
The Journey After the Journey: Family Counselling in the Context of Immigration and Ethnic Diversity

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ABSTRACT

The development and implementation of a specific model for providing family counselling to immigrant and refugee families is examined. Conjointly developed by staff at a non-profit agency in the settlement and integration sector, and a team of consulting family therapists, the Multiple Partnership Model arose from community-based work and the demonstrated need for equitable and accessible counselling in languages other than English. The influence of narrative theory in its ability to address the challenges of ethno-cultural diversity and the imbalances of power inherent in cross-cultural counselling are discussed. As well, the dynamics of a co-therapy partnership between ethno-specific settlement counsellors acting as bi-cultural consultants and an on-site family therapist are highlighted. The specific workings of this partnership are outlined and case examples provided.

RÉSUMÉ

Cet article examine l'élaboration et l'application d'un modèle désigné pour les services de consultations familiales destinées aux familles immigrantes et aux réfugiés. Le *Multiple Partnership Model* [Modèle de partenariats multiples] a été conçu par le personnel d'un organisme à but non lucratif implanté dans le secteur de l'établissement et de l'intégration, en collaboration avec une équipe de conseillers familiaux consultants. Ce modèle est né du travail orienté sur la collectivité et des besoins manifestes de services de counseling équitables et accessibles dans des langues autres que l'anglais. Dans cet article, on étudie également l'influence de la théorie narrative dans sa capacité de traiter les défis présentés par une diversité ethnoculturelle et par la disparité des pouvoirs inhérente au counseling interculturel. De même, on met en lumière la dynamique d'un partenariat de thérapie conjointe entre les conseillers spécialisés dans l'établissement de groupes ethniques particuliers et agissant en tant que consultants biculturels, d'une part, et des thérapeutes familiaux sur place, d'autre part. Le fonctionnement détaillé de ce partenariat est esquissé et des exemples de cas particuliers sont inclus.

Almost a decade ago, a team of family therapists and settlement counsellors representing nine different language groups took up the challenge to establish a meeting ground between dominant culture counselling services and the specific needs of ethno-cultural groups. In the context of referring immigrants and refugees to various social services, settlement counsellors at Surrey Delta Immigrant Services Society (SDISS) found themselves increasingly asked to deal with family

counselling issues. These concerns were outside the society's mandate at the time, but it was also evident that, because of multiple barriers, immigrants and refugees were not accessing dominant culture mental health and counselling services (Minister of Supply & Services Canada, 1988). As a result, the society consulted with White Rock Family Therapy Institute (WRFTI) and the result was the development of the Multiple Partnership Model (MPM).

This model of family therapy responds to the counselling needs of immigrant and refugee families by providing a bridge between existing expertise and resources in the dominant culture, and the solutions available in various language and cultural groups. It also provides multiple language access to services without the need for new monies or the creation of parallel mental health services. Moreover, it seems to offer a context in which trust is more easily fostered, and in which family problem-solving methods from the non-dominant group can be transmitted and evolve in conjunction with dominant culture methods. This report will discuss the experience of working within this model. Specifically, it will look briefly at comparative models, discuss the theoretical underpinnings, highlight implementation through case examples, suggest benefits and difficulties, and review evaluations to date.

OTHER MODELS OF CROSS-CULTURAL THERAPY

Much has been written on the exploration of suitable modalities for cross-cultural work (e.g. Atkinson, Thompson, & Grant, 1993; LaFromboise & Rowe, 1983. Pine, Cervantes, Cheung, Hall, Holroyd, LaDue, Robinson, & Root, 1990; Sue, Ivey, & Pedersen, 1996; Sue & Sue, 1990; Sue & Zane, 1987; Taft, 1977; Tseng & Hsu, 1979). The consensus of this research is that certain factors are essential for effective and appropriate response: counsellor credibility (Sue & Zane, 1987); first language access (Altarriba & Santiago-Rivera, 1994; Sue & Sue, 1990); availability of ethnically similar counsellors (Atkinson & Lowe, 1995); culturally sensitive and skilled counsellors (Atkinson, Morten, & Sue, 1998; Eleftheriadou, 1997); and nonreliance on intrapsychic models of problem etiology and intervention strategies (Atkinson et al., 1998).

To address the limitations of intrapsychic approaches, several cross-cultural models have been proposed based on the transformation of Western strategies to more inclusive constructs. Important features of these models include attention to racial identity development (Helms, 1990; Sue & Sue, 1999), acculturation levels (Atkinson et al., 1993), and the wider context of indigenous methods of helping (Atkinson et al., 1993; Sue et al., 1996). On a micro-level, attention has been paid to communication strategies (Westwood & Borgen, 1988), self-validation models (Ishiyama, 1989), and skills training models (Nwachuku & Ivey, 1992), while other consideration has focused on specific approaches such as morita therapy (Aldous, 1994) and existential psychology (Ibrahim, 1994). On a macro-level, Atkinson et al. (1993) devised a three-dimensional model that intersects the continua of etiology, acculturation, and goals to define counsellor role. Another theory, developed by Sue et al. (1996), provides an organizational struc-

ture for understanding and accessing universal helping approaches. These two macro-level theories give particular emphasis to the multiple levels of experience and contexts in which humans exist, and make the point that addressing the totality of contexts is necessary for effective counselling. Here, narrative theory would agree and further emphasize that to be helpful in a multicultural context, the therapeutic process must address issues of dominant culture power and privilege (Tamasese & Waidergrave, 1993; White & Epston, 1989). During the development of the MPM, it was considered important to provide both settlement and family counsellors with a counselling theory able to navigate as much as possible the problems of ethnocentric bias (McGoldrick & Giordano, 1996), the effects of the sociopolitical context, and the challenges of facilitating discourse across cultural boundaries. Thus, with full consideration of the necessary elements for appropriate and effective cross-cultural therapy as defined by the research (e.g., Atkinson et al., 1998; Sue & Sue, 1990) the developers of the MPM looked to narrative theory to provide access to multiple contexts and issues of power.

NARRATIVE IDEAS AND PRACTICE IN THE CONTEXT OF DIVERSITY

The narrative approach addresses the politics of therapeutic relationships and the power relations inherent in ideas and practices (Waldegrave, 1990; White, 1991). From the narrative perspective these issues are always present, but accentuated in situations in which persons of a non-dominant culture enter into a context which is defined and operated by persons of the dominant culture. Problem formation and resolution is located in the linguistic, social, and historical relational contexts of all persons, families, and communities, and takes the form of interpretations of experience or "stories" (Lax, 1996). Such accounts not only make sense of experience but also shape it (Henley, 1994; White, 1995; White & Epston, 1989).

Reflection on these "stories" reveals two important characteristics with implications for the practice of therapy in multicultural contexts. First, they are culturally mediated, and second, they are multiple, embodying different, even contradictory views from the total logos of the person's experience. Since expressions are culturally mediated, problem dominated expressions can be spoken of in relation to historical and generative contexts and seen in relation to context rather than inherent to persons or relationships (Epston & White, 1992; Freedman & Combs, 1996; Lax, 1996). The multiplicity of accounts makes available to the therapeutic conversation the likely availability of a preferable or alternate version to the "problem saturated" account or expression. In other words, there is likely to be within the person or family's own rendering, themes or counter-plots (White, 1997) to the dominant version. These alternative renderings have been termed "unique outcomes" (i.e. experiences, ideas, actions, dreams, or reflections) that run counter to the dominant, problem-saturated formulations. Thus, the counsellor's position shifts from diagnostic expert, who knows what to prescribe, to respectful conversationalist who knows how to promote helpful discourse.

In the multicultural context, what is critical about this change in position is that it frames change as occurring through the medium of the person's or family's own accounts rather than one imposed by the therapist fraught with its own unwitting cultural biases. This is not to say that this frees the therapeutic discourse altogether from cultural selectivity and the built-in imbalance of the therapist/client relationship, but that it does suggest steps in the direction of a more respectful and egalitarian relationship. The MPM takes further steps in this direction through the process of cultural consultation.

MULTIPLE PARTNERSHIP MODEL AND THE ALTERNATIVE STORY: CASE EXAMPLES

The MPM emphasizes the on-going collaboration of on-site settlement counsellors and a Western-trained family counsellor. This collaboration occurs in three ways. First, the settlement counsellor provides counselling and consults with the family counsellor through case review and, occasionally, co-counselling. Second, the family counsellor is the primary counsellor with the settlement counsellor involved in co-therapy as a *cultural consultant*. It is important to note that the latter role is not that of an interpreter alone; rather it involves access to culturally appropriate verbal and non-verbal messages, the exchange of which are crucial to effective counselling (Sue & Sue, 1990). Finally, the client(s) may elect to see the family counsellor alone, depending on their ease of expression in English. Accountability in the model is addressed through team-based case reviews, on-going liaisons with referring and collateral agencies, and external case consultations with WRFTI.

The MPM gives the dominant culture counsellor an opportunity to give and to receive cultural interpretation and thus to appreciate a "richer description" (Freedman & Combs, 1996; White, 1995) of alternative stories. Firstly, in simply facilitating communication across language barriers, the presence of a cultural consultant adds to the depth of understanding. For example, during a session with a Latin American refugee, the family counsellor asked the cultural consultant about the context in which the client was speaking about her uncle's death in order to gauge the impact of trauma. After translating the words, the cultural consultant further explained that, while the client had used the Spanish phrase meaning "my uncle died," the client's shift in tone, manner, and emphasis indicated that the way in which the uncle met his death was clearly felt. Thus, through collaboration of language and cultural understanding, a better picture of the client's experience was achieved.

To give the reader a fuller example of how this collaboration of language and cultural context works, an excerpt of another session follows. This example involved a couple recently from India who were suffering marriage breakdown due to the husband's alcoholism. The man had been mandated into group counselling for his addiction. The portion of the session related here involves the man's reported "change" for the better. Of additional interest and value is that in many examples, such as the one here, the client, or one of the clients in a family group,

may have some knowledge of English and is therefore privy to the consulting process between the counsellors. The therapist can use this fluency in a type of reflecting team approach which enhances the client's ability to be part of the process and co-create the solutions. In the case offered here, the woman understands much of the English used, but rarely communicates back in English. The husband has almost no understanding of English, which in itself can create a power imbalance in the session and must also be addressed by the counsellors. For the sake of brevity, the portions of the session in Punjabi are omitted and simply marked *Punjabi*. The result, then, will give non-Punjabi speaking professionals a sense of the exclusion from information and the necessary reliance on the cultural consultant for session continuity. CC is used to stand for "cultural consultant"; and DC for dominant culture counsellor.

MAN: *Punjabi*

CC: Ok, so in this group there are a number of men who have a No Contact Order and can't see their families. So, he's realizing that he was lucky because at least he has been staying with his family while he has been going through this process. And I asked him a question, but I haven't been able to get the answer yet . . . if you want to form it differently? His wife is still not sure about how long this [not drinking] change will last, and I asked him how could you assure your wife that the change you have been bringing into your life will stay and become a pattern in his new story. And his answer was that seeing these other men made him think he's lucky to be in his house.

DC: Well, I'm wondering, aside from reassuring his wife, how will he know when this change is really part of him? What will be the signs for himself?

CC: That's a good question. Let's see how he feels because I think he hasn't been in the group for a long time.

WOMAN: *Punjabi*

CC: Oh! It's finished now? How many sessions did you go for?

WOMAN & MAN: . . . eight, nine.

CC: Ok, so, (to husband), I'm sorry, I thought you had just recently acknowledged that you have to break the pattern. *Punjabi*

MAN: *Punjabi*

CC: *Punjabi*. Uh huh, Ok, so you are thinking that alcohol has taken over your family.

MAN: *Punjabi*

CC: So you felt . . . *Punjabi*

MAN: *Punjabi*

CC: That's great. I will tell Karen, because Karen is quiet over here (laughs). You know when we asked him the question when would he notice that the change had come and how would it continue? . . . he said that part of bringing the change had been staying with him for a long time.

DC: Yeah, because in the last session he asked, "How do I do this?" So obviously there's a wish.

CC: There was a wish there . . . and he keeps bringing back, "in the group." He realized there that other men were doing it. That confirmed his belief that he can do it.

DC: So now I want to go back to his wife's concern. It sounds like he feels very confident . . . so I think it's fair to go back to your question about how he can show his wife. But let's ask (wife's name): What would show you that the change was a long-term one? What do you need to see?

WOMAN: *Punjabi*

CC: Let me explain to Karen —

WOMAN: *Punjabi*

CC: (to Karen) You guessed it . . . that she's worried —

DC: — that after probation's over everything will go back to the way it was.

CC: That's what her worry is.

The approach used here centres on how change will be identified for and by the couple themselves rather than by a Western model of "success." They collaborate with the process; they are part of a team where everyone is open to understanding and an effort is made to address practices of power and privilege.

Whenever a dominant culture counsellor is working with a non-dominant culture client, attention must be given to the question of power and privilege (Sue & Sue, 1990; Sue & Sue, 1999; Tseng & Hsu, 1979). The MPM facilitates an environment where such power imbalance may be deconstructed. For example, many times clients will begin by giving all of their attention to the dominant culture counsellor even while speaking in their first language and despite the presence of the cultural consultant. They are responding to the assumption of dominant culture privilege and, therefore, acknowledging the one who "counts." Here, the dominant culture counsellor can redistribute this sense of entitlement by communicating with the cultural consultant in a manner that is obviously collaborative. A shift in body language, such as turning towards the cultural consultant instead of the client, or responding to the consultant in a culturally appropriate way to signify camaraderie, can begin to deconstruct the notion of dominant culture privilege. As sessions continue, and the model continues to support collaboration, power very much becomes the client's as he or she experiences the co-construction of meaningful change.

In the same way the MPM facilitates an individualized, and hence meaningful, definition of "counselling." By incorporating the client's understanding of "help," the task for the dominant culture counsellor becomes, not one of having to explicate the boundaries of Western counselling, but, rather, of co-evolving a process in which the Western counsellor contributes to the healing. Co-creating this meaningful change often involves deconstructing a Western diagnosis and treatment plan. About three years ago, a young South Asian woman was referred to the program by medical sources with the diagnosis of anorexia and post-traumatic stress disorder. The woman had only been in Canada for a matter of months when she was raped. The referral source identified both the woman and her family as "resistant" to help, and looked to the SDISS program for the addition of cultural sensitivity.

During the first meeting, the young woman appeared, to Western eyes, to be sad and inattentive. She sat with her legs drawn up under her, eyes focused on the floor, and spoke in soft, hesitant Punjabi, punctuated with silence and tears. She expressed that she saw no need for counselling, nor wanted any continued “outside” involvement. The session proceeded to examine the depth of her suicidal ideation and food refusal, but also involved an exploration of her understanding of help and healing. Rather than assume her behaviours and refusal of service were maladaptive, the counsellors began a conversation about what she *and her family* knew about this pain, how it served them, and how it would be allowed to leave or change.

An important clue to her story of healing also came from her manner of dress. Her *duputa*, or shawl, was loosely wrapped around her head and shoulders in the characteristic gesture of respect for a *family* in mourning. Draping oneself in such a manner can also symbolize the safekeeping the woman in mourning is receiving from her family. Yet the *duputa* was black: the colour of retreat, of shutting out the world, of pain that has grasped the heart. As the cultural consultant related this information to the dominant culture counsellor, together they began to understand more of this woman’s experience of the trauma. It very much involved *a collective* experience; her burden was that of her own and her family’s pain. If the focus of counselling were only on what she was experiencing or what might be helpful to her, it would effectively disengage her from being able to express her needs. Instead, the conversation revolved around how pain had settled on this family, like the *duputa*, and how the family was shielding itself from this pain. The client’s retreat into the “isolation” of the family home, came to be viewed as a necessary step into the safekeeping of the extended unit, not as an indication of resistance to help. From that point, the therapeutic conversation — again, one that involved the client’s understanding of healing — evolved to consider the ways in which the “outside” world might contribute. Sessions also included meetings with family members that resulted in the counsellors becoming part of the “team” in the family’s view, not adversarial interference.

The Multiple Partnership Model is also effective in creating a bridge between two distinct cultures which may exist within one individual, such as in the case of first generation Canadian-born or those who are raised in an intercultural setting. An interesting example can be found in the case of a woman born into a cross-cultural family, with the paternal side being Eastern and the maternal Western, she herself having been raised in the East. She had referred herself to the family counselling program for her own marriage problems. Her husband was Eastern, like her father, but her concept of a “happy marriage” was infused with Western ideals. Based on a Western understanding of the counselling process, that is, that it would aid her in forming individual goals, she was, at first, hesitant about the inclusion of a cultural consultant. This doubt was based in her desire to deny, or at least, submerge her non-Western self in order to affect the change she believed to be only possible through the Western perspective, that being the decision to leave her marriage. What occurred, however, was that the collabora-

tion allowed her to creatively explore the meaning of her own bicultural reality. Western counsellor, Eastern counsellor, and client became a team capable of giving voice to the whole of her experience. Through the therapeutic conversation, she came to understand the duality and the nature of the conflict within herself and, eventually, to form a solution which embraced both value systems.

For every client who comes to SDISS's program, immigration begins the process of rewriting the understanding of his or her story in the new land. To some extent, each immigrant must incorporate new values and beliefs into a story with a past in one world and a future in another (e.g., Adler, 1975; Anderson, Waxler-Morrison, Richardson, Herbert, & Murphy, 1990; Baumeister, 1986; Chan & Lam, 1987; Furnam & Bochner, 1986; Taft, 1977). The impact of this process is always a consideration in the counselling offered at SDISS. For example, a Vietnamese refugee told his story of immigration as one where hopelessness conquered hope; the promise of freedom and plenty withering in the face of language barriers, lost education, and racism. The opportunity to explore and enact the dual nature of their new reality through the NWM seems to be both respectful and helpful.

CLIENT AND COUNSELLOR BENEFITS

To summarize, the advantages of the MPM seem to exist along the continuum of crosscultural communication insofar as it elucidates and facilitates understanding among multiple realities. From the dominant counsellor's point of view, the MPM seems to be an effective vehicle for cross-cultural education and access. The on-site availability of cultural consultants has both challenged and enlightened the process of therapy. The effect of being in a session where English is little used, if at all, also asks the therapist to question her or his own dependency on language and the constructs it creates. This loss of control over language releases the therapist from any possibility of being "the expert" and demands that the therapist work through a third party's mind and experience, to reach that of the client. Outside the session, the dominant culture therapist participates in multicultural case reviews, where nine different cultures are represented, which provide the opportunity to co-create a truly multicultural space. Finally, working within the MPM challenges the dominant culture therapist to assess and reassess her or his own tools of power and sense of entitlement.

From the client's point of view, the MPM seems to provide access to language and culturally appropriate service along a continuum that acknowledges the client's identification or non-identification with the dominant culture (Sue & Sue, 1999). By building on the initial relationship formed with the cultural consultant, the MPM seems to negotiate the challenge of creating trust between a dominant culture therapist and a non-dominant culture client. As well as enabling culturally appropriate verbal and non-verbal messages, the cultural consultant also models, by virtue of their own experience of immigration, the

process of becoming bicultural for the clients. Finally, the MPM also facilitates, through consulting partnerships with external health services, access to more specialized mental health care.

DIFFICULTIES AND IMPLEMENTATION

While working within this model has engendered much enthusiasm, there are difficulties that require consideration. First is the question of interpretation. As Atkinson et al. (1998) indicate, translation of counselling concepts may be difficult if not impossible, and there remains the possibility of the interpreter censoring or editing content because of personal discomfort. As a result, one must have not only a common conceptual framework with the co-therapist, but also a deep level of trust and shared purpose. Thus, trust and the prerequisite internal team-building form the second consideration. Cross-cultural communication needs to be established among the team of counsellors themselves; hence the use of narrative techniques in case review and consultation. Next, trust between the co-therapists needs to evolve as with any collaboration. This relationship is especially important to ethical practice because one cannot observe what the other therapist is doing without language access. Fourthly, then, are the considerations of ethical practice.

Accountability, as mentioned above, is reliant upon relationship as much as record-keeping. Confidentiality is complicated by different cultural expectations and definitions, as well as by the reality that the cultural consultants operate in small communities with the attendant conundrums of dual relationships and privacy. Finally, the advantages of ethnically similar counsellors may be undermined by what McGoldrick and Giordano (1996) explain as, the over-identification of the ethnically similar counsellor with the client that results in a collusion with resistance. Here, again, only a solid co-therapeutic relationship between the counsellors will enable post-session debriefing, with the basis in narrative therapy providing access to conversations about power and oppression.

EVALUATIONS AND COMMUNITY RESPONSE

As a community-based program, evaluations thus far have been limited in size and scope by the constraints of budgets and time. A more rigorous outcome evaluation has yet to be done and would add greatly to isolating the factors that are indeed helpful in this model. That being said, some interesting themes and results have emerged from the evaluations to date.

In 1995, the MPM was one of 10 projects selected for evaluation by the BC Settlement Grants Program. One of the evaluation's goals was to examine program impact from the client's perspective. To address this goal, a questionnaire using rating scales was developed and administered to 43 respondents currently in the program. The results showed that 81% rated the service as "very useful" and 67% found the service matched their expectations "very well." This evalua-

tion also included qualitative interviews with program management and service providers. Analysis of these interviews highlighted the availability of language specific, culturally similar counsellors who understood the immigrant experience as a key factor in the program's success.

Another external qualitative evaluation of the MPM was done in 1997, involving clients from four different ethnic groups. The evaluation was conducted by an external, dominant culture professional with the assistance of an interpreter where necessary. Clients were invited to participate by means of the cultural consultants who gave consideration to confidentiality and safety. The theme analysis indicated three main strengths of the model. The first involved the dual features of cultural congruence and counselling competence. Specifically, these features emphasized the importance of an ethno-specific counsellor along with a collaborative approach to goal identification and intervention strategies. All those interviewed reported a strong sense that the solutions evolved in counselling were unique and particular to their needs. The second strength was that these features have resulted in a program that is valued by clients and referring professionals alike. Again, all respondents spoke of feeling safe and listened to, and all indicated that they would recommend the service to others. The third strength identified was the experience of *mentoring*. Here, clients spoke of the value of the cultural consultant as a bicultural role model who had more extensive experience in the dominant culture.

CONCLUSION

From a social constructionist perspective, it might be said that the success of a counselling initiative is only as great as clients perceive themselves to be encouraged and changed for the better (Boss, Dahl, & Kaplan, 1996). From this point of view, the MPM seems to be successful. Request for service has steadily increased since 1995. A contract review done in 1996 by the Ministry of Health, Mental Health Services, found the program was used by nine language groups encompassing 16 culturally defined communities. In 1998 a full 59% of referrals came from the cultural communities themselves in the form of self-referrals. Ministries, other government bodies, and dominant culture agencies comprised another 30% of the referrals. These two percentages (totaling 89%) seem to indicate that the model meets the goals of the dominant culture as well as the needs of culturally different communities. As well, the ability of the model's narrative approach to construct alternative conversations in which new and preferred possibilities evolve, deconstructs the power of the dominant discourse and the practices that support its ideals. Hence, whole areas of experience from which the client might construct meaning are made available and may fill in the "missing portions of the pie" that Tseng and Hsu (1979) suggest clients in cross-cultural settings often crave.

Thus, the experience over the past 10 years has been both rewarding and challenging; it often hints at answers and perennially begs more questions. Most of all,

working within this model demands a constant reappraisal and recommitment to the development of therapeutic modalities that provide equal access to all.

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