

## A CAREFUL BALANCE: MULTINATIONAL PERSPECTIVES ON CULTURE, GENDER, AND POWER IN MARRIAGE AND FAMILY THERAPY PRACTICE

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*In this study, we examined how marriage and family therapists from various countries and diverse cultural backgrounds address the intersection of gender, power, and culture in therapy. Twenty participants from 15 countries responded to an Internet survey that included several hypothetical, clinical vignettes not associated with any one particular culture or nationality. Participants selected a vignette based on its similarity to clinical situations they face in practice within their cultural contexts, and provided information about their conceptualizations of gender, culture, and power, along with treatment recommendations. We analyzed data using analytic induction and constant comparison methods. Results indicate the careful balance with which the participants work to engage clients in therapy, respect cultural values and practices, and promote equitable gender relationships.*

In some parts of India, there is a cultural phenomenon in which the lowest-status woman in a family, usually the youngest daughter-in-law, begins to see visions and predict people's futures. Believing that a goddess has entered her body, the family takes care of her, dotes on her, gives her food and respect, and supports her special status. This culturally sanctioned event successfully upsets the family hierarchy for a brief period of time and provides the woman a brief respite from her lowly status and responsibilities.

This illustration of one cultural tradition for addressing gender (and age)-based power inequities highlights a culturally sanctioned strategy for relief, albeit temporary, from the oppressive forces upon women. In a similar vein, we were curious about what culturally sanctioned or culturally sensitive family therapy practices might be used by practitioners in multiple countries, including the United States. That curiosity was fueled not by a desire to understand the "exotic" customs of other lands, but to gain insight into how therapists address gender and power in diverse cultural contexts that are relevant to practitioners, whether in the American heartland or the megacities of Asia. We maintain that each therapist and each client represents multiple cultural identities (e.g., nationality, ethnicity, race, gender, sexual orientation, and membership in multiple subcultures), regardless of location, and that addressing the interwoven phenomena of culture, gender, and power is important to therapists everywhere.

### CULTURALLY SENSITIVE PRACTICE

Many authors call for cultural sensitivity and understanding, and make a strong case for knowing and appreciating cultural differences (Al-Krenawi & Graham, 2000; Kim, Bean,

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& Harper, 2004; Pinyuchon & Gray, 1997; Yeh & Inose, 2002). Others go beyond understanding and appreciating differences, and call for therapists to support actively values of equity and social justice (Hardy, 2000; McGoldrick, 1998). Almeida (2003), for example, calls for “cultural circles” of supportive communities of men and women to challenge cultural norms that support oppression and male dominance. Of course, the challenge is to be culturally sensitive and, at the same time, address interpersonal inequity.

Therapists working cross-culturally should be aware of how their cultural lenses can pathologize or judge the practices of other cultures. For example, Rothbaum, Rosen, Ujiie, and Uchida (2002) pointed out that therapists from the West may label the closeness between a Japanese mother and her child as enmeshment, whereas a Japanese worldview may define such closeness as positive and nurturing. Similarly, certain collectivist, patriarchal cultures may value the common good over individual choice, respect for elder decisions over self decisions, and male opportunity over female opportunity. Should we move too quickly to “help,” we run the risk of colonization. That is, through our own influence, we may exert a “might makes right” philosophy (Dolan Del Vecchio & Lockard, 2004) and impose outside cultural values that obscure, dismiss, or demean the richness of the cultures of those we intended to help. According to Waldegrave (1998), “These days, colonization is not carried out through the barrel of a gun, but through the comfortable words of those who change the hearts, minds, and spirits of people. Therapists and teachers have a huge responsibility here” (p. 412). We are mindful that the “barrel of the gun” has not disappeared from the landscape. Our own work calls for vigilance to avoid acts of colonization, no matter how inadvertent.

Many who write about culturally sensitive practice also encourage practitioners to work carefully within the existing cultural/family structure (Ben-David & Good, 1998; Rastogi & Wampler, 1997; Seegobin, 1999). For example, Tien and Olson (2003) suggested that American therapists learn about Confucian-based culture so that they might employ “culturally congruent reframing” of family problems (e.g., where harmony has been disrupted, perhaps the therapist can help the family to look for positive ways to reestablish harmony). In addition to cultural congruence, some authors discuss the importance of viewing cultural differences as a source of strength (Supervision Bulletin, 2002). Of course, just because a behavior is embedded in culture does not automatically make it appropriate. For example, even though domestic violence is more widely accepted in some cultures than others, therapists should not be expected to condone such behavior. Waldegrave (1998) discussed critical postmodernism, which includes the notion of “preferred meanings”—meanings that emerge out of values (e.g., preferring gender equity over male domination). According to Waldegrave, being culturally sensitive does not mean being value neutral or glossing over unjust practices.

Numerous marriage and family therapists have published recommendations, drawn from personal and clinical experiences, to describe cultural factors influencing families, couples, and individuals from diverse nationalities or cultural groups (Almeida, 1996; Geilen & Comunian, 1999; Gerhart, 2003; McGoldrick, Pearce, & Giordano, 2005). However, the cultural competence literature and the feminist psychotherapy literature (which addresses gender and power) have developed for the most part in parallel (Fassinger, 2004).

## SENSITIVITY TOWARD GENDER AND POWER

Cultural practices that perpetuate gender inequity relate directly to a number of social and family problems worldwide, such as reproductive health, human rights of women and children, mental health, and HIV/AIDS transmission (Cook, Dickens, Scarrow, & Wilson, 2001; Joint United Nations Programme on HIV/AIDS [UNAIDS], United Nations Population Fund [UNFPA], & United Nations Development Fund for Women [UNIFEM], 2004; World Health Organization, 2002). In contrast, cultural practices can also be a source local knowledge, which can contribute to creative practices that help people on their own terms (Waldegrave, 1998).

For example, Comas-Dias (2003) pointed out the liberating power of the Black Madonna as a “gender-specific” and culturally appropriate icon for Latina clients, in particular, dark-skinned *morenas* who endure an extra measure of prejudice because of their skin color. Local knowledge may also take the form of culture-specific values and traditions that support the resilience of women (Kikoski, 2001; Lijtmaer, 1998; Malone, 2000; Rabin & Lahav, 2001; Tien & Olson, 2003; Williams, 2006).

To foster therapeutic experiences that address family and social problems influenced by gender inequity, we first wanted to understand how practitioners from a variety of cultural groups address issues of culture, gender, and power in ways that are both respectful and effective (Almeida, Woods, Messineo, & Font, 1998; Bryan, 2001; Hall & Greene, 1994; Nimmagadda & Cowger, 1999). Specifically, we posed the following research questions: Do selected therapists from diverse countries employ culturally sensitive practices to address inequities, and if so, how? And, what can we learn from work in a variety of cultural settings that might help therapists address the intersection of culture, gender, and power? To answer these questions, we developed a Web-based, qualitative survey in which participants (therapists) responded to one of six fictitious clinical scenarios, not representative of any particular culture.

### ABOUT THE RESEARCHERS

Our research team consisted of two faculty members and five doctoral students in a university marriage and family therapy (MFT) graduate program with common interests in multicultural applications of MFT and cultural sensitivity. Both of the faculty members have worked extensively in international settings, particularly in Southeast Asia, have conducted therapy with a highly diverse clientele domestically and abroad, and have published on multicultural and international issues in MFT (Keeling & Bermudez, 2006; Keeling & Nielson, 2005; Keeling & Piercy, 2005; Piercy, Soekandar, Limansubroto, & Davis, 2005). Of our student team members, one lived in Eastern Europe for 2 years, one is an international student from India, and two have multicultural clinical and research experience with domestic violence and women’s issues. All of the team members except our colleague from India are White European Americans. Five team members are female, and two are male.

Throughout the research process, we were openly conscious of our position as “outsiders” to most of the cultures and situations we were studying. Although we each have had experiences with cultural differences and power inequity, we acknowledge our privileged position, and attempted to conduct this research with humility, openness, and the guidance of cultural insiders.

### METHODS

#### *Sample*

We used emergent, purposive sampling to seek a criterion sample with maximum variation (Patton, 2002) to identify therapists who identify and work with varied cultural groups in the United States and abroad. We solicited the participation of authors of articles and chapters about therapy with particular cultural populations; foreign-born MFTs; international student MFTs at the doctoral level; and family therapists from a wide range of countries, including therapists from the United States who are themselves immigrants and/or who work with immigrant populations. We obtained contact information through international therapy organizations and through personal referrals. The sample size was determined by saturation of the categories of data (Creswell, 1998), as well as our desire to obtain in-depth information from participants reporting from disparate cultures and geographic regions (Patton, 2002). We aggressively contacted 164 potential participants in two waves of data gathering (Creswell, 1998).

We made our inclusion criteria broad because of the inevitable complexities of defining an individual's cultural identification. We specified that participants should have a minimum of 2 years of family therapy practice, that they have training in MFT or a related field (psychology, social work, counseling, etc.) Because MFT is not yet a widespread mental health field internationally, many family therapy practitioners abroad have training in other mental health disciplines. We also specified that participants self-identify as "international family therapists." Participants were asked to describe their cultural identification in more detail in the survey.

Twenty family therapists from 15 countries responded to the qualitative survey. Participants' years in practice ranged from 2 to 33 years ( $M = 14.80$  years). All participants are members of the majority cultures/ethnicities in their cultures of origin (e.g., participants from Latin countries identify as Latino/a, participants from Hong Kong identify as Chinese, etc.). All but one participant have some experience in clinical practice in their countries of origin (COO), with the majority working most or all of their years of practice in their COO. Seven participants are currently residing and practicing in the United States. Of the two participants who listed the United States as their COO, one identified as "international," meaning the participant has lived in multiple countries for extended periods; the other identified as Anglo with mixed European ancestry. Twelve participants hold a master's degree or equivalent in their fields; seven hold doctorates, and one indicated no advanced degree. Seventeen participants indicated MFT as the field in which they were trained; three are trained as psychologists. Table 1 reflects characteristics of participants (nationality, gender, years in practice, scenario chosen, and theoretical orientation).

### *Instrument*

Our team developed a qualitative survey consisting of 40 items, including open-ended questions to give participants maximum freedom in their responses, and close-ended short-answer or multiple-choice questions to gather demographic information.

Central to the instrument was a set of six fictitious clinical scenarios, one of which could be chosen by each participant as a stimulus for the survey questions. The scenarios were not identified with or intended to represent any nationality or culture; therefore, participants were free to select the scenario that most resembles an actual clinical situation they would expect to encounter in their culture. We decided to provide a selection of clinical scenarios, to allow both choice and consistency, and to ensure that each scenario portrayed gender and power issues. The clinical vignettes are listed below:

1. A couple seek therapy for help with parenting. The husband says that his wife does not maintain adequate discipline in the home, or show proper respect for him. He admits to hitting her occasionally to enforce order in the home. He feels justified in the practice. The wife acknowledges that she could do a better job, and would like to know how to better manage the household.
2. A woman comes to therapy with symptoms of depression. She is unhappy because her husband spends a great deal of time with another woman. However, because divorce is difficult to get and is not approved of by the couple's family, the husband and wife stay married. The wife does not feel like she can complain as the husband holds the power and wealth in the family.
3. A mother wants her adult son's wife to stop working in order to provide full-time parenting for the couple's young children. However, the wife wants to continue to work. The husband feels loyalty to both his mother and his wife and is not sure who to support. The wife is angry about her mother-in-law's continual interference in their marriage.
4. The husband is HIV-positive and the wife is not. The husband does not want to tell his HIV status to his wife. You know that they are having unprotected sex because the couple wants a child. How would you intervene with this couple?

Table 1  
*Characteristics of Participants*

Nationality	Gender	Years in practice	Years in practice within COO	Selected scenario	Theoretical orientation
China-Hong Kong	F	20	16	1	Bowen, Strategic, Experiential
China-Hong Kong	F	19	10	5	Cognitive Behavioral
India <sup>a</sup>	F	6	2	2	Bowen, Structural, Strategic
Japan <sup>a</sup>	F	12	4	2	Bowen, Collaborative
USA/international <sup>a</sup>	M	20	10	3	Bowen, Structural, Strategic
Mexico <sup>a</sup>	F	3	0 <sup>b</sup>	1	Bowen, Emotion-focused
Iran <sup>a</sup>	M	6	0	1	Structural, Emotion-focused, Experiential
India <sup>a</sup>	F	18	4	3	Bowen
Singapore	F	18	13	2	Intergenerational, Emotion-focused, Systemic
Panama	M	16	13	2	CBT, Solution-focused, Narrative
Mexico	M	6	0 <sup>b</sup>	1	Intergenerational, Experiential, Social Justice
Greece	F	21	17	3	Bowen
USA <sup>a</sup>	F	33	33	1	Collaborative, Filial
Israel (U.S.-born)	F	30	3	2	Narrative
England	M	25	25	6	Narrative
Mexico	F	4	4	1	Narrative
Denmark	F	2	2	3	Narrative
Ireland	F	20	20	none	Social Constructionist, Systemic
Brazil	F	12	12	6	Bowen, Collaborative, Narrative
Philippines	F	5	5	1	Structural, Strategic, Solution-focused, Narrative
Total: 15 countries	F = 15; M = 5	M = 14.80 years	M = 9.65 years		

*Note.* COO = country of origin.

<sup>a</sup>Indicates participants who currently practice in the United States.

<sup>b</sup>Indicates participants with no experience within COO, but extensive clinical and research experience with clients of the same cultural descent living in the United States. The participant from Ireland did not respond to a particular scenario, but chose to discuss practices that exemplify his theoretical stance.

5. Parents find out that their 17-year-old son is having sex with another 17-year-old boy. This is against their religion and belief system. The boy tells you privately that he is gay. This is something that the parents have said that they cannot tolerate.
6. A man describes his depression and alcohol abuse, both of which he describes as chronic. He is currently separated from his wife. He says he has no close friends he can talk to. He talks about how difficult it is to be a strong leader for his extended family while dealing with his own problems. He worries that he will end up like his father, who died prematurely due to alcohol abuse.

To develop the clinical scenarios for the survey, team members generated multiple therapy vignettes from their own clinical experiences, from situations they had observed in particular cultural settings, and from personal experience. We also recruited the assistance of several members of the international communities at two universities to generate vignettes depicting believable family problems from their cultural contexts, for which a family might seek therapy. These initial scenarios stemmed from individual experience and observation, and thus were associated with the particular cultures of those (cultural informants) who suggested them. From this initial set, we refined the scenarios, combining some and editing others. Our intention was that the scenarios would be sufficiently generic, yet plausible, that a reasonable number of participants could identify with them regardless of their nationality or culture. To facilitate the survey and allow participant responses to be as unrestricted as possible, we kept the scenarios brief (one paragraph), leaving many of the details up to the participants' imagination and cultural context. Once we developed this refined set of scenarios, we sent them, along with a draft version of our survey, to four international colleagues for their feedback. Based on their feedback, we made minor refinements to the scenarios and survey questions.

We asked participants to describe how they might intervene with their selected scenario. We also asked how issues of culture, power, and gender influenced their intervention, and how those issues influence their practice in general. Finally, we asked participants to generate metaphors describing gender relationships in their cultural contexts, and describing their experience of working with gender and power issues with clients from their cultures. Such imagery can be useful in understanding participants' underlying thoughts, feelings, and experiences, some of which would not be readily accessible otherwise (Zaltman, 1996, 1997, 2003). In addition, we hoped that such metaphors might bring our findings to life and help our readers connect with the findings on both an affective and intellectual level (Piercy & Benson, 2005).

### *Procedures*

We contacted all individuals on our list by e-mail, providing them with general information about the survey and our research team. The e-mail message contained a URL link to a Web page containing more specific information about the survey, inclusion criteria, our IRB approval, and our informed consent document. The informed consent page displayed a link to the actual survey. Individuals were contacted up to three times over a period of 1 month. Individuals who e-mailed us to decline participation (six, primarily due to ineligibility) were taken off the e-mail list and were not contacted subsequently. Eight e-mail addresses were returned as undeliverable, but given the nature of international Web-based surveys (Dillman, 2000), this is probably a small percentage of those that were actually undeliverable. Other than having e-mails "bounced" back as undeliverable, we had no way to verify whether e-mail addresses were accurate and active. Also, because of the great heterogeneity across the world of browser capabilities and line transmission speeds (Dillman, 2000), as well as language barriers, we do not know how many potential participants were able to respond to our invitation. These limitations are a calculated trade-off of an ambitious study such as this one, which reaches out beyond our own borders to address important issues that are also without borders.

### *Analyses*

In keeping with our desire to learn from practitioners' experience, and to derive useful theoretical knowledge concerning issues of gender, culture, and power, we chose to use a modified grounded theory methodology. We conducted open, axial, and selective coding procedures in two iterations until saturation of the categories was achieved (Patton, 2002; Strauss & Corbin, 1998).

*Open coding.* Initial coding involved data from the first 12 participants. Consistent with grounded theory analytic procedures, we chose to analyze and gather data in iterations (Strauss & Corbin, 1990). The principal investigator and two doctoral student team members worked individually in the first stage of open coding, then worked by consensus to refine our coding scheme. Initially, the three team members read through the data for each individual participant, reading the material at least twice to gain familiarity with specific answers in the context of the entire open-ended survey. During these readings, team members wrote memos noting key ideas, tentative ideas for codes, as well as any questions triggered by the material. In a third reading, team members identified meaning units and began developing a more refined code set, relying heavily on verbatim excerpts (in vivo codes).

Following this step, the principal investigator examined the team members' preliminary codes and developed a tentative, cohesive coding scheme using NVivo qualitative software. The tentative coding scheme was then presented back to the student team members to determine whether the scheme appropriately captured their original coding, and to gain consensus on the final coding scheme.

*Axial coding.* Following the open coding process, the same three team members developed axial codes in two phases: first we examined the data for individual participants, then across participants. We completed this process first individually, then by consensus, as in the open coding procedure, with data for four participants, which constituted one third of our participants at the time the analysis began. Categories were developed based on clusters of open codes with similarities such as (a) classification of type of response (e.g., behaviors, values, client-focused, directives, level of cultural identification); (b) clusters of similar meaning units within each participant's responses (e.g., recurring emphasis on certain concepts); and (c) consistencies/similarities across the group. Team members continued to write memos revealing their rationales for their axial coding, suggesting possible alternatives, and posing questions. Axial codes represent an intermediate level of interpretation, as categories are formed around phenomena, in comparison with the largely verbatim, fragmented open codes (Strauss & Corbin, 1990). Subsequent to team axial coding of the first four participants' data, the principal investigator employed the axial coding scheme with data for the remaining eight participants using NVivo software. We added axial codes as they emerged, although the team's original coding scheme remained largely intact. Upon completion of this step, the principal investigator shared the set of axial codes with team members for discussion and refinement. The organization of axial codes and categories in this stage was influenced by the sensitizing concepts represented in the survey questions. For example, in connection with questions about the intervention that participants would employ for their chosen scenarios, the category "Intervention" emerged, with initial subcategories such as "joining," "goals," "strategies," and "therapist behaviors."

*Selective coding.* The three team members responsible for the analysis examined the complete coding set (tree-child nodes in NVivo) individually over a period of several days. During that time, the team members compared the codes to their original memos and to the original data set of 12 participants to see if they accurately captured the essence of the data, and to determine areas where rich data had been obtained, and where the data appeared "thin." Each team member considered what major themes were emerging, what knowledge the data appeared to reveal, and what questions appeared to be generated by the data. As we did this, we noted our thoughts. We then met to discuss these

preliminary findings and to make suggestions about selective coding. We determined a tentative selective coding scheme by consensus, but agreed that in some areas, the data were thin and that additional data needed to be gathered before we could be confident about our emerging conclusions.

*Second iteration of data gathering and use of key informants.* In order to achieve saturation of data in our categories (Patton, 2002), we conducted a second wave of recruitment following the same procedures as the first. We also conducted in-depth follow-up phone interviews with four of the initial 12 participants, who conduct research and have published on topics of culture, gender, and power. We contacted these four participants by phone because they were able to provide additional data to enrich particular categories. We also considered these participants to be key informants (Patton, 2002). That is, their expertise and reflections provided additional perspectives from which the data could be considered. Other key informants, who were not survey participants, were solicited at two professional conferences (one regional, one international), who attended presentations about this study and responded to our research questions through discussion. The nine conference attendees who provided us with feedback were well-established authors/researchers in the areas of diversity studies and multicultural applications of MFT. The additional survey data and transcriptions of the phone interviews were coded by the principal investigator using NVivo software. No new categories emerged, but the existing “thin” categories were enriched sufficiently that we believed we had achieved saturation. Categories formed during the axial coding process were collapsed or combined to reflect coherent themes. In addition to the modified grounded theory analysis, we used a modified version of the Zaltman Metaphor Elicitation Technique (ZMET; 2003) to solicit metaphors and identify themes related to culture, gender, and power, both in general and in therapy. We identified themes composed of responses from at least one quarter of our participants, the cutoff level suggested by Christensen and Olson (2002). This method resulted in themes that achieved a critical level of consensus. Feedback from conference participants who were key informants was not analyzed as data, but notes and comments they made during our conference discussions were influential in our interpretation of the findings.

## RESULTS

The core construct that captures most of our findings is *a careful balance*. As we looked at the major themes across our sample, we were struck by how carefully our participants approached the intersection of culture, gender, and power with their clients to maintain a balance between numerous elements that could influence the progress and success of therapy. Participating therapists discussed their intentions to balance their values with their clients' values in an effort to be mindful and respectful of both without imposing their values on clients. They also described balancing their attention to all members of the client system so that they could attend to all perspectives and take each member's needs and preferences into account. Several discussed their need to balance ideal goals with what they could realistically achieve. Most espoused a sensitive, cautious approach that reflected how difficult it is to both challenge clients and create a nonthreatening environment that would keep clients engaged in therapy.

Three major categories within this core construct capture our participants' responses: Interventions, Gender and Power in Practice, and Metaphors of Gender and Power. Because space would not allow a full portrayal of all categories and themes, we chose to portray those categories and themes that met the following criteria: (a) they depicted therapist variables rather than client variables, in keeping with the focus of the research questions; (b) they constituted the largest categories, and the largest themes within those categories. Table 2 displays a complete list of all categories, themes, and subthemes.

Table 2  
*Complete List of Categories and Themes*

Category	Themes	Subthemes
Interventions	Strategies	Flexible modalities
	Goals	Collective family goals; empowering women
	Therapists' behaviors Therapists' beliefs and values Things to avoid Assessment <sup>a</sup> Case conceptualization <sup>a</sup>	Immediate family (nuclear); extended family; larger systems
	Cultural factors <sup>a</sup>	Family values; cultural values; societal change; sanctioned means of coping
Gender and power in practice	Symptoms/emotions <sup>a</sup>	Wife; husband; children; extended family; unspecified; relational
	How to discuss gender and power When to discuss gender and power When not to discuss gender and power Therapists' perceptions of gender roles Importance in therapists' practice <sup>a</sup> Issues in scenario/case <sup>a</sup> Contextual constraints <sup>a</sup>	
Metaphors of gender and power	Appreciate multiple perspectives	
	Appreciate interconnectedness	
	Be sensitive to power dynamics	
	Women in service to men	
	Women have influence Balance and symmetry	
<sup>a</sup> Indicates category or theme not included in portrayal of data.		

*Category One: Interventions*

The Interventions category contains descriptions of how the participants would intervene in their chosen case scenarios. Five major themes emerged: Strategies, Goals, Therapist Behaviors, Therapist Beliefs and Values, and Things to Avoid.

*Strategies: Flexible modalities.* Participants suggested numerous strategies, but the major theme that emerged was the need for flexibility in selecting client systems and subsystems with which to work. This flexibility represents therapists' acceptance of certain cultural restraints, such as male family members' potential reluctance to attend therapy. They were also sensitive to the influence of the extended family, and the operation of particular subsystems within the family. Data that comprise this theme describe individual, conjoint-immediate family, and conjoint-extended family modalities. Although participants often identified particular family members who would be seen in therapy, most discussed the influence of larger family and social systems, and kept those influences central to the cases. In many instances, who would be

included in therapy depended on the willingness and availability of family members to attend. For example, a participant from India illustrates an intergenerational focus that includes extended family:

Invite the couple and all family members who live together to come for the first session. Find ways of joining with each person. Do a genogram. If the employment of the wife is the main concern, I might meet with the couple to ascertain how they feel about the job, their overall family life, parenting issues, etc.... I would then find ways of exploring the [mother-in-law's] needs as a woman, and a senior member of the family.... I would invite her to come in and I would show appreciation for her level of care and concern for the family.

*Goals: Collective family goals.* A second major theme that emerged from the Intervention category was an emphasis on working with every member of the client family to determine needs, preferences, and goals. Collective family goals were concentrated around generating choices, adjusting family structure, and collaboration toward goals. One participant from the United States, who identifies as a "third culture kid," having lived for extensive periods in Latin America and Asia, described this structural approach:

My goal would be to create a clearer executive subsystem for this parenting need. For this to happen, likely the covert conflict between wife and mother for son/husband's attachment will need to be addressed more openly. A positive outcome will likely be marked by the mother and wife's flexibility to collaborate in opposition to the husband, so that he is not always in between them. Both wife and mother will need a shared commitment for the best child outcomes.

*Goals: Empowering women.* Besides collective family goals, our participants were particularly interested in finding ways to empower women. Empowerment involves fostering a greater sense of self-agency and opening up a wider array of choices for clients. In relationships, it may also involve the therapist supporting a disempowered or marginalized family member to reduce the effects of power inequities. Empowerment included validation and support, establishing boundaries in relationships, and lifting oppressive emotions. The participant from Panama illustrated this goal:

I think it's basic to empower the woman. Protect her from further personal distress. Help her develop a possible self and even a dream or two for her, and help her by believing she can make a different life for herself in the future. The key issues are recognizing what is doable within the constraints of her situation. I would probably discuss with her options, but guide her not to make a quick decision.

*Therapist behaviors.* Therapist behaviors are those actions (i.e., specific interventions) participants said they would take in response to their chosen scenarios. The most frequently mentioned behavior was exploration. The primary purpose of exploration appeared to be increasing therapists' understanding of client circumstances, contexts, relationship dynamics, and preferences. Exploration represented a listening to rather than a listening for stance (Anderson 1997). Exploration took three distinct time orientations: exploring past influences and context; exploring current dynamics and needs; and exploring potential for change. For example, a participant from Ireland described how she would explore the past:

I would explore with the clients their understanding of the situation and the influences that have contributed to their understandings, which might include a discussion of both the historical and societal ways in which gender is constructed and how that may or may not impact on their ways of being together.

Exploring the present, a participant from Greece commented:

I would explore how else they relate as a couple: do they have other triggers for conflict? [Do] these triggers come from outside or inside the nuclear family? What are the positive aspects of their couple and family life?

Looking to the future, a participant from Brazil suggested questions that might be asked of a man suffering from depression and alcohol abuse, to help him envision the act of challenging the problems, and to suggest involving others for support.

*Therapist beliefs and values.* Participants' personal and theoretical assumptions also influenced the interventions they devised. Overall, therapists' beliefs and values revealed advocacy in the form of support for gender equity, blended with respect and appreciation for clients' resources and cultural values. Some participants' beliefs and values appeared to take precedence over clients' goals, but most focused on an optimistic, strengths-based approach and the commitment to respecting and preserving culture. One participant from Mexico illustrated how this might be done with a family in which the father asserts his leadership through violence:

I would focus on the father.... At the beginning you need to get the collaboration of the father if work is to proceed.... Hoping to redirect his energy to what he wants for his children. In Mexican families [the] idea [is] to work hard to improve the situation of not only the family but to provide a better future for their children. Then I would focus on how the family can better accomplish those goals in a more productive and nonabusive manner. It is necessary to work with the hierarchy that is already in place. If the therapist can gain the father's respect and contribution, the therapist will be able to work with the family. If not, he may take the family out of therapy and no aid can be provided to the family.

*Things to avoid.* The last intervention theme contains numerous ideas from our participants about practices they regard as counterproductive to therapy in their cultural contexts. Things to avoid included colonizing people's experience, ignoring hierarchy, making assumptions, and imposing the therapist's perspective. Common across these ideas is the threat of an ego- or ethnocentric bias that blinds therapists to clients' values and constraints, increasing the risk for insensitive irrelevance (at best) or coercive, oppressive practices (at worst), and contributing to the likelihood of offending clients and running them off. One participant from India warned against:

Assuming that "all families are the same." Assuming you know exactly what to do because you KNOW what is dysfunctional. Assuming you know what the couple wants because they share some cultural heritage with you. Not taking into account the intersection of gender, culture, education, and social class.

A participant from Mexico cautioned against imposing the therapist's perspective:

[I would avoid] any intervention that would make them feel like I'm judging them in any way. Even if the things they do or think are different from what I would think or do, I must never take them for being "wrong" or "bad" or "sick." Interpretation or advice, even if well intentioned, may put myself in a position of power over them, which would only maintain and preserve the dominant ideas that are making them feel unhappy and unfit. The questioning of the dominant ideas should come from them, when I ask them about how those ideas affect their lives and the way they think they should or should not act.

### *Category Two: Gender and Power in Practice*

The themes that emerged from participants' proposed interventions for their chosen clinical scenarios are congruent with the ways participants describe their actual practice. In the category of Gender and Power in Practice, we discovered guiding principles and practical tips for discussing issues of gender and power with clients in a variety of cultural contexts. It should be noted that, in our survey, we consistently used the word *challenge* to indicate exploring and deconstructing gender and power with clients, as well as more pointed questioning or confrontation of these issues. In that several of our participants interpreted *challenge* to represent the more confrontational end of the spectrum, some took exception to the term. Therefore, we use the term *discuss* here to more accurately represent the stance of the majority of our participants. The initial five major themes that emerged in this category were (a) how to discuss gender and power with clients; (b) when to discuss gender and power with clients; (c) how *not* to discuss gender and power with clients; (d) when not to discuss gender and power with clients, and (e) participants' views of their clients and their own gender roles. Because the theme "how *not* to discuss" overlapped with the "things to avoid" theme in the Interventions category, it was combined with things to avoid and eliminated from this category, resulting in four major themes.

*How to discuss gender and power with clients.* All participants advocated a respectful, non-threatening approach to address gender and power issues with their clients. Most of the participants reported that they consider gender and power to be important issues in most of their cases, and that they regularly discuss them openly in therapy. Two responded that, ordinarily, they discuss gender and power only when it seems appropriate to a particular case, and one stated that "under no circumstances" would he openly discuss gender and power with clients from his cultural context. Three participants advocated open confrontation of gender inequity, but only in the context of a well-established therapeutic alliance. Practices for discussing gender and power included nonthreatening approaches, client- and culture-centered work, therapist's use of self, and deconstruction and reconstruction of meaning. An example of a nonthreatening approach was suggested by a participant from Panama, who connected broader cultural values to family dynamics and individual decision making:

I would probably talk [to the wife] about how male-dominated culture frames you and ... some men ... in our culture, [I would] talk about the story of her own parents, and help her value what is valuable in her relationship with her husband and recognize if it is enough for her—the way it is—to make her somewhat content.

In addition, several participants mentioned the importance of mindfulness and the need for therapists to continually deconstruct and challenge their own ideas about culture, gender, and power. Ways that participants hold themselves accountable in their use of self include consulting with peers, being reflexive, owning one's opinion when expressing it to clients, and incorporating transparency and humor to facilitate connection with clients.

*When to discuss gender and power with clients.* As in comedy, timing is everything when it comes to discussing gender and power issues with clients. Participants commented on the need to gauge client readiness and openness for this kind of discussion. They emphasized that the therapist has to "have the trust of the clients," that the client must be "willing to go there," and that the therapist needs to "find a way to interest [the client] in this area." In contrast, participants also saw the need for therapists to initiate conversations about gender–power inequities when they judged the clients' situation to be dangerous, or when they thought it necessary to produce progress. A participant from Mexico discussed how inequities threaten both the privileged and the disempowered:

When they [gender-based power inequities] are making people feel inadequate and making them react in destructive ways towards themselves or others... If I am in a

position where I can see the effects of these ideas I should point them out, and challenge them.

*When not to discuss gender and power with clients.* Participants' concerns about clients' readiness or willingness relate to whether clients might perceive such a discussion as aggressive, as directly challenging their position, or whether the clients are able to see the relevance of gender and power issues to their situations.

In contrast to participant recommendations in favor of discussing gender and power when abuse or severe dysfunction is present, some participants saw these as times when such a discussion may be harmful. For example, it would not be in clients' best interest to pursue such a conversation "if it endangers the safety of any person." Participants also thought discussing gender and power with clients might be contraindicated with unstable clients until sufficient stability was established. One participant commented that discussing gender-based power inequities might also be inappropriate in cases where a husband is being abused by his wife. This participant pointed out that in such a case, traditional gender-based power inequities that privilege males may not be relevant, and that in his cultural context, the husband would be greatly shamed to openly comment on his disempowered position. Finally, participants recommended against discussing gender and power if it would be perceived by clients as judgmental, or if it elevated the therapist to a position of appearing to know more than the clients.

*Therapists' perceptions of gender roles.* We were curious about what our participants saw in their regular practice with regard to gender roles—both those of their clients, and the reciprocal influence of their own gender with their clients. Therapists' perceptions of their male clients' gender roles, although from a variety of cultural contexts, portrayed traditional, patriarchal qualities such as the man as the head of the household, feeling responsible and providing for his family, and not being socialized to feel comfortable with emotion or intimacy. Likewise, female clients were portrayed in traditional roles as homemakers, helpers in submission to their husbands, and mothers responsible for child care. A participant from Panama commented:

Some males in my culture see infidelity as part of their rights for being a good provider for the family. And several women would put up with it, depending on education, economical status, and family background.

A participant from India further elaborated on traditional, patriarchal gender roles and the constraints placed on both men and women:

Men are not socialized to have a healthy intimate relationship with their spouses. Men are not socialized to deal with emotional issues in the family in a healthy way. Women are socialized to focus on children and extended family. They adopt passive aggressive ways of dealing with issues. Society [is] not supportive of single and divorced women. Families do not have resources to support single and divorced women.

Participants' comments about their own gender roles in relation to their clients revealed greater complexity, disclosing the pitfalls of power, as well as the ways in which therapists' gender fostered greater empathy and connection with clients. Commenting on their therapy with men, female participants expressed some positives, but more negatives. Although some participants asserted that men may "open up" more to a female therapist, or relate to her as a respected older sister or aunt, others commented that the therapist's power position may be incongruous with her status as a woman, and may be threatening to male clients. In addition, some worried that men would expect a female therapist to take the side of wives, and to blame

the men or try to make them feel guilty. A participant from Greece noted that in her scenario, “I would pay attention not to overwhelm the husband as he is already pressured by the two women.”

The relationship between female therapists and female clients was generally viewed as positive. Participants commented that women might “feel less intimidated” by female therapists, and that there may be a sense of empathy, connection, or identification that facilitates joining with female clients. As a participant from Singapore stated, “The woman would feel comfortable talking with another female therapist.”

Female participants reflected on the pervasive and constant influence of gender, the importance of being mindful of its influence, as well as the importance of acknowledging sensitivity to certain issues and situations based on their personal experiences with gender inequity. A participant from Japan candidly admitted that she would have difficulty with the woman in her chosen scenario, which involved a woman who suspected her husband of infidelity: “I can see this case is challenging for me as a therapist because I could get frustrated with the client for not standing up for herself.” A participant from Israel noted, “I would examine if my sensitivity was in the way of my client’s perceptions. If [it was] I would put [it] to the side and get her version of this story.”

Like the female participants, male participants also viewed their gender as a disadvantage in some circumstances because of the risk of inadvertently abusing their gender and role privilege. Male participants’ mindfulness of privilege called for an awareness of bias, reflexivity and transparency, and a commitment to resisting oppressive practices. A comment from one participant from the United States reflected the sentiments of several participants:

Any use of direction or authority must be carefully multilateral and indirect so that no one feels I have used my educational/male role/authority coercively.... Also, the issue of whether a male can speak to the question [of gender inequity] at all is very much a drawback going into the case. The right to address things will have to be carefully earned for the family as a whole.

### *Category Three: Metaphors of Gender and Power*

In one of our questions, we asked, “What is a metaphor, proverb, or expression that describes what it is like to address issues of gender and power with clients in therapy?” We identified three themes that met Christensen and Olson’s (2002) criteria for inclusion using the ZMET (Zaltman, 2003), which stipulate that a theme must be shared by one fourth of those responding.

*Appreciate multiple perspectives.* The strongest theme involved the importance of understanding and appreciating the perspectives of all. For example, one participant from India states, “I picture a circle where it is important to include the needs of all.” A participant from the United States, in reference to the Oscar Wilde quote, “Life is too important to be taken seriously,” explains, “A little lightness and a lot of empathy can go a long way to helping a family ‘heal’ itself.” A participant from Mexico captured the issue of gender and power in therapy in terms of a prism. This participant states, “A prism can reflect light in many different ways, depending on the side you are looking at and the side the light is hitting, so you can choose how to place the prism and how to look at it in different situations, according to what you need for getting a better life.”

*Appreciate interconnectedness.* Therapy involving gender and power, according to some participants, involves appreciating the interconnectedness of each spouse’s behavior to the other. An Indian participant, for example, described interconnections as a “web.” This participant explained, “Disturbing one strand affects all the others. [There is a] careful balance.” Another participant mentioned the classic Chinese film by Zhang Yi Mou, *To Live*, as her

metaphor. This film, which is one family's story of male privilege in China before and during the Cultural Revolution, depicts in striking clarity how one family member's behavior affects and is affected by both the behaviors of other family members and by larger societal influences.

*Be sensitive to power dynamics.* Metaphors captured both overt gender-specific power (e.g., the Chinese film *To Live*) and more subtle influence (e.g., "On the surface the man appears to be the head of the household, yet the woman is the one who directs his mind..."). An Iranian participant, perhaps reflecting rigid male-dominant power structures in his country, considered therapy for gender and power issues an "impossible dream, for now." Another participant underscored the fluidity of power with the metaphor of a frying pan, stating, "Who is holding it ... holds the power." This participant also acknowledged that the issue of gender could (perhaps like the frying pan) be "slippery and difficult to handle." Whereas different participants clearly had different views of power and gender, it is clear that each suggested a therapist's sensitivity to gender and power issues was important.

We also asked our participants to give us a metaphor, a proverb, or an expression that described gender relationships in their own cultural context. These themes are presented below.

*Women in service to men.* The strongest theme included metaphors that captured patriarchy, and women's role as supporters and service providers to men. For example, one Mexican participant painted this picture of gender expectations in her culture: "Women should always keep a nice and clean house with well-behaved children and feel gratified by her husband's achievements (his position, power, money, and possessions)." Similarly, an Israeli-U.S. participant provided this metaphor from her culture: "A woman is a man's helper to stand against him or to support his growth." The service metaphor was also captured in the old saying one Japanese participant shared: "A woman serves three men in her lifetime: her father, her husband, and her son." An Indian woman shared a similar saying from her culture: "A girl belongs to her father, a woman to her husband, and in old age she belongs to her son." Reflecting the traditionally lower status of women, a Panamanian participant shared the saying, "The man eats the best part of the chicken," noting that, in many low-income families, this continues to be more than a metaphor.

*Women have influence.* A significant minority of participants identified metaphors or sayings that connote the influence, however subtle, of women. For example, a participant from Hong Kong stated, "Women play a subtle role in controlling the power of a family. They give in to men in most things but women can influence the outcome of major decisions." Similarly, a Greek participant shared the popular Greek saying, "The man is the head of the family but the woman is the neck and can move the head in any direction she wants."

Whereas a participant from Denmark agrees that women in her culture have power, she questions their use of it. Stating that "the shit is the same—it's only the flies that are different," she explains that "even though women of today have more power, they very often don't use it for ... justice, but ... for themselves to get richer and more powerful."

*Balance and symmetry.* Some participants, both from Western and Eastern countries, provided metaphors that captured the balance and symmetry in gender and power relationships. For example, one U.S.-multinational participant spoke of women as "the other half of the orange" (*la otra mitad de la naranja*). An Indian participant spoke of the cosmic dance between Siva and Shakti—"both powerful and beautiful, and having the power to make or break the other." One participant used her own relationship with her husband to reflect efforts to find balance and equity:

In my own family of origin and current family, we have the concept of shared leadership. My husband and I have tried the canine dominance hierarchy approach, but never could figure out who was the alpha-anything. It shifts with the day, ... [It] wasn't easy getting there, but it seems to be working!

## DISCUSSION

We found the strength and consistency of responses on several issues remarkable, given the ethnic, cultural, regional, and religious differences of our sample. While no researcher would venture statistical generalizations from our findings (which, of course, is not our purpose), researchers and clinicians can still benefit from the rich clinical wisdom and the nuanced, thoughtful ways in which our participants approached the clinical challenges we presented.

### *Findings in Relation to Research Questions*

Our first research question was “Do selected therapists from diverse countries employ culturally sensitive practices to address inequities, and if so, how?” Our findings indicate that our participants are mindful of the intersection of gender, power, and culture, and that they are deliberate in choosing practices that address gender-based power, inequities in culturally sensitive ways. For these participants, cultural sensitivity appeared to consist of respecting cultural values, traditions, and (for the most part) gender role expectations, while trying to generate alternative behaviors within the cultural framework. For example, for a scenario in which a father was unhappy with his wife’s management of the children, and admitted that he occasionally disciplined his wife with physical abuse, participants recommended being empathic toward the father’s desire to have a well-ordered household, while exploring alternative behaviors that would help the father achieve order in the family without violence, and which would help his wife feel like a more effective parent while freeing her from the fear of abuse. In another scenario describing a wife’s unhappiness with her husband’s suspected infidelity, participants recommended involving the extended family to provide the wife with support, or to shame the husband because of the consequences of his inappropriate actions on the reputation of the family. This approach conforms to that espoused by McGoldrick and Giordano (1996), who stated that “the therapist’s role ... may be that of a cultural broker, helping family members to recognize their own ethnic values and to resolve the conflicts that evolve out of different perceptions and experiences” (p. 21).

Our second research question was “What can we learn from work in a variety of cultural settings that might help American therapists address the intersection of culture, gender, and power?” This seems to be the more difficult question, as several participants emphasized the need to “know exactly what you’re doing,” and attested to the “tricky” nature of cultural sensitivity, even among practitioners working within their own cultural contexts. We can conclude that the importance of being knowledgeable about any particular culture, along with the ability to “read” nuanced cultural behaviors will be more difficult for cultural outsiders than for insiders. However, even these cultural insiders admitted to the need to explore clients’ cultural contexts from a not-knowing stance (Laird, 1998). They warned against the tendency to assume that clients from a particular group are all the same, or that they are highly similar to the therapist because of a shared nationality or culture. They seemed to apply these principles across the board—to explore, learn, and deconstruct along with clients, and to respect their cultural expertise. These participants, who possess insider knowledge of their clients’ cultures, do not necessarily rely on static notions of culture, but continue to challenge themselves in “learning how to learn about culture” (Laird, 1998, p. 23).

### *Additional Findings*

In addition to findings related to the research questions, another lesson we learned about sensitivity was the need for therapists to address gender and power issues delicately, humbly, and sometimes strategically or indirectly. Accomplishing this involves understanding the power structures of the (often extended) family system, using humor and transparency to admit one’s own struggles, and allowing equity to emerge as a by-product of highly pragmatic solutions

aligned with clients' values and goals. Although only a handful of participants (3) said they would directly challenge clients about gender–power inequities, all of the participants who said they would discuss issues of gender, power, and culture with their clients (19) emphasized that a climate of trust would have to be established first. That climate of trust appears to depend on gaining the cooperation of powerful family members (whether husbands, fathers, or mothers-in-law) who can either facilitate or sabotage therapy, a practice consistent with that recommended by Ng (2003). Gaining cooperation was accomplished by respecting the wishes and goals of powerful family members, relying on them as consultants and allies, showing empathy, and eliciting their own needs and preferences.

A final lesson was the importance of not imposing the therapist's perspective on clients, either through ethnocentric norms, through personal judgments or agendas, or through practices that silence and subjugate clients, however subtle or inadvertent. This conviction relates to Waldegrave's (1998) warnings against colonization. Refusing the tendency to impose one's values requires therapists to first be aware of their values—especially regarding normative expectations, pathology, and the desire for gender equity—and aware of the power of their influence with clients, for good or ill (see Ng, 2003; Ziemba, 2001).

### *Reflections of the Research Team*

Our team had varied reactions to the data that revealed another aspect of the “balancing act.” Some members of the research team interpreted participants' caution as markedly conservative. They wondered whether some participants were privileging culture in a way that would preserve the client systems' status quo and inadvertently perpetuate gender and power inequities. They noted also that more of the interventions targeted women than men. The other team members countered that, for many clients from populations unaccustomed to (and stigmatized by) therapy, seeking professional help for family problems would itself be so challenging that therapists would have to work hard to join with family members. They would need to establish trust, support clients' values and priorities, and work in nonthreatening, even indirect ways with whomever was willing to attend. We balanced our perspectives by considering our points of view as (predominantly) outsiders to the cultures represented in the study and as service providers to populations with a broader acceptance of therapy. From that perspective, we could better appreciate the careful approaches of our participants. In constructing a continuum ranging from maintaining the status quo to openly challenging inequity, we found our participants to be located in a very balanced position in the center, encouraging change and empowerment within the strengths and constraints of their clients' cultural frameworks.

### *Clinical and Research Implications*

The findings of this study illustrate two sets of commonalities—the commonalities of gender-based power inequities in multiple cultures; and common principles for culture and gender-sensitive family therapy practice. Our participants all recognized the culturally embedded power inequities (i.e., gender and intergenerational inequities) in the scenarios they chose as reflective of their own cultures. This points to the relevancy of gender and power issues across cultures and with a variety of clinical problems. Findings also suggest that, although familiarity with specific cultural practices and values is important, our participants consistently emphasized the importance of learning about culture as it manifests in families. Such learning requires deep empathy, sensitivity, and wisdom. Far from a “one size fits all” philosophy, the approach espoused by our participants called for examining one's own cultural assumptions, and slowly and humbly learning about another's culture, so that what is invisible to clients (and therapists) can become visible to all.

In addition, findings provided vivid examples of interventions designed to diminish power inequities based on gender, while drawing on cultural strengths and resources. Concrete

examples such as these can serve as a useful guide for clinicians who desire to practice in gender- and culture-sensitive ways, but are not quite sure how to go about it.

This study contributes to the research literature by extending and integrating the cultural competence and feminist family therapy literature. It extends the literature by moving it further out of the theoretical realm in the direction of practical principles and practices. It integrates the literature by connecting the recommendations for cultural competence and gender sensitivity and applying them across a variety of cultural contexts, client situations, and theoretical orientations.

#### *Limitations and Directions for Future Research*

Online surveys have many advantages, and several clear disadvantages. Although they offer researchers the advantage of soliciting participants in faraway places, one disadvantage is the difficulty of reporting a truly accurate response rate (Dillman, 2000). Another limitation brought to our attention was based on a few objections to our clinical scenarios. For example, one participant critiqued the scenarios as deficit-focused and inattentive to larger social contexts, such as racism. In addition, one of our contacts, who refused to take the survey, e-mailed the principal investigator to object to a particular scenario's stereotypical depiction of Latino culture, and chiding us for using the word *machismo*. In fact, the word *machismo* did not appear in any of the scenarios, and a good deal of effort was taken to assure that no scenario depicted any one culture. Still, it is clear to us that such scenarios may potentially be seen as derogatory and/or stereotypical of one culture or another. Future studies may be enhanced through in-depth interviews that allow participants to generate their own scenarios. However, the majority of our participants reported their chosen scenario as moderately to highly representative of family therapy situations in their own cultures.

Finally, we acknowledge that a single, qualitative study does not constitute conclusive empirical research. This investigation represents an exploratory first step. In future research, we plan to cultivate more personal contacts with the international therapist community through networking at international conferences, and through electronic correspondence, so that we can conduct more in-depth interviews face-to-face, and/or maintain extended correspondence or discussion boards that would allow us to explore these issues in greater depth and specificity. Where possible, we would like to conduct observations of therapy to get a better idea of what therapists actually do and say to address culture–gender–power issues with their clients.

Although there are many political and cultural differences among and between the groups we studied, there also appear to be certain constants at the family level. In this study, we explored how family therapists from a wide range of countries address issues of culture, gender, and power. We learned from participants about respect, patience, engendering trust, and fostering fairness and equity in the midst of sometimes conflicting values. The issues are difficult, but our participants understood them well and generated clinical wisdom that may be useful in the difficult task of addressing the intertwined influences of culture, gender, and power.

In some parts of the world, there is a cultural phenomenon in which family therapists begin to see visions of a future wherein practice honors culture while promoting social justice. Believing that their profession has entered a new era, the family therapists reach out to other practitioners and researchers, with curiosity and respect, and support clinical wisdom's special status. This exploratory event upsets the disconnect between researchers and practitioners for a brief period of time, to provide a brief respite from the status quo and to focus on our responsibilities for change.

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