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Cultural Sensitivity as an MFT Common Factor

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ABSTRACT

Cultural sensitivity is a state of attunement, emotional resonance with, and meaningful responsiveness to others. MFT professionals continue to discuss cultural sensitivity in relationship to models and therapists. We see cultural sensitivity as a common factor that spans models, rather than resides within them. We present a case vignette to illustrate the distinction between *doing* cultural sensitivity and *being* culturally sensitive. We also discuss implications of conceptualizing cultural sensitivity as an MFT common factor for teaching and research.

Introduction

Marriage and family therapy (MFT) clients are becoming more and more diverse (AAMFT, 2014). While we have learned many things about various cultural groups, we have also learned that there is a great deal of variation within these groups (McGoldrick, Giordana, & Garcia-Preto, 2005). People experience, interpret, and live their culture differently. Therefore, it is important for therapists to be sensitive to each client's experience of his or her culture (Cheung & Chan, 2002). There has been a great deal of discussion in MFT about cultural competence, sensitivity, and humility. Some view certain models as more culturally sensitive than others. For example, Cheung and Chan (2002) praise the Satir model (2002) for attuning to issues of diversity, while (2001) critiques structural family therapy as being less sensitive to diversity issues than other models. We have concerns with such critiques, since at the heart of them is the assumption that some models are inherently culturally sensitive while others are not. In other words, these critiques assume that cultural sensitivity is a feature of the model and not the therapy process. We aim to show how cultural sensitivity can and should span models. In fact, we see it as a common factor that cuts across MFT models and can be nurtured regardless of one's particular therapy model.

In the present paper, we argue that cultural sensitivity spans models, and justify why we believe that cultural sensitivity may be an additional common factor. We

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draw a distinction between doing cultural sensitivity and being culturally sensitive, and will illustrate this distinction in a case vignette. We will also discuss the implications of considering cultural sensitivity as a common factor.

Background

For the purpose of this paper we have chosen to use the term "cultural sensitivity" over "cultural competence." Cultural competence is the presence of cultural awareness where awareness refers to a state of having insight and knowledge about diversity issues (Hardy & Laszloffy, 1995; Laszloffy & Habekost, 2010). The term "cultural sensitivity" refers to a state of attunement, emotional resonance with and meaningful responsiveness to the needs and feelings of others (Hardy & Laszloffy, 1995; Laszloffy & Habekost, 2010). It involves empathic resonance and the capacity to not only understand another's' perceptions and feelings, but the ability to modify one's own behavior to adjust to the other (Hardy & Laszloffy, 1995; Holcomb-McCoy & Myers, 1999; Laszloffy & Habekost, 2010).

Cultural sensitivity and cultural humility are important components of marriage and family therapy practice and training. Authors have suggested several ways to incorporate cultural sensitivity into MFT training and supervision, such as the use of cultural genograms, cultural immersion assignments, and activities that help student therapists acknowledge and address their cultural bias (Laszloffy & Habekost, 2010). There is growing evidence that therapists whose work is sensitive to clients' cultural value achieve better results (Cheung & Chan, 2002; Muir, Schwartz, & Szapocznic, 2004; Sprenkle, Davis, & Lebow, 2009; Yutrzenka, 1995). Therapeutic alliances also involve attuning to the client's culture (Sprenkle et al., 2009).

Culture and MFT models

Some MFT researchers identify certain models as better suited for some cultures and genders than other models (McGoldrick, Giordano, & Garcia-Preto, 2005; Sprenkle et al., 2009). We argue that all models can be implemented in a culturally sensitive way because cultural sensitivity is a feature of the therapist, not the model. That is, cultural sensitivity is not an element of a model, but rather, an element of the therapist's' way of being (Fife, Whiting, Bradford, & Davis, 2014). Therefore, cultural sensitivity should be considered a common factor in MFT. The primary aim of the present paper is to present evidence to support the construct of cultural sensitivity as an important common factor in MFT. We will provide examples of how cultural sensitivity can work in synergy with a wide range of MFT models.

Doing vs. being culturally sensitive

In discussing our ideas about cultural sensitivity as a common factor, we make a critical distinction between *doing* cultural sensitivity versus *being* culturally sensitive. Cultural sensitivity is inevitably embedded in the *therapist's way of being*. Fife

and colleagues (2014) discuss a meta-model called the therapeutic pyramid which can be superimposed over any therapy model. This meta-model describes how two common factors (therapeutic alliance and techniques) interact with the addition of another common factor—the therapist's way of being. This "way of being" is not about techniques, but about forming a genuinely caring connection. We propose that *being* culturally sensitivity is a vital part of the therapist's way of being. It includes traits like curiosity, respect, humility, and interest in the client's culture.

We caution against thinking about cultural sensitivity as just a model, intervention, or technique, which are forms of *doing*. *Doing* cultural sensitivity suggests implementing an intervention that is consistent with the culture of a particular individual or group. Therapists who simply *do* cultural sensitivity are not necessarily connecting with their clients at a deeper level. One example is bringing up aspects of one's culture in therapy when they are irrelevant (e.g., discussing *machismo* with a Latino family or *parentification* with an Asian family when neither relates directly to the presenting problem or to the family dynamics around the problem). Certainly, there are times when these concepts are helpful and applicable, but *doing* without *being* reduces our clients to their cultural group. Out of the best intentions, therapists-in-training may be eager to learn how to *do* therapy and learn the skills involved. Similarly, many see culturally sensitivity as a tool to be used in therapy. However, if we conceptualize cultural sensitivity as an intervention, it is easy to think about it as something we do *to* clients.

We do not mean that skills and interventions that focus on or address culture are unnecessary. Rather, those techniques become more effective if delivered by a therapist who is not only *doing*, but *being* culturally sensitive. Fife and colleagues (2014) suggest, "…effective use of *skills* and *techniques* rests upon the quality of the *therapist-client alliance*, which in turn is grounded in the therapist's *way of being*…" (p. 21). We acknowledge that both are important, but being culturally sensitive conveys that the therapist's deep understands of the premise of cultural sensitivity, and they are not just carrying out an intervention without true understanding (S. Fife, personal communication, 2015, July 4).

Being culturally sensitive as a common factor

Several studies in the MFT field have found links between cultural sensitivity of the therapist, and therapy outcome (Keeling & Piercy, 2007; Muir et al., 2004; Yutrzenka, 1995; Murphy, Park, & Lonsdale, 2006). Specifically, when therapists do not practice in a way that is culturally sensitive, they are likely to misunderstand, or unnecessarily pathologize practices of other cultures (Keeling & Piercy, 2007; Muir et al., 2004; Uehida, 2002). Cultural sensitivity is an essential aspect of successful therapy that cuts across effective therapy models (Cheung & Chan, 2002).

Common factors are conceptualized both narrowly and broadly (Sprenkle & Blow, 2004). Broadly, common factors are grouped into non-technique aspects of therapy including, client factors (e.g., motivation, expectations, and hope), therapist factors, (e.g., training orientation, way of being) therapeutic alliance

factors (Sprenkle & Blow, 2004). The broad conceptualization of common factors includes dimensions of the treatment setting (Sprenkle & Blow, 2004). This view is consistent with Lambert's (1992) Four-Factor model of therapeutic effectiveness. Lambert (1992) further identifies static characteristics of the individual, which includes culture and race. Non-static characteristics are variables such as level of family cohesion, expressed emotion, and commitment. Relationship factors are the strength and quality of the therapeutic relationship (Lambert, 1992). The process of forming a strong therapeutic relationship is heavily dependent on the cultural sensitivity of the therapist (the being), and the way in which the therapist expresses his or her cultural sensitivity (the doing) (Epstein, Curtis, Edwards, Young, & Zheng, 2014). Expectancy or placebo effects also can be influenced by culture. Culture may well play some role in who does or does not present for therapy as well as the client's' expectations about what will happen in therapy.

Forming a therapeutic relationship is heavily dependent upon the therapist's ability to be culturally sensitive to the client. Many therapy models include explicitly or implicitly the importance of the therapeutic relationship, though they all use different language when discussing how to form a therapeutic relationship. For example, structural therapists would "join"—because that is what the structural model says about how to form a therapeutic relationship—but *how* they join in a culturally sensitive way depends on the therapist. In contrast, a narrative therapist would allow a client to tell his or her story. How they reframe or punctuate that story would depend on how the therapist includes or ignores the client's culture. Both of these model-specific ways of joining are likely to lead to the end result of a strong therapeutic alliance, despite using different language.

In the narrow sense, the term "common factors" refers to the therapeutic intervention techniques that are embedded in all effective therapy models (Blow, Sprenkle, & Davis, 2007). Change mechanisms in the various MFT models are overlapping (Henggeler & Sheidow, 2002; McFarlane, Dixon, Lukens, & Lucksted, 2002). Rather than focusing on the unique techniques of a branded model (Lebow, 2013) a focus on common factors draws attention to the underlying mechanism for change (Norcross & Newman, 2003). In a narrow conceptualization of common factors, the focus is on the nonspecific aspects of therapy models, such as creating change in meaning, reframing, and externalizing problems (Sprenkle & Blow, 2004). This narrow focus also includes the therapist's' cultural sensitivity.

Common factors theorists' believe that models work through therapists (Sprenkle & Blow, 2007). Therefore, any model can be carried out in a way that is culturally sensitive. In other words, cultural sensitivity does not rest in the model; it rests in the therapist's way of being (Fife et al., 2014). Such culturally sensitivity positively influences therapeutic outcomes (Muir et al., 2004) and has been shown to improve therapist-client relationships and

clinical effectiveness with numerous diverse populations (Sprenkle et al., 2009). Below, we present a case vignette to exemplify this common factor conceptualization of cultural sensitivity, followed by several suggestions for therapists, supervisors, and educators. Informed by Rober's (2005) concept of inner conversations, we present the outer and inner therapeutic dialogue to illustrate a therapist's process of learning how to be culturally sensitive.

Case vignette

Michael is a 33-year-old, African American, cisgender, male veteran, struggling with financial stability, and relational distress after leaving the military. Michael's wife, Ann is a 33-year-old African American, cisgender, female teacher struggling with relational issues after her husband returned from the military. They also have an eight-year-old son. Michael and Ann seek couple therapy with Robin, a 51-year-old biracial, cisgender, female therapist who identifies as Eurasian. Robin has been a therapist for more than twenty years, but her experience working with military veterans in limited. In their first session, Michael and Ann describe their relational and financial concerns (Table 1).

The rest of the session focuses on tools Michael can use to organize his job search and to instill hope in Michael and Ann that Michael can indeed find a job.

Table 1. First session vignette transcript.

Outer conversation	Therapist's inner conversation
Michael: I've been discharged for a few months, and the civilian life has been rough…for me.	I don't feel confident working with Michael. I don't know much about working with veterans, and our backgrounds are so different. Maybe I should focus on his family dynamics, something I do know about.
Ann: I guess our son and I got into a routine. It was hard to get used to life without Michael. Now we are re-adjusting to life with him again.	I'm trying to wrap my head around what Ann is saying.
Michael: Yes, they already have their routine set up, and I'm just trying to bond with my kid. On top of that I got to find a job, and accept that it will probably be a job I won't get as much respect doing. People don't necessarily know the sacrifices I made as a veteran. I really need a job though! [frustratingly shakes his hands]	Maybe I should ask more about his military experiences and discharge, but I don't want to come off like I have no clue either.
Robin: How has your job search been going?	He seems really angry about this job issue. I can ask him about that.
Michael: Horrible! [shouting] I've gone on several interviews and gotten no call backs.	Maybe it's because he's black….
Robin: You seem angry. Do you think the issue is because you're…African American?	I hope that wasn't an awkward way to put it.
Michael: What do you mean by that? No, I'm angry because I'm qualified for the jobs I'm applying for. That affects whether or not I can even provide for my family without a secure job.	Why did I assume it was about his race? I feel like he looks confused and annoyed. What do I say now?
Robin: Oh okay. What kinds of jobs have you tried to apply for?	That was uncomfortable. I should redirect the conversation, but where?

Robin decides to call her supervisor, as she does whenever she needs guidance on a particular case. She explains what happened in session and expresses concerns about her alliance with the client, given her less-than-eloquent stumble around the issue of racial discrimination. Her supervisor makes a few suggestions.

SUPERVISOR: It seems from the beginning, you experienced some discomfort around working with Michael and maybe also Ann because of your differences, such as racial and ethnic background, military culture, generational gap, and so on. You feel like you should be more experienced and know more about the client's culture. Why not approach with curiosity and explore his cultural context–his gender messages about needing to provide, what his military service means to him, and race plays a role. He seems proud of his military experience and wants others to know what he has to offer. If that's something you felt too, ask about it.

ROBIN: Yes, I was aware of the ways in which we are different, and it made me feel uncomfortable asking questions. I was also afraid I would come off incompetent. How do you think I should approach these topics? What can I do?

SUPERVISOR: Sometimes, it's not only a matter of what you are *doing* in therapy room. It's also about showing him you want to learn from him. That goes a long way and is part of being culturally sensitive. Take for instance when you asked about whether his race is related to his job search experiences. It seems like you had some cultural awareness regarding racial discrimination in the hiring process.

ROBIN: Correct. I wanted to explore that.

SUPERVISOR: You were well-intended. You wanted to be respectfully curious about his experiences as an African American person. So be kind to yourself; race and other aspects of diversity are difficult for many therapists to discuss. One time, a therapist working with a Filipino client around parenting styles directly asked if her restrictive parenting values had to do with being Asian. In an attempt to be culturally sensitive, the therapist made an inherent assumption about Asian parenting. Thinking back at your case, I wonder if you may have made any inherent assumptions about your client's experiences in your conversation.

ROBIN: I asked about the client's race when he became angry about not getting a job. I may have inadvertently associated blackness with anger, and that when an African American person becomes angry, it must be related to racial discrimination…which may or may not be the case. I can't assume that.

SUPERVISOR: Exactly, you can't assume. I suggest you explore your own cultural biases. You assume these differences between you and your client, but your actual view of these differences are inevitably shaped by your own cultural lens. Deepening your understanding of your own cultural experiences may help you feel more competent, and hopefully more curious rather than fearful and avoidant.

ROBIN: That makes sense. Should I bring this up again the next session?

SUPERVISOR: Sure, if the timing is right. It is important to be sensitive to when is a relevant time to bring up race, gender, religion, and so forth. Secondly, I

Table 2. Second session vignette transcript.

Outer conversation	Therapist's inner conversation
Michael: I've been on a couple of job interviews actually. Feeling better about that. The position I really want, I may not get though.	That's an improvement.
Robin: What makes you doubt the potential of getting the job you want?	
Michael: It's hard to explain. I know it's a competitive position, and I also get a vibe off of the way the interviewers respond to me. They just seemed a little wary or something.	Hmm, I want to know how he interprets the interviewers' responses and whether or not it's related to race.
Robin: Maybe this doesn't fit with your experiences, but as a biracial female, in her 50s, I sometimes wonder if the way people respond to me in interviews is based on my outer racial appearance and how they see these aspects of who I am.	Either he says it fits or not, it's okay. I'm just curious if that's part of the issue.
Michael: You know that's an interesting point. It might be because of me being black. I also thought maybe it's because of my military background. I don't have other work experiences aside from the Army, and some people see discharged soldiers in negatively.	So Michael is describing several ideas and how they come together.
Robin: That is an interesting point. Ann, have you ever discussed this with Michael before?	
Ann: No, but I've thought about it before, how people see him and see us.	So Ann has her own perspective, which I need to explore as well.
Robin: Can you tell me more?	
Ann: There's so things people assume, like when Michael was away in the military and it was just me and my son, people assumed I was just another single, black mother with an absent father.	
Michael: Maybe they're right [somberly]. I can't even get a job to support my family.	
Robin: What if they are wrong? Can you both talk about how they may be wrong?	How can we dispel these negative stereotypes?

wonder if there is a way you can talk about race, as you intended to, but in a way that invites Ann and Michael rather than confronts them. Finally, don't forget the relational aspects in this case. Make sure you attend to the couple dynamics as well.

Robin thanks her supervisor, and over the next week, she reflects on her own cultural bias. As she gains more understanding of her perspective, she recognizes how important it was to see Michael and Ann as multi-faceted people. Her biracial identity does not portray the full picture of who she is, and neither does Michael's and Ann's. Two weeks later, Michael and Ann returns for their second session (Table 2).

Discussion

The session continues as Robin helps Michael and Ann explore different aspects of who they are, including their identities as a soldier and a teacher, an African American man and woman, a husband and wife, and a father and mother. Robin wonders about how transitioning from soldier to veteran affects Michael's self-image, confidence, and personhood. She asks him to reflect on this and define how his identity as a husband and father intersects with other identities (e.g., race,

ethnicity, gender, military background) that come together into the complex picture of who he is. She may discuss new research that debunks the myth of the absent African American father to dispel this stereotype. Robin also explores with Ann her identity as a wife and mother, how it intersects with other identities, and ways in which harmful stereotypes about black men and women shape the tensions in their relationship. A strong therapeutic alliance facilitated by Robin's genuinely caring about Michael and Ann is necessary to cushion uncomfortable topics such as stereotypes and racial discrimination. Also, the act of creating space for these conversations strengthens the therapeutic alliance.

The combination of being and doing cultural sensitivity allowed Robin to nurture a better therapist-client relationship by discussing different aspects of diversity—hers, Michael's, and Ann's- and by being curious. Therapists need to explore their own understanding of culture and how it connects to their therapeutic approach. It may help to view culture as being an extension of context, an opportunity to deepen our understanding of particular contextual issues (L. Kim, personal communication, 2015, July 23). Ultimately, the goal of cultural sensitivity is to help therapists see their clients more fully and, at the same time, acknowledging the complex intersections that shape who they are as people.

Implication for family therapy practice and training

To be effective, supervisors must feel comfortable talking about cultural differences and biases. A comfortable supervisory relationship is essential for supervisors to highlight and challenge cultural assumptions and bias in their supervisees. When therapists do not feel safe disclosing such biases in supervision, they run the risk of spilling over into the therapy they do. Supervisors must engage in their own self-work, which includes challenging their own biases and understanding the intersection of their own multiple identities. They can also make the point that each person holds biases, and that many of us have experienced varying levels of oppression and privilege due to those bias. Supervisors can normalize the feelings of guilt, shame, and embarrassment that often occurs during conversations about diversity.

Supervisors can encourage supervisees to track their cultural sensitivity by collecting client feedback. One way is to administer the Cole, Piercy, Wolfe, and West's (2014) measure of client perceived cultural sensitivity to their clients. The therapist can use this feedback to make adjustments to his or her therapeutic approach. Likewise, supervisors can administer the same measure to their supervisees to track their own level of perceived cultural sensitivity. The cultural sensitivity between therapist and supervisor may be an isomorphic process to the cultural sensitivity between therapist and client. Therefore, supervision that models cultural sensitivity by working with them in a culturally sensitive manner, and leaning towards rather than away from these cultural conversations, supports the process of therapists becoming more culturally sensitive.

Experiential learning activities have been identified as effective in integrating cultural sensitivity into clinical and supervisory activities, rather than as separate activities (Banks, 2001). Laszloffy and Habekost (2010) identified several experiential activities including those in which students experience being a minority (e.g., attend a religious service of a different faith than their own or attend events where they are in the position of a minority) and brief simulations (e.g., performing a different gender role and limiting their use of resources to understand socioeconomic status). To add to this list, we suggest two activities that support students on their journey toward cultural sensitivity.

The cultural sensitivity skills lab

We have adapted an activity from D'Aniello and Perkins (2016) titled "The Cultural Sensitivity Skills Lab." Creating a common factors-based 'cultural sensitivity skills lab' provides an opportunity for students to apply basic cultural sensitivity skills in situations they are likely to face with clients. Professors could organize a 'skills lab' a by creating flash cards with scenarios relating to cultural sensitivity. Students would blindly select a card, and then role-play the scenario with simulated clients (classmates). Classmates would then be asked to provide constructive feedback to each therapist. For example, a card may read: "You are seeing an interracial couple, who are struggling with how racial differences influence their relationship." Students would be assigned the roles of clients, therapist, and observer (s). The therapist can use his or her preferred model, combined with a culturally sensitive, common-factors lens, to practice discussing racial differences when one partner disagrees with the salience of race in their relationship problems. In the next section, we suggest an exercise supervisors can use in training. The activity is described with specific questions supervisors can use to cultivate supervisees' cultural sensitivity.

Training exercise to focus on cultural sensitivity

Cole, Piercy, Wolfe, and West (2014) developed a scale for clients to rate the degree of cultural competence (broadly defined) of their therapist. Several items of this scale could be the focus of classroom discussion and homework activities. For example, the item, "My therapist appears to understand that therapy needs to fit me/my family (i.e., race, class, gender, culture, sexual orientation, religion, etc.)." The instructor might ask the class to discuss this item in dyads or small groups using such stimulus questions as: What would the therapist's attitude need to be to get across such an understanding? Think of a person you know who this statement is true for in your life. How does that person get across such understanding? How would you, using your preferred therapy model, get across this understanding? Each of you takes a turn being the therapist and demonstrates how you might get this understanding across. In the next week, after each of your therapy sessions, write down in a log how you showed a respect for race, class, gender, culture, sexual orientation, and/or religion in that session.

Future research

Therapists can incorporate cultural sensitivity into their way of being regardless of the model used. The present paper provided a justification and examples for including cultural sensitivity as an MFT common factor, though it is not without limitations. The present paper is a conceptual paper, and does not rely on empirical data. Quantitative and qualitative inquiries are critically important for continuing this research. Qualitative inquiry that seeks to understand trainees' experiences of the process of developing cultural sensitivity would be valuable contributions to this area of research. Further, quantitative research aimed to generalize qualitative findings to larger samples would be useful in contributing to the field's understanding of how cultural sensitivity develops.

To be culturally sensitivity is to connect across our cultural differences and see the humanness, the personhood that binds us all. To only see similarity is ignoring our unique experiences and to only see difference is to miss our shared humanity. A culturally sensitive therapist does both. This is at the heart of facilitating an authentic, culturally sensitive way of being with our clients.

References

American Association for Marriage and Family Therapy. (2005). *Accreditation standards graduate and postgraduate marriage and family therapy training programs: Version 11.0*. Retrieved from http://www.aamft.org/imis15/Documents/Accreditation_Standards_Version_11.pdf

American Association for Marriage and Family Therapy. (2014). *Accreditation standards graduate and postgraduate marriage and family therapy training programs: Version 12.0 Draft*. Retrieved from http://www.aamft.org/imis15/Documents/COAMFTE/COAMFTE_Proposed_Accreditation_Standards_Version_12_SecondDraft.pdf

Banks, A. (2001). Tweaking the Euro-American perspective: Infusing cultural awareness and sensitivity into the supervision of family therapy. *The Family Journal: Counseling and Therapy for Couples and Families*, *9*, 420–423.

Blow, A. J., Sprenkle, D. H., & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself? The role of the therapist in common factors. *Journal of Marital and Family Therapy*, *33*, 298–317.

Cheung, G., & Chan, C. (2002). The Satir model and cultural sensitivity: A Hong Kong reflection. *Contemporary Family Therapy*, *24*, 199–215.

Cole, E. M., Piercy, F., Wolfe, E. W., & West, J. M. (2014). Development of the multicultural therapy competency inventory-client version. *Contemporary Family Therapy*, *36*(4), 462–473.

D'Aniello, C., & Perkins, S. N. (2016). Incorporating common factors into clinical training programs. *Contemporary Family Therapy*. doi:10.1007/s10591-016-9377-7

Epstein, N. B., Curtis, D. S., Edwards, E., Young, J. L., & Zheng, L. (2014). Therapy with families in China: Cultural factors influencing the therapeutic alliance and therapy goals. *Contemporary Family Therapy*, *36*, 201–212.

Fife, S. T., Whiting, J. B., Bradford, K., & Davis, S. D. (2013). The therapeutic pyramid: A common factors synthesis of techniques, alliance, and way of being. *Journal of Marital and Family Therapy*, *40*, 20–33. doi:10.111/jmft.12041

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

Henggeler, S. W., & Sheidow, A. J. (2002). Conduct disorder and delinquency. In D. H. Sprenkle (Ed.), *Effectiveness research in marriage and family therapy* (pp. 57–61). Alexandria, VA: American Association for Marriage and Family Therapy.

Holcomb-McCoy, C. C, & Myers, J. E. (1999). Multicultural competence and counselor training: A national survey. *Journal of Counseling and Development*, *77*, 294–302.

Keeling, M. L., & Piercy, F. P. (2007). A careful balance. Multinational perspectives on culture, gender and power in marriage and family therapy practice. *Journal of Marital and Family Therapy*, *33*, 443–463.

Laszloffy, T., & Habekost, J. (2010). Using experiential tasks to enhance cultural sensitivity among MFT trainees. *Journal of Marital and Family Therapy*, *36*, 333–346.

Lambert, M. J. (1992). Implications of outcome research for psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94–129). New York, NY: Basic Books.

Lebow, J. (2013). *Couple and family therapy: An integrative map of the territory*. Washington, DC: APA Books.

McFarlane, W. R., Dixon, L., Lukens, E., & Lucksted, A. (2002). Family psychoeducation and schizophrenia: A review of the literature. *Journal of Marital and Family Therapy*, *29*, 223–245.

McGoldrick, M., Giordana, J., & Garcia-Preto, N. (2005). *Ethnicity and family therapy* (3rd ed.). New York, NY: Guilford.

Muir, J. A., Schwartz, S., & Szapocznik, J. (2004). A program of research with Hispanic and African American families: Three decades of intervention development and testing influenced by the changing cultural context of Miami. *Journal of Marital and Family Therapy*, *30*, 285–303.

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

Norcross, J. C., & Newman, C. F. (2003). *Psychotherapy integration: Setting the context. Handbook of psychotherapy integration*. Oxford, England: Oxford University.

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

Sprenkle, D. H., & Blow, A. J. (2004). Common factors and our sacred models. *Journal of Marital and Family Therapy*, *30*, 113–129. doi:10.1111/j.1752-0606.2004.tb01228.x

Sprenkle, D. H., & Blow, A. J. (2007). The role of the therapist as the bridge between common factors and therapeutic change: More complex than congruency with a worldview. *Journal of Marital and Family Therapy*, *30*, 109–113. doi:10.1111/j.1467-6427.2007.00375.x

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice*. New York, NY: Guilford.

Yutrzenka, B. A. (1995). Making a case for training in ethnic and cultural diversity in increasing treatment efficacy. *Journal of Consulting and Clinical Psychology*, *63*, 197–206.