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Published in *The Family Journal: Counseling and Therapy for Couples and Families* 17:3 (July 2009), pp. 229-235; doi: 10.1177/1066480709337798 Copyright © 2009 SAGE Publications on behalf of International Association of Marriage and Family Counselors. Used by permission. http://tfj.sagepub.com/cgi/content/abstract/17/3/229

Published online June 8, 2009

Therapy with Muslim Couples and Families: Basic Guidelines for Effective Practice

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Abstract

Despite the growing numbers of Muslims in the United States, there is a scarcity of research dealing with mental health practitioners working with Muslim families. This lack of research may leave clinicians unprepared to adequately help Muslim patients and families faced with discrimination and misunderstanding, which may inadvertently lead to the perpetuation of biases in therapy. Therefore, the purpose of this paper is (a) to provide mental health practitioners with foundational information regarding the Islamic faith and the values of the traditional Muslim families and (b) to provide culturally sensitive guidelines for clinical practice.

Keywords: Islam; Muslim; culturally sensitive therapy; religion and therapy

It is clear that, even in the post 9/11 era, and despite the steady increase of Muslims in America, there is a scarcity of research dealing with mental health practitioners working with Muslim families (Carolan, Bagherinia, Juhari, Himelright, & Mouton-Sanders, 2000). This lack of research may leave practitioners unprepared to adequately help Muslim patients and families faced with discrimination and misunderstanding. In fact, reports have shown a wide variety of discrimination experienced by American Muslims since the terrorist attack in New York on September 11, 2001, with the highest number of Muslim civil rights complaints ever being reported to the Council of on American Islamic Relations (CAIR) occurring in 2006 (CAIR, 2007). In particular, the discrimination appears to be based on ethnic and religious beliefs. This increase in discrimination may lead more Muslim Americans to seek mental health services to cope with the fear, anxiety, and stressors evoked by the experience of discrimination (Ali, Liu & Humedian, 2004).

In addition, there are many stereotypes and misconceptions about the Islamic faith that may perplex and even prejudice educated professionals (Ali, Liu, & Humedian, 2004). Consequently, mental health providers need some understanding of Islamic faith—especially when working with recent immigrants (Rasheed Ali & Ming Liu, 2004), which may be a "key to counseling" success (Carter & Rashidi 2003, p. 399). As a result, culturally-sensitive mental health practitioners need to be somewhat familiar with the religious beliefs, customs, and traditions of Muslim clients so they will be better able to help and engage Muslim Americans in mental health services (Hedayat-Diba, 2000; Rehman & Dziegielewski, 2003).

The purpose of this article is to address important service and practice implications for mental health practitioners by addressing the following issues: (a) Important Islamic tenets and practices and (b) Linking beliefs and barriers to engagement to general principles of therapeutic intervention. These guidelines may be useful to family therapists, counselors, social workers, and psychologists who provide services to Muslim individuals, couples, and families regardless of one's theoretical orientation (Hall & Livingston, 2006).

An important preface to the discussion of Islamic tenets and practices is the need for mental health practitioners to create a context for understanding. Practitioners are encouraged to merely observe the tenets and to

aim for a basic comprehension. A postmodern stance of curiosity or "not-knowing" is encouraged (Anderson & Goolishian, 1992). A "not-knowing" stance encourages understanding outside of one's own experience and allows practitioners to more fully engage in the realities of their clients. This stance is critical when working with any client who is culturally-different. However, this is particularly important when working with Muslim clients in that many beliefs and practices initially appear to run counter to the dominant American culture. At risk is that mental health practitioners may unknowingly reinforce the discrimination that brought their clients into their offices in the first place. The key point here is to avoid viewing diverse cultures through the same assumptions of one's own cultural lens. Suspending one's cultural assumptions and favoring a curious stance of genuine not-knowing is a critical step for every non-Muslim practitioner in working Muslim clients.

WHAT IS ISLAM?

Islam is the second largest and fastest growing religion in the world, preceded only by the Christian faith, with approximately 1.3 billion adherents (Esposito, 1998; Kobeisy, 2004). In fact, it is estimated that there are between 6 and 8 million followers of Islam, or Muslims in the United States, of which 75% are immigrants and 25% have been born in America (Al-Krenawi & Graham, 2005). Though connected by the common thread of Islam, there is great diversity in the Muslim population where native customs and traditions modify the practice of Islam and bring variations to family life (Asian, 2006). For example, Muslim immigrants come from Indonesia, Pakistan, India, Bangladesh, Turkey, Iran, Egypt, and Nigeria. Consequently, the majority of Muslims in the United States are not Arabs from the Middle East and do not speak Arabic, with the exception of reading the Qur'an and saying prayers.

The religion of Islam originated in Arabia in the seventh century with the life and ministry of Muhammad (570 CE–632 CE). Over a period of 23 years, Muhammad received revelations for Allah, which after his death were eventually compiled into the Holy Qur'an in about 670 CE. Muslims are not a monolith, but are divided into various sects with slightly different beliefs and practices. The two major groups are the Sunni who comprise about 80% of all Muslims and the Shia at about 15% of the Muslim community. The Shia are divided into five sects who live mostly in Iran, Iraq, Lebanon, and Yemen.

The Qur'an is believed to be God's perfect words, and the hadiths are examples of the exemplary model of Muhammad. Muslims read the Qur'an daily and consult hadiths when making personal and family decisions (Sherif, 1995). Islam literally means "submission" to Allah, and so believers must surrender their wills to God in all things from the time they get up in the morning to pray until they go to sleep at night. "The [Qur'an] holds directives for life to which all [Muslims] must submit" (Hall & Livingston, 2006, p.143). Islam is a way of life not a token faith of selective beliefs and periodic practices.

Five basic principles are universally accepted by all Muslims and serve as the "foundational principles" of their life (Ali et al., 2004: Esposito, 1998), known as the Five Pillars of Islam. These pillars include: (a) the shahadah, the profession of faith that there is only one God, Allah, and that Muhammad is the messenger of God, (b) salat, the five daily prayers, (c) sawm or fasting during the month of Ramadan, (d) zakat, giving charity to the poor, 2.5% of one's profit, and (e) the hajj, the pilgrimage to Mecca at least once in a lifetime if health and finances permit (Haneef, 1996). Muslims share many general beliefs with other faiths. For instance, Muslims believe that a person who lives a moral life on earth will be resurrected and earn peace and companionship forever in paradise or jannah (Hedayat-Diba, 2000). Thus, life is a test to see whether one will obey God and follow his principles of right living. Muslims also believe in sin and repentance. Sins are thoughts and actions forbidden by God that are hurtful to self or harmful to others. These include pride and arrogance, gossiping and slander, lying and theft, murder, adultery, disrespect of parents, greed, oppression of the poor, abuse of family members, and negligence in performing the Five Pillars of Islam.

In addition to the Qur'an and hadiths, there is a third component of Islam, Shariah law (i.e., the way or the path), that governs much of Muslim behavior in many countries such as in Iran, Nigeria, Sudan, Pakistan, Afghanistan, and Saudi Arabia (Hashim Kamali, 2008). In Iran and Saudi Arabia, Shariah law is the primary legal system, while in Indonesia, Bangladesh, Turkey, and India only certain aspects of Shariah family law are incorporated into the states' legal systems. These laws are so important that Shariah courts exist and operate in many European cities such as London, Paris, and Amsterdam (Islamic Shariah Council, 2008). In London, for example, Sheikhs (i.e., religious scholars) issue fatwas (i.e., rulings) primarily on family matters such as marriage and divorce, child custody, and inheritance, but their edicts are usually subject to local secular laws and civil courts. Surprisingly, some aspects of Shariah law have even been incorporated into the legal system of a few countries in Europe. In the United Kingdom, for example, welfare payments can now be made to Muslim men who have more than one wife (Wynne-Jones, 2008).

Ideally, in Islam there is no separation of church and state as occurs in Western democracies (Lewis, 2002). The religion and the state are one entity—both governed by religious principles and regulations. Thus, Islam is a religious, social, and political system. Many Muslim immigrants in America have been influenced by Shariah law and this affects what they believe to be right or wrong conduct both in their own families and in the wider social milieu. Although Shariah law does not gov-

ern American society, some understanding of this aspect of Islam is recommended for those who work with Muslims. Even in a few large cities in America, such as Chicago, local Shariah courts may mediate some family problems such as divorce, alimony, and child custody.

Additional examples of Shariah law include the prohibition of usury (i.e., lending money with interest), which is forbidden in the Qur'an, thus banks in many Muslim countries cannot charge interest on loans. The Qur'an states that fornication and adultery are great sins and under Shariah law (in some countries) the penalty may be flogging the fornicator and stoning the adulterer. Modesty in dress is enjoined in the Qur'an, and in many Muslim countries women are required by law to wear head scarves, long-sleeve shirts, and full-length dresses that cover the feet. The intent of this law is to respect and protect women from impure thoughts or actions of men. In the Qur'an, God requires adult children to care for aged parents, so Shariah laws mandate that adults provide housing, food, and health care for their elderly parents. Alcohol is forbidden in the Qur'an, thus in most Muslim-majority countries, it is illegal to produce, transport, or sell alcoholic beverages (Denny, 1994).

One last important element of Muslim life is the community of believers, the ummah (Haneef, 1996). In general, traditional Muslim societies are collectivistic not individualistic. Regardless of country of origin or ethnicity, Islam teaches that all Muslims are brothers and sisters. The ummah supersedes loyalty to the host country or to any particular sect of Islam. Muslims should help one another and aid those in distress due to famine, war, or any type of religious repression. The ummah includes first and foremost one's extended family, followed by friends from the mosque, local religious leaders, merchants, teachers, bankers, and health care providers who are Muslim.

These people are knit together by shared religious beliefs (i.e., the Five Pillars), customs, rituals, festivals, and a common set of values. Therefore, a Muslim family is not an isolated unit but is part of a greater whole, the "ummah." This community has the potential to meet many of the emotional needs of its members and provide channels for talking about personal or family unhappiness and distress. Distressed Muslim couples are enjoined by the Qur'an to first seek reconciliation by consulting one or more relatives from each side of the family. The wife as well as the husband can choose a mediator. Thus, within-family mediation is the first line of defense against separation and divorce, not professional counseling (Adbul-Rauf, 2007). This is one reason why Muslims may not feel the need for professional therapy.

In the family, there is also a strong emphasis on the collective whole rather than the individual wants and needs of family members. Family well-being is fostered by cooperation, mutual dependency, sacrifice, loyalty, and conforming to expected roles and behaviors (Ali et al., 2004). This flies in stark contrast to Western values of individuality, independence, and self-sufficiency, which are an anathema to Muslim family life (Carter & Rashidi, 2003). In fact, pleasing others (mosayara) is more important than personal freedom and self-expression. Loyalty, obedience to parents and religious leaders, and conformity to cultural norms and family expectations is required.

PATRIARCHAL CULTURE

The patriarchal family is the most common type of Muslim family and typically dictates that family members observe specific customs and rules as directed by the head of household. In fact, Chaleby (1992) argues that the collectivistic nature of the family affects the individual concept of himself or herself as an independent person. Consequently, the concept of autonomy, as encouraged by our Western Culture (and many therapists), would be in direct conflict with their world view, and could lead to further alienation of that individual from his or her support group. Although this patriarchal culture places men in a dominant position over women and may be viewed as oppressive by Western Culture, it does have important influences in helping families deal with crises. For example, the patriarchal unit plays a critical role in strengthening family ties, creating a broad support system for family members, and clearly defining family roles (Chaleby, 1992).

Traditional Islamic patriarchy requires complementary gender roles (Haneef, 1996). Wives should care for the children, protect and manage her husband's household, and perform all domestic chores. With her husband's permission, the wife may work outside of the home but she is not required to do so. A wife's job opportunities, however, vary by country, by religious orthodoxy, and by the personal preferences of the husband. For example, many married women work outside of the home in Turkey, Iraq, and Indonesia while most women in Iran, Pakistan, and Saudi Arabia do not (Roald, 2001). Though Muslim women may be restricted to domesticity, women in general are encouraged to get an education and learn useful skills (Abi-Hashem, 2008). Men are expected to be breadwinners and to be good examples of faith and right living on the straight path of Islam.

Other manifestations of patriarchy are arranged marriage and family honor. Arranged marriage is commonplace even in America. Compatibility based upon similarities in age, ethnic heritage, religious sect, education, and religious piety are considered the basis for marital happiness not romantic love or sexual passion (Adbul-Rauf, 2007). The mother usually finds a prospective partner through relatives and close friends. Then she and her husband gather information on the possible son-in-law or daughter-in-law. If they agree, then the name is presented to the son or daughter for consideration. If the son or daughter agrees then the wedding is planned.

Family honor is determined by the social and sexual behavior of any and all unmarried daughters. Unmarried women, including teenagers, must not associate with marriageable men in any context without proper supervision. A girl who meets in private or goes on dates without proper supervision may bring disgrace to the family. If she engages in any type of sexual behavior—even kissing and hugging— it is a serious breach of family honor (Goodwin, 2002). In fact, in many Muslim families, adolescents are not free to date or even attend social activities (e.g., parties, dances, concerts) where boys and girls can mix freely without adult supervision. Unmarried daughters such as those in college or those working are often not allowed to live independently because of the possibility of unsupervised mixed-sex interaction. Lack of awareness of family honor by therapists when dealing with Muslim families may lead to additional conflict, or the pushing one's cultural values. This could be especially true when working with parent-adolescent issues.

THE CONNECTION OF RELIGIOUS BELIEFS TO THERAPEUTIC INTERVENTION

Although the basic tenets of Islam have a direct bearing on working with Muslims as a therapist, it is also critically important to become familiar with the cultural expectations of the broader family. Additionally, this familiarity with the broader cultural expectations must also occur in concert with not ignoring the individuality of the person. Carolan et al. (2000) articulated that one must be able to strike a "balance between ethnic understanding and sensitivity with awareness of the commonality of the human experience" (p. 69). In other words, while cultural and religious components are important to understand, sensitivity to the uniqueness of each individual client may be a prerequisite to doing good therapy (Carolan et al., 2000).

In the following section, we will present specific practical guidelines when working with Muslim families that in many cases will make intervention more manageable and effective. We give these practical guidelines with a word of caution that they cannot apply to all cases and all situations. In fact, Muslim families vary considerably due to ethnicity, sect of Islam (e.g., Sunni, Shia, Sufi), religious devoutness, extent of integration into American society, if they are recent immigrants or native born Americans, and their unique personal and family values. These guidelines are just broad-spectrum suggestions that may assist the family therapist, in giving help and support to Muslim individuals, couples, and families.

ASSESS YOUR BIASES

First, the therapist should evaluate his or her own biases and prejudice toward the Islamic faith and Muslims in general. Very few Muslims are Islamic radicals or militant jihadists. Most adhere to the nearly universal value of "Live and Let Live." Sometimes a therapist may let personal issues get in the way of helping the client. For example: Do you think Muslim women are oppressed by a patriarchal family system? Do you believe that homemakers are inferior to women who work outside the home? Do you think that adolescents should have the freedom to date, attend social functions, or engage in sexual behaviors? Such closely held opinions may frustrate a therapy session with Muslim clients. Consequently, self-of-the-therapist issues are an important component of any good therapy and can aid mental health providers in recognizing one's owns biases or strengths when working with this population.

In addition to assessing personal biases, it is also important to critically evaluate biases of one's theoretical model of practice. Mental health providers need to ensure that they are using their theoretical models in a culturally flexible manner. This is particularly important for the Modernist theoretical models which posit the presence of universal assumptions about healthy family functioning. Clinicians can use this new information about Muslim culture in order to recalibrate their hypothesizing and conceptualization in a culturally-informed manner. In doing so, theoretical assumptions of how family hierarchies should or should not be aligned and healthy levels of closeness and distance, for example, can then be culturally relevant to Muslim clients.

ENCOURAGE THE RELUCTANT CLIENT

Many Muslims, depending upon education and occupation, time in country, and religious devoutness, are disinclined to seek mental health services because of their belief that Islam should provide all the answers to personal and family problems (Sayed, 2003). God is the definitive source of truth and knowledge and it is to him one should petition for guidance and support. Consequently, God is viewed as the ultimate helper (Barise, 2005). Thus, a troubled husband, wife, or parent may be more likely to consult a sheikh at the mosque than a secular, non-Muslim therapist. Because of this orientation, it would be prudent for the therapist to perform a brief religious history to understand how devout the family is, how they practice religion, and whether they perceive a connection between the presenting problem and some sin or laxity of faith (Chaleby, 1992; Hedayat-Diba, 2000). It is sensible to determine the degree of difference in religiosity between parents and adolescent children as this may be an issue in parent-child conflicts.

DETERMINE LEVEL OF ACCULTURATION

When working with culturally diverse clients, it is important for mental health practitioners to assess for level of acculturation. Acculturation is commonly defined by

generation within the United States, preferred language, linguistic proficiency, and social activity (Burnam, Hough, Karno, Escobar, & Telles, 1987; Marin & Gamba, 1996; Paniagua, 2005). Family members in later generations are generally assumed to have the highest level of acculturation and family members in the first generation the lowest level. Questions that target one's preferred language or linguistic proficiency when speaking with others and the cultural diversity of those with whom one prefers to engage in social activities are additional ways to assess level of acculturation. The more one prefers to speak in his or her native language with others and the more one prefers to socialize with others within his or her racial or ethnic group, generally, the lower the person's level of acculturation, and vice versa. Thus, determining each family member's level of acculturation helps to inform assessment and subsequent treatment planning.

DON'T RUSH THERAPY

Take time to develop a warm and trusting relationship before beginning a formal intake assessment. The therapeutic alliance may require extra time and effort by the mental health practitioner. Therefore, do not just dive in and ask about personal and family issues prior to developing a relationship of trust. For example, it would be inappropriate to ask sensitive questions on the first visit such as: "Were you ever abused as a child?" "Have you ever abused a family member?" "Have you ever considered suicide?" "Do you have a drinking or gambling problem?" These questions directly affect family honor and personal shame. Because of this, Muslim clients may feel like they are betraying their family by divulging inappropriate behaviors by self or other family members. Dr. Abi-Hashem puts it nicely: "Inquire gently! Be patient. Do not demand information or put pressure on them to quickly disclose their issues or to completely describe their pain, needs, etc." (Abi-Hashem, 2008, p. 165).

BE RESPONSIVE TO A DIFFERENT COMMUNICATION STYLE

Communication about family problems is more indirect than direct, more closed than open, more reserved than expressive, and more reluctant than forthcoming (Abi-Hashem, 2008). Because family honor and personal shame are at stake, Muslim clients may not quickly and honestly divulge personal and family problems. Marital issues may be difficult to articulate. The client may not respond openly and frankly to direct questions such as: "How do you feel about your spouse? What are your major concerns about your marriage?" Muslim clients may be reluctant to express negative thoughts or emotions such as "My father-in-law is demanding and critical" or "I am angry and disappointed in my son or daughter." It is important to understand that in Muslim families indirect and implicit communication is preferred. Do not "misinterpret shyness, slow self-disclosure and low expressiveness, periods of silence, or minimal eye contact as defensiveness, resistance, or lack of interest in participating" in therapy (Abi-Hashem, 2008, p. 164).

BE A LEARNER

Ask the client to teach you about Muslim culture and religion so you can more fully understand the context of the client's situation. Talk with the clients about how religious values and practices impact current personal or family problems. For example, mental health problems may be interpreted as God's punishment for past sins or even as possession by evil spirits (jinn). The Arabic word for mental illness or insanity is "jinnoon," derived from the noun jinn, which means devil or evil spirit. Thus, a treatment plan may involve the blessing and prayers of a Muslim religious leader, reading the Qur'an, and fasting. Therapists who take a not-knowing stance and are open to use their clients' faith and beliefs in the treatment process may experience less resistance and ambivalence from them.

ASSESS HISTORICAL STRESS

Some recent Muslim immigrants, such as those from Bosnia, Sudan, Nigeria, Iraq, Afghanistan, Somalia, and Palestine may have suffered serious psychological trauma, physical harm, or "prolonged and unresolved grief" due to war, armed conflict, assault, kidnapping, and even the murder of family members (Abi-Hashem, 2008). Many may have lived in refugee camps and other temporary settlements in three or four countries before finally immigrating to America. The residual pain and suffering endured, often over many years, may leave clients vulnerable to Posttraumatic Stress Disorder, depression, anxiety, and more serious psychotic disorders. Thus, an immigration history is warranted where the client describes where they have come from, what they have endured in the country of origin, as well as any discrimination they have experienced in America (Nasser-MacMillan & Hakim-Larson, 2003). As part of this assessment, it may be prudent for the mental health providers to ask about polygamy, as a male immigrant to America may have another wife in another country (Hassouneh-Phillips, 2001).

USE CAUTION WHEN USING DIAGNOSTIC SCALES AND INVENTORIES

Psychological testing using standard American-made instruments may lack validity with Muslim clients. "It is essential to remember that the vast majority of avail-

able tests were originally designed and standardized in the West. As a result, they reflect the psychoemotional structure and cognitive-mental views of this group" and have serious limitations if applied to Muslims, especially to new immigrants (Abi-Hashem, 2008, p. 147). For example, Olson's (1991) measure of family cohesion, adaptability, and communication (FACES) when used with Muslim clients may indicate enmeshment, role rigidity, and restrictive communication, but these results are not necessarily dysfunctional in Muslim families (Daneshpour, 1998). Relationship inventories that assess equality in household chores, parenting duties, and joint decision making may give a false impression of Muslim family life.

RESPECT THE ROLE OF FATHER IN MUSLIM FAMILIES

Muslim families are usually patriarchal, meaning the husband or father is the authority figure in the family. Thus, it is important to get his trust and support to treat other family members. If the father becomes alienated he may pull the plug on therapy for the entire family. Show him respect and keep him involved in all family discussions. Remember that there are clearly defined gender and marital roles in Muslim families and that "changes in the role of the wife are one of the most important reasons for marital problems" (Al-Krenawi & Graham, 2005, p. 305). However, although gender and marital roles may appear rigid and confining, they may be quite functional for many Muslim families.

BE AWARE OF THE WHITE COAT EFFECT

Clients may defer too quickly and easily to advice given by the counselor or therapist because of the unconscious feelings of shame or assumed inferiority engendered while living in a Western, mostly Christian country. Submission to authority is a general Muslim belief and this may be carried into the therapeutic setting (Hedayat-Diba, 2000). Thus, the mental health provider should make a special effort in creating a therapeutic alliance with the client so the client has input into the therapy process. Collaboration, when clinician and client both take an active role in diagnosis and in determining the treatment plan, is paramount.

LOOK FOR THE "INSHALLAH" MINDSET

Some Muslim clients may take a fatalistic view of life and believe that all things that happen are as God wills it, which is commonly expressed in the Arabic slogan "inshallah" (as God wills it). The client may believe that one must accept life as it is—for all things are under God's control. In fact, Hedayat-Diba (2000) further supports this mindset and argues that this tendency to resign oneself to God's care can also lead individuals to neglect or deny symptoms they may be experiencing. Thus, a client may feel helpless and unable to make changes that would benefit him or her. The therapist may then ask the client about the concept of free will and self-determination. For even in the Qur'an, Allah says: "God does not change people until they change themselves" (Ali, 2002).

ASK ABOUT THE PROPRIETY OF MIXED-SEX INTERACTION

Islamic customs mandates that a husband or a wife should never be alone with a nonrelative adult of the opposite sex in any situation. While for second and third generation families, this issue may not be as pertinent, it is nonetheless a potential issue in therapy. Consequently, therapists should be aware of this custom, and ask clients, in the first session, whether this would prohibit you from working with them or any other family member during the course of therapy. This will allow the clients to articulate their values, concerns, and beliefs regarding this issue, and provide an opportunity to find solutions. For example, cotherapists or additional referrals may be a potential solution to this problem (Engineer, 2008).

CONCLUSION

It is clear since the 9-11-2001 terrorist attack in New York City that many Americans have little knowledge of the Islamic religion, and how that faith influences Muslim individuals and families. In fact, Ali et al. (2004) argue that they remain one of the most misunderstood communities in the United States. It is our belief that mental health practitioners can gain much from understanding who Muslim Americans are and the role that Islam plays in their everyday life in providing culturally congruent mental health services. Ultimately, when working with Muslim families, mental health practitioners are encouraged to lead with a stance of openness and practice the ability to conceptualize and intervene through each client's cultural lens. This is similar to how therapists are able to maintain multidirected partiality in working with multiple family members with differing viewpoints (Boszormenyi-Nagi & Krasner, 1986). It may be the clients who have differing cultural viewpoints, and/or it may be that parents and children within a family have different levels of acculturation. Regardless, mental health practitioners' learning about the family through a not-knowing stance and then adapting their theoretical models enables them to honor multiple perspectives and still work toward a common goal. In essence, the ability to do culturally-informed practice with clients who are culturally different is equifinality at its finest!

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