Second Skins: Family Therapy
Agendas of Migration, Identity
and Cultural Change

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Abstract
As cultural and hybrid identities evolve to different degrees in each family member, family
therapists working with immigrants and refugees must adjust therapeutic aims to variations of
generations and cultural realities. Since systemic models, psychodynamic agendas, develop-
ment and life cycle goals are framed by culture of origin histories as well as host country reali-
ties, family therapists in cross cultural work are challenged by issues of therapeutic alliance,
counter-transference and process goals. Cultural formulation may provide a framework for the
therapist to map factors that influence their assessments. Family therapy is a useful intervention
as long as systemic thinking is coupled with a flexible openness to the unknown cultural histo-
ries and realities of families in the midst of cultural assimilation or culture change. This paper
will present both clinical examples and theoretical models to promote the family therapist’s
skills in developing their reflective and imaginative therapeutic strategies with immigrant fami-
lies.

Key words Family therapy, Culture, Assimilation, Hybridization, Bicultural, Cultural
formulation

Introduction
The predicament of Otherness (identities outside the host country framework) may present therapeutic and countertransference challenges for the family ther-
pist working with immigrant and refugee families as they dynamically adjust to
However, it is not possible to generalize these clinical challenges, as refugee and immigrant families process and live diaspora solutions to their family life in unique ways while they adopt a new country and embrace various levels of acculturation. Many authors have commented on the ethnocentric Euro-North America bias pervasive in training, as well as in the psychotherapy and the family therapy literature (Canino 2001 Dinicola 1985, McGoldrick 1982, Sue McGoldrick 2003, Zimmerman 2001). While nuclear family orientations of Minuchin (1981) and other systemic therapists (Canino 2001) offer meaningful structural interventions, application of family therapy theory should proceed with respect for cultural context. In addition since host country or dominant cultural frameworks or idioms are not universally in harmony with, or relevant to the realities of immigrant families, socio-cultural elements need careful consideration to avoid pathologizing diverse populations. Enmeshment, for example has, been used with a pathologic inference in the past for families who live in collectivist cultures. In most of Asia or Africa where collectivist values are traditionally prevalent, life-long familial or group aims rather than autonomy driven aims of individuals are predominant determinants of family life cycle and developmental themes.

Achieving an increasing capacity to reflect on therapeutic obstacles to our “knowing”, or comfort with “not knowing” Others, is an important cultural competency aim. As the family therapist has to maintain some capacity to construct empathic connections with all family members, culture brokers or co-therapists may be helpful. In addition, language differences can strain or challenge the task of therapeutic “joining” and require some skills of working with interpreters. Establishing an alliance can be related to the client’s sense of “cultural safety”, a term developed originally in working with New Zealand Maori people who asked that the dual cultural values (Maori and colonizers) be acknowledged in nursing care (Williams 1999). This paper will focus on some seminal theoretical models which may be applied to culture change and offer a few clinical case studies.

Some models of cultural identity formation relevant to family therapists

A. The location of culture
We might ask ourselves where to place cultural change in terms of the intra-psychic world. The paediatrician and psychoanalyst, Winnicott, wrote a seminal paper “On the Location of Cultural Experience” (1967) as part of his conceptualization of transitional phenomena. Working in post-colonial London, Winnicott...
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postulated that cultural experience, like play or identity, had some plasticity as a constantly evolving element in our lives. This psychological location was neither completely internal nor completely external but rather “in between” or transitional. His concept of transitional space thus locates cultural experience as an “experience of relating to objects” or “the potential space between the individual and the environment (originally the object)”, without constraining or giving an absolute definition to the word “culture” itself.

Furthermore, identity, creativity, play and cultural change were seen by Winnicott as endlessly repositioned and reworked over the life cycle. “Play is in fact neither a matter of inner psychic reality nor a matter of external reality.” He underlined the important oscillation between the outer world (“actual world”) and the intra-psychic world, where experiences were the driving element to promote the flow of imagination, mythic context, emotional states and identity essential to transitional phenomena. Winnicott and saw transitional phenomena as an endless working through experience of relating and attachment.

Winnicott’s paper was one of the first papers to propose the linking of play, cultural spaces and creative potential as flexible movements between or across mental spaces or positions as part of an endless individuation agenda. In international metropolises and urban settings, we see that mixing of multiple cultural meanings and metaphors has become a common experience for both the host societies and immigrants, for both the therapist and the clients. Acknowledging Winnicott’s insights, a family therapy session can be seen as offering a transitional working space implicating identity and change. The family therapist is promoting the family’s capacity to create solutions, as well as acquire skills, encountering developmental obstacles, clarifying or approaching conflict resolution and amplifying parenting capacity.

B. The second skin: emerging migrant identities

Otherness might be constructed as a psychic “skin” or representation. Migrant children move between bicultural worlds of school and home, and learn to master “code switching” between cultural contexts as an early skill. They may later marry across cultures or migrate, developing hybrid identifications. However, deeper identifications may remain embedded and co-exist with assimilation shifts, education, and socioeconomic mobility.

When Esther Bick (1968) presented her idea of an infant’s formation of a Self, she depicted the emerging self in the beginning as a delicate psychic skin that “holds” the infant’s self together. Entry into an assimilation process is similarly a formation of a competent self within a new holding environment of the host coun-
try: as a member of the social space the immigrant gives rise to representations within the host country while, at the same time, recognizing how he or she is represented by the host society. This gradual process involves moving between representations of the self. Hybrid, bicultural or multiple aspects of identity are a reality of an increasingly globalizing world, since each person has one Self with many possibilities of social or self representations. A “skin” is used here as a metaphor for a cultural identity. I will use the frog prince fairy tale to present an aspect of bicultural “skins”. Fairy tales were often teaching stories which dealt with the arrival of the Stranger or the symbolic ‘Other’. Though there are versions of the frog prince across Europe and Asia, this is a European variant of the story:

Fairy Tale of the Frog Prince

A princess is playing by a pond and loses her favourite golden ball in the water. When she begins to lament and cries that the ball is lost, a frog appears. The frog promises to retrieve the ball if she will allow him to stay with her in the palace. After he gives her the golden ball, the princess reluctantly allows the frog to accompany her (in some versions she shuts him out of the palace until her father the king prevails upon her to honour her promise). The frog then requests to sit beside her (or, in some versions, to sit on her pillow or to kiss her), transforming him to a prince who marries her. Since the skin of the frog remains an element of his ‘Other’ identity (by day a frog, by night a prince or vice versa), the princess (or sometimes the king) burns this frog skin in order to keep him in a form that is not repulsive to her. The destruction of his skin, however, removes his magical strengths (something essential to the prince she loves).

As a part of a collective mythic legacy, such tales can impart themes of outsiders and insiders, embodiment, frames of privilege or power, good and bad outcomes, presenting an imaginative space to revise or to shift the possible outcomes. In the clinical setting, “Otherness” or a foreign cultural identity may similarly evoke in the host culture therapist many unconscious or conscious responses that influence alliance or counter-transference issues.

We might identify with the princess as therapists, as we respond with frameworks of altruism (the wish to help the Other), denial (e.g. we are neutral and need not consider cultural diversity in our clinic), exoticism or estrangement (e.g. the “Other” constructed from projections of the cultural stereotypes), distancing (e.g. difficulty to attune to the different as valued or valid), criticism or overly patronizing (e.g. therapist educates to shift the “Other” into the host cultural
norms) or dissonance (e.g. implicit or explicit conflicted relationships with the cultural ideals). There is a surprising scarcity of counter-transference or supervision accounts of the family therapist and the encounter with “Otherness” in therapy. The therapeutic issues will vary if the therapist is from a host or dominant culture origin, a visible minority (Holmes 1992, Tummala-Narra 2007) or in a situation of family therapist–client ethnic match. Clearly “Otherness” does invoke the cultural imaginations of the therapist as well as that of the patient (Adams 1996).

C. A third individuation process
Salman Akhtar (1995) proposed an important theoretical model of immigrant identity as a third individuation. He suggests that this endless identity formation happens both individually and systemically as part of assimilation and acculturation. Using Margaret Mahler’s (1975) developmental model of the first individuation, he suggests that cultural identity (like gender identity) is a parallel identity issue that is reworked throughout our lives but has particular relevance for immigrants who are creating bicultural or hybrid identities.

The immigration predicament positions identity somewhere between the identity of the country of the origin (the mother country) and the country of the migration (the adopted mother). There is a mixed agenda of gains and losses, creation and mourning, idealizations and devaluations, closeness and distance, hope and nostalgia as the back and forth movements of the process. Akhtar (1995) addresses the shifting emotional valences projected into the origin cultures versus the host culture, as shifting investments of love, hate or ambivalences. Akin to the rapprochement of childhood or adolescent separation-individuation, closeness and distances between the bicultural polarities appeared to be an endless identity individuation. An immigrant’s pursuit of “an optimum distance” interpersonally and intra-psychically between his “two mother lands” is termed the third individuation.

While Akhtar works mainly as an analyst in dyadic analytic settings, his thesis encompasses the dimensions of emotional states and shifts in the migration experience as having both intra-psychic and psychosocial dimensions. He suggests that transmigration experiences engage the person on all levels of mind (i.e. emotion, morality, identity, mutuality) implicating time, language, interpersonal and sociopolitical domains. The family therapist is also engaged on all levels in making the working alliance and defining the work tasks as well as the therapeutic space in these dimensions.
Since therapeutic processes are always attuned to follow the affective and defensive shifts that are in the interest of family function, the family therapist needs to understand bicultural identity issues. These culture change shifts will differ for family members and with migration histories. While parents who are working in the host cultural space, or children who assimilate in schools, may more readily rework their bicultural identities, mothers at home may not have similar assimilation rates. Establishing a secure sense of host culture belonging, by moving between cultural identities in familial versus public spaces, family members may seek optimal distances, repress, idealize or repudiate their familial cultures depending on psychosocial factors, race and gender. These levels of identification are a unique process for each family or cultural group, and influenced by intra-psychic agendas (e.g. losses, gains, mourning and individuation), temporal elements (time in the adopted country, age at migration), historical legacies (e.g. political, intra-generational legacies), oppression or racism (in the host society or country of origin) amongst other issues (Holmes 2006, Young-Bruehl 1996). The cultural agendas of any family or group are heterogeneous and it is not advisable to assume a homogeneous legacy of elements influencing the psychological agendas of families even for immigrants from the same cultures of origin.

Case example: The special son
A Pakistani couple with two young children were referred by a social worker (and an interpreter), who had worked with them for one year. The social worker was concerned about the couple “getting worse”, and she was very “frustrated” with their helplessness and passivity, though she had offered solutions to help them with unemployment and a recent eviction from their apartment. The interview was conducted in Punjabi with the whole family present – their preschool son playing and drawing, the other child breast fed and sleeping.

The wife was a competent mother but appeared sad. Her husband had had a clinical depression with weight loss and insomnia since he lost his job a year before. He said he felt “lost, ashamed” and felt his life had disintegrated. In the session he related his distress, described as “charges of electricity” (of rage) that jolted his body and caused him to “shake” or in rages to put holes in the wall. After losing his job, he was no longer contributing to the extended family’s income and a conflict had erupted within the joint family (his mother, his elder brothers and their wives). His brother’s wife was from a higher status family and had been denigrating to his wife over the past year. More importantly, he was devastated that his widowed mother, to whom he had been close, now sided with
his siblings and refused to visit him since he had no income. His brother had refused to return previous loans, so he had been unable to pay his rent.

He had always been treated as the favourite son. When he was an infant a great aunt had told the family that he resembled a long-deceased paternal great grandfather who had been renowned in his Pakistani village area as a mystic or “good spirit”. As a child, he stated he always felt “a presence” with him. He was not psychotic but related incidents in his childhood where this spirit or presence had saved him from harm. These co-constructed family narratives had reinforced his mother’s indulgence. In fact, he had been favoured by his mother and envied by his siblings as her overindulged “special” son, especially after his father had passed away in his early childhood.

When his mother and his siblings stated that he was “nothing special”, he was devastated. He felt that he had been dutiful in supporting them financially for previous post-migration years, but now he had lost his “special” status in the extended system. He had allowed his wife to bear the burden of his family’s rejection, while for weeks he had withdrawn, cried, had “shakes” or hit the walls. On leaving the building with his nuclear family, his brother had accused his wife of being evil (“possibly a witch”) and trying to kill her husband (“since a bad wife is responsible for family misfortune”).

His explanatory framework of extended family conflict resulted in intense emotions or “electric jolts”. His early family legacy had reinforced his magical connection to his saintly grandfather (accompanying presence). The family crisis precipitating dislocation of his usual secure attachments (with resulting rage and sorrow). As well an individuation crisis of differentiation from his mother and his identity within the collective framework reframed his distress.

After the “shock” of the eviction, he had begun to recognize that the social worker (his Canadian or adopted mother) was more helpful than his own family in the midst of this conflict. His helpless anguish and repressed rage shifted as he recognized more realistically that he alone was responsible for his children and his wife. He had been expecting his family to change and to reestablish the previous homeostasis of being his mother’s favourite child. He said he recognized in the session that the social worker was their ally, that migration was offering them a new start. This was a shift from a cultural expectation of extended family’s mutual or collective support to an unexpected pressure to individuate and shift towards a nuclear family situation which he expressed as “more like a Canadian”.

With clarification of his familial issues, he expressed his motivation to find a new apartment for his family and then seek a new job. He clearly needed to work through his grief as losing his extended family and shifted to investing in a
stronger alliance with his wife, whom he always regarded as supportive despite the «frightening rages» she had witnessed at home. He had not disclosed the spiritual legacy of his life to the social worker as he worried she would not understand his culture or would consider him “crazy”. On discussion of the special status that this gave him in the family, he agreed that his “gifted” position as a special child could be a “good or bad thing.”

It emerged that the marriage of his brother to a more wealthy woman had upset the power balances in the extended family, displacing him as an entitled son before he lost his job. He realized that he had focused on losses (sense of entitlement in the past), while suffering from the negative aspect of the unexpected envy and family cruelty as though all his “good fortune” was in decline. Though he was distressed by the family’s retaliation, his religious beliefs supported a more balanced, resigned attitude. During the consultation he accepted a reframing of his “having many blessings to count” (i.e. two healthy children, immigration opportunities). The couple felt that the consultation was reparative as it allowed them to share a cathartic narrative and allowed reframing of the shift in family dynamics as an emotional restructuring of their family trauma.

The husband seemed readily to idealize the social worker in place of his lost mother, when he felt he had lost his family. He did not view his distress as “depression” possibly because high stigma is attributed to the diagnosis of “mental illness”. He stated he would be interested in antidepressants only if the symptoms persist. Both members of the couple said that after these events they were no longer nostalgic for Pakistan and ready to have more positive attitudes to building a life for themselves in the West, including sending their young child to French daycare. While the story of witchcraft and spirits, family feuds and conflict may not have changed the social worker’s instrumental plans, sharing the context of distress had reframed the symptoms and strengthened her working alliance of the family and therapist. The spiritual framework was not interpreted directly in the session; however, the social worker was able positively to use this framework in supporting the husband’s duties as a provider and reducing his shame.

**East-west paradigm shifts: Collectivist and individualism frames of development**

While the writings of Sudhir Kakar (1978), Allan Roland (1988), and T. Doi (1971) had earlier explored the ethnocentrism of the Euro-North American psychotherapeutic and developmental models, these issues came to the family ther-
apy literature later in such work as Monica McGoldrick’s (1982) first edited volume on ethnicity and family therapy. Kakar, Roland, Doi, Obeyesekere (1990) and others had provided clinical and anthropological data that the developmental motifs and mythic bedrock of the eastern world had significant differences from and dissonances with the models of development and normative aims of life cycle cited as universals in the Euro-North American worlds. Doi related the nuanced dependency motifs of Japan; Kakar related the life cycle dependency motifs of Hindu childhood; Obeyesekere explored Buddhist Hindu mythic underpinnings of behaviour in exploring psychological symptoms; Roland explored the self emerging in collectivist systems of India and Japan. The cultural paradigms of the East often position duties and attachments to encourage sons to live with parents or remain their primary support, and with individuation of both genders marked by rituals and passages (e.g. arranged marriages) different from western nuclear family norms and ideals.

When post-World War II immigration shifted – from largely European and North American cultural movements across the Atlantic, to the growing movement of the East to West and South to North migrations – clinicians and scholars unravelled a fresh look at immigrant realities. The historical contexts of current migrations, social class, trauma, war and opportunity to return home have different implications for the adjustment process or definitions of home.

The family is also an elastic or culturally defined entity. In Euro-North American literature, family usually means the nuclear family. In collectivist cultures, family often embodies a wider gestalt of extended family or group identifications, where decisions may be made or influenced by elders or significant figures in the community. Family therapists then might need to explore a migrant family’s bonds and attachments, their context of hierarchy, structural power, designated decision makers, developmental concerns, ritual or life markers, gender parameters and value systems as well as explanatory models of distress.

Allowing time for an exploration of this landscape of relationships in the consulting assessment is crucial to understanding systemic issues. In addition, technology and travel allow both families and therapists to make connections across continents and “refuel” attachments across vast distances. Decision making in family councils (e.g. via Skype, telephone or visits), reinforcement of familial traditional values (e.g. arranged marriages), input on long-term unresolved conflicts or revitalization of strengths have been revived as active elements in the familial gestalts.

Middle age or old age agendas in the life cycle may cause a revision of gains, mourning and losses (e.g. inability to return home). The marriages of children, care of the family elders or unfinished obligations to family of origin (which may
have been renounced or avoided) are important in collectivist cultures. These issues may carry a psychological legacy of guilt, shame or burdens that remains unspoken until the family therapy narrative emerges. Akhtar speaks about the “illness of nostalgia” to describe the unresolved and sometimes un-resolvable agendas of grief or mourning that are part of a family leaving behind unfinished legacies, abandoned elders, extended family obligations or strong attachment ties to the country of origin.

Case example: Reworking losses

An Afghani family consisting of a single mother Aliya and her two young sons (aged 4 and 8) had been followed for many years by a social worker and general practitioner before they were referred for a cultural consultation. Aliya was seen with an interpreter and her social worker in a crisis, when the family was refused refugee status after many years of waiting for a federal review process.

Aliya had first been seen by a male psychiatrist and refused to speak to him. She was agitated and outraged as she had been raped and abused in her country of origin: “I have no use for men.” She was now threatening to kill herself and her children. Her clinicians felt she had not responded to many trials of medications, though she continued taking antidepressants as the medication reduced insomnia. She had a good alliance with her therapist who was now considering youth protection, placement or hospitalization. We agreed that the children should be in daycare and about other activities that would reduce her caretaking burdens and provide protective care without placement.

Aliya was socially isolated and felt ostracized by her conservative Islamic community after her account of rape had been revealed. However, her parents had not burdened her with stigma and had supported her escape as a refugee. She had a strong positive identification with her family of origin but had renounced all religious beliefs as “God has deserted me”.

Since her arrival in the United States she had again been raped in a refugee detention centre, resulting in pregnancy. Aliya had later learned about the death of her parents who had always been supportive when she was a victim of domestic violence in her marriage. She felt she had never really accepted their death – “it seems like a dream” – nor had she been able to attend their funerals to mark their leaving ritually. Reality testing around the finality of death and the implications of her death threats became the focus. The memory of her deceased parents was her strongest remaining influence of good objects, reinforcing feelings of hope, fam-
ily duty and stability. During the consultation we also encouraged phone calls to her siblings to reinforce a connection with meaningful attachments.

In order to process the agitated mourning of Aliya, the family therapist placed chairs for the deceased parents. Aliya was encouraged to talk to her parents, as though they were present, about her suicide-infanticide plan and how to face this impending immigration crisis. A ritual of mourning was later put in place in the family therapy context. In the interim, the family therapist asked Aliya to place her parents’ photos in a prominent place at home to reinforce the hopeful and life-sustaining messages that the patient articulated from her imagined parents. Reviving in fantasy these good object relations (to reduce her alienation and to strengthen her parental values), helped shift Aliya’s attention to both realistic planning and more empowered discourse to redirect her rage. Understanding the gender-based violence and making a safe context to rework Aliya’s vivid traumatic memories were important issues in creating the therapeutic contract. This strategy was used rather than the clinic’s initial response of youth protection: placement of her children would have been a traumatic rupture, likely to reinforce a suicide gesture or passive helplessness rather than shifting the patient’s attention to constructing hopeful strategies.

The patient mounted a vigorous legal struggle and a year later had achieved immigration status. The family therapy agendas then shifted to the effects on her children of the traumatic aftermath of her depression and behaviour, as well as reducing her social isolation by starting employment.

**Cultural formulation: Tools and challenges**

The inclusion of a cultural formulation in the American diagnostic manual DSM IV, provided an outline to be considered in evaluation of the cultural axis (Lewis-Fernando 1996, 2002, APA 1994). The outline begins with a focus on identity (i.e. cultural reference groups, language, cultural factors in development, involvement in culture of origin and host culture involvement) and cultural explanations of illness (i.e. idioms of distress, meaning and severity in relation to cultural norms, explanatory models or perceived causes, help seeking). These issues are largely embedded in the family therapist’s capacity to understand or uncover the intimate cultural map of individuals and families they treat.

In collectivist social systems (such as most Asian and African family systems emphasizing life long inter-dependent or group-clan obligations) compared with individualist oriented systems (such as Euro-North American cultural norms oriented to nuclear families and autonomy-driven individuation agendas), the agen-
The family therapy premises of therapeutic alliance built upon Minuchin’s concept of “joining” (Minuchin 1981), often must be adapted to the contexts of collectivist values and structural realities embedded in frames of reference outside of Euro-North American life cycle agendas. Cross cultural therapy may be challenging as the therapeutic setting may evoke premises that are experienced as undermining to the elders or the parental figures as the family generations proceed in their discourse. The familial agendas of closed systems with emphasis on resolving conflict only within extended family systems (e.g. groups who maintain less permeable boundaries with the public space, such as orthodox Judaism or orthodox Hinduism), do not support open disclosure of family issues, or a therapeutic model of seeking resolution in a “stranger’s” office. The family therapist who sets out to respectfully assist or mediate cultural impasses may need a culture broker to decide on viable choices or possibilities for therapeutic work. On the other hand, the therapist may successfully serve as a valuable ally of communication, reframing and mediation of the intra-generational conflicts of children who may have individuated with host society values. Therapists must evaluate the possibilities for alliance and empathy in choosing individual or family therapy approaches by taking into account cultural frames of reference as well as their own frames of reference. Since the therapy setting itself may undermine the usual structural process amongst family adults or elders, the neutrality of the therapist as observer and guide may be challenged, impeded or welcomed in different ways across the generations of the family.

The imagination of the therapist becomes a tool essential for joining, alliance building and focus of the working through mandates of the families or individuals in the consulting room. The dictum of Murray Bowen (1978) that the systemic model can be applied to individuals not just families seen in therapeutic consultation becomes highly relevant in cultural consultations.
Case example: An arranged marriage offer

A seventeen-year-old high school girl who was a recent Asian immigrant, sought the support of her high school counsellor, revealing that she was being pressured to marry a cousin in the country of origin as soon as she graduated. The counsellor had considered youth protection or placement, but she had insisted that this would destroy her family connections forever. She appreciated his support and listening, but wanted to make her own decisions about this marriage.

During a cultural consultation, arranged in secret so her parents would not know, she related her close affection and attachments to maternal aunts and uncles. Her aunts had raised her in a joint family prior to a move with her mother to reunite the family in Canada. Unlike her mother, she felt they would support her through indirect family negotiations and understand her wishes both to pursue an education and to stay in the West. She was a very good student and her father was affectionate though he had been largely absent for her childhood. In short, she felt her maternal aunts were more sympathetic than her mother, whom she described as unhappy and envious of her affection for her father. She begged the counsellor not to alert youth protection. We agreed with her plan as long as she was not being abused and let us know if she changed her mind on these options. These complex family negotiations were done by phone and went well.

Several years later the girl wrote to the counsellor to thank him as she had moved to Europe and was studying after her marriage to her cousin. While the counsellor had felt very uncomfortable in his role, she felt he was an “understanding” parental mediator. He had withheld his urge to intervene with the parents and convert her to western norms. He was able to work with her trust and alliance by understanding her cultural and relational map where she saw the extended family as a resource of strength though they were thousands of miles away. A family systems perspective was important to listening to this adolescent struggling with power and attachments in the context of family and culture change.

Often immigrant women, to varying degrees across generations, may positively shift their power positions within the legal and social framework of the west (Guzder 1991). This can result in assimilation benefits to children and families through mutuality and empowerment. However, while a woman may feel supported by the enhancement of her options for autonomy or economic self sufficiency, these shifts can also create dynamic conflicts within gendered hierarchies. These changing relations may have an impact on couple relations, child rearing, possibilities of divorce or young people leaving home, or may lead to conflicts related to
dismantling or diminishing (particularly shaming or devaluation) of patriarchy or power of elders. The therapist may feel implicated or therapeutically challenged within these contexts to join with one member or another, losing sight of a systemic mediation possibility. Family violence may erupt, moving the agendas of the family therapy solutions in other directions.

Case example: The “dead” wife

A psychiatrist referred an African couple for treatment as he was unable to address a couple issue with a controlling husband who was reducing his wife’s medication for her serious Bipolar Disorder. The husband maintained he was trying to be helpful to his “sick wife” as she had become “dead” on the medications. He wanted her to be more “alive” as she had been before her illness. Exploration in couple work revealed initially his disappointment that her sexual drive was affected by the medication (“deadness”), but later it was also clear that her diagnosis with a mental illness was difficult for him to grasp or accept. While she had felt her Bipolar illness had been debilitating and she had been relieved to be treated, he was mourning the loss of “the wife I married”. When she had been psychotic he had barricaded her in her room after she had run naked in the street, screaming about her visions and saying she could fly, until he realized that she needed hospitalization. He felt he had saved her from certain death and always been her protector, but now that she was stable, he had become verbally abusive and controlling.

The eldest son of the couple had also become depressed with the escalation of the husband’s verbal abuse of his wife. His underlying fears that his son and his wife were affected by an “evil eye” phenomenon increased and he saw his son as “too sensitive and like a woman”.

In therapy his rage shifted to sadness as he began to discuss his “inconsolable” grief that he had lost his country, his children (i.e. they had become “western” and had individuated towards autonomy with “lack of respect for him”), and his wife who had “changed for ever” (i.e. she now had a mental disorder requiring medication).

The family therapist used the therapeutic space to hold his mourning. Family therapy provided both a psycho-educational approach and dynamic approach based on family of origin work. Both partners were empowered to negotiate their options in adjusting to the implications of her serious mental illness. The husband stopped intruding on her medication management though the rage and sadness he felt with his accumulated losses remained an issue. As he became progressively less abusive and controlling, he was faced with his issues of sadness and shame in
many levels of cultural loss and adjustment. He left therapy after many months with the declaration "you are telling me that my world has changed and I have to accept that my wife is forever changed".

His wife continued her therapy, improving steadily and remained well. Their children achieved a high level of education and individuated, increasingly accepting western norms. However, the husband felt he was greatly diminished by the migration experience as he entered his later middle age.

Since ethnic match is rarely possible unless therapists from various ethnicities are trained and available, family therapists might need to develop skills to use interpreters or culture brokers effectively (Singh 1999). In any case, ethnic match may not always be acceptable to the client, especially where the community is small or where confidentiality anxieties exist. In addition, generationally, individuals might wish to distance themselves from the culture of origin to promote assimilation or take a safe distance from emotionally charged ethnic or familial conflicts by working with a therapist from the host culture or not using their familial language. Often women in these transitions prefer a therapist from outside their culture of origin when family dynamics have been oppressive.

A family’s focus on a cultural paradigm or fixation on cultural frames as immutable can sometimes mask an avoidance of underlying dynamic issues which the family is not yet prepared to discuss. Since dealing with resistance or alliance building is the main task of family engagement, these embedded positions may be a challenge. Indeed the therapist’s own proximity to either the origin cultural context or the host country context might well prejudice the therapist’s choice of intervention focus as well.

The family resistances might also be blurred by the family’s institutional transferences or the route of referral to one’s office. Many migrant families, for example, find themselves forced to seek mental health intervention through the insistence of schools or social service agencies, rather than self referred for family therapy. Finding common ground and dealing with the stigma of mental health problems may be the first dissonance and deserves an open process to understand the views or cultural norms of the family. Often the first step to creating a psychotherapeutic space is this initial negotiation of cultural safety as a preliminary to establishing alliance in the consulting room. The better a therapist understands their own viewpoint and orientation, the more it is likely they will anticipate issues and feel at ease to approach the negotiation of a co-constructed problem-solving at the onset of the family therapy project. Therapist blind spots, and the complexities of western explanatory models of mental illness have led to develop-
ment of models of care that focus on unravelling cultural axis obstacles in family therapy (Kareem 1992).

Case example: Autism as a dilemma

Varuni was a six-year-old Sri Lankan Tamil girl who had an autism diagnosis as well as complex seizures since the age of three. Cultural consultation as a family was called upon when her parents were refusing special schooling and social services were considering placement of the child. Though there was clearly good instrumental care, social services felt that denial of Varuni’s schooling needs and denial of her autism were serious problems.

In the family sessions, her parents (particularly her mother who was a nurse) were able to speak in Tamil giving their narrative of the war. They related that the war had left most of their family in devastating circumstances.

They now felt that Varuni might be under a curse owing to the envy of a member of their family (a war survivor who did not have the option of immigration). They could not accept her diagnosis of autism as it was a mental disorder (although they accepted her epilepsy because it was a physical disorder) and had sought help from many diverse sources (i.e. Catholic holy water, Buddhist prayers, Muslim imams, Hindu pujas). In the sessions, her parents expressed concerns that Varuni could not speak, was very aggressive and socially regressed. They wanted her to go to school. They were aware that she was an attractive child so they focused on a hope that someday she would marry.

Holding their traumatic narrative in the family sessions was the first achievement of joining the family system with an interpreter who could speak their language. The parents were upset that previous professionals had “no time to hear our story” and had assumed their English skills were sufficient for understanding. Their search for alternative healers was framed as a sign of concern. The therapist did not focus on acceptance of the autism diagnosis but rather on the evident gaps in the child’s development and the parental aims for her mastery of self control and learning while accepting that a mourning process was underway for their many losses. This approach was crucial for the family alliance. They accepted a progressive integration into an appropriate school as working with their accepted aims for her education. Their own separation fears from Varuni and their high level of distress that previous professionals had not acknowledged their belief systems nor “heard” their traumatic legacy, had led to anger and previous resistances.
The alliance building possibilities through the cultural safety of speaking in Tamil and elucidating underlying trauma narratives were crucial to the assessment. The threat of placement of child assumed that the parents intended to obstruct the child’s care, while in fact resistances related to parental fears, misunderstandings, iatrogenic drug errors, and difficulty with institutional barriers. The family therapist did not interfere with the alternative healers mentioned by the parents as these agendas did not impede the family work, and worked instead on framing the autism as uneven development that they must support in order for the child to go to school.

In cross cultural psychological work there has been a growth of inter-disciplinary input from anthropology and social sciences that continues to be especially helpful to inform our understanding of the multiple threads defining psychosocial distress or social suffering (Horowitz 2007, Kleinman 1997, Littlewood 1982). While the anthropologist posits that his very presence changes the family realities that he is trying to study (Bateson 1972), similarly the family therapist has to understand how his own identity is perceived within the family context. In order to resist the harm of appropriating family voices or projecting stereotypic agendas the therapist may need a culture broker to unravel the family’s map around premises of intimacy, child developmental aims, conflict resolution and attachment. Cultural knowledge may then allow the therapist to make use of therapy tools from structural theory (Minuchin 1981), intra-generational maturation processes (Bowen 1978), circular interviewing (Tomm 1998), strategic interventions (Selvini Palazzoli 1978), and narrative therapy (White 2007). The family therapist can apply these multiple tools within a flexible approach, allowing them to gather a narrative, attune themselves to the relevant emotional states, establish problems defined by families and therapeutic judgment, and frame the impact of culture change. Our therapeutic task remains to seek shifts in competence of family functioning that enhance the family’s capacity to move forward in developmental and life cycle aims.

Conclusion

While family therapy offers an extensive literature that is universally relevant to supporting parenting capacity and family functioning, culture change presents interesting divergences. Alliance building, formulation of aims, identity or developmental agendas and life cycle shifts present complex cross cultural agendas for working with immigrant families.
This paper has explored the need to attend to the family therapy setting as a “culturally safe” holding environment, where the continuities and discontinuities of migration narrative can be heard or integrated, attuned with the family’s agendas or temporality. Investigating institutional transferences and the availability of interpreters or culture brokers as well as working in teams can be helpful to the family therapist.

Multiple identity agendas across generations must acknowledge that many issues are not necessarily intra-psychic but rather related to social suffering, institutional or host society issues. The generational agendas of families and the wider definition of families across distance or time underlines a need to understand collectivist versus individualist oriented values often redefined or renegotiated in families post migration. Shifts in power may often elevate children or women and disrupt previous structural rhythms of family systems, presenting the family and the family therapists with their own dissonances and re-evaluation of directions in the therapeutic stance or aims.

As migration impact and factors are varied and dynamic, there is a danger of losing flexibility, imposing projections rather than maintaining a respectful listening stance. Cross cultural work demands a realignment of the family therapist’s listening, continuously monitoring our oscillations of constriction, openness or facilitating focus in helping the family seek solutions. This work requires a relative comfort with unknowns and seeking narrative continuities as we create a holding environment of therapy. Family therapy tools remain helpful provided that we have defined the family, and remain actively engaged with transitional phenomena to promote the resilience of families with uneven assimilation agendas.

Bibliography


