Gender, Power and Ethnicity in Cultural Consultation

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The young women with amber skin, hair and brows of black
as crows' wings, eyes of lionesses in heat,
dressed in silks of delirious hues…
they wander through foreign rooms in the last daylight of the century
painting their eyes…
somewhere out of them, alive or dead I have sprung
yet no one seems to recognize me.

From: "Ancestors" by Rishma Dunlop (2004, p. 31)

Introduction

Gender, power and ethnicity are universal factors in structuring clinical work, influencing the therapeutic alliance, transference, countertransference and the processes of assessment and intervention. In any clinical encounter, the identity of the clinician influences the process, but these issues are thrown into relief when the clinician comes from a visible minority or racialized group (Fernando, 1991; Pinderhughes, 1989; Tummala-Narra, 2004, 2005). While clinicians' personal backgrounds, including the dynamics of their family of origin, are always relevant in clinical work (Catherall & Pinsof, 1987), this dimension is especially important for consultants from minority backgrounds, whether working individually or as members of multicultural teams.

To illustrate the interplay of gender, power and ethnocultural identities in clinical work, this chapter will present CCS cases seen by two South Asian origin consultants and a French-Québecois child psychiatrist (CR) trained in Canada with extensive South American and European experience. The South Asian therapists were a third-generation Indian origin, Canadian-trained

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child psychiatrist (JG) with clinical experience in Canada and India and a first-generation immigrant to Australia (RSM), with training and clinical experience in India, Australia and Canada as a child and family clinical psychologist. The cases we present were chosen because they show how the ethnicity and gender of the minority clinician can evoke a range of systemic, cultural and dynamic issues in work with a heterogeneous South Asian clinical population. In addition to the consultants' reflections, these issues were further analyzed and discussed at the weekly CCS case conferences where the consultants, referring clinicians, colleagues and students all contributed to case formulation. These interdisciplinary case conferences played an important role in highlighting systemic factors and understanding the dimensions of power, ethnicity and gender. As the case material will illustrate, the South Asian clinicians embodied the host country's institutional power and its deficiencies, and yet the fact that they also shared background and identity with patients allowed them to represent or mirror the shifting experiences of vulnerability and strength of patients and their families at intrapsychic, intra-familial and sociopolitical levels.

Contextualizing Clinician Identity and Training

The seminal work of Fanon (1961, 1967) drew attention to the power of gaze of the Other as a mediator of racism and to the cultural scotomas that blind participants to this destructive power. Fanon's reflections on his experience as a Black psychiatrist treating both the White colonist and the colonized subaltern provided the first in-depth analysis of the impact of colonialism on the clinician's own identity. His reflections also propelled subsequent work in postcolonial studies, addressing the social meanings and power dynamics of race, class, gender, ethnicity, nationality and language (e.g., Davar, 2009; Gilroy, 2004; Nandy, 1980; Said, 2003a, 2003b; Spivak, 2006). This literature is particularly relevant to minority clinicians, who themselves are part of diasporic peoples and must regularly negotiate expressions of power, prejudice, identity and cultural dissonance that reflect this colonial history (Akhtar, 1995; Hickling, 2007; Fernando, 1995, 2002; Kareem, 1992; Maiter & Stalker, 2011; Young-Bruehl, 1996).

Earlier work on the racially or culturally different clinician has identified multiple ways in which these socially constructed identities influence clinical work, including racial bias, cultural countertransference, as well as culturally or historically rooted phantasy (Adams, 1996; Akhtar, 1999; Holmes, 1992; Kareem, 1992; Tummala-Narra, 2007; Young-Bruehl, 1996). Effective cultural consultation requires an awareness of the constraints of these factors on clinicians' agency, engagement and positioning as well as on clients' responses (Bhui & Bhugra, 2002; Kareem, 1992; Maiter, Stalker, & Allagia, 2009). The process of cultural consultation strives to create conditions that promote cultural safety (Kirmayer, 2012; Williams, 1999). The clinician's identity is integral to the process of creating cultural safety by bringing other perspectives to clinical assessment and intervention. Though an initial positive alliance may be strengthened by language, gender or ethnic match of therapist and clients, these same factors can also disqualify or disempower the clinician. In this chapter, we will use clinical vignettes from the work of the CCS to illustrate this process in the work of South Asian female consultants. The need to protect confidentiality limits our discussion of how the cases are complicated by the unique heterogeneity and hybridity of South Asian diasporic communities and families, but the cases reveal some of the common predicaments associated with migration and acculturation (Bhugra, 2004; Guzder, 2011; Fernando & Keating, 2009; Akhtar, 2005). Despite the apparent ethnic matching, clinician and client may be similar only in skin color or limited shared cultural knowledge, and the consultation often requires the presence of interpreters and culture brokers to bridge gaps in communication and mutual understanding. The superficial appearance of similarity can result in an initial positive alliance, as well as resistances

that undermine cultural safety. In addition, the female consultant may face power issues embedded in traditional South Asian-gendered hierarchies that mirror patients' individual or family predicaments in the North American context.

While mainstream Euro-North American culture has integrated a variety of psychotherapy approaches to deal with mental health problems, South Asian societies tend to deal with distress and conflict through culturally embedded frameworks that include familial and religious strategies (Kakar, 1982; Chaudhry, 2008; Rahman et al., 2009). Cultural consultation aims to understand these frameworks and integrate them into clinical work with migrant families and individuals (Akhtar, 2005; Comas-Diaz & Greene, 1994; Malat, van Ryn, & Purcell, 2006; Tummala-Narra, 2004).

Diverse pathways of migration, generational differences, sociopolitical histories, religious and faith-based practices, caste hierarchies and familial and community dynamics all impact on the integration and assimilation patterns of the South Asian diaspora. Since each family member may acculturate in markedly different ways, they may view the consultant in different ways through processes of cultural transference that reflect these different realities and phantasies. The conflicts, resonances and dissonances that surface in cultural consultations challenge clinicians' professional training which is rooted in mainstream Eurocentric models of developmental psychology and psychotherapy. Though the South Asian clinicians brought culturally informed understandings of these families, as well as linguistic competence in several languages of the Indian subcontinent (Tamil, Gujarati, Hindi, Urdu and Punjabi), the consultations demanded rethinking their own sociopolitical and historical positioning as well as some of the assumptions of standard mental health theory and modifying practice to include the use of interpreters or culture brokers from the community.

The clinical literature documents the ways in which migration and culture change lead South Asians to experience shifts in roles or power, as well as problems of institutional and familial dissonances (Abbasi, 2008; Bhugra, 2004; Davar, 1999; Guzder & Krishna, 2005; Maiter & Stalker, 2011; Maitra, 2006; Singla, 2005; Tummala-Narra, 2007). There is also a substantial interdisciplinary literature exploring historical, cultural, caste, political and legal dimensions of South Asian subaltern and female identity (Guha & Spivak, 1988; Lau, 1995; Thapan, 1997; Uberoi, 1999). Gender and power emerge in this literature as critical issues which often silence subalterns, women and children (Jack & Ali, 2010; Spivak, 2006). Silencing of women within the gendered hierarchy inhibits their self-expression, agency and power but secures the homeostasis of the family system or social group by avoiding potential escalation of conflicts, with retaliation, loss or injury to other family group or community members. By integrating aspects of attachment theories, relational theories and cognitive theories of depression, the "Silencing the Self" model (Jack & Ali, 2010, p. 7) can help explain the increased vulnerability to depression and suicide found among South Asian women in some contexts (Guzder, 2011).

Negotiating Gender and Power in South Asian Immigrant Families

South Asia has enormous cultural diversity, yet there are commonalties in traditional norms not only with regard to collective value systems that contrast with the emphasis on individualism in the West (Bhugra, 2004; Fernando, 2003; Kakar, 1997; Roland, 1991) but also with regard to women's roles both within and outside the family (Eilberg-Schwartz & Doniger, 1995, 1996; Guzder & Krishna, 1991; Thapan, 1997; Trawick, 1990; Uberoi, 1999). Traditional structures of caste or religious affiliation, which provide a sense of continuity, meaning and identity, may contribute to social or systemic stability and protect families and individuals from some of the destructive effects of poverty, caste, war or other adversities. Compared to women, South Asian men traditionally inherit a familial status that confers more privilege and power. Women often negotiate power more indirectly within the family, accumulating power within gendered

hierarchies based on the status of their natal family, motherhood, the birth of sons and the accrued respect of age (Guzder & Krishna, 2005). There is a split in the cultural roles of women in these societies who may be idealized and revered as matriarchs and yet, in reality, may remain devalued and undermined within the patriarchy (Kakar, 1990; Guzder & Krishna, 1991). Though feminine status seems to be promoted by the mythical status of the goddesses, the revered position of religious renunciants, the popular admiration of Bollywood stars or limited numbers with prominent roles in political and economic elites, in reality, most women in traditional South Asian families continue to struggle with issues of voice, agency and power. Tensions between cultural idealization and devaluation of the feminine may emerge in migratory contexts and are complicated by social class, caste and other divisions of power. As a group, South Asian women are also vulnerable to social injustices including foeticide, dowry death, physical abuse and rape (Guzder & Krishna, 1991, 2005). These injustices are maintained by gendered hierarchies, as well as unequal legal status and socio-economic standing. Kakar (1989) and Obeyesekere (1990) have suggested these inequities are also psychologically maintained by issues of sexual ambivalence and intrusive dependence (Kakar, 1989). Women's identities are organized around mythical and cultural ideals enacted in laws, moral codes and ritual practices which strive to maintain cohesion and homeostasis of family hierarchies. Boundaries of sexual purity or restraint versus impurity or transgression (Doniger, 1999; Douglas, 1966; Spivak, 2006; Thapan, 1997) are often constructed in terms of the honor (*izzat*) of family, clan or menfolk (Guzder & Krishna, 1991). *Izzat* (a Hindi, Urdu and Farsi term) refers to a code of honor prevalent in the northern Indian subcontinent regions. The concept of *izzat* not only maintains perceptions and codes of social conduct but also is tied to the reciprocity of families or groups who must strive to settle social debts after violations of honor codes, including, in some instance, seeking revenge through "honor killing" (Coomaraswamy, 2005; Jafri, 2003; Penn & Nardos, 2003). This cultural embedding encompasses sexual purity, social conduct and honor. These agendas are challenged by migration and modern lifestyles, which may increase options for autonomy and identity differentiation for women and children in urban, cosmopolitan places, expanding their capacity to resist devaluation or abuse. Contemporary social realities of the Indian subcontinent offer increasing options for women as evolving cultural, social and political contexts have opened new possibilities for identity, gender roles and agency. Despite these changes, a 2007 research report prepared by the Indian Government on child abuse indicated that a majority of girl children wished they had been born male (Kacker, Mohsin, Dixit, Varadan, & Kumar, 2007).

In the past 20 years, migration of South Asian families to Canada has increased and included more families escaping pre-migratory trauma such as civil unrest, war or torture in parts of Sri Lanka, Bangladesh, India, Nepal and Bhutan. Some families bring preexisting fragility while others transplant frames of reference such as enduring caste conflict or honor codes. In the Quebec context, social changes since the 1970s have emphasized gender equality and displaced traditional Catholic attitudes to marriage and women's roles in favor of more flexible definitions of family and couple relationships. The political expectation for immigrants and their children has been on rapid acculturation to Quebec values and language. Quebec society has focussed on its own vulnerability as a francophone society trying to maintain its language and culture in the predominately English-speaking North American context. This has led to a shift in political language from the multiculturalism embraced in the rest of Canada to the notion of *interculturalism*, which acknowledges Quebec as a distinctive culture interacting with the traditions of newcomers. The diversity of the metropole of Montreal and the increasing proportion of non-European immigrants to Quebec have stimulated debate on "reasonable accommodation" around the extent to which mainstream institutions should be altered to meet the needs of newcomers (Bouchard & Taylor, 2008). Although Quebec has both French and English public school systems,

with the passage of the Charter of French Language in 1977 (Bill 101), all immigrant children, including those for whom English was their previous language of instruction, must attend a *class d'acceuil* (welcome class) to prepare them for integration into French schools. As a result, in most of the case histories we present below, the children speak French, English and multiple Indian dialects to varying degrees, while their parents and the South Asian origin consultants often spoke English and Indian dialects. In many cases, therefore, the adults have less mastery of French than the children, further complicating processes of identification and acculturation.

Local host culture tensions sometimes compel immigrant families to redefine or reorient their structure and functioning by shifting developmental positions and assigning new roles to members. With shifts from extended to nuclear family, each generation and gender may encounter new and unexpected pressures and predicaments (Akhtar, 1999). Studies in India of culture change with urbanization and shifts in traditional family structure indicate that both adolescents and women are particularly vulnerable to increased mental disorders due to the way these changes affect family life (Carstairs & Kapur, 1976; Goodman, Patel, & Leon, 2008). Atif Rahman and colleagues (2009) have shown that the risk of depression among young Pakistani women increases with marriage and disturbed family relationships. In a large sample of Goan adolescents, Pillai et al. (2008) found that families adhering to traditional constraints or values had adolescents with very low rates of mental disorders, while families living in the metropoles that offered more autonomy choices experienced rates comparable to those of Euro-North Americans.

Migration can bring both successes and losses for South Asian men who may experience unanticipated upheavals in their personal and family identity with social dislocations and an increase in some mental disorders (Bhui & Bhugra, 2002). The loss of male peers and role models, shifting positions in the extended family system, challenges to the entitlements of patriarchal power and loss of culturally sanctioned mediators, such as trusted extended family members, are some of the factors that may undermine previously adaptive identities and coping strategies. While some men respond to the challenges of migration with resilience, others may experience intense resistance to change, and the stresses of acculturation may result in substance abuse, gambling, domestic violence or other mental health problems. Some of these men perceive little compensation for their losses after migration to Western societies, especially if their roles as providers, positions of power and self-esteem are undermined. For men, the changes in status associated with migration may intensify issues of shame or dishonor and increase the risk of violence related to perceived threats to family or group honor (Guzder & Krishna, 1991; Ghosh, 1994).

In contrast, South Asian women, although affected by changes in family networks, support, mediators and role models (Uberoi, 1999), may find themselves in a host society which affords them new options for negotiating power and economic possibilities that allow greater independence or autonomy for themselves and their children. Legal rights, including the option of leaving abusive spouses, divorcing and retaining child custody rights, are new possibilities for these women. Those who choose the path of separation or divorce may be distressed by the loss of support from the extended family even if they are relieved to escape from oppressive family situations (Guzder & Krishna, 1991).

Both men and women may be compelled in varying degrees to undertake a transformation of values and renegotiate their marital relationships as they adapt to new realities post-migration. Research documents the increased socioeconomic status of second-generation Canadian South Asian immigrant women, who surpass their male counterparts (Ghosh, 1994). These women face fewer social obstacles to economic advancement post-migration than they encountered in their societies of origin.

Encountering a female South Asian therapist in a clinical setting inevitably raises issues about the rescripting of gender norms with migration. The female clinician may be viewed ambivalently as a substitute for traditional cultural mediators, who usually are elders, religious figures, members of the wider extended family circle or a cohesive community. She may also be seen as a

mediator with the host country, a position which can be perceived either as helpful or as a betrayal. These complex and often simultaneous role attributions play a key role in the therapeutic process, especially when the therapists' gender and power attributes are dissonant with traditional constructions of identity.

Gender in Cultural Consultation

Although there is some evidence that immigrants access medical services at the same rates as those born in Canada (Kirmayer, 2008), most South Asian families do not voluntarily seek medical help for mental health problems. They may feel reluctant to seek a consultation and have considerable apprehension related to stigma and the dangers of institutional power, since mental health issues are traditionally resolved in the privacy of the family (Kakar, 1982; Timimi & Maitra, 2005). In addition, when these families enter treatment with a South Asian woman consultant, the clinician's position of power may directly challenge and threaten to destabilize the traditional gender hierarchy. The clinical encounter then may intensify existing vulnerabilities of masculine identity. While therapy is intended to provide a space to reframe issues of power and role dissonances, this opportunity may be welcome by some family members but resisted by others. In the clinical vignettes below, we explore the paradoxical dynamics of having a South Asian woman therapist for migrants who reside in the traditional structural rubric of power and gender.

As a clinician, the female family therapist implicitly borrows the power of the host society's health care institutions. Since migrant South Asian families, particularly men within these families, already feel systemically disempowered by the host culture, the reversal of the traditional gender hierarchy in the clinical encounter becomes a double disempowerment. This may then lead to individual or family resistances to the consultation or intervention process because the therapist is affectively situated in an ambivalent oppressor role. At the same time, as a South Asian woman, the clinician may evoke positively invested gender norms associated with matriarchy, of respect, submission and obedience. Her position of power within the therapeutic space then is paradoxically both a reminder of gender role reversal and a reproduction of familiar gender interactions which were possible in the pre-migratory period. These dialectical positions create the possibility of using a transitional space (Winnicott, 1966) for considering options, reframing, individuation and therapeutic work. As Fruggeri (1992) points out, power need not be celebrated nor demonized "Rather, the therapist should take responsibility for his or her power construction within the constraints of the relational/social domain." Thus, "power negotiation" is a critical tool available to the therapist who may need to invalidate her position of power to empower the family.

Case Vignette 8-1

Begum was a 32-year-old Bangladeshi Muslim woman who had made multiple suicide attempts. She had been raped in the detention center of another country en route to Canada where she had claimed refugee status and given birth to this child shortly after her arrival. She was referred to the CCS from the regional refugee service for advice on the treatment of her depression. During the initial CCS interview with a male psychiatrist, she remained essentially mute and wept. A second consultation was arranged with a South Asian female consultant, where Begum openly expressed her outrage at the subservient position of women in her country of origin, recounted her own history of domestic violence and the circumstances of her rape. She explained her silence during the initial interview as reflecting her association of the male consultant with the patriarchy of her culture of origin, as well as Canadian immigration authorities and institutional power hierarchies.

Since the CCS work is done within university hospitals, consultants are endowed with the power of both health institutions and academia.

Although women increasingly dominate the helping professions in South Asia, often without occupying power positions equivalent to men, their presence in the therapeutic context is likely to reflect the possibility of shifts in power. The culture of institutions both idealizes and devalues female professionals. The South Asian consultant working within these institutions must be aware of their own possible over-identification with the family's struggle to deal with dominant institutions such as refugee boards, youth protection or schools. In the family's struggle with power both within the family and also in the broader context of host society institutions, the female South Asian consultant may be identified as a matriarchal resource with strong positive transference overriding the family's anxieties about institutional power and this may facilitate assessment and treatment. In this case, however, the consultant may be idealized and viewed as having exaggerated power. She may be asked to advocate on behalf of the family or transgress institutional constraints. Alternatively, the consultant may be seen in a persecutory light as an extension of the host society's obstacles to validation or acceptance. These responses may be obstacles to assessment or may help to uncover underlying clinical issues.

Case Vignette 8-2

A South Asian psychiatrist (JG) was asked to consult on an inpatient unit for a 14-year-old boy from Pakistan who had spent months out of school at home with his anxious mother. Shortly after the consultation, the mother shared with the referring treatment team that the South Asian consultant had put microphones in restaurants and was sending persecutory messages to her. After months of her son and husband not disclosing her delusions and hallucinations, her paranoid delusional response to the therapist's name and ethnicity helped the team clarify the diagnosis and explain the school phobic behaviors. The shared ethnicity of the consultant was a clear factor in this disclosure.

An understanding of cultural and intrapsychic themes related to gender helps the consultant navigate the shifts in power and position from validating to invalidating and closeness to distancing during the consultation. CCS consultants work with their own subjectivity regarding the cultural underpinnings of gender and power, by listening to their internal discomfort and anxieties that arise in response to their positioning as both insider and outsider. Since ethnic match often creates an initial positive working alliance (Malat & Hamilton, 2006), the consultant and the institutional setting may be perceived as less "strange" or "estranged." Initially, the fear of being among strangers may be mitigated by sharing a common language and heritage, while issues of gender may become clearer as family conflicts or other power issues emerge. Anxieties about strangers may also be projected onto others involved in the consultation, including professional interpreters hired from the regional health care interpreter service. Attitudes toward interpreters may include concerns about confidentiality and the potential for indiscretion or leaking secrets to the community and mask fears of the clinician or institutional setting. The fears of disclosure may take on a persecutory quality. However, the presence of interpreters usually increases safety and alliance. In some instances, interpreters and clinician may be "adopted" as fictive family members (i.e., aunt, sister) or may be called for help in crisis situations. The CCS consultants aim for a position between these extremes, as close but not intimate. In this process, gender is sometimes a disqualifying element ("you are turning my wife against me") or a necessity for alliance ("I will only see you as you are a woman").

Social and political realities, including events such as the terrorist attacks of 9/11, have heightened public anxieties about certain ethnoracial groups (Tummala-Narra, 2005) and have had an impact on levels of persecutory anxiety, cultural difference or mistrust experienced by minorities in the clinical encounter. For effective consultation, these anxieties about cultural difference must be acknowledged as they may also arise in the referring team or the consultant. A similar response of validating rather than denying differences that impact on the clinician–patient

relationship is advocated by Holmes (1992) using the situation of a Black female clinician working with White clients. Holmes notes that working across difference can be difficult or at times impossible when the therapist's own equilibrium is disrupted, for example, when the patient's focus remains on difference and mistrust and this prevents the establishment of basic trust and a working alliance with the consultant. A focus on "racial enactments" or other forms of cultural difference can be useful to the clinical process. The recognition of difference need not impede progress, though "racial enactments typically implicate the very issues— idealization, envy, jealousy and devaluation—likely to upset one's narcissistic equilibrium" (Leary, 2006, p. 650). Blindness to the basis of cultural differences in values, developmental experiences, rituals, maturational markers and goals and aspirations limits the options for clinical rapport and intervention. As Tummala-Narra (2005) and Apfel and Simon (2000) point out, most clinicians are not familiar with analyzing their political positions when confronted with racial or ethnic conflicts and may defensively resort to detachment, isolation, hyper-professionalism (Dunayevich & Puget, 1989) or fall into over-identification with the minority patient with whom they share ethnicity.

Gender, Color, Ethnicity and Loyalty: Cultural Consultation Deconstructed

The cases described below were seen at the JGH CCS (Chapter 3) or the MCH Transcultural Child Psychiatry Team (Chapter 4). The consultants worked with the referring clinicians, sometimes alone or with their teams, who were generally present for initial consultations along with interpreters. The MCH service usually used a reflecting team in a group including the family but respected the wishes of patients, if they preferred to be seen with several members of the team. Though the CCS usually provides limited consultations, some of the case vignettes reflect more extended interventions undertaken with individuals or families due to their complexity. A team consultation was offered to the referring agency or case manager if the patient refuses direct contact with the CCS team.

The next case illustrates how ethnolinguistic matching may allow improved communication and a positive identification with the female consultant by reframing gender and power issues in ways that promote resolution of conflict between a migrant family and host society institutions.

Case Vignette 8-3

A consultation was requested by an inpatient team for the family of Sevaanan, a 10-year-old boy from Sri Lanka hospitalized for several months for suicide threats and severe anorexia. Sevaanan had a history of oppositional behaviors and had recently disclosed abuse by his father to his school. The initial assessment by a South Asian CCS consultant and a Canadian child psychiatrist (CR) was followed by several family sessions with the South Asian consultant (RS) which took place in the hospital.

The family had migrated to Canada 15 years earlier from Sri Lanka during the upheaval of civil war in a context of severe hardship. The couple had managed to cope with parenting and marital issues during their first 9 years in Canada until their second child, a daughter, was diagnosed with autism. Despite their previous capacity to cope, the couple experienced a crisis, with the father progressively removing himself emotionally from the family and accumulating gambling debts. A youth protection investigation had not been able to validate the boy's allegations of physical abuse by his father, while the parents were mainly concerned that he was losing weight. Though the family had been seen by a series of professionals, the history remained unclear. The parents had said they understood English and had not insisted on an interpreter because Sevaanan was fiercely opposed to it, and they did not dare oppose him fearing his anorexia would worsen. The inpatient unit had relied on Sevaanan for interpreting.

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As an initial step, the consultation addressed the linguistic barriers as a power issue and obstruction to a therapeutic alliance with the parents. Sevaanan tried to boycott the use of Tamil during the assessment, but the alliance between the South Asian consultant and the child psychiatrist persuaded the parents not to give in and to acknowledge their need to use Tamil in therapy. By introducing a South Asian female clinician who spoke Tamil, a positive alliance was quickly established between the couple and the team. The consultant asked the parents "How was it for you when you were not able to speak to the team and Sevaanan was doing all the talking?" The mother responded that she had not thought that the team would listen to the distorted picture Sevaanan had related because "he is just a young boy." The parents had been deeply shamed by the boy's allegations, which had brought their family under a youth protection mandate. They had no youth protection system in Sri Lanka and did not understand that a child could accuse his parent and be taken seriously. The parents' sense of being heard, understood and empowered by the South Asian consultant, who represented both host and culture of origin societies, was a significant turning point in the consultation. For almost a year, Sevaanan had triangulated his parents, diminishing his father's role to that of "abuser, gambler and failure." The triangulation made the marital strain more explicit as Sevaanan appeared to champion his mother. This powerful family position contributed to his strong resistance to the introduction of the female South Asian consultant who displaced his central role as mediator of all communication with the family. Once the language barriers were addressed, the process of parental re-empowerment and team building was identified as a priority and allowed the team to begin addressing the marital schism and family losses.

There were several ways in which the father perceived himself as powerless and a failure: he had failed in his role as an eldest son to look after his parents, renouncing his filial duties and abandoning them in Sri Lanka during war time; he was powerless to protect his daughter from a serious disabling illness; and, because of gambling, he had failed to provide for his family. His position as "bad, abusive father," rather than an effective parent who could be productive in the family, had been reinforced by trauma as well as underlying distress, guilt and shame.

It was possible to re-empower the father because both parents positively identified with the female consultant at a collective ethnocultural level and recognized the institutional power that enhanced her position. Alliance building included listening to their discussions of numerology and Hindu explanatory frames of reference. As a way to construct hope for the father, the therapist introduced the story of Prince Yudhisthira from the *Mahābhārata*, a hero who falls from grace due to gambling but redeems himself with honesty and family loyalty (Smith, 2009). These shared stories from Hindu mythology provided a vehicle for the family's co-construction of a narrative that renewed the father's power (Briggs, 1996) and created momentum for change in the family. At a deeper level, the mythological story reduced the dissonance between the host society and culture of origin by encouraging the couple to assert their parental power by negotiating within the institutional frame. Once child abuse accusations were withdrawn, Sevaanan shifted his position progressively to a less dominant, less victimized identity and was less emotionally burdened by his role in the family. His parents worked on strengthening their parental functioning. When the son expressed his resentment of the female consultant, disparaging her interventions with open hostility, both parents were able to mobilize a joint

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response to his defiant stance, identifying with the consultant as a respected matriarchal figure. Reframing the father's position and emphasizing the son's need for the parenting team's authority helped them to mobilize a structural shift to reassert appropriate parental boundaries. Further couple sessions explored marital strain, difficulties coping with the younger child's diagnosis of autism and the impact on mother of the father's previous losses, while family sessions focussed on the developmental needs of both children.

In this case, the female South Asian consultant was a bridge between the family and the treatment team. She engaged the parents and particularly the father in ways that helped them regain their sense of agency and power in part by validating his loss and grief. The consultant's language skills and cultural knowledge were relevant not only to facilitate communication but to make use of mythic paradigms and stories that are part of oral tradition to convey the potential for reconciliation to loss and failure and the possibility of resilience and renewal. While the son initially resented the female therapist and actively disparaged her interventions, both parents were able to identify with her as a respected professional figure. The child psychiatrist consultant's "in-between" position helped to move beyond the splits or polarities of South Asian family versus Canadian hospital team. Modelling authority and mobilizing a structural shift to assert a need for parental boundaries were two critical steps that allowed therapeutic progress.

The next vignette involves similar configurations of power and gender but this time with an adult patriarch who discounts the consultant. It illustrates how a strategic reframing allows the female consultant to join with a father, who initially challenges her authority, allowing him to feel less threatened and to shift to accepting help from a professional who comes to embody the role of an elder matriarch, despite her youth.

Case Vignette 8-4

A cultural consultation was requested by the outpatient team of a children's hospital for Mala, an adolescent girl with first-episode psychosis and mild mental retardation. Mala's family, from Bangladesh, was struggling to come to terms with their youngest daughter's illness. Six months into treatment, her father remained fiercely overprotective and kept her home from school. Her mother tried to reintegrate the girl into normal activities, insisting her daughter begin with simple household chores, but this approach was resisted by father who felt that mother should be a caretaker because their daughter was "fragile" and "sick."

The cultural consultant, who was a South Asian woman in her thirties, agreed to follow the family for a few joint therapy sessions with the Canadian child psychiatrist. During one of the family therapy sessions as parental conflict was being clarified, the mother said: "It has always been difficult, as he never supports my decisions when it comes to the ways of disciplining our children." When the therapist asked the father to respond to what the mother had just said, he replied by addressing the therapist, "You are quite thin. Is your health all right?" This apparently tangential remark questioned the therapist's physical strength and, by analogy, her ability to deal with the family's difficulties. Of note, the father never made this type of personal remarks to the Canadian clinicians. The South Asian therapist's first reaction was to receive this as direct disqualification of her as a professional and a deliberate attempt to derail her line of inquiry. In effect, an older South Asian man was responding in a patronizing way to a much younger South Asian woman who had trespassed boundaries and challenged him, albeit gently, to respond to his wife's perception of his lack of support. The remark could be seen as his defensive

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response to having his paternal role disqualified, by disqualifying the therapist's role, in turn. It could also be understood as an indirect expression of his powerlessness in the hospital interactions dominated by White female clinicians. Realizing this, the therapist responded by saying, "You feel like looking after everybody, especially the women. You want to take care of your daughter and your wife. You even worry about my health." This positive reframing moved the focus from his defensive stance to his positive efforts to be a caretaker and benevolent provider. He received this reframing as a reassurance of his valued position in the family hierarchy. Feeling less threatened, he proceeded to express his helplessness and impotence in dealing with the crisis of his daughter's psychosis. The discussion of vulnerability allowed realignment of parental positions and the common theme of powerlessness that joined the parenting couple. This strategic therapist response was cognisant of gender and power attributes by the client and made it possible for the couple to process other themes of dependence, silencing, control and autonomy related to their fears and advocacy for a vulnerable adolescent with a first-episode psychosis.

During family therapy sessions with South Asian families, it is not uncommon for the female therapist to feel disqualified, as described in the two preceding vignettes. Although the challenge from the family may be expressed more directly if the therapist is of South Asian origin, the power position of the mainstream female clinician may also be resented and contested. Reframing the disqualification of the South Asian clinician allowed the clinician to join with the family's feelings of being disqualified in relation to host society institutions. These interventions consolidated the therapeutic alliance and allowed the consultant to explore the broader implications of each family member's experience of being rendered powerless or silenced whether by the larger society, cultural community or internal family dynamics. The use of gender- and hierarchy-based challenges to the clinician's authority is similar to the defensive manoeuvres of cultural camouflage discussed in Chapter 7 (see also Friedman, 1982), where underlying psychodynamic or systemic issues are camouflaged by invoking cultural norms and motifs. To circumvent this potential use of culture as camouflage, the cultural consultant must remain attentive not only to the obvious cultural themes and issues but also to significant issues of family process, structure and affect. The consultant strives to establish a systemic position as mediator (Messent, 1992). The mediator's empathic understanding of family and collective values provides an opening for identifying cultural strengths. In the cases above, substituting a Western model of individual voice or interpreting the father's response as simply a diminution of matriarchal influence might have closed the possibility of validating cultural strategies to strengthen the common ground of the parenting couple. Silencing is a common issue in gendered hierarchies (Jack & Ali, 2010). In clinical assessment and intervention, silencing has the effect of segregating women's experience, limiting the possibilities for dialogue and an inclusive negotiation of the position of both genders. The systemic approaches of narrative therapy and the strategy of circular questioning which asks family members to reflect on each other's responses deliberately work to include marginalized and silenced voices and introduce new options for dialogue guided by the therapist.

Women in South Asian societies learn to claim their power and position through modelling the behaviors of their older counterparts in the extended family who negotiate power by diplomatic shuttles between men, and sometimes between senior women, in the hierarchy. This modelling of instrumental effectiveness and tacit power is not available in the nuclear family of migrants, who also must contend with radically different notions of gendered power in the new host culture. However, while women's position and power may change profoundly with migration,

at the same time, they represent and are expected to maintain continuity with the lost world for the family as a whole and, in particular, for the men. The tensions between the new opportunities for power and agency that come with migration and the obligation and desire to maintain cultural continuity may apply both to the women in the family and to the "other" South Asian women who encounter the family as consultants.

As in the case of other migrant communities, South Asian couples and families must renegotiate their roles to meet new demands of the Canadian milieu. For example, as Sluzki (1979) has suggested, migrant families may initially negotiate or develop splits between instrumental and affective roles with a key member, usually the male provider, functioning in a present-oriented provider or "survivor" mode, while another family member, often a woman, "holds" the past intact. The parenting couple thus preserves family stability until the emergent role of individuating children at adolescence or other events often destabilize this strategy. Pregnancy can be an especially critical time for immigrant women who may be more vulnerable to depression owing to a lack of extended family and community supports or other stresses associated with migration (Zelkowitz et al., 2004). Families may achieve a precarious balance that hides male role dislocations or downward social mobility, until the occurrence of unexpected stressful events such as the diagnosis of developmental disorders in a child, behavioral or mental health problems in an adolescent, serious medical conditions of a parent or the loss of a job by a breadwinner. The following case vignette illustrates issues of gender and power exposed by a postpartum crisis.

Case Vignette 8-5

Ajanta, a 22-year-old Muslim woman, who had emigrated from Pakistan 3 years earlier, was referred for cultural consultation by a community clinic for postpartum depression, anorexia and somatic complaints unresponsive to multiple consultations. She was seen initially with her husband, her French Canadian therapist, an interpreter (who had been refused by her husband but requested by the patient) and the caretaker of her children, who remained in the waiting area with her 18-month-old twin girls. The interpreter was an older Pakistani woman who had been in Canada for more than 20 years, had children and a career, who introduced, through her own self-disclosure in the later sessions, another layer of complexity and identification to the therapeutic encounter.

Ajanta had been unable or unwilling to wean the twins. She adamantly refused to put them in day care, because she equated this step with acquiescing to her husband's plans that she was "not returning home." The couple was at an impasse in their conflict over the husband's wish that his wife and the twins remain in Canada rather than moving back to her country of origin or even going for a brief visit to renew her links with her parents. The husband agreed that young mothers usually return to their natal families especially after a first childbirth as part of the nurturing of the young mother and support of her child care skills. Ajanta had been determined to go home to her natal village where she longed to be cared for by her parents and also to complete her mourning for a recently deceased uncle to whom she had been strongly attached in childhood. Her husband strongly resisted her plans to visit to Pakistan, insisting that the twins might be kidnapped or fall ill. He showed little empathy for his wife, who was a maternal cousin, and wanted to be present for the consultation "to supervise" the intervention rather than involving himself as part of the process of problem solving. The couple were seen for four sessions alternately together and alone.

Though diagnosed in primary care with postpartum depression, Ajanta had rejected antidepressant medications. She was afraid of the limitation on breast feeding when taking medication. Additionally, she felt that

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"depression" was highly stigmatized because it implied she was "mad" and further disempowered her voice and agency in negotiations within the family. She appeared to be appeasing her husband who had labelled her depression as "weakness and laziness," though in individual therapy sessions, she attributed her lack of direct assertion of her motives to the powerful patriarchal position of her husband and his family. He was angry that she had not adapted well in Canada ("so many people want to come here… she is so fortunate and ungrateful"). He wanted her to get a job and accept Canada as her home. Her passive strategies of resisting acculturation, symptoms of anorexia and refusal to wean the twins appeared to limit the husband's sense of control and undermined the hierarchy.

Ajanta felt that, as a South Asian woman, the consultant could both mediate the marital strain and understand her extended family pressures which she had not shared with the referring therapists ("they don't understand"). She attributed enhanced power to the therapist as a matriarch who could counter the husband and his close alliance with his mother and sister. When seen individually, she discussed her ambivalence about married life both in Canada and Pakistan. She insisted that her husband was not physically abusive, though clearly he was extremely controlling. She emphasised that she appreciated her husband as a good provider and father. Additionally, she felt she could not explicitly reveal her marital unhappiness to him or to their relatives in the extended family, especially as this was a cousin marriage. She explained that direct confrontation would cause great "family problems," including raising problems of dishonor (loss of *izzat* or honor) and bringing shame on her father. After voicing her frustration with her husband's family, especially his loyalty to his mother and sisters, who had advised him not to send her home, she began to focus in the sessions on options for her autonomy in Canada.

Identification with the therapist helped Ajanta in building bicultural frames of reference. She proceeded to wean the babies and agreed to put them in day care. However, she resisted her husband's push for her to return to work prematurely by using the support of the clinic therapist who she felt was "outside the culture and could shame him." But resisted her husband's push for her to work prematurely by using the support of the clinic therapist who was "outside the culture and could shame him." She felt relieved that her voice was heard in the marital and individual sessions though she was disappointed that the consultant had not been able "to force my husband to send me home". She stated she had seen the consultant as an elder matriarch who appeared to have considerable institutional and social power from her husband's perspective.

Both members of the couple were grappling with losses and cultural shifts which were the focus of this intervention. The husband needed to be seen as a strong caretaker who nevertheless masked his deep sense of powerlessness and struggles of divided loyalty between his family matriarchs and his young wife. Despite his apparent dominance and continual assertion of patriarchal authority, the referring therapist pointed out that the husband was unable to change his wife's feelings and his coercive strategies were viewed negatively by the clinic.

In the course of the consultation, the husband was seen briefly individually, and it emerged that he had been intimidated by a Pakistani gang in Montreal and felt he could not relate the resultant shame and fears to his wife. In fact, he had gone to the police in Canada without telling his wife, but he was more concerned about the gang's threats to his family's safety should they return to his country of origin. Disclosing this predicament to the consultant elicited

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feelings of shame and discomfort but then allowed him to relate these issues to the other professionals involved and later to his wife. He stated that he felt tremendous relief that he could speak safely about his vulnerabilities with a South Asian clinician. However, he remained ambivalent and suspicious of the consultant, mentioning later to the referring clinician that if the consultant continued to see his wife, she might become less obedient. In the last joint session, he left saying, "If you ask me to change I will become more depressed than my wife, then who will look after us?"

In this case, the South Asian consultant provided a transitional space to reconsider the diagnosis of depression, revisit role shifts and cultural adjustments and support the couple's move from a symbiotic relationship with the twins to an appropriate stage of differentiation and gradual autonomy. During the individual session with Ajanta, the interpreter had offered additional support to the young wife through her own self-disclosure as a South Asian woman who had moved back and forth between Pakistan and Canada, offering another model of identification and validating future possibilities of integration. The interpreter had also asserted herself when the husband dismissed a need for her interpreting skills during the intense discussion in the therapy sessions, reinforcing the need for the young wife's "voice" to be heard and directly opposing the husband's silencing strategies.

The referring clinic felt that a hospitalization for an anorexic crisis in the wife had been averted by the consultation, because the wife began to eat as the marital tension remitted and the couple's functioning improved. The clinic staff had taken a position of advising rapid assimilation, emphasizing to the couple the need to adopt local or "Quebec" values rather than exploring the couple's own cultural frames of reference. However, the couple's strain and impasse suggested their issues were embedded in the dislocation of family paradigms, traditional roles, external issues (threats from a local gang), dynamics of cousin marriage and the loss of the usual cultural supports with a first child. Ambivalence over the demands of acculturation was experienced by both partners in the couple but was framed in terms of gender and power agendas.

In cultural consultation, the institutional context interacts with issues of gender and power and sometimes reveals forms of institutional racism (Fernando, 2002). These patterns of discrimination can be quite subtle and difficult to expose because they are associated with strong cultural norms and ideologies. The CCS and MCH teams were located within university hospitals that represent the power of health institutions and academia, which are rooted in the values of the dominant culture. Parts of the world where institutional values reflect familial patriarchal entitlements may be perceived by North American mental health practitioners as disempowering and oppressing women. This same attitude may be extended to the perception of the consultant from a minority background, complicating her interventions with colleagues.

Case Vignette 8-6

A South Asian woman who was about to be deported while actively suicidal and threatening to kill her children was evaluated by the CCS, and a report was prepared for a humanitarian appeal to the immigration board. A psychiatric consultant for the government agency called the South Asian CCS consultant to question her "overly" sympathetic report and asked if the consultant was favouring migration of South Asian woman due to her own ethnicity.

While the potential for over-identification is certainly possible in any clinical interaction when countertransferential issues are raised, in this case the desperate situation of the patient was discounted by the government consultant who questioned the CCS consultant's "objectivity", with little substantive basis to his speculation. In addition to a general scepticism about the claims of refugees, it is likely that gender bias contributed to this attempt to dismiss the consultant's report. This type of disqualification by professionals can be difficult to manage. The existence of a service like the CCS can provide an institutional and academic base from which to respond to such biases. Political, legal, ethical and institutional racism issues or realities may also arise that require a discussion with the referring and consulting team.

Of course, strong identification with patients can occur and make the consultation process particularly difficult as illustrated in the following vignette.

Case Vignette 8-7

A South Asian married woman refugee reported being raped during police interrogation in her country of origin. She wanted to see the South Asian consultant to share her feelings of despair after being raped by her immigration consultant in Quebec who had directed her to her lawyer. She was terrified to see him alone or to reveal these rapes to her husband as she would be considered irremediably impure. She also feared the agent had contacts back in her home country who could hurt her children left behind. She wanted to share these issues with the consultant but did not want to disclose them more widely. She said that God could hear her despair better now, and she prayed that her sons would someday avenge her. She named her sons as part of the patriarchy who would be outraged by the rape and uphold her communal and personal honor. However, she explained that she feared that disclosure of the rape would diminish her in her husband's eyes and permanently undermine their marital relationship. This narrative was very distressing for the consultant who was bound by confidentiality not to disclose the events but sought legal advice on how to guide the patient toward appropriate legal recourse.

Again, in cases like this, a high level of identification between consultant and patient may make disclosure of some kinds of difficult material more possible, but it also poses difficulties for the consultant who will benefit from team or peer supervision to manage the potential personal and professional issues. Additionally, the issues of refugee rights and advocacy in legal processes raise other dimensions of power which are realities in cultural consultation work.

Case Vignette 8-8

Ayad, a 24-year-old South Asian male refugee claimant, was referred by a community care facility where he was being carefully monitored and medicated after discharge from a hospitalization for several suicide attempts. He was awaiting an appeal of his application for refugee status, and the cultural consultation was requested by a male staff member of the facility who had developed a close alliance with the patient and accompanied him for a single consultation visit. Trials of many different medications and consultations with other mental health professionals had led to no improvement in Ayad's self-harm behaviors.

Ayad was homosexual and had had a relationship across caste lines with the son of a prominent politician in his place of birth in South Asia. He had been kidnapped for ransom and the father of his companion had made death threats to his family. His mother secretly sold some family land to pay the ransom, contravening his father's

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decision to refuse to accede to the coercion. After his mother paid the ransom and obtained his release, Ayad broke his promise to his mother to end the affair and returned to his former partner. The relationship finally ended when the partner's father sent his son away to get married. Ayad's father was devastated by both the public exposure of his son's homosexuality and his violation of caste boundaries in the relationship. His father was furious when he discovered that his wife had taken money for the ransom from their dowry and retirement savings.

Ayad was devastated when his lover's father issued death threats. He had attempted suicide in India, telling his family he was still in love with this young man. His father had then "excommunicated" him from the family. His mother, however, had raised enough funds to send him to Canada "to be safe." His affair became common knowledge in his urban setting and led to the disruption of his sister's arranged marriage, which further exacerbated his guilt. He had made suicide attempts in Canada both out of "lovesickness" and guilt. When his father had received news of the last suicide attempt, he wrote to Ayad and advised him to "be a man and complete the suicide as his mother was in a deep depression" so that "the family could be rid of his bad influence in order to marry his sisters." However, Ayad's mother begged him not to suicide and believed he should make a new life in Canada.

The referring treatment team held more egalitarian views on his right to homosexuality and to grieve his lost partner, joining with him to validate the injustice he had endured as a victim and expressing outrage on his behalf in response to his father's advice to suicide. While they were supportive and protective of the patient, their strategies had not had a positive impact, and, in fact, his distress, suicide threats and acts of self-harm escalated. The therapists at the care facility partly blamed Ayad's problem on the impact of the "primitive cultural taboos" and prejudice of his family and South Asian culture. They understood the patient's guilt at being unable to resolve hopeless family issues and his attachment to his lover. They felt they were empowering Ayad, by discussing the potential to allow himself opportunities for gay life in Canada as major incentives for wellness, provided the uncertainty of his refugee status was resolved. The staff identified Ayad's resilience in his ability to work, and he was seen as having good potential for social integration, but they did not understand why his suicide ideation and attempts continued despite their active support.

As Ayad related his story to the South Asian female consultant, his main focus was his feelings of outrage at his father's lack of support and his response of acting out the father's message. He minimized the impact of his actions on his relationship with his mother, his sisters and family. It appeared that his mother was also now depressed and possibly suicidal. Ayad had a sense of entitlement to his mother's resources and showed little gratitude or respect for his mother's efforts to save him and get him to Canada. Ayad's preoccupation with his love affair had blinded him to the advocacy and courage of his mother in getting funds to pay the ransom for his release and allow his flight.

Ayad's suicide gestures were considered in the light of the gender, legal and structural violence inherent in his family situation. The consultation focussed on broadening his sense of choice and agency to allow him to consider alternate identifications and pathways to conflict resolution. He had not recognized how his feelings about his parents played a significant role in his suicide behaviors. While the female therapist, joined with his male care facility staff,

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could be supportive of his romantic attachment, the intervention focussed on parental and systemic aspects of the suicide behaviors and his feminized position of agency with respect to his father.

Kakar (1997, 1981) has explored the maternal feminine identifications and bisexuality of identity formation in South Asian context. Despite some recent increase in acceptance of open homosexuality in large urban centers, in most of South Asia, homosexuality remains discrete and hidden. The emergent gay discourse in India has not mitigated the tensions of a social space where homosexuality, bisexuality and other variations in sexuality or gender identity evoke phobic responses and A (Bose & Battacharya, 2007). In traditional families, homosexuality is often countered by forced marriage in an attempt to change the sexual orientation and normalize the situation with a social façade of acceptable heterosexuality as illustrated in this clinical vignette by the family's solution for Ayad's partner.

In this case, over-identification with host country perceptions of tolerance of homosexuality may have inadvertently reinforced the father–son conflict as the referring treatment team colluded in exacerbating the patient's acting out, without eliciting a more inclusive picture of the family's predicament. The referring clinicians' acknowledged that they had not considered the impact of the patient's behavior on the female members of the family nor had they understood the parental dynamics, issues of caste privilege, gender hierarchy, impact on arranged marriage, socio-economic or political context. The client felt the cultural consultation opened a renewed opportunity to show gratitude to his mother, and his suicide attempts stopped despite his anguish.

Conclusion

The cases we have presented illustrate how, in considering issues of gender, ethnicity and power, the cultural consultant must reach beyond the dominant paradigms of mental health training to allow multiple voices and perspectives to emerge. Working with the cultural contexts of collective values and gendered hierarchies inherent to South Asia families broadens the horizon of clinical conversations and the construction of solutions. Cultural parameters must be recognized to understand the divergent perspectives of the patient, family and the institution. Acknowledging these elements provides the basis for a reflective process of inquiry, but even with ethnic matching, deliberate efforts to identify blind spots and attempts to adapt perspectives, confusion and uncertainty may remain.

Cultural consultation requires an understanding that power relations in host societies and institutions interact in complex ways with the social fabric of gender and family structures from non-Western cultures. Creating secure transitional spaces within therapeutic settings allows families or individuals to rethink and renegotiate their agency, position and power in contexts of cultural change and the destabilization or hybridity of cultural norms that comes with migration. These power negotiations involve deeply embedded identifications, structural issues including political and social issues, changes in hierarchical strategies and increasing tolerance for the options and confusion of values related to cultural change. Clearly, the changing dynamics of gender, race, ethnicity and culture cannot be captured through generalizations. These dynamics must be constantly reassessed not only for each patient but also over the course of treatment. As we have seen in the clinical examples, the process of empowering individuals within systems can have unexpected, destabilizing and harmful repercussions or provide openings for positive and creative solutions. Through his or her gender and ethnicity, the consultant may embody specific identities that can be threatening or validating positions for different generations of family members of either gender.

Following Foucault (1967), we would argue that power can be thought of more as a strategy than a possession—as ways of configuring relationships that emerge from cultural narratives and discursive practices, that circulate within local and transnational communities and that are

revised in new contexts. As therapists, we are constantly revisiting our blind spots and striving to acknowledge hidden power relations by searching for projections, implicit or hidden meanings, listening to silence, working with confusion, identifying institutional agendas and tracking affective responses in the clinical encounter. We seek to unmask power to understand the underlying agendas and intentions in both social and familial interactions. Since medical encounters usually subordinate the patient's voice to that of the physician (Addilakha, 2008), we often fail to hear the suppressed narratives of patients and their families. These blind spots become particularly hazardous in the context of intercultural work, where misunderstandings or missed understandings are even more likely.

Migration and cultural hybridization are part of lifelong developmental processes of individuation that may suppress or validate various identifications and strategies in the ongoing flux of life events and change (Akhtar, 1999). Using examples of work with South Asian families, we have tried to show how consultants' personal characteristics, especially gender and ethnicity, whether they work alone or within a hybrid team, can provide entry points for clinical dialogue and possibilities for therapeutic intervention. We emphasize that clinical work cannot be separated from wider agendas of power that are embedded in host country institutions and cultural frameworks. The cultural consultation process constructs a collage from the diverse perspectives of referring clinicians, patients, families and consultants. In this process the diversity of identities among clinicians and sometimes consultant may facilitate the representation of the relations among genders, across generations and between minority and majority groups. This *bricolage* allows us to look at intersecting frameworks rather than rooting our work in a single model drawn from the dominant ethnocentric discourses of biomedicine, psychiatry, mental health or social services. Power and gender, language and ethnicity and sameness and difference are dimensions of clinical work which must acknowledge the multiple dialectics, diverse realities and complex transformations of identity inherent to migration experience.

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