FAMILY PROCESS

Up Close: Family Therapy Challenges and Innovations Around the World

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Family therapists from 10 different countries (China, India, Israel including Palestinian citizens, Japan, Mexico, Peru, Spain, Turkey, Uganda, and the United Kingdom)[1] describe systemic therapy in their contexts and current innovative work and challenges. They highlight the importance of family therapy continuing to cut across disciplines, the power of systems ideas in widely diverse settings and institutions (such as courts, HIV projects, working with people forced into exile), extensive new mental health initiatives (such as in Turkey and India), as well as the range of family therapy journals available (four alone in Spain). Many family therapy groups are collaborating across organizations (especially in Asia) and the article presents other ideas for connections such as a clearing house to inexpensively translate family therapy articles into other languages.

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#Author names are given in alphabetical order by last name except for Janine Roberts who solicited and edited all sections as well as wrote the introduction and conclusion.

[1]The sections are presented in alphabetical order by nation. Unfortunately space constraints limited this to 10. The authors represented here are people who graciously responded to my initial request for people to write about their countries and carved time out of their busy schedules. Many thanks to each and every one of them, and to Noel Slesinger for her timely and thorough help with translation, references, and editing.

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Authors in each of the following 10 sections explicate ways family therapy continues its tradition of thriving in different disciplines. Nakamura describes how the Japan Family Therapy Association, 1,000 strong, has among its members lawyers, teachers, nurses, and probation officers. Sim highlights that a large effort is being put into training social workers in China in family therapy (as well as other parts of Asia, see Sim, 2010) and Abu-Baker writes that in Israel most of the family therapy training has always been in social work programs. In Peru where few formal support networks exist for clients, Chong and Zevallos share how therapists create them in tandem with priests, doctors, and nutritionists. More than ever it is key that journals, professional organizations, training programs, clinicians, and researchers stretch and reach across boundaries.

Other authors feature institutions that are benefiting from systemic ideas. Mexico has numerous training programs in universities as well as private institutes. Fortes de Leff explicates how they collaborate with family judges, centers for juveniles, and people who have been forced into exile from Mexico because of drug related violence. In the United Kingdom, Fredman and Messent tell us about projects with elders and people with intellectual disabilities. I (Janine Roberts) recently worked at Maltepe University in Istanbul and it was powerful to see how undergraduates that work with street boys (who are forced into state shelters) embraced the importance of listening and multiple perspectives, family time lines, and doing family and street "floor" plans (Roberts, 2010) as techniques to learn more about the boys' families and connect with them.

At the same time, Kamya writes eloquently about how groups use systems ideas in Uganda to slide in other agendas. What happens when organizations come in from outside a country and use counseling services as a way, for example, to then convert people to fundamentalist Christian beliefs?

Many countries have new government initiatives to promote family therapy and/or mental health. Reid details some of the challenges a new ministry in Turkey (headed by a female minister) faces in implementing a large "family counseling centers" project throughout the country. Subrahmanian describes how a new mental health care bill in India needs to be more inclusive of family therapists. She also makes a strong case for doing projects such as taking common factors across systems models and making them more available to lay people in India (and I would add other countries).

Throughout the sections, authors speak about the importance of calling upon local beliefs and practices as well as adapting theories and models to their contexts. They remind us to take into account historical events and policies (such as the Holocaust and the one-child law in China) which have huge impacts on families. Diez and Martin articulate how Spain is adapting to increased immigration and changing family forms and they highlight the extensive special issues published in journals in their country on these topics. Fredman and Messent beautifully demonstrate how in the United Kingdom local evidence-based practices inform systems work. Many authors mention family work being done within NGOs (nongovernmental organizations). Family therapy educators should expand training in this rich and proliferating arena, one that has much to teach us about family and community work (Roberts, 2010).

As family therapy grows around the world, most of the writers highlighted needs for training materials, more networking, supervision, and support. In a recent survey of over 700 clinicians working in lower and middle-income countries, family based interventions

scored highly as an area for increased resources and research (Tol et al., 2011). One small way the Family Process Institute (www.familyprocess.org/about-us/) will address this is by making available on the Wiley Family Process website (summer 2014) access to a collection of articles published in the journal over the years about supervision and training. These will be organized with ideas and suggestions of how to adapt and use them using technology resources. By using Skype or Face Time, collaborative supervision networks could be created within cities and regions of countries to read and discuss articles. Small groups of people could do live short role plays of challenges they face. Skype participants could watch them and brainstorm solutions to the challenges. Once people are comfortable with this, genograms of actual cases could be emailed and video excerpts of clinical work shown over secure platforms.

As you read the following, please note that as each author could only contribute a few pages, they could not cover everything happening in their countries. However, there is an exhaustive reference list at the end. Also, each country has a unique historical family therapy context. For example, the article begins with China where family therapy is quite new and ends with the United Kingdom where people have developed schools, theories, and models for over 50 years which are widely represented in published literature. Each context shaped what the writers covered. Finally, I asked authors to write in their voice about "recent innovative practices and projects" in their country, and each section reflects their unique voices and selections, often with a focus (for example in the Israel/Palestinian section), on things that are not as well known.

The world is seeing increased migration.[2] In 2013, the United States hosted the largest number of international migrants (45.8 million) of any country (esa.un.org/unmigration/wallchart2013.htm). More and more families are transnational (Falicov, 2005). Learning about family therapy work in other places is a rich resource to understand and work with people from a range of backgrounds in the United States as well as to work across borders with transnational families (Roberts, 2005).

Anne Fadiman wrote in 1997 in *The Spirit Catches You and You Fall Down:*

> I have always felt that the action most worth watching is not at the center of things but where edges meet. I like shorelines, weather fronts, international borders. There are interesting frictions and incongruities in these places, and often, if you stand at the point of tangency, you can see both sides better than if you were in the middle of either one. (p. x)

You are invited to read this article from various points of tangency—for example the country where you work and each country written about in the following pages. Or the tangencies you discover at intersections of the 10 countries described. We need to keep learning from therapists, families, and trainees around the world.

INTRIGUING DEVELOPMENTS IN FAMILY THERAPY IN THE PEOPLE'S REPUBLIC OF CHINA. TIMOTHY SIM[3]

Marriage and family therapy is a fledgling profession in China. It is limited to mostly urban areas, accessible mostly to the middle class and those currently connected with university settings (Miller & Fang, 2012). It first emerged in the field of psychiatry in the mid 1980s, and the Chinese psychology community officially embraced it when the first family therapy course for psychology graduate students was mounted in the mid 1990s (Deng,

[2]More people than ever are living abroad. In 2013, 232 million people, or 3.2% of the world's population, were international migrants, compared with 175 million in 2000 and 154 million in 1990. http://esa.un.org/unmigration/wallchart2013.htm

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Lin, Lan, & Fang, 2013). Family therapy did not develop significantly in the field of Social Work in China until 2012, when the Shanghai Association of Social Workers inaugurated the first family therapy training, generously funded by the Chinese government.

Deng et al. (2013) consider 2005 to the present to be the "Fast Growing" stage of family therapy development in China, with a proliferation of family therapy publications both locally and internationally. From a preliminary literature search of the China National Knowledge Infrastructure using key words such as "China", "family therapy", and "marital therapy" from the years 2007 to 2013, there are some intriguing findings. A total of 294 journal articles on family therapy were found in this brief 7-year period. This is close to a 50% surge compared to only 199 journal articles over more than three decades from 1978 to 2006 (Sim & Hu, 2009). Postmodern approaches, particularly narrative therapy and solution-focused brief therapy, accounted for one-third of the publications since 2007. This is a noteworthy development given the common assumptions and generalizations about the help-seeking behaviors, expectations, and emotional expressions of Chinese families in family therapy (Deng et al., 2013; Liu et al., 2012; Ma, 2000; Miller & Fang, 2012). Are the Chinese people becoming more open to the socially constructed 'truths' in life? Or is it because the practical, action-oriented, short-term, and relation-oriented nature of these postmodern approaches is more consistent with the Chinese culture (Lim, Lim, Michael, Cai, & Schock, 2010)?

There is an apparent increase in Western family and marital therapy researchers who are interested in the development of marital and family therapy in China despite the language barrier (e.g., Adams et al., 2013; Dias, Chan, Ungvarsky, Oraker, & Cleare-Hoffman, 2011; Liu et al., 2012; Miller & Fang, 2012). *The Journal of Family Psychotherapy* recently devoted a special issue to marriage and family therapy in China (Miller, 2012). What will this increasing connection with the West do to the development of family therapy in China? As family therapy is an imported commodity, should indigenizing professional practice take precedence over professionalizing indigenous practice? In any case, when implementing any form of therapeutic approaches, the need to respect Chinese culture and its ancient worldview that include filial piety, deference, family obligations, and duties cannot be overemphasized (Lim et al., 2010; Liu et al., 2012). Moreover, as Miller and Fang (2012) aptly cautioned, any attempt to understand contemporary Chinese family issues must recognize and acknowledge the diversity within the culture given its rich tapestry of ethnic and racial groups.

Sze, Hou, Lan, and Fang (2011) found that the proportions of the three therapy modalities (individual, couple, and family) differed significantly from western findings in that families predominated, followed by individuals, and then couples in a Beijing psychotherapy center, in comparison to the descending order of individuals, couples, and families in the west. This is intriguing in that, while China is experiencing an increasing rate of divorces (Dias et al., 2011; Lim et al., 2010; Miller & Fang, 2012), fewer people seek couple therapy to improve their marital well-being. These characteristics seem to suggest that Chinese cultural values prioritize parent–child relationships over the couple relationship. And when conducting marital therapy, Adams et al. (2013) found that for some Chinese the inclusion of friends and family members who are key support figures is important to the therapeutic process.

In a nutshell, while recognizing that the family is a central construct in Chinese life (Dias et al., 2011; Lim et al., 2010; Liu et al., 2012), therapists need to be astutely aware of the way Chinese families continue to be in flux and challenged by a plethora of unique issues and family dynamics in view of China's idiosyncratic population policy (e.g., one-child policy) and rapidly aging population. Clinically, Chinese therapists may need to face the challenge of providing powerful and effective therapy within a shorter time frame and implement some form of change in the first session in addition to collecting information (Deng et al., 2013). For family therapy to continue to develop, systematic development of

supervision (Miller & Fang, 2012), mentoring, and continued research particularly in the areas of Chinese family processes, understanding "what works for whom under what conditions", and "in what ways western approaches need to be adapted to fit the Chinese cultural and socioeconomic contexts" (Sim & Hu, 2009) are a few of the urgent tasks to be completed.

FAMILY THERAPY IN INDIA: IT TAKES A SYSTEM. CHITRA SUBRAHMANIAN[4]

Marriage and the family are central to the social fabric and cultural ethos of India. Rapid development in the past two decades has had a great impact on these twin structures in both urban and rural areas.

Despite the social climate in India becoming more open and liberal, marriage and the family remain deeply private realms. Interpersonal difficulties, including mental health issues in individual members, are covered up and seen as "family problems" that are supposed to be dealt with within the boundaries of the system. This, coupled with the dire shortage of adequate mental health services throughout the country, ensures that nuclear and extended family members are responsible for problem solving and caregiving. Families bear the burden valiantly, fiercely safeguarding the reputations of their members while struggling to maintain their integrity in the face of prying eyes and widespread social stigma. In the process, the family can become a source of tyranny, with the needs of the individual suppressed for the "greater good" and secondary to the reputation and standing of the family as a social unit. Gender inequities, regressive traditions, and patriarchal ideologies abound. These particularly restrict women and contribute greatly to their suffering, while preventing men, women, and children from experiencing their true potential.

Marital and family conflicts can remain unaddressed and unresolved for long periods, exacerbating the stresses and strains of daily living (Carson & Chowdhury, 2000). Marriage is strictly regulated in many families and communities. Cases of coercion, abuse, child marriage, honor killings, and dowry deaths often make the news. Marriage is frequently seen as a solution for mental illness (Srivastava, 2013) to "settle down" mentally ill or rebellious young men and women.

Rapes and violent crimes against women and children are receiving a great deal of attention and shining an unwelcome light on serious social problems the country has yet to face up to and address in a systematic way. High rates of suicide, especially among young people, are occurring (Patel et al., 2012). Of the 187,000 estimated suicides in India in 2010, 40% of male suicides and 56% of female suicides occurred in the age group of 15–29. It is expected that suicide will be the leading cause of death in this age group in the years ahead (Patel et al., 2012; Shidhaye & Patel, 2012).

Since the turn of the century, many authors have written cogently about the relevance and need for family therapy in India, documenting therapists' personal experiences in the field and cautioning against blindly applying "western" models of family and psychotherapy (Carson & Chowdhury, 2000; Mittal & Hardy, 2005; Nath & Craig, 1999; Natrajan & Thomas, 2002; Prabhu, 2003; Rastogi, Natrajan, & Thomas, 2005; Singh, Nath, & Nichols, 2005).

My own work in the field of HIV counseling in Mumbai from 1992 to 2005 taught me that it is not only possible, but critical, to involve spouses and extended family members in the counseling process. Contrary to commonly held beliefs, clients did consent to bring in family members. Even more interestingly, family members often presented first, to share their concerns about a relative who was HIV positive, and many times family members knew about clients' HIV status before the clients themselves. A diagnosis of HIV in a

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couple could set off ugly feuds between the two families of origin. Women were usually expected to stay and care for male spouses if they were infected, while in the reverse scenario, men were often encouraged to leave their infected spouse. Given these realities, it was very important for the counseling team to have a basic understanding of relational systems and how they operate, as well as basic skills in relating to multiple family members. Our team had to navigate boundaries between treatment and client systems and within client family systems, recognizing and balancing competing needs.

Family therapy as a specialization in India is woefully underdeveloped. This is not surprising given that mental health generally has been badly neglected (Pathare, 2005; Shidhaye & Patel, 2012). The "mental health gap" is profound while mental health needs are expected to increase greatly in the coming years. According to one estimate, mental health disorders contribute 11.8% to the overall disease burden in the country, with only 10% of those affected receiving any kind of evidence-based treatment (Shidhaye & Patel, 2012). With regard to facilities and trained professionals, the statistics tell a sorry tale; the WHO Atlas of mental health resources (2001) stated that India had 0.25 mental health beds per 10,000 people and 0.4 psychiatrists, 0.04 psychiatric nurses, 0.02 psychologists, and 0.02 social workers per 100,000 (as cited in Pathare, 2005).

New initiatives such as the National Mental Health Care Bill (Ministry of Health and Family Welfare, 2013) promise to transform the mental health landscape in India. This bill approaches mental health from a social perspective as opposed to a strictly medical one and makes it incumbent on the government to create, fund, staff, and maintain structures at the national and state levels to deliver services for all. Access to them is seen as a human right, as is the need to solicit informed consent and safeguard the rights of affected persons to make decisions about their own care and treatment. The bill permits individuals to make advance directives, which empower them to decide how and by whom they will be cared for in the event of a future illness, and decriminalizes suicide (Chatur, 2012). These developments bode well for the development of family therapy or perhaps, more appropriately, the application and integration of systems and relational approaches to mental health care in the country.

In the absence of Government programs, many NGOs and community groups have developed innovative programs for the delivery of mental health care (Thompson, 2012; Shidhaye & Patel, 2012). Sangath, a pioneering nonprofit in Goa, has developed models for training lay persons, community health workers, teachers, and others to provide psychosocial services in the areas of depression, schizophrenia, HIV, adolescent health, learning disabilities, and early childhood development (www.sangath.com). The Banyan, a nonprofit in Chennai, serves mentally ill, homeless women by integrating medication, counseling, and rehabilitation with the goal of reintegrating women into their communities (www.thebanyan.org). The Schizophrenia Research Foundation in Chennai provides telepsychiatry via mobile psychiatric clinics, which serve over 800 hard to reach villages in rural Tamil Nadu, bringing together technology and community training in innovative ways (Thara, John, & Rao, 2008; Thompson, 2012).

Much still needs to be done. The current definition of mental health service provider, as conceptualized by the Mental Health Care Bill (Ministry of Health and Family Welfare, 2013), is restricted to psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses. Given the enormous mental health care needs in the country, this definition needs to be broadened to include personnel from a range of disciplines including family therapy, counseling psychology, social psychology, child and family development, and sociology. Trained lay counselors and community workers should also be recognized as important resources (Shidhaye & Patel, 2012). Given the number of theoretical perspectives in our field, it would be helpful to train these counselors in common factors that cut across models, such as recognizing patterns of interaction, developing strong alliances,

encouraging and motivating clients, addressing interpersonal conflicts, and building on strengths and resources (Sprenkle, Davis, & Lebow, 2009).

Currently only a handful of family therapy training programs are available to psychiatrists and clinical psychologists. Such programs need to be available in many more institutions and across a range of disciplines in the social sciences, especially disciplines in which the family is a topic of study, as well as for community counselors. Furthermore, these programs, when available, provide only brief exposure to family therapy. For instance, the family therapy module offered by the flagship mental health institute in the country, NIMHANS, is only 3 months long. Graduate and postgraduate programs that provide broader, in-depth training in systems and relational models including research and clinical skills are needed to train professionals in India to meet long-term mental health needs.

Regulatory mechanisms for safeguarding the rights of consumers and ensuring ethical practice need to be established. The Ministry of Health and Family Welfare is looking at ways to regulate health care providers from a variety of disciplines. Psychiatrists and clinical psychologists are the only professionals who are currently regulated.

Additional needs include the creation of standards for supervision and continuing education, structures for delivering these services, and the development and dissemination of psycho-educational materials from a relational perspective on a range of topics relevant to the general public. Professional family therapy networks that link practitioners within each state and at the national level and promote the exchange of ideas, techniques, and projects are urgently needed along with formal connections with other stakeholders in the larger mental health system.

The complex, day-to-day realities in the world's largest democracy are fascinating and frustrating in equal measure. The central place occupied by marriage and family in the Indian social system suggests that systems-based and relational models and interventions aimed at couples and families will have great value in the mental health field in India. While much remains to be done, there are encouraging signs that government, civil society groups, and the general public are beginning to recognize the gaps and articulate the need for accessible and comprehensive mental health services.

NINETY DIFFERENT CULTURAL GROUPS: CHANGE, TRAUMA, AND STABILITY IN ISRAELI JEWISH AND PALESTINIAN FAMILIES. KHAWLA ABU-BAKER[5]

Family therapy was founded in Israel by Dr. Mordecai Kauffman in the early 1960s. Trained as a family therapist for 3 years in the United States and England, he established the Kibbutzim Center in Tel Aviv for training and services. In the late 1960s, Avner Barcai, who studied with Salvador Minuchin in Philadelphia, directed the child and teenage clinic in Hadassah Hospital in Jerusalem where he implemented family therapy. Later, he joined the Kibbutzim Center. In Tel Aviv, Kauffman established the Telem Center and Barcai established the Barcai Institute, both centers for teaching systems work (Elizur & Ben David, 1998). In the 1970s, Dror Wertheimer Shmuel Ron trained social workers to become family therapists. In 1977, the Israeli Association for Marital and Family Therapy (IAMFT) was established and Dr. Israel Charny, an American citizen (who had immigrated to Israel in the early 1970s and worked in the Kibbutzim Center as a supervisor), became the first president of IAMFT.[6] Those who worked in public institutions tried to develop and disseminate systems approaches in psychiatry departments (Elizur & Ben

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[6]The presidents of the Association since then have been Drs. Zev Segal, Synthia Carel, Yael Giron, Sozan Zydel, Ruth Malkenson, Eva Enat, Daniella Mac, Aviva Mazor, and Omar Lans. The current president is Dr. Nahmi Baum.

David, 1998), community residential care (Elizur, 2012), and daycare centers (Somech & Elizur, 2012). In 1984, Dr. Charny established the first academic program of family therapy at Tel Aviv University. Family therapy in Israel is taught and learned in masters programs in social work. In addition, private institutions train masters level students from therapeutic professions such as psychology, criminology, art therapy, educational counseling, special education, and social work. IAMFT is the only group which licenses family therapists and supervisors. They helped found the International Family Therapy Association (IFTA) in 1987.

As the first founders and the major figures in the field of family therapy in Israel were trained in North America and England, training and therapy approaches in Israel reflect the field there. Minuchin lived and worked in Israel as a child psychiatrist from 1947 to 1950. Later, he visited occasionally as his mother and siblings immigrated to Israel. He supported Kauffman's work and offered training and supervision for Israeli therapists. In 1989, he published with Joel Elizur *Institutionalizing Madness: Families, Therapy and Society*. Through the personal stories of four Israeli families, who each had a family member institutionalized, the authors examined the relationship between the individual, family, and therapeutic institutions in the country. They revealed the confusion and distress of the patients and their families as a result of the rigidity of the therapeutic system in Israel, therapists' prejudices, and training approaches that did not understand the complexity of the patients' problems and the intricate needs of the families. The authors suggested a model of comprehensive community care which integrates individual and family therapy with mobilization of community resources that provides support in times of stress. Minuchin is the most influential figure for family therapists, supervisors, and trainers in Israel (Y. Elizur, personal communication, February 8, 2014).

Virginia Satir visited Israel and is another important influence. Today, IAMFT in cooperation with private training institutions provides intensive training seminars. Some are taught by leading figures in the field who travel to and provide training in structural family therapy, narrative work, emotionally focused therapy, and attachment-based family therapy within the country. The Israeli dominant academic and therapeutic groups are westernized in their professional approaches. This explains the lack of "Israeli theory" or an "Israeli approach" to family therapy despite the early founding of family therapy.

Jewish Israeli society has communities from about 90 different cultures. In addition, the Palestinian society makes up about 18% of Israel. This group differs from the Jewish Israelis by its language (Arabic is their mother tongue) and religion (they are Muslims, Christians, and Druze).

Family therapy with the Palestinians in Israel started in 1997 when Khawla Abu-Baker became the first Palestinian to attain her Ph.D. in family therapy. Her work in Arabic, training, and publications (Abu-Baker, 2003b, 2005b, 2006a,b) helped to spread family therapy ideas among Arabs in Israel and the Arab world. Palestinian families in Israel share three cultures: the Palestinian, the Israeli, and the Arab. They suffer from overt and covert policies of the state against them which contributes to daily stress. In addition, since the establishment of the country, families have been fragmented and disconnected, unable to reunite for local and international political reasons (Rabinowitz & Abu-Baker, 2005). A third of the Palestinians in Israel suffered the trauma of being uprooted from their homes and relocated as refugees in their own country during the establishment of Israel. They also have experienced the wars of Israel quite differently than the Israeli Jewish society (Abu-Baker, 2012). Now they live mainly within their own villages and towns. Therapy with them has to take into consideration their national traumas, culture, religions, and traditions (Abu-Baker, 2003a, 2004). Couples grapple with the changing structure and functions of the traditional Palestinian family (Abu-Baker, 2003a, 2005b). Gender issues (Abu-Baker, 2003b) and sexual violence were silenced in the past

and are now among the common issues in therapy (Abu-Baker, 2005a, 2013; Abu-Baker & Dwairy, 2003).

Recently, Palestinians have begun specializing in family therapy. There are six Palestinian family therapists who are registered as members of the Israeli Association for Marital and Family Therapy. Four of them are licensed, and one is a licensed supervisor. While there are warm personal relations between Israeli Jewish and Israeli Palestinian family therapists, there are no common projects. While Palestinian therapists are bilingual (speaking both Arabic and Hebrew) and some of them are bi-cultural (Arab and Israeli), most Jewish therapists do not speak Arabic nor learn the culture. This creates obstacles for professional collaboration.

The mainstream Israeli Jewish society is composed of three major ethnic groups: (a) The Ashkenazi (European heritage), (b) the Sephardic (Middle Eastern heritage), and (c) the Russians who emigrated in the 1990s from the former Soviet Union (Ben-David & Lavee, 1994). Furthermore, ultra-religious Jews in Israel maintain a lifestyle that is distinct from mainstream Israeli society. Couples in this group marry between the ages of 17–19 and do not use contraception. Most men are involved in learning the Torah, leaving women to take care of work, household, and child rearing. Religious Jewish family therapists work with the ultra-religious population, usually collaborating with their Rabbis.

Family therapy work in Israel is influenced by the state of security in the county. The obligation to serve in the army for all of the Jewish secular population creates intense stress. Some Israeli families have more than one family member in the army during war time. Also, most healthy men between the ages of 22–42 have to serve 8 weeks each year in the reserve force. Many unsolved couple's problems are exacerbated during this period.

It was expected that peace between Israel and its neighbors would relieve stress on Israeli Jewish families. However, peace accords sometimes further contributed to family, couple, and individual pressures. For example, Israeli Jews who had settled after the Six-Day War in 1967 on Egyptian lands were uprooted in the late 1980s, after the peace agreement with Egypt. Family therapists supported families during these relocations (Wamboldt, Steinglass, & Kaplan De-Nour, 1991; Lev Wiesel & Shamai, 1998).

Researchers of family therapy in Israel have studied primarily three key topics: (a) the influence of the Holocaust on family relationships across the generations (Davidson, 1980; Hellinger, 2003; Hollander-Ggoldfein, Isserman, & Goldenberg, 2012; Kellemann, 2009; Gopen & Hyman, 2001; Volkan, Ast, & Greer (Jr), 2002); (b) the influence of the structure of the Kibbutz on families (Albert & Beit-Hallahmi, 1982; Chaitin, 2007; Gerson, 1978; and (c) the influence of prolonged exposure to war trauma on Israeli families and society (Danielli, 1998; Lieblich, 1978, 1989, 1995). Key clinical work has been therapy with survivors of the Holocaust (Davidson,1980; Kellemann, 2009). There are about 200,000 Holocaust survivors in Israel. Among them, some 40,000 suffer from the late effects of trauma exposure. "AMACHA", The Israeli Center for psychological and social support for survivors of the Holocaust and their families, has 20 branches, 190 mental health professionals, and 600 volunteers who provide services to 10,000 clients (www.amcha.org/indexEn.htm). They work with survivors on trauma issues, while their partners and other family members receive therapy as witnesses to the effects of trauma. The dominant therapy approaches are psychodynamic, cognitive-behavioral, solution-focused, and narrative (O. Shetret-Aharon, personal communication, February 19, 2014).

Current challenges that the field faces include the fact that the Israeli parliament has not yet enacted laws regarding psychotherapy and family therapy in the country. This causes ambiguity and chaos in the field. In most cases, family therapy is not supported by health insurance. Also, most family therapy training programs in Israel do not offer

training for cultural qualifications in therapy. Given the many different ethnic, cultural, and religious groups who call this part of the world home, this needs to be addressed.

THE EVOLUTION OF FAMILY THERAPY IN JAPAN. SHIN-ICHI NAKAMURA[7]

In 1984 the Japanese Association of Family Therapy (JAFT) (http://jaft.org/) was founded in Tokyo with close to 200 members. As of 2013, it has over a thousand members consisting of various mental health professionals including psychiatrists, clinical social workers, clinical psychologists, nurses, family court mediators, school teachers, probation officers, and lawyers.

Before the founding of JAFT, Japanese psychiatrists in the mid 1960s began studying the family "pathology" of schizophrenics. They learned a lot from the pioneering works of Bateson, Wynne, Lidz, Bowen, Haley, etc. The group at Nihon University, led by the late Dr. Tsuneo Imura, was the most active in researching communication patterns in "schizophrenic families." But after Dr. Koji Suzuki came back from the United States in 1973 and reunited with Dr. Imura's group, they shifted their focus from family pathology to family therapy. They continued their monthly conferences for almost a decade and finally came up with the idea to start JAFT. About ten core members were chosen from the earlier conference group including this writer, Dr. Shin-Ichi Nakamura, to organize JAFT (Makihara & Nakamura, 2013).

A current important activity of JAFT is family support for the survivors of the 2011 earthquake and tsunami in northeast Japan, especially the evacuees from Fukushima Prefecture after the nuclear power plant meltdown. We invited Dr. Pauline Boss to conduct workshops on grief counseling for mental health professionals who were providing mental health services in the affected regions. We continue our support for the survivors by sending experienced family therapists to give workshops on grief counseling and systemic approaches for local staff. They provide therapy for people who have lost loved ones as well.

Recently JAFT began implementing a certification system for family therapy supervisors. It is very important in the future evolution of JAFT to ensure family therapy effectiveness in Japan through education and training for mental health practitioners. For example, for HIKIKOMORI (socially withdrawn young adults), the systemic-oriented family based approaches might be most effective compared to other therapeutic interventions. They responded better to treatment in a family setting as opposed to a clinical environment during the initial stages of therapy (Kondo et al., 2011).

Furthermore, we have been working closely with our Korean counterparts at the Korean Association of Family Therapy (KAFT) over the past decade through academic exchanges and many joint case conferences. Through CIFA (Consortium of Institutes on Family in the Asian Region: http://www.cifa-net.org) meetings and AAFT (The Asian Academy of Family Therapy: http://www.acafamilytherapy.org) activities based in Hong Kong, Asian family therapists are collaborating via training workshops. AAFT's priorities include supervision, training, and certification of family therapists throughout Asia to promote higher standards of care.

Recently our Korean, Taiwanese, and Malaysian colleagues joined us for a 3 day intensive case conference in Hokkaido, Japan. During a discussion on the comparative study of couple dynamics in Japan, Korea, Taiwan, and Malaysia, an interesting issue came up: extramarital affairs in Taiwan and Japan. When it comes to the heated topic of infidelity, it was observed that Taiwanese couples tended to be more confrontational in comparison to their Japanese counterparts. The reason for this might be that Japanese culture is less amenable to open displays of emotion.

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An example of collaborative work among Asian family therapists can be found in the September 2013 issue of *Family Process* (wileyonlinelibrary.com/journal/famp). In this article (Lee et al., 2013), results were presented of a study of how 10 couples from each of five Asian regions (Hong Kong, Japan, Korea, Taiwan, and Mainland China) argued in their respective cultures. Video recordings of the 50 couples discussing unresolved disagreements provided raw data for quantitative and qualitative analyses. Interestingly, couples from Korea and Japan had conflict styles that were subtler and less direct than those of couples from the other regions. For the Japanese participants, one reason for this finding may be due to the fact that Japanese couples tend to use nonverbal and nonconfrontational methods of argument. In the study, we concluded that with traditional Japanese clients, therapists should pay keen attention to nonverbal communication as the context takes precedence over the actual content. If mental health providers disregard or do not take into account clients' nonverbal cues, background, and other aspects of indirect communication, the result could have serious implications for further treatment. For example, a client might feel the therapist does not understand him/her, which might lead to them discontinuing counseling.

FAMILY THERAPY AND ITS LONG HISTORY IN MEXICO. JACQUELINE FORTES DE LEFF[8]

Family therapy in Mexico has entered its fourth decade of development. It was first accepted by psychiatrists and psychologists and was well received by clients, as the family represents a valued, unifying concept in Mexican and indigenous cultures and all social strata. Trainers from North America, Europe, and Australia who had developed numerous therapy models visited Mexico. As well, therapists from Mexico trained in other countries, returned, and founded different therapy institutes (Eguiluz, 2004; Macías, 1988; Macías, Espejel, & Avilés, 2000). Cultural knowledge from the widely diverse regions of Mexico further enriched family therapy practice.

Since the end of the last century, Mexico has experienced instability and social polarization. Currently, there are challenges to reconcile a peaceful state with poverty, social inequality, gender issues, and the claims of various social and indigenous groups facing economic pressures. The drug trafficking issue has penetrated society—in the course of production, distribution, and supply and demand of the drug, as well as cartel infighting and government issues—and exacerbated social problems and corruption. A climate of tension, violence, and uncertainty affects everyone's lives. This complicates the situation of the different Mexicos that exist: the rural and the urban; the Mestizo and the Indian; the union, business, and politics; and the myriad social classes.

Family therapists have focused on understanding these problems and looking at them in creative ways from the perspectives of training, clinical care, and researching and addressing social problems. The models being used are mainly postmodern, social constructionist, and brief therapy.

Domestic violence has been extensively studied by the Center for Domestic Violence (CAVIDA), coordinated by Ignacio Maldonado and Flora Aurón (since its inception in 1996 through 2009) and by Ignacio Maldonado and Adriana Segovia from 2009 at the Latin American Institute of Family Studies, ILEF. They use a complex model that integrates social constructionism, narrative therapy, and spirituality. Their focus is to understand the phenomenon of violence within families including its transgenerational transmission, construction, and shifting social identities (I. Maldonado, personal communication,

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February 25, 2014, and Maldonado, 1999, 2002, 2003, 2005). They also provide group therapy for adolescents, men, and women, as well as mixed groups for those with previous therapeutic experience. Reflective teams are organized in the training of therapists as action research groups that research and study clinical care. CAVIDA offers a diploma course on violence which has spread to other cities in the republic. They also assess government community programs[9] (Aurón & Maldonado, 2003; CAVIDA, 2001, 2005, 2012; Maldonado & Aurón, 1999; Segovia et al., 2001; Maldonado & Segovia, 2010; Nájera, Rodríguez, & Segovia, 1998, 1999).

The Regional Institute of Family Study, IREFAM (in Chihuahua, one of the states with the highest rate of violence), also does very interesting work on these issues.[9] They train municipal police,[10] school teachers,[11] parents, lawyers, government personnel, and therapists who work with familial violence.[12] They also work with families where members (primarily women) have been murdered.[13]

Family therapy has permeated other important sectors of the state governments, advising policymakers and programs. The Instituto de la Familia (IFAC) collaborates with family judges in Mexico City, serving couples in legal proceedings from their clinic, CIFAC (T. Margain, Director of CIFAC, personal communication, February 25, 2014). Their work with remarried couples and their families is described in Gómez Fonseca and Weisz Fidel (2005). CRISOL works with the City Attorney to serve families where people have "disappeared" (desaparecidos) (J. Vicencio, Director of CRISOL, personal communication, February 25, 2014); the Instituto Personas collaborates with them to serve victims of violence (A. Freidberg, Co-director Instituto Personas, personal communication, February 25, 2014).

The issue of criminal violence has affected various training institutes in family therapy; some have stopped teaching their courses because of the risk, or because of attrition of students affected directly or indirectly by the violence problems. CRISOL, directed by Javier Vicencio, suspended courses in Guerrero and Mazatlán "for security reasons . . . we have students who have had to drop out because they have lost a family member or because they themselves are in danger" (J. Vicencio, personal communication, February 25, 2014).

ILEF recently developed a project related to criminal violence (The Migrants in Exile Assistance Group) that creatively uses new technologies. Via Skype, their experienced therapists work with Mexicans affected by criminal violence who are living in forced exile in the United States. The therapists receive group supervision as well as self-care support (A. Segovia, President of ILEF, personal communication, February 25, 2014).

In Mexico, family therapy has also penetrated the health sector. For example, IFAC has a long tradition of collaboration with hospitals where family therapists are part of the care team, such as in the Children's Hospital of Mexico (Espejel Aco, Esquivel Camacho, Bautista Santiago, & Pacheco Segura, 2009, 2011; Macías et al., 2000). IFAC also awards

[9]For many years Aurón was a member of the Council for the Care and Prevention of Violence in the City, which oversees the implementation of laws against domestic violence in Mexico City and develops proposals for public policy related to domestic violence.

[10]FAM delivered a diploma course (in collaboration with the Chihuahua Women's Institute) to Municipal Police; Response to Situations of Violence and Gender. In addition to training, they developed Preventive Programs for applications in schools, public institutions, and communities.

[11]Diploma courses delivered to teachers: "The Person of the Teacher" (2005) and "The Creation of Resilient and Loving Environments for Caregivers with Extended Working Hours." Ministry of Education, in collaboration with the Chihuahuan Business Social Fund (2010).

[12]Diploma course: "The Care of the Person of the Therapist", for staff working with family and gender violence in the Mobile Units and Center for Women's Justice in Chihuahua and Juarez City (2011).

[13]Project "Assistance to Victims of Femicide and their Families" in Juarez (2006) in collaboration with INDESOL: the National Institute for Social Development, a part of the Ministry of Social Development, SEDESOL.

a Diploma in Medical Family Therapy that is offered through the newly created Department of Family Medical Therapy at Angeles Lomas Hospital in Mexico City (T. Weisz Fidel founder and director).

The Ericksonian Center of Mexico (T. Robles) has developed prevention and growth models in communities and health care institutions related to health issues, violence, and abuse for both families and couples, as well as with the staff that serve them, working with stress and chronic fatigue syndrome (Robles 2013). C.A.I.P.S.I., a representative of the MRI in Mexico, works with the brief therapy model (Cadena, Castro, Miranda, & Mondellini, 2010).

Family therapists have also impacted addictions work. CRISOL has worked closely with the Center for Juvenile Integration (CIJ), training their therapists in family therapy. Another highlight is the work with CIJ on the national level by Fernández-Cáceres, González, Yashiro, and Barrera (2006), Fernández-Cáceres, González, and Gómez (2008), and Fernández-Cáceres and González Sánchez (2011). They have developed systemic-focused psycho-educational groups, and social support networks focused on gender and integration.

Interesting work in communities has been developed in different states. In Mérida, Yucatán, the Kanankil Institute works with different social and cultural groups using a postmodern, social constructionist model with collaborative practices (Ayora Talavera & Chaveste Gutiérrez, 2009; Ayora Talavera & Faraone, 2012).[14] In Durango, a multidisciplinary approach that incorporates family constellations, individual, group, and family therapy empowers communities and social agents (Ramírez Castañeda & Soto Alanís, 2011). The University Center for Family Studies (CUEF) of the Autonomous University of Tlaxcala has conducted research on functionality in families (Espejel, 2008; Nava, Hernández Ariza, & Juárez Ortiz, 2012; Nava & Jiménez, 2013) and convened several forums for analysis and discussion of family therapy (Jiménez, Barrientos, Juárez, & Centeno, 2000). The Grupo Campos Eliseos working from a social constructionist/collaborative approach has developed projects in different contexts such as schools (Fernández, London, & Rodríguez-Jazcilevich, 2006; London & Rodriguez-Jazcilevich, 2007; Tarragona, Fernández, & London, 2005), clinical work (Fernández, Cortés, & Tarragona, 2007; London & Tarragona, 2007), and communities, nationally and internationally (London, St. George, & Wulff, 2009). London coordinates the collaborative practices, and Tarragona coordinates the area of positive psychology. They are affiliated with the Galveston and Taos Institutes, with whom they organize an annual International Summer Institute.

Cultural constructs and myths have been investigated and applied to therapy from social constructionist (Fortes de Leff & Espejel Aco, 2000), collaborative (Chaveste & Molina, 2013), psychodynamic, and culturalist approaches, integrating different social contexts and family and group histories (Eustace, 1998, 2000, 2001, 2003, 2009; Eustace, Aurón, & Azuela, 1995). Freidberg (2009) incorporates Eastern culture through storytelling in therapy from a humanistic-narrative approach at the Instituto Personas. Álvarez Cuevas, Carrillo Vera, and Ortiz Solís (2010) incorporate ideas from positive psychology, social justice, and accountability in their social constructionist model.

There is a diversity of themes and authors working in the arena of systemic work. Troya (2000, 2008, 2012; Rosenberg & Troya 2007, 2012) integrates history, culture, and society with complexity theory, psychoanalysis, and social constructionism, to analyze gender, sexuality, and love. Vicencio writes from an integrative epigenetic frame that integrates constructivism and social constructionism (2011, 2013). Macías (2012) has a systemic-dynamic-integrative approach. Pérez Alarcón (2003, 2008, 2011) has developed an ecologi-

[14]Espejel (2012) and London and Rodriguez-Jazcilevich (2004) make different proposals concerning supervision.

cal vision of the family, including the psychodynamic and linguistic processes they construct in space and historical time. Limón Arce writes from a postmodern approach (2005, 2012). Fortes de Leff , Aurón Zaltzman, Gómez Fonseca, & Pérez Alarcón (2009) all reflect on the person of the therapist.

In Mexico, knowledge from a multitude of writers, the different family organizations, and our vibrant social and cultural life with its varied world views has contributed deeply to family therapy development. The demand for training programs in therapy institutes and universities continues to be very high throughout the country. There are seven training programs recognized by the Mexican Association of Family Therapy (1981), four in Mexico City—IFAC, ILEF, Instituto Personas, and CRISOL—and three in different parts of the republic: IREFAM (north), Universidad Anahuac del Mayab (southeast), and the Autonomous University of Tlaxcala (central). The certification of therapists and programs represents a subject of great attention currently. The Mexican Council of Family Therapy (1996), created for this purpose, is currently being restructured, to ensure government recognition for these certifications, while the Mexican Association of Family Therapy is seeking to gain a larger representation among family therapists from different schools and regions in Mexico.

FAMILY THERAPY IN PERU: GRAINS OF SAND—WORKING WITH WHAT WE HAVE TO PROMOTE CHANGE. NELLY CHONG GARCIA AND ROXANA ZEVALLOS VEGA[15]

In Peru 25 years ago, few people came for therapeutic help. There was an ingrained prejudice that visiting a psychiatrist or therapist was associated with mental illness. As in most Latin American countries, psychoanalysis represented the most widespread form of psychotherapy. In this context, asking for the whole family's participation appeared to be an odd choice and therefore difficult to accept when seemingly only one of the members had a problem or difficulty.

It took time and many meetings to explain why and how families might participate together in treatment. Today, it is common for families seeking therapy to define the problem as a "family problem" and to describe therapy as an important space to share their concerns and talk about their difficulties. Similarly, professionals who earlier considered this strange or particularly innovative now ask for the presence of the family.

In Peru, given that social services that cover therapy are scarce or nonexistent, the challenge is to provide family therapy not only for those who can afford it, but for organizations working with low-income people. It is crucial to join forces and form networks capable of providing help and support, as real as they are durable (Elkaim, 1989). As resources are often insufficient, it is useful to work in teams that include different players such as priests, teachers, psychologists, lawyers, social workers, doctors, and nutritionists. For example, the Lopez family, reluctant to seek psychotherapeutic help, talked often with a priest, and it was he who suggested they attend family therapy and offered to attend a meeting or two to make the transition to therapy. In other situations, therapists use their contacts to steer families to socially sensitive individuals or programs. Thus, the professionals around the family are involved in expanding or building networks that were nonexistent before.

Family therapists work in public hospitals and government institutions under the Ministry of Women, the Ministry of Justice, and the National Family Welfare Institute. They also work in clinics and private institutions. However, as hospitals and health centers are

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scarce and many do not have family therapists, it is necessary to provide this help at little or no cost. One way to expand this work is by establishing agreements with groups such as parishes, municipalities, and schools, to train family therapists within them.

At the National Institute of Mental Health in Lima ("Honorio Delgado-Hideyo Noguchi", under the Ministry of Health), the Departments of Adults and Aging and Children and Adolescents offer systemic family therapy on both an outpatient and inpatient basis. Also, one of the therapists trained through IFASIL is in charge of a center at the Universidad Mayor de San Marcos, a public university in Lima, which provides care to families and couples. They will soon inaugurate a Department of the Family.

Like other professionals, family therapists who work in organizations that depend on the state often have difficulty sustaining their work projects. Many times, with a change in government policies, a project that is working fairly well is refocused or eliminated to make way for one that is more in line with ideas of the new officer in power.

Toward the end of the 1980s, training in family therapy began in Lima led by a psychiatrist, Alfonso Mendoza, whose work was well known in academia and public hospitals. Most students were professionals from FASIS hospitals. Currently this group no longer exists; however, at Valdizan Hospital—a public institution—there is now a department of mental and family health where seminars, courses, and workshops are conducted. However, they are not part of a regular course load. The other institution that pioneered systems training is IFASIL, founded in 1988 by the two authors of this section. Twenty-six years later, it has trained more than half of the family therapists working in the country. (Currently in Peru there are estimated to be around 800 fully trained family therapists, mostly in Lima.) IFASIL has an agreement with the Catholic University of Lima through which it offers a postgraduate degree to students who complete a certain number of hours and supervision. They then receive a certificate from the University.

Ten years ago, the Peruvian Center for Family and Couple Therapy, in an agreement with the Autonomous University of Barcelona, began offering a Masters in Family Therapy in Lima. Students come from the public and private sectors, including teachers and other professionals interested in the subject of the family. This center particularly focuses on a gestalt approach. In the city of Trujillo, 500 kilometers north of Lima, IFAMI (Institute for Training and Family Development) was founded several years ago. They offer training in brief and solution-focused therapy.

The training of family therapists still remains mostly within private institutions. In universities, family therapy courses are taught as part of the general curriculum in psychology; most do not yet have Masters or Doctorates in family therapy. Federico Villarreal National University offers a postgraduate specialization in Systemic Family Therapy.

In Peru, there is no connection between the varied places that provide training in family therapy. However, the interest and the number of professionals interested in family therapy have grown considerably in recent years. Many therapists without training in family therapy include the family as part of their therapeutic approaches. In the rural provinces, there are still not any institutions that provide training in a serious and consistent form.

But interesting work is happening there. For example, an alumna of IFASIL in Ayacucho (in the Andes of Peru) accompanies families when they discover the graves of people killed in the civil war between the army and Sendero Luminoso (Shining Path). She is a therapist born in the area who speaks Quechua. Her job is to support families at this difficult time as they identify and recover the body of the deceased.

Another alumna provides assistance in family matters to a group of teachers from an economically deprived area that is considered very dangerous given its high crime rates. This project arose following a request to the alumna by a priest in the parish (he knew she was a therapist). The teachers face extreme difficulties in the schools related to gangs,

drugs, violence, bullying, and family issues. The therapist supports these teachers by doing workshops with them both to address these problems and to prevent burn out.

IFASIL, run by the two authors, works using an adaptation of the reflecting team model proposed by Andersen (1994). This is seen as an alternative to the use of the one-way mirror as an opportunity to hear the voices of clients, many of whom are not heard in their daily lives. Close friends and neighbors are also brought in. The interventions take into account the strengths and resilience of those involved, see clients as experts, and build alternative solutions to their problems with them (Roberts, 2010).

The reasons families seek out help currently mainly relate to situations of sexual abuse and violence, as well as the effects of separation or destructive divorce with the participation of lawyers who perform claims and counterclaims, as well as eating disorders. Before, eating disorders presented primarily in the middle and upper economic classes. That is no longer the case.

As Dabas (2011) wrote, many events and actions are unpredictable and random, shift in encounters with others, and require us to map unknown territory. Yet, there are always these certainties: confidence in people's resources and strengths and the clear understanding that nobody can do it alone, especially in such difficult circumstances as in Peru. We need to take each grain of sand and together build with them to create change.

¡ARRIBA! ONWARD AND UPWARD IN SPAIN. CRISTINA DIEZ FERNÁNDEZ AND Mª YOLANDA MARTÍN HIGARZA[16]

In its beginnings in Spain in the early 1970s, family therapy was isolated and uncoordinated. However, these early advances introduced the practice of psychotherapy, psychotherapeutic instruments, and applications in different contexts, helped unify professionals, and implemented family therapy in public and private spheres. In the early 1980s, considerable focus and development led to the consolidation of the discipline and its implementation in the fields of psychology and clinical intervention. Organizing and forming associations, the regulation of training and accreditation criteria (AEN; FEAP; FEATF, 2011), in addition to the promotion of research and inclusion in regulated curricula, have all been part of crucial steps forward. Family therapy is now a recognized discipline in the fields of social, clinical, educational, and organizational intervention (Ríos González, 2009).

This institutionalization of systems work has included private and public initiatives; the formation of regional associations through the Spanish Federation of Family Therapy (FEATF), founded in 1991; and more recently, the presence of Spanish family therapy in the Spanish Federation of Association of Psychotherapists and the European Family Therapy Association (EFTA). In addition, there has been collaboration with the Portuguese Society of Family Therapy to create an Iberian family therapy network. The proliferation of publications dedicated to family therapy has also contributed like the pioneering *Cuadernos de Terapia Familiar* (*Journal of Family Therapy*), the first issue of which appeared in 1986, and later ones such as *Systemica* which began in 1995; *Mosaic*, a journal published by the FEATF also since 1995; and *Redes (Networks),* published since 1996.

The behavioral model had been predominant in Spanish universities' educational curricula and in psychological practice; consequently training and research in family therapy has been limited until recently. Studies about systemic work were not offered until the

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early 1970s and were initially linked to courses in pedagogy, evolutionary psychology, and family counseling. In the 1980s and especially the 1990s, some concepts, theoretical models, and practices of systemic family therapy began to be included in various subjects, and new curricula introduced subjects that highlighted the importance of interactional patterns, family contexts, and other key concepts of family therapy. The growing presence of couple and family therapy in academic departments and graduate training led to more research and specialized training (Espina, 1995). In addition, since 1997 the Spanish Association for Research and Development of Family Therapy (AEI+DTF) has promoted and coordinated interuniversity research and research in other institutions in the field of family therapy.

In recent years, the practice of family therapy in Spain has been sensitive to changing social contexts and the demands that these shifts generate in families. Interest has emerged about transcultural issues as globalization has contributed to the common presence in therapy of people from other countries. This requires new cross-cultural models and a focus on changing social identities and relationships (Bermúdez & Brik, 2010). In this same vein, the impact of new technology on family relationships has been the object of a multitude of professional meetings and publications, with many novel interventions developed (*Livro de Resumos,* 2012). Other important themes are new family models: blended families, adoptive families, gay couples, etc. (Mosaico no. 44, 2010; Livro de Resumos, 2012); different network formats (Mosaico no. 41; Mosaico no. 47); challenges of parenthood in different life cycle stages, such as adolescence (Mosaico no. 41; Mosaico no. 47); and the varied forms of domestic partner and family violence (Fontanil, Ezama, & Fernández, 2004; Muñiz & Lopo, 2004).

Another important development in the adaptation of therapy family professionals to the emerging needs of the country has been the inclusion of family mediation as an area of interest with some regional associations promoting it. Also community social services have implemented family mediation in family work (Garrido, Casares, Grimaldi, & Domínguez, 2009).

These advances have contributed to increased recognition and expansion of family therapy in Spain, although there are more tasks ahead. We believe there should be a more consistent presence of family therapy in universities, in graduate study as well as a wider variety of options in undergraduate studies, which are now limited to a few electives. There is also a need for greater support for research so that advances in the practice of family therapy are backed by rigorous, quality studies. Equally, we consider it essential that the accreditation of family therapists be recognized by institutions throughout Spain so that it is considered an accepted and valued qualification in the field of public administration as well as others that are dedicated to helping families across the country.

All of these challenges are seen from the perspective of professionals working to help family therapy in Spain reach the level of recognition it deserves and have it seen as an effective, robust method of therapy.

A RISING NEW PROFESSION IN TURKEY. FATMA TORUN REID[17]

Family therapy in Turkey is in its infancy, yet like some babies who do not crawl but walk immediately, the profession is beginning to take serious steps. Turkey has a recently established Ministry of Family and Social Policies (headed by a female minister) which

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has given priority to a national "family counseling centers" project that targets the prevention of domestic violence, assistance for the continuation of marriages, divorce counseling, single parent support, and most recently, premarital counseling. Starting in five pilot provinces in 2012, some of these services are carried out jointly with family courts, especially in the protection of children during custodial conflicts. The Social Services and Child Protection Agency, SHÇEK, with a history dating back to the early 1920s, is also an important government agency presently working under the family ministry.

Turkey is a country in transition affected by globalization and large rural to urban shifts, yet at the same time it is a culture particularly devoted to family and friendship ties. These values still hold people together and provide the best support system at times of natural or economic crises as well as in raising children. They can also be sources of stress and conflict in close relationships. In new marriages, for example, the support given by parents or parents-in-law can sometimes turn into over-involvement in the lives of their adult children which can contribute to a cycle of defensive distancing between partners. Strong ties with a parent figure or with the family of origin can sometimes hinder new couple bonding (Reid, 2011, 2012).

There is obviously a felt need for couple and family therapy in Turkey given the impact of macro systems on the family. The challenge is how to meet these needs through professional services when the profession is at its beginnings. Up to the present, they have been met mainly by psychologists, psychiatrists, counselors, and social workers, some working with a systemic approach but most using a variety of individually focused therapy approaches. According to a study by the Turkish Family and Marital Therapy Association (AETD), 13% of the 321 professionals practicing couples and family therapy in Turkey are psychiatrists and 77% are psychologists (Eraslan, Camoglu, Harunzade, Ergun, & Dokur, 2012, p. 135).

Interestingly, the Ministry of Family and Social Policies seeks to align its new services under the name "family counseling" rather than "family therapy". The reason seems to be twofold. First, in Turkish, the term "therapy" carries the implication of medical treatment and would fall under the jurisdiction of the Ministry of Health, whereas the Ministry of Family has the Ministry of Education as its partner in this project. Second, the term "family counseling" is meant to flexibly encompass the numerous mental health professionals who do not have formal family therapy training. At present, the ministry requires that those who work in the family counseling centers close gaps they have in their knowledge of family therapy by adding 450 hours (including 150 hours of supervision) of family training. The country's handful of formally trained family therapists is understandably concerned about the maintenance of standards in family therapy practice as the new program takes shape. Even though the "baby has skipped crawling and has started walking," s/he needs more practice before training programs with supervision can stand securely on their feet. Fortunately, there is now active collaboration between ministry representatives, universities, and members of the country's professional family therapy associations, such as CATED (Couples and Family Therapies Association), an organization less than 2 years old with 150 members.[18] The association has a quarterly bulletin (*Sistemik Bulten*) of some 20 pages which promotes family therapy in Turkey. Its recent study, *The Preferred Models of Therapy* (presented at the October 2013, Istanbul EFTA conference), showed systemic, solution-focused, and CBT as the most favored therapy approaches in Turkey. There are, however, a variety of psychodynamic, insight-oriented therapy approaches used by individual therapists, including Transactional Analysis (Erskine, 1995), which is integrated into the academic programs of Bilgi and Yaşar universities. In my own practice, I focus on the father's participation, which makes

[18]Among its founding members are Nilufer Kafescioglu, Yudum Akyil, and Sibel Erenel.

a big difference in the outcome. Traditionally parenting was mostly mothers' business in Turkey, and fathers were authority figures from a distance. As fathers gain insight into their own childhood needs and become acquainted with their own internalized parental models, it gives them an incentive to be more involved and seek better parenting approaches. Here, I find Transactional Analysis to be a highly effective approach. In working with couples, I use the metaphor, "Your relationship is your first baby," by which I invite the couple into a joint effort and cooperation which lessens defenses and enhances communication. In new marriages, becoming a "we" often takes a long time because of the over-involvement of extended family members—usually the mothers of the groom or the bride. The couple taking ownership of their new relationship, without being disrespectful or breaking ties with the parent figures, needs new insights and skills (such as the handling of disputes or the appreciation of differences), which I call IOSB, insight-oriented skill building. I prefer also working with subsystems to focus on and strengthen the partners' relationship so that they can cope with problems coming from the larger family system more effectively. Time wise and financially this is also more economical.

An older family therapy association, founded in 1997, AETD (Turkish Family and Marital Therapy Association with 340 members), is a member organization of IFTA and EFTA. It hosted the 2004 IFTA and the 2013 EFTA congresses in Istanbul. The 2004 IFTA congress was a major event in raising awareness about family therapy in Turkey.

The need for education and training in the field is presently being met by a limited number of private institutes and university certificate programs. Over the years, two psychiatrists in Istanbul, the president of AETD, Murat Dokur (trained at MRI), and Nuşin Sarımurat (trained at Ackerman) have been running training programs whose trainees meet EFTA standards. Similarly, psychologist Emre Konuk (MRI trained), the general secretary of CATED, has been offering programs on strategic and solution-focused therapy at his institute, DBI (Davranış Bilimleri Enstitusu/The Behavior Sciences Institute). In Ankara, a number of academics have pioneered work with families: Profs. Hürol Fısıloğlu of ODTU (Middle East Technical University), Işıl Bulut, at Başkent University, and Ayşe Yalin at Hacettepe University. In Istanbul, Profs. Sunar & Fişek (2005), all originally of Bogaziçi (Bosphorus) University have through their teachings, outreach programs, and research made contributions especially in regards to Turkish culture. As Kagıtçıbaşı (2005, 2007) has pointed out in Turkey, families live in a 'culture of relatedness' with emotional and economic interdependence. This is reflected in everyday life as one sees parents and even adult children walking arm-in-arm on the street, as well as in the tendency of family units of the same extended family to live on different floors of the same apartment building.

In Izmir at Yaşar University, Ozge Alkanat leads a family therapy training and supervision program assisted by the Hiebert Institute in Illinois, USA. The director of this İnstitute, Hiebert (1993), has had a vital role in family therapy in Istanbul through years of training programs he has offered, sponsored by the AŞAM Psychological Counseling/Child and Family Development Center.

University certificate programs in the country are mostly connected with graduate school counseling departments, such as those in Izmir's Ege University and Dokuz Eylül University, or under clinical psychology graduate school programs (as at Bilgi University in Istanbul). This year Bilgi will begin to offer a masters program in family therapy (replacing the present certificate curriculum). Having a graduate level program in family therapy in the country is a big step forward. In the meantime, I hope territorialism doesn't hinder the progress that today's good will and collaboration promise in family therapy as a profession and service in Turkey.

FAMILY THERAPY IN UGANDA: CHALLENGES AND DEVELOPMENTS. HUGO KAMYA[19]

Family therapy in Uganda is both old and new. It is old because it fits in well with the traditional culture of the people, but it is new because it is building its own processes that will legitimize it. Most importantly, it must be seen in the context of traditional healing strategies which are anchored in religious and spiritual beliefs and practices of the community, including the power of the natural world.

Located in East Africa, Uganda is one of Africa's 55 countries on a continent with over a thousand tribes, each with its own religious system (Mbiti, 1990). The country has a population of 33 million people with over 15 ethnic tribal groups: Baganda (17%), Banyankole/Bahima (10%), Basoga (8%), Bakiga (7%), Banyarwanda (6%), Langi (6%), Acholi (5%), Bagisu (5%), Lugbara (4%), Banyoro (3%), Batoro (3%), and Karamajong (2%) (U.S. Department of State, Bureau of African Affairs, n.d.). There are 45 individual languages and dialects in Uganda, with English as the official language. Other widely spoken languages include Luganda and Swahili. The main religions are Christianity (85%), Islam (12%), and other faiths (3%) (Central Intelligence Agency, 2012). Uganda's population is predominantly rural with a high density in the southern regions (Senyonyi, Ochieng, & Sells, 2012). Spiritual powers—the supreme god, other divinities, the spirits, and one's ancestors—are invoked and prayed to, and sometimes libations are poured to honor them. Many Ugandans integrate traditional spiritual practices with Christianity (Odoki, 1997; Kamya, 2005a,b). It is crucial to understand these Ugandan belief systems in context including history, economics, politics, and colonialism.

Unlike many countries in Africa that were colonies of European countries, Uganda was a protectorate of the British Empire. The status of a protectorate allowed the kingdoms that made up Uganda to function as autonomous entities. In 1962, Uganda gained independence and was granted self rule, becoming a republic in 1967. The years that followed independence were riddled by internal conflicts which culminated in the military dictatorship of Idi Amin, who brutalized the country in his 8-year rule from 1971 to 1979. Following his overthrow, Uganda has suffered a civil war with over 30 years of guerrilla warfare by the Lord's Resistance Army based in northern Uganda, the Democratic Republic of the Congo and South Sudan. This war, along with the devastation of the country's infrastructure, has affected community and family well-being.

Family therapy in Uganda can be located within counseling which Senyonyi et al. (2012) suggest falls in three areas: nonformal guidance offered in the traditional culture, clan, and family; guidance counseling offered in schools; and counseling to address the devastating effects of the HIV/AIDS epidemic. Many counselors work in tandem with cultural and religious beliefs.

Uganda's traditional religions can be described as animistic (Mbiti, 1990, p. 9), or referring to soul or spirit, derived from the Latin for breath. Because religion permeates all aspects of one's life, religion is expressed through mystical power, magic, witchcraft, and sorcery that the western world would consider not religious. Belief in the divine or spiritual beings translates into a commitment to worship in varied forms. Diviners and medicine men/women use their skills in engaging help seekers to find answers to failed relationships, marriage, or even suspected evil spells.

For Ugandans, one's identity is found the community's identity. A Ugandan proverb, "I am because we are," underscores this community identity. Ugandans, like most Africans, integrate the sacred and secular into one harmonious, cooperative, and communal orientation without formal distinction between the sacred and the secular, between the religious

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and the nonreligious, between the spiritual and the material areas of life. The emerging field of family therapy seeks to build on this too. This indigenous philosophy of life has become the framework of family therapy in Uganda.

Some religious groups have connected with churches, mosques, and temples to provide counseling. There are groups, such as Victim's Voice, which seeks to address stress and its consequences within the individual and the family as well as the community for people who have been affected by violence and conflict; WORLD VISION, which works toward the transformation of communities through empowerment processes that target children and families; and TASO (The AIDS Service Organization), which provides HIV/AIDS counseling to families, to name a few. These groups work in small or large units seeking to develop a sense of connection, purpose, and meaning for the families and communities they work with, including celebrating their relationship with the divine. There are also training institutes associated with some of these organizations dedicated to training counselors in family therapy. Most services, however, tend to work closely with health clinics.

For example, in the case of HIV/AIDS, counselors appeal to a sense of wholeness and wellness associated with being in harmony with nature and building a sense of purpose and meaning in this relationship. Because HIV/AIDS has affected almost everyone in Uganda, the scourge of AIDS is seen as a collective responsibility. Family therapy is best conceived in community groups or caucus groups (Tamasese & Waldegrave, 2008). Indeed, around HIV/AIDS, family counselors speak not only about life propagation but also the quality of life that is passed on. With such a focus, counselors commonly talk about safer sex practices with couples and families and teens. Family therapy practitioners engage with issues of religion, spirituality, culture, values, politics, history, agriculture and economics to understand the problems that families encounter (McDowell, Brown, Kabura, Parker, & Alotaiby, 2011).

Another practice approach in Uganda is the telling of stories and the use of proverbs as they permeate family life. Here are a few proverbs that connect to people's lives:

One who sees something good must tell it.
He who loves you, will still love you with your dirt (love is selfless and unconditional).
An old man sits and enjoys the trees he planted years back (invest in your youth, reap in old age).
As the brave cry, the cowards laugh (do cowards have any idea what war means?).
Caution is not cowardice; even the ants march armed.
When two elephants fight the grass gets trampled.
He who hunts two rats, catches none.
The person who has not travelled widely thinks his or her mother is the best cook.
An elephant can never fail to carry its tusks.
The path to your heart's desire is never overgrown.

Stories about hope, life, family life cycle and structure, and child rearing practices that already exist within the culture are seen as a powerful resource. Stories and proverbs are used by counselors to deliver key life lessons. They provide families comfort, connectedness, and control.

Family practitioners also engage many outside consultants to reach families, especially in those areas where families prefer to keep to themselves. It is not uncommon that domestic violence and power relations among men and women often get addressed through key cultural brokers that work closely with family practitioners. Such brokers include local community members who regularly check on families and their well-being.

Among the Baganda of Uganda, the living-dead who are believed to dwell around homesteads are considered to be benevolent spirits. In some groups, family counselors assist

people with entering into trances and meditative states believed to connect them to spiritual beings. Another practice that has been used in war ravaged northern Uganda are dramatic representations of cleansing ceremonies to address trauma including helping survivors of war to perform healing rituals through dance and drama. Through them, communities connect with the living and the dead, with ancestors, and with spiritual beliefs, nature, history, and culture (Kamya, 1997; Mbiti, 1990).

But family therapy in Uganda faces major challenges. Uganda has endured a long civil war since 1990, largely ending in 2006 with displacements of over 1.6 million people, most of whom are in northern Uganda. The Lord's Resistance Army (LRA) has been accused of the abduction of around 30,000 children, many of whom are forced into becoming child soldiers (http://www.insightonconflict.org/conflicts/uganda/). Some have become street kids roaming the cities. (According to UNICEF, Uganda has over 10,000 street children [http://www.unicef.org/infobycountry/uganda_58936.html].) Some have been exploited while others have been forced into child labor under tough conditions. Regional conflicts and the plight of HIV have created new types of families, like child- and granny-headed households, families with multiple wives/mothers, families living in war zones, and child soldiers (McDowell et al., 2011). The prevalence and predictors of violence in the aftermath of war have been well documented in a recent study that focused on couples in Northern Uganda (Saile, Neuner, Ertl, & Catani, 2013). Because of the war trauma, parent–child relationships have been affected, contributing to intergenerational transmission of violence.

One major challenge that faces family therapy/counseling in Uganda is what I like to call the "deluge of well wishers". These trainers are often sponsored by religious organizations sponsored by their countries of origin and have varied ideas about how to help families and couples. While some of these groups have engaged in culturally sensitive approaches that attend to the local Ugandan community, such as HIV/AIDS counseling programs, others have imported strong evangelical ties, many of which are foreign to Ugandans.

In conclusion, family therapy as a field is both old and new. It is a young field as seen from the western viewpoint, but it has a long tradition that is rooted in the culture and religious traditions of the people of Uganda. The future of the field is strong and promising. The support and will of the government to advance the field will be key, as will the training of Ugandans. Research and publications of work by family therapists in Uganda will add to the knowledge base of the field. To this end, the establishment of the Uganda Counseling Association (UCA) with over 800 active registered members, two registered training institutions, and 14 registered private firms is a promising step in advancing family therapy in Uganda. The UCA has sought to professionalize the field by developing accreditation and certification guidelines, standards, and a code of ethics, all of which build legitimacy.

RECENT INNOVATIVE PRACTICES IN THE UNITED KINGDOM. PHILIP MESSENT AND GLENDA FREDMAN[20]

McFarlane (2012), walking mostly in the United Kingdom, describes how he has retraced the steps of others. He writes about the landscape that he encounters as projecting into us "not like a jetty or peninsula, finite and bounded in its volume and reach, but instead as a kind of sunlight, flickeringly unmappable in its plays, yet often quickening and illuminating." He sees one of the questions that we should ask of a landscape as being "What do I know when I am in this place that I can know nowhere else?"

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We can ask ourselves this same question in relation to the landscape of family and systemic therapy in the particular context in which we operate, although as MacFarlane describes above in relation to physical landscapes and their impact, this too may be "flickeringly unmappable" and hence difficult to decipher comprehensively. Borcsa, Hanks, and Vetere (2013) have considered the development of family therapy across the European context and describe in a similar way how "single model approaches can be seen to cross the boundaries of family/individual conceptualizations, and extend themselves into the direction of cultural customs *in a process of mutual influence*" (our emphasis). They go on to suggest that one of the important features in ensuring that models retain "cultural sensitivity and socio-historical relevance" is the recognition of locally generated "practice-based evidence", emphasizing the influence of the local landscape upon practice development.[21]

Large-scale US research trials have generated models such as Multisystemic Family Therapy, Multidimensional Treatment Foster Care, and Functional Family Therapy (FFT), all with important elements of systemic thinking and practice. These have developed an evidence base warranting their recognition as effective by UK government bodies like the National Institute of Clinical Effectiveness and therefore attracting government funding for extensive pilot schemes in the United Kingdom. It is too early to say what we can know about the operation of such models in the United Kingdom that cannot be known anywhere else; indeed, much of the emphasis in their delivery is upon compliance with the models, as though these can be invariable. Callaghan (2013) has written about the experience of finding a way to be "hospitable" to the practice of FFT as he takes part in a research trial in Brighton, seeing this manualized approach as a "secure base" with creativity taking place in the "space between" the model's steps and techniques.

One important contextual factor in the development of family therapy in the United Kingdom has been its adoption within public services, both the National Health Service (NHS) and in local government provided social services. During the period of public sector expansion between 1997 and 2006, family/systemic therapist posts were created particularly in Child and Adolescent Mental Health Services throughout the United Kingdom (Messent, 2008), enabling the use of team approaches such as reflecting teams and outsider witness groups. These allow for the sharing of systemic ideas with colleagues from other disciplines (Messent, Pearson, & Skillicorn, 2011) as well as for the development of creative and playful approaches such as the use of puppets to make such interventions relevant to children (Brown, 2009; Fredman, Christie, & Bear, 2007).

Hills (2013) has described the development of such a team in an NHS Psychological and Addictions Service for adults, making use of an existential systemic-phenomenological approach, seeking ways to create an existential validating experience for the family through the therapeutic dialogue formed from the temporary attachment to the team, that release their own beneficial resources and capacity to live with less stress and distress. The development of family/systemic therapy in adult mental health services in general in the United Kingdom has been much less developed, as the medical model in this field is much more dominant. Another exception has been an approach to working with first episode psychosis described by Burbach, Fadden, and Smith (2010), involving an integration of psycho-educational, cognitive-behavioral, and systemic models.

An important development in thinking in social work practice in the United Kingdom has been the influential "reclaiming social work" model first developed in the London

[21]The authors sought the advice of UK practitioner/managers by posting a question on a national 'Heads of Family Therapy' email discussion group about what was thought of as innovative practice in the United Kingdom; what follows draws upon the replies that were received. For a more comprehensive and recent overview see Stratton and Lask (2013).

Borough of Hackney and having an impact widely across England, containing within it an important systemic component as described by Pendry (2011). This represents a move away from social work as a bureaucratic processing of individuals, toward an emphasis upon the importance of connection and relationship forming, with practitioners receiving training to make use of social learning theory and systemic ideas in helping them to orient themselves in their task of building relationships with client families and generating change. UK-based Systemic/Family Therapy training institutions are increasingly occupied in delivering in-house packages of such training to social workers, who may become accredited "systemic practitioners", a half-way house to a full training as a family/systemic therapist, with its own validity and status. Borcsa et al. (2013) point out that across Europe, the popularity of this accreditation can be seen as the success of family systems thinking—its recognized relevance and applicability to all health and social care professionals in private, voluntary, and public sector services.

An emphasis upon the importance of paying attention to issues of power and difference has been particularly important for a country like the United Kingdom with its colonial history and diverse communities. The work of Roper-Hall (1998) and Burnham (2012) in developing the use of the Social GGRRRAAACCEEESSS model has provided practitioners with an effective tool (and ever developing mnemonic!) for helping to ensure that thinking about differences get considered in shaping hypotheses and therapeutic encounters. An example of the way that practice-based evidence in a local context can be generated over a period of time is in the work of Messent (1992, 2004), who has described the way in which systemic work has shaped responses to the needs of different minority communities in the London Borough of Tower Hamlets, an area in London Docklands with a rich history of migration. He describes for example the work of the African Family Service, with its emphasis upon workers honoring African parents' sense of themselves as having authority to decide about interventions offered to their children and families by meeting them first, and addressing forms of punishment not acceptable in the United Kingdom, from a position of respect for parents' good intentions for their children.

Other UK developments in using systemic approaches with marginalized groups oppressed by pathologizing discourses include practices to counteract the effects of discrimination and isolation and to facilitate collaboration and community with older people (Fredman, Anderson, & Stott, 2010), people with intellectual disabilities (Baum & Lynggaard, 2006), and people with physical health problems (Christie & Fredman, 2001; Fredman, 2004). The intention of such work is to create contexts where the person designated "patient" has a voice and choice and where all involved feel connected and empowered, drawing upon principles named as the "Systemic C's"—collaboration, communication, connection in relationship, context, circularity, and also competence, choice, curiosity, cocreation, and community (Webb Peploe & Fredman, 2012). Such work is described as "systemic" rather than "family therapy" as the people designated "patients" are usually connected in large networks of relationship with family, community, and practitioners providing health, mental health, social care, and education services.

Starting from the position that "the person is not the problem, the problem is the problem" (White, 1988) and the "solution is not only personal" (Denborough, 2008), this work aims to enable possibilities for collective contribution through creating "resource-full communities" with clients and practitioners and acknowledging, collectively documenting, and valuing all people's specialist knowledges. Two examples of these practices include: (a) The Advisory Group of Older Patients that draws on the Council of Elders work of Katz, Conant, Inui, Baron, and Bor (2000) and invites older people to act as consultants to a clinical psychology service (Milton & Rapaport, 2012) and (b) Tree of Life workshops (based on the work of Ncube (2006) and Denborough (2008)) as an approach to relapse prevention to encourage connectedness and community with older people ending treatment

with mental health services (Clayton et al., 2012) and to facilitate transition to adult services with young people living with diabetes (Casdagli, Fredman, & Christie, 2011).

Multiple Family Therapy is another practice which creates such communities, drawing upon a combination of psychodynamic, group, and systemic therapy. With origins in the USA in the 1940s and 1950s where several teams (e.g., Ross, 1948) experimented with using large group work in the treatment of psychotic patients, and UK ideas from the therapeutic community movement and milieu therapy, the family day unit at the Marlborough Family Service was developed (Asen et al., 1982). Practices of working with "multi-problem" families grew into the Marlborough Model of Multiple Family Therapy (Asen, Dawson, & McHugh, 2001) with applications in other settings such as schools and teams working with eating disordered adolescents (Scholz & Asen, 2001), widely used both in the United Kingdom and Europe (Asen & Scholz, 2010).

We briefly highlight some of the innovative practices which have emerged from the local landscapes, perspectives, and knowledges in the UK context: what we know that we could know nowhere else. We hope that in trying to describe these "flickeringly unmappable" landscapes (MacFarlane, op cit), we have been able to do justice to the variety and liveliness of this still developing field.

EXPANDING OUT: GOING MORE PLACES

Historical and political country specifics—as well as ethnic, cultural, gender, racial, sexual orientation, and age differences within them—shape models of family therapy, training, and practice. These authors demonstrate that we should be asking questions such as: How do the political aspects of mental health infrastructures and higher education affect training and the delivery of services? Who has access to systems training? At what age/developmental stage? What keeps others away? What status/power do family therapists have? How will these dynamics shape the future of family therapy in different countries, and around the world?

As well, the varied ways human resources for mental health are developed impacts theories and treatment. Going outside of one's country for training and bringing ideas back, or learning from outside subject matter "experts" who come to your country, is qualitatively different than developing therapeutic practice that draws upon local knowledge. This behooves us to think across countries and what strategies are used to develop systems work, and question how this might skew models and areas of focus. Within a region or county, people might make deliberate shifts in other directions. For example, how might family therapy training be different if more attention was paid to indigenous knowledge? (See Hernandez-Wolfe, 2013, for very thoughtful descriptions of ways she has done this.)

It also behooves us to pay more attention to how our location within a society and our social identities affect training dynamics (Almeida, Hernandez-Wolfe, & Tubbs, 2011; Hernandez-Wolfe & McDowell, 2012). As Philip Messent stated, particularly about teaching and work he has done in Uganda, "I think that as a white European visitor to Africa, every encounter that I have is imbued with all the encounters that white people have had both in our colonial past and in our more recent post-colonial world" (personal communication, February 23, 2014). We need to resist, as Messent has done powerfully in his work (2009), relationships of power inequalities and continuously develop more equitable models and training situations (Borsˇtnar, Bue'ar, Makovec, Burck, & Daniel, 2005; McDowell & Hernandez, 2010).

Writing from people from around the world and websites are cited by the authors. We encourage you to delve into topics you have not explored before, and let your students, clinical and research colleagues, and others know about the resources of this article.

Intriguing family therapy journals and bulletins are described from the four different journals in Spain alone, to the new Bulletin in Turkey. Many excellent ideas in the field are not being widely disseminated because articles are usually available in only one language. Recently editors of family therapy journals met at the EFTA conference held in Istanbul (in November 2013, in conjunction with the Turkish family therapy association). One idea that came up is to see if a platform might be created for all the family therapy journals around the world where people pay per article to read it in a different language. Given translation costs, it would have to get enough hits that the translations would be relatively inexpensive.

It is also crucial to continue to bring in new voices to the family therapy field. Toward that end, Ruben Parra-Cardona and the international committee of the Family Process Institute has launched a writing workshop and mentoring program for clinicians and researchers in Latin America (www.familyprocess.org/about-us/). Some journals such as *Families, Systems and Health* accept articles for review written in Spanish. Other journals publish their abstracts in different languages.

It is also important to ask "What is not in these pages?" Obviously a multitude of countries around the world are missing. I invite authors from these countries to email me (janine@educ.umass.edu) if you are interested in writing 5–6 pages in a format similar to what you see here. If there is enough response, these pages can be edited and posted on the Family Process website, to keep expanding the dialogue.

We are also missing client voices. Perhaps a future article could focus on clients speaking and writing (like narrative therapy authors have done), especially in countries where not as much has been published about family therapy.

It was impossible to cover every center, institute, training program, etc., in every country. In particular, independent groups (not sanctioned by organizations for example, or universities) are absent. For example, C.E.F.A.P (Center of Family and Couples Therapy: www.cefap.com) in Puebla, Mexico—directed by Felipe Gutiérrez—runs extensive certificate programs in areas such as systemic, brief, and play therapy, and couples work.

As the authors in this article write, people everywhere are thinking outside the box when it comes to systems work. How fortunate we are to be in a vibrant field that is spreading on all the continents (except Antartica!).

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