is now relevant that we turn our attention to the SISM. Parham's (2002)

Table 1.1 Five Domains of Elements Representing Culture

Group / *Issue*	*African American*	*Latina/o American*	*Asian American*	*American Indian/ Alaska Native*	*Middle Eastern American*
Ontology	Reality is a spiritual-material union in which spirit is that energy and life force that permeates everything that exists in the universe; an inner connectedness between all things that exist in the universe.	An integration of personal and familial lived experiences, religious/spiritual insight and history (i.e., an understanding that life is a combination of one's will and efforts and divine intervention), ancestral knowledge and connection, and an understanding that Western forms of health and healthcare can be limitations to one's growth and well-being.	Reality is grounded in a belief in harmony with nature, interconnectedness with family and close relations, the spiritual world, ancestral knowledge, holistic perspectives of health, and faith in external forces (natural world, religious intervention, etc).	To be is to be spirit. To become is to evolve toward one's destiny. All that is has spirit, is interconnected, is conscious, and possesses energy. Everything is to everything else.	Intense reliance on destiny and fate (fatalistic). Reality is based on an integration of personal and familial lived experiences. Espouse a holistic perspective of health and faith in external forces (natural world, religious interventions). Life is a combination of God's interventions and individuals' and families' free will.
Axiology	Collective survival, holistic self, emotional vitality and expressiveness, oral history and language, harmony within the universe, experiencing time in the present with an orientation to the past, contribution to one's community as a measure of worth.	Collectivistic; one's worth is based on one's contribution to the group's well-being and advancement; present and past oriented; group/cultural survival and ownership—*donde hay gana, hay mana; ponle ganas; cuando uno quiere la flor, necesita soportar las espinas*—language preservation and acquisition; connection to cultural traditions; representation	Strong cultural emphasis on family and group needs. Children are socialized to pursue familial goals and avoid shame of embarrassment to the family name. Within a collectivistic value orientation, there is recognition of traditional hierarchies, which are often associated with gender	To give to family and community defines humanity's task in this world. Choice is inviolate, never to be forced. Our past connects us to the spirit world and to our ancestral roots. We learn who we are by learning how we are to contribute to our world—our unique gift and destiny.	Negotiated individualism within the collective. Family is the heart of the community, which is composed of close friends and extended kinship systems. Emphasis is on interdependence and being for others, responsibility for caring for those within the kinship system and those less fortunate. Greatly values education, accepts modern science but with humility and

(Continued)

Table 1.1 (Continued)

Group / Issue	*African American*	*Latina/o American*	*Asian American*	*American Indian/ Alaska Native*	*Middle Eastern American*
		of motherhood is connected to spirituality and seen as protector, love, and as a source of strength for all.	and age. Cultural focus on hard work and fitting in.		against the backdrop of creationism. Respects knowledge of elders and distrusts those in power. Great deal of respect for parents, elders, and those more educated. Subscribe to a code of honor, shame, personal accountability, and humility.
Cosmology	Spiritual connection to the divine force within the universe; divinity is represented within each person; omnipotence of God.	Spiritual/religious connection as integration of family and culture; divinity falls on a spectrum of ancestral hierarchy that dictates a reverence for those who have preceded us and to our Creator; connection to, conservation, and protection of Mother Earth. Reverence for women and the strength seen therein (e.g., Virgin de la Guadalupe).	High respect for aspects of nature, the spiritual world, and universe. Spiritual and religious beliefs are bound to interdependent connections and community building. Aspects of nature and the spiritual world have significant cultural meanings.	The material and immaterial are parallel aspects to the universe. The eye of the universe is the immaterial energy that imbues all that is. We know this energy as the ineffable, transcendent, and the many aspects of the divine.	Spirituality is defined by the strength of the relationship to an omnipotent God who is invisible, yet near. Divinity is represented within each individual, and all are connected to the divine. The universe in its totality is a creation of an omnipotent God.
Epistemology	Belief in the value of direct experience.	Oral history (i.e., ancestral and cultural history), direct lived experiences; Western science can be limited and may not been seen as the universal truth of insight and	Ancestral and cultural history. Acknowledgment of the hard work and suffering of past generations. Value in the holistic experience	We are born with a history. We are not blank screens. Therefore, we learn of our role and our destiny through the nurturing of family and community.	A combination of values transmitted through the family and the community as well as individual experience. Science is valued, and divine

Group / Issue	*African American*	*Latina/o American*	*Asian American*	*American Indian/ Alaska Native*	*Middle Eastern American*
		understanding. The more one is connected to culture and the more solidified one is in one's identity development, the more one understands the limitations to universally accepted truths and discovers and defines one's own reality.	integration of mind, body, spirit, matter, nature, and the universe. Many Asian ethnic groups place a high value on Western science while also recognizing its limitations.	Learning from experience in the world allows our spiritual knowledge to emerge.	knowledge is transmitted through the Prophet. One can reach God through knowledge of the universe. Learning is valued at all levels and for all ages. Inherently skeptical and distrusts systems of power or authority. Means of acquiring knowledge is domain specific: emotions are understood by the heart, and the brain is the seat of reason, yet one needs both for wisdom.
Praxis	Ethical/moral laws and principles (i.e., MAAT) that guide human conduct.	Religious/spiritual guidance as standard for one's thoughts as behaviors; family guidance and shared wisdom; shared lived experiences influence the integration and acceptance into one's behavioral repertoire and provide a source of validation for the way one lives one's life.	Interpersonal and familial obligations that are culturally bound dictate and influence human conduct. Ethical and moral principles strive to maintain social and relational harmony.	Hunters, gatherers, and warriors live in communities of extended family systems. Action is highly valued in terms of how it supports the tribe. Such action includes ceremonies and sacred rituals that sustain the community and enable the people to prosper and mature through culturally specific life stages.	Religious doctrine of Judeo-Christian-Islamic heritage. Obligations are to God, family, and kinship systems. Say no evil, do no evil, think no evil.

Skills Identification Model includes the *what* and *how* of providing culturally responsive interventions to clients. The model proposes that all service providers need to ask two questions: (1) What is important for me to achieve therapeutically with my clients? and (2) How can I achieve these goals using specific culturally appropriate techniques? The SISM assumes that the "cultural competence" notion is comprehensive yet elusive, and thus dissects the therapy process into manageable parts by identifying six tenets that we believe all therapists address during the therapeutic encounter: (1) connecting with clients, (2) conducting a culturally relevant assessment, (3) facilitating awareness, (4) setting goals, (5) taking action and instigating change, and (6) feedback and accountability. The model is a framework that should only be used as a guide to inform therapists about the possibilities that exist when working with ethnoculturally diverse clients. The SISM is not comprehensive, nor is it linear. It is a reflection of the tenets we believe most therapeutic relationships entail, regardless of one's theoretical orientation. For a more in-depth understanding of the model, readers are referred to Parham (2002). The purpose of this book is to provide an expanded version of the model to reflect its usability with other ethnocultural populations. Therefore, only a brief description of each issue is provided as a starting point and to frame the discussion for readers.

Connecting With Clients

Townsend and McWhirter (2005) conducted a literature review over a span of 19 years and found that connectedness continues to remain at the forefront of psychologically healthy relationships and personal functioning. The authors go on to state that connectedness is of significant importance when taking into account the economic, political, cultural, ethnic, and social forces that impact people's lives. Their findings also provide support for the common factors literature addressed above, in which the therapeutic alliance serves as the base of all therapeutic relationships. Regardless of the theoretical orientation of the provider, clinical instincts, or diagnostic formulations, the process of remediating clients' concerns cannot happen without the establishment of a therapeutic connection. In essence, our connection with clients becomes the most important therapeutic intervention we can implement in the course of therapy (Lambert & Barley, 2001). This connectedness provides a foundation of trust, commitment, and collaboration between therapist and client. It is the key element by which the therapeutic work impacts and strengthens clients' lives. In order to understand what it means to connect with clients in a cultural context and with cultural consciousness, we must extend our definition of *connecting* beyond the physical realm (e.g., handshakes, visiting one's office) to also include joining at the intellectual, affectual, and spiritual levels (Parham, 2002). Connections on

these levels challenge therapists to move beyond the safety of the emotional and professional boundaries that have been enforced through graduate school training programs and professional ethics codes.

Conducting a Culturally Relevant Assessment

In the context of traditional training programs, there has been an emphasis on the use of assessment tools to determine qualitative and quantitative information on a specific person or characteristic. Assessment practices and psychological tests are currently under examination for their use with ethnoculturally diverse populations (Suzuki, Kugler, & Aguiar, 2005). Often, assessment can be conducted using specific screening tools or by simple observations (Parham, 2002). The challenges of establishing the reliability and validity of clinical interview instruments/processes, and of other psychological assessment measures, continue to be a failure in considering cultural and social factors. In addition, research indicates that although some of these instruments may have some clinical usefulness in the counseling setting, the interpretation and results remain culturally inconsistent with ethnocultural groups (Butcher, 1996; Graham, 2006). Culturally responsive assessment avoids pathologizing clients by recognizing their strengths and factors that have contributed to the establishment of sustaining, purposeful, and functional behaviors. The use of culturally appropriate screening tools and assessment measures must be developed from an emic perspective (Butcher, 1996; Cepeda-Benito & Gleaves, 2000; Cheng, Kim, & Abreu, 2004; Velasquez et al., 2002; Whatley, Allen, & Dana, 2003), rather than with an etic foundation (Suzuki et al., 2005). Regardless of the tests used, tests must be interpreted with caution and in a culturally responsive manner and within the client's social, political, and cultural context (Butcher, 1996; Graham, 2006; Suzuki et al., 2005). In addition, we must also acknowledge and culturally assess the unspoken words, the unexpressed emotions in body language, and the unconscious attitudes and beliefs expressed in the behaviors of clients. Ultimately, we encourage therapists to employ these additional strategies when conducting an assessment to acquire information about their clients. In addition to utilizing any culturally interpreted and normed measures, we encourage therapists to consider identifying preexisting strengths, identifying clients' preexisting resources, potentially inviting family into the therapeutic data-gathering process, separating that which is environmental from that which is internal to the client, and investigating the client's cultural background on your own rather than relying solely on the client to educate you about who they are. Although client self-report always supersedes textbook knowledge and information, it is our responsibility as providers to understand and investigate our clients' cultural backgrounds, much like we would when a client presents with a specific diagnosis about which we have limited knowledge. In both the former and latter examples, the information is used

as a starting point by which we then understand better what questions we might consider asking, in what way, and at what time during the course of treatment, while understanding the individual who sits before us is unique.

Facilitating Awareness

Insight and awareness have been found to assist clients to feel more in control of their everyday lives (Jinks, 1999), to be helpful factors in successful individual and group therapy (Holmes & Kivlighan, 2000), and to aid in symptom reduction (Kivlighan, Multon, & Patton, 2000). Facilitating awareness reflects the basis of a *psychology of liberation* (Aldarondo, 2007; Comas-Díaz, Lykes, & Alarcon, 1998; Freire, 1970). A psychology of liberation works within the client's own contexts to enhance his or her awareness of surrounding environmental circumstances that contribute to the establishment of behaviors and feelings of oppression, discrimination, and subjugation (Comas-Díaz et al., 1998). It involves recognition of the forces that shape, color, or otherwise exert influence on the physical, psychological, and spiritual aspects of his or her being. Discussion about race and ethnicity in the therapeutic relationship is one example of facilitating awareness in a culturally responsive manner (Cardemil & Battle, 2003). The process of facilitating awareness involves helping our clients to be heard and understood. Facilitating awareness also involves helping clients to understand their language; explore the dynamics of the past, current, and anticipated circumstances; discover how their life experiences color and shape how they engage current situations; and plan for future situations.

Setting Goals

Clients who are optimistic about achieving their valued goals for intrinsic reasons are more likely to actively engage in the therapeutic process, leading to more positive outcomes in therapy (Michalak, Klappheck, & Kosfelder, 2004). Goal setting is one of the most critical aspects of a therapist's work. Goal setting can focus on the outcome clients wish to achieve in therapy and can range from, for example, general goals of feeling less stressed to more specific goals of gaining more independence while continuing to honor and maintain ties to family. Ultimately, transforming therapeutic goals from mere wishes to a realization requires the establishment of a trusting and collaborative relationship between client and therapist. Clients need to feel motivated to achieve their goals and empowered to believe that their goals are achievable. Setting goals in a therapeutic sense is absolutely critical, but the process of crystallizing goals will require elements of realism, specificity (including cultural specificity), and perseverance (Parham, 2002). For some clients, goals can be simply aspirational, in that personal and environmental limitations prevent the realization of the client's stated goals. Incidentally, the client's stated goals and the goals actually achieved are typically the result of a collaborative perspective between

what the client and therapist have identified as important to strengthen and empower the client and the client's social, political, and cultural context. Ultimately, "the therapeutic relationship represents the negotiated tasks and goals between counselor and client" (Liu & Pope-Davis, 2005, p. 152). It is also worth noting that the need to balance the focus of goal setting between intrapsychic phenomena and sociocultural and environmental phenomena acknowledges the fact that not all client distress is intrapsychic and that some, or all, of their presenting concerns may be caused by the oppressive, racist, discriminatory, and dehumanizing realities of the environment in which clients interact and live. Consequently, the target of our therapeutic intervention must likewise be sociocultural and environmental.

Taking Action and Instigating Change

Taking action and instigating change are the procedural aspects for implementing the goals that have been set by the client and therapist. Taking action and instigating change involve both the conscious commitment to change and the desired actions or behaviors consistent with the intent to change. Of most importance in creating change is the collaborative relationship that has been developed with clients. Furthermore, when attempting to instigate change for the clients, it may be necessary to ask significant others in the client's life to participate in the successful completion of any desired outcomes and changes. This is consistent with our hope that therapists understand the context in which clients live and, in their attempts to extend the couch to the community, include any significant entities and relationships in the therapeutic process. Metaphorically, our clients are never alone in the therapy process, even if they may physically be there on their own. Clients bring with them both past and present relationships and the multitude of ways those relationships have shaped their worldviews, current life situation, and any anticipated future actions they may take. Action and change involve psychological and behavioral dimensions, thereby requiring an interpersonal sense of strength and empowerment, as well as a specific set of skills that clients are comfortable implementing (Parham, 2002). Hays (2009) encourages therapists to ask the following question of their clients: "What is the smallest possible step you could take that would feel like you are making progress?" (p. 358). She encourages clients to consider viewing any change from this perspective because it highlights the importance of breaking goals down into sustainable steps in order to ensure long-term success. We agree.

Feedback and Accountability

Feedback and accountability means providing, and receiving, information reciprocally to both the client and therapist about the change process in therapy. Providing clients with information about their progress and

movement in therapy helps them understand areas of particular strength and areas in which further growth may be needed. Feedback is a fundamental aspect in the therapeutic progress because the process itself provides the client and therapist with opportunities to further engage in the change process through periodic review and renewal of commitment (Parham, 2002). In this process, clients are reminded that successful interventions rarely occur as a single moment in time, but rather in a series of steps that continue to change the client's stated goals into tangible transformation in their everyday lives.

Of particular importance is feedback for the therapist. By receiving information about the therapeutic change process, therapists gain a deeper understanding of what the client is experiencing in the moment and what the client has found facilitative or disruptive about his or her therapeutic encounter and change process.

Our task in this book is to provide a framework or model that therapists can use to develop specific skills when working with ethnoculturally diverse clients. We hope that by adapting and integrating these nonexhaustive skill sets into your existing clinical foundation, you will achieve some measure of success during the phases of therapy outlined above.

Understanding the Content in Context

As accompaniments to the specific ethnocultural chapters in this book (Chapters 2, 5, 8, 11, and 14), we have asked our expert colleagues to provide case examples of how the SISM can be implemented. Therefore, Parts I through V include two case examples intended to further crystallize the model in context. What you find as you read through the chapters and case examples are commonalities as well as culturally congruent approaches to working with our ethnocultural communities. Each author and case example author has approached the content and conceptualization in ways that he or she feels resonates with his or her community. We have asked our colleagues to implement the model as they see fit and to critique it, where necessary, as a way to build upon past and current knowledge in this area.

We have also asked Dr. Rebecca Toporek (Chapter 17) to address how the principles put forth in this book can be implemented in the classroom as teaching resource and with students in training. We hope this chapter assists professors to implement the model in training programs. Lastly, we invited Dr. Jeff Harris (Chapter 18) to situate the content of this book within the larger multicultural discussion happening in the field today. It is our intent with this chapter to help readers locate the content of this book within the context of the multicultural literature and mandates. We are not so naïve as to think that this book is the be all and end all, and we understand that we are addressing one component of what it means to be culturally responsive. In fact, we would argue that one needs to have made the paradigm shift, or have the *psychological skill set,* before attempting to implement any behavioral skill

set discussed in this book. Chapter 19 outlines future directions and ways we can continue to expand the literature in this area. For the authors of this book, the psychological skill set is primary to any multicultural work one engages in. It is therefore essential that readers, including our Caucasian readers, understand that which is cultural for them before attempting to understand that which is cultural for someone else.

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