Individual and Family Issues in Intercultural Therapy: A Culturally Centred Perspective

Sandra A. Rigazio-DiGilio
University of Connecticut
Allen E. Ivey
University of Massachusetts

Abstract

To provide culturally-sensitive mental health services, clinicians must transcend the culture-bound assumptions implicit in traditional theories of counselling and psychotherapy and enter the unique worldviews of their clients. This article will describe two models of counselling and psychotherapy which are based on a synthesis of developmental theory and multicultural counselling theory with a co-constructivist epistemology. Developmental Counselling and Therapy (DCT) provides a culturally centred treatment framework for work with individual clients. Systemic Cognitive-Developmental Therapy (SCDT) extends the developmental framework to work with partners, families, and wider social groupings. Using these two models, the authors present five principles aimed at helping clinicians to expand their own understanding of self and client worldviews and to develop more culturally centred treatment practices.

Résumé

Pour effectuer la provision des services de santé mentale sensibles aux différences culturelles, il est nécessaire de transcender les croyances culturelles implicites dans les théories tradition-nelles de counseling et de psychothérapie. Il est aussi nécessaire pour les conseillers de pénétrer les mondes uniques de leurs clients. Cet article décrit deux modèles de counseling et de psychothérapie qui sont tirés de la synthèse de la théorie développementale et de la théorie de consultation multiculturelle dans une épistémologie co-constructiviste. Le counse-ling développemental et la thérapie (Developmental Counselling and Therapy, DCT) offrent un traitement dans un cadre interculturel pour aider des clients individuellement. La thérapie développementale-cognitive systémique (Systemic Cognitive-Developmental Therapy, SCDT) élargit le cadre développemental pour s'appliquer aux conjoints, aux familles et à d'autres groupes sociaux. Les auteurs utilisent ces deux modèles pour élaborer cinq principes dont le but est d'aider les conseillers à élargir leur compréhension de leur propre monde et aussi celui de leur client, et afin d'aider les conseillers à développer plus de traitements basés sur une sensibilité des différences culturelles.

Marshall McLuhan's concept of a Global Village has become a reality, and many of our daily interactions now reflect an intercultural quality. At work, we manage a diverse labour force (Markowitz, 1994). In education, we search for curricula that are multiculturally sensitive (D'Andrea & Daniels, 1991; Hilliard, 1991; Sleeter, 1991). Even at home, media news is increasingly international, as leaders attempt to define a new world order. The effects of world-wide communication and the infusion of racially, culturally, and ethnically diverse individuals and families[1] impact even our most remote communities.

Mental health professionals must now provide services within an inter-cultural context. However, while we tend to acknowledge the limits of

both traditional theories and approaches and of our own culture-bound assumptions, we have not yet gained sufficient knowledge regarding how to tailor services to diverse clients,[2] nor how to recognize how our own cultural filters affect our assessment and treatment practices.

Fortunately, there has been an increase in articles and books (Cheatham & Stewart, 1990; Ibrahim & Arredondo, 1990; Pedersen, 1991a; Ridley, Mendoza & Kanitz, 1994) and special journal editions (e.g., *Journal of Counseling and Development*, 1991; *The Counseling Psychologist* 1994) that encourage clinicians to revisit their culture-bound assumptions and learn intercultural frameworks that will challenge and enrich their current theories and practices. For example, many authors have provided information regarding how clinicians can recognize the fact that seemingly idiosyncratic individual and family cognitions and behaviours are actually expressions of a larger heritage that should be accounted for in the therapeutic process (Ivey, Ivey & Simek-Morgan, 1994; McGoldrick, Pearce & Giordano, 1982; Pedersen, 1991b). Others provide ways for clinicians to re-examine their own culture-bound assumptions, theories, and approaches (Atkinson, Morten & Sue, 1989; Falicov, 1988; Ivey, 1994; Pedersen, 1988; Wehrly, 1991; Wrenn, 1985).

This article provides one developmentally-oriented, co-constructive alternative that clinicians can draw upon to re-evaluate the role of culture as it impacts on the assumptions and tools of their trade on the therapeutic relationship. We contend that the cultural background[3] of the clinician and client must be accounted for in a new definition of mental health service, a definition that must lead to culture-centred therapy (Falicov, 1988; Nwachuka & Ivey, 1991; Pedersen & Ivey, 1994; Rigazio-DiGilio & Ivey, 1994). The general tenets of Developmental Counselling and Therapy (DCT) (Ivey, 1986, 1991) and Systemic Cognitive-Developmental Therapy (SCDT) (Rigazio-DiGilio, 1994, in press; Rigazio-DiGilio & Ivey, 1991, 1993) are first presented. Culturally sensitive treatment concepts are then illustrated using basic theoretical constructs underlying these two models.

DCT AND SCDT: OPENING THE WINDOW TO CULTURAL IDENTITY

DCT is a method of individual treatment that integrates developmental theory directly with therapeutic practice. SCDT represents a reinterpretation of DCT to therapy with families. Together, DCT and SCDT offer nonpathological, developmental, co-constructive, and integrative frameworks that are used to treat individuals, families, and larger social units.[4]

Essentially, DCT and SCDT posit that clients recycle through metaphorical reinterpretations of Piagetian stages of cognitive development (i.e., sensorimotor, concrete, formal, and dialectic/systemic) as the demands of their own development, situations, and socio-cultural environments change. The difference between Piagetian conceptualizations and

DCT and SCDT is that the four stages are not viewed from a linear and hierarchical perspective in DCT and SCDT. Rather, these states are viewed as four unique cognitive-developmental orientations that clients draw upon to experience, understand, and operate in their worlds. While clients can usually access a variety of orientations, it is also true that, at any given time, or in response to specific circumstances, they tend to rely on a predominant orientation that is easily identified in the natural language of the therapeutic dialogue. In fact, clinical and empirical evidence indicates that an individual's primary orientation and a family's collective orientation can be identified in the natural communication patterns that occur during therapy (Ivey & Ivey, 1990; Rigazio-DiGilio, 1994; Rigazio-DiGilio & Ivey, 1990, 1991).

Each orientation has value in its own right, providing individuals and families access to particular emotional, cognitive, and behavioural resources. Each orientation also has constraining qualities, especially when clients are unable to access resources inherent in other orientations, when they are unable to access orientations most in sync with developmental and situational tasks, or when they have not built a sufficient degree of mastery in a particular orientation. Basically, the more orientations a client can access, the more emotional, cognitive, and behavioural options are available. In contrast, when orientations are less available to clients, the range of cognitive, affective, and behavioural options is quite narrow. This point is given further elaboration in the following illustration.

Illustration 1. Clients who access the sensorimotor orientation count on direct sensory experience to understand and relate to one another and the environment. Those who over-rely on this orientation may become overwhelmed by slight variations in the environment. Clients who access the concrete orientations can view the world as a predictable flow of actions and consequences, and can act in an organized fashion. Those who rigidly rely on this orientation use linear descriptions of events, with little accompanying affect, analysis, or reflection. The abilities of reflection, pattern recognition, and abstract thinking are available to those clients who have access to the formal orientation. They rely on pattern recognition and abstract thinking to make sense of the world. Clients who analyze their issues, but are unable to act on or change these issues, or who "talk about" versus "experience" feelings, are over-relying on this orientation. Using the dialectic/systemic orientation, clients can understand the interrelated connectedness of their contexts and can rely on systemic thinking to develop complex views of the situations they deal with. If they cannot access other orientations, their views may simply be too overwhelming to decipher.

As can be seen, DCT and SCDT eschew the traditional notion that higher is better. Rather, each orientation is viewed as unique and useful

in its own right, depending on the issues clients are working through at the moment. One of the goals of DCT and SCDT is to assist clients to gain mastery using the resources available within each of the orientations so that they may effectively adapt to changing circumstances and environments.

The developmental and co-constructivist philosophies undergirding DCT and SCDT further suggest that culture permeates development and that our developmental and cultural histories shape our worldview. Clients co-construct their worlds of reality in a constant person-environment dialectic transaction (cf., Ivey, Gonçalves & Ivey, 1989; Harland, 1987; Harre, 1983). That is, clients co-construct their realities through the reciprocal interaction of two main contexts—the cognitive-developmental orientations through which they filter their experience and the cultural and social constructions of their environments over time.

DCT and SCDT provide frameworks that can be used to understand the client's surface level of content of human and relational existence in light of the mental structures and interactional communications used to process information. In this fashion, cognitive-developmental orientations are considered the background, consisting of preferred patterns of reasoning, emotional expression, and behavioural enactment. The foreground of human and systemic interaction reflects the cultural implications of larger social units (i.e., family, community, society, ethnic heritage). How clients respond to developmental or contextual demands is governed by the orientation they are predominantly relying upon, the cultural filters used to process information, and the expectations for the particular situation, as shown in the following illustration.

Illustration 2. The failure to get a desired promotion might generate very different emotional responses from a North American, a Japanese, or a first generation Italian-American. Consider what would occur for these three males all operating from within a sensorimotor orientation. Reflecting Western culture, the North American might blame organizational politics or an incompetent boss for the failure to gain the promotion. This might promote feelings of anger and resentment towards the organization or authority figures within the organization. The Japanese worker, immersed in Eastern culture, might instead aim his anger at himself for the shame that the lack of promotion brings to his family. Finally, the first generation Italian-American might be attempting to reconcile feelings generated by the clash of two cultures, on the one hand feeling anger towards a discriminating society while on the other hand feeling embarrassment for not fulfilling the role of ideal family provider. While each employee is predominantly relating to the situation from a sensorimotor orientation, each response is dramatically different

due to the developmental and cultural heritage that is a part of their total worldview and to the actual context of the moment.[5]

The patterns and content of human and systemic language provide insight into the worldviews of individuals, families, and larger social systems (Rigazio-DiGilio, Gonçalves & Ivey, 1994). Language is then the window to the client's primary cognitive-developmental worldview, and DCT and SCDT provide organized, comprehensive, and easily learned and implemented methods (Borders, 1994) for classifying natural language patterns as these emerge in the here-and-now of treatment sessions.

As the next illustration shows, a clinician can begin to work within a client's worldview by assessing a client's primary orientation, the cultural mores that filter their experience, and the influential forces of the larger society. This can be achieved by designing and implementing developmentally and culturally sensitive treatment plans.

Illustration 3. Misunderstanding a client's primary orientation may result in a belief that her or his failure to engage in formal dialogue reflects resistance rather than a mismatch between clinician and client language. Misunderstanding the cultural mores governing a client's expression might result in misdiagnosis. For example, it is often the case that Italian-American females entering the emergency room during a crisis are diagnosed as histrionic, while Irish-American females, under the same circumstances, are often diagnosed as depressed. Finally, misunderstanding the male/female power differential reflected in abusive relationships or the failure of our laws to adequately protect the victim of abuse, a clinician may prompt change in a couple that could increase the likelihood of further violence.

It also is true that clinicians need to recognize how their primary orientations, cultural mores, and the larger socio-cultural forces influence their thinking, feeling, and acting. As Ibrahim (1985) points out, effectiveness in cross-cultural therapy is partly determined by how well helpers are aware of how their worldview influences the therapeutic relationship. It is therefore incumbent upon clinicians to be sensitive to the exchange of cultures and the effects of socio-cultural and institutional forces during treatment. In this regard, DCT and SCDT suggest that therapy be framed as a cross-cultural exchange experience that occurs within the parameters of a wider contextual field.

All therapy can be analyzed within this cultural transactional paradigm. To explicate this point, we now explore five central DCT/SCDT constructs as they relate to an emerging view of culturally centred therapy. This is a broad exploration, intended to help clinicians expand their own windows to understanding self and client worldviews and to develop more culturally centred treatment practices.

DCT AND SCDT CONSTRUCTS AND CULTURE-CENTRED THERAPY

Construct One: Information-Processing Theory Can Be Used to Understand Client Worldviews

Optimal treatment conditions exist when clinicians are able to identify and calibrate their clinical interactions to the predominant worldviews and socio-cultural and historical contexts of their clients. Information processing theory provides a conceptual map for understanding how people make sense of their world. Chief concepts are the co-constructive nature of schemata, and the multi-dimensional nature of the person-environment dialectic interchange.

Schemata are patterns of mental or physical activity clients rely on to acquire information about and interact with their environment. Operating as primary filters, schemata are pre-existing knowledge structures that help classify general features of objects, events, or situations (Rumelhart, 1980). These are culture-bound and influence us to go beyond given data to co-construct an interpretation of information (Hamilton & Ghatala, 1994).

Clients and clinicians possess particular schemata about all aspects of treatment. The appropriate behaviours and verbalizations to use and the value judgements associated with the issues promoting therapy are all manifestations of schemata which are brought into the session. Schemata can be conceived of as paths to a person's worldview. While a client's constraining schemata are often the focus of treatment, the constructive qualities of the clinician's schemata also must be addressed in order to conduct culturally centred treatment. All schemata originally result from culture-bound interactions with human and physical environments, and cultural prejudices are present in clinician and client conceptualizations.

Information processing theory (Blumenthal, 1977; Anderson, 1985) suggests that during every moment of our existence, we are making sense of our perceptions within a person-environment dialectic transaction. Figure 1 represents a two-person processing model for therapy which can be extended to several persons within a clincial context (Ivey et al., 1994). This model makes it possible to understand how thoughts, feelings, and behaviours are reinforced, constrained, or transformed within a wider interpersonal interaction that includes both the client's and clinician's developmental, cultural, and historical backgrounds.

Referring to this model, culturally centred treatment starts when clinicians are aware of the influence of their own cultural and family background. The short term focus is then to uncover and explore salient events and themes of the client's cultural and family background by using appropriate questioning techniques. The long term thrust is to establish a treatment environment that enables the client and clinician
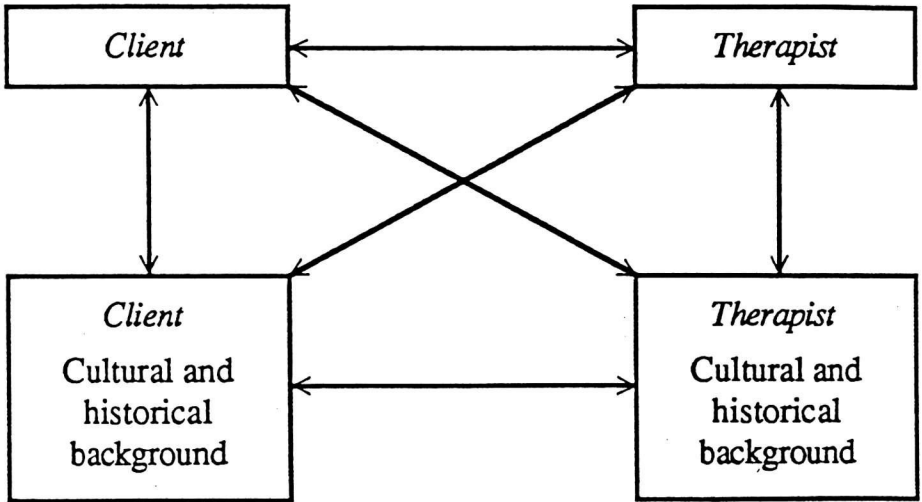
FIGURE 1
Cultural/Historical Background and the Therapy Process

to understand each other as both an individual or relational system and as a cultural being or system.

Construct Two: Piagetian Metaphors Can be Used to Access Client Worldviews

The Piagetian constructs of equilibration and cognitive developmental stages provide instructive information about the modification and transformation of worldviews. These two aspects of the construct are discussed below with practical illustrations.

Equilibration and client development. Equilibration describes how people maintain a sense of continuity over time (Piaget, 1954). As people interact with the socio-cultural world, they are faced with perceptions that are different than their existing schemata. People can respond in one of two ways to accommodate to or assimilate the discrepant data. Some schemata are more amenable to accommodative interpretations, promoting clients to review the views of the other. Other times the schemata are reinforced by adopting an assimilative style that alters discrepant data to fit a pre-existing interpretation. A balance between accommodation and assimilation propels clients to construct new frames of   reference   that can alter the cognitive orientation of pre-existing schemata. A change in schemata can lead to a change in a client's cognitive, affective, and behavioural options.

The equilibration metaphor helps to conceptualize the progress of therapy. Knowledge of a client's worldview concerning treatment issues can be gained by identifying what beliefs are accommodative or

assimilative. Using this information, clinicians can create culturally centred interventions that help clients move to more alternative, adaptive worldviews.

Illustration 4. An East Indian family was helped to broaden cultural expectations to account for the gender-role definitions to which the second generation East Indian-American children were introduced (i.e., an accommodative process). Initial sessions focused on understanding the different cultural orientations that each generation was trying to understand and synthesize (i.e., an assimilative process). It was found that East Indian values regarding unquestioning obedience were being challenged due to the family's exposure to American values regarding gender roles, independence, and self-reliance. A broader cultural more also surfaced in family dialogue, that is, the family's role in maintaining an atmosphere of intimacy and belonging, which was heightened due to societal oppression and discrimination. The goal of treatment focused on synthesizing learning from both cultures, using the family's values regarding belonging and intimacy as the stepping stone upon which such exploration could take place (i.e., balancing assimilation and accommodation). The resultant increased range of cognitive options significantly reduced the conflictual tension. The parents were able to understand and support their daughter's desire to become an engineer and their son's desire to become a teacher. They could also provide an environment where their children could develop self-worth despite the lingering effects of discrimination. This synthesis assisted the parents to maintain their role in the hierarchy while also facilitating the opportunity for the children to excel in their chosen fields.

Equilibration and clinician development. It also is important to determine what ideas within the clinician's schemata of therapy are accommodative or assimilative. Which culture-bound beliefs are most open to change? Is the clinician aware of the cultural implications of schemata relating to uses such as expectations for client disclosure or compliance? What type of reactions are triggered when clients respond in ways that are contrary to clinicians' culturally derived expectations? Unsuccessful or premature terminations can sometimes be traced to the unconscious, yet observable reaction of the clinician (i.e., those reactions that send messages such as "that behaviour is not acceptable here").

If clinicians are going to be able to assist clients from a wide range of cultural backgrounds, clinicians need to be sensitive to their own existing schemata. Intercultural education, continuing education, and supervision are helpful tools to assist clinicians in this endeavour (D'Andrea & Daniels, 1991; Garcia, Wright & Corey, 1991; Ivey & Rigazio-DiGilio, 1991; Midgette & Meggert, 1991; McRae & Johnson, 1991; Sue, 1991).

Cognitive-developmental orientations and structures. As previously stated, the primary schemata influencing the client's worldview can be categorized within four orientations. Where equilibration helps identify the rigidity or permeability of the client's worldview, the four orientations provide insight into the range and focus of the conceptual, emotional, and behavioural resources available to the client at any given point in treatment or in regards to a particular topic. For some topics, clients may rely on schemata firmly embedded within one of the four orientations (rigid structures), while, for other topics, they may be more flexible, using the same schemata but from the vantage point of several orientations (flexible structures). Finally, some clients may haphazardly and ineffectively draw from a variety of orientations to understand and act on a particular situation or event (diffuse or underdeveloped structures).

The choice of preferred orientation often reflects wider cultural expectations. All cultures communicate to its members acceptable ways of perceiving and making sense of the world. It should also be noted that within-culture differences also can be identified along lines of gender, socio-economic status, generation, and the like. Culturally centred therapy seeks first to identify the orientation of the client's worldview and then to work within that orientation to facilitate growth. DCT and SCDT provide detailed descriptions of assessment techniques (questioning strategies and linguistically-oriented cognitive-developmental profiles) that can be used to ascertain the client's predominant orientation in the immediacy of the therapy session.

Clinicians must also be aware of the primary orientation they are using and expecting in therapy (Rigazio-DiGilio & Anderson, 1995). For example, many therapy approaches are primarily geared towards a combination of formal and concrete orientations (see Ivey, 1986). Clients responding within this range are often viewed as model clients and experience higher rates of success and satisfaction with treatment. Clients relying on sensorimotor or dialectic/systemic orientations may be excluded from the benefits of "the talking cure." Culturally centred practice holds that the clinician is the one who must adjust the therapy environment to meet the preferred orientation of the client.

DCT and SCDT treatment environments. DCT and SCDT identify four therapeutic environments associated with each cognitive-developmental orientation. Each environment reflects a therapeutic style, a set of DCT and SCDT questioning strategies, and a set of therapeutic techniques conducive to work within an associated orientation. The environments help clinicians tailor interventions consistent with a client's predominant orientation (i.e., style-matching) or which encourage clients to explore ancillary orientations (i.e., style-shifting). The four types of environment are described in the following illustration.

Illustration 5. Environmental structuring offers a context for clients to be in direct contact with their affective sensations and sensory-based experiences. Interventions either amplify emotional expression or restrain chaotic affective experience. The intention is to co-construct a safe environment that facilitates effective expression of emotions and assists clients to gain mastery of this articulation process. The coaching environment facilitates clients to explore issues within a cause and effect perspective, by encouraging them to share stories and to analyze antecedents and consequences. Clinicians directly model and teach to help clients to understand and gain control over their feelings, thoughts, and behaviours. The consulting environment is co-constructed to facilitate a reflective process, promoting clients to identify patterns within their thoughts, feelings, and interactions. Clinicians emphasize the mutual relationship between clinician and client, validate client perceptions and help the client to enhance formal reasoning skills. The collaborating environment facilitates the exploration of ideas and concepts that penetrate the ontological nature of individual and collective worldviews. This environment supports the co-construction of multiple understandings about actors, actions, and contexts. Clients and clinicians work as colleagues to examine contextual forces (e.g., gender, culture, socio-historical patterns) that might be operating within the environment and the therapeutic process.

Thus, knowledge of how to identify orientations and how to co-construct therapeutic environments to match and later extend these orientations makes it easier to facilitate clients' movement from one perspective to another within a culturally sensitive framework.

Construct Three: The Individual Develops Within a Family in a Cultural Context

No person is cut off from cultural events that shape the familial context (Breunlin, Schwartz & Kune-Karrer, 1993; Minuchin, 1974; Pinsolf, 1994). Culture is communicated through the family along the dimensions of time and space.

Culture is transmitted to individuals by family activities and communication. What a family does together communicates culturally acceptable expectations for individual and group interaction (Anderson & Sabatelli, 1994). In some cultures, competition and individual achievement are valued, whereas in others, interdependence and co-operation are cherished. These messages will be mediated by the family and will inevitably leave their mark on each individual.

Culture is also communicated over time as particular ways of thinking, feeling, and behaving and is passed on from one generation to the next (e.g., Roberto, 1992). In this sense current functioning can be explained in terms of its socio-historical context. The meanings of behaviours can be understood in terms of the client's ethnic heritage, developmental

history, and contemporary situation. By attending to client worldviews, clinicians can determine the "cultural footprints" of their clients' socio-cultural and developmental history.

Clinicians are not devoid of cultural constraints when conducting therapy. Every aspect of the therapeutic encounter reflects the clinician's culture (e.g., location, setting, treatment focus). Clinicians must be aware of the cultural connotations of their behaviour, their words, and their work environments. Unexpected client reactions may be triggered from the hidden cultural aspects of the clinician's work patterns and, as much as possible, clinicians should be conscious of the impact of these patterns on treatment.

For example, our gender socialization and our degree of gender-awareness may affect how we interpret the needs of men and women. A clinician, recently introduced to the liberating effects of egalitarianism, may push a couple from another generation or culture to assimilate new ideas, resulting in misinterpretation or premature termination.

Those involved in culturally centred therapy recognize the importance of familial and contextual influences. Whether treating individuals or families, the extended family, social groups, and living conditions will all impact therapy. These issues must be accounted for in treatment plans that are specific to the unique life-space of each client. Eco-systemic methods (cf., Amatae & Sherrard, 1994; Becvar & Becvar, 1994; Neimeyer & Neimeyer, 1994) and network therapy models (e.g., Attneave, 1969) provide two examples of treatment that integrate understanding of wider contextual influences.

Construct Four: Client Issues are a Result of Historical/Contextual Development

Therapists need to move from viewing client issues as pathological to framing issues within a developmental and co-constructivist context. The traditional, deficit-model is laden with cultural messages which place clinician over client, rob clients of their power to decide and to change, and reduce client humanity.

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*) published by the American Psychiatric Association (1994) is a case in point. This deficit-based diagnostic tool emanated from Western, Euro-American, individualistic perspectives and social values that are often presented as science. This view is well stated by Kirk and Kutchins' (1994) who argue that the *DSM-IV* [American Psychiatric Association, 1994] oversteps its bounds. They indicate its authors seek to define how we should think about ourselves, how we should respond to stress, how much anxiety or sadness we should feel, and when and how we should sleep, eat, and express ourselves sexually. Although people base these judgments on personal and social values, the psychiatric association tries to extend its professional jurisdiction over daily life by arguing that its

definitions are based on science. This mingling of science and social values is evidenced by gay activists who succeeded in having homosexuality dropped from the manual, Vietnam veterans who had post-traumatic stress disorder included, and feminists who had self-defeating personality disorder deleted.

It may soon be the case that multicultural groups and mental health advocates dispute some psychiatric labels as well, such as histrionic personality disorder and oppositional, defiant disorder. It may also be the case that these groups will seek to add diagnostic labels that describe the effects of behaviour such as racism and oppression. If the field continues to gather momentum towards a developmental, co-constructive frame, a more positive, growth-oriented perspective will take hold that will communicate that clients are not crazy or defiant and that clients do have the capability to overcome current obstacles.

DCT and SCDT guide clinicians to accept and acknowledge the logic of the client's worldview. These models frame distress as a non-pathological and logical response to the stresses and strains of historical and contextual development which result when discrepancies emerge between clients and their wider social contexts. Within this framework, many pathological reactions can instead be seen as rational reactions to irrational or discriminant situations (Ivey, 1991). Using this perspective, clinicians can construct developmentally and culturally sensitive treatment plans that assist clients to refocus their issues as developmental and contextual and to generate a greater range of options to work through these issues.

The role of culture is critical here. Governing what is acceptable and reinforced, cultural mores establish and value a narrow range of functioning. Alternative forms of functioning are then undervalued or considered deviant. People involved in these alternatives receive messages that they are deficient. These people may seek treatment for depressions, substance abuse, violence, psychosomatic problems and relational issues. Through culturally centred treatment, clients are helped to view the cultural implications of their situations and are supported to choose broader and more effective options for response.

Difficulties which clinicians encounter in their work also can be viewed from a developmental and contextual perspective. Some clinicians have not been supported in working through the natural conflicts that emerge when two cultures collide. Other clinicians may experience frustration in viewing clients from an equal perspective and from engaging in dialogue within the dialectic/systemic orientation. DCT and SCDT supervision models (Carey, 1988, 1989; Rigazio-DiGilio & Anderson, 1995) articulate the role of understanding clinicians' worldview in order to help extend their theoretical and therapeutic repertoire. Adopting a developmentally oriented perspective about both client and clinician

growth can lead to the generation of more options within or outside the dominant culture.

Construct Five: Treatment Involves Matching and Mismatching Client Orienta tions in an Integrated Treatment Plan

The client's worldview is the central diagnostic focus of culturally centred treatment. An understanding of this worldview, in terms of preferred orientation, cultural mores, and historical and socio-cultural influences guides the treatment process. DCT and SCDT outline systematic ques tioning strategies that clinicians can use to structure therapy environ ments which are culturally and developmentally sensitive. Additionally both models provide metatheoretical classification schemata that can be used to integrate more traditional approaches to therapy. Both models suggest that clinicians draw upon these assessment and treatment strate gies to design treatment plans that are guided by identifying and mon itoring changes in client worldviews as communicated directly in therapy sessions.

DCT and SCDT suggest that treatment is based on co-constructing clinical realities to promote development. Clients are reactors and ac tors, being affected by and influencing therapy and clinicians. The clinical reality is, in effect, a joint construction. Even if the clinician seeks to impose a view, the client, in reaction, must act on the feedback if a new internal schemata is to be constructed. This is a basic assumption under lying co-constructivist philosophy. Clinicians and clients are affected by and influence the reality of the other and, once in sync with one another, a clinical reality is co-constructed.

DCT and SCDT treatment first assists clients to complete developmen tal tasks within their primary orientation. To accomplish this, treatment interventions are presented that match the client's worldview. These interventions can be intended to generate either assimilative or accom modative responses depending on the goals of treatment, but the lan guage, cultural implications, and personal impact should be considered beforehand by the clinician.

Once a strong foundation within the client's preferred orientation is demonstrated, treatment shifts to assist the client to access resources within other orientations. By mismatching interventions to facilitate client explorations within alternate orientations, movement to other perspectives can be achieved. It is important to monitor the client's reactions during such transition periods. Sometimes an inability to make the shift may indicate that the client is not ready or that the task/inter vention was culturally inappropriate. The following illustration elabo rates on this clinical issue.

Illustration 6. An African-American family, primarily operating within a concrete orientation and well connected with their church, might find it

difficult to discuss their son's defiant behaviour in therapy. If the clinician provided behavioural directives, the parents might respond to this instruction as intrusive and demeaning. However, if the therapist joined the parents in co-constructing predictable and effective reactions to the child's behaviour, such concrete interventions, which also account for the family's discomfort with therapy, would be more respectable and respected. Further along in therapy, the clinician may believe it to be beneficial to move to the formal orientation, assisting the family to understand how their dynamics play out in other situations and to generalize solution-oriented behaviours to these situations. However, the family may take this as a boundary intrusion and expect the clinician to maintain a clear focus on the treatment issue. In this case, the family might leave treatment feeling intruded upon and misunderstood, rather than leaving with the successful results of the first phase of interventions.

Other times clinicians may assume that an intervention is aimed at one orientation while the client interprets it as a path to a different orientation. Again, the client's perception would be the ultimate compass that guides treatment within a culturally centred paradigm, as shown in the next illustration.

Illustration 7. Consider a clinician working with a Jamaican mother to educate (i.e., concrete orientation) her son's teacher that his looking down when being spoken to is a sign of deference rather than defiance. Once successful, the clinician asked the mother to reflect on what she did to assist her son (i.e., formal orientation). However, rather than speaking about the successful implications of parent-teacher collaboration and the need to continue this across situations (i.e., formal orientation), the mother expressed anger, resentment, and sadness regarding the cultural naïveté of the teacher (i.e., sensorimotor orientation). This signalled the clinician that sensorimotor explorations regarding feelings about oppression and culturally bound assumptions were necessary and relevant to the family's continued development.

CONCLUSION

While it is important to infuse our practice with interculturally oriented strategies and knowledge, clinicians are not expected to become cultural anthropologists. However, we need to adopt a position that places culture at the centre of human and systemic interactions and interpretations. Pedersen (1991a) identified four benefits of defining culture broadly within the therapeutic domain. Basically, by doing so, he encourages clinicians to:

1. More acurately match a client's intended and culturally learned expectations with the client's actual behavior.
2. Become more aware of how their own culturally learned perspectives predispose them toward a particular decision outcome.

3. Become more sensitive of the complexity in cultural identity patterns.

4. Track the ever-changing salience of a client's different interchangeable cultural identities within a therapeutic interview.

The intent of this article is to offer one perspective on how clinicians can assume a broad, culturally centred persepctive in their work. All clients should have the opportunity to express their idiosyncratic worldview within the safety of the therapeutic relationship. Additionally, clinicians must be aware of how their own culturally shaped worldviews govern their professional functioning, and they must safeguard the right of clients to not be quickly labelled and treated in a fashion that discounts their uniqueness.

The role of schemata and knowledge within the four DCT and SCDT orientations can assist clinicians to assess client worldviews. By recognizing that culture permeates all worldviews and that families are a major force of that worldview, clinicians can more directly account for cultural variances within their treatment plans.

In adopting a developmental and co-constructive rather than deficit model of client functioning, clinicians gain access to cultural data and how to use these data to design treatment plans that match and mismatch client orientations. The goal of culturally centred treatment is to help each client develop a wide set of options to draw upon to work through developmental issues. DCT and SCDT provide clinicians with a wide range of therapy options to conceive, implement, and monitor culturally sensitive therapy.

Notes

[1] From this point on, the term *"family"* will be used to represent the full spectrum of relational systems (e.g., partners, couples, intact families, blended families, single-parent families, etc.).

[2] For this article, the term *"client"* refers to individuals, partners, families, and larger social systems seeking mental health services.

[3] What we mean by *"cultural"* is the several types of contexts we carry within us. These include our *"inherited cultures,"* such as our race, our generation and the influential generations before us, our gender, our class, and our sexual orientation. These also include our *"acquired cultures"* such as our professions, any disabilities, and our specific family type or structure.

[4] The intent of this article is not to provide a comprehensive overview of DCT or SCDT, but rather to illustrate the intercultural potentials inherent in both models. Readers interested in learning more about either model are encouraged to read other available publications on the DCT and SCDT models. Many are mentioned in the reference section.

[5] The examples used throughout this article are not intended to stereotype cultural behaviour, but are presented to begin the process of analyzing human interaction in terms of both the cognitive-developmental orientations and the cultural and contextual influences affecting all human and systemic behaviour. The authors are aware that there is as much variation within the same ethnic group as there is among different ethnic groups. As such, no one generalization about a person's ethnicity, gender, age, education level, or socio-economic history holds up for all members of that group. While knowledge of the cultural values of the larger ethnic groups a client belongs to is critical to effective treatment (cf., Ibrahim, 1985; McGoldrick, Pearce & Giordano, 1982), how the client reflects or rejects these values is also important (cf.,

Falicov, 1988). It is therefore important to keep in mind that the unique individuality and existential life space of each client must be accounted for in assessment and in the development of specific treatment plans.

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About the Authors

Sandra A. Rigazio-DiGilio, Ph.D., is an Assistant Professor in the School of Family Studies/ Marriage and Family Therapy Program at the University of Connecticut, Storrs, USA.

Allen E. Ivey, Ed.D., is a Professor in the Counseling Psychology Program at the University of Massachusetts, Amherst, USA.

Address correspondence to: Sandra A. Rigazio-DiGilio, Ph.D., University of Connecticut, School of Family Studies/Marriage and Family Therapy Program, Box U-58, Storrs, Connecticut, 06269-2058.