2019

Glancing Back at The Camel's Hump: An Interpretative Phenomenological Analysis of Saudi Family Therapists' Dual Epistemologies

Rana M. F. Banaja
Nova Southeastern University, rana_banaja@hotmail.com

Glancing Back at The Camel's Hump: An Interpretative Phenomenological Analysis of Saudi Family Therapists' Dual Epistemologies

by

Rana Mohammed-Fawzi Banaja

A Dissertation Presented to the

College of Arts, Humanities, and Social Sciences

In Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

Nova Southeastern University

2019

Nova Southeastern University
College of Arts, Humanities, & Social Sciences

This dissertation was submitted by Rana Mohammed-Fawzi Banaja under the direction of the chair of the dissertation committee listed below. It was submitted to the College of Arts, Humanities, & Social Sciences and approved in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the Department of Family Therapy at Nova Southeastern University.

Approved:

01/09/19
Date of Defense

Douglas Flemons, Ph.D.
Chair

Shelley Green, Ph.D.

Kara Erolin, Ph.D.

03/02/19
Date of Final Approval

Douglas Flemons, Ph.D.
Chair

Acknowledgments

This space is dedicated to my people, who supported, encouraged, and helped me through this journey. Without them, I would not have been able to do it. Completing my Ph.D. was not always easy; in fact, at times it was scary and felt impossible, especially when I lost my grandparents while I was completing my studies abroad. Whenever I felt unstable while big changes were happening back in my country—like when my uncle was diagnosed with cancer, or when I was in labor, alone—I knew I could continue, and even work harder, because I had the help and support of my people.

First, I would like to thank my mentor, supervisor, teacher, and Chair, Dr. Douglas Flemons. Thank you for helping me shape and polish this study. Thank you for creating a safe place for me to be myself. Thank you for your guidance, your insights, your teaching, which shaped me as a writer, a therapist, and a person. Thank you for making this a fun, creative, safe, and enjoyable journey. It is true, you made me cry sometimes; but I also laughed a lot during this journey, as I learned to face my challenges, to live and learn, to enjoy life even through difficult times.

I would like to also thank both of my committee members, Dr. Shelly Green and Dr. Kara Erolin. Thank you for your support, encouragement, and feedback; they really helped improve my study. I also want to thank my editor, Dr. Denise Fournier, for editing this dissertation and making the document look smooth and clean. Thank you also for your encouraging words.

I would like to extend heartfelt thanks to both of my parents. Thank you, mama, for your unconditional love, support, and guidance. Thank you for being you; thank you for believing in me, and for being my role model. You were the first person to encourage me to do this. Thank you for that, and for everything. Father, no words can describe my gratitude for you, baba. Thank you for always being here with me, and for supporting me and my kids.

Thank you for being patient and loving to us, always. This would not be possible without both of you, mama and baba.

I would like to thank my siblings, Ruaa, Aziz, and Omar, for believing in me, for looking up to me, and for all your love and support. I would like to also thank other family members, friends, and colleagues, especially Aalaa, Annette, Bedoor, Deema, Jemena, Jumana, Layal, Sara, and Viktoria. Thank you for being part of my support system. Thank you for your patience, and thank you for encouraging me to continue.

I also want to thank my father-in-law for his faith in me, and for encouraging my husband and me to take this step. And I want to thank Ahmed, my husband, for making this happen. Thank you for believing in me, and for allowing me to come with the kids to do this journey without you, knowing how difficult it could be for both of us. Thank you for your support, love, and trust.

I want to thank my kids for making this happen, and for making my life so lively, colorful, and full of energy. Yasmina, my daughter, thanks for being you. Thank you for your support, and for always asking about my progress. Eisa, my son, thank you for your big heart; thank you for your love and for your support. Yahia, my Ph.D. baby, thank you for adding so much to our life. Thank you for being so sweet, funny, and loving. And I forgive you for all the terrible twos events that happened during my studies. To my kids, I thank you for helping me and thank you for understanding. I am a stronger woman because of you.

Finally, I extend my sincere appreciation to the participants in this study. It was my pleasure to meet with you and talk about a very sensitive matter: who you are as therapists. Thank you for being yourselves in the interviews and throughout our discussions. Thank you for being supportive, encouraging, and open. I hope that your experiences with me were as meaningful as they were for me.

TABLE OF CONTENTS

Abstract

Since family therapy was brought only recently to Saudi Arabia, studies exploring the field in this context are few. This dissertation will be the first to focus on the self of the Saudi Arabian family therapist (SAFT). In particular, it will be the first to pay close attention to SAFTs' ways of dealing with the differing and, perhaps, incompatible epistemologies of Saudi culture and religion on one side, and systemic thinking and family therapy on the other. This study seeks to shed a phenomenological light on what informs SAFTs and what influences their work. Using interpretative phenomenological analysis (IPA), I interviewed seven SAFTs, identifying the challenges they encounter as they undertake their practice, and clarifying how these therapists are adapting Western knowledge vis-à-vis the Saudi culture. An old saying in Arabic conveys the self-reflective challenge of examining epistemological assumptions. We say "a camel can't look at its own hump." This dissertation is an attempt to at least steal a glance at it.

Keywords: epistemology, culture, cross-cultural, adaptation, self-of-the-therapist, self-awareness, cultural awareness

We find that different peoples of the world have different ideologies, different epistemologies, different ideas of the relationship between man and nature, different ideas about the nature of man himself, the nature of his knowledge, his feelings, and his will.

—Gregory Bateson (1972, p. 486)

But epistemology is always and inevitably personal. The point of the probe is always in the heart of the explorer: What is my answer to the question of the nature of knowing? I surrender to the belief that my knowing is a small part of a wider integrated knowing that knits the entire biosphere or creation.

—Gregory Bateson (1979, p. 88)

CHAPTER I: INTRODUCTION

Family therapy is currently one of the most nationally recognized mental health professions in the United States. Although the profession originated more recently than other mental health disciplines, it has grown rapidly and continues to expand broadly. Professionals within the field started exporting their methods and epistemological understandings to other countries in the 1960s and are still doing so across the globe (Kaslow, 2000). This profession has traveled—and continues to travel—throughout the world to different countries, encountering diverse religions, beliefs, statuses, and worldviews. One of the recent destinations of this knowledge was the Kingdom of Saudi Arabia (KSA). Although several authors have agreed upon the importance of implementing family therapy in the KSA, family therapy is still not fully recognized there (Gassas, 2017). Family therapy was exported to Saudi Arabia only recently, so family therapy studies in a Saudi context are few.

The ideas and practices of family therapy have primarily spread from the United States in two ways: (a) leading American family therapists have traveled to other countries, offering workshops and trainings to interested professionals; and (b) students from other countries have come to the United States to learn and train in university-based marriage and family therapy graduate programs and then returned to their home countries to spread their new knowledge (Kaslow, 2000). The stage of development of family therapy, and the acceptance of its ideas and practices, varies from country to country and culture to culture, depending in part on how long such information exchanges have been underway.

Family therapy differs from other mental health professions in that it involves practitioners making an epistemological shift as they learn to help people in distress. This distinct way of thinking was first presented by the Palo Alto research group assembled by Gregory Bateson. According to Auerswald (1987), a small group of behavioral scientists

began family therapy as a movement that was considered the beginning of an epistemological shift, as it challenged the epistemology of medical and psychodynamic therapies. The systemic epistemology that is foundational to the teaching and learning of family therapy can be challenging to accept, particularly for learners whose original epistemology differs greatly from it. For this reason, the acceptance and functionality of the family therapy discipline differs from place to place. In some countries, family therapy is well known and well developed; in others, it is unknown or still evolving from its Western origins.

This dissertation research was designed to address the exporting of marriage and family therapy to the KSA, a collectivist society. I was particularly interested in exploring the self of the Saudi Arabian family therapist (SAFT), to understand the challenges these therapists experience and the ways they deal with the competing demands of their dual epistemologies: the epistemology of Saudi culture, which is derived greatly from the Islamic religion, and the family therapy epistemology, rooted in Western philosophical ideas and scientific understanding.

The dual and very distinct epistemologies held by SAFTs can create personal and professional conflicts and challenges. As clinicians, they may hold assumptions about family therapy in terms of change, the role of the therapist, the importance of not imposing their beliefs on their clients, and the embracing of a not-knowing and non-normative stance. However, Saudi Arabian culture and religion offer a clearly defined understanding of what is proper and improper; within this context, there is a societal expectation that the primary responsibility of the professional helper is to offer interventions congruent with Saudi religious and spiritual norms and beliefs. Family therapists in Saudi Arabia may, therefore, encounter conflict as a consequence of being guided by two incompatible epistemologies.

The significance of epistemology—or, in this case, epistemologies—is mostly implicit; however, it can also appear through actions. This is challenging, since the implicit

assumptions—including views on human rights, ethnicity, gender, hierarchy, society, religiosity, marriage, children, and mental openness/closedness—can inform an individual's judgments, roles, and goals. Next, I will present the context of the study, exploring the influence of the implicitly held assumptions that guide it.

Context of the Study

As a Saudi student obtaining a Ph.D. in family therapy, I have been exposed to two different epistemologies: one from the rich religious and cultural values found in the KSA, and the other from the family therapy ideas I have learned in the United States. Recognizing and honoring both epistemologies has not been easy; I still sometimes struggle to find my way between the two belief systems. In the collectivist KSA, religion and culture are undoubtedly significant. Citizens and residents of the KSA—considered by Saudi citizens to be the center of both the Muslim and Arab worlds—view culture and religion as sources of power that play an important role in society (Gallarotti & Al-Filali, 2012). Saudi culture is deeply ingrained in Saudis and central to their identity, both personally and professionally. Identity consists of the distinguishing characteristics by which individuals define themselves; it can be determined by factors such as their social class, racial and ethnic heritage, values, religion, and more (Maxwell-Hubert, 2004). This means that our overall identity is informed by a variety of components. As Morris (2014) explains, "Cultural and ethnic identities are important components of an individual's overall identity" (p. 4).

The seeds of religion and culture can grow within individuals, not only as a sense of identity, but also as a framework for reality and perception. McOmie (as cited in Al-Issa, 2005) aptly articulates that culture "is a way of seeing, a way of perceiving, and a way of behaving on the basis of that perception" (p. 145). This assumes that culture, religion, and identity are interrelated and intertwined, along with knowledge, which informs people's epistemology and is translated through their perceptions and actions.

Keeney (1983) notes that any act of epistemology affects how people behave and perceive. Similarly, Bateson (1972) argues that ontology and epistemology cannot be separated, as individuals' beliefs about the world determine how they see it and act within it. He asserts that our ways of perceiving and acting determine our beliefs about the nature of the world. In other words, what we believe is true, and what we perceive is true, so we orient ourselves according to these perceived truths and act on them without necessarily noticing the influence of our epistemology, identity, or belief system. The challenge occurs when a person has two contrasting sets of beliefs and truths. For example, some beliefs that a Saudi or a Muslim can hold as truths pertain to how people should be, look, think, and believe. These beliefs can determine how therapists deal with their clients. On the other hand, believing in a systemic way of thinking also influences how therapists act with their clients. The primary question guiding this study is how SAFTs with both belief systems are guided in their practice of therapy.

As Heiphetz, Spelke, and Banaji (2014) reflect, "Beliefs are invisible contents of the mind" (p. 22). It is my view that all beliefs are invisible, but some beliefs live tacitly in relationship to—or communication with—others. Bateson (1972) states, "The relationship is the exchange of messages; or . . . the relationship is immanent in the messages" (p. 280). This suggests that the distinction between the components—in this case, what we believe in and how we act—is dissolvable; thus, beliefs and actions cannot be easily separated from each other. Bateson's explanation of binocular vision is a rich example of the intertwined nature of the relationship. He thought of two parties in an interaction as two eyes, each giving a monocular view of what goes on; together, they offer an in-depth, binocular perspective. Bateson (1979) stated, "The binocular image, which appears to be undivided, is in fact a complex synthesis of information" (p. 65). The binocular relationship between beliefs and actions helps reveal the way implicit assumptions or tacit beliefs live through relationships,

present in our doing, saying, orienting, and working.

Keeney (1982) reflects on the invisible yet connective nature of the therapist's epistemology and habits of action. He proposes that what therapists bring into the therapy room will probably affect what unfolds in the therapeutic encounter, despite the fact that they remain largely unrecognized by the therapist and client. Individuals, and especially therapists, need to remain aware of what influences the way they operate and function, and what determines how they orient themselves in therapy. According to Keith (2000):

> When you look for the I in you, you enter a labyrinth constructed of mirrors, encoded messages, and other pseudo-objective deceptions. To engage in the search requires that you be an impeccable observer. There are many distractions. Some of them are cultural pathologies. . . . By attending to the labyrinth of the unknown, you encounter the depth of people and the world. (p. 276)

Traditionally, family therapy programs advise therapists to engage in self-of-the-therapist work in order to seek clarity and better understand themselves, personally and professionally. As Regas, Kostick, and Doonan (2017) explain, "Substantial evidence suggests that effectiveness in therapy depends greatly on a therapist's own emotional maturity, personality, and degree of self-understanding" (p. 18). Carlson and Erickson (1999) assert that personal understanding has become one of the central concerns in the family therapy tradition; in order for therapists to be in touch with this understanding, they must encounter and reflect upon their values, assumptions, and biases.

Bateson (1972) asserts, "As therapists, clearly we have a duty. First, to achieve clarity in ourselves" (p. 493). With such clarity, therapists can utilize awareness of their beliefs, values, and biases to take a less judgmental, less biased stance with their clients. As Clarson and Erison (1996) point out:

> This sense of awareness of the therapist's own invisible self is a learned skill in the

field of family therapy, which usually encourages therapists to explain their values and beliefs according to systems theory ideas, or to any family therapy theory. (p. 56)

Therapists who explore themselves develop greater awareness of their personal issues, which can allow them to be more open to their emotions and less reactive in therapy (Clarson & Erison, 1996).

This study explored the challenges that SAFTs who trained in the United States and have practiced, or are currently practicing, in the KSA are encountering as a result of operating from these two epistemologies. As a researcher, I was not interested in judging or analyzing the belief system of these SAFTs. Instead, I was motivated to understand the implicit assumptions located within the blurry relationship between culture, religion, and professional identity. As I noted before, I studied and explored SAFTs' experiences, to understand how they adapt and balance the rigid value system from their culture and/or religion with a professional orientation grounded in a willingness to question authority, habit, and convention. This complex relationship constituting SAFTs' personal and professional selves represents the heart of this study.

Personal Background

After earning a family therapy master's degree in 2010 from Nova Southeastern University in Florida, I went back to my home country, excited to give back and practice what I had learned. Seeing clients in a private practice setting, I worked with individuals, couples, and sometimes families. One of my clients was a young woman with a culturally challenging issue; her presenting problem was related to her gay sexual orientation—something considered taboo in Saudi culture. As her therapist and a fellow Saudi, I was trapped within the culture's rules, assumptions, and standards. I knew the client's presenting problem was not culturally accepted, but if I counseled her from this perspective, I would be turning my back on my training.

I felt puzzled about what I was feeling and struggled to determine how to address the issue from both a systemic perspective and one aligned with Saudi culture. I was trapped. I found it impossible to focus and had no idea what to do. It was then that I started thinking about what was informing me and my assumptions as a therapist. This experience was one of the reasons I decided to continue learning, in order to resolve the conflict between my two epistemologies. Going through this challenge helped me in a way; it added clarity and congruence to my learning process by putting me in touch with what I was experiencing and allowing me to find ways to adapt.

According to Lum (2002), "The development of the self of the therapist is a significant aspect of becoming an effective therapist. The use of self has been recognized by various therapists as being the single most important factor in developing a therapeutic relationship" (p. 181). I am thankful to now celebrate the synthesis of my personal and professional selves, with a new sense of enthusiasm for my future. This was not the first or last time I got stuck between the two worlds that I think and work from—the two epistemologies upon which my knowledge, understanding, and perception depend.

Developing My Approach to Change

During the years I have spent learning family therapy, I have often questioned the process of change—curious about how it happens, and if, in fact, it really can happen. I remember hearing colleagues express a sense of pride at seeing their clients change, and silently doubting that such change is possible. I thought to myself, "When am I going to see visible change through my clients, instead of reading examples of change from the books?" I used to view change as a substance or product that stands solely by itself. Eventually, I decided to express my frustration to one of my professors in a clinical supervision meeting. He informed me that change is not an object; rather, it is an orientation that starts from the first session. He also told me that in order for me to see change, I needed to start asking

clients about what had shifted. I wondered, “Why would I ask my clients what has shifted if I do not know that they, in fact, have changed?” I was still viewing change as an object separate from myself.

Later, in one of the advanced semesters of my Ph.D., program I was a teaching assistant in a hypnosis class offered within the program. In one of the lectures, the professor explained that language helps create change, and that when change happens gradually, people tend not to be aware of it. Listening to the professor, I thought to myself that this must be one of the reasons therapists ask clients what is changing or what is different. By answering these questions, clients can become aware of and oriented toward difference. Even if they do not notice, at first, that anything has shifted, the larger frame of the question can invite them to alter their orientation, allowing them to gain awareness of change.

An interesting thing happened to me after I processed my own knowing as a therapist and connected the dots to make sense of change in a different way: I noticed the absence of change in my sessions, and also the absence of asking my clients about change. Keeney (1983) explains, “To become aware of how one knows and constructs an experiential reality entails knowing about one’s knowing. This necessarily requires that we see ourselves constructing and construct ourselves as seeing” (p. 107). After viewing change as both an observer and part of what I observe, I realized that I am a participant in my observations. This caused a significant change in my perception. My experience followed Keeney’s assertion that “one’s knowing about therapy changes one’s therapy, which subsequently changes one’s knowing about therapy” (p. 23).

With my new orientation to change, I was adopting a cybernetic epistemology, a conceptual lens focused on patterns rather than materials, and on perceptions rather than realities (Keeney, 1983, p. 95). My choice to avoid asking my clients what had shifted was informed by implicit assumptions that change is not real. As Keeney (1983) articulates,

"What one knows leads to a construction and what one constructs leads to knowing" (p. 108). In this example, my implicit assumptions doubting change influenced my perception, which possibly led me to not ask clients about change. Bateson (1972) explains:

> Our perception is our own creation of the world, and what we perceive is actually informed by our own belief. This belief influences our perception in a way that enables us to adjust the reality that we see to match and confirm this belief. (p. vii)

This implies that perception works like a lens, adding depth, meaning, and difference to what is perceived. According to Keeney (1983), "An observer always participates in what he observes" (p. 30). This observing is shaped by the observer's epistemology and colored by beliefs that remain invisible unless they rise to conscious awareness. The influence of these beliefs "will determine how [the observer] sees it and acts within it, and his ways of perceiving and acting will determine his beliefs about its nature" (Bateson, 1972, p. 320).

We all have implicit assumptions that include our beliefs, opinions, and views of the world. These invisible beliefs are informed by our epistemology and, therefore, can appear to us not just as perception, but also as unquestioned truth. Williams (2005) asserts that "assumptions are what we 'take for granted', and the worst kinds of assumptions are those which are out of our awareness, hidden and never challenged in our reflective thinking processes" (p. 126).

There is an old Arabic saying that suggests a camel is not capable of seeing its own hump. Similarly, Bateson (1979) talks about the inaccessibility of our own beliefs:

> The processes of perception are inaccessible; only the products are conscious and, of course, it is the products that are necessary. The two general facts—first, that I am unconscious of the process of making the images which I consciously see and, second, that in these unconscious processes, I use a whole range of presuppositions which become built into the finished image—are, for me, the beginning of empirical

epistemology. (p. 32)

Although a camel cannot see its hump, it remains one of its most important resources. Similarly, our invisible beliefs are still alive somewhere within us, remaining active and influential:

> What hold we have on the invisible world within us; what hold, through this, we have on the visible world about us, and what, through these both, on the future, visible and invisible, which lies before us—that future without which the present perishes, as the flower plucked from the stem, leaving no seed behind it. (Bascom, 1876, p. 5)

These questions about the visible and invisible influences on our thinking raised other questions and considerations for me, especially with respect to my role as a Muslim Saudi therapist. I started wondering what identity other SAFTs work from, and what beliefs inform them in the room. I also started wondering about the assumptions these therapists hold, and whether they are cultural and religious or derived from the systemic epistemology they learned in the West. I began to wonder about the challenges SFTs might encounter as a result of choosing one frame over the other, or in trying to somehow merge them. How, I wondered, have they adapted since returning home?

Statement of the Problem

In a collectivist society, where everyone has similar views and assumptions about life, therapists may need to differentiate themselves from the rest. Being able to see the bigger picture can allow SAFTs to perceive clients' problems from a different angle, thereby introducing change into the system. Being aware of our implicit assumptions can allow us to access our therapeutic resources more deeply, expanding our role as therapists. This role depends on the beliefs informing it. If SAFTs are informed only by religion and culture, they will assume the position of the Imam, or Islamic religious leader, telling clients what they should and should not do. In contrast, if they are only informed by their professional theories

and knowledge, they will lack awareness about the influence of culture and society.

Purpose and Significance of the Study

This dissertation is the first to focus on the self of the SAFT. In particular, it is the first to pay close attention to SAFTs' ways of dealing with their dual epistemologies: Saudi culture and religion, and the systemic thinking guiding the tradition of family therapy. This study shed a phenomenological light on what informs SAFTs and what influences their work. My purpose in interviewing seven SAFTs, including myself, was to glance at the camel's hump, identifying the challenges SAFTs encounter as they undertake their practice, as well as clarifying how these therapists are successfully and creatively adapting Western knowledge vis-à-vis Saudi culture. The study not only helped clarify current struggles in the adoption of MFT ideas and practices in the KSA, but also aided in constructing part of the history of the field in the KSA. This is the first study to bridge Western knowledge of family therapy and the self of the Saudi family therapist. This study can be considered timely for SAFTs, as it articulates and normalizes the challenges they face, potentially bridging the gap between Western knowledge and Saudi culture on the one hand, and the current cultural shifts in the KSA on the other.

Research Question and Objectives

This study was guided by the following research question: To what extent are current SAFTs self-reflective about the contrasting epistemological assumptions of their profession and their religion/culture, and how are they managing the personal and professional challenges this contrast brings about? The objectives for this study were the following: (a) to identify the challenges, if any, that SAFTs who graduated from Western universities encounter when working from the dual epistemologies of systemic family therapy and Saudi religion and culture; (b) to investigate what informs the therapeutic work, theory, and orientation of SAFTs; (c) to explore how aware SAFTs are of their implicit biases, beliefs,

and assumptions; (d) to distinguish the ways SAFTs accommodate, adapt, reject, and/or utilize their layered epistemologies; (e) to recognize different perceptions of the professional identity of SAFTs; and (f) to understand how SAFTs understand their role.

Definition of Terms

To help make implicit beliefs more visible, it is necessary to be transparent in the research process by clarifying the meaning of key concepts. The following terms, therefore, need to be defined in as distinct and simple terms as possible.

As I mentioned before, every individual operates according to their beliefs, assumptions, religion, culture, and so on. These are considered the heart of an individual—the operator that runs a person's thinking and doing. *Epistemology* is the umbrella term containing all of these foundational aspects. The word itself is derived from the ancient Greek *episteme*, meaning *knowledge*, and the suffix -*logy*, meaning *logical discourse* (derived from the Greek word *logos,* meaning *discourse*). Epistemology, as Bateson (1979) described it, includes our knowledge, or what we know, as well as how we know what we know; but this is only part of the equation. All aspects of mind are relevant when considering a person's epistemology, including how they think, how they act, and how they think about their thinking and acting. In this dissertation, I contrast the epistemologies of family therapy and Saudi culture.

The term *culture* refers to a group of beliefs, assumptions, views, customs, and perceptions that belong to a particular group of people (Rathod, 2017). Culture can be considered an important influence on one's epistemology, shaping perceptions, knowledge, and ways of viewing the world. In this dissertation, I explore the role of culture in defining a person's worldview. I use the term *cross-cultural* to refer to the juxtaposing or relating of two or more different cultures. This term is most relevant in the exploration of family therapy in

the context of different cultures. I use it in my examination of the various cultural responses to the imported knowledge of family therapy.

Adaptation refers to the process of attempting to achieve a better fit (Irfan, Awan, Gul, Aslam, & Naeem, 2017). In this dissertation, I use this concept to explore how therapists from different cultures, including Saudi family therapists, have adapted to the Western knowledge base of family therapy. *Self-of-the-therapist* is a unique aspect of family therapy training that encourages self-exploration, as well as an examination of its implications in the therapeutic context (Carlson & Erickson, 1999). *Self-awareness* can be considered a branch of self-of-the-therapist work. It is the process of being aware, either personally and/or professionally. Within the context of this study, self-awareness is discussed in relation to the therapist in the therapeutic or supervisory context. In the family therapy literature, *cultural awareness* is a topic most often discussed within self-of-the-therapist work (Culver, 2011; Lopez-Bemstein, 1997; Pedersen, Crethar, & Carlson, 2008); it is concerned with therapists' awareness of their cultural assumptions and values.

Research Design

I conducted an autoethnographic and phenomenological study to explore the implicit assumptions of SAFTs, which are informed by their religion, culture, and personal and professional identities. As part of an autoethnographic exploration of myself as an SAFT, I interviewed myself to explore and reflect on my own experiences in this context. I then conducted some face-to-face and videoconference interviews with SAFTs who graduated from Western MFT programs, in order to explore their unique lived experience. In particular, the study focused on how Saudi family therapists integrate both Arabic culture and Western knowledge. The purpose of in-depth interviewing was not to examine hypotheses, but rather to understand participants' lived experience and the meaning they make out of it (Seidman, 2003). To pursue this research interest, I developed sample questions, which I posed during

in-depth, semi-structured qualitative interviews. These questions will be introduced in Chapter III.

Summary

This chapter addressed the purpose of this study and introduced the context in which it was conducted. In Chapter II, I examine this context more deeply through a literature review that explores the development and current state of the family therapy field in Saudi Arabia. Chapter III includes an in-depth discussion of my research methodology, as well as descriptions of the research sample and research variables. In Chapter IV, I present the findings from the study, while illustrating the themes I derived from my analysis. In Chapter V, I discuss the implications of this study for SAFTs and the burgeoning field of family therapy in the KSA.

CHAPTER II: REVIEW OF THE LITERATURE

To support the exploration of Saudi family therapists' dual epistemologies in this study, it is important to establish a foundation that includes a review of the scholarly literature pertaining to this topic. In this chapter, I will explore the practice of family therapy, both nationally and internationally; the process of becoming a family therapist; and the ways in which family therapists bring their practice to their home countries.

Family Therapy in the United States

According to Rambo and Hibel (2013), "family therapists do not necessarily see whole families; they may see individuals, couples, or groups. What makes family therapy a distinction is its relational focus" (p. 3). Family therapy can be explained from a variety of historical, epistemological, and model-specific perspectives, so it is important to begin with a clear definition of the practice. Throughout the different sections of this chapter, I will apply the focus of this study to answer the following question: What is family therapy? To begin, I will present a brief history of family therapy and its status in the United States.

Brief History

Flemons (2017) notes that brief therapy, one of the original approaches in the family therapy tradition, began between 1952 and 1962 as a research project. Gregory Bateson assembled a team for this project, which came to be known as the Palo Alto group. John Weakland and Jay Haley were the first members of the Palo Alto team; two psychiatrists, William Fry and Don Jackson, joined them later. After that, Virginia Satir, Richard Fisch, and Paul Watzlawick joined the group.

The members of this team were later considered pioneers of family therapy (Stagoll, 2006). Taggart (as cited in Henry & Storm, 1984) explains that these:

> pioneers of family therapy were troubled by the failure of traditional psychotherapists to alter the behavior of persons labeled 'schizophrenic' or 'delinquent'. This concern

> evolved into action as these pioneers tried different therapeutic and social 'experiments' to alleviate human suffering. (p. 41)

Despite difficulties regarding the empirical validity and applicability of this new theory of schizophrenia, it was considered a foundational discovery and the origin of the field of family therapy. The work of the Palo Alto group began to shift the focus from the intrapsychic perspective of psychoanalysis to a broader perspective, incorporating the network of interactions between people (Stagoll, 2006).

In 1965, Fisch proposed a brief approach to family therapy as a research project for consideration by the Palo Alto team. Later, this brief therapy research group developed what is now known as the Mental Research Institute (MRI) approach. The team's goal was to construct a therapeutic frame for time-limited, goal-directed, strategically oriented, and change-focused interventions. The MRI was influenced by Gregory Bateson's ideas on communication and the therapeutic strategies derived from the work of Milton Erickson (Flemons, 2017). The MRI group created what is now considered the first distinctive family therapy institute in the world. However, also in the 1950s, Murray Brown developed a family therapy model grounded in natural systems theory (Rambo & Hibel, 2013). After that, other new forms of therapy came to life, including Milan, narrative, solution-focused, and others (Stagoll, 2006).

Status of Family Therapy in the United States

Marriage and family therapy is well established in the United States, and—according to the U.S. Bureau of Labor (2017)—there are currently around 42,000 practicing family therapists throughout the country. In addition, the federal government considers family therapy a core mental health profession; it is supported and regulated in all 50 states (AAMFT, 2018). According to the American Association for Marriage and Family Therapy (AAMFT, 2018), "The number of states regulating marriage and family therapy in the United

States has grown rapidly from 11 in 1986 to 50 in 2009 (plus the District of Columbia)" (MFT Licensing Boards section, para. 5). It all started in 1949, when the American Association of Marriage Counselors (AAMC) became the AAMFT. This association was not only the first family therapy organization, it is also currently recognized as the most influential organization of its kind in the country.

Through the efforts of the AAMFT, and with the cooperation of the National Council on Family Relations, the process of marriage and family therapy (MFT) licensure and regulation commenced (Northey, 2010). After graduating from an accredited program at the master's or doctoral level, family therapists are required to go through a period of post-graduate supervised clinical experience—for a minimum of two years, in most cases—in order to be licensed or certified. When the supervision period is complete, the therapist can take a state licensing exam or the national examination for marriage and family therapists conducted by the Association of Marital and Family Therapy Regulatory Boards (AMFTRB). This exam is used as a licensure requirement in most states (Simmons, 1996).

Recently, in an effort to overcome what was identified as a quality chasm in mental health care in the United States—a gap between the treatment clients are getting and the care they should have—the AAMFT created a set of core competencies for the practice of marriage and family therapy; these competencies were approved and adopted by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) as one of the MFT principles (Northey, 2010).

After the establishment of family therapy in the United States, and after AAMFT's establishment of standards, competencies, and regulations for practitioners, the profession's discussion has more recently been oriented toward exporting the principles of the practice to the rest of the world. Glebova, Bolotina, and Kravtsova (2014) note that there is a visible

effort, especially in recent years, to internationalize family therapy, making it a cross-cultural and safe domain.

Family Therapy Throughout the World

Although the roots of family therapy were first established in the United States in the 1950s and 1960s, the field was already being exported to different parts of the world by the 1970s and 1980s. Family therapy journals, books, and conferences spread to most of the world, except for most of the Arabian and the African countries. South Africa and Israel were the only countries in these regions to develop this new approach (Kaslow, 2000).

Family therapy was implanted in many other countries, including China, India, Japan, Mexico, Peru, Spain, Turkey, Argentina, Brazil, England, Germany, Yugoslavia, and more (Kaslow, 2000; Roberts et al., 2014). This shows how family therapy has spread to various counties and continents comprised of different religions, beliefs, races, colors, and cultures. To become family therapists, people from these countries take courses, attend trainings, or earn family therapy degrees in the United States (Kaslow, 2000). In other cases, especially in countries in which family therapy has only recently been established, lead family therapists from the United States or other countries in which the field is well established are invited to offer family therapy education and training (Kaslow, 2000).

Many authors have shared their experiences of teaching, training, consulting, or supervising therapists in other countries (Charles, 2007; Charles & Piercy, 2003; DuPree et al., 2012; Piercy et al., 2014). One of the noticeable patterns among family therapy consultants' experiences is an acknowledgment that the development and practice of family therapy is unique to each country, shaped by its particular culture, language, and perceptions. Family therapy seems to vary from country to country, not only in its overall image, but also in its process of maturity and growth. In some countries, family therapy is well planted, meaning that it is not only taught in universities, but also represented by organizations and

associations. Japan offers an example of this. In 1984, the Japanese Association of Family Therapy (JAFT) was founded; since then, the field of family therapy has grown not only within Japan, but also in collaboration with other Asian countries through the Consortium of Institutes on Family in the Asian Region (CIFA) and the Asian Academy of Family Therapy (AAFT) (Roberts et al., 2014).

Another example of the vast expansion of family therapy is Korea. According to Lee et al. (2013), family therapy matured in an integral way in Korea, with support from the Korean government; this has been accomplished "by making family counseling a legally mandated service at healthy family support centers, as well as recommending it at a variety of human service settings, such as youth counseling centers, community welfare centers, and especially family courts" (Lee et al., p. 398). This example illustrates that family therapy is well developed and, at the same time, still evolving in some countries. In other countries, family therapy might not be a major domain in the helping professions, but it is still expanding and growing slowly. In India, for example, the field of family therapy has existed for quite some time, but it still is not considered a formal profession (Mittal & Hardy, 2005). In other regions like Saudi Arabia, family therapy is still in its infancy, as there are not yet any family therapy associations, and the number of scholarly articles in this domain is limited (Al Gassas, 2018). Clearly, family therapy is spreading broadly throughout the world and is in different stages of growth in different regions and countries.

Kaslow (2000) explains the typical process by which family therapy grows in a country:

> Eventually individuals working together in each country have synthesized the multiplicity of ideas and techniques they have learned and evolved their own indigenous brand of marriage and family therapy so that it is more congruent with their traditions, needs, expectations and overall context, and have begun their own

> training institutes and academic departments and incorporated courses in marriage and family therapy. (p. 27)

This illustration of the growth process of family therapy outside the United States indicates that once the seed is planted by trainings or other means, it evolves and becomes personalized, depending not only on family therapy theories, but also on the culture and people it serves. Kaslow (2000) explored both the unique aspects and commonalities of family therapy programs across the globe, noting that the international interconnectedness of the field is done through the help of regional and international associations, which provide:

> exciting forums for the exchange of ideas, for building friendships, and for collaboration in a variety of projects, and it is prognosticated that they will grow in numbers and strength as we all recognize 'It's a small world after all.' (pp. 31-32)

Responding to the internationalizing of family therapy, the International Family Therapy Association (IFTA) was founded in 1987. It is one example of the integration of therapists, consultants, and supervisors who come together from around the world to "provide international conferences to promote, strengthen and improve the quality of family therapy, the quality of relationships within families and to promote well-being and peace within our world" (Mission Statement section, para. 1). Along with other international family therapy communities, it includes diverse and vibrant members and presenters.

These associations continue to grow and expand, coinciding with the general trend of globalization happening in the world today (Kaslow, 2000). As Melendez-Rhodes (2018) points out, this process of globalization promotes first-hand interaction with other cultures as a process of cultural bridging, encouraging family therapists to become internationally competent. The development of family therapy in all countries follows the trend in the United States (Kaslow, 2000); this includes the process of becoming a family therapist.

Becoming a Family Therapist

Cullin (2014) explains the process of learning family therapy by saying, "It's not like learning any particular 'model' of therapy. It's different [from] that. It involves an epistemological shift, and not everyone can (and not everyone wants to) make this shift" (p. 357). The epistemology of family therapy—in other words, what and how family therapists think—has been described well by philosophers and pioneers, who make it clear that there are particular kinds of professionals who want to learn family therapy. Since family therapy is different, learning and teaching it should be different as well. As a domain with a rich epistemology, the family therapy approach can be challenging to learn, especially since family therapists are encouraged to explore different perceptions, beliefs, theories, and experiences (Ham, 2001).

In the following section, I review the literature about family therapy training, focusing specifically on the epistemological foundations, since they encompass the therapist's actions and cognitions (Keeney, 1983). I also explore the literature on the interpersonal implications of becoming a family therapist, since the self of the therapist is relevant to the therapist's knowing and being in therapy as well. However, this is not to say that becoming a family therapist only involves these two aspects. Indeed, learning to become a family therapist includes various stages of growth and development beyond the learning of therapeutic tools.

Unlike most professions, family therapy involves a combination of knowledge, clinical training, and clinical reasoning (Steele, 2006). Becoming a family therapist is a complex process that includes learning models, history, and clinical techniques, as well as grasping the epistemological foundations of the systemic point of view and developing an identity as a therapist. All of these are critical to becoming a family therapist, but only the last two are relevant to this dissertation: deriving an epistemological understanding and exploring the self of the therapist.

Learning Epistemological Foundations

According to Keeney and Sprinkle (1982), "Although there is a distinction between epistemology and action, as well as aesthetics and pragmatics, there is always a relation between the two levels such that their interaction modifies and tempers one another" (p. 481). This illustration indicates that family therapists have a clear epistemology that is related to their practice of the profession. Keeney explains, "It's as if one's hand draws outlines on one's own retina. The process is recursive—what one draws, one sees and what one sees, one draws" (pp. 45-46). This means that any person will think and act according to his or her epistemology; and since family therapy has a unique epistemology, it must be included in the teaching and learning of the family therapy approach. Dickerson (2010) outlines several reasons for teaching students about epistemology:

> In my mind [the] most significant reason for the importance of being clear about one's epistemological positioning is how it shows up in clinical practice. The therapeutic position from which I operate influences greatly what it is I attend to in my conversation with a client. (p. 364)

Cullin (2014) confirms Dickerson's (2010) point and expands upon the notion of epistemology as meta to our beliefs; it informs how we think and how we act. This also includes theory. Dickerson (2007) notes that "theories can fit within the same epistemology, with the defining factor being how they conceptualize person, problem, and change" (p. 24). This means that epistemology can be thought of as the overarching umbrella for what we think, do, and believe. Since epistemology is directly connected to practice, family therapists are encouraged to be aware of it while in therapy sessions; for that reason, family therapy educators are encouraged to teach the connection between epistemology, theory, and practice. In a more recent study about the most and least meaningful learning experiences for MFT

students, Piercy et al. (2016) found that participants valued MFT programs that connect theory with practice, teaching students how to learn and do therapy.

Regarding the learning and practice of family therapy, Keeney and Sprinkle (1982) explain that "although there is a distinction between epistemology and action, as well as aesthetics and pragmatics, there is always a relation between the two levels such that their interaction modifies and tempers one another" (p. 481). The authors not only confirm the connection between epistemology and practice for therapists, but also demonstrate the importance of both the epistemology (aesthetics) and techniques (pragmatics) of therapy. They go on to say:

> One implication is that a concern for technique and pragmatics without any regard for the broader aesthetic context leads to the vulgarization of technique and pragmatic effort. Similarly, efforts to achieve aesthetic standards without serious regard for technical mastery inevitably lead to vulgar art. Each extreme represents the use of only half of one's brains. In contrast, ecosystemic epistemology involves the total interactive system with levels of pragmatics and aesthetics. (Keeney & Sprenkle, 1982, p. 489)

As previously stated, I am not emphasizing pragmatics or techniques, since they are not relevant to my study; however, that does not mean they are irrelevant in teaching, learning, and becoming a family therapist.

Henry and Storm (1984) pose a central question regarding teaching epistemology in family therapy programs: "How can this new epistemology be incorporated into clinical training?" (p. 41). As a possible answer to this question, Anderson (1985) discusses the implications of training family therapists by explaining that "the use of observation, consultants, teams, and live clinical work have become important symbols for training therapists to think circularly and systemically" (p. 80). Nelson and Prior (2003) also mention

that therapists who have a clear idea of what informs them in therapy, based on the decisions they make when choosing their interventions, are considered especially competent and effective. The authors note that some MFT programs assign theory-of-change papers or projects to help therapists connect their practice with their knowledge.

Flaskas (2014) explored the complicated relationship between epistemology and practice in the teaching of context and found that reflection, recursiveness, and reflexivity are considered the key orientation points. He underscores "the recursiveness of knowledge and practice in family therapy, and the recursiveness of your use of self in bringing to bear what you 'know' about practice and therapeutic change potentials" (pp. 292-293). This gives the impression that there is fluidity not only between epistemology and practice, but also between the teaching of family therapy and the person of the therapist who is learning it. In an article about knowledge and practice, Flaskas (2005) argues that the epistemology of a family therapist is a layered one, infused with his or her original knowledge. In contrast, Dickerson (2010) argues that a family therapist cannot work from more than one epistemology but can integrate theories and practices under the same epistemology. Though they present different perspectives, both Flaskas and Dickerson, along with other authors mentioned previously, seem to agree on the connectedness between family therapy and the epistemology that supports it.

Up to this point, my discussion about the epistemology and practice of family therapy has been from the teacher's point of view. Rhodes, Nge, Wallis, and Hunt (2011) conducted a study to explore the student's perspective; they examined the influence of family therapy training on trainees' development. The students in the study reported that their training helped them learn to see the world in a more systemic and relational way but also challenged their beliefs. Sherbersky (2016) asserts that family therapists need to examine their position regarding religious fundamentalism in relation to the relativist, social constructionist

continuum. Sherbersky believes that by engaging with uncomfortable questions about their beliefs and by exploring their inner selves, therapists can understand their own personal process before exploring their clients'. Similarly, Keeney (1983) states that "examination of our epistemological assumptions will enable us to more fully understand how a clinician perceives, thinks and acts in the course of therapy" (p. 7).

According to Shurina-Egan (1985), graduate students and family therapy clients can experience confusion and frustration through the learning process, especially when they are introduced to new ideas or perceptions. This frustration seems to be true for family therapy students no matter where they come from, be it a different culture, language, belief system, or philosophy. When they are first introduced to the epistemology of family therapy, they can find it challenging, especially if it differs from their original epistemology. Rhodes et al. (2011) explain that this challenge can trigger personal reflection for family therapy trainees, who describe a shift in thinking in both their professional and personal lives. This shift seems to help trainees enhance their awareness about relationships and patterns of interaction.

Looking from another angle at the challenges that come with learning the epistemology of family therapy, Rober, Elliott, Buysse, Loots, and De Corte (2008) note that therapists often have different and sometimes opposing thoughts, which reveal themselves as inner voices. They explain that:

> these inner voices respond to voices in the outer conversation, but they also respond to each other: questioning each other, disagreeing or complementing each other, each representing different positions the therapist can take or different concerns the therapists might have. (Rober et al., p. 413)

This illustration of the inner conversations therapists might experience due to their diverse and sometimes challenging thoughts brings us into their inner world and reveals the interrelatedness between epistemology and the self of the therapist. As Khan (2002) explains,

"in family therapy training there is a focus on exploring the personal self of the therapist, in particular how individual experiences, values, and ways of seeing the world impact on the professional self-of-the-therapist" (p. 100). Next, I review the literature about the necessity and value of this work in the family therapy tradition.

Learning Self-of-the-Therapist Foundations

Timm and Blow (1999) define self-of-the-therapist work as "the willingness of a therapist or supervisor to participate in a process that requires introspective work on issues in his or her own life, that has an impact [on] the process of therapy in both positive and negative ways" (p. 333). There is no singular definition of self-of-the-therapist work, but it is noticeable in the literature that it is continuously presented in relation to the therapeutic context and process. Studies that view the self of the therapist from the family therapy perspective do not view the self as an entity separate from the therapist; instead, it is viewed as the therapist's process of experiencing (Rober, 1999). Viewing the self of the therapist as an experiential process mirrors the overall relational and systemic view of family therapists' perspective and philosophy. According to Bateson (1972), "No man is 'resourceful' or 'dependent' or 'fatalistic' in a vacuum. His characteristic, whatever it be, is not his but is rather a characteristic of what goes on between him and something (or somebody) else" (p. 303).

This relational understanding has influenced family therapists' view of the self of the therapist. Thus, the original Freudian understanding of the concept, which includes the idea of countertransference from the analyst, was not picked up by family therapists (Aponte & Winter, 1987). Shadley (2000) interviewed family therapists to explore the meaning of the self of the family therapist. Most of the participants agreed that the professional and personal selves of a family therapist are constantly evolving and changing due to continuous interaction with different systems. As Keeney and Sprinkle (1982) explain, "The history of

family therapy's individuation includes its characterizing and understanding individuals within the context of relationship ecologies" (p. 1). The self of the family therapist exists within relationships, in continuous interactions with self and others; viewing it within such a relational context is a unique aspect of family therapy.

The topic of the self of the therapist has been discussed and reviewed widely in the field of family therapy. Virginia Satir, Murray Bowen, and Carl Whitaker are pioneers from the field who advocated for exploration of the self of the therapist (Baldwin, 2000); other authors later followed their lead. As popular as the self-of-the-therapist topic became in the family therapy tradition, the main theme of the work has remained a consideration for the therapist's self as the center of the therapeutic context, providing self-awareness and advancing the therapist's effectiveness. Satir (2000) emphasized the importance of self-of-the-therapist work, as she considered the therapist to be central to successful therapy. Simon (2006) confirms that in order to maximize their effectiveness, therapists must focus on their selves in relation to their models. This focus on the self of the therapist is, as Simon named it, "the heart of the matter" (p. 343).

Authors who have explored the self-of-the-therapist topic have discussed it in many different ways, using a variety of approaches, but in general, they consider it within the training context (Aponte & Winter, 1987; Carlson & Erickson, 1999; Deacon, 1996; Regas, Kostick, & Doonan, 2017). Some authors have examined the subject within the context of supervision (Aponte & Carlson 2009; Todd & Storm, 1997). Other studies have been conducted on the self of the therapist in relation to a therapist's chosen therapeutic model (Aponte & Carlson 2009; Deacon, 1969; Minuchin, Lee, & Simon, 2006; Steele, 2006). The topic of the self of the therapist has been presented in many ways, using approaches that are interwoven and connected. For example, a study about the self of the therapist within the training context can still address the concepts of therapeutic models and/or supervision.

The subject of self-of-the-therapist work also appears in the literature in relation to therapists' self-awareness and cultural awareness. Both are relevant to my study of Saudi therapists' dual epistemologies.

Therapists' Self-Awareness

Steele (2006) notes that unlike most professions, family therapy requires therapists to learn more than just the tools of therapy. Instead, family therapy training involves a combination of multiple dimensions, including self-awareness. This implies that family therapists bring together the self of the therapist, along with the techniques and tools of therapy. It is noticeable in the literature that many authors attend to the integration of the tools of therapy, along with the self of the therapist in the teaching and training of family therapists, noting the influence of these factors on the therapeutic outcome.

In their study, Regas, Kostick, Bakaly, and Doonan (2017) verified the interrelatedness between therapists' personal and professional growth with the outcomes of their work with clients in therapy. Mojta, Falconier, and Huebner (2014) studied novice family therapists' self-awareness in relation to their therapeutic alliance by using internal family systems therapy. This study confirms that self-awareness reflects on family therapists' clinical work.

The self of the therapist is now considered an important component of learning family therapy. Many studies have integrated the concept of self-awareness as part of self-of-the-therapist work in different ways, but all have confirmed its relatedness to the therapeutic process and the outcome of therapy. Carlson and Erickson (1999), for example, offered a personal approach to theory and practice by including their own beliefs in their study. Their intention was to encourage therapists to engage in self-exploration and recapture their own values, beliefs, and commitments, as well as the values that are inherited in their chosen theory. The researchers claim that when therapists practice self-awareness, it benefits them as

well as their clients, especially since therapists' values and beliefs work as a lens through which they view reality.

In another study, Aponte and Winter (1987) found and agreed that therapists' understanding and awareness of their own personal lives may affect the therapeutic process and is, therefore, vital in achieving therapeutic competence and effectiveness. This implies that therapists should take responsibility for exploring and understanding the impact of their epistemology on the therapeutic process. Williams and Fauth (2005) studied therapists' self-awareness in session and found it to be more of a help than a hindrance to both therapist and client.

Another way of addressing self-awareness and the self of the therapist in the literature is through the dialogical perspective or, as some authors have named it, inner conversations in relation to the therapeutic process. The self, from this perspective, is perceived as an inner dialog (Rober, 1999, 2005; Rober et al., 2008). Rober (1999) studied the distinction and relationship between the outer therapeutic conversation and the therapist's inner conversation. In his study, he encouraged therapists to reflect on their inner conversation before presenting it to the outer conversation with the client.

In a more recent study, Rober et al. (2008) studied therapists' dialog and conversations with themselves in relation to their own concerns. The researchers argue that when therapists attend to their own concerns, it helps them localize the dialogical conversation in time and space, as well as understand the complexity of the inner conversation. In another study, Rober (2005) juxtaposed the subject of therapists' inner conversation with the concept of therapists' not-knowing. Rober debated that therapists' inner dialog can enrich the therapeutic conversation through the use of reflections and the not-knowing position. Not-knowing, in this case, was demonstrated through self-awareness from the therapists, who reflected their inner conversations to their clients.

Therapists share their reflections with clients as a way to understand and be in sync with them. This process, Rober argues, can be a tool or a bridge between therapists' knowing and not knowing. Anderson (1997) states:

> A therapist cannot be a blank screen, void of ideas, opinions, and prejudices. . . . To the contrary, we each take who we are, and all that entails—personal and professional experiences, values, biases, and convictions—with us in the therapy room. (p. 137)

To put everything together, it seems that family therapists have no choice but to bring their professional and personal selves into the therapeutic process; they do, however, have a choice about whether or not to be aware of their dual selves in the therapeutic process (Baldwin Jr., 2000).

Self-awareness can be the primary stepping stone toward utilizing the therapist's self. Aponte and Winter (1999) note that the essence of self-of-the-therapist work is to utilize the therapist's personal self and use it in his or her professional life. Satir (2000) explains, "There is a close relationship between what I believe and how I act. The more in touch I am with my beliefs, and acknowledge them, the more I give myself freedom to choose how to use those beliefs" (p. 26). In an interview about the use of self in therapy, Carl Rogers stated that he uses his personal self in the process, bringing his characteristics of caring and acceptance into the therapy room (Baldwin, 2000). Timm and Blow (1999) examined self-of-the-therapist work from a more balanced and inclusive perspective, in order to appreciate the issues of the therapist as well as the resourcefulness of those issues.

It seems that the field of family therapy has recently moved toward a focus on resources rather than focusing exclusively on resolving problems and addressing therapists' blind spots (Aponte & Winter, 2000). According to Satir (2000):

> We started out knowing that the person of the therapist could be harmful to the patient. We concentrated on ways to avoid that. Now, we need to concentrate on ways

in which the use of self can be of positive value in treatment. (p. 26)

The focus on this kind of self-of-the-therapist work seems to utilize therapists' blocks, turning them into stepping stones (Timm & Blow, 1999). Through self-awareness, family therapists can utilize what they already have in order to benefit the therapeutic context. They can also benefit from being culturally aware, which allows them to better understand themselves within a cultural context and work more effectively with clients from different cultures (Bula, 2000).

Therapists' Cultural Awareness

The term *culture* has several definitions, but mostly it refers to the characteristic structures and way of life shared by a group of people in a place or time, including shared beliefs and values, habits, customs and norms, language, religion, history, or geography. All cultures are learned behaviors that are influenced by our families and societies; they shape how we act, think, and communicate (Morris, 2014). Through the relational family therapy lens, culture becomes not only a place to visit, see, and learn from, but also something that can be touched through relationships. According to Ellenwood and Snyders (2006), "Culture is the existence of patterned sets of connected events and behaviors in a domain of relationships. These networks of relationships have also been depicted as clouds of correlated events" (p. 68).

From these cultural networks of relationships and the therapeutic context, the therapist's beliefs, values, and culture can be considered components of the therapeutic process. Pederson (2009) asserts that culture is an important construct in psychotherapy. Several authors agree that therapists' perceptions are not created in a vacuum; rather, they are culturally constructed (Baker, 1999; Simon, 2006, 2010). This culturally constructed view of the therapist usually winds up being represented when working with clients. Wiggins (2009) contends that therapists bring their cultural viewpoints and personal history of spirituality and

religion into the therapeutic context. According to Mirsalimi (2010), the many ecosystems that have shaped therapists' development have profoundly influenced their view of the human experience, the nature of psychopathology, the formulation of patients' problems, the healing process in psychotherapy, and the assumptions central to psychotherapy. Therapists who adopt this perspective can consider the cultural influence on their own views. It is for this reason that many therapists, authors, and researchers seem to be interested in studying the therapist in relation to his or her culture, encouraging cultural awareness for therapists and therapists in training.

Some studies identify cultural awareness as one of the family therapy competencies. In a study about the process therapists in training go through with regard to their own culture, Lopez-Bemstein (1997) recognized the importance of therapists' cultural self-awareness as one of the multicultural counseling competencies, and as mandatory for the development of therapists' ethical values. In another study, McDowell, Fang, Yong, Khanna, Sherman, and Brownlee (2006) began with the premise that in order for family therapists to develop cultural competency, they need to raise both their cultural awareness and sensitivity. Thus, their study focused on the necessity of including racial awareness in family therapy training. In another study about training and therapists' cultural competency, Hardy and Laszloffy (1995) focused on the importance of both cultural awareness and cultural sensitivity, outlining the differences between them. They identified cultural awareness as a consciousness of the culture, and cultural sensitivity as a delicate and respectful responsiveness to this culture.

Other studies have explored the importance of therapists' cultural awareness in relation to the therapeutic relationship, emphasizing the importance of family therapists being culturally aware of their own assumptions in order to be culturally empathic toward their clients (Mojita, Falconier, & Huebner, 2014; Pedersen, 2009). Taylor and Smith (2011) noted

that such cultural self-awareness is critical when working cross-culturally. According to Baker (1999), studies have shown that therapists' racist and discriminatory attitudes may slip into a blind spot; therapists who develop cultural awareness expand the size of the lens through which they view the therapeutic relationship.

Lopez-Bemstein (1997) declared that in order for therapists to be culturally self-aware, they need to look within and question their own personal agenda, including their biases, values, and expectations, which are mostly culturally based. Kraemer (1973) explains that being culturally aware means recognizing the cultural influence on your own thinking. Bula (1999) also emphasizes the importance of self-awareness in relation to culture, race, ethnicity, sexuality, and other personal identifiers. Bula notes that therapists' developing awareness of their own assumptions, values, and biases is an important first step—before even learning about techniques and strategies. Pedersen, Crethar, and Carlson (2008) underscore the importance of racial awareness as part of cultural sensitivity:

> Whether we know it or not, we are all taught to assume certain things about who we are and how to behave. Most of these assumptions are unspoken but can be brought to a level of consciousness whereby we can articulate them. (p. 59)

Many family therapists underscore the importance of developing sensitivity not only to their own culture, but also to their clients' culture. According to Wieling and Marshall (1999), "Several authors in the field of MFT have made strong cases for the need to properly train therapists to become culturally aware and sensitive, not only to the therapist's culture of origin, but also to the culture of others" (p. 318). This focus on awareness and sensitivity of the client's culture seems to have grown with the rapid growth of diversity in the United States among both clinicians and clients, as many therapeutic encounters are now cross-cultural (Niño, Kissil, & Davey, 2016).

This emphasis on multiculturalism can help therapists better prepare for their work

with clients whose cultural backgrounds differ from theirs (Niño et al., 2016). Many authors in the family therapy field discuss cultural aspects in different ways, such as transcultural, acculturation, multicultural, cross-culture, international dialog, and more. Some studies have been conducted on multiculturalism in the United States (Gallardo-Cooper & Zapata, 2014; Murphy, Park, & Lonsdale, 2006). Other authors have expressed interest in the global and international realm outside of the United States (Charles, 2016; Charles & Piercy, 2003; Deng, Lin, Lan, & Fang, 2013; Halpern, 1985; Mittal & Hardy, 2005; Sim et al., 2017).

Though the topic of culture is discussed openly and in varied ways, most of the studies that discuss cultural aspects through multiculturalism or nationalism within the family therapy field seem to promote cultural awareness either for the therapist's culture, the client's culture, or both. McDowell et al. (2006) note, "Both multiculturalism and internationalism require sensitivity to diversity, inclusion, and equity" (p. 2). Next, I will focus on the experiences of family therapists who learned in the West and exported their knowledge of family therapy internationally or, in some cases, brought this knowledge back to their home country, taking with them their self-awareness, cultural awareness, and sensitivity to other cultures.

Taking Family Therapy Internationally

Family therapists who take family therapy out of its original region—the United States—face some challenges in their attempts to fit non-Western cultures with Western knowledge. This makes sense, given that the practice of therapy involves encounters of the therapist thinking about, communicating with, and viewing the client. Reflecting on their experience as international consultants teaching family therapy in non-Western countries, Charles and Piercy (2003) discuss the necessity of exploration and cultural conversations with their non-Western students to enhance awareness about cultural assumptions. They also emphasize cultural exploration in therapy, identifying therapy as a continuous cultural

journey.

Several authors agree with the need for family therapists to engage in cultural exploration in non-Western cultures. For example, Epstein, Curtis, Edwards, Young, and Zheng (2014) note that it is necessary for family therapists in China to be sensitive to their clients' cultural values, beliefs, and traditions to help develop therapeutic alliances and create effective therapy sessions—especially since families in different cultures have different problems, epistemologies, cultural values, and/or religious beliefs (Gallardo-Cooper & Zapata, 2014). Not only is the culture different in non-Western countries, but certain ideas can be particularly influential there, especially since most non-Western cultures are collectivist.

In a study about parenting in the Indonesian context, Riany, Meredith, and Cuskelly (2017) discovered how influential the Indonesian culture can be. The strong cultural influence in a country like Indonesia can be simulated in other domains and situations in Indonesia and other non-Western, religious, or collectivist countries. Considering the influential nature of culture, Baker (1999) notes the necessity of therapists being aware of their own culture as well as that of their clients so that they can be sensitive when practicing therapy with non-Western clients. With this sensitivity and awareness, Western knowledge and therapy practices can be applied in non-Western cultures.

Epstein et al. (2012) assert that "the potential for cross-cultural application of therapy models is great, as long as therapists approach families with sensitivity and respect for their ways of life" (p. 235). Therapists' exploration of and sensitivity to non-Western cultures is essential when importing family therapy to regions outside of the United States. In addition, several authors emphasize the need for adapting, tweaking, and altering the Western family therapy approach to fit non-Western lifestyles. Tse, Ng, Tonsing, and Ran (2012), for example, report that family therapy is becoming widely recognized and used in Hong Kong

and China, but with a little twist. Family therapy, in its traditional Western style, cannot be readily applied without suitable accommodations for the Chinese culture.

Exporting family therapy to some regions—especially for therapists with a clear and fixed map of people's religion, culture, and political stance—can be more challenging than other regions, especially since family therapy may introduce a different way of thinking. In the next section, I will review the literature about Western trained family therapists who apply family therapy in religious/political states.

Taking Family Therapy to Religious/Political States

Roberts et al. (2014) conducted a multicultural study including China, India, Israel (both Jews and Palestinians), Japan, Mexico, Peru, Spain, Turkey, Uganda, and the United Kingdom; they found that family therapy continues expanding across disciplines, as systemic ideas are being spread in widely diverse settings and institutions. The researchers pointed out that "historical and political country specifics—as well as ethnic, cultural, gender, racial, sexual orientation, and age differences within them—shape models of family therapy, training, and practice" (Roberts et al., 2014, p. 568). In another international family therapy article, DuPree et al. (2012) confirmed that family therapists around the world acknowledge the impact of their own culture, society, government, and healthcare system on the development of family therapy in their particular country. Since family therapy training and practice seem to meld and interlace cultures, I explore the literature pertaining to the challenges international family therapists experience in the process of adapting and mixing those cultures.

Therapists' Challenges

Family therapists can face many different challenges when returning to their home country to practice family therapy or train other therapists. Some challenges can be considered cultural barriers, which often keep therapists from practicing therapy

appropriately. Other challenges are political, which therapists cannot change and instead need to understand and abide by in order to practice therapy safely. Additionally, the absence of legal and ethical standards for practicing therapy, such as official licensing, can also be challenging—especially if the rules are not yet clearly defined or established.

In a cross-national study of family therapy training, Piercy et al. (2014) found that some existing structures in a country, such as the government and religious organizations, can present different barriers to the development of family therapy in that country. The researchers also recognize that sometimes the absence of certain structurers, such as licensure, accreditation, and professional coursework, can also present major barriers to the growth of this therapeutic orientation. They also point out other considerable barriers, like cultural issues and the lack of collaboration with other mental health professions.

In some countries, the original way of healing sometimes remains the standard; this can challenge family therapists' work, because therapy is either unfamiliar—and, therefore, not trusted—or culturally unacceptable. For example, in the Yoruba land in Nigeria, healers still use the Yoruba way of healing to help families with their problems. This ancient practice is still suitable for Yorubians, even in the modern age. However, most foreign systemic interventions and techniques are not appropriate in this culture; the Yorubians present resistance due to their rooted culture, which contains years of traditions and ancient beliefs. Yorubian families are satisfied with their traditional way of healing, as their problems have been relieved, and for that reason they refuse any new or different way of healing (Adekson, 2003).

Traditional healers can differ from place to place. In Uganda, healers are usually sponsored by religious organizations, presenting a major challenge for therapists there (Roberts et. al., 2014). On the other hand, "most Indians experiencing marital problems go to native healers, gurus, shamans and exorcists" (Jagasia, 2008, p. 6). Similarly, in some

countries people use family and friends as a resource for helping or healing familial problems, which makes it hard for family therapists to reach these people and help them help themselves. Deng, Lin, Lan, and Fangnoted (2013) note that "according to traditional Chinese beliefs, families 'do not wash [their] dirty linen in public' [and] 'even an upright official finds it hard to settle a family quarrel'" (p. 432), leading some Chinese families not to seek out family therapy. In a cross-cultural study conducted with a combined-country sample, Piercy et al. (2014) found that men's resistance to attending family therapy sessions, along with the issue of confidentiality, are considerable cultural barriers for family therapists.

Cultures can stand between therapists and clients, and they sometimes play a central role in the development of a particular discipline within a particular region or country. For example, in their article about the future of family therapy in India, Mittal and Hardy (2005) note that family therapy in India is still in its primary stages, and to advance the process of its development, therapists need to be aware of their cultural traditions and ways of thinking in order to bridge the gap between Indian culture and the values associated with family therapy. According to the authors, this can be an issue—especially since they think cultural assumptions are not on the radar of persons from the same culture. They state, "Many of these issues, unfortunately, are usually so integral to the nuances of culture that they are virtually impossible to identify by someone inside the culture" (Mittal & Hardy, 2005, p. 294).

People understand through the filters or lens of their own culture. Watts (2005) explains that "knowledge is socially embedded and relationally distributed. It is derived from looking at the world from some perspective or the other" (p. 268). People understand the knowledge of family therapy through the unique perspective of their culture, which can be challenging to therapists whose cultural belief system differs significantly from the family therapy epistemology. Spirituality and religion, as part of the culture, can also influence

people's perspective and understanding of family therapy (DuPree et al., 2012). Every culture, religion, or belief system can have a different and specific family therapy identity; this can challenge and confuse therapists, especially if they trained in one place and practice in another. As Carlson (as cited in Ng, 2003) notes, "people from different cultures differ [in] how they experience pain, what is labeled as a symptom, how they communicate their pain or symptom, their beliefs about causation, and their attitudes toward those who try to help them" (p. viii).

The language of a country or region can also contribute to the vision and understanding of family therapy there. Furthermore, language can be considered a barrier for international family therapists who learned therapy in one language but use another language in session with clients. In an article about Spanish-English bilingual psychotherapists, Verdinelli and Biever (2009) note that using two languages can be challenging for bilingual therapists when they are trained in one language and asked to use the other in therapy. They point out that therapists usually translate the material themselves, without getting any training in using the other language professionally. This can be challenging for therapists, mainly because it "requires a high level of proficiency in the language as well as cultural knowledge and understanding" (Biever & Santos, 2016, p.133).

A further challenge for family therapists occurs when multiple cultures and/or languages are found in one country or region. An example of this can be found in the multiracial and multilingual populations of Singapore. Knowledge of a particular culture does not ensure that therapists will provide culturally sensitive therapy to all the populations in the region (Augustine, 2003). Bucher and Costa (2003) consider the greatest challenge facing the family therapy movement in Brazil to be the identification of a stable and balanced way to deal with the mixture of Brazilian family systems.

In Israel, therapists are challenged by the absence of cultural courses or trainings;

"given the many different ethnic, cultural, and religious groups who call this part of the world home, this needs to be addressed" (Roberts et al., 2014, p. 553). For example, an attempt to provide sex therapy to Arabs in Israel using Western techniques and interventions proved to be harmful instead of helpful, raising difficulties and challenges for the professionals in the psychotherapy disciplines (Lavee, 2003). Globalization and warfare are some central reasons for the increase in communication between cultures and multicultural stances within individual cultures. Both of these aspects can appear around the world, and the challenges therapists are facing in Israel and Brazil will soon be present in many other regions, if they are not already.

Regarding legalities, ethical dilemmas, and professional issues in family therapy worldwide, the AAMFT requires accredited programs to teach a course about professionalism that includes legal, ethical, and professional issues in family therapy (Harris, 1995). Since family therapy is a Western body of knowledge, these issues are taught from a Western point of view. For this reason, international family therapists can face challenges when dealing with different ethical and legal matters.

According to Carson and Chowdhury (2000), "Training of mental health professionals, and research pertaining to mental and emotional disorders, are greatly lacking despite existing national policy guidelines" (p. 393). Similarly, in Japan, a primary concern for therapists is the absence of a state licensing credential, as the government does not recognize the family therapy discipline (Tamura, 2003). Carson and Chowdhury (2000) clarify what is lacking in the field of family therapy in India: availability of family therapy theories, models, and methodologies that resonate with Indian families. The authors also point out that there is a lack of modified professional and ethical standards appropriate to Indian culture.

In his study about the legitimization of marriage and family therapy in the United

States and its implications internationally, Northey (2009) notes that "the first challenge is determining internationally what constitutes the essence of family therapy, that is, what are the fundamental competencies?" (p. 314). He also considers the implementation of certifications and accreditation to ensure a standard for marriage and family therapists training internationally. As shown, therapists who work cross-culturally can experience different challenges regarding their international family therapy practice, including political, legal, and client-centered issues; however, the challenge most relevant to the present study, and thus the one I will focus on below, is the application of knowledge from the West in non-Western regions.

Therapists' Adaptations

Combining two different cultures, values, or points of view can be challenging; equally challenging is the blending of Western knowledge with non-Western cultures. As Roberts et al. (2014) articulate, "Going outside of one's country for training and bringing ideas back, or learning from outside subject matter 'experts' who come to your country, is qualitatively different than developing [a] therapeutic practice that draws upon local knowledge" (p. 568). Nonetheless, this can happen with few changes, adaptations, or modifications.

Once they have acknowledged and developed awareness of their culture, non-Western therapists can blend their Western knowledge of therapy with knowledge of their non-Western culture. Several authors agree on the necessity of adaptation. Jaladin (2013), for example, conducted a study of Malaysian therapists who graduated abroad. He found that Malaysian therapists who were trained in the West were alarmed by the amount of modification needed to culturally adapt the therapeutic process they had learned abroad. He also highlighted the importance of adapting Western theories, skills, and techniques to suit the social and cultural norms of clients, maintaining consistency with issues of diversity and

multiculturalism in the Malaysian context. Deng et al. (2013) conducted a similar study to examine the development of family therapy in China, within the context of three stages. The researchers declared it necessary for family therapists to adapt the practice to the Chinese culture.

In another Chinese study about the implementation of family therapy, Epstein et al. (2012) explored the relevance and applicability of various family therapy models in China, questioning whether adaptation would make Western-derived models more acceptable and relevant for Chinese families. According to the researchers:

> Human relationships tend to be universal, therapy models that were developed in one culture are likely to be relevant to the experiences of families in other cultures. However, family-of-origin influences, current family structure, stable interaction patterns, belief systems, and emotional response patterns often take different forms from one culture to another, which must be taken into account in applying a therapy model to a different culture. (Epstein et al., 2012 p. 235)

Miller and Fang (2018) confirm that Western-oriented family therapy is spreading in China, but cultural differences remain a barrier. For this reason, adaptation is needed to help establish theories and techniques that fit Chinese sensibilities. In an experimental study that explored adaptation in the therapeutic context, Natrajan, Karuppaswamy, Thomas, and Ramadoss (2005) explored the adaptation of a culturally considerate family therapy training instrument that would suit the Indian cultural context. The researchers made several changes to the instrument, while also maintaining its integrity. They reported moderate achievement of their exploration, noting that further changes are needed.

Dunne (2016) offered an illustration of cultural adaptation from a session she conducted in a non-Western country with a non-Western client. She started the session with a plan to stick to one theoretical approach—solution-focused—and try to reach a decisive goal.

Her plan did not go well, but she stated that the experience invited her to position herself more systemically by considering cultural aspects in more detail. In another study about therapists' cultural adaptation in Pakistan, Irfan, Awan, Gul, Aslam, and Naeem (2017) found that cultural adaptation goes beyond the literal translation of a manualized type of therapy. The researchers note that this kind of adaptation requires the therapist to be aware of the client's culture, engage with the client, and adjust the technicalities of therapeutic work so they are applicable for the client.

Addressing the issues of cultural sensitivity, adaptation, and alteration, Polanco (2016) advocates the adoption of a "fair trade" approach to the implementation of family therapy in other countries, going beyond literal translations or adaptations of foreign therapeutic theories and generating collaborations that can invent new possibilities for locally rooted knowledge and practices. The "fair trade project involves redefining both the content of family therapy knowledge by local practitioners informed by local practices . . . and the terms of the current unilateral global and international training of family therapy in other countries around the world" (Polanco, 2016, p. 67).

Several other authors have addressed the subject of cultural utilization, confirming that it preserves systemic strengths and healing practices that have been passed from generation to generation to assist with problem resolution (Comas-Díaz, 2006; Gallardo-Cooper, & Zapata, 2014; Ng, 2003; Pedersen, 1997). Considering the dance between non-Western cultures and Western knowledge, Charles (2016) confirms that family therapists who work outside their countries must be open enough to blend with traditional approaches while also remaining consistent with the theoretical umbrella of family therapy. In another study that emphasized finding a balance within multicultural therapeutic contexts, Quijano (as cited in Polanco, 2016) concluded that as therapists, "we ought to stop being what we have not been, and what we will never be, and what we have to be. . . . We ought to stop

being strictly modern" (p. 68). In their effort to find balance and connect opposing realms, Gallardo-Cooper and Zapata (2014) found that "exploring different family paradigms and providing strength-based culturally sensitive interventions facilitates optimum functioning for families. Our task with families is to respect uniqueness, bridge the old and the new, discover resourcefulness, and nurture their collective spirit" (p. 519).

Commenting on the cross-cultural process by which family therapists connect their knowledge as therapists with the culture, Bloch (2004) states, "I can find my own way to dance. We can listen to the music, listen to the other dancers, know our relation to them—and find the common story it is best to tell at this moment" (p. 339). Even if the client and therapist are different, cultural sensitivity can still allow the therapist to be empathic; through feedback, the therapist can dance the dance with the client. Similarly, Wieling, and Mittal (2002) note that incompatible differences between therapists and clients—in terms of gender, ethnicity, culture, or other factors—cannot be easily fixed with clinical models, but they can be addressed by therapists committing to continually trying to understand the other's culture and challenging themselves and their perspectives in search of a wider outlook.

Exploring how family therapy has been brought to non-Western countries, it can be seen that family therapists in non-Western regions try to adapt Western knowledge to the culture—or, alternatively, the culture to Western knowledge. Such an approach seems to be an attempt at striking a balance between the two different worlds. Bernal, Bonilla, and Bellido (1995) discuss the balance between the two worlds—emic (within the culture) and etic (outside the culture) perspectives—examining how both perspectives integrate within a given phenomenon. Recently, authors have been focusing not only on adaptation, but also on the utilization of a culture's domestic knowledge for the benefit of an overall theoretical and pragmatic approach to helping. Next, I discuss the implementation and adaptation of family therapy, along with the possible challenges that come with it, in a unique non-Western

culture with a strong belief system of its own: the Arab world.

Psychotherapists and Family Therapists in the Arab World

Because there is a limited body of literature on family therapy in the Arab world, I will more broadly address cross-cultural psychotherapy in the Middle East. According to Nobles and Sciarra (2000), "the Arab world consists of 21 countries divided geographically into two major parts, one in South-west Asia, the other in North Africa. These nations cover considerable territory and vary in size and population" (p. 182). Though Arabic nations are united by their non-Western, Arabic, and Muslim-majority identity, they still have different cultures, values, norms, traditions, and beliefs. Abi-Hashem (2015) notes that there are many layers within a culture that create subcultures, even if the culture is in one geographical area.

Arabs live in several countries—including Iraq, Palestine, Yemen, Qatar, Egypt, Lebanon, Jordan, and Saudi Arabia—but share a common language. The Arabic language they speak differs from the English language in many ways; it even uses a different alphabet. Not only is the language different, but the cultures, belief systems, and customs mark a distinct East-West divide. Arabs think and perceive the world differently from people in the West:

> In the Arabic language, there is no single term or word to describe the English parallel of "culture." Rather, several terms are used, at times, to convey the meaning of culture and to capture its overall essence, like, Hadaarah (civilization), Thihneyyah (mentality), Thakaafah (educational civility), and Turaath (living tradition). (Abi-Hashem, 2015, p. 661)

If the word for culture itself cannot be translated accurately to Arabic, this tells us about not only the possible gap that cultures and languages bring, but also the different meanings a culture can create about a single term. Any discussion of an Arab sensibility must include what is considered most unique in the Arab region: its primary religion. Nobles and Sciarra

(2000) note that "though not all Arabs are Muslim, or Muslims Arab, it is hard to overestimate the influence of Islam on the Arab world, in which religion regulates everyday behavior" (p. 138).

The Influence of Culture and Religion

It is evident in the literature about Arabic therapists that the influence of religion and culture is strong. According to Abi-Hashem and Driscoll (2013), "Cultural norms and habits inform religious values and practices, and religious faiths and ideals affect cultural heritage and history in a reciprocal relation" (p. 2). Religion is an integral part of human culture that helps order experience, beliefs, values, and behavior. The religious components of the self and culture emerge in many ways (Abernethy & Lancia, 1998). This is true of all religions, including Islam, which is a way of life integrated within Muslims' daily activities from a young age. Muslims define themselves by their religion first, followed by their culture of origin (Nassar-McMillan & Hakim-Larson, 2003). Islam, then, can be considered an entire way of life to Muslims (En-Nabut, 2007), as it represents not just a religion, but also an ideology and way of forming cultural values and beliefs (Kelly, Aridi, & Bakhtiar, 1996). In a recent study about psychotherapy in Egypt, Kassem (2012) concluded that "Egypt is a culture heavily influenced and shaped by religious traditions, starting from the Pharaohs of ancient Egypt and ending with modern day interpretations of the three monotheistic faiths, chiefly Islam" (p. vi).

Islam holds a unique, non-Western epistemology and set of beliefs; for this reason, Muslims have a different way of perceiving the world. Nobles and Sciarra (2000) reviewed the different cultural patterns of Muslims and explained that Arabs and Muslims have a unique perception of subjects like family, socioeconomic status, child-rearing practice, sexuality, hospitality, and the expression of feelings. For example, as Laher (2015) notes, Muslims view the self differently, perceiving it as a mind-body-spirit continuum, instead of

as only comprised of a body and mind. Therapists who are trained in the West, but work in Arab regions, need to be sensitive to these differences as they work with this unique and rich culture; they must also be careful about what they bring to therapy. Religion is an important consideration within the context of this study, especially since researchers consistently note its strong influence on culture, beliefs, perceptions, and worldview.

Therapists' Cultural Awareness, Challenges, and Adaptation

In their study about Western psychotherapy in traditional Arabic societies, Dwairy and Sickle (1996) found that Western psychotherapy could impact Arabic clients in ways that result in conflict if it is not adapted to the Arabic culture, tradition, and collective identity. In a similar study about integrating cultural rituals into family therapy with Bedouin-Arab clients in Israel, Al-Krenawi (1999) raised an interesting question: "As mental health practitioners trained in the use of Western techniques, what can we offer to a family from such a different society?" (p. 69).

Al-Krenawi (1998) notes the importance of using therapeutic interventions that are rooted within clients' cultural context. He explains that "the effectiveness of this intervention largely depends on the therapist's awareness of, and sensitivity to, traditional values" (p. 8). Similarly, Hilliard, Ernst, Gray, Saeed, and Cortina (2012) emphasize the necessity of adapting Western treatment strategies to fit with clients' culture. The authors also point out the importance of therapists' awareness of their own biases and assumptions when serving the Arab population. These articles bring forth and extend the concept of adaptation and cultural sensitivity among Arab therapists. They serve as a reminder for therapists to pay attention to the unique Arabic culture and not just apply Western knowledge to it blindly.

Abi-Hashem (2014) emphasizes the importance of adapting Western knowledge and respecting the original culture, noting the danger of "unmodified, un-adapted, or blindly used materials" (p. 161) from the West. Abi-Hashem also addresses the necessity of not only

adapting and utilizing clients' culture, but also being aware of one's own culture. He stresses the importance of therapists' self-awareness and ability to distinguish between the clinical and the cultural. Abi-Hashem confirms that this act can be challenging, especially since it requires therapists to constantly adjust their cultural lenses, check their assumptions, and modify their worldview. In another article, Abi-Hashim (2015) notes that cultural awareness is a continuously evolving process that shifts in response to one's life changes. This shows how the emphasis upon cultural awareness and sensitivity that started in the United States has been spread through non-Western countries, including the Arab world. It also makes clear that because of the many differences between cultures, regions, religions, and belief systems, therapists must be culturally sensitive and pay attention to the self of the therapist in order to approach their therapeutic encounters with sensitivity (Mittal & Hardy, 2005). The importance of self-awareness and cultural awareness is something that seems to be agreed upon by Westerners and non-Westerners alike, including Arabic psychotherapists.

Next, I review the family therapy literature in the KSA, a non-Western and Arabic region with rich and unique traditions, rules, values, and customs.

Taking Family Therapy to Saudi Arabia

Overview of the Kingdom

Part of the Arabic peninsula, the KSA makes up almost 90 percent of the Arab world geographically (Bowen, 2015). Though most people in the Arab world speak Arabic, they use a variety of accents, expressions, cultures, and customs (Gassas, 2017). This is also true of Saudis; however, there are variations from region to region within the Kingdom. According to the Saudi General Authority for Statistics (GSA), the Saudi Arabian population is estimated to be over 32 million as of 2018. The majority of the population in the KSA is young, which can influence its culture, "putting a great pressure on the economy, culture, educational system, and religion" (Bowen, 2015, p. 4).

Religious and Cultural Influence in the Kingdom

According to Gallarotti and Al-Filali, (2012) the main religion in the Arab peninsula is Islam. Saudi Arabia is considered the birthplace of the Islam religion, as it is the land of the two holiest mosques: Al-Masjid al-Haram (the Sacred Mosque) in Mecca, and Al-Masjid an-Nabawi (the Prophet's Mosque) in Medina. Islam is not only a religion for Saudis; it is what determines their worldview (Algahtani, Buraik, & Ad-Dab'bagh, 2017). Worldview, according to Abi-Hashem (2017):

> is the outlook one has about life. It is a paradigm by which the individual or the group interprets reality and acts upon life. It is how we normally view and conceptualize the world. . . . Worldviews represent our pragmatic framework on existence and [shape] our beliefs, attitudes, actions, and philosophies. (p. 1)

Al-Sabaie (1989) notes that Islam has two basic sources: the Koran (or Quran) and the prophetic tradition. Based on these two sources, Muslims decide what is lawful or unlawful, as "there are many verses in the Holy Quran that address human behavior and characteristics" (Shawly, 1980, p. 218).

In Saudi Arabia, people operate from a solid belief system that focuses not only on religion, but also on culture. Religion and culture shape the lifestyle, government, rules, and orientations; somehow, the culture of religion and the religion of culture have become so intertwined that even Saudis mix them up sometimes. For example, Hubbard and Alsultan (2017) note, "The kingdom's strict gender rules are often seen as an extension of its deep connection to its ultraconservative interpretation of Islam[;] they are, in many ways, deeply entrenched cultural norms" (para. 4). Strict gender roles serve as one of many examples of confusion between religious and cultural norms in the Kingdom.

Shifting Gears

Recently, Saudi Arabia has been changing dramatically in many ways, including socially, economically, and politically, as well as in terms of overall strategy. These recent transformations, initiated by the KSA's crown prince, Mohammed bin Salman, have been both rapid and widespread. Prince Mohammed has explained the shifts by asserting that the ultra-conservative state in Saudi Arabia for the past 30 years is neither the normal Islam nor the identity of Saudi Arabia. He explains that the rigid ideology that was governing Saudi society was a reaction to the Iranian revolution in 1979 and, therefore, that Saudi Arabia today is only returning to the moderate Islam present before the revolution (Chulov, 2017).

Dr. Ali Nafisah, director of the Interior Ministry's Department of Guidance and Enlightenment (2008), notes that Saudis must

> condemn ourselves and . . . exert great efforts to revise our culture, dear as it is to us, which directs our activities, education, and the sermons in our mosques, in order to purge it of what causes this rigidity that leads to extremism and violence against others and eventually against ourselves. This is a practically hard and psychologically painful mission, but it is unavoidable to do it if we want to restore our normalcy, which we had enjoyed before this ideology spread in our country. (p. 3)

Similarly, Maclean (2017) notes that the Saudi authority is planning to move to a "more open and tolerant interpretation of Islam" (Society & Culture section, para. 3).

Today, the government of Saudi Arabia is changing, and the culture is slowly responding. The KSA's beliefs, traditions, customs, and identity are transforming and adopting a more modern worldview. An example of this can be found in the changed attitudes authorities are taking toward Saudi women, including accepting them as government ministers, allowing them to be part of Shura—the consultative council—and permitting them to vote and run for office. More recently, women were allowed to drive for the first time, and

are now allowed to go to sport stadiums, which was previously forbidden. These changes taking place in the Kingdom can be considered part of the new vision for 2030 created by Prince Mohammed. The project for 2030 is aimed at the economic, social, environmental, and cultural development of the country.

With all the rapid changes that have happened and continue to happen in Saudi society, Saudis have begun to debate a number of social topics, such as gender equality, women's rights, and women's roles in the development of Saudi Arabia (Alhajjuj, 2016). According to Al-Bahadel (2004), the existence of a family therapy profession in the Kingdom can be considered necessary, especially given the rapid social changes that touch many aspects of Saudi life, including the role of women and family relationships. Al Garni (2004) notes that this is especially necessary, since the social changes happening in the Kingdom may contribute to varied social problems. Nevertheless, as Alshareef (2005) articulates, "It could be argued that though modernity has put down roots in Saudi society, society has firmly held on to its traditions and norms" (p. 35).

Several authors have noted that marital and family difficulties have widely emerged in the KSA for different reasons, including social change (Afifi, Al-Muhaideb, Hadish, Ismail, & Al-Qeamy, 2011; Mogaddam, Merdad, Alamoudi, El Meligy, & El-Derwi, 2015; Tashkandi & Rasheed, 2009). These authors agree about the importance of incorporating MFT into mainstream mental health care in the KSA. In the midst of the confusion between religion and culture, and in an effort to adapt to current changes and shifting realities, Saudi identity is transforming in both personal and professional ways. This dissertation aims to explore SAFTs' ways of handling the different epistemologies of Western knowledge and the Arabian culture in the midst of the striking cultural changes the KSA is currently facing. Next, I will present the current status quo of MFT in Saudi Arabia.

Family Therapy in Saudi Arabia

With limited studies of family therapy in the KSA, "many generic mental health professionals are the gateway to marriage and family therapy" (Gassas, 2017, p. 2). One example of such a generic mental health professional is Al-Saqaby (2016), a self-proclaimed family therapist, who recently released a tutorial titled *How to Beat Your Wife* that misrepresents a number of religious and cultural principles. Fortunately, not all psychotherapists or family therapists in the KSA have the same view of family therapy. In her dissertation about the standard of care in marital and family therapy interventions in Saudi Arabia, Gassas (2017) noted that most of the mental health professionals who participated in her study described the domain of family therapy in a way that is in line with the MFT profession in the United States. Still, some of the less qualified participants described family therapy as "advising, guiding, consulting, and providing direction" (Al-Gassas, 2017, p. 235).

In the midst of the multidimensional understanding of family therapy in Saudi Arabia, psychotherapists and family therapists acknowledge the importance of implementing this profession in the Kingdom (Al-Bahadel, 2004; Gassas, 2017). For example, Al-Bahadel (2004) explored the feasibility of implementing family therapy in the KSA, concluding that it is important to do so, given the rapid social changes taking place. Still, SAFTs agree that importing such knowledge, therapies, and theories from the West can result in challenges for the therapists adopting it, as well as the clients being treated by it (Al-Garni 2004; Al-Gassas, 2017; Algahtani, Buraik, & Ad-Dab'bagh, 2017). In the next section, I will focus on studies that address the challenges therapists experience when using such approaches from the West.

Saudi Therapists' Challenges

Algahtani, Buraik, and Ad-Dab'bagh (2017) outlined the existing challenges and potential implications for the therapeutic process in the Saudi culture. They presented some

key Saudi cultural factors, such as the role of family, gender differences, religion, and polygamy. They assert that it is important for "local therapists to realize, address and handle cultural issues that may interfere with the specific principles and techniques of the different therapeutic modalities" (Algahtani et al., 2017, p. 116). For example, when it comes to certain key cultural topics, such as polygamy, it is important for therapists not to impose their own beliefs onto their clients (Algahtani et al., 2017). What makes it even more challenging for therapists is that Saudi society is considered collectivist, meaning that most Saudis agree on particular societal norms. At the same time, however, there are subcultures within the larger culture that hold different views. Gassas (2017) addresses "some special concerns that might exist in a collectivist and paternalistic society, such as males' guardianship over women, gender power differentials, gender roles, divorce and child custody, parenting styles, and sexuality" (p. 4). Because Saudi culture is considered collectivist, and since therapists are part of the society, it can be challenging for Saudi therapists to differentiate and think for themselves.

Another challenge for Saudi therapists is that their culture is shifting and changing. Several authors discuss the cultural shifts in the KSA, which have resulted in societal confusion and challenges due to changes in family roles and traditions (Al-Bahadel, 2004; Al-Garni, 2004; Gassas, 2017). Therapists are part of the society; therefore, the cultural shifts and twists influence them personally and, in relation to working with clients, professionally. Al Garni (2004), for example, notes that due to these shifts in society, traditional therapies are no longer suitable for Saudi clients. This means that Saudi therapists need to figure out what works for their clients and is also a fit for them personally.

Another challenging aspect in the culture of Saudi therapists is fitting Western modalities with Saudi culture. Al-Garni (2004) notes the difficulty and possible implications of importing Western therapies without taking Islamic beliefs and Saudi norms and culture

into account. Although the topic of therapeutic challenges due to importing and adopting Western knowledge is agreed upon in the literature, the topic of therapists' own challenges with cross-cultural ideologies has barely been tackled. According to Al-Gassas (2017), implementing Western therapy can challenge therapists to accept Western family therapy theories, requiring them to negotiate the confusions and uncertainty of implementing theoretical knowledge imported from the West. This process also includes the delivery of interventions in the Saudi context, where there are limited resources and research about the effectiveness of using these interventions.

Saudi Therapist's Cultural Awareness and Adaptation

Al-Garni (2004) notes that it is important for Saudi therapists to adapt, modify, and reshape Western knowledge to fit Saudi clients and be congruent with their cultural and religious values. He explains that religious beliefs, values, and cultural norms should be taken into account when using Western interventions. Furthermore, he emphasizes that therapists should utilize suitable Western models, not by applying them blindly, but by incorporating them as they are practiced in their original culture. Similarly, Algahtani et al. (2017) emphasize the need for cultural awareness, especially among Saudi therapists working in a collectivist culture:

> Saudi and expatriate psychotherapists need to achieve a balanced and informed stance that, on the one hand helps them consciously guard against the risk that their own opinions on Saudi cultural constructs may overshadow their therapeutic judgment and intellectual neutrality, and on the other does not lead to avoidance of honest and non-judgmental discussion of cultural issues that may be interfering with the therapeutic alliance. (p. 116)

Even in the Saudi context, culturally sensitive therapy is all about finding a balance and being aware of the shifting culture of the KSA while remaining sensitive and adaptive,

especially with regard to Western knowledge. In light of this review of the existing literature, the following questions remain: How and when, if at all, do Saudi therapists become aware of the influences of their culture on their therapeutic choices? And how do Saudi therapists choose to leave behind, utilize, or adapt Western knowledge?

Summary

This chapter provided an overview of the status of marriage and family therapy in the United States and throughout the world. I also included an overview of the literature about becoming a family therapist in the United States and exporting the knowledge broadly, including into the Kingdom of Saudi Arabia. This literature review helped inform the interview questions I used in my study. In the next chapter, I present the methodology, including information about the study sample and my data collection methods, as well as the form of analysis I employed.

CHAPTER III: METHODOLOGY

Qualitative Research

As indicated in the earlier chapters, this study aimed to understand the self of Saudi family therapists, in general, and the experience of dealing with two epistemologies, in particular. This study is the first to explore the self of the SAFT through in-depth qualitative interviews. According to Creswell (2013), "We conduct qualitative research because we want to understand the contexts or settings in which participants in a study address a problem or issue" (p. 48). This means that researchers who use qualitative designs are not only interested in knowing the problem or issue that the participants address, as well as the participants themselves, but also in the participants' process and experience, including the context in which it takes place.

As a family therapist, I am trained to see the world in terms of relationships, patterns, and context-informed meanings. According to Bateson (1979), "Without context, words and actions have no meaning at all" (p. 15). Since the intention behind qualitative design is to understand the context, and family therapists view the world in context, this design fit well for a family-therapy-informed exploration of SAFTs. It aligned not only with my assumptions as a family therapist, but also with my research curiosity. I was interested in exploring and understanding the experience of SAFTs within the context of culture, religion, and therapeutic philosophy or epistemology. According to Lichtman (2013):

> The main purpose of [qualitative research (QR)] is to provide an in-depth description and understanding of the human experience. It is about humans. The purpose of QR is to describe, understand, and interpret human phenomena, human interaction, or human discourse. When we speak about phenomena, we often think of lived experiences of humans. (p. 14)

This research method was a good fit for my topic; it helped me listen to, engage with, and attempt to understand the epistemology of Saudi therapists through the language used by the participants in the study. According to Keeney (1983), "since what we think, say, and do is determined by our particular epistemology, to understand cybernetic epistemology one must speak and hear its language" (p. 17). This means that my understanding of the Saudi family therapists' experience and epistemology can help develop an overall understanding of challenges faced by family therapists in Saudi Arabia. Keeney (1983) notes that an "examination of our epistemological assumptions will enable us to more fully understand how a clinician perceives, thinks, and acts in the course of therapy" (p. 7). This is important, especially because family therapy is just starting to develop in the KSA and because this will be the first attempt to study SAFTs' experiences. Both autoethnographic and phenomenological research approaches helped me capture and make sense of the epistemological assumptions of SAFTs by interviewing both myself and my participants.

Autoethnography

Autoethnography is a qualitative research method that gives voice to the personal experience of the researcher, in order to extend sociological understanding (Wall, 2008). This method has been used among researchers for more than 20 years, but under different titles (e.g., heuristic inquiry, and/or personal narrative) (Wall, 2006). Describing the approach, Douglass and Moustakas (1985) assert:

> Our aim is to awaken and inspire researchers to make contact with and respect their own questions and problems, to suggest a process that affirms imagination, self-reflection, and the tacit dimensions as valid ways in the research for knowledge and understanding. (p. 40)

My purpose for interviewing myself was to reflect about my processes and experiences pertaining to my culture, religion, and knowledge as a SAFT. Through the auto

interview, I was able to describe my experiences as a therapist while also reflecting on and analyzing my descriptions as I was constructing them. Boufoy-Bastick (2004) outlines two different processes of autoethnography: the subjectivity and reporting process (emic), and the exploratory analysis (etic). By engaging in these processes, the researcher can better understand the phenomena that connect the person with the culture (Mendez, 2013). As a Saudi therapist myself, I was culturally aware and sensitive to the sub-cultural differences of my participants. This helped me attune to them as I strived to understand their point of view without judging their experience.

As one of the participants, I needed to decide how to include information derived from my own experience. Rather than devoting a separate section to presenting my autoethnographic reflections and analysis, I simply incorporated the information from my interview with myself into the others. I assigned myself a pseudonym, along with the others, helping to ensure all of us anonymity and confidentiality.

Phenomenology

My aim for this study was not to find the truth about Saudi family therapists, but to explore and understand their experience. As Spinelli (as cited in Eatough & Smith, 2007) articulates, "Experience is subjective because what we experience is a phenomenal rather than a direct reality" (p. 196). Worldview is subjective and, therefore, experiential. This subjective view of the world aligns with my topic of interest, as well as my choice of research method. According to Adams and Manen (2012):

> Phenomenological research is the study of lived or experiential meaning and attempts to describe and interpret these meanings in the ways that they emerge and are shaped by consciousness, language, our cognitive and noncognitive sensibilities, and by our preunderstandings and presuppositions. (p. 2)

Another reason for choosing a phenomenological research design is that the experience of Saudi family therapists is significantly under-researched. I wished to explore Saudi family therapists' authentic and unique experiences of managing the dual epistemologies of their systemic worldview and the Saudi cultural/religious perspective. The phenomenological approach supported my efforts to explore the therapists' unique ways of combining these two worlds in how they perceive, how they understand, and how they practice. Patton (2002) notes that in phenomenological research, the focus is on figuring out people's experiences and how they interpret the world. In this study, I gathered data through semi-structured interviews with each of the participants, then analyzed the data using interpretative phenomenological analysis (IPA).

Interpretative Phenomenological Analysis

Angen (2000) articulates, "Because we cannot separate ourselves from what we know, our subjectivity is an integral part of our understanding of ourselves, of others, and of the world around us" (p. 385). To understand my participants' understanding of the world, I needed to interpret it. Therefore, my understanding and view of the world were also included in my perceptions of the participants. Since this kind of analysis is focused on examining the personal lived experience of participants, the analysis included both the researcher, who is trying to understand through interpretation, and the participants, who are explaining their personal experiences. As Angen (2000) notes, "There can be no understanding without interpretation" (p. 385).

According to Eatough and Smith (2017), "interpretative phenomenological analysis (IPA) is concerned with the detailed examination of personal lived experience. IPA is part of a family of phenomenological psychology approaches" (p. 2). The IPA approach came to life in the United Kingdom in the 1990s within the field of clinical/counseling psychology

(Eatough & Smith, 2017). This approach is centered on the following three philosophical traditions: phenomenology, hermeneutics, and ideography (Eatough & Smith, 2017).

Phenomenology draws from the work of four major phenomenological philosophers—Husserl, Heidegger, Merleau-Ponty, and Sartre—who emphasized the significance of experience and its subjective nature, each in a unique way. Regarding the relationship between phenomenology and hermeneutics, Adams and Manen (2012) explain that "phenomenology becomes hermeneutical when its method is taken to be interpretive (rather than purely descriptive as in transcendental phenomenology)" (p. 3). Through hermeneutics, the researcher works dynamically with the data. Eatough and Smith (2017) expand upon this way of dealing with data by showing the different ways this interaction can take place. They explain it as a process of:

> examining the whole in light of its parts, the parts in light of the whole, and the contexts in which the whole and parts are embedded and doing so from a stance of being open to shifting ways of thinking what the data might mean. (p. 10)

This definition shows the different possibilities available to the researcher for interacting with the data. As noted, one way is to focus on a participant individually and in relation to all other participants; this focused way of understanding data is influenced by a philosophical tradition called idiography.

As Eatough and Smith (2017) explain, "idiography is concerned with how to understand the concrete, the particular and the unique whilst maintaining the integrity of the person" (p. 9). This study was guided by my interest in learning about the participants' experiences, knowing that they all have different realities, perspectives, and worldviews. My aim was to understand the phenomena through the patterns shared across all participants, while respecting each participant's individuality. The main characteristic of idiography in IPA is individualism; through idiography, the individual voices of the participants are

honored and heard, even though the final result is reflective of the group as a whole (Dunworth, 2011).

Participants and Recruitment

Because family therapy is not widely practiced in Saudi Arabia at this time, I recruited a small sample of seven participants, including myself, according to specific inclusion criteria: (a) participants must be from Saudi Arabia; (b) must have practiced or are currently practicing family therapy in KSA; and (c) must have graduated from an MFT program in the West, specifically in the United States or Canada. This last criterion was important because the term *family therapy* in the KSA does not necessarily imply systemic thinking; I wanted to ensure that the participants were MFTs in a way that would be recognized in the West.

As part of the autoethnographic method, and since all the inclusion criteria applied to me, I was the first participant in this study. For the other six participants, I applied a targeted sampling approach for Saudi therapists who graduated from a Western MFT program. As for my recruitment strategy, I first utilized existing professional relationships that I have with a Saudi family therapist and a Saudi psychotherapist to access other Saudi family therapists who graduated from the West. After collecting some names, phone numbers, and email addresses of such therapists, I reached out to them by phone and email. I then used snowball sampling to recruit other participants. As Miller and Brewer (2003) explain, "In its simplest formulation snowball sampling consists of identifying respondents who are then used to refer researchers on to other respondents" (p. 275). All participants were not only open to participating in the study, but also agreed to connect me with other family therapists they knew. I contacted the rest through phone and email. Using both recruiting methods, I found and interviewed six participants, at the conclusion of which I determined that I had reached

"saturation," which Given (2008) explains as "the point at which no more data need to be collected" (p. 2).

Data Collection

Once I received confirmation from Saudi family therapists willing to participate in my study, I sent them the consent form to sign. This form included an acknowledgement that the interview would be audio recorded. It also explained the nature of the study. Because one of the inclusion criteria for the participants specified that they be graduates of family therapy programs in the West, I assumed that they would be mostly fluent in English. I thus requested that we conduct the interview in English. I explained to them that they were free to revert to Arabic whenever needed and that, indeed, they could choose to conduct the entire interview in Arabic if necessary. I also clarified that they had the freedom to stop the interview and withdraw from the study at any time if they started to feel uncomfortable.

To ensure the participants' confidentiality, I attached the consent form in an encrypted password-protected Word document, sent to their private email, and I asked them to send it back to me in order for us to proceed. After I received the signed consent forms, I started scheduling the interviews. When participants were located in the same Saudi city I was in, I met with them face-to-face in their private offices. I interviewed the other participants using Skype video conferencing from my own private office in Saudi Arabia, using headphones and maintaining privacy by keeping the door closed. My preference was always to engage in face-to-face meetings, but the participants' schedules did not always allow for this. All of the interviews lasted approximately one hour. I audio recorded the interviews, including the one I completed with myself as a participant. During that interview, I asked myself each of the sample questions and then responded. I also transcribed and analyzed my transcript along with the transcripts from the other participants' interviews. In the analysis, I decided to incorporate information derived from my own interview into the other participants' data

rather than devoting a separate section to my autoethnographic reflections and analysis. To ensure the anonymity and confidentiality of all participants, I assigned everyone a pseudonym, including myself.

In-Depth, Semi-Structured Interviews

According to Hugh-Jones and Gibson (2012), semi-structured interviews "involve direct questions but with freedom for either the interviewer or interviewee to raise issues not previously anticipated or to dismiss questions deemed less relevant to particular participants" (pp. 101-126). The simultaneous directivity and freedom of the interviewer insure that questions are more dialectic and conversational than specific and tied. I entered into the interviews organized by topics of curiosity (Flemons, personal communication, February, 2018), rather than by specific questions. These topics included factors that inform the therapists' therapeutic work; the relationship between culture, religion, and family therapy; and adaptation, utilization, and alienation in the therapeutic context. For each of these themes, I composed sample questions that I could ask; however, I did not articulate them in just this way. The sequence of questions asked was determined by the flow of the conversation, not by the order in which the questions are listed below.

The Major Sample Questions

- How do you identify yourself in the therapeutic context, and what informs your decision?
- What does your practice look like in terms of theory and change? What models and ideas do you use, and why do you choose to use them in therapy?
- How do you view the role of the therapist?
- What, if any, challenges do you encounter when dealing with Western knowledge and Saudi culture?
- How, if at all, do you work with and function from two differing systems and

worldviews?

- How, if at all, do you adapt to working from two different ideologies and epistemologies?
- What challenges, if any, do you experience in the adaptation process?
- How are you responding to the cultural changes taking place in Saudi Arabia?
- How do you self-identify professionally?
- What language do you use for conducting therapy and what language do you use for thinking about therapy?
- To what degree you believe that your gender shapes what you are able to do (or not do) as a family therapist practicing in SA?

Questions Regarding Influences

- What informs your work as a therapist? How much, if at all, are you aware of the epistemologies (orienting belief systems) informing what you do?
- How do you decide when to ask a question from a particular epistemology (orienting belief system)?
- Have you noticed yourself working from one epistemology (orienting belief system) more than others? When?
- What theory/model informs you?
- How have you made the decision regarding how to ask questions in session and from which model/theory/epistemology?

Questions Regarding the Relationship Between Culture, Religion, and Family Therapy

- What is the relationship between religion, culture, and your theory of change in your work as a therapist?
- How, if at all, do you utilize religion in your sessions?
- What is your orientation as a family therapist?

- What kind of relationship do culture, religion, and theory have for you?
- Can a Saudi therapist manage to draw clear distinctions between religion, culture, and theory?

Questions About Adaptation, Utilization, and Alienation

- What do you do when clients have a dilemma that you, the culture, the religion, or the government do not accept, such as equality, male guardianship, gay and lesbian orientation, pregnancy before marriage, etc.? What is it like when you encounter such a thing in your practice? How do you react? What are some of the factors that made you think and work this way?
- What do you think of the changes happening within our society, especially as a family therapist? Has this influenced your work?

Other Questions

- How do you connect with your clients? What informs what you do and how you do it?
- What is your philosophy of change?
- Do you experience any challenges regarding these ideologies and epistemologies? If so, what are the challenges? What is your solution? How do you cope?
- While you were studying in your family therapy program in the West, did you address the issue of self-of-the-therapist in any way?

Follow-Up

After transcribing and analyzing the interviews, I conducted a validity check for each of the participants, excluding myself. I allowed the participants to review the final analysis in an encrypted password protected Word document sent to their private email. After that, I gave the participants the choice of providing written feedback on an encrypted Word document or sharing it in an encrypted private conference call, using Skype. Having

graduated from Western graduate programs, all participants were fluent in English, so they were prepared to judge my analysis in English.

Data Preparation

I created a file in my computer for all the data collected from the participants. Within this file, I created a folder for each participant, which included the following: (a) the audio recording; (b) my notes from the interview and post-interview journaling session; (c) the signed informed-consent document in Arabic; (d) the interview transcription; (e) the participant's feedback, if applicable. I saved the data from each interview in both my password protected laptop and an external hard drive. The documents were encrypted, and computer and hard drive were stored securely in a locked filing cabinet in my office, whether in Saudi Arabia or Florida.

Data Analysis

After each interview, I listened carefully, more than once, to the audio recording. After that, I reviewed the notes I took during the interview, as well as any I wrote after it. Next, I transcribed the audio recording, utilizing my notes about the interview and the interview itself to help me engage fluidly with the text. This prepared me to engage in IPA data analysis using Smith, Flowers, and Larkin's (2009) recommended guidelines. Smith et al (2009) describe IPA as "an iterative process of fluid description and engagement with the transcript. It involves flexible thinking, processes of reduction, expansion, revision, creativity and innovation" (p. 81). I used Nvivo transcription software to help me transcribe the interviews. Such close engagement helped me become more familiar with the data.

Step 1: Reading, Rereading, and Taking Notes

Once I transcribed an interview, I reread my transcription again and again while listening to the recording. I then read through it yet again, this time with an eye toward the details. As I repeated this process several times, I reminded myself of the interview and the

essence of it, which evolved by adding layers to my perception. At this stage, I took notes of the interview experience and my reactions to participants' responses. This helped me enter the participants' world, understanding the conversation and the details within it, such as metaphors, inside jokes, distinctive phrases, or emotional responses. This first step was crucial, as it determined how well I was able to analyze the data. Dey (1993) noted that "the aim of reading through our data is to prepare the ground for analysis" (p. 83).

Step 2: Transforming Notes Into Emergent Themes

This stage involved treating my notes, in addition to the transcript itself, as data. Analysis involved transforming these notes into emerging themes. In order for this to happen, I needed to move from the concrete to the abstract, formulating brief phrases that categorized relevant segments. Explaining this process, Smith (2012) states that "the researcher tries to formulate a concise phrase at a slightly higher level of abstraction which may refer to a more psychological conceptualization. Nevertheless, this is still grounded in the particular detail of the participant's account" (p. 7).

Step 3: Searching for Connections Across Emergent Themes

This stage involved looking for connections among the emerging themes identified in the previous step. Categorizing the data is not only about connecting the related data; it also "involves differentiating between the included and excluded observations" (Dey, 1993, p. 96). Connecting the themes required me to first look for patterns that had conceptual similarities or made sense together, then group these themes accordingly. I then provided each cluster of themes a descriptive label. Some of the themes were dropped at this stage, as they did not fit well with the emerging structure. As Dey (1993) explains, "categorizing the data allows us to compare observations in term of relations of similarity and differences" (p. 96). I engaged in this process separately for each participant, which allowed me to examine and explore each case in depth. For each participant in the study, I derived a unique cluster of

themes. In order to avoid being overly influenced by the results of the first case and applying its themes to the others, I maintained a journal, tracking my process and thoughts about it.

Step 4: Looking for Patterns Across Cases

In the final step of data analysis, I looked for patterns across the themes I derived from each case. In order for me to see the clustered themes across participants, I used a poster board to arrange the themes derived from all the interviews. This helped me gain a broader view of the themes and the relationships among them. I then collected some information about how the participants' unique perspectives connected with one another. This is reflected in the final chapter of this dissertation, in which I discuss the results of my analysis and relate the identified themes to the existing literature. Chapter V also includes my reflections on the research, as well as my comments about the implications of the study, its limitations, and ideas for future research.

Validity and Quality of the Study

Angen (2000) discusses two types of validity for IPA qualitative research: ethical validation and substantial validation. Creswell (2013) notes that "ethical validation means that all research agendas must question their underlying moral assumptions, their political and ethical implications, and the equitable treatment of diverse voices. It also requires research to provide some practical answers to questions" (p. 283). Interviewing myself as part of the autoethnography helped me not only be aware of and clear about my own values and thinking, but also be more sensitive and aware afterwards while I was interviewing the participants. I kept a journal to reflect and write my assumptions, thoughts, and reflections during and immediately after interviewing the participants.

During the interviews, I was sensitive to each participant, respecting his or her assumptions, values, and worldview. Though all participants were Saudis, their amount of religiosity and open-mindedness varied. Angen (2000) notes that ethical validation requires

the researcher to take a cooperative, non-expert stance with each participant. When conducting the interviews, I utilized my therapeutic skills, bringing my curiosity and empathy to my questions, and communicated my respect for the participants. Explaining substantial validation, Angen (2000) notes that "this process includes a consideration of one's own understandings of the topic, understandings derived from other sources, and an accounting of this process in the written record of the study" (p. 390). To this end, as described above, I maintained a journal of my personal thoughts as I conducted the study. I used it to help establish not only the substantial validation of the study, but also the ethical validation.

Ethical Issues

As this study required Nova Southeastern University Institutional Review Board (IRB) approval, I did not start interviewing the participants until I got permission from the IRB committee. I then started the research process with a mindful consideration for the ethical well-being and safety of my participants. I provided each participant with a description of the nature and purpose of the research, along with information about what would be asked of them. I requested that they sign a consent form that asserted that they understood the study and agreed to participate.

My dissertation topic might be considered sensitive, especially for Saudi therapists, since the topic of the self of the therapist has not yet been addressed in the Kingdom. For this reason, I made sure to let the participants know that they were voluntarily participating and could withdraw at any time. Given that our conversations involved reflections about culture and religion, and knowing how this topic can be sensitive to Saudis, I assured the participants that their identity would remain confidential, explaining that I would assign them pseudonyms and alter the details of their backgrounds to mask their identity. I took into consideration any hesitancy or difficulty they had speaking up. I treated such reluctance with patience and empathy, utilizing my therapeutic training and knowledge.

Summary

In this chapter, I presented an overview of my methodology. I described autoethnography and IPA, and I explained the ways I applied them to and modified them for my study. I also discussed how I recruited and interviewed participants, paying attention to privacy and safety. Finally, I highlighted the importance of ethical validation, possible ethical issues, and self-of-the-researcher concerns. In Chapter IV, I present the findings from the study using excerpts from my interviews with the participants, including myself, and representing various themes that I derived from my analysis.

CHAPTER IV: FINDINGS

This chapter is dedicated to displaying original excerpts that represent the participants' voices through my own descriptions and understanding. All participants were willing to share and give examples about both their personal and interpersonal experiences of being family therapists in the Kingdom of Saudi Arabia (KSA). The analysis presented in this chapter is organized to reveal the contrasts among personal, interpersonal, and societal complexities. The participants' personal process allowed them to position themselves as therapists in relation to their realms of thinking, believing, and perceiving the world while practicing therapy in the KSA.

Within the domain of personal complexities, I address the therapists' awareness of their dual epistemologies as Saudi Arabian family therapists (SAFTs); share the process they take while handling both epistemologies; and reflect their emotional responses to having a dual epistemology. In the second half of the analysis, I share the SAFTs' interpersonal and societal complexities, including their ways of holding their family therapy values and managing their differing societal perspectives. Within this section, I explore how participants discussed a range of challenges, including issues of safety, reputation, and the steps they have taken to ensure their professional status and continued learning.

In the excerpts that are shared in this chapter—particularly those related to personal complexities—the participants' exemplars have a sense of continuity; their process appears to be ongoing. The word *process* is defined as "perform a series of operations to change or preserve something" (Waite, 2012, p. 573). As the participants aimed to manage both epistemologies while practicing family therapy, their process continued, and I expect it will remain ongoing. Given the many differences between the two value systems, SAFTs may need to continually organize and process their position as part of being self-aware in their practice. Sometimes delays in the development of clear understandings and practices are out

of the therapist's hands, especially when it comes to a lack of government or professional policies or ethical guidelines available. Given the newness of the profession and the lack of a professional structure in Saudi, therapists will necessarily continue to search on their own to resolve certain issues, and this, at times, will leave them confused as they struggle to find their way between their two epistemologies.

Interestingly, the participants in this study were not locked into one position; rather, they remained in an ongoing process of organizing information from the two epistemologies. Some of the participants found ways to pinpoint the similarities and differences between their two worldviews. Others contextualized both epistemologies in interesting ways; some utilized their religion and culture to contextualize their understanding and how they perceive the world, while others used their identity as family therapists to contextualize their cultural and religious beliefs.

Before presenting the findings, I will first introduce the participants. However, due to the sensitivity of the topic, I limit and slightly alter non-essential details so as to keep their identities confidential. This is especially important, given that there are so few family therapists in the Kingdom. The participants were diverse in terms of gender, age, experience, education level, and political and religious views. Four participants were female, and three were male, and they came from different regions in Saudi: two were from Riyadh, three from Jeddah, and two from Dhahran. The participants worked in different sectors, including public hospitals, universities, private practice, or some combination of these.

Participant Descriptions

Sophia

Sophia has a master's degree in marriage and family therapy from the United States, which she earned within the last three years. Immediately after graduating, she returned to the KSA and started practicing family therapy in a private practice. The private practice that she

works in is located in one of the larger, more open cities in the Kingdom. Sophia is also a licensed family therapist from the Saudi Commission for Health Specialties. She has completed several workshops about topics related to family therapy while residing in the Kingdom.

Noah

Noah has a master's degree in clinical social work from the United States, which he earned more than 20 years ago. A few years after graduating, he completed a postgraduate family therapy program, also in the United States. Today, Noah has a Ph.D. in social work, and he identifies himself as both a family therapist and a social worker. He works in both the private and public sectors, in addition to teaching, and he is a member of the Saudi Mental Health Supervisory Board. He also presents workshops about family therapy to educate his local community. Noah is a licensed family therapist and social worker from the Saudi Commission for Health Specialties.

Asia

Asia completed her undergraduate and graduate studies in the United States. She graduated with a Ph.D. in family therapy within the last three years. Asia currently practices as a family therapist in one of the main cities in the KSA, where she has worked in both the public and private sectors for the last two years. She trains and educates people about family therapy ideas, techniques, and concepts related to the self of the therapist.

Ali

Ali graduated with a Ph.D. in medical family therapy from the United States within the last five years. Previously, he earned a master's degree and license in mental health counseling, also in the United States. Ali presently works in private practice. He has eight years of experience working as a family therapist in the medical sector in the United States

and currently supervises graduate students in the KSA. Ali is also a licensed family therapist from the Saudi Commission for Health Specialties.

Mariam

Mariam earned her master's and Ph.D. in family therapy in the United States. She has worked in private practice in the KSA for three years and recently secured a position teaching family therapy in a public Saudi university. Mariam is a licensed family therapist from the Saudi Commission for Health Specialties.

Salim

Salim completed all of his schooling abroad. He graduated with his master's degree around 10 years ago and is now considering pursuing a Ph.D. in the United States. Salim has worked for over eight years in the private sector in one of the biggest cities in the KSA.

Hind

Hind graduated from an online counseling program in the United States that had a concentration in family therapy. To complete the AAMFT clinical fellow evaluative track, Hind decided to take family therapy courses, practicums, internships, and supervision in Canada. She completed her internship in the KSA while receiving supervision from her supervisors in Canada via Skype. Hind now works in a private practice in the KSA.

Personal Complexities

Saudi family therapists who practice in the Kingdom undertake and go through various personal processes as they handle their two divergent epistemologies. The analysis below details their experiences and reflections.

SAFTs' Awareness of Their Dual Epistemologies

An awareness of dual epistemologies begins with an awareness of each epistemology individually; in the case of the participants in this study, this includes awareness of the therapist epistemology, as well as the Saudi and Muslim epistemology. Later in this chapter, I

address specific ways in which these two epistemologies intersect for the various participants in the study. In the following section I simply establish that, minimally, all the participants expressed an implicit awareness of their dual epistemologies; however, some explicitly made statements about their sense of themselves as both Muslims/Saudis and family therapists.

Self-of-the-therapist. Referring to the different phases a family therapist goes through, Mariam explained that she first began to identify herself as a family therapist during her master's program:

> I learned family therapy in the U.S., and then I had this identity of a family therapist there for the first time, and then I graduated and started seeing clients in Saudi Arabia. I feel every phase of my growth as a therapist is different, and the things that informed me in the master's are different than what informs me today.

Transitioning from the awareness of oneself as a therapist to explicit training in the concept of self-of-the-therapist in the KSA, Asia emphasized her experience with training other therapists:

> I always use it also with the people who I train, or the interns who present in the room with me in the clinic. I always talk about self-of-the-therapist [challenges] and just being aware of your own cultural background, your own issues, and strengths that you have. And how all these things are being present in the room.

Self as a Muslim/Saudi. In a statement that clearly shows awareness of her Muslim identity, Hind stated, "I am influenced with all that I learned in school, but because I am a Muslim, there are ethics that I learned about, like confidentiality." Another participant, Sophia, clearly showed her identity as a Muslim and Saudi while practicing family therapy in the Kingdom, but also distinguished her beliefs as a Muslim from the beliefs of her clients:

> Because a lot of my clients in Saudi . . . you can find people who are very religious to mild, and there are people who are very open-minded, very Westernized . . . and

> actually I have clients who don't practice, and they say it out loud. So, and they see me, for instance, I cover my hair even if I went outside. They know, and they see me pray. But they continue to do therapy with me, and that for me makes me very happy. Because I am not going to put my religion on them, and this is why they feel comfortable to continue.

Awareness of both worldviews. Sometimes while practicing, participants were explicitly aware of the fact of their two epistemologies, and sometimes this awareness faded into the background. Participants had different ways of realizing what awareness can do for them as therapists, as well as what it can bring to their sessions. For example, Mariam explained that she strives for clarity in her relationship with clients, distinguishing between her own values and theirs. She explained:

> Connection for me is not just in one way or the other, but just being there with the client, being empathic, trying to understand the client's language, normalize, summarize, and things like that. Being there and really trying to understand the clients themselves instead of trying to filter my values through theirs. And I think awareness brings a lot of that; being aware of my ideas helps in knowing my values and helps me understand clients' values separate from mine.

Asia took a step further, explaining that she not only keeps her values separate from her clients', but also takes care to not impose her values onto them. She stated, "I have to be aware of my own reactions, and I have to be aware that I don't want to impose my own values." Asia continued sharing about her own process of becoming aware, elaborating on how this has helped her to strengthen the therapeutic relationship with clients.

> I think it strengthens the therapeutic relationship, because you are more aware of how you are not going to impose your own experience or your own assumptions about a family. You just become more aware.

Ali spoke about how he uses his awareness to decide whether and when to use his personal values in the therapeutic process:

> I need more discipline to be aware of my reaction when it comes to social justice. So sometimes, when it is not part of therapy, I let it go. Either it is about me or not about me . . . so, if it is related to the therapy and I can use it to help therapy, I would stop and process there; but if it is not going to benefit the therapy, I will let it go.

As a teacher of the basics of psychotherapy, Noah explained that he considers not only what is relevant for him as a therapist, but also what is relevant for his students as they learn how to be therapists. He spoke about his commitment to self-awareness and his practice of encouraging his students to do what he does:

> I always ask these questions [to my students]: Let us know, what do you have in your mind? Tell us more about your thoughts. What is the struggle for you like? Where did the struggle come from? When you ask other colleagues, have you talked to your supervisor? Did you go to other supervisors? Until they come along with something that will bring it to the conscious level, and then they can work with it. Most of the students that I asked did not really bring it to the conscious level; they think of it as just a challenge of Islamic teaching, especially accepting the client as is. But, when they think about it in depth, and they bring it to the conscious level, they just accept the idea.

Challenges with self-awareness. Three participants mentioned that it is sometimes challenging to be aware. Although Ali emphasized the need for therapists to be aware of their biases in the KSA, he described how being aware can be difficult at times.

> Well, I cannot say that I am not biased, but it is a challenge for the therapist to be aware of his or her biases, whether you are practicing in the United States or Saudi Arabia—more so if you are practicing in Saudi, due to the gap or the conflict between

> the philosophy of Western education that I have got and the culture that I am living and practicing in, which requires more awareness of our biases.

Noah stated that it can be challenging to be aware at all times, but also added that he is committed to making a great effort to be aware. Noah sometimes finds himself reacting in a certain way with a client, which then reminds him that he needs to differentiate himself and be more self-aware:

> I doubt that . . . no, I don't think I could be aware all the time. But I make a very great effort to remind myself every time; and when I reach my client, I prepare myself for the mixed session. I always tell myself, just as a practice for me, always. Yeah, I shouldn't; but sometimes, because it becomes a debate, and when you debate you lose the client. So, I don't tend to go into debates, and I will stop the debate if it comes. And clients will make sure that now we are going to debate, so let's just stop that, because it is not helping. So, yes, at that moment I will find out that I am not separating myself, you know. And I don't separate myself totally, actually.

Mariam also agreed that a therapist cannot be aware all the time; she went on to explain what helps her to go back to awareness:

> I think awareness is a really big thing. I can't say that I am aware all the time, though. But, because it's in my system, I'm always looking. [I pose questions to myself:] "Okay, where is this coming from? Why did I ask this question? What was informing me then?" Things like that.

Epistemology is a self-referential matter, which means that therapists either know about their epistemology or not. But regardless of whether or not they are aware, their epistemology will influence their way of thinking about therapy, talking about therapy, and doing therapy. Being aware of one's own epistemology makes it possible to choose how to react to it. As Satir (2000) explained, "There is a close relationship between what I believe

and how I act. The more in touch I am with my beliefs, and acknowledged them, the more I give myself freedom to choose how to use those beliefs" (p. 26).

In the next section, I display some of the participants' reactions to their dual epistemologies, emphasizing a set of processes that highlighted the relational aspects of those epistemologies. Therapists experienced these processes in different ways while handling the complexity of their dual epistemologies.

SAFTs' Processing of Their Dual Epistemologies

As part of the process of working from a dual epistemology, participants highlighted different positions regarding both of their value systems. In an attempt to organize these systems, participants sometimes highlighted the similarities, demonstrating their ability to see how both epistemologies harmonize. Other times, participants juxtaposed their epistemologies, pointing to the differences between them. At certain points in their process, some participants adopted one epistemology to understand the other. Other participants attempted to combine them. The participants in this study displayed various ways of dealing with the complexity of working with dual epistemologies.

Harmonizing: Similar position on ethics, confidentiality, and values. One of the positions that SAFTs take as part of their adapting process is to perceive the congruence between their two epistemologies. These participants found similarities between their knowledge of family therapy and their Saudi Arabian cultural assumptions and values.

Some participants were able to draw a line between Islamic ethics and the AAMFT Code of Ethics. For example, Hind stated the following:

> I am a Muslim, and many things in the AAMFT Code of Ethics are correspondent to the Islamic values. . . This is the code of ethics; but as a Muslim, these things are valuable for us, whether we have the AAMFT code of ethics or we do not have it.

In a different statement, Hind gave an example of how being influenced by Islamic ethics corresponds with the AAMFT code of ethics:

> Well, as I told you, I am influenced with all that I learned in school. But because I am a Muslim, there are ethics that I learned about, such as confidentiality. Let's say *alamana* [honesty in Arabic]; it is something from my religion. Whether it is in the American Association of Family Therapy or not, this is something that I am influenced from my religion and is part of my belief system and my values. If someone told me that this is a secret or something that is private, I would not say it, ever since when I was a child . . . I am a Muslim, and many Islamic values, many of the things in the Code of Ethics of the AAMFT, is correspondent to the Islamic values.

A different participant, Noah, explained that ethical values in both family therapy and Islam are not only similar, but also applied similarly in Saudi Arabia and the West:

> Now let me tell you something, in Saudi Arabia when I worked in a University, ethics was number one, and usually we get it from the Western ethics background . . . Confidentiality, for example, and also revealing or not revealing information of the client, are done the same. The secrets of the client and confidentiality is specifically the same. We do not reveal information, unless it is by the order of a judge, and if it is serving the client. It's the same strength here.

Ali confirmed the similarities between both value systems and policies:

> There is a common thing between law, my standards, policy, culture. They have common areas between them. They are not really against each other. You integrate them all together with the religion, and the culture, and the problem that the client has. There are some differences between them, but they share common concepts between them.

Contrasting: Differing positions on policies, guidance, ethics, and confidentiality. Participants taking a contrasting position compared and juxtaposed their dual epistemologies, recognizing some of their incompatibilities. Sometimes the incompatibility was a result of how young the field of family therapy is in Saudi Arabia and how few policies and guidelines there are for Saudi therapists. Participants taking this position described the differing loci of their dual epistemologies.

The guidance and rules of therapy are clear in the United States, where most Saudi family therapists learned family therapy; however, they appear to be less clear in the Kingdom, where these therapists actually do family therapy. While discussing the ways in which they are informed by incompatible value systems—whether in terms of ethics, legalities, or culture—some SAFTs described how they are challenged by the duality and inconsistency of their informing systems.

In the following exemplar, Ali explains how the differing position and guidelines of both epistemologies can contrast, even regarding age limits for privacy and confidentiality:

> It is challenging to work with a teenager. I don't know what the definition of a child is here. In the U.S., a child is [anyone] under 18. So, any time I conduct a therapy session with a child under 18, I should be in contact with his parents, and legally I have an obligation to stay in contact with the parents, even if I have consent to do therapy without the parents. Here in Saudi it is vague; sometimes I feel like the law says at 14 they are adult enough, and sometimes, even if they are 20, [they are] adult enough.

Policies and guidance are not the only aspect of therapy contrasted by the participants. They also elaborated and gave examples of the contrasting views on ethics and confidentiality. For example, Hind contrasted the clear ethics in the West with the culturally driven ethics in the Kingdom:

> In our community, we have . . . it's not individualism, like in the North America or Western society, it is more collectivism. You know how the authority of care here. So, for example, I have many clients who are adults in their 20s and 30s, and they are not married, and they are living with their parents. The mom sometimes comes, and she wants to know every single thing about her daughter; but the thing is, as we learn, if you are above 12, you can think for yourself and not everything your parents need to know about, and you totally have confidentiality.

Ali explained that it is difficult for him to take an ethical stance when the guidelines of therapy are unclear and so different from the ones he learned in the United States:

> I don't feel the confidence to say to the person who is 18 or 19, a college student, to say, "Whatever we say here will stay here. We don't disclose anything without your written consent." I say it verbally; not sure if I can stay with that, because when their parents ask when they are coming to the clinic, it will be a big challenge, and the administration staff will not support you on that. So, when the parents get mad at me for not disclosing all the details about their child, their son or daughter . . . and when it comes to the daughter, that's even another chapter when it comes to females. Gender here plays a significant role. Like if a woman, her husband called me and came to the clinic asking about his wife, it is very challenging to say, "Well, I can't disclose about her without written consent." It is starting to be better, but socially it is not really acceptable.

In this last exemplar, Ali not only explained the differing position of ethics in the Kingdom as compared to the West, but he also introduced the weight of cultural expectations compared to ethical concerns. Ali compared the ethical mandate of confidentiality with the patriarchal position of Saudi culture, thus revealing how challenging it is to practice therapy

in the Kingdom without clear protocols for handling such multilayered issues. Ali went on to explain the importance of being ethical and the struggles and concerns that come with it:

> When I say something, I have to be consistent with that. When I promise my client the first session will be confidential, I have to stick with that. But you know what, I am not protected. I could get in trouble legally and also socially.

Hind discussed the difficulty of using the Western ethical code, especially since it is tied to Western culture:

> Yeah, for sure it is challenging, because as you know, the code of ethics is designed for the North American society. For example, the duty to report in cases of abuse: Many of the families here are beating and hurting their kids. If this is in Canada, there are some forms in Canada. Like, I must inform that to other services. But here in Saudi Arabia, everyone is doing that unless someone will die or something. So, when I talk about this in my service agreement, like if I notice sexual abuse, or physical abuse, or child neglect, or . . . or [information about] a suicide or homicide: in this case, clients start . . . if you look at the faces of the parents, they get scared. So, until now, I'm having challenges with this part.

Noah gave an example that not only shows the difficulty of using Western ethics, but also illustrates a clash between the ethical standard of confidentiality and respect for clients' cultural beliefs:

> Women, when they come alone, is a little challenge for them, for us, for their privacy, for the setting. But I do also give the lead for the lady if she wants to leave the door open. I tell her people will hear what you are saying. Sometimes if any member of the clinic is available, and if she wants them to join, sometimes we do that. But those have reduced over the last 10 years by like one hundred percent.

Sophia pointed out the importance and necessity of having clear guidelines, policies, and ethical codes for therapists in the Kingdom.

> We have to have two cheat sheets: a sheet about the law and what to do as a therapist, and ethics for Saudi therapist[s] who are legalized in the Ministry of Health. We don't have that. The first rule, don't sleep with the client. We don't have that rule; you [can] get married to your client, apparently. I saw that, and that for me it is very wrong.

Using Western ethics. The participants agreed that since there are no legal guidelines or policies informing the practice of therapy in Saudi Arabia, they need to rely on other kinds of guidance. Some participants revealed that they use ethics standards from the American Association of Marriage and Family Therapy (AAMFT) to help them make therapeutic choices and decisions. Hind, for example, described her way of handling the lack of ethics guidelines in Saudi Arabia by utilizing the AAMFT Code of Ethics.

> So, what I am doing mainly to maintain the quality of my practice is sticking to the AAMFT Code of Ethics. So, this is what I am doing. And I always inform my clients in the service agreement that I am following this code of ethics. . . . Now they are starting to legalize things; but still, as far as I know, and specifically for family therapists or even counselors, I don't think that there is a code of ethics that they have here.

Noah drew a distinction between when he uses basic Western ethics standards, and when he resorts to reporting a dilemma to a higher committee to discuss a case.

> I'm going back to the basic ethics as long as it is not affecting the whole country. A terrorist guy is a dilemma, but if it is not a terrorist, everything is accepted in my belief. But if he will terrorize children or the country, then I have to work with the committee that I belong to; then we will have a meeting and we will discuss what's next. Do we have to inform? Do we have to protect the client? Like a schizophrenic

> who doesn't know that he has a mental illness, then do you have to admit him? We're still in the dilemma, of course, but on my behalf, when it comes to safety of the country, I think we need to act differently. We had cases in the past, and we discussed it with the commit-tee, and we came up with a solution. We thought that it was suitable for the prevention of whatever's behind that idea.

Ali explained that he turns to an ethics code, especially when there is a clash between the Saudi culture and his knowledge as a therapist.

> If there is no congruency between what I believe in therapy and the culture itself, definitely it is a struggle. Again, I am following ethics in my work that I believe is working. Again, I follow and consider ethical standards.

Contextualizing. Contextualizing was presented through this study in two opposing ways: contextualizing family therapy within religion and culture, or contextualizing religion and culture within family therapy. The first contextual frame is Islam, wherein cultural beliefs take precedence over knowledge of family therapy. Therapists who used this frame understood family therapy through the frame of religion. The second contextual frame is family therapy, wherein the identity of the therapist takes precedence over the belief system. Adopting the identity of family therapist as the overall umbrella influences therapists' ways of perceiving and reacting, both professionally and personally. In the following section, I will display exemplars from the participants to demonstrate both processes of contextualizing.

Beliefs as a Muslim take precedence over knowledge as a therapist. Saudis sometimes prefer to view—or find themselves inadvertently viewing—foreign knowledge through the well-known and familiar lens of their Islamic beliefs. This process is not unique to SAFTs; Saudis have Islamized many aspects of different knowledge bases throughout the years. Saudi family therapists who take the position of contextualizing their knowledge of

family therapy through the frame of Islam view and understand the practice of therapy from a religious and/or cultural perspective.

One participant, Noah, explained that the Islamic values embedded in his background followed him throughout his education in the KSA, as well as when he later studied family therapy abroad.

> I finished my bachelor's degree in 1982, and those values were there before I came to school, actually. As people, you know, Allah Almighty, people were born free, so they can decide whatever they want; that's the background philosophy of my life. And I found that these values matched the value of the school that I went to in Saudi, and then in the master's degree also the same. So, my values are evolving, but it is embedded in the, in my nature, and is embedded in the schools that I went to.

Noah went on to provide examples of how Islamic values are similar to, and compatible with, the values of the family therapy tradition. These examples reveal that Noah's Islamic perspective contextualizes his understanding of family therapy.

> The real thing that I believe in is that Allah Almighty lets people decide for themselves. Nobody can tell you what to do as long as it is between you and whom you believe; if it is Allah almighty, if it is Jesus, if it is Buddha, if it is whatever, it is between you and your value system; it should be well respected, and that is an Islamic base issue . . . I don't want to go through that, but it is embedded in Islam that you respect others.

Sometimes the process of contextualizing family therapy within Islamic beliefs is evident in therapists' decisions and reactions to clients' presenting problems. Two of the participants talked about their experience with a socially unacceptable presenting problem; they explained how difficult it was to handle this issue:

> But if I reach a point where I feel, well, I don't think I can help, because . . . it seems that it is touching a very core, let's say very core, sensitive, cultural religion with me, it might impact the therapy, because I am not on my, let's say not fully integrated with the treatment plan; and that's not even our essence. Our culture, as you know, is very highly sensitive about sexuality, without even talking about gay or lesbian [identities]. Sexuality itself is a very sensitive topic in our culture. Yeah, I can work with you; I will be happy to work with you. But, for example, if a person came to me and said, "I am a sex addict or porn addict," I will be happy to work with you. But if you say, "I am a porn addict, but I don't want my wife to know about it. Can you help me?" then my ethical standard [gets highlighted] . . . It is not my job to mislead your wife. My job . . . I can stop you from doing that, but I cannot help you in doing that. I can help you get better, but I cannot help you manipulate your wife. That's my ethical standard, and I don't think it is that far from the code of ethics, not harming your client. I believe it is harming you, so I will not help you, I am not going to harm you.

Ali explained that his way of handling the complex process of viewing clients' presenting problems from an Islamic and cultural perspective is to help clients only if they are willing to "get better and change." He spoke about his process of integrating his personal standards, culture, and religion to help him make therapeutic decisions:

> This is a problem for me, and I may say it is a challenge for me, to help you in your issue, because my hand[s are] just tied, and I am not sure if I am helping or I am doing more harm. So, I don't help my patients to harm themselves or family members . . . I function from . . . [a] Western ethical code, but [it is] also integrated with my personal standard, and also integrated with culture and religion. So, I am an integrated therapist. At the same time, I am a holistic therapist; I integrate all factors.

Hind explained her way of handling such issues and spoke about when she would consider referring or terminating a client.

> To be honest with you, when I was practicing in Canada, I was really worried that, you know, having partners who are not married, or having lesbian couples. . . . You know, I am a Muslim; and I know that it is haram (religiously prohibited in Arabic), so sometimes of course I can't refuse them, because this is my work, yes; but, I mean, I don't feel comfortable, because this is against my values. Like, for example, if I have a lesbian girl who came for depression, okay, it is very easy for me to help them, considering it a human thing, you know; but, you know, whether . . . Western society believes in values and the rights of homosexual couples, I don't feel comfortable to work with something like that, because I don't agree with that. It is against my values. Or [extramarital lovers]—it is something that is not accepted in our religion. So that's why ethically, if I feel that I am not comfortable with these cases, I need to refer them to another therapist. But I am telling you, until now, I didn't face something [like this]; because most of the people here, they come because they want [to change] that; it is wrong, and they want to change.

Sometimes the value that takes precedence over the knowledge of family therapy is not religious or cultural, but rather a personal value that the therapist holds dearly. In the next exemplar, Salim offers an example.

> I have zero tolerance for domestic violence, an absolutely zero tolerance. I take a stand that if I find a woman that is in a battered relationship, this is with breaking all of the rules that we learned that we never tell our clients what to do. That is the one time that I tell my client what to do. . . . So, literally, I tell the woman, "Leave. Get the hell out. If he raised his hand on you once, he would do it again." Unless he seeks real help and he treats himself, otherwise, it is going to escalate with them. In the

> U.S., yes, my zero tolerance is the same; except in the U.S., I have options, and I have help [at] hand. I can call, I can call the police. . . . Here, the rules are not clear, unfortunately. I don't know where to go, and I don't know what to do.

This exemplar from my interview with Salim reveals that there is a clear relationship between epistemology and practice. Another participant, Sophia, stated that she disagrees with therapists who contextualize family therapy within the framework of Islam or the culture. She explained how it is familiar to other therapists in the community to be primarily influenced by their religious and cultural epistemology.

> I did a workshop, and for me it was ok, good; but a lot of people asked and questioned me about the reason [for] not adding the religious perspective to my workshop. Most people think that religion is the core belief that you are going to be a good person. Because this is not our role as marriage and family therapists. This is one of the observations that I noticed that it is here in Saudi: integrating religion, a lot.

Identity as a therapist takes precedence over beliefs as a Muslim and Saudi. Participants who place their identity as a therapist before their personal beliefs presented their systemic way of thinking about problems and how they perceive clients. Those participants who take this position seemed to utilize religion and/or culture to address certain questions and challenges posed by clients in session. Instead of being trapped by their culture, these participants decided to be sensitive to it, exploring their clients' culture; they noted that they were careful not to make assumptions or judgments about their clients' culture or religion. Different participants adopted this position in different ways. For example, Mariam put it this way:

> Clearly, I'm influenced by my knowledge as a therapist, from the questioning style, the theory, the thinking process. All the things that I learned actually became a part of

my own values that I use in my work, not only in my professional life, but also in my personal one.

Conceptualizing sessions from a family therapy epistemology. Accepting clients as they are and viewing their presenting problems from a family therapy perspective is a clear indicator that a therapist has adopted an MFT identity. Different participants mentioned in the interviews that there is a clear and distinct line between what is religiously and culturally acceptable and what is not. Therapists who are accepting of clients—even those who present with culturally challenging qualities and quandaries—and who view clients' presenting problems apart from their cultural essence can be said to prioritize their role as an MFT over their beliefs as a Muslim and Saudi.

In the following exemplars, some of the participants offer different examples of how they view their clients' presenting problems from a family therapy perspective. Noah, for example, spoke about how he usually starts his first session by informing his clients that his work is informed by family therapy knowledge.

> The session starts with me informing the client in the first session that I will do this session through a scientific approach using theories. I usually tell them some of my preferable theories, like system theories, Salvador Minuchin. And they have the right to question me, but usually they just nod, and they agree.

Mariam described her process of contextualizing from a family therapy epistemology, and explained how it influences her way of perceiving the world.

> It's interesting how I stand in the middle of two cultures, how my ideas or my thinking and being as a family therapist let me stand [on] a different ground, I guess. I can't see just one reality now; I can't say I am a Muslim, and this is my culture without being aware of everything else, anything else. I can't [say] everything else is wrong and I'm right. I can't see the world this way anymore. I feel now that I am a

> different therapist and person. I can see different realities, and I think that this will help me as a therapist to see, to respect, to value, and to understand the different realities of clients. And to be able to understand them as they are, instead of judging them or trying to [get] people [over to] one side [or another], like "Oh, no, you need to be this or that." This is not my role as a therapist, and I am very clear about that. And definitely my lens, my family therapy lens, gave me this bigger view, gave me this accepting view, I guess.

Because epistemology is self-referential, therapists' ways of thinking about a problem or way of questioning can be a clue, a little window, that reveals their epistemology. One of the participants, Sophia, spoke about her approach toward questioning her clients, explaining how her questions are not culturally and/or religiously limited.

> Okay, I am an MFT who really believes in a lot of mixture of Bowen and others. But when I ask a question, if I say at first, I told you that, I ask by culture. Yes, I am asking about the culture itself, but I am not going to judge. For instance, yesterday, I had a client; a lot of people tell me, "Why you are putting all of this stuff on your intake sheet?" . . . I ask questions like, "Do you drink? Do you do alcohol?" A lot of clients say, "No, why are you asking this question? We don't drink." If I ask [influenced only] by culture, I'm going to assume that people don't drink, or assume that people have no sexual activities, [but this is] absolutely wrong; a lot of people do that.

Asia described her process of looking at a client's presenting problem and trying to understand what it means for the client, instead of limiting the meaning to an Islamic or cultural context.

> The male partner said, "I'm the man." So, I was like, "Help me understand what you mean by 'I am the man.'" So, you just let the person reflect back on what does it

> mean when he says he is the man, and he is the head of the family, and, therefore, the woman should listen, or his wife should listen to him. So, just allowing him the space to reflect, like, "Help me understand; I don't know what you really mean by saying 'I'm the man.'" So that really slows the process. Because sometimes people throw certain things out without allowing the time to reflect back on what does it really mean to be a man. And saying that, and explaining that in front of his wife.

This exemplar reflects how Asia decontextualized the meaning of, "I am the man of the house," instead of taking it as an ultimate truth. She went on to explain how she contextualizes clients' problems:

> Okay, so I'm feeling that I am a collaborative therapist; so I need to understand the concern from their point of view, and I want to understand their goals, also what brought them here. So collaboratively, once we have this conversation, if I see that there is a cultural aspect, then I will go there. If I see that there is a religious aspect, so I will ask about the meaning of those things. So collaboratively, I guess the frame is, usually I need to be collaborative when it comes to culture/religion. I need to allow them to tell their story about how they see their religion playing into this concern. How they see the culture playing into this concern. How they see also, like, the gender differences playing into this concern when I'm working with couples. So, I guess, being . . . just being reflective and being collaborative, and coming from the stance of I don't know it all, that they will inform me. I guess this is how I see my framework and play into helping people.

Noah emphasized how challenging it can be to perceive a religious or cultural issue from a family therapy lens.

> Yeah, [with regard to] most of the things that have religion impact, and have specific explanations: We as therapists are not mufti or sheikhs. There is a challenge when it

> comes to religion . . . everywhere in the world. It is not easy, especially when, you know, especially when it is utilized by one of the partners as a power issue. It will take longer sessions to challenge both clients about it. I always ask clients if it is a power or control [issue]—if it is a struggle in that area, and how this is serving their relations. I ask these questions to ease it [for] them, and to reduce the strength of it, if I can say so when I have a chance to do this, without having any negative impact on me as a therapist. Sometimes people surprise you: You think it is affecting them negatively, but when you ask the right question it is okay. For example, women and guardianship [i.e., a legal code in Saudi Arabia that renders women dependent on men. Regardless of their age, education, or marital status, women need to have a male guardian: a father, uncle, husband, or even younger brother or son]: Some people are against it, but I don't take it for granted. So, when people come to me and the wife is accepting the guardianship, then I respect that. When I find another woman who is against it, then I will challenge that as, how is that serving the relationship or serving the current problem? Is it a hidden conflict between the couples? Does it come from real belief, or is it a challenge?

Other participants, in different ways, spoke about how they manage culturally unacceptable presenting problems by viewing them from a systemic perspective. Salim, for example described it this way:

> I had one clear example that I can give you. A 19-year-old came with his aunt, the sister of his father from the paternal side. It was the first session, and I said, "What brings you to therapy?" or "How can I help you?" He said, "I am gay, and the aunt is the only person who knows." I said, "Ok, so hey, it is great. People . . . usually it's a journey; it takes them years to discover, and come up, and finally open up to themselves, and you are sitting here and saying 'I'm gay'." I said, "Alright, so how

> can I help you?" He said, "Cure me!" He said, "Well, you know, our culture and where we are, it is not acceptable. I cannot be who I am. So, and I would like to have children one day, so then I want to be cured." So I told him, "This is not a disease for me to cure you." So I still couldn't tell him that I am concerned there is nothing wrong here, but I looked at the aunt here, and I said—because I could see that she is looking at me—and I said, "I am not a religious Shaikh, and yes, thank God, I am Muslim. But I cannot help you from a religious point of view on how you going to deal with this. All I'm saying is that we do not consider this to be an illness, so I cannot cure him. But what I can do for you," I said, "I can help you with safety and how to be yourself."

Sometimes clients can be concerned about their safety when it comes to a culturally or religiously unacceptable matter. Hind spoke about one of her clients, who was hesitant to speak with her about such an issue. She described the way she handled the issue from a systemic point of view, taking a non-judgmental stance:

> But I see people who have ideas about atheism or [who are] agnostic—Muslim girls who grew [up] in . . . really conservative families, and then when they grew up . . . they went out of Saudi Arabia for school, [to earn a] . . . Ph.D. or master's degree. They start to get these ideas against Islam and want to be out of Islam, you know. One of them, she told me, "I am afraid to tell you now that I have these atheist ideas, and then you will report it, and then they will come and kill me." I told her, "Well, this is not my business whether I agree or disagree with your ideas. I am not an Imam or a Shaikh. I am a therapist, and you are here because you have Borderline disorder, and you need help with that, and I will help you with that. Your ideas that you are talking about, that you do not believe in God, or that you believe in Taoist ideas, it is not my

> business. This is something different than what I do. If I am in a masjid [i.e., a mosque] or something, then it is a different story."

Hind went on to offer a different example of how she contextualizes the Islamic religion and culture with her family therapy views. In the next exemplar, she explains how she dealt with a controversial issue between a client and her mother without siding with the cultural norm.

> So, I remember also, another case about the hijab. . . . Some people don't see that they need to wear hijab, and some people think that hijab is covering the face. . . . The mother comes talking about her daughter, saying that "She is not covering her face. What do you think?" I tell her that it is not my profession to tell her that. What I mean is that covering the face, you cannot force anybody, cannot force your daughter, this is what I think. People here don't understand that this is not a place to talk about religion; this is what I think. People will see me as secular, but you don't want to get in trouble with misunderstanding.

In a similar case, also about the issue of wearing a hijab, another participant, Sophia, spoke about her position as a therapist, emphasizing how strongly she feels about prioritizing the role of therapist over her personal beliefs. She emphasized her view that the role of the therapist is to listen and not give advice or make judgments about right and wrong behaviors.

> Every day, female clients, 16 and 17, or even 25, come to me [with] question[s] about [their] hijab; this is a big topic. And I am a hijabi [i.e., a woman who wears a hijab], but a lot of my friends took off their hijab. So, for me, I am not going to say anything. I'm just going to go with her flow: "Where this is coming from? Why do you want to do that? Are you ok with that? You find it ok to do it?" As long as she is happy, I am not going to tell her not to do that. So, I am trying to be a therapist, and this is my role. If she wanted to do research and talk to me about it, I am open. And it is going to make me in a great knowledge, but I am not going to [tell you that] you have to pray;

> no, no, it is not my role. It is very . . . I don't like it. Unfortunately, I see a lot of therapists do that. I talked about it with some therapists and colleagues. It is absolutely wrong—this is my opinion.

Sometimes SAFTs who take this position find themselves acting as mediators between clients and their families. They maintain a systemic point of view, even when the clients and their family members view things from a religious perspective, and they recognize that all parts of the system influence the larger family system. Sophia offered the following example:

> Ok, let's say one of my clients came to me and said, "My mom has a problem. She has a boyfriend." For me it is fine, but it is culturally not acceptable. Religion wise, I don't know, it is not my business; but culture wise, it is not acceptable by the family, [but] she feels that it is ok. So, my role is to go with her flow and understand where she is coming from, where her mom is coming from.

Hind spoke about how she handles the hierarchy in client families, providing an example of a time she worked with a client and her mother by listening to both and differentiating each of their goals.

> This is what lately I am really tired of: moms who are coming and trying to do things about their girls. And I can't say, for example, especially with those who are in relationship, multiple relationships, with different boyfriends and having sexual activity. The mom is really concerned: "Are you okay working with her if she is doing, well, if she is still doing something?" I told her, "Well, I couldn't do anything, you know. She is working on her goals." For example, [she] came with her to the center because she is doing this, and this is not allowed in Islam to have this sexual relationship and multiple relationships with one guy or with 10 guys. So, this is the goal of the mom. I talk with the girl, and I tell her, "Okay, these are the goals of your

mom. What are your goals? She said “Well, nothing is wrong, and I want to change, but I have other things that I need to work on.” “Okay, well, what is the priority for you, and what is the first thing that you want us to start with?” And then she lists something for me. I start with her goals. I tell her, “Your mom needs to know about it,” and we work from there.

Asia explained that building a relationship is her way of handling the challenge of viewing a presenting problem from a systemic approach, especially when seeing families.

One of my clients was raised as a female all her life, and then she felt like she is a male more than a female. And [the one] who brought her to the clinic was her mom. The girl is like 18 or 19 years old, so she is an adult. But, yet, who brought her and always, like, [was] paying for her sessions was her mom. So, the mom comes in with the idea, “Correct my daughter. She is a girl. She’s supposed to be a girl.” And the client sees herself as a male, and she wants to live like a male, and she wants to have all the privileges that her brother has. She doesn’t want to cover, and she doesn’t want to do all those aspects. It’s really challenging for me as a therapist, because I want to tell [the mother], “Let your daughter do whatever she needs to explore this aspect of herself, the male side of her.” Yet if I told her that from the first session, or if I don’t even allow her to come to the therapy room, I will really lose the client. So, I saw them together, and then I saw the mom alone and saw the daughter alone. So, it’s really challenging how to convince the mom to let her [daughter] explore this side, and then she can decide if she wants to do a particular operation or not. From the beginning, she is telling me what I should be telling her daughter. So, I really had to take one or two sessions to build a relationship and to tell her, “I’m not really in a place to tell your daughter what to do. But I am here to help her help herself, and that you really need to back up from changing her. She needs to.” And I felt that the mom

> was ready then to hear this, because we already built a relationship. I saw her alone, although the appointment was for her daughter. So, giving her that space. But it was so difficult, because part of me is thinking the daughter is already an adult, and her mom should not be there. Because the mom wants to be there, it is not because the daughter who wants her mom to be there. Then, like, culturally, she is the one who is 18 years old 19 years old and still under the parents' umbrella yet. So, I really needed to modify my approach.

Noah spoke about the way he deals with culturally or religiously unacceptable issues presented by clients and described his way of looking at presenting problems in a systemic way.

> We have many kids who are atheists, and it's ok when they know there is something different in the culture, and they know I don't treat them like less than a client. They are clients, and if it is not an issue for them, then we will move on with other issues they have. If some of the family members, they think it is an issue, so we talk to the member of the family [about] how it is affecting the entire system. You think of it as a presenting problem rather than [as] a problem of the client.

Utilizing beliefs. Most participants, in different ways, explained how they utilize beliefs in their sessions. Instead of using their belief system as a guide for therapy or correcting and modifying clients' beliefs, the participants expressed a willingness to utilize clients' religious beliefs, and/or their own knowledge about these beliefs. The following exemplars reflect the different ways in which the SAFTS in this study utilize beliefs in therapy sessions.

One participant, Asia, mentioned that the topic of religion is always present, as her clients usually bring it up in sessions. She explained how she utilizes her clients' religion in a way that can help them discover their resources.

> People always put religion into therapy. So, once they open that door, I would ask them about what religious values do they attach to this certain aspect of the information that they are sharing. Let's say, like, the guardianship . . . I would ask them about it. So, once they bring it up, I will talk about it. Once they bring it up as a coping mechanism, I would explore it further and further, and how can I utilize religion, like prayer and those aspects that would help them to cope with certain situations. . . . I would ask the question, like, as an aspect of their coping mechanism or their support. What else do they do when they are under stress? What else do they do? So, then the topic of religion is always . . . will be open.

Similarly, Noah shared that he utilizes clients' beliefs, especially in the context of couples therapy, to help clients recognize how their beliefs either help or hinder their relationship.

> As usual, even if I am pro [a certain position], I do not bring it [up as if] . . . I am pro 100%, because probably I will find a male [who] is embedded in his belief that this is religiously prohibited; and in his wife's perspective, it is not prohibited religiously. So I will utilize this as for them to have an exercise to check how that will help them to either become apart or they become more for close by certain[ty about] what is best for them. So, I turn it always to favor[ing] . . . the relationship.

Salim was another participant to share that he utilizes religion in his sessions; however, his approach was distinct. He stated that he utilizes his identity as a Muslim when a client is religious or uses Islamic language. Salim explained that he does that in an effort to communicate messages to clients using their language.

> If I see that they are religious, more on the religious side, then I can go that way to help them. Because I also, thank God, I read the Quran, so I know, and I can say, "But in the Quran, it mentioned this and this." So, going back to that example, I made sure

that I would give him sentences from the holy book when I wanted to enforce a message.

Noah also talked about utilizing his belief system as a Muslim, but only when a client mentions Islam and religion in session. He described his way of incorporating and asking clients about the meaning of certain beliefs to better understand them.

I allow them to bring, let's say [using a verse from the Quran], "We have made love and mercy among them." This is a huge introduction for people who believe in intimacy and mercifulness in the relationship. They will bring it, and I will utilize more about it and let them talk about how is that for both of them. I usually go, if it is couples, I always make sure that the meanings for both of them and the concepts are within the same reach for both of them. Sometimes one thing means different things to two people; so yeah, even if it's different with the acceptance of each of them, you know, you go with the system.

In contrast, Hind shared her belief that the act of utilizing or not utilizing religion might offend certain clients, depending on their particular religious perspectives. She explained that in light of this, she tries to explore clients' culture and religion first, before deciding whether to utilize, in the session, her religion, the client's religion, or neither one.

It depends on the client. Because, for example, you might offend the client if you utilize it, and you might help a client if you utilize it. If the client is willing to utilize it, I will help them do that. If the client is not willing, that's it. As I mentioned to you, it helps me know from the background of the client if they have a religious background, and how they are, and what is the value of religion.

Ali stated that he welcomes the topic of religion in sessions, as long as either the client mentions it first, or it is discussed for a therapeutic reason.

> If it is part of their belief system, yes, I would utilize it. If it's not, again, how much is that helping the therapy if they value religion and that will help them? I don't really care what their belief is as long as it is helping. We can process that.

Mariam distinguished between utilizing her religion and the client's religion:

> I don't think I'm going to alienate anything. I don't think I'm going to alienate even religion if the client brings it up in a session. Yes, I'm not going to say that you need to be this or that, because in religion it's this or that. But still, I am going to think about religion . . . knowing that this is the limit of religion, or respecting that this is the culture, and being aware of the religion and the culture. When it comes to utilizing, I'm always going to utilize whatever the client brings . . . but I'm not going to utilize my religion, just because in religion there are many yeses and nos—this is right, and this is wrong. So, I can't utilize it and say ok, religiously. I am assuming that once I utilize my religion in a session, that means that I'm going to tell the client this is right and this is wrong, which is not my role. And so, I'm not going to do this. So, I can be aware of it, I can respect it, ask the client about their relationship to it, but I don't think I am going to utilize my religion or my knowledge about it in my sessions.

Providing an example of an experience she had giving a workshop about family therapy in the Kingdom, Sophia elaborated on the fact that some learners criticized her for not utilizing and integrating the subject of religion.

> I did a workshop, and it was good. But a lot of people asked and questioned why I didn't put the religious perspective. Most people here think that religion is the core belief for you to be a good person. Because this is not our role as marriage and family therapists. This is one of the observations that I notice . . . here in Saudi: They integrate religion a lot.

Being culturally sensitive. Several participants mentioned that they are sensitive to clients' culture. D'Aniello, Nguyen, and Piercy (2016) explain that the approach a therapist should take when addressing this "includes traits like curiosity, respect, humility, and interest in the client's culture" (p. 236). The following exemplars illustrate the issue of cultural exploration and sensitivity.

Noah explained that he pays attention to diversity with his clients and asks them about their culture in an effort to better understand them.

> Let's say some clients are from the south and some from the north. I will pay attention to their beliefs, or their habits, or their culture, and ask them questions about the culture: "How is your culture about that?" And they will let me know. Then I will utilize it in the sessions. I always ask a question in the sessions: "Is this in your culture?"

Noah continued elaborating about cultural sensitivity by explaining that he focuses on being sensitive, even in the words that he uses with clients.

> . . . how to phrase a question, and how to re phrase it. For example, you frame it, but the client is not happy with it, so you rephrase it again until they know what you say about it without prejudging them, without hindering them, without saying to them, "This is my right."

Asia talked about being present and sensitive to the subject of culture, but in relation to building a therapeutic relationship with her clients.

> The culture can be present, because in Saudi, there [are] different cultural backgrounds. So, I don't cover my face, and that is a big sign. My accent, that's a big sign. So, those things that really, like, signal we might be from a different cultural background. I was raised in different cultures, so this knowledge of being similar or different is always there. So, I always need to check it with other people, if I am really

> understanding them or not. And this is part of building our relationship, and this is what common factors inform me about the therapeutic relationship, that I really need to be there, present with them, and to check if this relationship is going where it needs to be.

Asia went on to explain that being culturally competent is part of her knowledge and identity as a family therapist.

> The knowledge that I had as a family therapist, that I need to be also culturally competent, I need to ask the question, just to throw the question first, to just give them the permission that it's ok to talk about the cultural difference; it's ok to approach me. That if they think that I'm not going to understand them because I come from a different cultural background, it's ok for them to talk about their cultural difference from a different cultural background.

Regarding his position on cultural sensitivity and respect, Ali stated,

> I integrate the culture, all parts of the culture, meaning religion, an area that you love, education that you have, economy, status. I usually consider all that when I am doing therapy. So yeah, I pay close attention to the culture; not even the culture, but I try to pay attention to the culture [in] all respects.

Similarly, Mariam described how she attends to clients' culture to make sure that she is respectful of their cultural values.

> I will put in mind the client's culture, knowledge, learning, where is this person from, which tribe he or she belongs to, where in Saudi, is this person religious or not. I will put in mind all of these different things. I can't just ignore [them]. So, what drives me is my knowledge, and my questions are driven from my knowledge as a therapist; but, at the same time, I need to put in mind and respect the client with all their diversity.

Being flexible as a therapist. Therapist flexibility in this context means that a therapist has the readiness to move fluidly and not remain stuck in one belief system. They do this by accepting clients' beliefs while also allowing their own belief systems to be fluid and flexible. Kendall and Chu (2000) explains, "Unlike definitions of competence, flexibility does not automatically assume superior outcomes. Conceptually, flexibility addresses how the therapist responds to the clinical situation while adhering to the manual" (pp. 210-211). This position of flexibility requires therapists to accept clients and explore their beliefs without holding too tightly to certain biases or techniques. Therapists who have flexibility are those who use their knowledge as therapists to be malleable, instead of taking a strict or biased position.

Hind explained how she allows clients to help her make therapeutic decisions. This reveals that she does not have a rigid manual to work from, but rather depends greatly on her clients and where they stand. Noah described his commitment to striking a balance between his dual epistemologies, as well as exercising flexibility. He talked about his continuous process of questioning himself about where he stands:

> I always had the questions, that always, do I have to stick with a stated theory, or should I step by step going through the Arab Muslim cultures and use whatever is there and modify it? Actually, I am capable of modifying most of the theories a little bit, but I am afraid of losing the track. So, this is one of the challenges.

Mariam shared her thoughts about being flexible in balancing both epistemologies:

> I guess balancing comes with not taking sides, not taking the family therapy and saying, I am a family therapist, and I am professional person, but then ditching everything else: this is not professional. Or taking culture and religion and saying, "This is it."

She went on to emphasize that therapists can't follow a rigid manual that dictates how they act. She elaborated on the many factors that a Saudi therapist must keep in mind when practicing in the Kingdom and how these different factors make every session different.

> I can't say that this is black or white, or I'm going to be using this or that, because in every session, in every question, and in every idea, there are many aspects: there is me, the client, the culture, the religion, family therapy, the ideas, the metaphors, the acceptability. It's a lot of things.

Some participants shared that they deal with their differing epistemologies by separating them, putting one in the background and one in the foreground, depending on the client. Sophia offered an example of how she attempts to fluidly weave her epistemologies while remaining sensitive to her clients' beliefs. She stated that in her work, she aims to keep her personal and professional values separate.

> I also have a lot of clients who are openly gay or bisexual, and they are in Saudi; but you see the culture now, and the TV and everything. Personally, and I used to practice this in the state, personally, if you should tell me in the corner, and you say, "Are you ok with gays and lesbians?" personally, no, I am not ok. But my role as a therapist, I am definitely. It is not my business, like seriously. If a client came to me to fix . . . that he is gay, I can't do that: it is not my role, not my specialty. I did not learn that, and it is not my values as a therapist; because when I worked in the States, my university, one of the core essences is encouraging the LGBT community. I respect that; I want everybody to feel safe. But for me, my role as a therapist is to go with the flow with the client, if they are feeling ok with that and how to work with that. "I want to change because of my mother, because she caught me sleeping with a girl." "No, you, *you*, what do *you* want to do? You feel that you are ok with being a lesbian

> or not?" So, my personal [ideas] will not be integrated whatsoever when it comes to the community of the LGBT.

Mariam explained that even though she works from one epistemology as a therapist, it does not negate or eliminate her other epistemology.

> I think that my theory of change has nothing to do with religion and culture, as I said before. But, at the same time, there is [the] me who's asking the questions, which [is a reflection of] how I was raised, but not [as] an immediate influence.

Hind offered a personal example of how she remains aware of her dual epistemologies while intentionally working or practicing therapy from only one of them.

> Ok, as you know, how we were trained, you shouldn't [impose] your religious ideas and views on your client, ethically [speaking]. So, it's the same thing. For example, where I live, there are lots of Shia group. I will not talk about anything related to [their religious views]. It is important to understand what they believe, so I don't offend them with saying anything wrong. I respect their background. It was the same thing when I used to work in Canada. And let's say they are Sunni; there are people who are liberal and people who are conservative. So, for example, for me, I didn't think from my religious point of view that it is right to have sexual relations before marriage. This is what I think; but I have many clients who come, and they had these episodes.

Ali described his process of sending his personal beliefs to the background and using only his knowledge as a therapist in the therapeutic context.

> Therapy is not about me, so I should not be judgmental and impose my values, my culture, my beliefs in therapy. I still hold my beliefs, and I am comfortable in my skin with my beliefs, culture, identity—all that stuff. But it is not about me. So, I can help them with their issue regardless of what is my belief.

As shown from the previous examples, therapists' flexibility can be present in many different ways. One participant, Noah, spoke about the flexibility he adopts in order to be accepting of a wide range of clinical issues.

> I believe strongly in accepting the clients as they are. Let's say we have a patient who has AIDS, and I am against [the] behavior [by which he contracted HIV]—from extramarital relations or whatever. I accept him as is. If I have a client who is a Hindu, I will accept his religious background as his guideline for his life. I am not implementing my own value system. Actually, I tell the patient when they ask me, "Is that right?" I say, "I don't think you need my "right," because my right is different than yours. So, let's talk about what's right for you and not for me as a guidance for your life." So, yeah, accepting the clients as they are is one of the big things in my practice.

Later in the interview, Noah shared a different way in which he practices flexibility, explaining that he chooses which theory to work from depending on the particular clients and their presenting problems. He also emphasized his practice of valuing clients' belief systems, no matter what they are.

> So, I am following a specific theory; but, in the beginning, I see what clients are talking about and thinking, and then I think of which theory I will implement with them according to the presenting problem. Usually you will hear it during the presenting problem, and then you will think, okay, I will go with this Salvador Minuchin structural family therapy. And then I move on with them towards that theory, focusing more. And this family will be totally in these sessions grounded in theory. Nothing specific. But, of course, being here in Saudi, most of [those we] come across are Arabs and Muslims. Thus, the focus will be more toward the value system of being a Muslim. And we meet other clients who are not Muslims and from other

> different countries; so, the value system of clients will come on the top of the discussions.

Dedication to the client. Those participants who preferred to work with clients from their family therapy worldview seemed to prioritize their clients. For example, Noah explained that he insists on the importance of his clients in the therapeutic context. He stated, "The top thing is the client. . . . The client always come first. Their ideas, and their thoughts, and their manifestation, their orientation, their anything, it's their right." Asia spoke about her way of prioritizing her clients, their ideas, and their decisions by always giving them the freedom and support to be themselves.

> This is about clients; it's not about me. So, if this aspect that they want to try out, or they are comfortable doing that, then that's for them to decide. I'm not at a place where I say this is right or wrong, or religiously acceptable or not acceptable; because I'm not a clerk or anything. I'm there just for them to feel that they are being supported in the relationship.

Hind explained that she demonstrates dedication to her clients by being non-judgmental.

> Usually we just talk, and I watch my body language and facial expression, being not judgmental, hearing what they are saying, and being compassionate, and being empathic with them. And the non-judgmental part, I think, like, now it's been nine years since I started to practice; I think being non-judgmental is one of the best things. I can't generalize that, but you know in our community how people can be judgmental in religious matters. "She is not wearing her hijab, she is a bad person, she is doing this, she is bad." Being not judgmental is one of the best things that helped me to have a strong relationship with my clients. And also, I am sure you know the common factors theory. I think the relationship, I believe that the relationship with clients is the most, one has the most influential for therapy to continue and to be successful.

> Unfortunately, people here are really focusing on assessment and theories and questions, and I don't know, but they are giving it more importance than . . . the factors of the relationship with clients, the clients factor, the client theory of change, and all these things.

Ali spoke about his belief that the therapeutic relationship is a necessity in the therapeutic context.

> I am a big believer in common factors and change—having a therapeutic relationship. It is a cure itself; it is necessary, but not sufficient. I believe that without a therapeutic relationship, you can go nowhere in therapy. But it is not enough. When you secure a good relationship, that means therapy just started. And I believe that the therapeutic relationship sometimes is trust. I think you can use the therapeutic relationship to intervene with your patients.

Asia emphasized the importance of the therapeutic relationship and explained her own process of building a relationship with her clients.

> So, what informs me is the common factors, in the first place. So, I want to establish a relationship with the families that I meet, with the couples that I meet. So, building this relationship takes lots of . . . listening, reflecting, and also . . . paying attention to the cultural cues—who is in the room. Let's say if someone showed up with an elder, I really need to pay certain attention to the elder in the room first. So, those types of things that inform me how I am going to invite this family to participate, who I will approach first.

Asia continued:

> So, if I can be there, present, and, like, with them in the room, I think that this really take care of lots of aspects. . . . I just feel you need to be there, present with them,

> connecting with them, that I understood them, and just allowing them to talk about the problem.

Salim elaborated even further on the importance of establishing a good therapeutic relationship with clients.

> For me, it is about our passion for the work to start with. What is the driver that is making me be a therapist? And, as I am sure that you know, what makes therapy really work is how well you connect with your client; clients read us.

Salim took his clients' perspective.

> I am referring cases now. Like today, all my clients, I am referring them to others; and they both mentioned that it is important that whoever's next, we click with them, because that is 50%, is right there. So, in order to get there, you have to see how much you are into it. When I am in therapy, I give 100% to therapy; I'm focused with my clients, and they see me. And then with that, ok, how can I help this client in the best way?

SAFTs' Emotional Responses to Holding Dual Epistemologies

The SAFTs who participated in this study used different ways to express their emotional response to holding two differing epistemologies. For some participants, it was an unpleasant feeling of confusion and struggle; for others, it was a delightful feeling of approval and appreciation.

Confusion and Struggle. Some participants explained that they struggle as therapists when their family therapy knowledge and aspects of their culture are incompatible. Asia talked about her experience of being challenged and not knowing what to decide: "It's not as easy sometimes. I had to talk to my colleagues about it, because it was really hard. What I am supposed to do?" Sophia also talked about her struggle as a therapist. She explained that her

feelings of anger and frustration are a result of not finding compatibility between the rules and guidelines of therapy she learned in the United States and the rules in Saudi Arabia.

> There were challenges, especially in 2015-2016 for me, because I have been practicing in the U.S., and I felt like I am losing the power of something, especially in domestic violence for women. . . . At that time, when I saw clients in the U.S., and I did see couples who had physical violence during the sessions, and I used to report. So, I used to report, and I had the power, and they continued doing therapy, and everything went smoothly, and I had a team to work with. But here, I feel very angry, actually; the word angry, the emotions, are anger and frustration that I cannot get to anything. I start to collaborate with everyone, but they are not really collaborating.

Sophia also shared her thoughts about how a family therapy orientation contrasts with the mental health community in Saudi Arabia.

> The other observation that I noticed last year in the psychology conference . . . Every time I talk, they look at me like I am coming from a different cultural background, and even the Arabic books of therapy are very old, dated. For me, that's challenging, because when I talk with a therapist who doesn't know English, that for me is a challenge. Not to click with a lot of therapists is very sad for me. I have to click with someone who knows the rules and the ethics.

Ali spoke about his own struggle, comparing his current challenges with those he encountered upon graduating and returning to Saudi Arabia.

> The first couple of months, and honestly until now, not just the first couple of months, I am still struggling with critical issues, fundamental issues. For example, when it comes to domestic violence and abuse, child abuse, all that type of violence, it is kind of a headache here in Saudi Arabia, for one reason: The policies are not clear. There is not enough guidance to help therapists through that process.

Approval and Appreciation. Though some participants shared feelings of confusion and struggle, others spoke about their sense of approval and appreciation. Asia, for example, explained that she feels glad and free, as she has the ability to perceive the world from two different perspectives. She stated, "I think I'm glad that I had my education outside, so I can look at certain aspects as an outsider sometimes, to involve in the culture and religious aspects. So, I feel that I can step in and out." Another participant, Salim, revealed that he feels privileged by having the knowledge of family therapy as well as an understanding of Saudi culture: "I think, Rana, we are privileged, both you and me, because we have the cultural aspect as well." He went on to say that he feels lucky to be a Saudi family therapist, as it is allowing him to learn and mature. He explained it this way:

> Yes, of course, I changed. I tell some of my clients, "You don't believe how lucky we are, because we learn from you so much." They enrich our lives, and we learn; and I love new clients when they come because they have such a splendid journey that they come with.

Mariam expressed that she feels clear about her way of doing therapy and is excited to juggle both epistemologies, according to what is best for the client.

> It will come naturally for me, because the base is clear for me; the base is family therapy. So, I don't think it is either this or that. Yes, once I was trapped in the middle between the two dictums, after graduating from the family therapy in the master's; but now, just being aware of it and knowing that this happened helped me know myself as a therapist and helped me know my role as a therapist. I'm now excited to explore, to be myself and experiment with ways that are fair for both worldviews and safe to the client.

Interpersonal and Societal Complexities

After processing their internal complexities, Saudi family therapists must then address the complexity of holding Western values in a Muslim context. They do not need to grapple with two epistemologies; rather, they must learn to hold one set of values while the culture holds another. Saudi family therapists practicing in the Kingdom deal with issues related to safety and community reputation, especially when addressing sensitive topics with clients. Interpersonal and societal complexities are commonplace for therapists practicing family therapy in a religious state; but it is important to note that these complexities are due to the contrast with the culture, not something internal to the therapist.

SAFTS Practicing Family Therapy in a Saudi Context

It seems that some Saudi family therapists practicing in the Kingdom work towards implementing their knowledge of family therapy in a Saudi context, which means thinking about the broader systems. Some participants talked about the societal complexities of employing the practice of family therapy in the Kingdom, and others mentioned ways that they deal with these complexities.

Attending to political/legal safety. Some participants shared that they attend to their safety as therapists by exercising caution when adopting a family therapy lens and addressing sensitive topics. They explained that their family therapy lens allows them to think outside the box, accepting a wide range of clients without any limitation. One participant mentioned the stark contrast between the guidelines and policies related to cultural acceptance in Saudi Arabia and the common standards in the West. Salim, for example, explained that he must be vigilant when taking a different cultural stance as a therapist.

> It is challenging, and it is also at times scary, because you are going to face clients who have addiction issues, and you have same-sex issues as well. And those two, you know, drugs are not legal in the country. . . . Here you have to be very careful as a

> therapist. The fear here would be if clients go out and say that our therapist said it is ok for me to be gay or have drugs. You know what the consequences of that [would be]!

Mariam emphasized that it is important to be safe and, therefore, to know the rules and limits of flexibility.

> I don't think there is one answer to how I am going to work with the two different epistemologies. But one answer is that I need to know the rules, the ethics in Saudi Arabia. If not . . . just, like, for me to be safe, you know, if there are no rules, then I'm going to depend on being sensitive and respectful to religion and culture.

She works to keep in mind clients' safety, as well as her own.

> Being a family therapist is to listen, to understand, to be with the client, to let the client be themselves, and then also to have the responsibility to accept the culture, the religion, and to be safe, and to feel safe, and to let the client be safe. Like yes, family therapy is about accepting and questioning; it is about change and all of that. But if it's not safe to question, then as a therapist I'm not going to question; because there are priorities, but at the same time, professionality is something very important. . . . Figuring how to be safe, knowing how to keep the client safe, being yourself, and at the same time being professional, and at the same time let the client, which is the most important thing, feel safe to be themselves: [All are] very important.

Accommodating to community. Two participants identified that they attend to their society in different ways, remaining informed by family therapy while at the same time being respectful of the Saudi society. For example, Noah mentioned that he feels free to ask clients anything but focuses on the way he asks the question.

> But yeah, I think yes, questioning is always not difficult for us. I was taught to question about things that are tough to be asked; but you need to state it in a way that

> makes it less threating for the person who hears it. That's the balance that you need really to work on.

Sophia mentioned that her way of attending to the culture and to the society is by avoiding taboo subjects. She stated, "Anything that goes with something taboo, I'm not going to mention it. Because I think people are still not ready to hear about that." Ali explained that he recognizes the need to attend to community reputation, especially since Saudi society is collectivist: "Your reputation . . . and, as you know, the culture is collectivistic, so verbal things will be very easily moving from one person to the other."

Enhancing community awareness. Two participants stated that they are educating the community to lessen the gap between family therapy ideas and Saudi culture. For example, Noah stated that he has presented workshops to students in schools and universities about gender mixing, to show them that it is religiously okay.

> This challenge we will continue having. We have challenged that male client in a family or couple; they are reluctant to come. This is the issue that we are working on by delivering workshops in schools and universities. I call it the Islamic feminist movement . . . because the prophet was with women, but people translated [this] differently. So, we take [off] from that . . . [point], and we work with the kids.

Another participant, Asia, also trains new therapists, particularly on the topic of self-of-the-therapist: I always use it also with the people who I train or the intern who is present in the room with me in the clinic. I always talk about self-of-the-therapist.

Seeking peer consultation. Four of the participants stated that they seek peer consultation as another way of managing the complexity of being informed by a set of epistemologies that can interfere with Saudi society. As Ali put it,

> Personally, I try to keep, let's say, peer consultation, and to process with peers, because I miss supervision. I am a supervisor myself. I miss being supervised, so I have to find ways to do that.

Asia also shared that she seeks peer consultation when in doubt, struggling, or in need of support.

> I really had to go back and talk to colleagues. I had to talk to my colleagues about it, because it was really hard. What I am supposed to do so sometimes when I feel, like, challenged at a different aspect? I go back to my colleagues, and I talk to one or two about what can I do in this particular case. The literature tells you this is what you should do, and this is how you should approach this particular problem. But, then the cultural aspect that says this is forbidden. . . . Seeking other colleagues who are similar to my background, and who also had their education overseas and are practicing for a while in the Kingdom. So, I do seek their support.

Hind mentioned that while she does not have the luxury of calling or meeting with peers to consult about cases, she finds it helpful to be a member of a group with other therapists.

> I have the WhatsApp group, some of my colleagues created it, and sometimes it is good, because they discuss cases and you feel that you are not alone. . . . They talked one time intensively about the homosexuality and these things. And the sexual orientation, and even the view in here, and even different views in the West that is against and with that, and the history of that; because . . . some of them are students in North America or the U.K.. These students are adding value to the group.

Noah also stated that he and his team of therapists not only talk to each other for support, but also engage in workshops to educate themselves about topics within the therapeutic context.

> In my practice, I have 14 great therapists, and you probably met some of them already. And we usually, if something came up and it is making us not at ease, then we will pick up the phone and say we want to talk. We do also sessions, always workshops about topics that relate to the therapist. Usually we just pick up the phone and say, "Listen, I am having this. Let's talk about it." then we just talk about it. And things will come up in the discussion, and it is an emotional release if something went wrong for me as a therapist or [for] the clients.

Seeking supervision. Some of the participants spoke about their efforts at managing the complexity of the disharmonized and differing values of being a therapist within Saudi society. Sophia described how supervision has helped her with this.

> We don't have official supervision. I have a lot of therapy, like, friends, they don't have supervision. It is something I worked for a while without supervision, but that was not ok for me, as I need to talk to somebody who is more experienced and comes from the same MFT background. So, I talk to him. I got to know that he has a Ph.D. in MFT, and I asked him if he can be my supervisor. He was so surprised. I don't pay him anything; I only talk to him when I feel I need to talk, and that was very helpful—both ways, even for him. Because we both graduated from the States and coming back to Saudi.

Seeking self-help. One participant, Hind, shared that self-care is one of the things that helps her manage and deal with the burden of becoming a Saudi therapist.

> I try to do my exercise, to have relaxed, and try best. It's not always possible to have the hat of the therapist. At home I take it off, because it is really hard when you carry the story of your clients all the time. It is not easy, but as more as you practice, it will be a skill.

She went on to illustrate another self-help practice she uses to manage the complexity of having a dual epistemology.

> Through journaling, I journal and then I shred it. This is what I used to do in my training. And I also share it with my supervisor, as I have already the consent with my clients.

Attending to cultural change. Two therapists mentioned that they attune to cultural changes by being aware of them and their influence on clients' choices. Noah explained it this way:

> For the last three, four years, things changed rapidly; and people are, you know, sometimes they don't know what is good for them, or if that's working for them or not. So, we are now in a humongous, if I may say, change, cultural and everything . . . Clients are rapidly changing, and people are struggling with it sometimes. Family issues are now a big challenge for any therapist, any type of therapy.

Ali spoke about change in relation to the feminist approach, stating that he not only attends to change, but also remains careful when approaching the subject in therapy.

> It's hard to, let's say, to conceptualize and understand what's happening right now. It's hard to absorb and discuss. Not just me personally, but also for me as a therapist, it's confusing. Especially now as a male, I really need to be very careful, as the feminist approach is spreading around, and sometimes I feel like I am walking on eggshells. I love social justice, and feminism is part of me as a therapist and as a person.

Summary

The results of this study support many of the findings in the existing literature about the exporting of family therapy internationally, and about the challenges family therapists deal with when bringing their knowledge back home. However, the inclusion of the personal

and interpersonal processes of Saudi Arabian family therapists expands upon what has already been said in the literature. The excerpts presented in this chapter illustrate a variety of subjects that are particularly relevant to the Saudi participants in this study, who shared their unique experiences and stories, providing rich exemplars that reveal the cultural aspects of their process.

In Chapter V, I make connections between the findings presented in this chapter and the existing research literature on the internationalization of family therapy. I also offer suggestions for future studies to expand upon what has been found in this exploration of Saudi family therapists' experiences. Finally, I discuss the implications of the study and its relevance for the field of family therapy.

CHAPTER V: DISCUSSION AND IMPLICATIONS

Making Meaning of the Study and Its Results

This study was designed to understand and explore SAFTs' self-reflectivity about their dual epistemologies, and the ways they manage the complexity of holding two worldviews. Since epistemology is an implicit matter, I had concerns before interviewing the participants that they might not make sense of my questions about their double belief systems. I worried that they might not feel comfortable sharing with me their thoughts about such a personal and sensitive topic. However, all participants were open in talking about their experiences, stories, struggles, and unique processes of managing the personal and interpersonal complexities they go through as Saudi family therapists.

Through the participants' cooperation with me and their willing exploration of each question, I was able to gain a sense of their experience as Saudi therapists. Every participant had a unique story, and I strove to preserve that uniqueness and capture each person's distinct voice in my analysis. By keeping the participants' voices and identities alive, and by adding a new interpretation of the phenomenon, I hope to have conducted a study that can not only enhance our understanding of the practice of family therapy in the Kingdom, but also add to the literature on the richness of the international family therapy community.

The results of this study affirm what has been found by other researchers who have studied the exporting of family therapy to a global matrix. However, there are many unique findings in this study about Saudi family therapists. This is the first to characterize the self of the Saudi family therapist. As explained in Chapter II, researchers interested in taking family therapy abroad have asserted the importance of adaptation (Abi-Hashem, 2014; Miller & Fang, 2012) as they focused on international therapists' ways of adapting theories and techniques. Irfan, Awan, Gul, Aslam, and Naeem (2017), for example, described adaptation as therapists' adjustment to the technicalities of therapeutic work in ways designed to better

suit the client. In this dissertation, the focus was on both personal and interpersonal adaptation processes, addressing the clashes therapists experience when thinking, sorting, and working from a dual epistemology.

Usually before going through the adaptation process, international family therapists become aware and recognize themselves as therapists in this context. Self-awareness has been emphasized in the literature as one of the basic elements of a family therapist. For example, Minuchin (2017) stated:

> I believed that the poetry of therapy could be derived from this alphabet. But as I got more experience training therapists to use these techniques, it became clear that the techniques by themselves weren't all that useful. It was therapists themselves who were the instruments of change, and to be effective, they had to recognize the way they were part of the system and the process in the therapy room, not just a neutral observer. (p. 37)

Similar to what has been written about the importance of self-awareness for family therapists, all of the participants in this study demonstrated clarity about both themselves as therapists, and as Muslims and Saudis. Some participants talked explicitly about these issues, while others offered a more implicit understanding of managing both epistemologies.

In research studies on the self of the therapist, researchers have shown interest in the personal and professional resources therapists utilize in therapy (Aponte & Winter, 1987; Satir, 2000; Timm & Blow, 1999). In this study, participants demonstrated varied ways of utilizing religion in therapy, including both their own and their clients' knowledge and beliefs. The topic of therapist awareness in the literature has not been limited to the self of the therapist; some researchers have explored therapists' awareness of culture. Cultural awareness and sensitivity have grown in the United States among both clinicians and clients. As the country has become more diverse, more therapeutic encounters are now cross-cultural

in nature (Niño, Kissil, & Davey, 2016), and researchers in different countries throughout the world have studied and written about the importance of being culturally aware and sensitive (Baker, 1999; Cuskellya, 2017; Gallardo-Cooper & Zapata, 2014; Rianya, Meredith & Cuskellya, 2017). The topic of culture was present in this study as well, as participants spoke about the importance of being culturally aware and sensitive in the increasingly diverse KSA. Saudis vary in terms of accent, openness, and religiosity, depending on their region, education, and cultural assumptions and beliefs.

Because societies and cultures—along with governments, healthcare systems, religion, and social change forces—help shape family therapy, international family therapists who export the knowledge of family therapy bring awareness and sensitivity to the culture, creating a unique model of this domain. Roberts et al. (2014) and DuPree et al. (2012) have asserted that family therapy is unique in every country or place where it is implemented, depending on the degree of sensitivity to and interaction with cultural aspects of the societies. In this study, participants described unique ways of adapting to the Saudi culture; they allowed themselves to make alterations in order to fit within the Saudi system, while also trying to preserve the integrity of family therapy foundations.

While handling the differences and managing the complexities of their differing worldviews, some participants described experiencing emotional responses. This is identified in the literature, as therapists have described a variety of challenges that arise due to clashes between their culture and the professional knowledge they are accessing and using (Mittal & Hardy, 2005; Piercy et al., 2014). One of the challenges that has been addressed in the literature is international therapists' struggle to filter their understanding of family therapy through the lens of their own culture (Watts, 2005). The process of contextualizing the knowledge of family therapy and understanding this knowledge through the lens of religion or cultural beliefs was identified in this study, but not as a challenge therapists face. Instead,

some participants shared that they sometimes chose their religion to be a contextual frame for their understanding as part of a process of adaptation.

Previous researchers have recorded patterns of the evolution of family therapy in different countries, revealing the steps that have been taken to develop and establish the profession of family therapy (Kaslow, 2000). In the following section, I will discuss some implications of this study's findings, as well as suggestions for future research, in hopes that this dissertation can serve as a stepping stone to further developments in the study and practice of family therapy in the KSA and around the world.

Implications of the Study

This study has wide-ranging implications for Saudi family therapists, as well as for the evolution of the field of family therapy in the KSA. Because the field is in its infancy in the Kingdom, and because this is the first study to address the self of the Saudi family therapist, there are many implications to address—for the profession as a whole, for future practice, and for future research.

Implications for the Field

Several participants in the study mentioned the need for a sense of community and support as family therapists, as well as a need to communicate with family therapy professionals who share similar training and a relatable way of thinking. When discussing their practice as family therapists, the participants also mentioned the need for overarching policies and ethical standards for the practice of family therapy in the Kingdom. This shows the need for the establishment of a family therapy organization in the KSA that can bring all SAFTs together to create a sense of community, but also to create and maintain guiding principles and regulations.

After exporting the knowledge of family therapy to Japan, several Japanese family therapists gathered in a monthly conference until they formed the Japanese Association of

Family Therapy (JAFT). As a result, both JAFT and the field of family therapy in Japan started to grow and mature (Roberts et al., 2014). Therapists from other cultures and countries have shared a similar need to organize. Talking about family therapy in Greece, Softas-Nall (2008) stated:

> Like our clients, we also needed guidelines. In the early 1960s, a small team of social scientists, under the inspiring guidance of our teachers, were looking for answers to burning questions about who we were and where we were going as members of our families, as professionals, citizens of our country and members of the world community. (p. 88)

Informed and inspired by such efforts, as well as by the perspectives of my participants, I will next introduce explore ideas for helping the field of family therapy grow and flourish in the Kingdom and throughout the Middle East.

Creating family therapy organizations. One of the first tasks for coming together as a field is to create a family therapy organization. Because there are several already established mental health organizations in the Kingdom—including the Saudi Psychiatric Association, Saudi Psychologists Association, and Saudi Health Social Work Association—SAFTs could benefit from the previous experiences of mental health professionals who created these associations to help generate a Saudi family therapy organization. Reaching out to other already established mental health associations can help as a guidance of the logistics to creating a national organization of MFT in Saudi. This organization will not only help family therapists communicate with each other, but also create a standard of care for the practice of family therapy in Saudi. For example, referring to the national association of family therapy in Australia, MacDonald and Peters (2010) explained:

> The formation of a national association [is] seen to be an important and positive development for the profession of family therapy within Australia, and a way of

> creating a greater sense of national cohesion in line with other fields such as psychology and social work. (p. 219)

Creating a Saudi family therapy association can also help in generating communication between family therapy and other mental health professions in the Kingdom as well as supporting the representation of SAFTs in the global arena.

Forging relationships with other MFT personnel, associations, and organizations. Depending on their experiences and leading positions in Western countries, SAFTs can invite consultants or Western pioneers to visit the KSA to broaden the field of family therapy. This is not a new protocol; it is common to bring in family therapy consultants to train and educate newly emerging professionals and organizations. For example, international consultants have influenced the growth of family therapy in Ireland and other countries, presenting workshops, attending conferences, and consulting on trainings (Carr, 2013; Kaslow, 2000).

Forging a relationship with other associations is another way to support the growth of this domain in the Kingdom. Communicating with leading organizations like AAMFT to ask for support and guidance can be another possibility for SAFTs to explore; and building a relationship with an international association like IFTA can enrich and diversify the Saudi experience and knowledge of MFT (Ariel et al, 2014).

This study on family therapy in the Kingdom can also raise important questions about melding Western knowledge with religion and culture by forging relationships with family therapy organizations in religious states, especially countries or contents that already exported family therapy a long time ago, such as the Asian Association of Family Therapy. It would be also beneficial to seek future relationships with Arabic organizations for further collaboration and support. The joint work between Korea and Japan represents a good example for other related countries to collaborate in papers, workshops, and conferences (Lee

et al., 2013). But because Arabic family therapy organizations are not well known in the Arab world, attending congresses that invites national and international associations of family therapy can be beneficial.

Forming family therapy conferences. In their efforts to come together and work as a community, SAFTs will benefit from organizing a series of at least yearly regional conferences that include SAFTs from different regions and cities in the Kingdom. One example of this is the Saudi Psychiatric Association's international conference, which was held recently in 2018 to address the future of mental health services and the field's vision for the year 2030. Gerhardt (2003) explains that conferences served as a turning point in the growth of family therapy in South Africa. Similarly, SAFTs can not only create family therapy conferences in the KSA, but also initiate conferences throughout the Middle East, perhaps starting with the Kingdom's ally countries. They can begin to build toward the development of a pan-Asian conference and other international conferences in the future. Through these conferences, the gap between Western and non-Western knowledge—especially Arab culture—can be discussed, along with topics such as accepting the Other, diversity, adaptation, and global change. These conferences can be hosted in an Arabic country like The United Arab Emirates, where many diverse international conferences have convened in an open and safe manner.

Creating a national journal. When family therapy is exported to a new country, it is often the case that a national journal is established, typically by the official organization or association of family therapy in that country. An academic journal can help evolve and mature knowledge of family therapy within the particular cultural context of a country. The Korean Journal of Family Therapy, which was created by the Korean Association of Family Therapy, is an example of an international journal that not only benefited Korea, but also helped scholars and practitioners around the world exchange ideas (Lee et al., 2013). A

family therapy journal could not only benefit SAFTs, but also support the work of family therapy professors in Saudi universities. This is especially the case, considering that there is limited access to family therapy materials—including textbooks, Arabic journals, and articles about family therapy—in the KSA.

Another way SAFTs can benefit the practice and teaching of family therapy is by writing and translating family therapy textbooks and articles. At first, this can be done within the context of other Saudi arts, humanities, or social studies journals, like the Saudi Social Studies Society, Saudi Journal of Humanities and Social Sciences, Journal of Advances in Education and Philosophy, and Journal of Faculty of Arts and Humanities at King Abdul Aziz University. By doing this, SAFTs can reach out and learn from these already established journals to support the creation of their own journal, which will benefit them nationally and allow them to communicate their knowledge internationally.

Publicizing social and governmental law. According to the Kingdom of Saudi Arabia Bureau of Experts at the Council of Ministers (2014), the Saudi Commission for Health Specialties created the Mental Health Care law and the Saudi Mental Health Supervisory Boards, which were both approved by King Abdulla in 2014. Carlisle (2018) explains, “The Saudi Arabian government has cooperated with the World Health Organization (WHO) in collating data about its mental health services and in developing policy” (p. 18). Still, most of the participants in this study, who were from different regions in the Kingdom, did not know about these regulations and policies. Publicizing these regulations for all mental health sectors can lessen the gap between the laws and the practice of therapy, helping to guide Saudi practitioners in their practice. This is a point of particular emphasis, since several participants in the study mentioned that the lack of policies and ethics is one of the biggest challenges they experience when practicing family therapy in the KSA.

Unlike psychiatrists, psychologists, social workers, and counselors, family therapists are not mentioned or included in articles, boards, or laws and regulations related to the mental health sector in the KSA (Carlisle, 2018). For that reason, including family therapy as a profession within the mental health sector in the Saudi Commission for Health Specialties can be a first step in helping the field of family therapy to grow in the Kingdom. Having a campaign to inform the general public and other mental health practitioners about the field of family therapy can help expose who family therapists are and what services they can provide.

One of the challenges mentioned several times during the interviews with participants was the issue of child abuse. Publicizing family therapy in general, and Saudi programs like the national family safety program in particular, can be fruitful in terms of collaborations and knowledge exchange. It can also provide family therapists in the Kingdom with resources and guidelines about the procedures that need to be undertaken in cases of child abuse. The next step can be collaboration with AAMFT and/or IFTA to create a specific family therapy policy for the KSA that can translate the family therapy epistemology and knowledge base in ways that also attend to the country's unique societal and cultural context.

Applying to insurance plans. According to the Council of Cooperative Health Insurance (2017), individuals with insurance policies are covered for acute and non-acute mental health disorders during the duration of their coverage. Yet it is not clear whether family therapy is included under mental health care, especially since the field of family therapy is not mentioned by the Council of Cooperative Health Insurance as a profession. Including family therapy in insurance coverage will surely be a step that advances the growth of the field in the KSA, as well as benefits clients by broadening the scope of mental health care. It could be beneficial to discuss the capacity and scale of coverage for family therapy clients, figuring out ways to cover relationship issues.

Implications for Training and Practice

The practice of family therapy was only initiated in Saudi Arabia in the last 15 years. In the following section, I address some implications for training and practice.

Teaching family therapy. It is important to expand the conversation to a generation of SAFTs who are now receiving training in the Kingdom. Family therapy classes are taught in different sectors and in many universities throughout the KSA, but there is no central standard of care or application. Because family therapy is a Western discipline, it can be difficult for international students to absorb and accept this knowledge, especially if it contrasts with their epistemology. For that reason, implementing the topic of self-of-the-therapist in the curriculum through discussions, assignments, groups, and/or trainings can help students recognize, explore, utilize, and handle epistemological issues. Aponte et al. (2009) assert:

> Person-of-the-therapist training is not just a method. It is also a philosophy. It is a way of thinking about the use of self in therapy. It is a belief that because the medium through which we do therapy is our "selves" in relationship with clients, we need training about the use of our own person—our history, culture, values, family life experiences, personal psychology, and thematic personal struggles—in the development of ourselves as therapists. (p. 13)

The gap between the Saudi epistemology and family therapy covers the complexity of knowledge and society as illustrated by the participants in this study. One way to address this complexity is for teachers of family therapy in the Kingdom to be sensitive, respectful, and aware of the society and the culture. Ham (2001) explains that engaging with society and culture adds important richness to the teaching of context, as learners can encounter a transformative opportunity to bring together the content they are learning and the context of the society in which they will be practicing.

Training of family therapists. Several Saudi family therapists have started giving workshops about family therapy techniques and modalities in Saudi Arabia. Additional trainings and workshops, especially about self-of-the-therapist, can also benefit SAFTs, addressing the complexities they experience. It will be necessary, for years to come, for therapists and trainers to offer workshops on the complexities of managing the epistemological differences that were explored in this dissertation. This will provide support for new therapists, helping them grapple effectively with challenges that could otherwise be seen as confusion or disorientation. This training can take place not only in conferences and workshops, but also within university curricula, so that future family therapists can become aware of the epistemological differences they will encounter. Other topics that can be addressed include therapists' awareness, utilizing the self of the therapist, self-care, burnout, cultural awareness, and cultural sensitivity

Validating supervision. Some of the participants revealed that they need supervision to maintain a good practice in the KSA. Credentialing family therapy supervisors can enhance the practice of family therapy in the Kingdom, helping SAFTs manage their self-of-the-therapist issues as Muslims and Saudis, especially considering the personal and interpersonal complexities that were shared in this study. Supervision can be especially valuable, since the teaching of family therapy courses in the KSA will bring a second generation of SAFTs who have graduated or were trained locally. Thinking about the requirements and logistics of establishing supervision for family therapists can be a valuable first step.

Implications for Future Research

Because few research articles have been published on family therapy in the KSA, the possibilities for future studies are unlimited. In this section, I present some of the research ideas that relate to this study. A longitudinal study about SAFTs' dual epistemologies that

studies the same participants at five, 10, and 30 years, to examine the growth and maturity of this domain in the Kingdom, would provide valuable information about family therapy in the KSA. Also, articles that narrate the history of family therapy in the KSA, starting with the first family therapists who graduated from the West, would be an important addition to the literature.

Research about teaching and learning family therapy in the KSA will be applicable and beneficial in this context. Another area of research can be self-of-the-therapist training and its influence on SAFTs and their practice. Other topics can include the development of an SAFT identity, or the therapy models and theories that fit the culture of the Kingdom. Since some participants in this study talked about the necessity of having supervisors, research about the logistics of establishing and making use of credentialed supervisors would add to the international family therapy literature and support the practice of SAFTs. Papers about family therapy ethics and laws that can fit certain cultural and religious contexts while adhering to international rules and guidelines can bridge the gaps between the knowledge, the rules, the culture, and the practice of family therapy. Finally, topics about the acceptance of family therapy as a profession in the KSA—including the logistics, difficulties, and possibilities—will be a valuable contribution to the literature.

Limitations of the Study

My perceptions and understandings are limited by my own belief system. Although personal limitations are expected in the research process, being aware of these limitations can help lessen biases and decrease tunnel vision. Keeney (1983) states, "We encounter a general self-referential paradox underlying all observing systems: the observations may include [the observer's] observing" (p. 32). Another possible limitation concerns my participants and their ability to be forthcoming with me or even with themselves. Because the Saudi culture is both prescriptive and proscriptive, the therapists I interviewed did not always feel comfortable

revealing information about their personal or professional life experiences. I did everything I could to reassure them of my commitment to their confidentiality and anonymity; this allowed them to openly divulge how they think and what they do in their professional lives.

Concluding Self Reflections

Going back to the camel's hump, this study was a gateway to exploring myself as a therapist and as a person. Through the journey of self-reflection, I not only gained a clearer understanding of my role and beliefs as a therapist, but also matured and was nourished through the process of learning and exploring. Through this study, I managed to look back at the camel's hump, despite the warning of the Arabic saying; and instead of ignoring what might be scary, I managed to explore it instead. This is something I learned about in the first semester of my Ph.D. studies, specifically in a course called Thinking Systems, where I was introduced to the work of Gregory Bateson. I learned about not controlling the problem, but instead inviting it. One of the reasons I chose to conduct this dissertation was that I wanted to face this uncomfortable issue that I encountered back then.

In Chapter I, I gave an example of a client I worked with after my master's program and described how I grappled with her gay sexual orientation, as it is prohibited in my culture and religion. Being self-reflective through the process of conducting this study not only helped me point out what challenges me, but also enabled me to learn and change. Issues of sexual orientation are no longer a struggle for me, as I now know I perceive the world through my systemic and family therapy lens. I hope this study serves to not only encourage self-exploration, but also illustrates how self-reflection and self-awareness can help therapists pinpoint their struggles and discover ways to utilize them. In a recent interview about the person-of-the-therapist training he provides, Aponte (2017) stated:

> My struggles are an opportunity for me to stretch myself, to dig deeper into who I am, and in the process to change, and to grow, and to be more of what I am capable of

> being. So, these blocks that are in front of me are not a wall that impedes me; they can be set up as something that I can step up and climb over to become a better person. (pp. 13:43-14:29).

With my decision to explore my challenges as a Saudi family therapist came a commitment to explore myself and help others do the same. After completing this study on the lived experience of SAFTs, I am eager to utilize the results to support the growth of the family therapy field in my country. Although I found in my analysis that SAFTs experience different complexities due to their dual epistemologies, I am enthusiastic that they will receive this study as an invitation to look within, explore, and see their struggles as learning opportunities that they can utilize both personally and professionally. This is an ideal time for Saudi therapists to give themselves permission to be themselves and explore their process; they can now look within and find their own unique ways of practicing family therapy, maintaining the essence of the knowledge while applying it in a new religious and cultural context.

References

Abassi, G., Zadeh, S. S., Janfaza, E., Assemi, A., & Denghan, S. S. (2012). Language, translation, and culture. *International Conference on Language, Medias, and Culture*, *33*, 83-87.

Abernethy, A. D., & Lancia, J. J. (1998). Religion and the psychotherapeutic relationship: Transferential and countertransferential dimensions. *The Journal of Psychotherapy Practice and Research, 7*(4), 281–289.

Abi-Hashem, N., & Driscoll, E. G. (2013). Cultural anthropology. In K. D. Keith (Ed.), *The Encyclopedia of cross-cultural psychology* (pp. 292-295). Malden, MA: Wiley-Blackwell.

Abi-Hashem, N. (2014). Cross-cultural psychology and counseling: A Middle Eastern perspective. *Journal of Psychology and Christianity*, *33*(2), 156–163.

Abi-hashem, N. (2015, October). Revisiting cultural awareness and cultural relevancy. *American Psychologist*, 70(7), 660-661. doi: 10.1037/a0038984

Abi-Hashem, N. (2017). Worldview, the concept of. In D. A. Leeming (Ed.), *The encyclopedia of psychology and religion* (pp. 1-6). Springer Living Reference Online.

Adams, B. C., & Manen, M. Van. (2012). Phenomenology. In L. M. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (pp. 615–619). Thousand Oaks, CA: Sage Publications.

Adekson, M. (2003). Indigenous family work in Nigeria the Yoruba experience. In K. S. Ng (Ed.), *Global perspectives in family therapy: Development, practice, and trends* [Kindle version] (pp. 146–160).

Afifi, E. M., Al-Muhaideb, N. S., Hadish, N. F., Ismail, F. I., & Al-Qeamy, F. M. (2011). Domestic violence and its impact on married women's health in Eastern Saudi Arabia. *Saudi Medical Journal*, *32*(6), 612-620.

Al-Bahadel, D. (2004). *The feasibility of introducing counselling for women and family therapy into society within Saudi Arabia* (Doctoral dissertation, University of East Anglia).

Algahtani, H., Buraik, Y., & Ad-Dab'bagh, Y. (2017). Psychotherapy in Saudi Arabia: Its history and cultural context. *Journal of Contemporary Psychotherapy*, *47*(2), 105–117.

Alhajjuj, K. K. (2016). *Learning to manage: How Saudi female doctoral students in education manage academic and motherhood roles in us universities* (Doctoral dissertation, University of Kansas).

Al-Garni, M. (2004). Solution focused therapy: Cross cultural application to school counseling in Saudi Arabia. *Journal of School Social Work, 13*(2), 40-59.

Al-Issa, A. (2005). When the west teaches the east: Analyzing intercultural conflict in the classroom. *Intercultural Communication Studies XIV*, *4*, 149-166.

Al-Krenawi, A. (1998). Family therapy with a multiparental/multispousal family. *Family Process*, *37*(1), 65-81.

Al-Krenawi, A. (1999). An overview of rituals in Western therapies and intervention: Argument for their use in cross-cultural therapy. *International Journal for the Advancement of Counselling*, *21*(1), 3-17.

Al-Sabaie, A. (1989). Psychiatry in Saudi Arabia: Cultural perspectives. *Transcultural Psychiatry*, *26*(4), 245–262.

Alshareef, K. S. (2005). *The role of religious beliefs and practice in the lives of older men in residential nursing homes: A case study of the role of Islam in nursing homes in Saudi Arabia and the implications for policy and practice* (Doctoral dissertation, University of Warwick). Thesis: 418147.

Alsultan, T., & Hubbard, B. (2017, December 23). As prince accelerates changes for women, Saudis adapt at varied pace. *New York Times.* Retrieved from https://www.nytimes.com/2017/12/23/world/middleeast/saudi-arabia-photos-women-gender.html

American Association for Marriage and Family Therapy. (2018). *MFT licensing boards.* Retrieved from http://www.aamft.org/imis15/AAMFT/Content/Directories/MFT_Licensing_Boards.aspx

Anderson, H. D. (1985). The new epistemology in family therapy: Implications for training family therapists. Dissertation Abstracts International: Section B. *The Sciences and Engineering, 46*(1-B), 341.

Anderson, H. (1997). *Conversation, language, and possibilities: A postmodern approach to Therapy.* New York, NY: Basic Books.

Angen, M. J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research*, *10*(3), 378–395.

Anonymous. (2008, May 09). *BBC monitoring Middle East*. Retrieved from http://search.proquest.com.ezproxylocal.library.nova.edu/docview/459048503?accountid=6579

Aponte, H. J. (2017). Person of the therapist (POTT): *Background, insight, and observations. Part1: History & description.* (Video). Retrieved from https://harryjaponte.com/books/#single/0

Aponte, H. J., Powell, F. D., Brooks, S., Watson, M. F., Litzke, C., Lawless, J., & Johnson, E. (2009). Training the person of the therapist in an academic setting. *Journal of Marital and Family Therapy, 35*(4), 381-394.

Aponte, H. J., & Winter, J. E. (1987). The person and practice of the therapist: Treatment and training. *Journal of Psychotherapy & the Family*, *3*(1), 85-111.

Aponte, H. J., & Carlsen, C.J. (2009). An instrument for person-of-the-therapist supervision. *Journal of Marital and Family Therapy*, *35*(4), 395–405.

Ariel, S., Keith, D., Martinez-Ortiz, D., Prosky, P., Shi, L., Tiurean, A., & Whiteside, R. G. (2014). The birth of family therapists: The Kosova systemic family therapy training program. *Journal of Family Psychotherapy, 25*(3), 225-245.

Augustine, T. (2003). Postmodern Singapore. In K. S. Ng (Ed.), *Global perspectives in family therapy: Development, practice, and trends* [Kindle version] (pp. 57–56).

Auerswald, E. H. (1987). Epistemological confusion in family therapy and research. *Family Process*, *26*(3), 317-330.

Baker, K. A. (1999). Acculturation and reacculturation influence: Multilayer contexts in therapy. *Clinical Psychology Review*, *19*(8), 951–967.

Baker, K. A. (1999). The importance of cultural sensitivity and therapist self-awareness when working with mandatory clients. *Family Process*, *38*(1), 55-67.

Baldwin Jr., D. C. (2000). Some philosophical and psychological contributions to the use of self in therapy. In M. Baldwin, (Ed.), *The use of self in therapy* (2nd ed.) (pp. 90-106). New York, NY: Haworth Press.

Baldwin, M. (2000). Interview with Carl Rogers on the use of the self in therapy. In M. Baldwin (Ed.), *The use of self in therapy* (2nd ed.) (pp. 29-38). New York, NY: Haworth Press.

Baldwin, M. (Ed.), *The use of self in therapy* (2nd ed.). New York, NY: Haworth Press.

Bascom, J. (1876). *Science, philosophy and religion*. New York, NY: Putnam & Sons.

Bateson, G. (1972). *Steps to an ecology of mind: Collected essays in anthropology, psychiatry, evolution, and epistemology*. San Francisco, CA: Chandler.

Bateson, G. (1979). *Mind and nature: A necessary unity*. London, England: Wildwood House.

Beels, C. C. (2002). Notes for a cultural history of family therapy. *Family Process*, *41*(1), 67–82.

Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology, 23*(1), 67-82.

Biever, J. L., & Santos, J. (2016). Ofredendo terapia en el idioma de preferenda del cliente: El modelo de preparación profesional calificada en dos idiomas de ollu. In L. L. Charles, & G. Samarasinghe (Eds.), *Family therapy in global humanitarian contexts: Voices and issues from the field; family therapy in global humanitarian contexts: Voices and issues from the field* (pp. 51-63). New York, NY: Springer.

Bloch, D. A. (2004). Carlos Sluzki: Cross-culturalist. *Families, Systems and Health*, *22*(3), 338–339.

Boufoy-Bastick, B. (2004, January). Auto-interviewing, auto-ethnography and critical incident methodology for eliciting a self-conceptualised worldview. In Forum Qualitative Sozialforschung/Forum: Qualitative Social Research (Vol. 5, No. 1).

Bowen, W. H. (2014). *The history of Saudi Arabia*. Santa Barbra, CA: ABC-CLIO, LLC.

Bucher, J., & Costa L. L. (2003). Family therapy in Brazil: Memoir and development. In K. S. Ng (Ed.), *Global perspectives in family therapy: Development, practice, and trends* [Kindle version] (pp. 194–206).

Carlisle, J. (2018). Mental health law in Saudi Arabia. *BJPsych International, 15*(1), 17-19.

Carlson, T. D., & Erickson, M. J. (1999). Recapturing the person in the therapist: An exploration of personal values, commitments, and beliefs. *Contemporary Family Therapy: An International Journal, 21*(1), 57–76.

Carlson, J. (2003). From the series editor. In K. S. Ng (Ed.), *Global perspectives in family therapy: Development, practice, and trends* [Kindle version] (p. vii).

Carr, A. (2013). The development of family therapy in Ireland. *Contemporary Family Therapy, 35*, 179-199.

Carson, D. K., & Chowdhury, A. (2000). Family therapy in India: A new profession in an ancient land? *Contemporary Family Therapy*, *22*(4), 387–406.

Charles, L. L. (2007). Cultural competency as a relational process. *Qualitative Inquiry*, *13*(8), 1160–1176.

Charles L. L. (2016). Engaging the humanity in front of you: Family therapy task shifting in the context of armed conflict. In L. L. Charles, & G. Samarasinghe (Eds.), *Family therapy in global humanitarian contexts: Voices and issues from the field* (pp. 222-252). New York, NY: Springer.

Charles, L. L., & Piercy, F. P. (2003). Reflections on teaching family therapy in several non-western countries. *Journal of Systemic Therapies*, *22*(4), 15-28.

Chulov, N. (2017, October 24). I will return to Saudi Arabia to moderate Islam, says crown prince. *The Guardian*. Retrieved from https://www.theguardian.com/world/2017/oct/24/i-will-return-saudi-arabia-moderate-islam-crown-prince

Comas-Díaz, L. (2006). Latino healing: The integration of ethnic psychology into psychotherapy. *Psychotherapy*, *43*(4), 436–453.

Council of Cooperative Health Insurance. (2017, March 30). *Does the policy cover psychological cases?* Retrieved from https://www.cchi.gov.sa/en/Providers/FAQ/Pages/Q7.aspx

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Cullin, J. (2013). On learning and teaching family therapy. *Australian and New Zealand Journal of Family Therapy*, *34*(4), 352–369.

Culver, R. E. (2011). *Program evaluation: Marriage and family therapy programs' multicultural competency* (Doctoral dissertation, Kansas State University).

D'Aniello, C., Nguyen, H. N., & Piercy, F. P. (2016). Cultural sensitivity as an MFT common factor. *The American Journal of Family Therapy, 44*(5), 234-244.

Deacon, S. A. (1996). Using experimental activities in the training of the person of the therapist. *Family Therapy, 23*, 171–187.

Deng, L., Lin, X., Lan, J., & Fang, X. (2013). Family therapy in China. *Contemporary Family Therapy*, *35*(2), 420–436.

Dey, I. (1993). *Qualitative data analysis: A user-friendly guide for social scientists*. New York, NY: Routledge.

Dickerson, V. C. (2010). Positioning oneself within an epistemology: Refining our thinking about integrative approaches. *Family Process*, *49*(3), 349–368.

Douglass, B. G., & Moustakas, C. (1985). Heuristic inquiry: The internal search to know. *Journal of Humanistic Psychology, 25*(3), 39-55.

Dunne, K. (2016). Reconciling international differences. In L. L. Charles, & G. Samarasinghe (Eds.), *Family therapy in global humanitarian contexts: Voices and issues from the field* (pp. 327-333). New York, NY: Springer.

Dunworth, F. (2011). Interpretative phenomenological analysis. In R. Thorpe & R.

Holt, *The SAGE dictionary of qualitative management research* (pp. 116-120). London, England: Sage Publications.

DuPree, W. J., Pierce, J., Luthra, B., Huff, S., Green, S., & DuPree, D. G. (2012). International perspectives of family therapy: A phenomenological approach. *Journal of Family Psychotherapy*, *23*(4), 304–321.

Dwairy, M., & Van Sickle, T. D. (1996). Western psychotherapy in traditional Arabic societies. *Clinical Psychology Review*, *16*(3), 231–249.

Ellenwood, A.E. & Snyders, R. (2006) Inside-out approaches to teaching multicultural techniques, *Journal of Family Psychotherapy, 17*(1), 67-81.

En-Nabut, I. (2007). The lived experiences of immigrant Arab Muslim women in the United States: Implications for counselors and other helping professionals. *University of New Orleans Theses and Dissertations.* 549. Retrieved from http://scholarworks.uno.edu/td/549.

Epstein, N. B., Berger, A. T., Fang, J. J., Messina, L. A., Smith, J. R., Lloyd, T. D., … Liu, Q. X. (2012). Applying Western-developed family therapy models in China. *Journal of Family Psychotherapy*, *23*(3), 217–237.

Epstein, N. B., Curtis, D. S., Edwards, E., Young, J. L., & Zheng, L. (2014). Therapy with Families in China: Cultural Factors Influencing the Therapeutic Alliance and Therapy Goals. *Contemporary Family Therapy*, *36*(2), 201–212.

Eatough, V. & Smith, J. A. (2017). Interpretative Phenomenological Analysis. In C. Willig, & W. S. Rogers, (Eds.), *The SAGE handbook of qualitative research in psychology* (2nd ed.) (pp. 193-209). Thousand Oaks, CA: Sage Publications.

Flaskas, C. (2013). Teaching and learning theory for family therapy practice: On the art and craft of balancing. *Australian and New Zealand Journal of Family Therapy*, *34*(4), 283–293.

Flaskas, C. (2005). Relating to knowledge: Challenges in generating and using theory for practice in family therapy. *Journal of Family Therapy*, *27*(3), 185–201.

Flemons, D. (2017). Brief family therapy. In J. Carlson & S. Dermer (Eds.), *The SAGE encyclopedia of qualitative research methods* (pp. 182-186). Thousand Oaks, CA: Sage Publications.

Gallarotti, G., & Al-Filali, I. Y. (2012). Saudi Arabia's soft power. *International Studies*, *49*, 233–261. doi: 10.1177/0020881714532707

Gallardo-Cooper, M., & Zapata, A. L. (2014). Multicultural family therapy. *APA Handbook of Multicultural Psychology*, *2*, 499–525.

Gassas, R. F. (2017). The standard of care in marital and family therapeutic interventions in Saudi Arabia: A modified Delphi study on the current status and needs. Dissertation Abstracts International: Section A. *Humanities and Social Sciences, 77*,10-A (E).

Gerhardt, C. (2003). Finding your own voice: The development of family therapy in South Africa. In K. S. Ng. (Ed.), *Global perspectives in family therapy: Development, practice, and trends* (pp. 161–172). New York, NY: Brunner- Routledge.

Gibson, S. & Hugh-Jones, S. (2012). Analysing your data. In C. Sullivan, S. Gibson, & S. Riley (Eds.), *Doing your qualitative psychology project* (pp. 127-153). London, England: Sage Publications.

Given, L. M. (Ed.). (2008). *The Sage encyclopedia of qualitative research methods.* Thousand Oaks, CA: Sage Publications.

Glebova, T., Bolotina, N., & Kravtsova, N. (2014). Training across the Pacific: Women create an international family therapy program. *Women and Therapy*, *37*(1–2), 24–35.

Halpern, E. (1985). Training family therapists in Israel: The necessity of indigenous models. *American Journal of Family Therapy*, *13*(1), 55–60.

Ham, M. D.-C. (2001). Broadening the space of family education and training: Opportunities for transformation. *Journal of Systemic Therapies, 20*, 24–35. doi: 10.1521/jsyt.20.1.24.19407

Hardy, K. V., & Laszloffy, T. A. (1995). The cultural genogram: Key to training culturally competent family therapists. *Journal of Marital and Family Therapy*, *21*(3), 227–237.

Heggen, K., & Guillemin, M. (2012). Protecting participants' confidentiality using a situated research ethics approach. *The SAGE Handbook of Interview Research: The Complexity of the Craft*, 465–476. doi: 10.4135/9781452218403.n33

Heiphetz, L., Spelke, E. S., & Banaji, M. R. (2014). The formation of belief-based social preferences. *Social Cognition, 32*(1), 22-47.

Henry, P. W., & Storm, C. L. (1984). The training metamorphosis: Teaching systemic thinking in family therapy programs. *Journal of Strategic & Systemic Therapies, 3*(2), 41-49.

Hilliard, M. E., Ernst, M. M., Gray, W. N., Saeed, S. A., & Cortina, S. (2012). Adapting pediatric psychology interventions: Lessons learned in treating families from the Middle East. *Journal of Pediatric Psychology*, *37*(8), 882–892.

Irfan, M., Saeed, S., Awan, N. R., Gul, M., Aslam, M., & Naeem, F. (2017). Psychological healing in Pakistan: From Sufism to culturally adapted cognitive behaviour therapy. *Journal of Contemporary Psychotherapy*, *47*(2), 119–124.

Jagasia, J. S. (2008). Culturally appropriate Indian applications of marriage and family therapy interventions explored through an HIV example. *Human Development Specialization in Marriage and Family Therapy*, 11–13.

Jaladin, R. A. M. (2013). Barriers and challenges in the practice of multicultural counselling in Malaysia: A qualitative interview study. *Counselling Psychology Quarterly*, *26*(2), 174–189.

Kaslow F. W. (2000). History of family therapy. *Journal of Family Psychotherapy*, *11*(4), 1-35.

Kassem, L. (2012). *Psychotherapy between two cultures: A portrait of psychotherapists in Egypt*. University of Chicago, Division of the Social Sciences, Department of Comparative Human Development. Retrieved from http://search.proquest.com.ezproxylocal.library.nova.edu/docview/1032543047?accountid=6579

Keeney, B. P. (1981). *Cybernetic patterns in family therapy: A Batesonian epistemology*. ProQuest Dissertations & Theses Global. (UMI No. 8123663)

Keeney, B. P. (1983). *Aesthetics of change*. New York, NY: Guilford Publications.

Keeney, B. P., & Sprenkle, D. H. (1982). Ecosystemic epistemology: Critical implications for the aesthetics and pragmatics of family therapy. In R. B. Miller (Ed.), *The restoration of dialogue: Readings in the philosophy of clinical psychology* (pp. 477–495). Washington, DC: American Psychological Association.

Keith, D. V. (2000). In M. Baldwin (Ed.), *The use of self in therapy* (2nd ed.) (pp. 257–281). New York, NY: The Haworth Press.

Kelly, E. W., Aridi, A., & Bakhtiar, L. (1996). Muslims in the United States: An exploratory study of universal and mental health values. *Counseling and Values*, *40*(3), 206-218.

Khan, S. (2002). Visible differences: individual and collective risk-taking in working cross-culturally. In B. M. A. Sawyer (Ed.), Exploring the unsaid: Creativity, risks and dilemmas in working cross-culturally (pp. 95-110). London: Karnac

Kraemer, A. J. (1973). Development of a cultural self-awareness approach to instruction in intercultural communication. *Technical Report 73-17*. Retrieved from https://files.eric.ed.gov/fulltext/ED129682.pdf

Laher, S. (2014). An overview of illness conceptualizations in African, Hindu, and Islamic traditions: Towards cultural competence. *South African Journal of Psychology*, *44*(2), 191–204.

Lavee, Y. (2003). Family therapy in multiculticultural society: The case of Israel. In K. S. Ng (Ed.), *Global perspectives in family therapy: development, practice, and trends* [Kindle version] (pp. 174–193).

Lee, S. H., Chun, Y. J., Chung, H., Shin, S. I., Lee, I., Lee, D. S., & Choi, Y. S. (2013). The profession of family therapy in South Korea: Current status and future directions. *Contemporary Family Therapy*, *35*(2), 388–399.

Lichtman, M. (2013). *Qualitative research for the social sciences*. Thousand Oaks, CA: Sage Publications.

Lopez-Bernstein, E. (1997). *Realms of culture: Therapists' perspectives on self and others* (Doctoral dissertation, Syracuse University). Retrieved from http://eprints.auis.edu.krd/id/eprint/4.

Lum, W. (2002). The use of self of the therapist. *Contemporary Family Therapy*, *24*(1), 181–197.

MacDonald, C., & Peters, V. (2010). ANZJFT and AAFT. *Australian and New Zealand Journal of Family Therapy, 31*(3), 219-220.

Maclean, W. (2017, November 8). Shifting sands: What is changing in Saudi Arabia? *Discover Thomson Reuters*. Retrieved from http://www.reuters.com/article/us-saudi-arrests-milestones/shifting-sands-what-is-changing-in-saudi-arabia-idUSKBN1D8181

Maxwell-Hubert, K. E. (2004). The professional identity of the marriage and family therapist in private practice. (Doctoral dissertation, Kansas State University).

McDowell, T., Fang, S.-R., Griggs, J., Speirs, K., Perumbilly, S., & Kublay, A. E. (2006). International dialogue: Our experience in a family therapy program. *Journal of Systemic Therapies*, *25*(1), 1-15.

Méndez, M. (2013). Autoethnography as a research method: Advantages, limitations and criticisms. *Colombian Applied Linguistics Journal, 15*(2), 279-287.

Miller, J. K., & Fang, X. (2012). Marriage and family therapy in the People's Republic of China: Current issues and challenges. *Journal of Family Psychotherapy*, *23*(3), 173–183.

Miller, R. L., & Brewer, J. D. (Eds.). (2003). *The A-Z of social research: A dictionary of key social science research concepts*. Thousand Oaks, CA: Sage Publications.

Minuchin, S. (2017, January/February). Systems therapy: The art of creating uncertainty. *Psychotherapy Networker, 37*. Retrieved from https://www.psychotherapynetworker.org/blog/details/1099/family-therapy-pioneer-salvador-minuchin-on-the-therapists

Minuchin, S., Lee, W., & Simon, G. M. (2006). *Mastering family therapy: Journeys of growth and transformation* (2nd ed.) Hoboken, NJ: Wiley & Sons.

Mirsalimi, H. (2010). Perspectives of an Iranian psychologist practicing in America. *Psychotherapy*, *47*(2), 151–161.

Mittal, M., & Hardy, K. V. (2005). A re-examination of the current status and future of family therapy in India. *Contemporary Family Therapy*, *27*(3), 285–300.

Mogaddam, M., & Kamal, I. (2015). Prevalence of child abuse in Saudi Arabia from 2000 to 2015: A review of the literature. *Journal of Oral Hygiene & Health*, *3*(6), 189. doi: 10.4172/2332-0702.1000189.

Mojta, C., Falconier, M. K., & Huebner, A. J. (2014). Fostering self-awareness in novice therapists using internal family systems therapy. *American Journal of Family Therapy, 42*(1), 67-78.

Morris, B. (2014). *The impact of culture & ethnicity on the counseling process: perspectives of genetic counselors from minority ethnic groups*. (Doctoral dissertation, University of South Carolina).

Murphy, M. J., Park, J., & Lonsdale, N. J. (2006). Marriage and family therapy students' change in multicultural counseling competencies after a diversity course. *Contemporary Family Therapy*, *28*(3), 303–311.

Natrajan, R., Karuppaswamy, N., Thomas, V., & Ramadoss, K. (2005). Adaptation of two family therapy training instruments to culturally suit the Indian context. *Contemporary Family Therapy*, *27*(3), 415–434.

Nassar-McMillan, S. C., & Hakim-Larson, J. (2003). Counseling considerations among Arab Americans. *Journal of Counseling & Development*, *81*(2), 150-159.

Nelson, T. S., & Prior, D. (2003). Theory of change projects in MFT programs. *Contemporary Family Therapy*, *25*(2), 133–151.

Niño, A., Kissil, K., & Davey, M. P. (2016). Strategies used by foreign-born family therapists to connect across cultural differences: A thematic analysis. *Journal of Marital and Family Therapy*, *42*(1), 123–138.

Nobles, A. Y., & Sciarra, D. T. (2000). Cultural determinants in the treatment of Arab Americans: A primer for mainstream therapists. *The American Journal of Orthopsychiatry*, *70*(2), 182–191.

Northey, W. F. (2009). The legitimization of marriage and family therapy in the United States: Implications for international recognition. *Journal of Family Psychotherapy*, *20*(4), 303–318.

Patton, M. Q. (2002). *Qualitative evaluation and research methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Pedersen, P. (1997). *Culture-centered counseling interventions: Striving for accuracy*. Thousand Oaks, CA: Sage Publications.

Pedersen, P. (2009). Inclusive cultural empathy: A relationship-centred alternative to individualism. *South African Journal of Psychology*, *39*(2), 143–156.

Piercy, F. P., Chang, W.-N., Palit, M., Chen, R., Karimi, H., Jaramillo-Sierra, A. L., … Antonio, A. (2014). A cross-national study of family therapy training: a collaborative pilot project. *Contemporary Family Therapy*, *36*(2), 250–259.

Piercy, F. P., Earl, R. M., Aldrich, R. K., Nguyen, H. N., Steelman, S. M., Haugen, E., … Gary, E. (2016). Most and least meaningful learning experiences in marriage and family therapy education. *Journal of Marital and Family Therapy*, *42*(4), 584–598.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal, 20*(1), 7-14.

Polanco, M. (2016). Knowledge fair trade. In L. L. Charles, & G. Samarasinghe (Eds.), *Family therapy in global humanitarian contexts: Voices and issues* (pp. 327-333). New York, NY: Springer.

Riany, Y. E., Meredith, P., & Cuskelly, M. (2017). Understanding the influence of traditional cultural values on Indonesian parenting. *Marriage and Family Review*, *53*(3), 207–226.

Rambo, A., & Hibel, J. (2013). What is family therapy? Underlying premises. In A. Rambo, C. West, A. Schooley & T. V. Boyd (Eds.), *Family therapy review: Contrasting contemporary models* (pp. 3-8). New York, NY: Routledge/Taylor & Francis Group.

Rathod, S. (2017). Contemporary psychotherapy and cultural adaptations. *Journal of Contemporary Psychotherapy, 47*(2), 61-63.

Regas, S. J., Kostick, K. M., Bakaly, J. W., & Doonan, R. L. (2017). Including the self-of-the-therapist in clinical training. *Couple and Family Psychology: Research and Practice*, *6*(1), 18–31.

Rhodes, P., Nge, C., Wallis, A., & Hunt, C. (2011). Learning and living systemic: Exploring the personal effects of family therapy training. *Contemporary Family Therapy*, *33*(4), 335–347.

Rober, P. (1999). The therapist's inner conversation in family therapy practice: Some ideas about the self of the therapist, therapeutic impasse, and the process of reflection. *Family Process*, *38*(2), 209–228.

Rober, P., Elliott, R., Buysse, A., Loots, G., & De Corte, K. (2008). Positioning in the therapist's inner conversation: A dialogical model based on a grounded theory analysis of therapist reflections. *Journal of Marital and Family Therapy, 34*(3)*,* 406–421.

Rober, P. (2005). The therapist's self in dialogical family therapy: Some ideas about not-knowing and the therapist's inner conversation. *Family Process, 44*(4), 477-495.

Roberts, J., Abu-Baker, K., Diez Fernández, C., Chong Garcia, N., Fredman, G., Kamya, H., … Zevallos Vega, R. (2014). Up close: Family therapy challenges and innovations around the World. *Family Process*, *53*(3), 544–576.

Rhodes, P., Nge, C., Wallis, A., & Hunt, C. (2011). Learning and living systemic: Exploring the personal effects of family therapy training. *Contemporary Family Therapy: An International Journal, 33*(4), 335–347.

Satir, V. (2000). The therapist story. In M. Baldwin (Ed.), *The use of self in therapy* (2nd ed.) (pp. 17–27). New York, NY: The Haworth Press.

Saudi Arabia Bureau of Experts at the Council of Ministers website. (2014, August 29). *Royal decree: Mental health care law.* Retrieved from https://www.boe.gov.sa/ViewSystemDetails.aspx?lang=en&SystemID=343&VersionID=319

Seidman, I. (2013). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (4th ed.). New York, NY: Teachers College Press.

Shadley, M. L. (2000). Are all therapists alike? Revisiting research about the use of self in therapy. In M. Baldwin (Ed.), *The use of self in therapy* (2nd ed.) (pp. 191–211). New York, NY: The Haworth Press.

Shawly, A. T. (1980). Toward an educational-vocational guidance model in the Kingdom of Saudi Arabia (Doctoral dissertation, University of Wisconsin).

Sherbersky, H. (2016). Family therapy and fundamentalism: One family therapist's exploration of ethics and collaboration with religious fundamentalist families. *Clinical Child Psychology and Psychiatry, 21*(3)*,* 381–396.

Shurina-Egan, J. S. (1986). Learning process in family therapy: An experiential perspective. Dissertation Abstracts International: Section B. *The Sciences and Engineering, 47*(5-A), 1575.

Sim, T., Yi Fang, X., Chan, S., Teik Cheok Loy, J., Sng, S., Lo, R., … Singh, R. (2017). Co-constructing family therapy in the Asian Chinese family Diasporas of mainland China, Malaysia, Macau, Singapore and Taiwan. *Journal of Family Therapy*, *39*(2), 131–150.

Simmons, D.S. (1997). The relationship between academic training and the clinical practices of marriage and family therapists. *Dissertation Abstracts International: Section B. The Sciences and Engineering, 57*(10-B), 6174.

Simon, G. M. (2006). The heart of the matter: A proposal for placing the self of the therapist at the center of family therapy research and training. *Family Process*, *45*(3), 331–344.

Simon, G. (2010). Self-supervision, surveillance and transgression. *Journal of Family Therapy*, *32*(3), 308–325.

Smith, J. A., Flowers, M. P., & Larkin M. (2009). Interpretative phenomenological analysis: theory, method and research. Thousand Oaks, CA: Sage Publications.

Softas-Nall, L. (2008). A view of systemic therapy in Greece: An interview with Charis Katakis. *The Family Journal, 16*(1), 87-91.

Stagoll, B. (2006). Gregory Bateson at 100. *Australian and New Zealand Journal of Family Therapy, 27*(3), 121-134.

Steele, L. L. (2006). A study on the use of simulated clients in the training of clinical skills of marriage and family therapists. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, *67*(3–B), 1718.

Tamura, T. (2003). The development of family therapy and the experience of fatherhood in the Japanese context. In K. S. Ng (Ed.), *Global perspectives in family therapy: Development, practice, and trends* [Kindle version] (pp. 18–30).

Tashkandi, A. A., & Rasheed, P. (2009). Wife abuse: A hidden problem. A study among Saudi women attending PHC centres. *La Revue de Santé de la Méditerranée Orientale, 15*(5), 1242-1253.

Taylor, K. M., & Smith, T. (2011). The family therapist and diversity. In L. Metcalf (Ed.), *Marriage and family therapy: A practice-oriented approach* (pp. 509-532). New York, NY: Springer.

Timm, T. M., & Blow, A. J. (1999). Self-of-the-therapist work: A balance between removing restraints and identifying resources. *Contemporary Family Therapy*, *21*(3), 331–351.

Todd, T. C., & Storm, C. L. (1997). *The complete systemic supervisor: Context, philosophy, and pragmatics.* New York, NY: IUniverse, Inc.

Tse, S., Ng, R. M. K., Tonsing, K. N., & Ran, M. (2012). Families and family therapy in Hong Kong. *International Review of Psychiatry*, *24*(2), 115–120.

Verdinelli, S., & Biever, J. L. (2009). Spanish-English bilingual psychotherapists: Personal and professional language development and use. *Cultural Diversity and Ethnic Minority Psychology*, *15*(3), 230–242.

Waite, M. (Ed.). (2012). *Paperback Oxford English dictionary*. Oxford, United Kingdome: Oxford University Press.

Wall, S. (2006). An autoethnography on learning about autoethnography. *International Journal of Qualitative Methods, 5*(2), 146-160.

Wall, S. (2008). Easier said than done: Writing an autoethnography. *International Journal of Qualitative Methods, 7*(1), 38-53.

Watts, R. E. (2005). Global perspectives in family therapy: Development, practice, and trends. *Journal of Marriage and Family*, *67*(1), 268-269.

Wieling, E., & Marshall, J. P. (1999). Cross-cultural supervision in marriage and family therapy. *Contemporary Family Therapy*, *21*(3), 317–329.

Wieling, E., & Mittal, M. (2002). Expanding the horizons of marriage and family therapists: Towards global interconnectedness. *Journal of Feminist Family Therapy*, *14*(1), 53-62.

Wiggins, M. I. (2009). Therapist self-awareness of spirituality. In J. D. Aten & M. M. Leach (Eds.), *Spirituality and the therapeutic process: A comprehensive resource from intake to termination* (pp. 53-74). Washington, DC, US: American Psychological Association.

Williams, E. N., & Fauth, J. (2005). A psychotherapy process study of therapist in session self-awareness. *Psychotherapy Research*, *15*(4), 374–381.

Williams, V. (2005). Working with Muslims in counselling: Identifying sensitive issues and conflicting philosophy. *International Journal for the Advancement of the Advancement of Counselling, 27*(1)*, 125–130.*

Appendices

Appendix A

General Informed Consent Form

NSU Consent to be in a Research Study Entitled
Glancing Back at The Camel's Hump: An Interpretative Phenomenological Analysis of Saudi Family Therapists' Dual Epistemologies

Who is doing this research study?

College: College of Arts, Humanities, and Social Sciences

Principal Investigator: Rana Banaja, M.S.

Faculty Advisor/Dissertation Chair: Douglas Flemons, Ph.D.

Co-Investigator(s): N/A

Site Information:

Funding: Unfunded

What is this study about?

You are invited to participate in a research study. The purpose of the present study is to conduct a qualitative exploration of Saudi family therapists' experience of simultaneously honoring the western worldview of family therapy and the cultural/religious worldview of Saudi Arabia. The goal of this study is to explore the challenges that Saudi family therapists may be encountering as they undertake their practice, as well as clarifying how these therapists are adapting Western knowledge in the Saudi culture.

Why are you asking me to be in this research study?

You are being asked to participate in this study because you identify as a Saudi family therapist, have graduated from marriage and family therapy (MFT) program in the West, and currently are practicing family therapy in the Kingdom of Saudi Arabia (KSA). There will be approximately 6 participants in this study; each individual participant will take part in a one-hour individual interview with the researcher.

What will I be doing if I agree to be in this research study?

If you choose to participate in this study, the researcher will contact you to arrange a personal interview. If it is not possible to conduct the interview face-to-face, you will be offered the option of using Skype video-call technology. The interviews you will be asked to participate in for this study will last one hour. Your participation in this study is voluntary. You may withdraw from the study at any time without penalty.

What would be the language spoken in the interview?

The interview will be in English, but you are free to revert to Arabic at any time if you prefer to use it for offering nuance or clarification. Indeed, the whole interview can be conducted in Arabic if this is your preference.

Are there possible risks and discomforts to me?

The risks for participation in this study are considered minimal, meaning they are not thought to be greater than other risks you experience every day. Because of the sensitive nature of the topic, it is possible that you may experience some emotional discomfort while discussing your experiences during the interview. If you are asked a question that you do not feel comfortable answering, you may request to skip that question or take a break from the interview. If you experience significant discomfort and choose to withdraw from the study, we can refer you to someone who may be able to help you with these feelings, and/or you may do so without penalty**.**

Because participants will be sharing some private and personal information in this study, there is a minimal risk of invasion of privacy. To help avoid this risk, the researcher will be in a private location when communicating with you and when handling any materials pertaining to the study. To further ensure your privacy, you are asked to not share any information in the study that might be subject to mandatory reporting requirements. There is also a minimal risk of breach of confidentiality associated with your participation in this study. However, the researcher will take steps to minimize this risk by securing and keeping private all information pertaining to the study. If you have questions about the research, your research rights, or have a research- related injury, please contact Rana Banaja at 00966503632494.You may also contact the IRB at the numbers indicated above with questions as to your research rights.

What happens if I do not want to be in this research study?

You have the right to leave this study at any time or refuse to participate. If you do decide to leave or you decide not to participate, you will not experience any penalty or loss of services you have a right to receive. If you choose to withdraw, any information collected about you before the date you leave the study will be kept in the research records for 36 months from the conclusion of the study, but you may request that it not be used.

What if there is new information learned during the study that may affect my decision to remain in the study?

If significant new information relating to the study becomes available, which may relate to whether you want to remain in this study, this information will be given to you by the investigators. You may be asked to sign a new Informed Consent Form, if the information is given to you after you have joined the study.

Are there any benefits for taking part in this research study?

There are no direct benefits from being in this research study. We hope the information learned from this study will help the next generation of Saudi family therapists as they

embark on learning the profession, as well as family therapists from other countries who themselves are reconciling professional and personal worldviews.

Will I be paid or be given compensation for being in the study?
You will not be given any payments or compensation for being in this research study.

Will it cost me anything?
There are no costs to you for being in this research study.

How will you keep my information private?
Information we learn about you in this research study will be handled in a confidential manner, within the limits of the law and will be limited to people who have a need to review this information. Prior to participating in the interview, we will mutually choose a pseudonym for you, which will ensure the confidentiality of your contributions to the study. Transcription of the interviews will be conducted in a private setting using headphones to ensure participants' privacy and confidentiality. Transcriptions will be created and stored in the principal investigator's password-protected computer and flash drive. The data of the study will be available to the researcher, Ms. Banaja, and the dissertation chair, Dr. Flemons, the Institutional Review Board, and other representatives of this institution, as well as any regulatory agencies. If we publish the results of the study in a scientific journal or book, we will not identify you. All confidential data will be kept securely in a locked cabinet in the principal investigator's home office, to which only she has access. She will store all electronic data from the research on her private, password-protected computer and flash drive, which will be stored in a locked cabinet in her home office. All data will be kept for 36 months from the end of the study and will be destroyed after that time by shredding physical documents and permanently deleting digital information.

If you choose to participate in the interviews over Skype, be advised that Skype may collect information about you including (but not limited to) your name, address, phone number, email address, age, gender, IP address, etc. You can visit the Skype privacy policy website (http://www.skype.com/intl/en/legal/privacy/general/) if you would like further information. While Skype may not know that you are participating in this study, they may be collecting identifiable information.

Will there be any Audio or Video Recording?
This study will include audio recording of the interviews. This audio recording will be available to be heard by the researcher, Ms. Banaja, personnel from the Institutional Review Board (IRB), and the dissertation chair, Dr. Flemons. The researcher will keep the recording device stored in a secured, locked cabinet to which only she has access. Following the interview, the researcher will translate and transcribe the audio recordings in her private home office, using headphones. All transcriptions will be stored in a password-protected computer to which only the researcher has access. The recording will be kept for 36 months from the end of the study. After that time, the PI will destroy all recording by shredding

physical documents and permanently deleting digital information. Because your voice will be potentially identifiable by anyone who hears the recording, your confidentiality for things you say on the recording cannot be guaranteed, although the researcher will try to limit access to the recording as described in this paragraph.

Whom can I contact if I have questions, concerns, comments, or complaints?

If you have questions now, feel free to ask the researcher. If you have more questions about the research, your research rights, or have a research-related injury, please contact:

Primary contact: Rana Banaja, M.S. +19545621223 +966503632494

If this primary contact is not available, contact:
Douglas Flemons, Ph.D. 1-954-262-3012

Research Participants Rights

For questions/concerns regarding your research rights, please contact: Institutional Review Board
Nova Southeastern University
(954) 262-5369 / Toll Free: 1-866-499-0790
IRB@nova.edu You may also visit the NSU IRB website at www.nova.edu/irb/information-for- research-participants for further information regarding your rights as a research participant.

All space below was intentionally left blank.

Research Consent & Authorization Signature Section

Voluntary Participation - You are not required to participate in this study. In the event you do participate, you may leave this research study at any time. If you leave this research study before it is completed, there will be no penalty to you, and you will not lose any benefits to which you are entitled.

If you agree to participate in this research study, sign this section. You will be given a signed copy of this form to keep. You do not waive any of your legal rights by signing this form.

SIGN THIS FORM ONLY IF THE STATEMENTS LISTED BELOW ARE TRUE:

- You have read the above information.
- Your questions have been answered to your satisfaction about the research

Adult Signature Section

I have voluntarily decided to take part in this research study.

_____	_____	_____
Printed Name of Participant	Signature of Participant	Date
_____	_____	_____
Printed Name of Person Obtaining Consent & Authorization	Signature of Person Obtaining Consent & Authorization	Date

Appendix B

General Informed Consent Form in Arabic

نموذج الموافقة على المشاركة في الدراسة البحثية بعنوان

Glancing Back at The Camel's Hump: An Interpretative Phenomenological Analysis of Saudi Family Therapists' Dual Epistemologies

من يقوم بهذه الدراسة البحثية؟

الكلية: كلية الفنون والعلوم الإنسانية والعلوم الاجتماعية

باحث رئيسي: رنا باناجة، ماجستير

مشرف الرسالة: دوجلاس فليمونز، دكتوراه

الباحث المشارك (الباحثون): غير متاح

معلومات الموقع:

التمويل: غير ممولة

ما هو محور الدراسة؟

أنت مدعو للمشاركة في دراسة بحثية. الغرض من هذه الدراسة هو إجراء دراسة نوعية لإكتشاف تجربة المعالجين الأسريين السعوديين في الجمع بين واحترام كلا من النظرة الغربية للعلاج الأسري والنظرة الثقافية \ الدينية في المملكة العربية السعودية.

الهدف من هذه الدراسة هو استكشاف التحديات التي قد يواجهها المعالج الأسري السعودي أثناء ممارسته للمهنة، وكذلك توضيح كيفية قيام المعالج بتكييف المعرفة الغربية مع الثقافة السعودية.

لماذا قمت باختياري للمشاركة في المقابلة؟

يُطلب منك المشاركة في هذه الدراسة لأنك سعودي\سعودية، ومعالج أسرى، وقد تخرجت من برنامج العلاج النفسي الزواجي والأسري في الولايات الأمريكية المتحدة، ولأنك تقوم حاليًا بممارسة العلاج الأسري في المملكة العربية السعودية. سيكون هناك ما يقارب 6 مشاركين في هذه الدراسة. كل مشارك سيشارك في المقابلة، والتي ستستغرق ساعة واحدة.

ما الذي عليّ فعله إذا وافقت على أن أكون في الدراسة؟

إذا اخترت المشاركة في هذه الدراسة، سيتصل بك الباحث لترتيب مقابلة. هذه المقابلة ستجري بينك وبين الباحث. إذا لم يكن من الممكن إجراء المقابلة وجهاً لوجه، فستتم مطالبتك بالمشاركة في المقابلة باستخدام تقنية مكالمة الفيديو. ستستمر المقابلة التي سيُطلب منك المشاركة فيها لهذه الدراسة لمدة ساعة واحدة. أنت مخير في مشاركتك في هذا البحث. يمكنك الانسحاب من الدراسة في أي وقت.

ما هي اللغة المستعملة في المقابلة؟

ستكون المقابلة باللغة الإنجليزية، ولكن يمكنك الرجوع إلى اللغة العربية في أي وقت إذا كنت بحاجة إلى مزيد من التوضيح. يمكنك اختيار استعمال اللغة العربية في المقابلة كاملة إذا كان هذا هو ما تفضله.

ما هي المخاطر بالنسبة لي؟

تعتبر مخاطر المشاركة في هذه الدراسة ضئيلة، بمعنى أنه لا يُعتقد أنها أكبر من المخاطر اليومية التي تواجهها كل يوم. بسبب الطبيعة الحساسة للموضوع، من الممكن أن تواجه بعض الانزعاج أثناء مناقشة تجاربك أثناء المقابلة. إذا طُلب منك سؤال لا تشعر فيه بالراحة، فيمكنك طلب تخطي هذا السؤال أو أخذ استراحة من المقابلة. إذا واجهت انزعاجًا كبيرًا واخترت الانسحاب من الدراسة، يمكنك القيام بذلك.

نظرًا لأنك ستشارك بعض المعلومات الشخصية في هذه الدراسة، فهناك حد أدنى من خطر انتهاك الخصوصية. للمساعدة في تجنب هذا الخطر، سيكون الباحث في موقع خاص عند التواصل معك وعند تحليل أي مواد تتعلق بالدراسة. لضمان الخصوصية بشكل أكبر، يطلب منك عدم مشاركة أي معلومات في الدراسة قد تكون خاضعة لمتطلبات الإبلاغ الإلزامية. هناك أيضا الحد الأدنى من خطر انتهاك السرية المرتبطة بمشاركتك في هذه الدراسة. ومع ذلك، سوف يتخذ الباحث خطوات لتقليل هذه المخاطر من خلال تأمين والحفاظ على خصوصية جميع المعلومات المتعلقة بالدراسة. إذا كانت لديك أسئلة حول البحث أو حقوقك البحثية أو لديك إصابة مرتبطة بالبحث يرجى الاتصال برنا باناجة على ٠٠٩٦٦٥٠٣٦٣٢٤٩٤

يمكنك أيضًا الاتصال ب IRB على الأرقام المذكورة أدناه لأي أسالة متعلقة بحقوق البحث.

ماذا لو لم أرغب في المشاركة أو إذا رغبت في ترك الدراسة؟

لديك الحق في رفض المشاركة أو في ترك هذه الدراسة في أي وقت. إذا قررت المغادرة أو قررت عدم المشاركة، فلن تواجه أي إشكالية أو خسارة. إذا اخترت الانسحاب، فسيتم حفظ أي معلومات تم جمعها عنك **قبل** تاريخ ترك الدراسة في سجلات البحث لمدة ٣٦ شهرا من الانتهاء من الدراسة ولكن قد تطلب عدم استخدامه.

ماذا لو كانت هناك معلومات جديدة تم معرفتها أثناء الدراسة والتي قد تؤثر على قراري بالبقاء في الدراسة؟

إذا كانت هناك معلومات جديدة متعلقة بالدراسة تتعلق برغبتك في البقاء في هذه الدراسة سيتم إبلاغك بهذه المعلومات وقد يُطلب منك التوقيع على نموذج موافقة جديد خصوصا إذا تم إبلاغك بهذه المعلومات بعد انضمامك إلى الدراسة.

هل هناك أي فوائد للمشاركة في هذه الدراسة البحثية؟

لا توجد فوائد ملموسة للمشاركة في الدراسة، ولكنك قد تستفيد من التحدث عن تجاربك خلال عملية المقابلة.

هل سأتقاضى أجراً لكوني في الدراسة؟ سيكلف لي أي شيء؟

لا توجد تكاليف عليك أو للمدفوعات المقدمة للمشاركة في هذه الدراسة.

كيف ستحافظ على خصوصية معلوماتي؟

قبل المشاركة في المقابلة، سيتم تعيين رمز لك، مما يضمن سرية مساهماتك في الدراسة. جميع المعلومات الواردة في هذه الدراسة سرية للغاية ما لم يكن الإفصاح مطلوبًا بموجب القانون.

سيتم تأمين السجلات البحثية - والتي تشمل التسجيلات الصوتية والنسخ والمراسلات مع المحاور - في الكمبيوتر الخاص للباحث والمحمي بكلمة سر وسيتم تخزينها في خزانة آمنة ومقفلة في مكتب الباحث في المنزل. فقط IRB او الهيئات التنظيمية أو رنا باناجة او المشرف على الرسالة قد يقوموا بمراجعة سجلات الأبحاث.

إذا اخترت المشاركة في المقابلات عبر سكايب، يرجى العلم بأن Skype قد تجمع معلومات عنك بما في ذلك (على سبيل المثال لا الحصر) اسمك وعنوانك ورقم هاتفك وعنوان بريدك الإلكتروني والعمر والجنس وعنوان الباحث وغير ذلك. سياسة الخصوصية لسياسة Skype على الويب (/http://www.skype.com/intl/en/legal/privacy/general) إذا كنت ترغب في الحصول على مزيد من المعلومات. في حين قد لا تعرف Skype أنك تشارك في هذه الدراسة، إلا أنها قد تجمع معلومات محددة.

هل سيكون هناك أي تسجيل صوتي أو فيديو؟

سوف تشمل هذه الدراسة التسجيل الصوتي للمقابلات. سيكون هذا التسجيل الصوتي متاحًا ليتم الاستماع إليه من قبل الباحثة، رنا باناجة، وأفراد من والمشرف على البحث. ستحتفظ الباحثة بجهاز التسجيل المخزن في خزانة مقفلة ومؤمنة لا يمكن الوصول إليها إلا بعد المقابلة، سيقوم الباحث بترجمة وتسجيل التسجيلات الصوتية في مكتبها الخاص، باستخدام سماعات. سيتم تخزين جميع التسجيلات الصوتية في جهاز كمبيوتر محمي بكلمة مرور، ولا يمكن الوصول إليه إلا للباحث. سيتم الاحتفاظ بالتسجيل لمدة 36 شهرا من نهاية الدراسة. بعد ذلك الوقت، ستقوم الباحثة بإبطال كافة التسجيلات عن طريق قطع المستندات الفعلية وحذف المعلومات الرقمية بشكل دائم. نظرًا لأن صوتك ممكن التعرف عليه من قِبل أي شخص يسمع التسجيل، لا يمكن ضمان سرية الأشياء التي تقولها في التسجيل، على الرغم من أن الباحث سيحاول تقييد الوصول إلى التسجيل كما هو موضح في هذه الفقرة

بمن يمكنني الاتصال إذا كان لدي أسئلة أو مخاوف أو تعليقات أو شكاوى؟

إذا كانت لديك أسئلة الآن، فلا تتردد في سؤال الباحث. إذا كان لديك المزيد من الأسئلة حول البحث أو حقوقك البحثية أو لديك إصابة مرتبطة بالبحث، يرجى الاتصال بـ:

اتصال رئيسي:
رنا باناجة، ماجستير
+19545621223
+966503632494

إذا لم يكن هذا الاتصال الأساسي متاحًا، فاتصل بـ:

دوجلاس فليمونز، دكتوراه
1-954-296-8944

حقوق المشاركين في البحث

للأسئلة / المخاوف المتعلقة بحقوق بحثك، يرجى الاتصال بـ:
مجلس المراجعة المؤسسية
جامعة جنوب شرق نوفا
(954) 262-5369
الرقم المجاني: 1-866-499-0790
IRB@nova.edu
يمكنك أيضًا زيارة موقع
www.nova.edu/irb/information-for-research-participants على NSU IRB
للحصول على مزيد من المعلومات حول حقوقك كمشارك في الأبحاث.

المساحة الموجودة أدناه تركت فارغة عمدا

<u>قسم التوقيع والموافقة:</u>

المشاركة طوعية - أنت غير مطالب بالمشاركة في هذه الدراسة. في حال المشاركة، يمكنك ترك هذه الدراسة البحثية في أي وقت. إذا تركت هذه الدراسة البحثية قبل اكتمالها، فلن تكون هناك اي مسؤولية عليك، ولن تخسر أي فوائد تستحقها.

إذا وافقت على المشاركة في هذه الدراسة البحثية، فقم بالتوقيع على هذا القسم. ستحصل على نسخة موقعة من هذا النموذج للاحتفاظ بها. بتوقيعك هذا النموذج لن يترتب عليك أي مسؤوليات قانونية.

التوقيع على هذه الاستمارة فقط إذا كانت العبارات المدرجة أدناه صحيحة:

"لقد قرأت المعلومات المذكورة أعلاه"

تم الإجابة على أسئلتك بما يرضيك حول البحث"

قسم التوقيع للبالغين:

لقد قررت المشاركة في هذه الدراسة البحثية اختياريا.

_____	_____	_____
اسم المشارك	توقيع المشارك	التاريخ
_____	_____	_____
اسم الشخص الحاصل على الموافقة والتفويض	توقيع الشخص الحاصل على الموافقة والتفويض	التاريخ

Appendix C

Participant Recruitment Email

Email script:

Dear (participant),

I hope my email finds you well. I am a graduate student at Nova Southeastern University in the Family Therapy Department. I am conducting interviews as part of my graduate studies in the U.S. You are invited to participate in my study. The purpose of this study is to conduct a qualitative exploration of Saudi family therapists' experience of simultaneously honoring the western worldview of family therapy and the cultural/religious worldview of Saudi Arabia. You are being asked to participate in this study because you identify as a Saudi family therapist, have graduated from a family therapy program in the West, and currently practicing family therapy in Saudi Arabia.

There will be approximately 6 participants in this study; each individual participant will take part in an interview with the researcher. This Interview will be conducted face-to-face in the researcher private home office in Saudi Arabia, if possible, or online through Skype. The interview takes around 60 minutes.

If you are willing to participate please suggest a day and time that suits you and I'll do my best to be available. If you have any questions please do not hesitate to contact Rana Banaja at

+966503632494 or banaja@mynsu.nova.edu

Thank you,

Rana Banaja

Phone script:

Hello, this is Rana Banaja, a graduate student at Nova Southeastern University in the Family Therapy Department. I am conducting interviews as part of my graduate studies in the U.S.

You are invited to participate in my study. The purpose of this study is to conduct a qualitative exploration of Saudi family therapists' experience of simultaneously honoring the western worldview of family therapy and the cultural/religious worldview of Saudi Arabia.

You are being asked to participate in this study because you identify as a Saudi family therapist, have graduated from a family therapy program in the West, and currently practicing family therapy in Saudi Arabia.

There will be approximately 6 participants in this study; each individual participant will take part in an interview with the researcher. This Interview will be conducted face-to-face in the researcher private home office in Saudi Arabia, if possible, or online through Skype. The interview takes around 60 minutes.

If you are willing to participate please suggest a day and time that suits you and I'll do my best to be available. If you have any questions please do not hesitate to contact Rana Banaja at

+966503632494 or banaja@mynsu.nova.edu

Thank you,

Rana Banaja

Appendix D

Participant Recruitment Email in Arabic

نص البريد الكتروني:

عزيزي (المشارك) ،

اتمنى ان تكون بخير وصحة. انا طالبة دراسات عليا في قسم العلاج النفسي الزواجي والأسري من جامعه نوفا ساوث ايسترن. أقوم بإجراء مقابلات كجزء من دراساتي العليا في الولايات المتحدة الأمريكية وأنت مدعو للمشاركة في دراستي هذه. الغرض من هذه الدراسة هو اجراء دراسة نوعية لإكتشاف تجربه المعالجين الأسريين السعوديين في الجمع بين واحترام كلا من النظرة الغربية للعلاج الاسري والنظرة الثقافية/الدينية في المملكة العربية السعودية.

يطلب منك المشاركة في هذه الدراسة لأنك معالج أسري سعودي، وقد تخرجت من برنامج العلاج الاسري في الغرب، وتمارس حاليا العلاج الاسري في المملكة العربية السعودية. سيشارك في هذه الدراسة حوالي ٦ مشاركين؛ كل فرد مشارك سيشارك في مقابله مع الباحث. ستجري هذه المقابلة وجها لوجه في مكتب الباحث الخاص في المملكة العربية السعودية، ان أمكن، أو عبر الإنترنت من خلال سكايب. ستستغرق المقابلة حوالي 60 دقيقه. إذا كنت على استعداد للمشاركة يرجى اقتراح اليوم والوقت الذي يناسبك وسأبذل قصارى جهدي لأكون متاحه في هذا الوقت.

إذا كان لديك اي أسئلة يرجى عدم التردد في الاتصال على رنا باناجة.

banaja@mynsu.nova.edu أو+ 966503632494

شكرا،

رنا باناجة

نص الهاتف:

مرحبا، انا رنا باناجة، طالبه دراسات عليا في جامعه نوفا ساوث ايسترن، قسم العلاج النفسي الزواجي والاسري. أقوم بإجراء مقابلات كجزء من دراساتي العليا في الولايات الأمريكية وأنت مدعو للمشاركة في دراستي هذه. الغرض من هذه الدراسة هو اجراء دراسة نوعية لإكتشاف تجربه المعالجين الأسريين السعوديين في الجمع بين واحترام كلا من النظرة الغربية للعلاج الاسري والنظرة الثقافية/الدينية في المملكة العربية السعودية. يطلب منك المشاركة في هذه الدراسة لأنك معالج أسري سعودي، وقد تخرجت من برنامج العلاج الاسري في الغرب، وتمارس حاليا العلاج الاسري في المملكة العربية السعودية. سيشارك في هذه الدراسة حوالي 6 مشاركين؛ سيشارك كل فرد مشارك في مقابله مع الباحث. ستجري

هذه المقابلة وجها لوجه في مكتب الباحث الخاص في المملكة العربية السعودية، ان أمكن، أو عبر الإنترنت من خلال سكايب. ستستغرق المقابلة حوالي ٦٠ دقيقه. إذا كنت على استعداد للمشاركة يرجى اقتراح اليوم والوقت الذي يناسبك وسأبذل قصارى جهدي لأكون متاحه. إذا كان لديك اي أسئلة يرجى عدم التردد في الاتصال رنا باناجة على و ٠٠٩٦٦٥٠٣٦٣٢٤٩٤ او banaja@mynsu.nova.edu

شكرا لك، رنا باناجة