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The Cultural Ecogram: A Tool for Enhancing Culturally Anchored Shared Understanding in the Treatment of Ethnic Minority Families

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Abstract

Ethnic and racial disparities in mental health care continue to exist, highlighting the increasing concern within the realm of clinical practice as to how clinicians are to effectively integrate the central role of culture and context into the treatment delivery process for culturally diverse children and families. The current paper presents the Cultural Ecogram, - a clinical engagement tool designed to facilitate the development of a culturally anchored shared understanding – as one method that may facilitate clinician-client shared understanding on the client’s cultural, ethnic and racial context central to the effective implementation of treatments with ethnic minority children and families.

KEYTERMS

culture; ethnic minority children; treatment; engagement; cultural competence

INTRODUCTION

Research continues to highlight a trend in which ethnic minority children and their families are less engaged in mental health services compared to European American families (Garland et al., 2005; Freedenthal, 2007; Miller, Southam-Gerow & Allin, 2008). While several underlying causes of this engagement disparity among ethnic minority families exist, one explanation may be because conceptualizations of mental health problems and their prescribed interventions often fail to encompass cultural and ethnic factors, which results in the inability to engage ethnic minority families successfully (Lau, 2006). For ethnic minority clients, when culture is overlooked in the therapeutic process, misunderstandings may arise, stemming from conflicting worldviews, values and goals, resulting in client discomfort and poor treatment engagement and outcome (Huey & Pan, 2010). Further, the centrality of culture is particularly pronounced in the case of child and family treatments, because expectations and norms for child behavior and parenting practices are often culturally bound, thus requiring the clinician to be proficient in conceptualizing the case within a

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cultural frame and identifying treatment approaches that are culturally consonant (Lau, 2006; Wintersteen, Mesinger, & Diamond, 2005). Thus, understanding the influence of culture is markedly important considering the profound effects it can have on the effective engagement and implementation of treatments for ethnically and racial diverse children and families (Cavaleri, Gopalan, McKay, Messam & Elwyn, 2010).

This emphasis in integrating culture within the therapeutic context has been paramount to clinical practice. Across disciplines, culturally congruent practice has been identified as fundamental to effective treatment engagement and delivery (e.g. NASW, 2007; APA Multicultural Guidelines, 2003). Despite this, the articulation of these competencies has largely been philosophical and theoretical, resulting in an ideological struggle in the area of methodology and systematic training and skills. In fact, scholars have argued that one of the biggest challenges to the field of cultural competence is the direct transfer of conceptual understandings of cultural competence to practice situations in which concrete skills are applied to address the complex cultural diversity of client backgrounds (Boyle & Springer, 2001; Lum, 2011). Empirical evidence suggests this, for example, Petrovich & Lowe (2005) found that abstract theoretical knowledge of cultural competence was less likely to be translated into practice skills for MSW students and alumni. Maxie, Arnold & Stephenson, (2006) found that practicing clinicians often do not engage in discussions regarding cultural, ethnic and racial differences with clients. These findings reflect the limited availability of concrete strategies that incorporate conversations about culture, race and ethnicity into therapy in a tangible manner (Cardemil & Battle, 2003); highlighting the need for a practical tools that facilitate the systematic integration of culture and context into the therapy process (Cheung & Leung, 2008; Furness, 2005; Garran & Rozas, 2013).

LITERATURE REVIEW

Cultural competence in engagement- the centrality of a shared understanding

Of the numerous approaches to infusing a client's cultural, ethnic and racial context within a therapeutic encounter, we focus on one central to client engagement- the development of a shared understanding of the client's problems and treatment needs anchored in his/her individually defined conceptualization of culture. This emphasis on the development of a shared understanding has been highlighted by several models of cultural competent practice – Green's (1999) help seeking behavior model, Sue's (2006) concept of scientific mindedness, Lopez (1997)'s domain of engagement in his culturally competent process model, and the domain of shared understanding in Fischer, Jerome, and Atkinson's (1998) model of multicultural competence. We review each model briefly in relation to our argument for the application of a clinical tool that enhances culturally anchored clinician-client shared understanding.

Green's (1999) model of help seeking specifies the importance of understanding the client's definition and conceptualization of their "problem", which is idiosyncratically embedded within a cultural frame. Green describes that one critical challenge to effective treatment engagement and delivery is the cultural distance between clinician and client that often is displayed in the discrepancies in which each agent conceptualizes, labels and responds to the problem at hand. Thus, gaining an understanding of the client's individualized definition of

their experience and problem as expressed by culturally specific semantic labels of a client's explanatory model is fundamental to culturally responsive treatment.

Sue's (2006) model of cultural competent process expands on this, by describing the therapeutic processes by which clinicians can develop a shared understanding of the client's culturally and contextually embedded definition of their presenting problem. Of his three dimensions of culturally competent process (scientific mindedness, dynamic sizing, culture specific expertise), scientific mindedness reflects a therapeutic approach of constructing a shared understanding with the client through a continuous cycle of developing client specific hypotheses and testing these hypotheses based on cultural data acquired from the client. In this process, the clinician must present both openness to learning and accepting of client-specific "data" as well as adaptive skills in synthesizing the information to create a client-driven view of the problem and goals for treatment. This weaving together a cultural framework via scientific mindedness enables the clinician to culturally adapt their responses and treatment approaches, which in turn, enhances their "credibility" in the eyes of their clients -a particularly salient characteristic for ethnic minority clients (Sue 2006). In this way, scientific mindedness guides the clinician to view problems from within the client's context and tailor treatment to their specific needs.

The salience of a shared cultural understanding is underscored also in Lopez's (1997) four domain model of cultural competent process: a) engagement, b) assessment, c) theory, and d) method. Lopez (1997) describes engagement as the clinician's ability to identify, accept, and develop an understanding of the culturally symbolic meanings that illustrate how clients conceptualize their presenting problems and their view of treatment. Here, the clinician's skills center on facilitating a cultural exchange that directs the discovery of client derived meanings of the "problem". The uncovering of these meanings then helps build a "culturally anchored shared understanding" that encapsulates shared definitions of the problem and goals for treatment. According to Lopez (1997), the shared understanding that is derived in the engagement stage is what guides the course of assessment, theory and method, since the application of culturally congruent assessment and treatment approaches rests on a cultural and/or contextual shared understanding of the client's presenting problem.

Using a broader framework, Fischer, Jerome, and Atkinson's (1998) model of multicultural competence identifies a shared worldview between the client and clinician as a central domain. The shared worldview is described as a common framework between the therapist and client that allows for the therapist to conceptualize the problem in terms of the client's worldview. The transcultural perspective of a shared worldview emphasizes the sharing of similar languages, thought processes, understandings of causative forces in the client's world and conceptualization of mental health problems (Torrey, 1986). According to Fisher et al (1998) it is only when the client's problem is conceptualized in terms of his/ her worldview, the path opens for positive client expectations for change and a successful cultural tailoring of treatment.

The skill sets proposed by these models suggest that the development of a client driven, culturally anchored shared understanding is fundamental to culturally competent approaches to engaging ethnic minority clients in the course of therapeutic success. However, despite

these advances in conceptualizing cultural competent therapeutic processes that foster a shared worldview, concrete steps of how to put into practice these competencies remains obscure. As a response, we introduce the Cultural Ecogram as one method that facilitates clinician-client dialogue on the client's cultural, ethnic and racial context, values and goals central to treatment.

The Cultural Ecogram: Building on foundations of ecomaps, genograms and culturagrams

The field of social work has pioneered in the development of clinically effective approaches to assessing the family context. As concrete clinical methods, ecomaps and genograms have provided practical methods of understanding families in their environment by mapping out linkages between systems or persons within the microsystem as well as the nature of these relationships (Hartman, 1978; McGoldrick, Gerson, & Shellenberger, 1999). More recently, Congress (1994, 2008) addressed the need for integrating the role of culture and developed the culturagram, a family assessment instrument that examines the family's sociocultural context in 10 domains (e.g. legal status, language, health beliefs etc). Used extensively in practice, these tools have paved the way for clinicians to practically assess and organize information on the family's cultural and ecological systems that directly or indirectly affect treatment delivery (Congress, 2008; Hodge & Williams, 2002; Mattaini, 1995).

In a similar manner, the Cultural Ecogram (CE) applies the use of visual tools to gather information about the ethnic minority family's culture and context however, with a central goal of establishing a shared understanding of the parent's view of their child's presenting problem that is defined by their individualized cultural framework. Developed by the first author, the CE is an interactive tool that uses visual pictorial aids (i.e. magnetic pictures depicting influences) as a press to a) elicit clients' responses or "data" on cultural, social and economic influences that impact their parenting, and b) open a dialogue between the client and clinician in which salient cultural and ecological influences are considered in the joint process of identifying problems and developing targeted goals for treatment; thereby facilitating the development of a client driven cultural framework that guides treatment. Stemming from the theoretical perspective that culture is infused throughout the various systems or levels of the ethnic minority client (Garcia-Coll et al, 1994), the CE aims at capturing an individualized definition of culture that anchors the family's understanding and experiences of their presenting problem (e.g. child problem behavior). In essence, the CE aims at extracting culturally nuanced experiences, behaviors and beliefs through the narratives elicited by client selected choices of personal, cultural and contextual factors. Thus, compared to the ecomap, genogram or culturagram that utilized specified frameworks for clients to share cultural and contextual information, in the CE, the client essentially builds an individually defined cultural framework through selection of personalized responses.

Specifically, the CE uses a range of pictorial cues depicting various cultural and ecological influences which the client identifies specific "influences" and "barriers" that shape their views, beliefs and practices in raising their child (see Figure 1). This approach, in which the client is given a directive role in selecting the conversation topic in session via their selection of "influences" and "barriers", facilitates two important processes in developing a

shared understanding - first, it naturally positions the client as an active partaker in the therapeutic process, thereby enhancing his or her level of engagement in the treatment process, and second, it gives liberty to the clinician to target clinical probes that elicit culturally and contextual relevant information related to the chosen influences/barriers that may typically be ignored or unaddressed. As such, the CE gathers salient ecological and culturally salient views, practices, beliefs of the client via the interactive dialogue between the clinician and client, which a) sets the therapeutic foundation for open exchange, and b) builds an overarching framework of shared understanding that guides collaboration in identifying problems and goals for treatment. In this way, the CE helps develop a critical foundation for the therapeutic relationship.

Process Skills for the Cultural Ecogram

A central feature of the CE is that it is a clinical tool that capitalizes on foundational skills of counseling. The basic skills of showing a genuine interest, active and empathic listening, attending to client responses and reactions, eliciting and tracking client responses through use of reflective listening or paraphrasing, summarizing and asking for feedback - are central to any therapeutic interaction (Ivey & Authier, 1971, Rautalink, Lisper & Ekehammar, 2007); and it is these skills that are utilized in the delivery of the CE. Although the CE does emphasize three main process skills (see below); it should be noted that all of these are based in core counseling skills that establish clinician-client therapeutic alliance. Thus, one of the advantages of the CE is that it can be used by all clinicians who have the basic foundational skills of counseling; lending itself as a clinical tool that can be used by trainees as well as seasoned clinicians.

A “learner” attitude and genuine interest—The CE is the gateway to developing rapport and building therapeutic alliance with the client. Since the CE is aimed at eliciting the client’s personal views and experiences of child rearing which can often be sensitive and personal, the clinician should demonstrate active display of empathic understanding and a genuine interest in learning the client’s unique cultural perspectives of child rearing and parenting. It is important that the clinician displays the attitude of a “learner” in which they communicate their naïveté of the client’s culture in order to sensitively approach often overlooked conversations about culture, race and ethnicity. This is critical in diffusing the power difference between the therapist and client as well as distinct cultural and social boundaries that may interfere with the development of therapeutic alliance. Central therapeutic processes for communicating the approach of a “learner” are:

- Responding empathically throughout session
- Communicating a genuine interest in learning about the client’s cultural background (e.g. values, traditions, beliefs)
- Sharing one’s naïveté regarding the client’s culture and cultural experiences

Eliciting client responses (client data) and active listening (developing hypotheses)—The CE targets two levels of information the clinician extracts from the client – the holistic and specific. The holistic level involves overarching themes of the client’s parenting worldview shaped by the selected influences. The specific level elicits

specific and concrete examples of parental responses and reactions to child behavior that stem from or are related to the chosen influences. Through scientific mindedness (Sue, 2003), the clinician should integrate active listening with the use of targeted clinical probes that press for “client cultural data”, followed by applying this new “data” to test formulated hypotheses about the client. The continuous “data” gathered through active listening and probing is applied and reapplied to the clinician’s developing hypotheses. This cycle of “data gathering & hypotheses testing” allows the clinician to balance his/her culturally based perceptions with the newly acquired data provided by the client, and it is through this process that the clinician comes to understand the idiographic experiences of the client – both as an individual and as a member of a cultural group - which guides cultural tailoring of treatment.

Central therapeutic processes to eliciting client data and constantly revising and solidifying their conceptualization of the client as a culturally embedded individual include:

- Responding to the client’s core themes that reflect their cultural context.
- Listening attentively and try and hear the themes of the messages and use these core themes to communicate with your client
- Verbally communicate your understanding and affirmation of the client’s self-experience

Confirming the client’s cultural frameworks—Achieving an accurate conceptualization of the client’s cultural framework involves the clinical practice of using culturally consonant communication to reflect back a summary of the hypothesized cultural framework. This process consists of conveying an acquired understanding of the client’s self-experience through affirming the client’s cultural experiences and using language that is culturally congruent and easily understood. The clinician should demonstrate to the client that s/he accepts and understands the client’s unique experiences, views, beliefs and communicate through affirmation of the client’s culturally specific experiences. Central therapeutic skills in testing cultural hypotheses through culturally congruent communication are:

- Summarizing the cultural hypothesis – inquire in the form of a question
- Communicating the clinician’s “learner” status in the communication of the hypothesis
- Using cultural language and forms of communication easily understood by the client
- If misunderstanding occurs –ask directly about the accuracy of the hypothesis and follow the client’s lead in helping better understand their view

In this manner, these central processes foster the foundation for a cultural exchange to take place through the gathering of client data and sharing one’s understanding via hypothesis testing while portraying a genuine interest.

IMPLEMENTING THE CULTURAL ECOGRAM: A CASE ILLUSTRATION

To demonstrate how the CE facilitates a shared understanding of client cultural and contextual influences on the presenting problems and goals for treatment; we provide a case example of the application of the CE.

Juanita is an 11 year old Mexican American girl referred to clinical services by the school counselor due to concerns about her defiance and academic performance at school. Juanita's mother, Maria reported that her daughter has had numerous conflicts with teachers and is constantly arguing with her at home. Juanita's grades have slipped and Maria is concerned that her extracurricular activities have negatively affected Juanita's focus on academics as well as her role in the family. Juanita lives with her mother Maria and younger sister Emelda, who is 7.

Maria was reserved in her speech and appeared defensive during the intake procedure. While reporting verbal commitment to participating in treatment services for Juanita, on numerous occasions, Maria indicated her disagreement as to why she should also engage in treatment. Maria reported that she does not believe that Juanita needs psychological services, but that she just needs more discipline. She stated that parenting is not an issue, rather, that Juanita just needed to "come to her senses to put family first".

Step 1: Introducing the overall session agenda & the Cultural Ecogram

At the beginning of the treatment session, Maria's clinician provided an overview of the overall structure of the session. The purpose of CE was described as an opportunity to develop a shared understanding of Juanita's problems and collaboratively identify appropriate goals for treatment. The clinician emphasized that working together to build a shared framework was necessary because they come from different backgrounds and worldviews and therefore, may not initially see Juanita's presenting problems in a similar manner. The CE (See Figure 1) was presented as an interactive activity that facilitates the building of a shared understanding through the use of pictorial cues that guide an open discussion of areas of the clients' lives that influence parenting practices and experiences of families. The clinician explained to Maria that learning from her about Juanita and their familial context is essential for building a partnership in developing mutual and shared perspectives on Juanita's problems and needs for treatment.

Step 2: Specific steps for the Cultural Ecogram

Ecological and cultural influences on parenting—The clinician asked Maria to choose 3 or 4 major influences (depicted pictorially) that she believed impacted her in learning how to raise children/being a parent. Maria selected the following influences: a) her parents, b) church, and c) extended family. Starting with the first selected influence, the clinician used select probes aiming at how her parents shaped her as a parent or ways she parented Juanita.

General Theme Probes: Eliciting overarching themes of the client's parenting worldview: In this initial step of the CE, the clinician elicits overarching themes of parenting related to the selected "influences" on following dimensions:

- Values, beliefs, attitudes about particular parenting practices
- Culturally anchored parenting practices
- Ideal ways of parenting

Using the visual prompts from the selection of influences, in a guided dialogue, the clinician probed Maria for how the selected influences generally impacted her parenting practices and beliefs. As Maria shared how her parents, church and Mexican culture influenced her view of parenting, themes emerged, reflecting salient culturally specific values and beliefs that appeared to govern her parenting behaviors (Table 1). For example, in describing how she was raised by her parents, Maria frequently noted the strong emphasis of placing the family first displayed in the strict adherence to family rules or fulfilling familial obligations above one's needs or desires.

Specified Probes: Eliciting concrete examples, specific perspectives: After successfully eliciting overarching themes of Maria's view of parenting, the clinician proceeded to ask for specific information on how these influences impacted Maria's actual parenting behaviors. In this step, the clinician is required to ask for specific examples of child or parent behavior (e.g. not listening, defiance). Eliciting specific examples and discussing concrete behaviors is an essential step, as it captures cultural influences on *actual parent behavior*, which can be operationalized through the mutual dialogue between the clinician and client. The clinician should apply the holistic themes of culturally anchored views of parenting to guide how culture and context shape the parent's day to day parenting practices in the following domains:

- Parental perspectives, attitudes and behaviors in regards to:
 - Child misbehavior as defined by client culture
 - Culturally anchored behaviors parents encourage in their child
 - Child behaviors encouraged within the client's culture

Drawing from the general cultural themes that emerged, the clinician extracted specific examples of Maria's parenting practices (Table 1). Probing for concrete examples facilitated the clinician's understanding of how cultural values of respeto and familism guided Maria's authoritarian approach to responding to Juanita's noncompliance and argumentativeness as well as her belief that Juanita should spend time helping the family than engage in after school activities. Acquiring this cultural insight was critical in understanding Maria's initial defensiveness regarding treatment, leading the clinician to reframe her parenting from her cultural perspective.

Barriers to Parenting—Parallel to the process of eliciting client cultural influences, the clinician asked Maria to choose one or two major barriers that she believed challenged her in effectively parenting their child/children. Maria selected the following: a) school system, and b) single parent. Starting with the first barrier, select probes were used to examine how these barriers challenged her parenting.

General Barriers Probes: Eliciting overarching effects of barriers: In this step, the clinician elicits overarching themes of how the selected barriers impact parenting behaviors on:

- Impact of barriers on managing child's behaviors
- Impact of barriers on parent self-efficacy
- Impact of barriers on parental resources
- Cultural perspectives on barriers to parenting

As Maria shared her frustrations regarding the barriers with the school system, themes of discrimination and cultural barriers emerged. Maria perceived the school as unhelpful, and prejudiced against Latinos which led to her distrust in the validity of the school's referral for Juanita (see Table 1). Gaining this perspective was critical for the clinician to approach Maria's resistance to engaging in treatment with empathy by acknowledging her ambivalence as stemming from the discrimination she encountered with the school system.

Specified Probes: Eliciting concrete examples of how barriers interfere with effective parenting: Similar to the influences, the clinician proceeded to probe for specific information regarding the challenges of parenting that stem from the selected barriers. The following areas were elicited:

- Unsuccessful examples parenting and its relation to the cultural context
- Examples of difficulties due to selected barriers
- Examples of socioemotional and economic impact of the barrier on the child and family

Eliciting specific examples of Maria's struggles with the school informed the clinician to display cultural sensitivity in helping Maria address how the experiences of discrimination negatively impacted her interactions with Juanita. For example, the clinician was able to engage Maria in a dialogue about her struggle of wanting Juanita assimilate (e.g. telling her not to speak Spanish at school) but desiring her to maintain her cultural identity which is displayed in Maria's insisting Juanita to put family first (e.g. restricting Juanita's time with peers).

Step 3: Summarize the overall influences and barriers the parent has shared and elicit feedback

At the end of the engaging in a cultural exchange with the client regarding the influences and barriers that shaped parenting beliefs and practices, the clinician summarizes the main messages from each domain (i.e. influences, barriers). Summarizing is critical for the CE because it a) allows the client to hear the clinician's understanding of the impact of their influences/barriers on their parenting, b) provides an opportunity for the client to provide feedback to possible misunderstandings by the clinician, c) enhances client trust by the experiencing the clinician's genuine interest in the client, d) helps the clinician to identify and retain (in memory) key cultural or contextual aspects that are pertinent to treatment, and

e) solidifies the shared understanding that guides the identification of presenting issues and approaches to treatment within the client's cultural frame.

After completing the CE, Maria's resistance to treatment appeared to decrease, as demonstrated in her comments of enthusiasm in working together with the clinician to help Juanita adapt to the different expectations of home and school. In particular, Maria requested one of the treatment goals to be for her and Juanita to discuss differences between American and Mexican cultures and together, identify skills that will help Juanita succeed in the American system that will not require her to fully compromise on her cultural beliefs.

Step 4: Integrating cultural influences and barriers into treatment

A final step of the CE is the use of the worksheet in consecutive treatment sessions. The worksheet lists the client's presenting problems and treatment goals followed by the influences and barriers identified in the initial CE (see Appendix I). This is important, as the mere practice of reviewing this form will help the clinician prepare consecutive sessions in line with the defined goals and the cultural/contextual influences and barriers identified by the CE. The worksheet focuses on using the CE to identify appropriate skills and strategies to target presenting problems and treatment goals, and areas where cultural adaptations to specific skills and strategies are necessary to the existing treatment. Adaptations should logically stem from the influences and barriers reported by the client during the CE – in this way, treatment approaches are based on the conceptualization of the client's cultural context derived from the CE.

In the case of Maria and Juanita, the CE helped identify a treatment goal that specifically centered on building knowledge and skills in regards to successfully navigating American and Mexican cultures. In alignment with this goal, consecutive treatment sessions involved psychoeducation on the process of acculturation for different generations (i.e. immigrant versus American born), identification of realistic expectations for Juanita's involvement at home and school that align with Maria's desire for her to succeed in American culture (e.g. engaging in extracurricular activities with peers) and implementation of strategies that reinforce Juanita's behavioral attempts at meeting identified expectations (e.g. positive reinforcement of Juanita's compliance to teachers, caretaking of her younger sister, scheduling family versus peer time to enable Juanita to connect with family and friends). In this way, the CE guided the cultural tailoring of the treatment, leading to active engagement and treatment outcome for the family.

CONCLUSION

Challenges to Implementation

While the CE has potential benefits as a clinical tool to enhance cultural competence, we also recognize that the tool may not be applicable for all families. During the development of the CE, one of the most frequent challenges was parents initially questioning the rationale for conducting the CE as the first activity in treatment since their desire was to promptly gain expert advice and skills that would lead to immediate solutions for their child's presenting problems. This initial resistance is reflective of Sue's (2006) concept of achieving

credibility through gift giving (giving clients a direct benefit from treatment) that may be particularly relevant among ethnic minority families who tend to perceive psychotherapy services with limited credibility. Learning from this, we modified our training to require clinicians to provide a very explicit rationale of the CE before implementation - that developing a shared understanding of their child's presenting problem is critical for clinicians to determine the best strategies or skills to meet the needs of their child, and that the teaching of skills or providing advice without such understanding can result in ineffective and inefficient treatment overall.

Another challenge we experienced earlier on was ensuring that the clinicians connect the conceptual cultural concepts derived from the client narratives tied to their selected "influences" or "barriers" to specific examples of the client's own parenting behavior or child's behavior. While having an understanding of the holistic framework of the client's individually defined culture is critical in mapping out treatment approaches, much of intervention work with families occurs at the specific behavioral or cognitive level (e.g. use of time-outs for temper tantrums), which requires an understanding of specific cultural manifestations of actual behaviors or cognitions unique to the client. Such has resulted in our manual and training a strong emphasis on eliciting actual examples of client behavior that are expressions of their cultural frame as it is these very behaviors that interventions may target.

Implications for Practice and Research

As the diversity of children and youth increases, efforts in attending to the role of client culture and context is needed to the guide clinicians in the effective implementation of treatments that adequately address contextually embedded client needs as well as a means to increase ethnic minority engagement in treatment. The CE presents a tangible tool that addresses this through developing a culturally anchored shared understanding and facilitating clinician-client exchange.

The practical aspects of the CE are several. First, it is a basic tool that may be particularly helpful for the training clinician who may have had limited contact with culturally diverse populations as it centers on eliciting culturally salient information key to treatment. Because the CE directs the client to identify cultural influences they view as central to their presenting problem through the use of visual cues, it inherently prompts the client to a discussion of "cultural" influences, thereby opening a door for the discussion of sensitive topics that may have been overlooked or neglected in an initial treatment session. The information derived from these discussions then become integral in tailoring the treatment to the client's cultural context. For example, one clinician shared that he was able to make better decisions as to what intervention skills worked for the family because of the cultural information gained in the CE. Second, it sets the stage for a collaborative approach to treatment which is central to building a strong therapeutic alliance. The stance of the CE is that the clinician takes an active attitude as a "learner" of the client's cultural and ecological context. Having the client "lead" the conversation based on the selection of specific cultural influences evidently involves the client as an active partner in the therapy process. Third, since the CE capitalizes on foundational skills of the counseling process, it does not require

that the clinician be thoroughly trained in specific skills prior to intervention delivery. Lastly, through conducting the CE, the clinician herself or himself also gains skills in cultural competency – through a) enhancing an increased awareness of the impact of culture on their and the client's worldview, b) increasing cultural knowledge via the information shared by the client, and c) applying the knowledge to collaboratively determine what skills or strategies be culturally adapted to fit the cultural context of the client. In this way, the CE may also serve as a tool for the clinician to increase their cultural competence skills across the domains of awareness, knowledge and skills.

The CE may serve as a possible tool that can assist in the empirical examination of how evidence-based treatments are currently being tailored to culturally diverse children and families. While the main goal of the CE is to enhance engagement, the plethora of information it gathers on ethnic minority families' cultural influences and barriers may suggest it can also serve as an assessment tool of cultural influences that lead to the cultural tailoring of treatments. Tracking of specific cultural influences/barriers central to client engagement and treatment across sessions and clients can help build an empirical base of the cultural or contextual factors that are integral to adaptations of specific intervention strategies or skills for minority families. In this way, the CE may be a tool that provides a systematic approach to identifying and documenting areas for cultural tailoring of evidence-based treatments.

The CE was originally developed as part of an engagement intervention combined with videofeedback (Author et al, 2013, Author, in press). Findings from the intervention trial indicated significant effects on client rated therapist cultural competence and therapeutic alliance. These preliminary results suggest the effectiveness of the intervention; however independent effects of the CE separate from the videofeedback are yet to be tested. Future research should test the effectiveness of the CE as a culturally based engagement enhancing tool.

In sum, the CE demonstrates one of many approaches in the application of concrete “tools” that can facilitate the integration of culture within the delivery of treatments. While much examination is needed to test whether the CE will serve as a conduit for identifying and documenting cultural tailoring of treatments, we hope that it will contribute to bridging the current gap between practice and research, and shed light into future scientific investigations on the systematic integration of culture into treatments with ethnically diverse children and families.

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Figure 1.
Example of the Cultural Ecogram

Table 1

Examples of Influences & Barriers and Elicited Client Information

Influences	Themes captured by general probes	Specific behaviors, examples capture by specific probe (her parents)	Specific behaviors, examples capture by specific probe (Maria's parenting & behaviors)
Parents & Extended family	Respect of elders (respeto) Emphasis on obedience	Maria never talked back to parents Followed family rules religiously (e.g. never came home late, dress inappropriately, hang out after school)	Reacts in anger when Juanita talks back (i.e. saying "no") or refuses to obey immediately Juanita argues with Maria that White kids can tell adults if they disagree so why can't she Maria views teachers as authorities at school and expects Juanita to respect them by not talking back
Parents & Extended family	Central focus of family (Familism) Family > Individual	As the oldest daughter, cared for her siblings at home Refrained from engaging in extracurricular activities due to parents' rule that "family comes first, all is shared"	Tell daughters that "family is most important, that we stick together" Frustration with Juanita's resistance to follow family expectations such as helping prepare dinner, caring for her younger sister Has restricted Juanita's time with peers due to emphasis on family which has caused arguments with Juanita
Parents & Church, Mexican culture	Submissiveness Sacrificing for your children Female role	Helped her mother in caring for siblings, cooking and household chores, was expected to stay at home Her mother solely cared for the children and home and served her husband	Desires daughters to live differently than she was raised (tells daughters "you can be anything if you work hard") Expects daughters to study hard and get a good education so they do not have to depend on a husband
Barriers	Themes captured by general probes	Specific behaviors, examples capture by specific probes	Specific behaviors, examples capture by specific probe (Maria's parenting & behaviors)
School system	Discrimination Cultural and language barriers	Juanita's teachers have commented on Maria's lack of involvement as her reluctance to "fit" her child into the US Teacher asked Maria if she was a legal resident Juanita told Maria that her teachers said she can no longer speak Spanish in the classroom School administration has minimally helped Maria process documents for Juanita to get an IEP despite numerous requests No bilingual staff at Juanita's school	Has given up trying to communicate with Juanita's teachers Tells Juanita that she needs to obey teachers at school and refrain from speaking Spanish at school Reports that education is the only way for Juanita to succeed in the US Maria avoided answering the teacher's question even though she now is a legal resident because of her past as an undocumented immigrant Avoidance of teachers and school staff
Single parent	Single motherhood	Struggles to balance financial security with caring solely for her daughters Lack of familial support Limited finances	Took a lower pay job due to its flexibility in hours that allows her to spend time with daughters Obligation to send money to her family in Mexico despite her own financial struggles Reports concerns in raising daughters with Mexican values because of limited family nearby Resisted returning to Mexico because she believes that her daughters' lives will be better in the US