

CROSS-CULTURAL MENTAL HEALTH  
COMBINING SSLD AND ICCP  
A TALE OF TWO SYSTEMS

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SSLD

STRATEGIES AND SKILLS LEARNING AND DEVELOPMENT

ICCP

INTEGRATIVE CROSS-CULTURAL PRACTICE

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**August 10, 2010**

- This presentation briefly introduces 2 practice systems I have been developing over more than 3 decades of direct practice
- Both systems are grounded in multiple contingencies thinking or modeling (MCM)
- Their combination can support effective practice in cross-cultural, mental health, settlement, and a wide range of service contexts

SSLD                      Strategies and Skills Learning and Development

ICCP                      Integrative Cross-Cultural Practice/Psychotherapy

# A Tale of Two Systems ...in Many Cities

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**SSLD**

Canada

China

Hong Kong

New Zealand

Korea

**ICCP**

Canada

India

Hong Kong

New Zealand

Taiwan

Turkey

# Case Example: New immigrant from China

## Fabricated Case Combining Elements from Different Cases

- Female, 42 years old, married with children (F/12, M/15)
- Husband returned to China, extra-marital affair suspected
- Senior professional before immigration, can only find low-paying menial work after coming to Canada, limited English
- Withdrawn socially; quit working; poor relationship with children; mother here to help out, lives together
- Reports delusional thoughts with paranoid content, perceiving neighbours and strangers as hostile (surveillance, intrusion, poisoning). Family member are suspected to be imposters who are part of a conspiracy to destroy her reputation (calling her a slut).

# Your Assessment & Formulation

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- Gross distortion of reality?
- Symptomatic of schizophrenic disorder?

# What is SSLD?

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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 Development of SSLD

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- Based on earlier work on Social Skills Training (SST) by Michael Argyle (Oxford University) and his colleagues in the 1960s and 1970s
- I started using SST in the 1970s (in Hong Kong):
  - treatment for adults with schizophrenic disorder
  - social skills training for children with infantile autism, with parallel training for their parents and caregivers
  - skills training for people who wished to improve their self-confidence and interpersonal relationship

# The Development of SSLD

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- Since then I have applied SST to a wide range of practice situations in mental health, social service, and human development, in Asia and in Canada
- Since the 1990s, I have developed approaches and procedures that increasingly emphasize (1) learner-centered design, (2) multiple contingencies thinking – addressing particular circumstances and needs, (3) empowerment, and (4) intersecting diversity
- In 2005, after reviewing the features and characteristics of my learning model, I decided to use a new name SSLD to distinguish it from the original SST Model

# SSLD has been be applied in many contexts:

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- Counseling and psychotherapy
  - Individual
  - Couple and family
  - Group
- Self-help groups
- Psycho-educational interventions: Education, learning and training programs
- Corporate training and organizational development
- Community work (development, organization, and social action)

# SSLD has been be applied to:

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- Mental health issues:
  - Schizophrenic disorder
  - Autistic spectrum disorder
  - Social phobia
  - Insomnia
  - Addiction and gambling
- Relationship and intimacy
  - Dating
  - Couple counseling
- Health promotion and management of chronic conditions

# SSLD has been be applied to:

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- Cross-cultural work
  - Counseling, psychotherapy, social work
  - International management
  
- Community development, AOP (Anti-Oppressive Practice)
  - Advocacy, activism, grassroots leadership development
  - Immigrant settlement
  
- Human resource and organizational development
  - Recruitment and employment
  - Front desk reception
  - Coaching and team building

# ICCP

## Integrative Cross-Cultural Practice

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- An integrative framework for cross-cultural practice (social work, psychotherapy, counseling, and other forms clinical practice in healthcare)
- Integrating (1) attitude, (2) knowledge, (3) skills, (4) research, and (5) personal , professional, and structural context of the practitioner
- Multiple contingencies thinking/modeling (versus linear categorical thinking)
- Addresses intersecting diversities, goes beyond ethno-cultural difference

# Intersecting Diversities

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- In clinical practice we deal with clients who are different from us in many ways, culture is just one of them
- Other diversities include: gender, sexual orientation, religion, age, socio-economic status, (dis)ability, and so on
- These diversities intersect with each other, contributing to valuable bio-diversity among human beings
- Theories or practice models that have chosen to address one of these often have to assume that the other variables are held constant, or insignificant
- Both SSLD and ICCP are based on **Multiple Contingencies** thinking, and are capable of addressing such complexity

# Multiple-Contingencies Modeling (MCM)

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- What is contingent is not fixed.
- A contingency refers to a possibility that one has to be prepared for, or a possible event that is incidental to something else, or the condition of being dependent on chance.
- What we know and what we do is contingent upon ...?
- Problems and challenges in everyday life often involve multiple contingencies, and the solution is not a simple linear sequence.
- Multiple contingencies thinking involves simultaneous consideration of a number of variables, and imagination of multiple trajectories of change.

# Multiple-Contingencies Modeling (MCM)

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Transcends linear categorical thinking, which is characterized by :

- If  $a$ , then  $b$
- Assumes  $a$  and  $b$  are discrete and homogenous categories

Examples:

If client has depression, use CBT

When working with Korean clients, focus on family solidarity

Contingency-based thinking questions whether all people within any given category (e.g., depression, Korean) are the same, and if the assumptions made by a practice system (e.g., CBT) are valid for all people.

# Multiple-Contingencies Modeling (MCM)

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Clinical intervention is contingent upon

- Client variables – N3C (needs, circumstances, characteristics, capacity), and culture is implicated in all these domains
- Process variables – the actual interaction process, we have to make many moment-by-moment decisions and perform countless micro-tasks
- Dyadic variables: Client-practitioner match and differences, chemistry
- Contextual variables – service mandate, organization, social location

# Development of ICCP

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- Developed by me and my colleagues at the at the Faculty of Social Work, University of Toronto (Usha George, Marion Bogo, Eunjung Lee) since the 1990s
- We started the first process-outcome study in cross-cultural psychotherapy in 1997 (funded by SSHRC), and have published several academic papers
- In 1998, I published a paper together with Usha George articulating the basic premise of the model (This is subsequently adopted by the New Zealand Social Workers Registration Board to define core competence in cross cultural practice)
- I have presented numerous lectures and workshops on this model in different parts of the world

# Critical Issues in Cross-Cultural Practice

- **Cultural literacy**
  - Homogeneity assumption (based on categorical thinking)
  - Exaggeration of intergroup difference
  - Neglects internal diversity (e.g., gender, class, age, sexuality)
  - Ignores internalized culture
  - Ignores the reality of multiple cultural sources
- **Classicism**
  - Relying on classical texts (e.g., Confucian), oversimplification
  - Static assumption – cultures change and become more complex
  - Ignores historical and contemporary reality (e.g., Cultural Revolution in China, cultural effects of Capitalism, international influence, internet and diverse cultural articulation and practice)
  - Orientalism and self-orientalization

# Integration Step One

## Two Approaches to Cross Cultural Clinical Practice

### Cultural Literacy Model

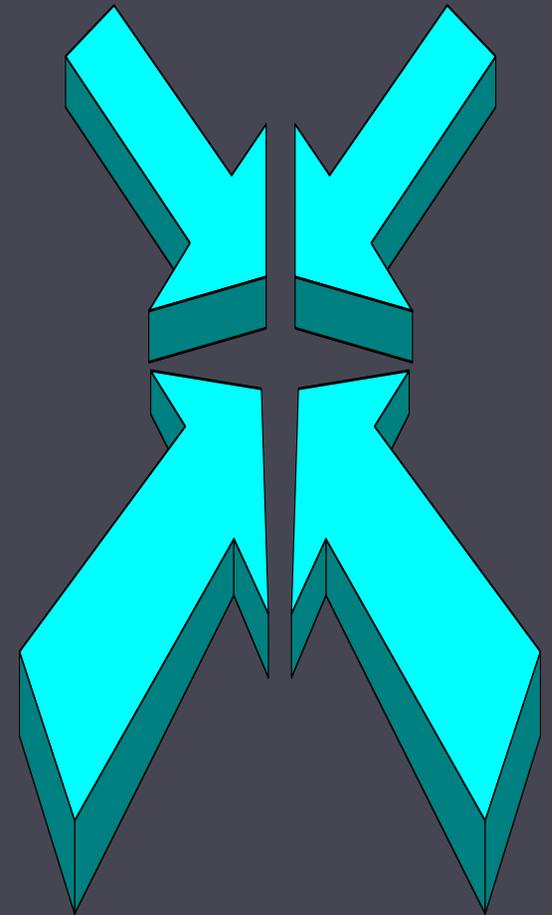
- Practitioner as expert
- Assumes superior knowledge
- Culture as homogenous
- Client as member of cultural group
- Culture-specific techniques
- Practically impossible

### Phenomenological

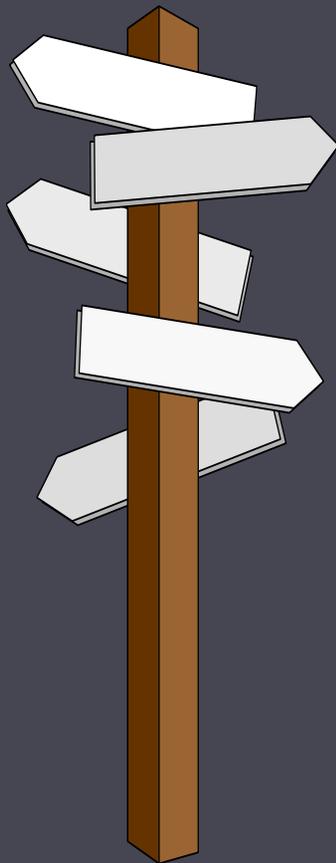
- Practitioner as learner
- Epoché or suspension
- Plurality of internalized culture
- Client as unique individual
- Process-oriented technique
- Critical self-reflection

# Integrative Model

- Attitude
- Knowledge
- Skills
- Research
- Personal, Professional, and Structural



# Attitude



- Commitment to justice and equity
- Valuing difference
- Openness to cultural difference
- Readiness to learn from the client, and to change
- Critical self-reflection and experiential learning

# Knowledge

- Culture-specific knowledge
- Systemic context of culture
- Power and discourse, structural analysis
- Acculturation process and internalized culture
- Dynamics of cross-cultural communication and understanding
- Clinical change process
- Building on chosen practice theory and personal style
- The Multiple Contingency Management (MCM) approach

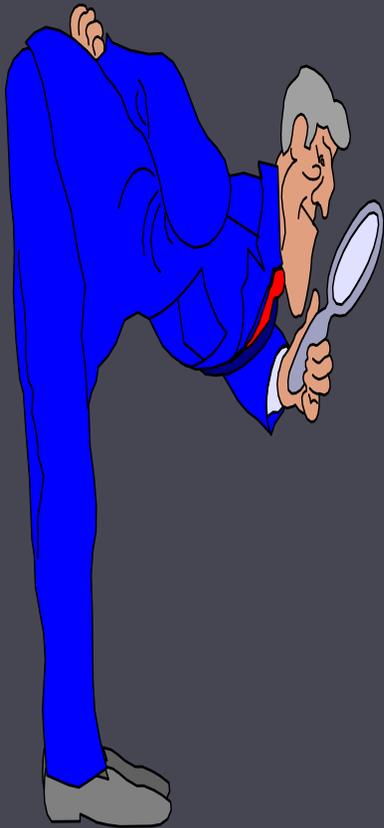


# Skills



- Communication, engagement, and relationship skills
- Clinical formulation and goal setting connected to client/patient reality
- Specific change strategies (in different domains of the MCM framework)
- Management of own emotional responses
- Professional intervention within institutional context

# Practitioner-Oriented Research and Knowledge Development



- Current models based on personal opinion, little empirical support
- Reliance on correlational design
- Lack of direct investigation of change process
- Categorical definition of ethnicity
- We aim at explication of practice wisdom
- Systematic process-outcome research to support model development (Tsang, Bogo, George, Lee)

# Personal, Professional, and Structural

- Professional self-care
- Personal development and comfort
- *Kappianangittuq* (Inukitut:, a safe, non-scary space) for open and honest sharing - beyond political correctness and tokenism
- Diversity positive policy
- Commitment and resource: The political economy of funding
- On-going learning and professional development – learning, training programs, consultation and supervision

# SSLD + ICCP = ?

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- The original articulation of ICCP offered an integrative conceptual framework (covering attitude, knowledge, skill, and research) and general practice principles
- Practitioners were expected to adopt this general framework to guide their practice. Specific instructions regarding actual clinical procedures were not operationalized in detail
- The SSLD System offers both a coherent framework for understanding clinical cases as well as concrete and specific practice procedures
- Both systems are based on Multiple Contingencies thinking and can complement each other to support direct practice

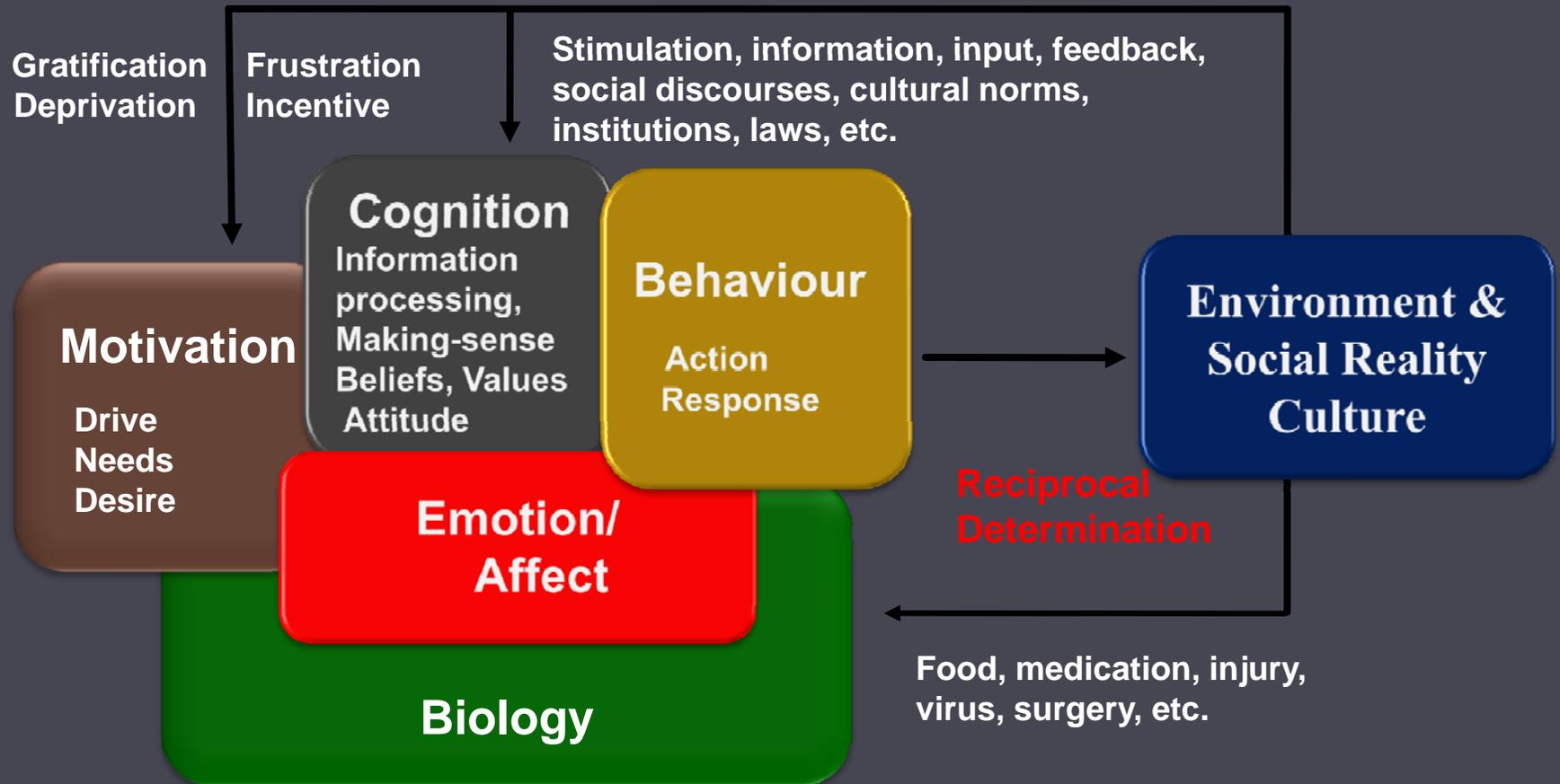
# SSLD Basic Theoretical Premise

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- Most human behaviours are motivated and goal-directed; the individual is conceived as an active agent
- Human action is embodied and mediated by biological, cognitive, and emotional processes
- Human action and external environmental realities interact with each other; and there is a process of mutual influence and transformation
- Most human behaviours are acquired through social learning: Informal everyday situations and structured programs

# The Person and the Life-World

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# SSLD Basic Theoretical Premise (cont'd)

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- Human behaviors vary in their effectiveness in addressing needs
- Problematic behaviours are ineffective or socially inappropriate attempts to meet human needs
- The mastery of effective strategies and skills can replace and/or displace previously learned ones that are ineffective or inappropriate

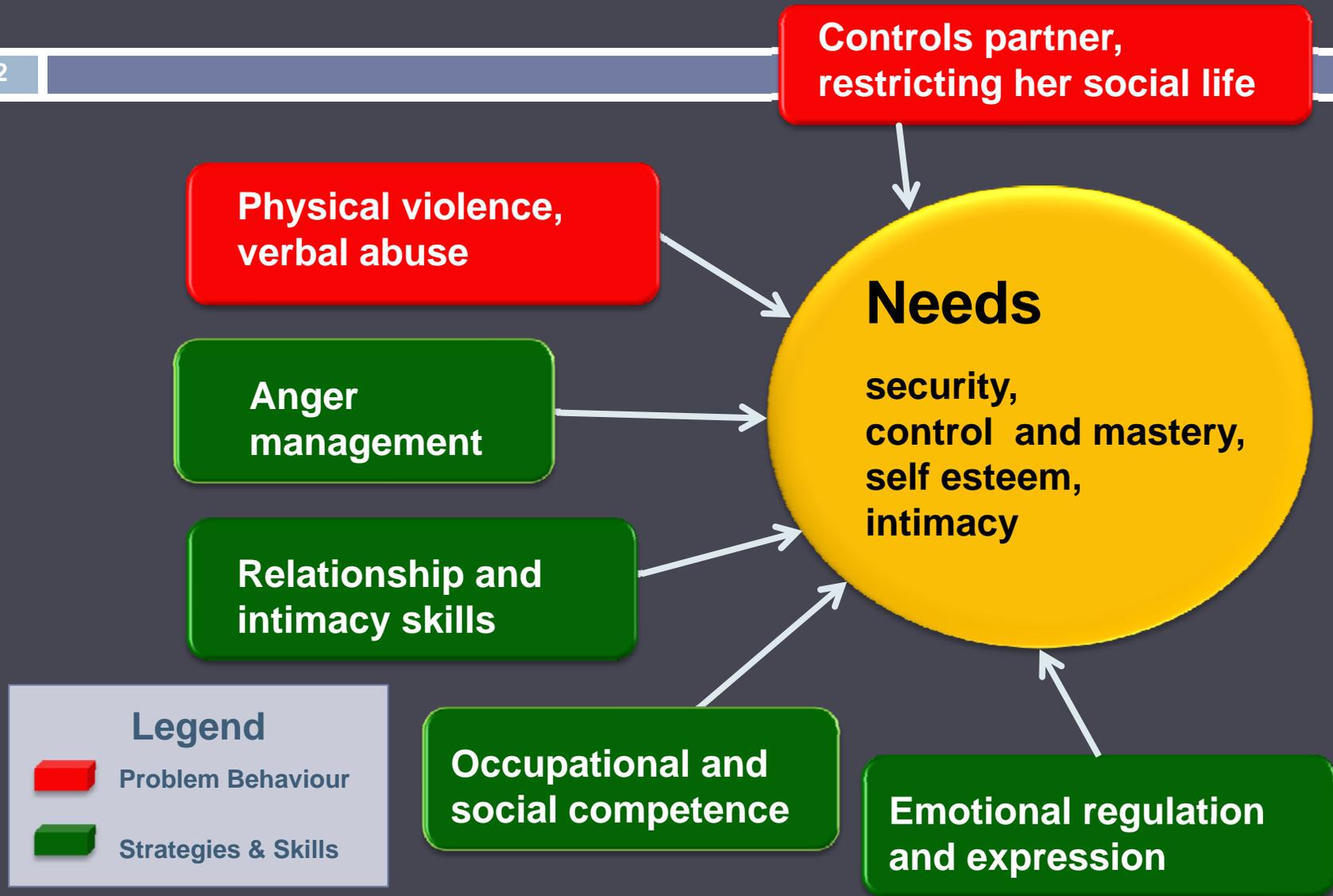
# Case Illustration 1: Addiction

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## Case Illustration 2: Partner Abuse

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# The Role of Culture

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- Environment and social reality:
  - Globalization, movement of bodies, ideas, capital, goods and services
  - Demography
  - Economic system
  - Language
  - Cultural tradition
  - Social institutions
  - Dominant discourse
  - Life scripts, templates, game rules

# The Role of Culture

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## Cultural Influence as Ubiquitous

- **Motivation:** Differential legitimization of needs, processing and translation into life goals, priorities (e.g., valuing family coherence versus individual autonomy)
- **Biology:** Diet, reproduction, tattoo, cosmetic surgery
- **Cognition:** World view, frameworks for making sense, value system
- **Emotion:** Constitution, processing/management, expression
- **Behavior/Action:** Norms, conventions, scripts, templates, rituals, and so on, conditioning how culture is performed

# The Role of Culture

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For the individual:

Objective Culture

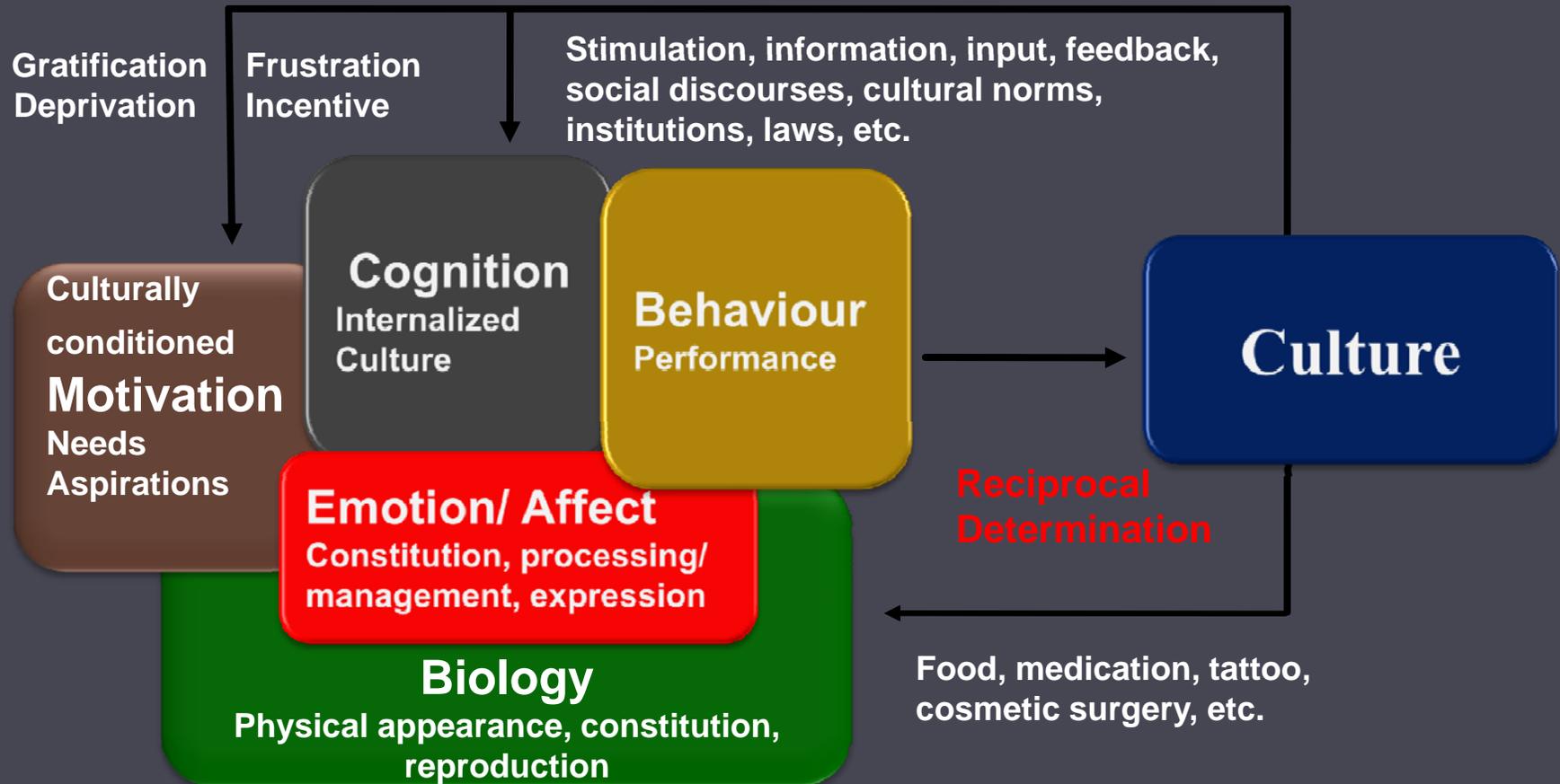
Internalized Culture

Performed Culture

- **Multicultural Exposure:** In a globalized environment, most people are exposed to multiple cultural influences instead of a single culture
- **Selective Assimilation:** We differentially adopt elements from various cultural systems in different domains of our lives
- **Differential Performance:** We perform different aspects of culture in different social sites and relational contexts

# The Individual and Culture

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# Deciphering Culturally-Coded Messages

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- Clinicians are alerted to potential cultural difference when the client presents something **unfamiliar, odd, or strange**
- Clinical presentation usually involves behavior and verbal responses – we experience the challenge of difference **when we are not sure** how we can interpret and/or deal with them
- Diagnosis (*dia*: across, *gnosis*: know): Our knowledge of the client has to cut across the presented
- When in doubt, seek information/clarification from client, or consult (family, community, knowledgeable informants, experts, internet)

# Some Useful Questions

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- 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? e.g., symptoms explained as demon possession or spiritual intervention
- What is the client (and family and community) **doing** about it, other than seeking professional help? e.g., preparing special food, herbal remedies, prayers, consulting shamans
- How is professional help (Western mental health service) understood? e.g., last resort, more scientific, government supported

# SSLD & Mental Health

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- Mental health issues are understood as unsuccessful attempts to address one's needs
- We read through the symptoms and presenting problems to gain understanding of the client's needs
- N3C Assessment:
  - **Needs:** Can be culturally conditioned
  - **Circumstances:** Work, family situation, social support, etc. Include citizenship, residency, and minority status
  - **Characteristics:** Personality, patterns of thought and action, can include internalized culture
  - **Capacity:** Current capacity in managing life, meeting needs and attaining goals, including ability to negotiate cultural differences

# SSLD Functional Analysis

## Client Reporting Delusional Thought (partial)

- Verbalization: releases anxiety (comfort, self-protection needs)
- Construction of delusion
  - A way to make sense of overwhelming or threatening situations (cognitive need)
  - Protects the self from psychological threat and damage (safety, self-esteem needs)
- Reporting delusional thought: A way to tell others that one needs help (social, affiliation needs)

# N3C Assessment: Step 1

## What Does the Client Need?

- Safety: Protection of self against external threats, real or imagined (related to information, mastery, control)
- Anxiety management/reduction
- Cognitive need to make sense of confusing/ threatening aspects of reality
- Articulation, expression of emotions or internal process: Fear, confusion, insecurity
- Attachment: Connection, affiliation, intimacy

# N3C Assessment: Step 2

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## Circumstances

- Major personal losses after immigration (job, status, support system)
- Previous strategies not effective in strange land
- Social isolation, compromised need gratification

## Characteristics

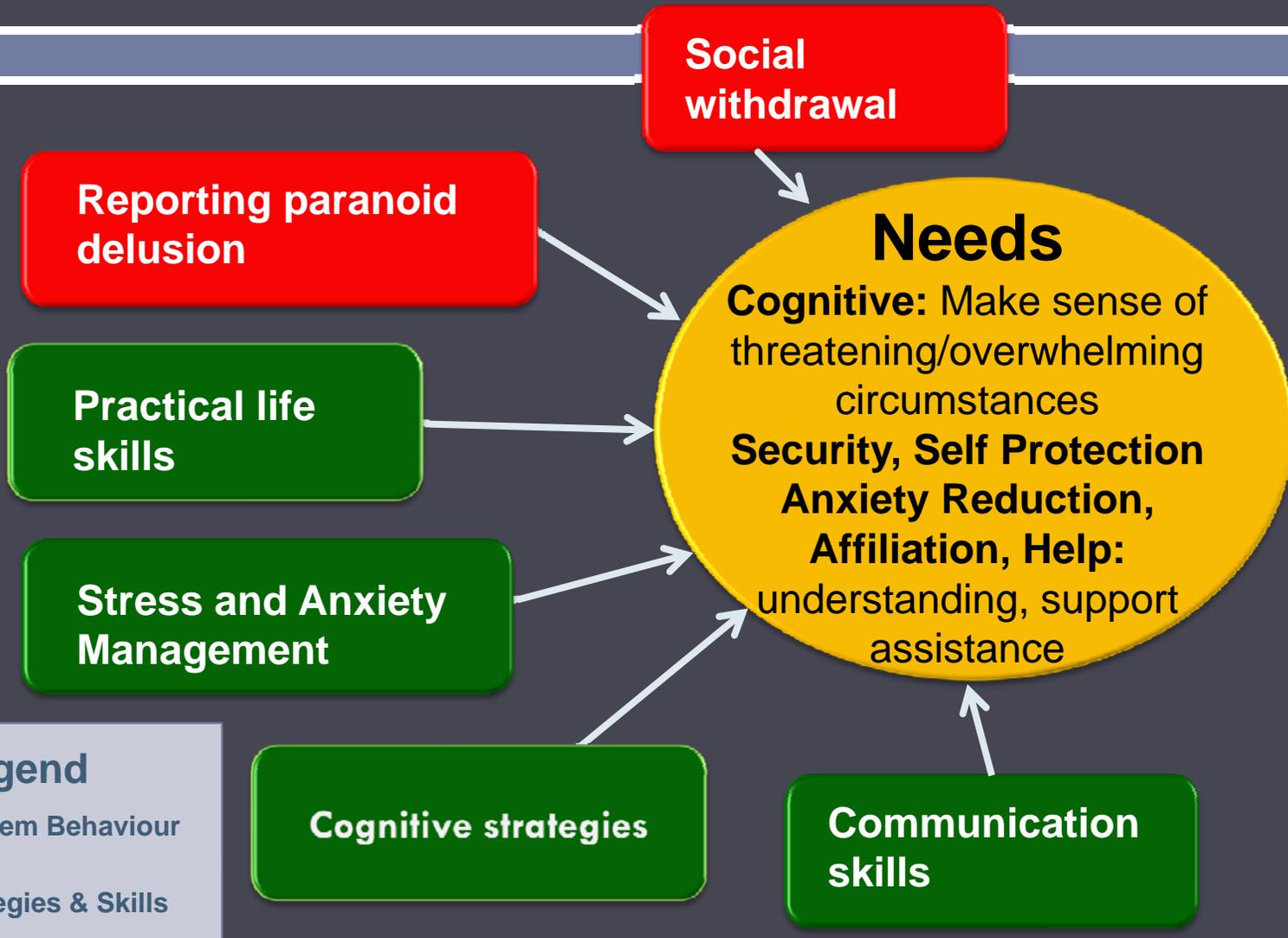
- Passivity, external locus of control
- Negative framing

## Capacity

- Inadequate repertoire of culturally appropriate strategies and skills for meeting personal needs (e.g., career development, affiliation)
- Specific cultural challenges (including language)

# Case Illustration 3: New Immigrant Reporting Paranoid Delusion

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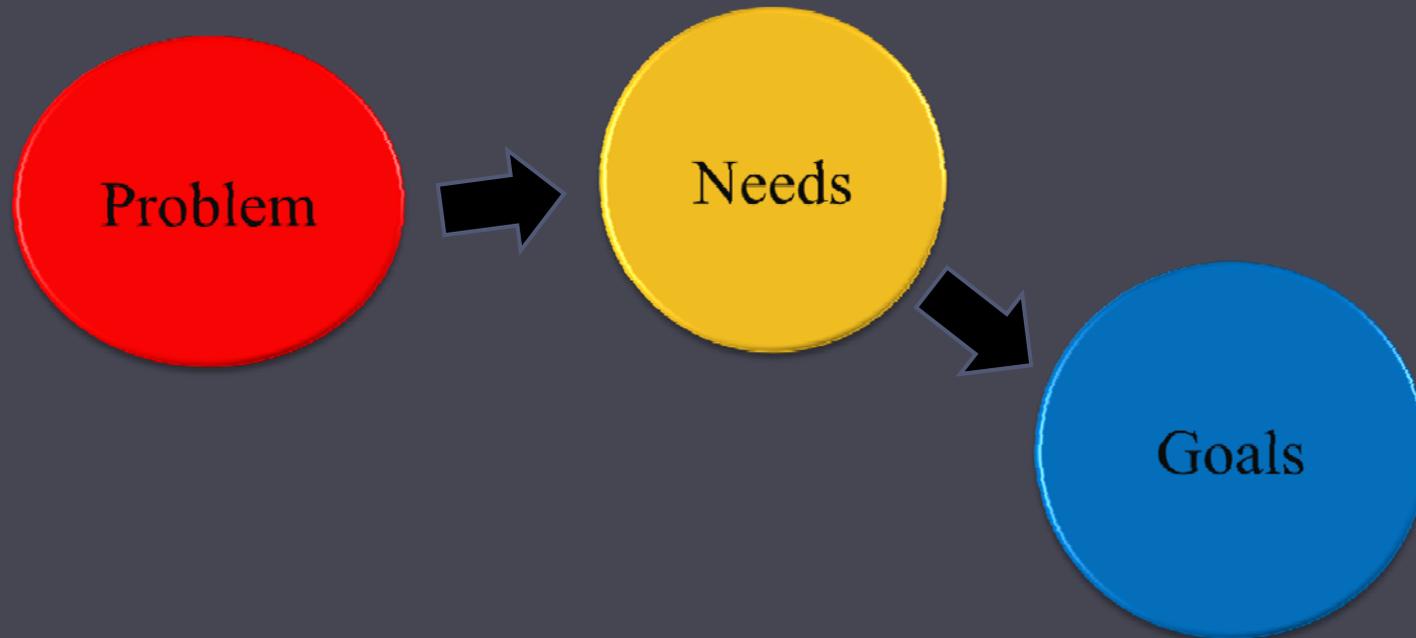
# SSLD in action

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1. Engagement and Problem Translation
2. Formulation of strategies and skills to be mastered
3. Systematic learning and development of strategies and skills
4. Evaluation: Mastery of strategies and skills, goal attainment, needs effectively met, enhanced self-efficacy

# SSLD Step 1: Problem Translation

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# Problem Translation and Engagement

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1. Presenting problems/issues understood as needs
  - When clients present an issue or problem, we always try to understand it with regard to needs
  - The issue usually involves unmet needs
  - Client action and behavior that are considered problematic or pathological are usually attempts to address personal needs
2. Engagement:
  - Recognition, acceptance, and empathic understanding of client needs
  - Shared understanding, positive expectancy (hope)
3. Collaborative goal setting
  - Realistic, incremental goals

# Engagement in Cross Cultural Clinical Practice

(based on process-outcome study, Tsang, Bogo, & Lee, 2010)

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## Engagement processes associated with positive outcome in cross-cultural psychotherapy/counseling

1. Recognition of the client's major needs and concerns
2. Communication of our understanding of them, leading to the negotiation of agreed upon purpose (collaborative goal setting)
3. Emotional engagement with the client.

## Negotiating ethno-cultural differences in-session

1. Focus on the clinical issue, cultural difference understood with regard to the client's needs and concerns
2. Explicitly address the difference
3. Let client tell us what is important (internalized culture)

# Translating Problems into Needs

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- The problem is not with the needs, but how we deal with them
- Problematic behaviors, including symptoms, are functional attempts to address unmet needs

## Examples:

- Flipping and spinning by child with autism: Agentive move to derive sensory pleasure
- Delusional accounts by client with schizophrenic disorder:
  - Making sense of overwhelming and threatening circumstances
  - Anxiety reduction, protection of self image
  - Communicative attempt, seeking understanding, support, help
- Drug use: Pain control, pleasure seeking, stress management

# What Is The Problem?

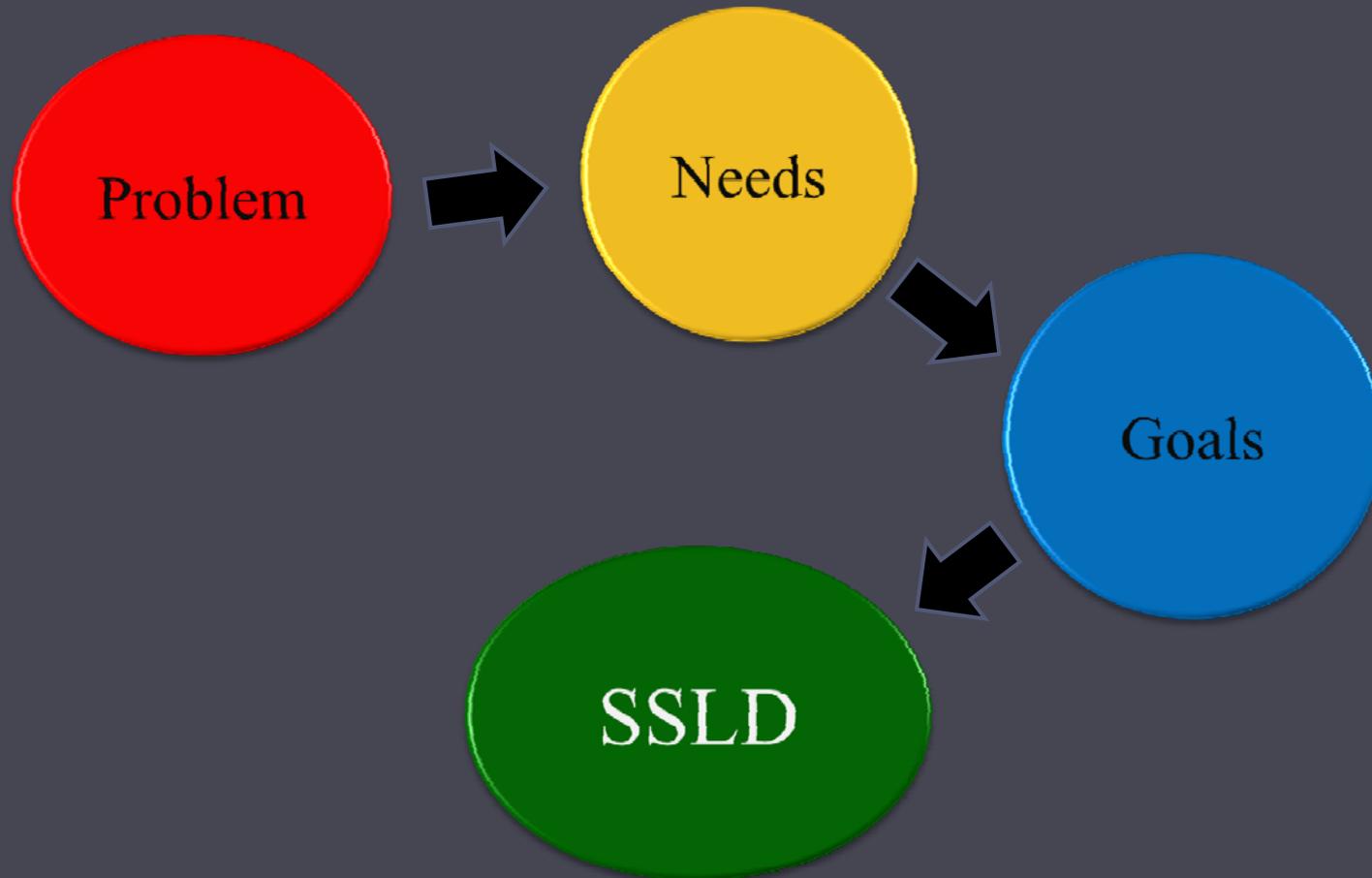
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- Confusing needs with wants, erroneous goal-setting  
e.g., I want a designer suit or plastic surgery (need for esteem , social approval)
- Unexamined scripts and templates  
e.g., I will be happy if I can get married
- Ineffective strategies and skills  
e.g., job search skills that cannot project confidence and creativity
- Inappropriate strategies and skills – incur personal and social cost, negative impact on other needs  
e.g., using violence to gain mastery and control in intimate relationships

# SSLD

## Step 2: Getting into Action

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# SSLD How Does It Work?

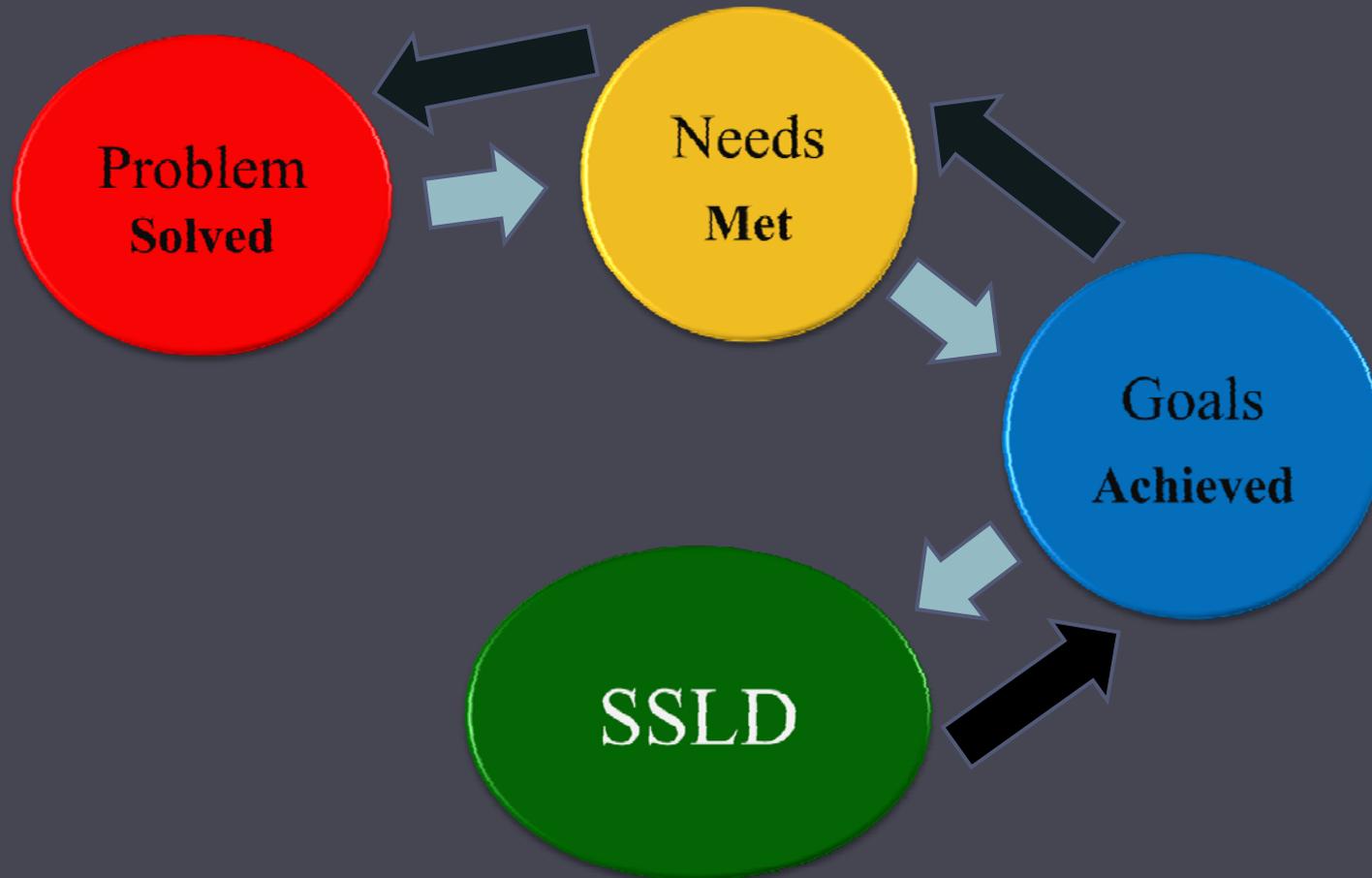
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- **Problem** presented
- **Needs** assessed
- **Goals** set
- Systematic **S**trategies and **S**kills **L**earning and **D**evelopment
- **Goals** achieved
- **Needs** met
- **Problem** solved

# SSLD

## How Does It Work?

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# Getting into Action

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- Goal setting, design and formulation of learning program
  - Effective and appropriate strategies and skills
  - Experience (practitioner and client)
  - Creativity and innovation (including Collaborative Generation)
- Learning and development
  - Agency and reflection: Beyond modeling and demonstration
  - Feedback, AV recording and review
  - Incrementalism and self-efficacy
  - 4Rs: Real-life practice (homework), report back, review, refinement
  - Motor skills metaphor: practice, practice, and practice

# Strategies, Composite Skills, and Micro-processes

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## Strategies

Developing trust  
Cultivating intimacy

## Skills

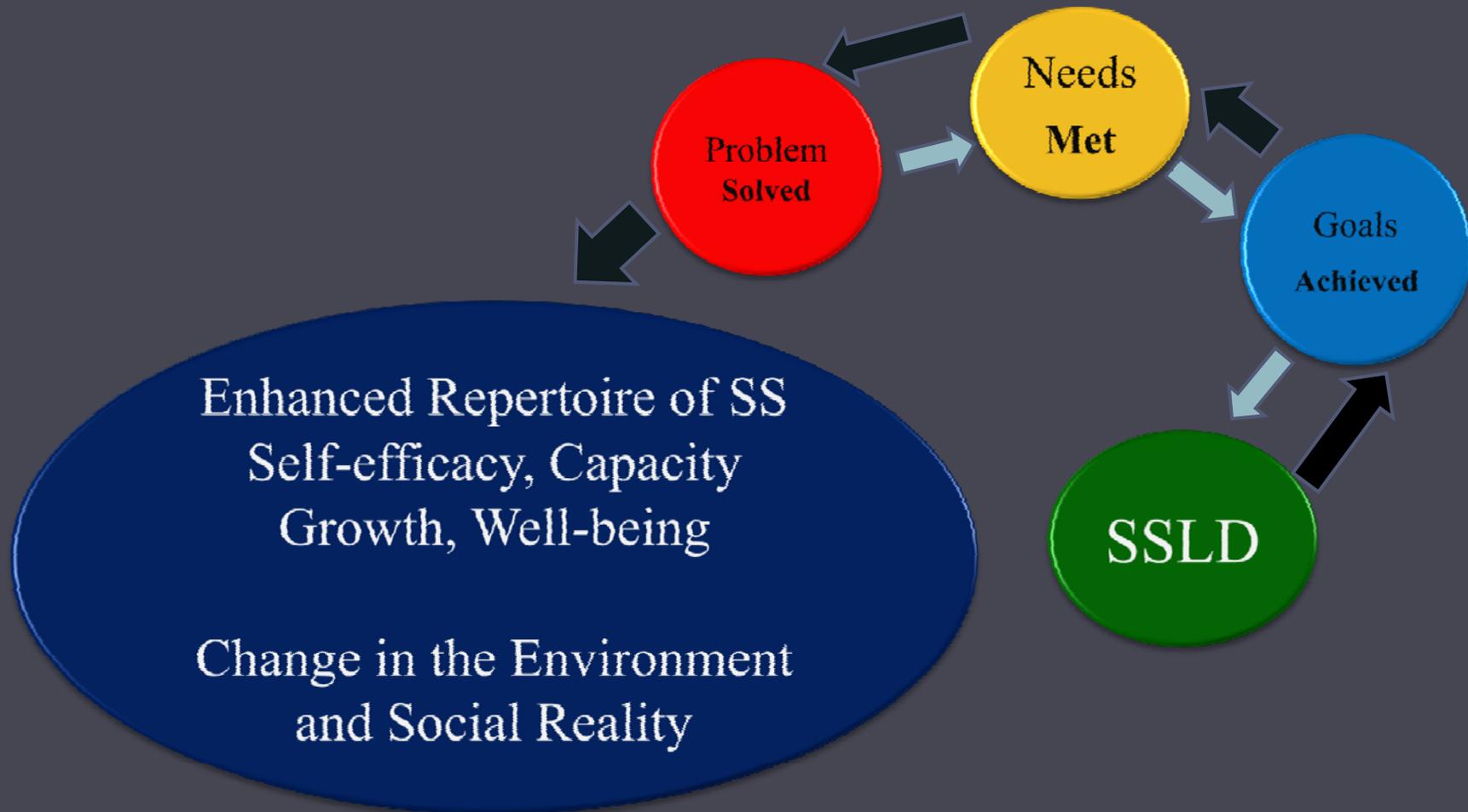
Self-disclosure, building common ground  
Emotional engagement, empathic responses

## Micro-processes

Using “we” language, sharing childhood experience,  
Reflection of feelings, emotional joining, positive affect

# SSLD Goes Beyond Problem Solving

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# SSLD Goes Beyond Problem Solving

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With SSLD, the client does not only have the problem solved, but will acquire an **expanded repertoire of strategies and skills**, which are more effective in meeting needs and achieving goals. This will lead to improved **self-efficacy**, associated with an enhanced **capacity** for addressing the demands and challenges in life. The client experiences personal **growth** and is more likely to attain **well-being**.

The client, applying newly learned strategies and skills, will bring about **change in the environment and social reality**.

# SSLD Outcome

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1. Clients acquire more options through expanding their repertoire of strategies and skills
2. Client goals achieved, needs more effectively met
3. Previous strategies, which are ineffective or inappropriate, are no longer necessary
4. Client action brings about change in the environment and social reality, personal and/or collective
5. Client self-efficacy (agency, autonomy) enhanced
6. Clients become less dependent on practitioner
7. Clients can become leaders, instructors or coaches, and help others

# More Information & Contact

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SSLD Website: <http://ssld.kttsang.com>

ICCP: [http://kttsang.com/about\\_diversity/XCCP\\_summary\\_090220\\_1.pdf](http://kttsang.com/about_diversity/XCCP_summary_090220_1.pdf)

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Watch out for the new book !!!

Tsang, A.K.T. (forthcoming). *Social Skills Training and Beyond: Learning to Change Lives through the SSLD Approach.*