Culturally Appropriate Indian Applications of Marriage and Family Therapy
Interventions Explored Through an HIV Example

by

Jotika S. Jagasia

Dissertation submitted to Faculty of Virginia Polytechnic Institute and State University
In partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

Human Development
Specialization in Marriage and Family Therapy

APPROVED:

Fred P. Piercy, Ph.D., Chair
Scott W. Johnson, Ph.D.
Margaret L. Keeling, Ph.D.
Katherine R. Allen, Ph.D.

January 29, 2008
Blacksburg, Virginia

Key Words: HIV, Marriage and Family therapy, India, Culturally Appropriate.

Copyright 2008. Jotika S. Jagasia
Culturally Appropriate Indian Applications of Marriage and Family Therapy

Interventions Explored Through an HIV Example

Jotika S. Jagasia

ABSTRACT

There are 5.7 million people in India who are living with HIV/AIDS and many more are indirectly affected by the epidemic (families, children). Since HIV/AIDS is a growing problem, further research for prevention and treatment is needed. Family therapists possess an important role in the AIDS crisis given that some family therapy models have been shown to work well with HIV issues. Although there is a need for family therapy in India, the profession of family therapy is in its infancy. This study attempts to understand what marriage and family therapy interventions work best with Indian clients especially those who are HIV positive. Psychoeducation, directive therapy, addressing the presenting problem and systems therapy (particularly focusing on the couple husband-wife system) are interventions found in this study to be most utilized by Indian therapists with their clients.

Key Words: HIV, Marriage and Family therapy, India, Culturally Appropriate.
ACKNOWLEDGMENTS

This dissertation has been a long and arduous process. I want to especially thank my advisor and chair Dr. Fred Piercy for his support, guidance and help throughout the process. Thank you to my committee members, Dr. Scott Johnson, Dr Margaret Keeling, and Dr Katherine Allen for helping me to shape this project and myself to be the best that it could be. Thank you, Dr Jay Mancini for your financial support and help. This dissertation would not be possible without my classmates, co-workers, family, and friends. To my mother, Kusum Jagasia, brother Vivek Jagasia and brother’s wife Simran Jagasia. Thank you for your faith and confidence in me. Finally, to my husband Arun Sivaraman and daughter Tulsi, we made it! Thank you, for the help with computers but more importantly for always being there for me.
# TABLE OF CONTENTS

Culturally Appropriate Indian Applications of Marriage and Family Therapy Interventions Explored Through an HIV Example .............................................................. i

ABSTRACT ................................................................................................................................ ii

ACKNOWLEDGMENTS ................................................................................................................................. iii

Chapter I: Introduction ................................................................................................................................. 1

Goals of the Study .................................................................................................................................. 3
AIDS in India ........................................................................................................................................ 4
Multiplicity of India ............................................................................................................................... 4
HIV and Women ................................................................................................................................... 5
Why is there a Need for Family Therapists in India? .............................................................................. 6
Why is there a Need for Family Therapists in India with a focus on HIV? ........................................... 7
Role of Marriage and Family Therapists in HIV/AIDS Prevention and Treatment ............................................................. 8
Self of the Researcher ............................................................................................................................. 10
Brief Overview .................................................................................................................................... 16

Chapter II: Literature Review ..................................................................................................................... 17
HIV/AIDS in the World ........................................................................................................................... 18
How HIV/AIDS Effects Women ........................................................................................................... 20
The Transmission, Biological, Social, Cultural and Psychological Perspectives of HIV/AIDS ............ 21
HIV/AIDS in India ................................................................................................................................ 22
Medical factors and HIV ......................................................................................................................... 23
Psychosocial factors and HIV ................................................................................................................ 24
Global Response .................................................................................................................................... 27
What is India Doing to Fight AIDS? ........................................................................................................... 27
Need for Therapy and Counseling Services among HIV Positive Clients and their Families ............ 30
The Range of Family Therapy Models that may be used with HIV Issues ........................................... 31
Profession of Marriage and Family Therapy ................................................................................................. 42
Need for Marriage and Family Therapy in India .................................................................................... 43
Evolution of Family therapy in India ......................................................................................................... 44
The Importance of Culturally Sensitive Therapy ...................................................................................... 46

Chapter III: Methodology ............................................................................................................................ 49
Research Question ................................................................................................................................... 49
Purpose of the study ................................................................................................................................ 49
Role of the Researcher ............................................................................................................................. 50
Qualitative Method of Inquiry ..................................................................................................................... 52
Modified Grounded Theory ......................................................................................................................... 53
Sampling .................................................................................................................................................. 54
Participant Selection ................................................................................................................................. 56
Protocol for Telephone Interviews ........................................................................................................... 62
The Process .............................................................................................................................................. 62
Interview Questions ................................................................................................................................. 67
Data Analysis ......................................................................................................................................... 69
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trustworthiness, Credibility and Transferability</td>
<td>71</td>
</tr>
<tr>
<td>Chapter IV: Results</td>
<td>76</td>
</tr>
<tr>
<td>Interventions</td>
<td>78</td>
</tr>
<tr>
<td>Cultural Issues</td>
<td>90</td>
</tr>
<tr>
<td>Unique issues a therapist faces in India</td>
<td>101</td>
</tr>
<tr>
<td>Role of therapist in India</td>
<td>107</td>
</tr>
<tr>
<td>Ethical issues</td>
<td>108</td>
</tr>
<tr>
<td>How to adapt family therapy to India / What to change in Eurocentric</td>
<td>110</td>
</tr>
<tr>
<td>theories</td>
<td></td>
</tr>
<tr>
<td>Conceptualizing themes of framing or seeing problems</td>
<td>113</td>
</tr>
<tr>
<td>Metaphor</td>
<td>113</td>
</tr>
<tr>
<td>Chapter V: Discussion</td>
<td>121</td>
</tr>
<tr>
<td>Interventions</td>
<td>122</td>
</tr>
<tr>
<td>Cultural Issues</td>
<td>124</td>
</tr>
<tr>
<td>Unique issues a therapist faces in India</td>
<td>128</td>
</tr>
<tr>
<td>Role of the therapist</td>
<td>130</td>
</tr>
<tr>
<td>Ethical Issues</td>
<td>131</td>
</tr>
<tr>
<td>How to adapt family therapy to India? / What to change in Eurocentric</td>
<td>132</td>
</tr>
<tr>
<td>theories?</td>
<td></td>
</tr>
<tr>
<td>Metaphor</td>
<td>134</td>
</tr>
<tr>
<td>Important Learnings</td>
<td>135</td>
</tr>
<tr>
<td>Policy implications</td>
<td>136</td>
</tr>
<tr>
<td>Strengths of the study</td>
<td>136</td>
</tr>
<tr>
<td>Limitations of the study</td>
<td>137</td>
</tr>
<tr>
<td>Directions for future research</td>
<td>138</td>
</tr>
<tr>
<td>Reflexive Comments</td>
<td>138</td>
</tr>
<tr>
<td>References</td>
<td>141</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>157</td>
</tr>
<tr>
<td>Appendix A: IRB form submitted to Review Board</td>
<td>159</td>
</tr>
<tr>
<td>Appendix B: Copy of IRB form sent to participants</td>
<td>164</td>
</tr>
<tr>
<td>Appendix C: IRB Approval</td>
<td>170</td>
</tr>
<tr>
<td>Appendix D: Letters, emails to the President of Indian Association of</td>
<td>171</td>
</tr>
<tr>
<td>Family Therapy (IAFT)</td>
<td></td>
</tr>
<tr>
<td>Appendix E: Letters, emails to the directors of CO-AMFT accredited</td>
<td>172</td>
</tr>
<tr>
<td>programs in USA universities Dear MFT Program Director,</td>
<td></td>
</tr>
<tr>
<td>Appendix F: Letters, emails to the moderator of the Indian marriage</td>
<td>174</td>
</tr>
<tr>
<td>and family therapists yahoo list serve</td>
<td></td>
</tr>
<tr>
<td>Appendix G: Letters, emails to the Indian MFT (referred by president</td>
<td>175</td>
</tr>
<tr>
<td>of IAFT) to invite them to participate in my study</td>
<td></td>
</tr>
<tr>
<td>Appendix H: Letters, emails to the Indian MFT (referred by director of</td>
<td>177</td>
</tr>
<tr>
<td>CO-AMFT program) to invite them to participate in my study</td>
<td></td>
</tr>
<tr>
<td>Appendix I: Letters, emails to the Indian MFT (referred by moderator</td>
<td>179</td>
</tr>
<tr>
<td>of Indian MFT yahoo list serve) to invite them to participate in my</td>
<td></td>
</tr>
<tr>
<td>study</td>
<td></td>
</tr>
<tr>
<td>Appendix J: Second emails to the Indian MFT (referred by president</td>
<td>181</td>
</tr>
<tr>
<td>of IAFT) to invite them to participate in my study</td>
<td></td>
</tr>
</tbody>
</table>
Appendix K: Second emails to the Indian MFT (referred by director of CO-AMFT program) to invite them to participate in my study..........................183
Appendix L: Second emails to the Indian MFT (referred by moderator of Indian MFT yahoo list serve) to invite them to participate in my study..........................................................185
Appendix M: Third emails (final emails) to the Indian MFT (referred by president of IAFT) to invite them to participate in my study.........................187
Appendix N: Third emails (final emails) to the Indian MFT (referred by director of CO-AMFT program) to invite them to participate in my study....................................................................................................................189
Appendix O: Third emails (final emails) to the Indian MFT (referred by moderator of Indian MFT yahoo list serve) to invite them to participate in my study....................................................................................................................191
Appendix P: Demographic Profile..........................................................................................................................193
Appendix Q: Interview questions for participants..........................................................................................................................198
Curriculum Vitae .......................................................................................................................................................200
LIST OF TABLES AND FIGURES

Figure 1: Map of India showing the states worst affected by HIV............................. 25
Table 1: Demographic Characteristics of the participants........................................... 58
Table 2: Strategies used by researchers to build on Trustworthiness......................... 74
Culturally Appropriate Indian Applications of Marriage and Family Therapy

Interventions Explored Through an HIV Example

Chapter I

Introduction

On a hot summer afternoon, I was working as a therapist in a hospital in Mumbai, India, counseling pregnant women about the risk of HIV/AIDS, before their mandatory HIV testing. That is when a 23 years old woman walked in the door. She said that she was seven months pregnant and the doctor had asked her to get tested for HIV. I explained to her the route of infection and asked her if she or her spouse had previously engaged in any risky behavior. The client innocently said no and said that she had come just a week ago from her village in northern India to Mumbai for the delivery of her child. She then went in for the blood test and was asked to come back after a week for the results. That is when my journey began with Farida Begum (a pseudonym) whose test result showed her to be HIV positive. Her reaction to the test result was just like she was being told that she had a “common cold.” Farida did not understand the gravity of the situation.

She explained that she lived with her husband, a construction worker, and his mother, three bothers and sister, in the nearby slums. She said that she left for her mother’s house in the village during the second trimester of her pregnancy and came back to Mumbai for the delivery of her baby. Her innocence and simplicity intrigued me, and she asked me to do whatever is necessary for the well-being of her child. Farida’s husband was called to be tested and admitted to having unprotected sex with commercial sex workers and having “fun” (anal sex) with some of his male friends while Farida was
in the village. After testing HIV positive, Salim was shocked and blamed the infection on Farida. Salim’s theory was that HIV was transmitted through injections and since Farida used to go to the doctors to take iron injections for her anemia, she was the one who gave him HIV. He totally discounted the fact that his behaviors put the couple at a much higher risk for contracting HIV than Farida’s iron injections. After psycho-educating the couple about HIV/AIDS, I explained to them that their goal was now to support each other in taking care of their health and to ensure the baby would be HIV negative. I explained to them the options of anti-retroviral medications, eating healthy, and a C-section to prevent mother-to-child transmission. The couple did not even have enough money to eat one square meal a day and definitely did not have the money for a C-section and medication.

With the help of the different resources including a team of doctors, a social worker and a government organization, I managed to get medication for Farida to prevent HIV infection from mother-to-child, and also money to do a C-section. Salim could not come for the delivery of his son, since he was bedridden with AIDS. Two weeks after the birth of the baby, I went for a home visit and saw the 12ft x 10 ft room they all lived in. Salim was very weak. Farida was breastfeeding, and her mother-in-law asked me the reason for my visit. I simply said that I came to check up on the baby. I then asked Farida, in private, to come and visit me sometime. Upon her next visit with me Farida said that her mother-in-law would shout at her if she did not breastfeed and so she could not bottle feed the baby. In two weeks I got a call from Salim’s brother that Salim had died. Not expecting for things to deteriorate so quickly, I went to Salim’s funeral, where Farida was holding her four-week-old baby and crying. When she saw me she cried
loudly and said, “You promised things would be better.” I hugged her and cried about her loss. This research is dedicated to not only Farida who is a mother, wife, daughter-in-law, HIV positive, and illiterate, but first and foremost a woman.

A woman like Farida who lives in a patriarchal society like India, comes from a lower socio-economic status, has little or no education, who is infected with HIV/AIDS, and who is a widow, is a four time minority or triple jeopardy. I am also an Indian woman, but I come from a higher caste. I come from a middle class and have a master’s level education with privileges attached. This not only gives me the resources to get my basic necessities like food, home and health care, but also gives me the advantage of getting a higher education and the opportunity to come to the USA to earn a doctorate in the feild. This contrast in condition between two Indian women, made me realize how I was the one in power, in control the majority and the dominator by default in this client-therapist relationship.

Goals of the Study

This case study will reveal how this research has built on previously established studies on HIV by examining the following ideas:

1. The overwhelming crisis of HIV in India
2. How HIV affects families
3. How HIV affects minorities, primarily women because of the dominating patriarchal society in India
4. How family therapists can be beneficial to families infected with and affected by HIV/AIDS
5. The need for growth of the profession of family therapy in India,
6. The importance of cultural sensitivity in culturally adapting Eurocentric family therapy interventions to Indian families, especially in situations concerning HIV/AIDS,

7. Challenges faced by and biases of Indian therapists who study Eurocentric theories and apply them to Indian families, and

8. The importance of looking at this research through a feminist lens

*AIDS in India*

There are 5.7 million people living with HIV/AIDS in India (World Bank, 2007). More than that, however, millions of uninfected persons are also impacted by this health crisis due to the fact they are being involved in the life of an infected person. This gives India the second largest HIV-positive population in the world behind South Africa. The challenge of HIV/AIDS is a grave one due to India’s large population. High population density, low literacy levels (and consequently low levels of awareness), low condom usage, cultural beliefs about the transmission of HIV and the dominating patriarchal society all add to the particular hardships faced by families in India dealing with HIV/AIDS (Bhattacharya, 2004).

*Multiplicity of India*

India is a sub-continent with a population of 1,095,351,995 people residing in 28 states, seven union territories, and speaking 15 official languages with many more different dialects spoken in different states (Population Council, 2006). Although Indians belong to the same country, their traditions and cultural beliefs are very diverse. Each region has its own language, cultural norms and values, with superstitions attached to them. These cultural assumptions play a role over peoples’ beliefs in mental and physical
illness and how they seek help. This diversity is in some ways helpful, but can also be a major drawback, especially in the prevention of HIV/AIDS.

In India, the percentage of literacy among men is 75.3% and 53.7% among women (2001 census). This plays an important role in understanding how they can deal with mental illness and physical illness. Due to illiteracy and superstition, people believe any physical or mental illness is due to their sins and can be cured if they please the gods, or god’s servant, the priest (Juthani, 2001). Shaman’s, priests and local healers take advantage of these beliefs and take money from poor people and give them local herbs and prasadam (food offered to God and then distributed to people) that they say will cure the illness (Juthani, 2001).

**HIV and Women**

In the previously mentioned example, Farida is not only HIV positive but also and more importantly, facing the stigma of being a young widow with a child (who may be HIV positive), of being poor, illiterate, and without any economic support. If her husband’s family finds out that she is HIV positive they might blame her for her husband’s death. The stigma that she will face due to HIV, since it is sexually transmitted, will likely affect her future gravely.

In India, not only do most women have a low legal status, but they are generally denied the right to property succession. Moreover, marital rape is not recognized in India (Bhattachrya, 2004). Most women do not have the right to control their fertility and have no recourse to sexual harassment or rape. Finally, there is a high rate of women and children being trafficked or sold to other countries for prostitution (Venkataramana & Sarada, 2001). This does not only disadvantage the women but also puts them in a
jeopardizing situation in the context of HIV/AIDS.

Why is there a Need for Family Therapists in India?

Due to globalization, industrialization and urbanization, the traditional hierarchical structure has changed in India, and there is a rise in nuclear families in an individualistic (Western) value system, which has led to mental health disturbances (Carson & Chowdhary, 2000; Natrajan & Thomas, 2002). Family mental health is addressed by non-governmental organizations (NGO’s) in India that mainly focus on providing material help to children, women and elderly people (Desai, 1991). Most Indians experiencing marital problems go to native healers, gurus, shamans and exorcists (Davar, 1999) before approaching a therapist, mental health practitioner or social worker. Going to a guru, priest or an older family member with marital and family problems has been an age old form of family therapy in India (Davar, 1999). Research has shown the need for professional family therapy in India (Baptiste, 2005; Carson and Chowdhary; 2000; Mittal, & Hardy; 2005, Nath, & Nicholas; 2005, Natrajan, & Thomas, 2003, & Sonpar, 2005, & Singh.). However, professional family therapy is in its infancy in India (Mittal & Hardy, 2005; Nath, & Craig, 1999; Nath, & Nicholas, 2005; Natrajan, Karuppaswamy, Thomas, & Ramadoss, 2005; Prabhu, 2003; Rastogi, Natrajan & Thomas, 2005; Shah, Vargese, Kumar, Bhatti, Raguram, Shobhana, & Juva, 2000; Singh, Nath & Nicholas, 2005 & Sonpar, 2005).

In their study done in a metropolitan city in southern India, Natrajan and Thomas (2002) found that some Indians have a fatalistic attitude, and it is difficult for them to come in for family therapy, no matter how beneficial it may prove. Some Indians believe that due to sins in their previous life (or bad karma) they deserve a bad marriage or
mental illness in this life. They believe in destiny and that destiny cannot be changed by going to therapy. Not only does the therapist have to overcome this barrier and be able to bring more clients to therapy, the most important thing is for the therapist to do culturally sensitive therapy and to culturally adapt Eurocentric theories to fit the Indian context (Dattilio, & Bahadur, 2005; Mittal, & Hardy, 2005; Natrajan, Karuppaswamy, Thomas, Ramadoss, 2005 & Rastogi, Natrajan, & Thomas). Many researchers call for cultural sensitivity and understanding. They emphasize not only knowing, but also being sensitive to different cultures (Dattilio, & Bahadur, 2005; Kim, Bean & Harper, 2004; McGoldrick, 1998; Mittal, & Hardy, 2005 & Natrajan, Karuppaswamy, Thomas, Ramadoss, 2005). Hardy (2000) and McGoldrick (1998) ask therapists to go a step further by not only being sensitive to different cultures but also to support values of social justice. Rothbaum, Rosen, Ujiie, and Uchida, (2002) ask therapists who work with families from other countries to be aware of their own cultural lens. This researcher wants to take this a step further and ask therapists to not only be aware of their cultural lens, but also for therapists who have come from the same culture as their clients to be aware of any Eurocentric education and thinking, while applying theories to their own homeland people.

Why is there a Need for Family Therapists in India with a focus on HIV?

Research has shown that people infected with and affected by HIV may suffer from depression and anxiety disorders, and hence need help to deal with the disease (Karasic & Dilley, 1999). Krishna, Bhatti, Chandra, and Juva (2005), have shown that HIV has a major impact on family systems, and that families often face the following: financial difficulties, changes in the family functioning, discrimination and stigma from
society, fear of being ostracized, fear of the death of a loved one, and feelings of helplessness. Most Indian HIV-positive women are at a greater disadvantage than the men, because in the patriarchal society of India, the woman is the caregiver and men get priority over women (Bharat, 1995). This shows that most people infected with HIV/AIDS not only need medical treatment but also alternative treatment like therapy to help them cope with the disease and deal with death and stigma attached to the disease.

**Role of Marriage and Family Therapists in HIV/AIDS Prevention and Treatment**

Marriage and family therapists (MFT’s) can directly impact the AIDS crisis. They can work in collaborative partnerships with patients and physicians to increase adherence to treatment regimens (Yarhouse, 2003). Marriage and family therapists can help HIV positive clients to disclose their status to their partners and help improve a poor relationships (Serovich, Kimberly, & Greene, 1998). One of the risks or liabilities that marriage and family therapists, or any mental health professionals, have to face is the duty to warn the third party who is at risk by the client since the client has refused to reveal his/her HIV status or changed behavior (Serovich & Mosack, 2000). This is a grey area in India since there is no law which forces the therapist to warn the third party (Krishnan, 2003).

There is discrimination against people living with HIV/AIDS (PLWHA) in health settings as well as at the work place. Marriage and family therapists could help HIV positive clients participate in normal occupational activity and also help them fight against discrimination by building their self-confidence. Marriage and family therapists could also work within communities to build a safe and supportive environment by providing welfare services that will encourage communities to accept people infected...
with HIV (Macklin, 1993).

Challenges. Research has shown that fatalistic attitudes of some Indian clients may prevent them from coming to therapy, even if they need it (Natraj & Thomas, 2002). Practicing culturally sensitive therapy and being sensitive to different traditions is another important challenge that therapists face (Dattilio, & Bahadur, 2005; Kim, Bean & Harper, 2004; McGoldrick, 1998; Mittal, & Hardy, 2005 & Natraj, Karuppaswamy, Thomas, Ramadoss, 2005). It is important to be culturally sensitive and to support values of social justice (Hardy, 2000 & McGoldrick, 1998). I want to go a step further and challenge the therapist. Even if they are from the same country as the client (in this case, India), they (the therapist) need to be aware of their own personal biases and Eurocentric philosophies because of their education in a Western country.

Living in America and getting educated here for only three years has changed me. When I go back to India, I should be aware of my own biases coming from this Western country. Waldengrave (1998) has expressed how in this day and age, colonization is accomplished not with guns and threats but through people who change the hearts, minds, and spirits of others by promoting their own cultural belief systems. It is therapists who have the duty to avoid acts of colonization. I believe in being culturally sensitive but not value neutral. I do not support unjust practices (Waldengrave, 1998). In most parts of India, patriarchy still exists and violence against women, female infants, and young girls, is culturally sanctioned. I definitely expect therapists to challenge such unjust norms and to challenge the culture in a sensitive manner to support gender equity.

Bhattacharya (2004) has explained culturally sanctioned norms in patriarchal India; men become more macho if they have sex with women other than their wives, but
women are called prostitutes if they have sex with men other than their husbands. Soundrajan, (1995) has explained that violence against women is ingrained in some parts of India and the expectation is that women should never ask their husbands any questions and remain passive and say “yes” to whatever their husband says. To add to the disadvantage, HIV itself is so stigmatizing because it is transmitted sexually. Many Indian people believe that should a person contract a sexually transmitted disease, the person got what he or she deserves because they are sinful and God punished them with an STD (Juthani, 2001).

Since marriage and family therapy theories and interventions are generally Eurocentric, it is particularly important to consider how these theories and interventions might be adapted to be more applicable to the problems of people in a developing nation like India, especially with regards to treatment issues related to HIV/AIDS. This is the overarching research question of this study.

**Self of the Researcher**

I am a woman interested in studying the lives of women, the opportunities they are given, and the difficulties they face. I think these points can be best studied by using the feminist theory. Gordon (1979) defines the feminist theory as “An analysis of women’s subordination for the purpose of figuring out how to change it” (p. 107). Feminist perspective emphasizes the oppression of women and their subordinate experiences, under the existing social arrangements of family, work, and society. Thus there is a need for commitment towards putting an end to this unjust subordination. It is necessary to understand that gender and gender relations are fundamental to all social life, including the lives of men. Thus, it becomes important to challenge the strong walls
of patriarchy, sexism, and classism. Many feminists have tried to understand and challenge these oppressive patterns to empower women through either their research or social activism. Some of these researchers include Rachel Hare-Mustin, Monika McGoldrick, Linda Gorden, Katherine Allen, Bell Hooks, Chandra Talpade Mohanty, Kristine Baber, and Judith Libow, while some of the activists include Patsy Mink, Betty Friedan, Gloria Steinem, Rosa Parks, Margaret Sanger, Juliet Mitchell and Alice Paul.

Being a feminist means believing that racism, sexism, heterosexism, ageism and classism curb the access of resources and power for women (Allen, 2001). Feminists have focused on different arrays of women’s lives from housework to equality in education, women’s political power, and work life outside the home, family relations, and the spiritual journeys of women (Harlan, 1998). Although women are socially, economically, legally, and politically devalued, feminists do not see women as passive victims but as actors, agents, creators of culture, and participants in making history.

The feminist theory also intrigues me due to my profession as a family therapist. The reason behind this is that, like other societal institutions, family therapy has been structured in ways that support the dominant value system while keeping hidden the organizing principles of our lives including culture, class, gender, race and sexual orientation (McGoldrick, 1998). This makes it important for me to challenge certain theories that I have learned. Libow (1986) shows how it is particularly difficult for female family therapists to assert control with a large, loud or aggressive family member or in cases where the therapist is trying hard to persuade the hesitant father into therapy. I have faced challenges in doing therapy with some authoritative male clients in the USA as well as in India. It becomes important that I at least acknowledge these difficulties that
female therapists may face.

Feminist theory, especially postmodern feminism, deconstructs beliefs and practices that maintain patriarchy and also challenges theories that ignore differences among women due to their culture, age, race, class or sexual orientation (Baber & Allen, 1992). Gender without race and class ignores the reality that other women and men in different racial, ethnic, socioeconomic status groups do not have the same social, political and economic power (hooks, 1984), which applies to me since I am a female therapist of color.

Mohanty (2003) has explained how she prefers feminist solidarity as opposed to sisterhood since she believes that we are united not because we are all oppressed but due to our own fight against oppression. In “Feminism Without Borders: Decolonizing Theory, Practicing Solidarity” Mohanty (2003) has explained that when models cast Third World women as victims of exotic oppression, such as dowry deaths in India, they (the models) only prove to be Eurocentric and preservative of the dominant value system. Since I am a ‘Third-World foreigner’ (Indian in the USA), I want to use the third world feminist lens for my research. This lens may help me to be conscious of my own gender, class and postcolonial history (Mohanty, 2003). I hope that through this study, I can construct the category of “women in” a variety of social and political context rather than generalizing all of them as either being Indian, or rich or poor or HIV positive.

Sexism, heterosexism, classism and misogyny are interwoven in the social fabric of the world we live in, and I am particularly interested in India. I believe that these ideas are so engrained in me that I have to take conscious steps to decolonize my Eurocentric belief system so that I do not aid this injustice (Mohanty, 2003). I also think that it is
important for me as a therapist and a researcher to comprehend what it is like to be a woman in India and what difficulties Indian women face due to patriarchy, class, caste, region, religion, color, etc. India is so diverse, and the multiplicity and complexity among people, especially women, is even greater. While there are women in India like my example Farida Begum, there are also women like myself and on the other end of the spectrum like India’s prime-minister, Indira Gandhi. This shows that not all women are equally vulnerable with respect to class, caste, race, etc. Some women’s voices are more likely to be heard than others (Lugones & Spelman, 1992).

I think Feminism helps me understand and respect the differences among women in India. This understanding helps me to not be judgmental or critical of my female clients. It opens up the door of communication so that I can understand the client’s standpoint and experience. I think the Feminist theory will be suitable for the Indian setting as long as the theory does not assume that changes perceived as making life better for some women will do the same for all women. Therefore, if the theory asserts that a woman’s life is better if she is in the workforce rather than at home, it may be detrimental to women who prefer being a homemaker rather than working outside the home. Likewise, asserting that women need to live separately from their in-laws may be disadvantageous to the women who prefer living with joint families where they can get help raising their children. It is very important for any feminist researcher to theorize in a respectful way. Finally, I think feminist theory for Indian women needs to be done separately from feminist theory for and by Black or Hispanic or White women. I agree with Lugones and Spelman (1992), that some white/Anglo women have more power and privilege than some women of color. Thus, it becomes very important to understand the
Indian culture and community before applying feminist theory or developing with a feminist theory specifically for India.

I have also worked in the field of HIV/AIDS in India for four years. In India, I was a therapist from a higher caste and most of my clients were from a lower caste or a minority. Caste system (Varna) played an important role in ancient India but even today has an important position especially in rural India (Rajshekar, 1987). In ancient India, the caste system was formed according to the occupation, function and economic place of people in society. They were Brahmin (priests), Kshatriyas (warriors and kings), Vaishya (merchants), Shudra (artisans and agriculturists) and Harijan (untouchables or out of caste people who cleaned toilets, made leather). Hindus believe that the caste is determined by profession and deeds but not by birth (Rajshekar, 1987). But over the years, this belief has been changed by the few powerful into the belief that you are born in a particular caste and you will die in the same caste. Rajshekar explains that being part of the upper caste is an advantage where one has access to all the resources like water, land, money, education and people. With higher education and increase in economic class, and reservation made by the government for the lowest caste there has been some improvement in cities, but in villages the caste system is still prevalent and practiced with rigidity. The government reservations are not practiced in most Indian villages (Rajshekar, 1987) and most of the Harijans still suffer and are ill treated by some of the upper caste. Some Harijans are not allowed access to the village well, school, voting and many essentials of daily living. Since the caste system is a very complicated 3000 year old construct which cannot be explained completely here, I only wanted to explain my own position as an upper caste woman who had the advantage by birth to access
resources which a lower caste woman may not have had.

During my doctoral education in the USA I have considered how the interventions that I was taught in class might fit in India, especially with the HIV population that I am interested in working with in the future. I have always thought that some marriage and family therapy interventions and strategies would work better than others in the Indian population, and I hope to learn more about this topic through my research. I also believe that human perception of reality is based on one’s personal experiences and circumstances, therefore multiple realities are created (Gergen, 1999). So even though I think that some interventions would work better than others in India, my other Indian colleagues do not agree with the same. I should be aware of my own biases especially while analyzing data and do justice to my findings instead of simply inserting my own interpretation. As a feminist, I believe that there are many truths or realities (Baber & Allen, 1992) and I am hoping to unveil some of them through this research.

Knowledge is constructed through a process of interaction with others and society (Hare-Mustin & Marecedk, 1988). Thus, I want to learn more about people whose roots are deeply embedded in the Indian culture, learn Eurocentric theories, and how to apply these theories and interventions to clients in a developing nation with unique difficulties. A consideration of this interaction of Eurocentric theories and Indian society will be helpful to both American and Indian therapists wishing to apply family therapy in India. Through my research, I want to work toward empowerment rather than labeling women from India as being all powerless and all dominated. Through the marriage and family therapy interventions I hope to find in this research, and by using a Feminist Solidarity/Comparative Feminist studies pedagogy (Mohanty, 2004), I hope to link the
global and local in ways that could challenge the now existing power and gender hierarchies.

*Brief Overview*

There are 5.7 million people in India who are living with HIV/AIDS and many more are indirectly affected by the epidemic (families, children). Since HIV/AIDS is a growing problem, not only is help and research required for preventing it, it can improve outcomes for those already infected or coping with the disease. Family therapists can directly impact the AIDS crisis and some of the family therapy models are seen to work well with HIV issues by researchers. Although there is a need for family therapy in India, the profession of family therapy is in its infancy stage.

*Research Question.* The overarching research question is “What are the marriage and family therapy interventions that work best with HIV positive clients and their families in an Indian setting?” This research question has guided the interview questions, discussed in chapter 3. To answer the research question I have used modified grounded theory method in a qualitative method approach. I used internet surveys to get the demographic profile of the Indian therapists and then interviewed them over the telephone.
Chapter II

Literature Review

The World Health Organization (WHO) with the World Bank has declared HIV/AIDS as not only a health problem but also a developmental problem, which has threatened the economic, psycho-social, and entire welfare of the human race (World Bank, 2007). Among countries, India has the largest number of people living with HIV/AIDS (UNAIDS, 2006). An estimated 5.7 million people live with HIV/AIDS in India. India has the second largest number of infected people in the world after Sub-Saharan Africa (Ramsundaram, 2002). The highest number of HIV/AIDS cases has occurred in the sexually active and economically productive group between the ages of 15 to 44 years (Avert, n.d.). 50% of the total population of India is in this age range (Census, 2001). The major mode of HIV transmission is through unprotected heterosexual sex, then injecting drug use.

The challenge of HIV/AIDS in India is grave due to India’s large population and population density, low literacy levels and consequently low levels of awareness, low condom use, cultural beliefs about transmission of HIV, and the dominating patriarchal society (Bhattacharya, 2004). Women have a low legal status and thus are at a disadvantage where HIV is concerned. This is because, in a patriarchal society like India, women are generally denied the right to property succession, and marital rape is not recognized (Bhattacharya). Moreover, women do not have the right to control their fertility and have no recourse to sexual harassment, and rape. Many women and children are being trafficked or sold to other countries for prostitution (Venkataramana, & Sarada (2001). This increases the HIV infection among women and children. Men may or may
not use condoms with their casual sexual partners (e.g. sex workers, concubines) but definitely do not use condoms with their wives, thus putting them at risk for infection. Many of these housewives get pregnant and do not know their HIV status. The HIV-positive wives may learn their HIV status at a late stage in pregnancy, and may give birth to an HIV-positive child, since medication to prevent mother-to-child transmission is expensive or not accessible. This increases the problems of HIV among women and children. In most cases it is the women who are in jeopardy, whether she is a sex worker, wife of a migrant worker/truck driver or a girl child with a HIV positive parent. The reason for this is because most women are more innocently jeopardized and face harder social consequences (Bhattacharya, 2004). Men in India are more likely to be more aware of HIV/AIDS and may get tested and may have more awareness about medicines and more accessibility to medication since they are more mobile than most women.

Due to the stigma attached to HIV, many people keep their positive HIV status secret and do not seek treatment infection. When a person finds out that he or she is HIV positive the person may seek out the help of a medical doctor, priest, tantrik, or shaman. Some Indians also believe that HIV is a punishment from God from previous sins, and hence people living with HIV/AIDS may seek out spiritual help (Bhattacharya, 2004). A medical doctor may refer the infected person and his or her family to a counselor, social worker, or psychiatrist for emotional help and coping skills (Juthani, 2001).

HIV/AIDS in the World

The number of people who are HIV positive has sharply increased in recent years. To date, around 65 million people world-wide have been infected with HIV and 25 million people have died of AIDS since it was first discovered in 1981 (UNAIDS, 2007).
In contrast to initial assumptions that HIV/AIDS was a disease of mostly gay men, UNAIDS (2006), reports that almost half of the adults living with HIV/AIDS today are women. The number of girls and women infected with HIV/AIDS has increased in every region of the world in the last two years particularly in Eastern Europe, Asia, Latin America, and Africa (UNAIDS, 2006). Approximately 38 million people are unaware that they are infected with HIV. An estimated 2.9 million people died of AIDS in 2006 while it has been likely that of 4.3 million were newly infected with HIV (UNAIDS, 2007). HIV/AIDS has become an epidemic in developing nations, especially Africa and Asia. I have mentioned statistics of HIV in some of the other countries to understand the gravity of the problem of HIV world wide and compare India with the other problem nations.

UNAIDS (2006) reports that at the end of 2005, in Sub-Saharan Africa, there were approximately 24.5 million people living with HIV/AIDS and 2.7 million additional people were infected with HIV that year. Sub-Saharan Africa has been more affected by this pandemic of HIV/AIDS than any other region, orphaning 12 million children (UNAIDS, 2006). In sub-Saharan Africa, women and girls make up almost 60% of adults living with HIV/AIDS (UNAIDS, 2006).

There are over a million people (estimated) living with HIV and 415,000 people living with AIDS in the USA (World Bank, 2007). AIDS has killed over half a million Americans. There was an estimated 940,000 people living with HIV at the end of 2005 in Russia (UNAIDS, 2006). Ann estimated 82,593 HIV positive people lived in the UK at the end of 2006 (World Bank, 2007).
How HIV/AIDS Effects Women

Women experience the impact of HIV more severely than men (Serovich, Kimberly & Greene, 1998). Not only are women more likely to be exposed to HIV due to the shape and mucosal surface of the vagina (it is more exposed during intercourse because semen is more concentrated than women’s vaginal fluid) (National Family Health Survey, India, 2006), but also low access to education and economic opportunity make women more dependent on men in their relationships. Thus most women are more vulnerable epidemiologically, biologically, and socially which makes HIV/AIDS a human rights issue for women (National Family Health Survey, India (NFHSI), 2006).

Women generally are the caregivers for their HIV-positive partner and suffer from discrimination and abandonment. Some women are blamed for their partner’s illness. Young girls may be at even more risk of exposure to HIV than adults. Their tender age leaves them in a vulnerable position, possibly unable to reject sexual advances. Most girl children are first removed from the school than boys and they have to either go out and work because their family is poor or take care of the sick family member (NFHSI, 2006).

Studies have shown that, in most cases violence dramatically increases women’s vulnerability to HIV infection (UNAIDS, 2006). It is important to critically evaluate and discuss the culture and norms in the world of AIDS.

In a male dominated society, women who have sex with different men are looked down upon, but a man who has sex with many women, is looked up to as ‘a player’ (Bhattacharya, 2004). This leads to stigma for women who are HIV positive since she is seen as a woman who has sex with many different men and has got the infection because of being a prostitute. A woman is also blamed if she passes on the transmission to her
child and the child dies, even if the male partner was the reason she got the infection in the first place. A study in Africa showed that men who worked in cities got themselves tested for HIV and if they were HIV positive would take medication for HIV. However these men did not tell their wives in the rural areas to get tested or get treatment. Because of this, the wife often showed symptoms before the husband did and he could blame her for giving him the infection (Gupta, 2007). In this example not only was the woman’s health was not only jeopardized but she is put to shame from society. The reason for citing an example which took place in Africa was because it explains the threat HIV/AIDS can pose to a woman, especially in a third world country. To understand HIV/AIDS better, it is particularly important to understand the transmission, biological, social, cultural and psychological perspectives of this epidemic.

The Transmission, Biological, Social, Cultural and Psychological Perspectives of HIV/AIDS.

HIV Transmission. The main routes of HIV transmission are through (a) sexual intercourse, (Bailey & Hutter 2006; Benziger, 2001; Bhatia, Swami, Parashar, & Justin, 2005; Bhattacharya, 2004; Bryan, Fisher; Fisher, Fisher, Misovich, et al 1996; Kinsler, Sneed, Morisky, et al 2004 & Venkataraman & Sarada, 2001) (b) blood transfusion, (Dandona, Sivan, Jyothi, et al, 2004) (c) intravenous drug use, (Reid & Costigan, 2002; Rowe & Liddle, 2003 & Vaswani & Reid, 2004) and (d) mother to child transmission (Beckerman, 1999; Macklin, 1988). Due to the sexual route of transmission there is a good deal of stigma attached to HIV. Initially HIV was only prevalent among gay men and sex workers in certain western countries. Therefore HIV/AIDS was called as a “gay disease” or the “disease of prostitutes” (Rotheram-Borus, Flannery, Rice, & Lester,
2005). Recently more heterosexual men and women are infected with HIV (Bhattacharya, 2004; Bryan, Fisher, Benziger, 2001; Fisher, Fisher; Malloy, 1996). In the next section I want to discuss specifically the HIV scene in India.

**HIV/AIDS in India**

More people infected with HIV/AIDS live in India than in any other country in the world (UNAIDS, 2006). The number of people living with HIV/AIDS (PLWHA) has increased from a few thousands in the 1990s to an estimate of 5.7 million at the end of 2005 (AVERT, 2007). Presently unprotected heterosexual intercourse is the most common mode of HIV transmission in India (Giri, Wali, Meena, et al 1995; Pais, 1996). In recent years the epidemic has shifted from high-risk groups like commercial sex workers, gay men, and truck drivers to housewives and children, which are the so called “low risk groups” presently being infected by HIV (Giri, et al; Pais).

The United Nations estimated 2.7 million AIDS deaths in India from 1980 to 2000, which they expect to increase to 12.3 million by 2015 and to reach 49.5 million deaths by 2050. (Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, 2003). In India, 39% of people living with HIV/AIDS are women (UNAIDS, 2006). Only 5% of Indian women have comprehensive knowledge about ways of preventing HIV/AIDS (National Family Health Survey, India, 2006). Most women in India face stigma and discrimination in relation to AIDS and are blamed for the spread of the disease, even though the majority of the women have been infected by their partners (National Family Health Survey, India, 2006). Women who risk violence, abandonment, neglect, destitution, ostracism from family and community are at greater risk of HIV and the stigma attached with it (National Family Health Survey, India, 2006).
This research hopes to challenge the gender and power dynamics that are engrained in most parts of the Indian cultures and by confronting the inequalities in relationships, begin to empower the minority partner. The next two subsections are on the medical factors and psychosocial factors that play a role on transmission of HIV and visa versa and then specifically about medical factors and psychosocial factors in India.

**Medical factors and HIV**

The increase in HIV/AIDS in the past few years has brought many new medical (medication and doctor visit) problems world wide. Some of these new medical issues include:

1. Not many people get tested for HIV and so they do not know their status.
2. Antiretroviral therapy medications are difficult to access and their availability is limited
3. Antiretroviral therapy is expensive and thus not many people can afford it;
4. Compliance with drug treatment of HIV/AIDS is difficult and patients often give up half way through the treatment, leading to the HIV/AIDS virus building resistance towards the drug,
5. Each doctor visit is expensive and time-consuming the patient and his/her caregiver waste a lot of time waiting in long lines to see the doctor,
6. HIV-positive pregnant women will need expensive C-section and medication for the baby.
7. Opportunistic infections like pneumonia and tuberculosis often infect HIV/AIDS patients. Treatment for these illnesses is expensive and in addition to treatment for HIV/AIDS (Karasic, & Dilley, 1999, Yarhouse, 2003).
In addition to the above mentioned problems, the health infrastructure in India is not built in a way that everyone has access to health care (Gupta, 2007). Rich people can access health care and afford private practitioners. In contrast, the poor have to travel far and stand in long lines even to meet a doctor and then may not have money for required prescriptions. Indian policy makers want to make amendments in the Indian Paten Act, which has threatened access to affordable generic medicines for millions of people living with HIV/AIDS in poor countries (Shaii, n.d.). Although India is one of the most prolific producers of cheap generic medication for HIV/AIDS, many Indians cannot afford to get these medicines (Gupta, 2007).

Psychosocial factors and HIV

Many psycho-social problems arise due to HIV/AIDS. These include poverty, caregiver’s need, support group, mental health, spiritual health, and stigma. There is AIDS related discrimination; attached to the patient and his/her family (Paxton, et. al., 2005; Macklin, 1993; Bailey & Hutter, 2006). These psychosocial factors play a major role in India which is explained below.

Trends and Transmission of HIV/AIDS in India. In India the HIV virus spreads primarily through commercial sex work, lack of condom use, and IV drug use. Each of these behaviors is affected by the issues of culture, gender and power (Bhattacharya, 2004). Due to the diversity throughout India, the spread of HIV in India varies among different states, regions, and urban areas (AVERT, n.d.). For example the northeastern states of Mizoram, Manipur, and Nagaland have high rates of HIV due to common use of injecting drugs, while Mumbai and TamilNadu have high rates due to migration and the high number of heterosexual contacts with commercial sex workers. Goa has a high
prevalence of HIV due to foreign tourism and the sex trade. States where more than 1% of pregnant women have HIV are considered high prevalence states. Andhra Pradesh, Karnataka and the above mentioned states have high HIV prevalence (AVERT, n.d.).

Figure 1: The map of India below shows the worst affected states:

Commercial sex workers are seen as important sources of HIV risk and transmission, especially since 85% of HIV transmission in India occurs due to heterosexual contact (Venkataramana & Sarada, 2001). Venkataramana and Sarada
(2001) observed that, due to poverty, large numbers of female sex workers have little knowledge about HIV/AIDS and rarely use condoms. Most of the sex workers are infected with HIV/AIDS (Venkataramana & Sarada, 2001).

Migration is one of the social factors responsible for the spread of HIV and other sexually transmitted infections (STI) (UNAIDS, 2001). Studies in Asia and Africa have demonstrated a link between migration and multi-partnered sexual networking (UNAIDS). Most of the migrant population, especially men, contract HIV through HIV positive women while they are away from home and then transmit it to their wives or regular partners when they return home (Poudel, Jimba, Okumura, et al 2004). Poudel and his associates found that migrant workers have multiple sexual relationships and usually unprotected sex and hence were vulnerable to sexually transmitted diseases and HIV/AIDS. This high-risk behavior is influenced by several factors such as alcohol abuse, peer pressure and norms, cheap sex, no family restraint, and lack of knowledge about transmission of HIV (Poudel et al).

Most long distance Indian truck drivers are considered to be an important vector of HIV transmission (Bryan, Fisher & Benziger, 2001). Due to their frequent travel and distance from family, the only entertainment truck drivers say they have are alcohol and sex. Their sexual partners could be commercial sex workers, other truck drivers, or eunuchs. The use of condoms among this group, with their secondary sexual partners, is very low. Moreover truck drivers do not use condoms with their primary sexual partners or spouses (Bhattacharya, 2004, Bryan, Fisher, & Benziger, 2001).

In the northeastern part of India, injecting drugs is common. 80.7% of the HIV infection is due to sharing needles between drug users in northeastern India. Drug use
through injection is also a major problem in urban areas such as Mumbai, Kolkata, Delhi, and Chennai (Reid & Costigan, 2002). The Vaswani and Desai (2004) study shows that most of the intravenous drug users, who typically come from a low economic backgrounds, are at high risk of HIV due to their needle and drug sharing practice and having unprotected sex with commercial sex workers. Some of the drug users also indulge in unprotected sex to get money for buying drugs. Due to the increase in deaths from HIV/AIDS among intravenous drug users, support is needed for family members to cope with their loss and the stigma involved. Thus commercial sex workers, migrants, truck drivers, and intravenous drug users are some of the highest risk groups that require medical help and psychosocial strategies to cope with HIV/AIDS.

*Global Response*

The fight against this world wide crisis of HIV/AIDS is internationally supported by the World Bank, World Health Organization (WHO), United Nations Children’s Fund (UNICEF), United Nations Joint Programs on HIV/AIDS (UNAIDS) and other funds like the Bill Gates Foundation and Clinton Foundation. These international organizations then fund the national organizations mentioned below.

*What is India Doing to Fight AIDS?*

*Government Organizations.* Due to the epidemic of HIV in India, the government established the National AIDS Control Organization (NACO) in 1992 (Bhupesh, 1992). NACO carries out India's National AIDS Program, which includes the formulation of policy, prevention, and control programs. The government also has started AIDS prevention programs in 25 states and 7 union territories. These are called the State AIDS Control Society (SACS), e.g. Maharashtra State AIDS Control Society (MSACS). Since
some cities like Mumbai have significant HIV/AIDS concentrations, therefore the government has started District AIDS Control Society, e.g. Mumbai District AIDS Control Society (MDACS). These programs includes voluntary counseling and testing services, HIV testing of all pregnant women, and training programs for medical doctors, nurses, staff, counselors, and social workers (Bhupesh). These counselors and social workers in turn train grass-root level workers who then train lay people in villages and cities. The government is also focusing on sex education in schools and condom production. Due to corruption and to pocket all the money, the government and Indian policy makers want to make amends in the Indian Patent Act and Indian Drugs and Cosmetics Act, which will hinder in access of cheap generic drugs for HIV to the poor countries and poor people in India.

*Caveat in the Government system.* The government has a top-down approach, meaning that policies and training programs are made at an international or national level by well educated people and then applied to rural or urban uneducated people (Gupta, 2007). The top-down approach has limitations and this case study narrated by Dr Gupta during her talk at Virginia tech is an example of that.

After a training workshop on ‘How to wear condoms and prevent HIV’ the trained grass root workers were asked to go and disseminate their knowledge to villagers in different parts of India. These workers were not provided with appropriate dildos to demonstrate the wearing of a condom. In a particular village one of the workers used a broom (as a dildo) and showed the people how to wear a condom. The government sent an evaluation committee after a year to find out the output of the program. The evaluation committee found that in that same particular village some
women were pregnant after they and their spouses had put condoms on the brooms and kept it outside the doors of their houses and had unprotected sex thinking that the broom with a condom would prevent the HIV virus from entering their house.

This shows how policy makers may not be aware of or sensitive to specific knowledge villagers have and the cultural issues in a variety of locations. For example it is a custom in some Indian houses to tie a lemon with two green chilies to the door of the house to keep the evil spirits out, especially when a baby is born. So it was culturally consistent (or understandable) for people to think that a condom on a broom outside their house could keep HIV/AIDS away.

The governmental organizations are doing work on prevention but there is very little work done on care and management of HIV/AIDS (Bhatia et al, 2005; Chandrasekharan et al, 2006; Dandona, et al 2004). Once a person is infected with HIV/AIDS s/he requires proper medical, emotional, and mental support. However, the government concentrates on prevention of HIV, so few services are available for those who have the virus. Although the focus is on prevention and abstinence, the only sexual contact 75% of HIV positive women have had is with their husbands (NFHSI, 2006). This shows that there should there be focus on abstinence before marriage for men and women. Also trust building among couples and possible pre-marriage counseling and testing is important. Since in some cases women are in jeopardy because they cannot say no to having sex with their infected husbands, women need to be empowered to negotiate condom use within their relationship.

Non-Governmental Organizations (NGOs). Most NGOs in India work on awareness, prevention, and training for HIV/AIDS [Cell for AIDS Research, Action and
Training (CARAT, 2001]. Some of them also specifically work on management care of people living with HIV/AIDS. Some NGOs also provide hospice care and residential care programs for people living with HIV/AIDS (PLWHA) [Examples include committed communities development trust (Ashray) in Mumbai, and the Jyoti terminal care center in Mumbai (CARAT). Some of the NGOs work to provide legal services to HIV positive clients (e.g., Lawyers Collective, HIV/AIDS unit). Due to discrimination of people living with HIV/AIDS in different areas of employment; basic health care necessities can be refused. Although these organizations help, the magnitude of HIV is far greater than they can serve. There is a need for more organizations working for prevention and management of HIV/AIDS (Gupta, 2007). The next section presents the need for therapy among PLWHA and explains how therapy can help.

*Need for Therapy and Counseling Services among HIV Positive Clients and their Families*

The number of people affected by HIV/AIDS is much greater than the number of people infected by it. HIV is recognized as an illness that not only affects individuals but also their families (Bor, Evans & Levitt, 2007). This is because it can be transmitted to the spouse and from an infected mother to her child. It not only impacts the family because of transmission but also because of family coping, stigma, and death. Not only does HIV/AIDS physically affect infected people it but also emotionally affects them and their family members (Bor, Evans & Levitt). This is because of the stigma attached to HIV. People infected and affected with HIV may suffer from depression, and/or anxiety disorders, and hence need help to deal with the disease (Karasic & Dilley, 1999). With the increasing number of people infected and affected with HIV/AIDS, care and support
is needed from professionals to help cope with the disease. Thus, there is a great need for counseling and therapy among people who are affected and infected by HIV/AIDS.

McKay and colleagues (2004) found that the Chicago HIV Prevention and Adolescent Mental Health Project (CHAMP) family program positively influences family communication, family decision-making and family-level influences, which impact the adolescent behavior to reduce HIV risk. Parents who participate in this program can talk openly to their children and adolescents, who then have lower-risk behavior for getting HIV. The family has great influence; open communication in the family can reduce a person’s risk-taking behavior. Hence the authors contend that family therapy can be useful. People living with HIV/AIDS face challenges not only from their family, friends, and work but also from society. Family therapy can be used to help people infected and affected by HIV.

*The Range of Family Therapy Models that may be used with HIV Issues*

Having explained the severity of the problem of HIV/AIDS globally and in India and highlighted specific ways this problem impacts Indians, I now want to now explain how family therapy may help individuals and families who are living with HIV/AIDS. Marriage and family therapy theories and models have been used to help people infected and affected with HIV/AIDS (Serovich & Mosack, 2000; Macklin, 1993). Family therapists can directly impact the AIDS crisis (Yarhouse, 2003). Family therapy models have been used to help HIV positive clients cope with the HIV diagnosis, help clients reveal their HIV status to family members, psycho-educate the client and his or her family on HIV, improve poor relationship between spouses, and help the family fight against discrimination, which then works towards building a safe environment for people
infected with HIV (Yarhouse). Family therapists can directly impact the AIDS crisis (Yarhouse). I am trained in marriage and family therapy and worked with clients who are HIV positive and found some family therapy models to be more useful with HIV issues than other theories and models.

Marriage and family therapy is apt for working with individuals and families who are HIV-positive (Serovich & Mosack, 2000; Macklin, 1993; Yarhouse, 2003). One of the important reasons for this is that HIV not only affects the individual but also the family of the infected person. Several family therapy models explained below have either been empirically or clinically supported to work with clients who are infected with HIV and their family members. I speculate that few more family therapy models would be effective with HIV-positive clients and their families based on either theory or my personal experience. I have mentioned only some of the family therapy model below even though I feel that most of the models will be a good fit with HIV issues.

Information, Behavior, and Motivation model. There are different interventions, strategies, and models used for HIV prevention and to help people living with HIV/AIDS cope with the infection. The information, behavior, and motivation (IBM) model (Fisher & Fisher, 1996) emphasizes that HIV prevention information, motivation, and behavioral skills are important determinants of HIV preventive behavior and that any deficits in these elements are associated with risk behavior. This model predicts that if an individual is well informed about HIV prevention and is well motivated she/he will apply this information and motivation to his or her behavior, thus changing behavior to a low or no risk of getting HIV. It maintains that information and motivation have a direct effect on preventive behavior. Bryan, Fisher and Benzinger (2001) demonstrated that the IBM
model has helped in assessing and understanding HIV risk behavior among Indian truck drivers and increasing condom use with secondary partners.

**Structural Ecosystems Therapy.** Structural Ecosystems Therapy (SET) can be tailored to each specific family. SET is a family based intervention that there are maladaptive ways in which families interact with one another and the therapist can help the family develop new functional interactions based on cultural norms to replace these maladaptive interaction patterns (Mitrani, 2003). Structural Ecosystems Therapy (SET) was helpful to prevent and reduce the psychosocial distress associated with HIV/AIDS among HIV positive African-Americans (Mitrani, 2003). It is unclear whether this approach is appropriate in India. There are a number of possible ways family therapy could be used to address HIV in the context of India.

**emotionally focused therapy.** Emotionally focused therapy is a short term, structured approach to couples therapy formulated in the early 1980’s by Sue Johnson and Les Greenberg (Johnson, 1997). EFT can also be used with families. Therapists use EFT to initiate new cycles of interaction and promote a healthy and secure bond between partners thus breaking the negative series of interaction (Johnson, 1997). Emotionally focused therapy (Johnson, 2003) could help emotionally estranged Indian couples bond with each other that have an alienated relationship due to HIV and the feeling of betrayal from the partner.

**Systemic therapy.** The core concept of systems therapy is that a system is more than the sum of its parts for instance a family system is not just a collection of individuals but also the interactions between these individuals (Bertalanffy, 1968). With systemic therapy clinicians began to realize that it is important to address the problems of the
family as a whole rather than just with one individual. In 1967, Mara Selvini Palazzoli, Luigi Boscolo, Gianfranco Cecchin, Guiliana Prata, (1978) came together in Milan, Italy and formed the Milan Systemic Approach to family therapy. Their theory was based on the notion that symptomatic behavior helps to maintain the ‘homeostatic tendency’ of the family. They discovered that if the therapy team offers counter-paradoxical intervention that suggests no change and that supports the homeostatic tendency, families would paradoxically reject the ‘no change’ directive and change in positive ways. The main features of their work are: a. hypothesizing, b. circularity, c. neutrality, d. the use of team, e. family rituals as interventions, f. positive connotation, g. the referring person, and h. a complete method of conducting family therapy based on systemic ideas. (Palazzoli, Boscolo, Cecchin, & Prata). Milan group’s ideas began to change and they began to think of systems evolving rather than being homeostatic or stuck. Systemic therapy appears to work well with cultures with complex extended family systems like India (Nath & Craig, 1999). Relationships are very important in a collectivist society like India and systems theory seems to be compatible in a collectivist society (Nath & Craig). Also since HIV not only affects the individual but also the family, systems theory seems to be a natural fit addressing the problem.

Bowenian family therapy. Murray Bowen believed that family should be the unit of treatment. Bowen (1978) explained that the problem of schizophrenia arose from undifferentiated families and if untreated it could extend down to the next generations. Bowen came up with the concepts of differentiation of self, triangulation, nuclear family emotional system, family projection process, multiple generation transmission process and sibling process (Bowen). These concepts help us understand families and their
dynamics, which is important for therapy with a family, couple, or an individual. Also the problem of HIV affects families and Bowen’s family therapy may help.

Structural family therapy. Salvador Minuchin was the founder of structural family therapy (Minuchin, 1974). Minuchin believed that restructuring family structures in therapy could lead to positive interactional changes (Minuchin, 1974).

Strategic family therapy. Jay Haley (1976) was a leader in the development of strategic family therapy. Therapists who follow Haley’s style of therapy take responsibility for directly influencing their clients’ either through paradoxical or straightforward directives and emphasize the social situation and context of the client’s problems (Haley, 1976).

Since structural and strategic therapies deal with families and children, they are a natural fit for HIV. Since HIV/AIDS is not only an individual problem but affects the individual’s family, these family therapy models seem to fit. In addition addressing family structures and hierarchies in Indian families may lead to better interactions within families and different power dynamics. Also strategic family therapy may help clients and their families with HIV issues to take responsibility for the problem and find solutions.

Solution-focused therapy. Steve de Shazer and Insoo Berg were influenced by the MRI approach and developed Solution Focused Brief Therapy (SFBT). Most models of therapy focus on problems, but solution focused therapy actually focuses on building solutions and exceptions to the problem (de Shazer, 1985). SFBT believes in the constructivist idea that nothing exists outside language (de Shazer & Berg, 1993). Thus the goal of SFBT is to change ‘problem’ talk to ‘solution talk’, and by changing the
language to help the client focus on his/her strengths rather than weakness and failures. The three cores of the SFBT are ‘miracle question,’ ‘exception question’ and the ‘scaling question’ (de Shazer & Berg, 1993). Since SFBT focuses on solutions rather than problems, I think that it would be a good fit because the focus would be on the future and finding solutions to live with HIV rather than how the client got HIV or just talking about the problem of HIV.

*Narrative Therapy.* Michael White is the founder of Narrative therapy. He was influenced by the work of Bateson and Foucault and developed the idea of ‘externalizing’ the problem (White & Epston, 1990). This approach of family therapy reconstructs the problem by externalizing it and thus not stigmatizing the client as the ‘identified patient’ (White & Epston). Epston, initiated the use of ‘letter writing’ to clients so that, even after they completed therapy, the letters could help clients remember how they dealt with the problematic situations and created new beginnings. Narrative family therapists recognize how narrative stories affect the client’s perception and the interpretation of those perceptions (White & Epston). Narrative therapists do not believe that problems are inherent in individuals or families but believe that problems only arise because people believe in self-defeating views of themselves and their world (White & Epston). By externalizing the problem, therapists make clients believe that they were fighting against a problem rather than the clients thinking of being/having the problem themselves. White was influenced by Foucault’s work and believed that there is no absolute truth in this world, and with the help of social constructionist axiom, wanted to deconstruct the truths that oppress people’s lives. Some of the therapeutic techniques of narrative therapy are a. externalizing: the person is not the problem; b. relative influence question: who is in
charge, the person or problem; c. re-authoring the story; d. reinforce the new story; and e. deconstructing destructive cultural assumptions (White & Epston). I also think that since narrative therapy helps externalize the problem (HIV) and not the person (who is HIV positive), it can help the client and his or her family re-authors their life story and copes with HIV issues better. Keeling and Neilson (2005) described the use of Narrative therapy with Indian women in the USA and discussed how Narrative therapy may be suitable for an Indian population, where mental health services are under utilized due to the stigma attached to therapy.

**Cognitive-Behavioral Therapy (CBT).** Cognitive Behavioral Therapy is a form of psychotherapy that is based on the idea that thoughts cause feelings and behaviors. Feelings and behaviors are not external things like people, situations and events (Hays & Iwamasa, 2006). Thus by changing the way a person thinks, that person can feel better even if the situation remains the same. Hays & Iwamasa show that CBT has worked well with people from different cultures, including American Indians, African Americans, Asian Americans and people of the Arab heritage. Kinsler, J., Sneed, C.D., Morisky, D.E., & Ang, A. (2004) have shown that cognitive-behavioral peer facilitated school-based HIV/AIDS education on knowledge, attitudes and behavior among school goers has a positive impact on them. The positive impact is an increase in positive attitude towards using condoms, as well as lower risk behavior.

Dattilio and Bahadur’s (2005) research shows that CBT can be easily adapted across cultures and to an individual’s or group are cultural beliefs. CBT can also incorporate spiritual beliefs and cultural norms which are very important for cross cultural application (Dattilio, & Bahadur). In their study, Dattilio and Bahadur have
shown how CBT was a good fit with an Indian family because of its flexible mode of treatment and demonstrate that CBT can be respectful to other cultures, which allows Indian families to change in a way which does not jeopardize their cultural beliefs.

*Feminist Family Therapy.* Rachel Hare-Mustin (1978) was the first to challenge family therapy from a feminist perspective. Feminist family therapists challenged the concept of circular causation that suggested that if everyone is responsible for a problem, then no one is responsible. Feminist Family Therapy focused on linear causation of historic patriarchy, sexism, and structural inequalities (Libow, Raskin, & Caust, 1982). They wanted to help women become more competent and successful, both in family and in general society, and emphasized therapy that would support a women’s personal agency and challenge sexism (Libow, Raskin, & Caust). Feminist family therapy may be a good way to address issues of patriarchy and male domination with an Indian couple and thus help empower an oppressed woman in the relation.

*How else can marriage and family therapists help?* According to Acuff and colleagues (Yarhouse, 2003), marriage and family therapists provide individual, couple and family therapy; case management; psychiatric evaluation; medication management; inpatient psychiatric hospitalization; emergency services; psychosocial rehabilitation; and residential services. The above mentioned services are especially useful for individuals and families, infected and affected by HIV/AIDS. Some of these services are explained below.

*Helping clients and their families cope.* Research studies have shown that marriage and family therapy is effective in treating a full range of mental and emotional disorders and health problems like drug abuse, alcoholism, marital distress, and
depression (Baldwin & Huggins, 1998; Granvold & Tarrant, 1983; O'Farrell & Fals-Stewart, 2003; Piercy & Sprenkle, 1986; Rotunda, Alter, & O'Farrell, 2001; Rowe & Liddle, 2003; Sherman, & Simonton, 2001; Vogel, 2005). A family therapist can help individuals, couples, and families deal with increasingly lengthy periods of chronic illness, crisis of HIV diagnosis, and feelings due to anticipatory loss (Bor, Evans & Levitt, 2007). Bor and colleagues suggest that therapists can train HIV health care teams to effectively deal with the complex, emotive and sometimes the ethically sensitive issues that are faced by HIV-positive people and their families.

Some HIV-positive people or their family members may go through a number of reactions such as shock, helplessness, guilt, loss of self esteem, anxiety, depression, and suicidal thoughts (O'Dowd, Biderman & McKege, 1993). Therapists can use psychotherapeutic interventions during pre-test and post-test counseling to help clients and their families better cope with the test result. Therapists can also help infected and affected individuals cope with chronic illness, caregivers’ burden, social and emotional problems of orphan- hood, adherence to complex anti-retroviral treatment regimes, and management of opportunistic infections (Bor et al, 2007).

Serovich et al (1998) helps readers understand the reactions that HIV-positive women face when they disclose their HIV-positive status to their family members and friends. Serovich and colleagues further describe the need for therapists to help an HIV-positive person disclose their status to family members. The therapist can also help the HIV-positive person cope with the negative reaction of their family members after disclosure. The therapist can help the family members cope with the disclosure and improve a poor relationship (Serovich et al).
Therapists as liaison. Fumaz, Munoz, Molto et al (2005) have shown how some patients develop neuro-psychiatric disturbances (e.g. depression and psychosis) due to taking certain prescribed anti-HIV medication. A joint consultation with the mental health practitioner, medical doctor, and the patient may help the client manage the above mentioned symptoms (McDaniel, Hepworth, & Doherty, 1992).

People with HIV/AIDS not only need medical treatment but also utilize alternative treatment like therapy to help them cope with the disease and deal with death and the stigma attached to the disease. Marriage and family therapists can directly impact the AIDS crisis; they can work in collaborative partnerships with patients and physicians to increase adherence to treatment regimens (Yarhouse, 2003). Yarhouse states:

Marriage and family therapists can directly impact the AIDS crisis. This may be accomplished in part by developing open and supportive lines of communication among family members so that accountability and support can be provided within family systems and outside the system. Education alone has generally been seen as less effective than education combined with psychological inoculation against increasingly persuasive messages regarding at-risk behaviors, social resistance skills, and self-management.

Family therapy can also help in disclosing HIV status to family and friends (e.g. parents to young children), thus becoming a liaison between family members. Therapists can also facilitate open communication among couples and across generations since HIV/AIDS effects parents and children. A therapist also can serve as a liaison between medical professionals and the HIV positive person (Bor et al, 2007).

There is not only physical but also emotional consequences for the family and
There is stigma associated with HIV since it is sexually transmitted. Once a person says she/he is HIV positive it is thought that the person is immoral and has many sexual partners. This also estranges the person and his/her family from religious organizations like the church, temple or mosque (AIDS action, 2000). The marriage and family therapists can also help HIV positive clients and their families by working with the religious organization to accept, help, and support clients and their families.

One of the risks that all mental health professionals, face is the duty to warn the third party who is at risk by the client in situations when the client refuses to reveal his/her HIV status or to change behavior (Serovich & Mosack, 2000). This is a grey area in India since there is no law there which forces the therapist to warn the third party (Datye, Kielmann, Sheikh, Deshmukh, Deshpande, Porter, Rangan, 2006).

There is discrimination against people living with HIV/AIDS in health settings and as at the work place. Marriage and family therapists could help HIV positive clients participate in normal occupational activities and also help them fight against discrimination by building their self-confidence. Marriage and family therapists could also work with communities to build a safe environment and support by providing welfare services and accept people infected with HIV (Macklin, 1993).

**Qualities of family therapists.** A family therapist is also well suited to deal with HIV, since therapy is a non-judgmental and explorative approach that supports open discussion of sensitive subjects like sexuality, fidelity, fertility, and dying (Bor et al, 2007). Family therapy can not only be used to deal with HIV issues but also for preventing HIV through psychoeducation as explained below.

*Marriage and family therapy used for prevention of HIV.* Family therapy
interventions can help in providing coping mechanisms for HIV positive individuals. Another important dimension of therapy is psychoeducation (Krishna, Bhatti, Chandra & Juva, 2005). Therapists can provide psychoeducation to individuals who they perceive to have risk behaviors, like drug abuse or unprotected sex with more than one partner. Therapists can also provide psychoeducation to the family of people living with HIV/AIDS, so that the fear of transmission does not keep the family from care-giving or loving the person infected by HIV.

The above mentioned models of marriage and family therapy seem to work for some Indian clients, at least in theory but this research will help practitioners and students better understand what will work with HIV-infected clients and their families in India. Since marriage and family therapists are important to help HIV positive clients and their families cope with the diagnosis and care giving, it is important to understand the history of this profession and about how the different theories and interventions came about.

Marriage and family therapy emerged from different parts of the world like Europe, Australia but mainly in the USA.

Profession of Marriage and Family Therapy

Although family therapy has a short history it has a long past. It grew in the context of individual therapy and psychoanalysis and to a degree, as a reaction to it. The initial concept was that change in one person would change the entire system (Bertalanffy, 1968). Some of the earlier family therapies included Bowenian family therapy (Bowen, 1978), contextual family therapy (Boszormenyi-Nagy 1966), structural family therapy (Haley, 1976), and strategic family therapy (Haley, 1976). Some of the newer social-constructionist theories are narrative therapy (White & Epston, 1990) and
solution-focused therapy (de Shazer, 1985). Feminist family therapy challenged some of the earlier therapy models due to their emphasis on circular causation, i.e., if everyone is responsible, then no one person is responsible. The earlier models lacked accountability, and focused on linear causation of patriarchy, sexism and structural inequalities (Libow, Raskin & Caust, 1982). In 1942, American Association for Marriage and Family Therapy (AAMFT) was founded, and was initially called the American Association of Marriage Counselors. Marriage and family therapy is now considered a profession, and is licensed in almost every state. An essential assumption of the profession remains that one can address individual and family problems by understanding family context and dynamics, and by interviewing with the family context in mind.

For further understanding of the profession the readers may wish to consult texts such as ‘Family Therapy Concepts and Methods’ (Nichols & Schwartz, 1991), ‘Family Therapy Sourcebook’ (Piercy & Sprenkle, 1986), as well as primary texts written by the original pioneers of Family therapy.

Need for Marriage and Family Therapy in India

Research has shown the need for professional family therapy in India (Baptiste, 2005; Carson & Chowdhary, 2000; Mittal & Hardy, 2005; Natrajan & Thomas, 2003; Singh, Nath, & Nicholas, 2005; Sonpar, 2005). Due to globalization, industrialization, and urbanization the traditional hierarchical structure has changed, and there is a rise in nuclear families in an individualistic (western) value system, which has caused mental health disturbances (Natrajan & Thomas, 2002). Family mental health is addressed by non-governmental organizations (NGOs) in India that mainly focus on providing material (clothes, books) help to children, women, and the aged (Desai, 1991). Thus, it is
important to understand how family therapy can help address mental health problems in India with the focus on HIV/AIDS. Natrajan and Thomas (2002) found that most Indians have a fatalistic attitude and it is difficult for them to come in for family therapy, although they may need family therapy. The, culture, illiteracy, misconceptions, and stigma on coming to therapy make it even more difficult for most Indians to go for therapy. Most people believe that they get married because God has made their partner for them, and a happy or bad marriage is in God’s hands. Similarly they believe that any illness is a curse from God or is due to the sins a person has committed, thus s/he has to bear the disease as a punishment (Juthani, 2001).

There has been an increasing need for a family based approach in the management of mental health and physical health issues in India (Prabhu, 2003). Family is the core of Indian society and the key focus of an individual has always been the centrality of marriage and family life (Mullatti, 1995). HIV is a physical problem with systemic impact or implications, i.e. affects individual and families and in turn the entire society so using the marriage and family therapy models and systems thinking would be a good fit for HIV positive people in India. Family therapy has been shown to be useful among HIV clients and their family members especially in providing access to reliable AIDS information about HIV transmission and prevention, revealing to family members about HIV and about promiscuity, drug abuse or gay behavior, projecting and encouraging a non-judgmental attitude and grief counseling (Frierson, Lippmann, Johnson, 1987).

Evolution of Family therapy in India

For centuries, Indian families who experience any familial problems go to gurus,
elders in the family or religious priests for advice (Davar, 1999). Most Indians still first ask family members and gurus before approaching a therapist or mental health practitioner (Davar). Professional family therapy is in its infancy stage in India (Mittal & Hardy, 2005; Nath & Craig, 1999; Natrajan, Karuppaswamy, Thomas, & Ramadoss, 2005; Prabhu, 2003; Rastogi, Natrajan & Thomas, 2005; Shah, Vargese, Kumar, Bhatti, Raguram, Shobhana, & Juva, 2000; Singh, Nath, & Nicholas, 2005; Sonpar, 2005). The formal involvement of families in family therapy settings started in early 1970s and resulted in the establishment of the Family Psychiatric Center at the National Institute of Mental Health and Neuroscience (NIMHANS) in Bangalore, South India (Nath & Craig, 1999). NIMHANS offers a three-month orientation course in integrative systemic family therapy as part of training for mental health professionals (Nath & Craig). In 1988, a group of professionals started a study of families in systemic therapy in Delhi. An interested group of professionals also attended an introductory seminar on the Milan approach given by a visitor from the Marlborough clinic, in London, and this was followed by a five-day seminar in 1989 attended by forty four people who returned in a year for further short courses that including role-play, case studies and theory. In 1991, the Indian Association of Family Therapy (IAFT) was established and was formally registered in 1994. Since then, practicing members have conducted biannual, two-day orientations for new members who have no previous experience with family therapy. IAFT also holds a conference every year in India. In recent years IAFT has focused on the application of Eurocentric theories to the Indian population. In particular it may be helpful to see how marriage and family therapists from India plan to apply marriage and family therapy to typical Indian situations (related to HIV, for research purpose). For
example, one typical Indian scenario might be a husband who is HIV-positive having unprotected sex with his wife without revealing his HIV status to her. What family therapy interventions might an Indian therapist use and why? The important issue is how MFT theories might be adapted to be culturally sensitive. What might an Indian cultural lens teach us about applying MFT theories to issues of HIV in India?

The Importance of Culturally Sensitive Therapy

Research has shown there is a need for therapists to do culturally sensitive therapy by adapting Eurocentric theories to fit the Indian context (Dattilio & Bahadur, 2005; Mittal & Hardy, 2005; Natrajan, Karuppaswamy, Thomas & Ramadoss, 2005; and Rastogi, Natrajan & Thomas, 2005). Many researchers call for cultural sensitivity and understanding and emphasize not only knowing but also being sensitive to different cultures (Dattilio & Bahadur, 2005; Kim, Bean & Harper, 2004; McGoldrick, 1998; Mittal, & Hardy, 2005; Natrajan, Karuppaswamy, Thomas, Ramadoss, 2005). Sue and colleagues (2001) explain “Multicultural competence is generally conceptualized as involving three main areas: therapists’ awareness of their own culture, therapists’ knowledge of the world view of culturally different client, and therapists’ behaviors or use of culturally appropriate treatment strategies and interventions”.

The lack of information about culturally competent therapy done with Indian families makes it difficult to form reliable judgments about therapists’ behaviors and related treatment strategies (McGoldrick et al, 1996). Messent (1992) has worked systemically with Bangladeshi families. Lau (1990) has written the importance for western therapists to understand and work with religious and cultural minorities that may differ from their own. Kakar (1990), Juthani (2001), and Natrajan et al (2002), have
written on the Indian psyche and family from a psychoanalytic point of view and expressed the need for therapy. Raguram (1997) and Nath et al (1999) have written about the need for cultural factors to be included in systemic work with Indian families.

Directive approaches have been found to be more suitable than psychotherapy or in-directive approaches for Indian families both based on theoretical speculation and empirical evidence (Mohan, 1972). Some culturally sensitive tools used to assess Indian families in treatment have been developed. Two such tools are Family Typology Scale (Channabasavanna & Bhatti, 1982) and Family Interaction Pattern Scale (Bhatti, 1986).

Hardy (2000) and McGoldrick (1998) have not only asked therapists to be culturally sensitive but also support equity and social justice. Therapists and other researchers should also be aware of their own social standing in front of the client they are seeing (Rothbaum, Rosen, Ujiie, Uchida, 2002). This is important in Indian settings where the therapists, in most cases, come from a higher class and educational level than the clients. Not only applying Eurocentric interventions and theories to a different culture may be inappropriate without adapting it, but also the therapists who think in Eurocentric ideas should be aware of his/her biases due to either their education or living abroad etc.

India was colonized under the British rule for over two centuries and still recovering from the losses that they faced. These losses could be financial or emotional and some of these come through the outbreaks of divide of Hindu and Muslims. Now bringing in colonizing ideas through therapy is the one of the acts of colonization that a therapist should avoid. This makes it essential for me to provide culturally sensitive therapy in my practice with Indians.

Providing culturally sensitive therapy does not mean being value neutral
(Waldengrave, 1998). It is important for a therapist, especially a feminist, to respectfully challenge the unfair cultural beliefs and customs (Libow, 1986). The use of “sexist” and “classist” language and ideas in therapy only reinforces the client’s already ingrained practices of sexism and classism (Waldengrave, 1998).
Chapter III
Methodology

Research Question

The overarching research question is “What are the marriage and family therapy interventions that work best with HIV positive clients and their families in an Indian setting?” This research question has guided the interview questions, which are mentioned in the later part of the chapter.

Purpose of the study

The purpose of this study was to explore marriage and family therapy interventions which work best with HIV positive clients and their families in Indian settings according to the perceptions of Indian family therapists. To do this, I have used modified grounded theory methodology in a qualitative method approach (Keeling & Piercy, 2007; LaRossa, 2005; Patton, 2002 & Strauss & Corbin, 1998). Strauss and Corbin (1990) have explained that interpretations must include the perspectives and voices of the people who are studied, and these interpretations should be used to understand the actions of individuals or collective actors who are being studied. I was interested in obtaining a rich description of the lived experience of her participants, because this was an exploratory research that may generate hypotheses for future research, so modified grounded theory was used. Modified grounded theory methodology was appropriately used in this study because (1) since there has not been much research done on marriage and family therapy models and interventions in India with HIV positive clients, the study is exploratory and represents a new area of inquiry, and (2) the Indian marriage and family therapy participants identified different marriage and family therapy
interventions, which would work best in an Indian setting and guided and developed theoretical categories. The reason it is not grounded theory but modified grounded theory is because the study adhered to principle features of grounded theory like theory generation but not theory verification and constant comparative method of data analysis. Further explanation is given below under modified grounded theory.

**Role of the Researcher**

The researcher is vital for qualitative research since she or he is the key instrument for data collection and analysis (Merriam, 1998). Just like any other instrument, a researcher can fail. Hence just like in quantitative research, a researcher talks about the limitation of the instrument she/he uses; in qualitative research she or he should discuss his or her biases. For example, I kept a journal to write about my reactions, my preconceived notions and emerging findings and reflections so that I and others could understand how I arrived at my conclusions of the study. But as a feminist, sharing personal knowledge with the participants strengthens instead of hindering the research results (Westmarland, 2001). Greed (1990) sums it up well in her quote:

So I am studying a world of which I myself am part, with all the emotional involvement and accusations of subjectivity that this creates. I do not attempt to keep my surveyors at arm's length and do research "on" them as my subjects whilst maintaining a dominant position, as is common in much traditional "objective" research (p.145).

In the research, I shared some of my personal experiences of difficulties that I faced as a therapist in India. By sharing my personal knowledge about how I felt about the theories and my fears of going back to India to put into practice what I learned,
especially since I am worried about the lack of resources and support system, made some of my participants actually open up more about their experiences. One of the participants said, after I revealed to her my personal experiences, that:

I am not embarrassed to express my feeling to you, since you share the same experiences. I was a little apprehensive initially to open up, since I thought you may think badly of me, and think that I am not a good therapist or a good Indian since I am scared to go to India and work. Your revelations about your fears have actually made me comfortable to talk to you about mine.

I worked in the slums of Dharavi, Mumbai (India) and on the streets of Kamatipura, Mumbai (red light area in Mumbai) as a social worker working to fight HIV. Initially, it was all so shocking but later looking at some six or seven year old girls being sold into prostitution and becoming HIV positive just made me cry. Losing clients to diarrhea, tuberculosis and other opportunistic infections and attending funerals of babies and young clients made me want to do something to fight AIDS. I was frustrated with my hands being tied for lack of money and/or lack of knowledge. I wanted to find better solutions and techniques to help clients cope, to get medicines for them and at least prevent opportunistic infections. But I was only a fresh graduate with a masters being paid $60 per month. The bureaucracy and corruption in the government did not help much either. I had lost a close friend to AIDS for no fault of his except that he needed blood transfusion and he got HIV infected blood. I saw some families break up and not many solutions. This is when I came across family therapy which sounded promising to help me get the knowledge to apply with families in India. So I decided to get further education in marriage and family therapy.
During my classes all I could think about is how would I apply this to Indian scenario, especially HIV? After lengthy discussion with mentors, professors and friends and introspecting and journaling I knew that the only way to find out was by researching it myself. I considered myself a feminist, thinking that it just meant equality, but I did not realize, until immersing myself into a western culture, that equality did not only mean that my husband would not abuse me or I could join the work force. Feminism made me realize how I could be an oppressor how I need to be careful in thinking, vocabulary and actions and be aware of ideas and thoughts that speak of being racist, sexist, and colonial. Doing research in USA has made me conscious of who I represent as a woman of color, minority, foreigner, mother, religious minority and a low-income student who is always under the speculation of the western eyes. Although I am learning some new ideas, I also have to unlearn some of my old ideas, which have been engrained in me for the past 25 years. I agree with Mohanty (2004) where I see the central challenge that an Indian feminist faces at this time is how to rethink the relationship of nationalism and feminism in the context of religious identities. Thus, I am especially required to work under the paradigm of decolonization.

Qualitative Method of Inquiry

Qualitative inquiry is used in this study for a number of reasons. First, qualitative research is gaining popularity among human and social sciences (Creswell, 1998). Researchers more and more trust, emphasize and rely on it (Creswell, 1998; Denzin & Lincoln, 2000; Sprenkle and Moon, 1996; & Patton, 2002). Secondly, qualitative research uses several methods that involve active participation of the participants (Creswell, 2003). Moreover, qualitative methods capture in detail the experience of individuals who
deal personally with the issue being studied (Creswell, 1998; Guba & Lincoln, 1981; Kazdin, 1998; Maxwell, 1996). In addition, qualitative research, being fundamentally interpretative in nature (Creswell, 2003), helps to make interpretations of the data and develop themes or categories that, in the end, will generate marriage and family therapy interventions/theories that will best suit an Indian setting. Qualitative research is also more appropriate for feminist research since it allows subjective knowledge (Duelli Klein, 1983) and a more equal relationship between the researcher and the researched (Jayaratne, 1983, Oakley, 1981, & Stanley and Wise, 1990). In the beginning itself, I made the purpose of the study clear and also explained how there were no right or wrong answers to the questions asked by her. I also asked the participants to call me by my first name and ask any questions during the interview. I also told the participants that they were the experts and tried not to be judgmental about any of the answers that the participants gave or their clinical experience or age.

*Modified Grounded Theory*

In qualitative methods there are different approaches a researcher can use to generate theory but the one that tends to rely on multivariate non-statistical set of procedures is called grounded theory methods. Glaser & Strauss (1967) have said that not only is generating theory an exiting adventure but also fundamentally necessary since it is a responsibility researchers serve. There is a lack of Indian therapists and Indian researchers in the field of family therapy (Mittal & Hardy, 2005; Nath, & Craig, 1999; Natraj, Karuppaswamy, Thomas, & Ramadoss, 2005, Prabhu, 2003; Rastogi, Natraj & Thomas, 2005; Shah, Vargese, Kumar, Bhatti, Raguram, Shobhana, & Juva, 2000; Singh, Nath, & Nicholas, 2005; Sonpar, 2005). This research will be especially useful for
therapists and other Indian mental health professionals who work with people who are infected and affected by HIV. Marriage and family therapy is a discipline where theory is valued; hence, modified grounded theory was used. Another important reason to use modified grounded theory was to derive useful theoretical knowledge from Indian family therapists about how to do culturally sensitive therapy using family therapy interventions with HIV positive Indian clients in India. Modified grounded theory is a new area of research and doing qualitative research helped me get an in-depth understanding of the interventions used by Indian marriage and family therapists and the reasons they use these interventions with HIV positive Indian clients. Using qualitative methods gave freedom to the participants to express the how and why questions of using certain marriage and family therapy interventions. I mainly used grounded theory to reflect on the procedure of analytic induction and constant comparison. When all these new ideas emerged, I made sense of them by using the constant comparison and analytic induction method and thus helped me identify themes. I could have used phenomenology but that only helps understand a particular phenomenon. Since action research is not what I tried to achieve, the reflective procedure of grounded theory worked best with this research. I conducted open, axial and selective coding procedures with analytic induction and constant comparison until saturation in categories was reached (LaRossa, 2005).

**Sampling**

The sampling procedure was purposive and theoretical. In grounded theory there is emphasis on theoretical sampling, since theoretical sampling helps refine and develop categories, and thus feed into data for more induction (Echevarria-Doan & Tubbs, 2005). Another reason of purposive, selective and theoretical sampling is because I wanted to
select individuals who would, not only be an expert in their field but mainly would contribute to this under studied area of research. The participants would also contribute the evolving theory (Echevarria-Doan & Tubbs, 2005). Hence, I used snowball technique to recruit the participants. I also had specific criteria that the participants must fit to qualify for participation. My main fear was getting Indian therapists who had very less knowledge about marriage and family therapy interventions or on Indian clients or no knowledge about HIV. After a long process of thinking and debating, my advisor and I came up with the selection criteria mentioned below. The rationale for the inclusion criteria was familiarity with culture (indigenous), familiarity with marriage and family therapy (by training or practice) and familiarity with HIV (by training or by practice).

1. The participant must be born and raised in India (for at least 12 years).
2. The participant must have at least a year of graduate training in marriage and family therapy.
3. The participant must have one month or three months training in marriage and family therapy from any Indian training agency e.g. NIMHANS, Bangalore.
4. The participant must have at least two years of clinical experience.
5. The participant must be a member of American Association for Marriage and Family Therapy (AAMFT).
6. The participant must be a member of Indian Association of Family Therapy (IAFT).
7. The participant must have worked with family or individual infected or affected with HIV/AIDS.
8. The participant must have published at least two articles on marriage and
Participant Selection

I identified 22 participants who were born and raised in India (for at least 12 years) and who met at least three of the above mentioned selection criteria. I used the following ways to recruit the Indian marriage and family therapists for my research:

- Wrote a letter to the directors of COAMFT- accredited marriage and family therapy degree programs, asking for the names and contact information of their graduate students from India (Appendix 2).
- I will also write to the Indian Association of Family Therapy (IAFT) in New Delhi, India, asking them for the contact information of their members (Appendix 2).
- I will collect names of possible participants through snowball sampling, beginning with professional contacts who are members of the American Association for Marriage and Family Therapy (Appendix 3).
- I will access participants through a Yahoo list serve for Indian marriage and family therapists, started by Indian therapists in the USA (Appendix 2).

The sample had researchers, clinicians and professors, both in India and USA. All of the participants were contacted initially by email. Then they were interviewed by the telephone at a later time. The email contained information on the inclusion criteria, and a URL link to a demographic profile information form, and information on the present research and the specific questions that were asked in the telephone interview (see Appendix 3). The IRB approval form was attached in the email, and consent was asked in the demographic profile URL link to the informed consent form (See Appendix 2 for a
90 potential participants were initially contacted. Only 31 participants filled out the demographic profile. Some participants did not respond back, some said that were not interested, a few participants said that they had been in so many recent studies as a participant that they feared being over sampled, and some were Indian Americans (born in USA with Indian decent). Some of the email addresses were wrong and so those participants could not be contacted. Out of the 31 who filled out the demographic profile, five were not born in India so they could not participate in the study. One of these five was interviewed for instrument development (discussed later). Three participants out of the 31 did not give their name, or any contact information for me to track them. One participant had only lived in India for 9 years so she could not participate because of the inclusion criteria. Ultimately, 22 participants were interviewed over the phone. The demographic characteristics of the participants are given below in Table 1.
Table 1: Demographic Characteristics of Sample

The following table will give the demographic data of my participants:

<table>
<thead>
<tr>
<th>Serial number</th>
<th>Gender</th>
<th>Age</th>
<th>Lived in India (in years)</th>
<th>Training in Marriage and family therapy (MFT)</th>
<th>Clinical Exp. (in years)</th>
<th>Member of AAMFT</th>
<th>Member of IAFT</th>
<th>Worked with HIV positive clients</th>
<th>Published article</th>
<th>Presented paper</th>
<th>Current work</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>32</td>
<td>23</td>
<td>Ph.D. from USA in MFT</td>
<td>10</td>
<td>✓</td>
<td>✔</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Professor in US university + seeing clients</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>32</td>
<td>20</td>
<td>Ph.D. from USA in psychology, some MFT courses training in PhD and masters.</td>
<td>7</td>
<td>×</td>
<td>×</td>
<td>✓</td>
<td>×</td>
<td>×</td>
<td>Private practice in India</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>40</td>
<td>40</td>
<td>Post Graduate program in psychological counseling from Indian university which included some MFT courses.</td>
<td>11</td>
<td>×</td>
<td>×</td>
<td>✓</td>
<td>×</td>
<td>×</td>
<td>Practice in India</td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>60+</td>
<td>50</td>
<td>PhD from USA in counseling psychology and worked at MRI in brief therapy</td>
<td>35</td>
<td>×</td>
<td>×</td>
<td>✓</td>
<td>✓</td>
<td>×</td>
<td>Working as a clinician consultant at a hospital in India</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>38</td>
<td>26</td>
<td>PhD from USA in MFT</td>
<td>17</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Professor in a USA university</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>6</td>
<td>M</td>
<td>24</td>
<td>20</td>
<td>Masters from India in counseling psychology which included MFT courses</td>
<td>5</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>Working for an organization as psychologist in India.</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>39</td>
<td>39</td>
<td>PhD from India, NIMHANS in social work which included MFT courses</td>
<td>8</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Professor in Indian university and sees clients.</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>43</td>
<td>41</td>
<td>Masters from India and then worked for brief therapy center in India</td>
<td>5</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
<td>Working at a NGO in India</td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>44</td>
<td>38</td>
<td>PhD from USA in MFT</td>
<td>4½</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>Seeing clients and student</td>
</tr>
<tr>
<td>10</td>
<td>F</td>
<td>29</td>
<td>25</td>
<td>Masters from USA in MFT</td>
<td>4</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>Working with clients in USA</td>
</tr>
<tr>
<td>11</td>
<td>F</td>
<td>+60</td>
<td>26</td>
<td>PhD in psychology in USA which included MFT courses and got training in MFT from workshops</td>
<td>30</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
<td>Private practice in USA</td>
</tr>
<tr>
<td>12</td>
<td>F</td>
<td>30</td>
<td>27</td>
<td>Masters in counseling education from USA which included MFT courses</td>
<td>6</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>Working for organization in USA</td>
</tr>
<tr>
<td>No</td>
<td>Gender</td>
<td>Age</td>
<td>Year</td>
<td>Qualification</td>
<td>Working Experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>--------</td>
<td>-----</td>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>F</td>
<td>30</td>
<td>28</td>
<td>Masters from USA in counseling psychology</td>
<td>Working for NGO in India</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>M</td>
<td>28</td>
<td>24</td>
<td>Masters from USA in MFT</td>
<td>Student working on PhD in MFT in USA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>F</td>
<td>29</td>
<td>28</td>
<td>Post graduate diploma in Counseling Psychology from India which included MFT courses</td>
<td>Working in a NGO in India</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>F</td>
<td>40</td>
<td>31</td>
<td>Masters in MFT from USA</td>
<td>Working in an organization in USA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>F</td>
<td>41</td>
<td>29</td>
<td>Masters in MFT from USA</td>
<td>Private practice in USA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>F</td>
<td>48</td>
<td>45</td>
<td>Master in Psychology which included MFT courses and training workshop in MFT</td>
<td>Consultant counselor at CGC and schools in India</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>M</td>
<td>53</td>
<td>53</td>
<td>Masters in Psychiatry and attended many workshops in MFT like Virginia Satir, Haley</td>
<td>27</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>20</td>
<td>F</td>
<td>33</td>
<td>25</td>
<td>Masters in MFT from USA</td>
<td>2</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>Working in a hospital in India</td>
</tr>
<tr>
<td>21</td>
<td>F</td>
<td>+60</td>
<td>+30</td>
<td>Masters in MFT from USA</td>
<td>9</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
<td>Private practice in USA</td>
</tr>
<tr>
<td>22</td>
<td>F</td>
<td>30</td>
<td>25</td>
<td>PhD in MFT from USA</td>
<td>7</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>Teaching in USA and working in organization in USA.</td>
</tr>
</tbody>
</table>
Protocol for Telephone Interviews

Once the participant agreed that he or she fits the above-mentioned criteria, the participant was directed to the demographic form through the following URL: https://survey.vt.edu/survey/entry.jsp?id=1161203291185. Submission of the demographic profile was evidence of the voluntary willingness of the participant to participate in the study. Then the demographic form was filled out. Participants who were interested in the next part of the study, the telephone interview, sent their phone number and a suitable day and time to be called for the interview. To get maximum participation three reminder emails, were sent each one week apart. If any individual declined participation then they were removed from the list of participants.

The Process

Institutional Board Review. The IRB form was completed and signed and submitted to the IRB committee on the university’s campus. After IRB approval was received, data collection began.

Electronic E-mail and the Internet. To get answers about the demographic profile of the participant, the Internet was used to collect data. Internet surveys have been found to have a faster return rate and a lower cost than traditional mail surveys (Schafer & Dillman, 1998). This was especially helpful, since the participants were all over the USA and India. However, on the other hand, the researcher should take into consideration whether his/her participants can easily access email or the Internet (Schafer & Dillman, 1998).

Raj and Sivadas (1995) have found that unsolicited email surveys are less likely
to be answered, unless participants are given prior email notification. Another key element to get a high response rate is to personalize emails (Dillman, Tortory & Bowker, 1998). Schafer and Dillman (1998) explain that the researcher can increase the response rate by sending the pre-notice letter/email to someone in authority that the participant knows, and by sending personal email messages directly to the individual rather than to list serves. For the above mentioned reasons I sent out emails to the president of IAFT, directors of COAMFTE accredited programs in USA universities and to the moderator of the Indian marriage and family therapist’s yahoo list serve (see Appendix 2). Then using the reference of either the director of their program, or the president of the IAFT or another therapist emails were sent to the participants. Also prior notification emails and follow-up reminders (Appendix 3, 4, & 5) to increase participation were sent out.

The emails had a copy of the attached IRB form (Appendix 1) and a URL link to the demographic profile form (Appendix 6) which contained the consent. I made sure that the survey could be easily accessed and the URL’s were working (Courtney & Craven, 2005; Dillman & Bowker, 2001). Also, a copy of the research questions, which were asked in the telephone interviews, was sent to the participants. This gave the participants an opportunity to think about the questions and answers to them.

Participants and the Internet. The first step in using the Internet for research is to find out if the participants have access to Internet/email (Schafer & Dillman, 1998). Universities, faculty and students, at least in the USA, widely use email and internet for conducting day-to-day business. Thus, using email and the Internet for the participants in the USA seemed appropriate.

Using email or the Internet also limited the sample to only those Indian marriage
and family therapists who regularly use it. I was not able to contact those marriage and family therapists who did not have email or did not check their email or have little or no access to email since they were working in India. But sending them the demographic profile by regular mail using paper-pencil techniques would have created the following problems:

a. The packet could be lost in the mail, especially in India if the researcher did not have a correct postal address.

b. Participants may forget to post it back to the researcher.

c. Sending regular mail to India and sending a pre-paid envelope would add to the research expenditure.

d. Asking the demographic profile on the telephone would again increase the cost since I would spend at least 15 minutes asking these questions. But I asked the demographic profile to three participants in India over the phone since they mentioned that it would be difficult and a hassle for them to access the Internet for a few days.

e. Asking the participants both demographic and interview questions would increase dramatically the time of the interview and the participant may not have two hours to spend on this research.

Thus, although the sample only had participants who could access Internet/email, it was better than facing the above mentioned problems like extra time and money.

**Instrument Development.** I interviewed one Indian decent marriage and family therapist for the instrument development in the form of an interview protocol. An American colleague also read the interview questions and demographic profile to decide
if the language was easy to understand. This process helped determine if the research questions and the interview protocol were easy to understand and could be completed in a reasonable amount of time. No changes appeared to be necessary.

**Demographic Form.** The demographic form (Appendix 8) was be attached to the email (Appendix 2, 3 and 4) and sent to all the participants. The participants were asked to provide basic information about gender, highest degree of education completed, clinical practice, number of years lived in India, clinical orientation and how strongly they identified themselves as Indians. I asked these specific questions to understand the familiarity of the participant to the Indian culture, to marriage and family therapy and to HIV. The richness of the data depended on the participant’s familiarity with the above mentioned criteria.

**Phone Interviews.** Interviewing is a process of understanding the meaning people give to an experience (Seidman, 1991). I used semi-structured telephone interviews to collect data from 22 Indian marriage and family therapists who lived in the USA or in India. Telephone interviews appeared to have a number of advantages since the participants were spread out all over the USA and India. These interviews helped me understand the participants understanding of the application of marriage and family therapy interventions to HIV related issues in India. The participants were either studying, practicing or teaching marriage and family therapy in the USA or in India.

The phone interviews with the participants were audio-taped and then transcribed. I used open-ended questions to explore their use of family therapy interventions with HIV related issues prevalent in India. To avoid loss of data in the case of technical failure (e.g. if the audio taping does not work), I took notes during and after the interviews.
A limitation of phone interviewing is that it depends on the skills of the interviewer to get information. But since I did the interviews myself and also practiced how interviews are conducted during the instrument development phase, I hoped to overcome this limitation. Interviewing requires skill, since it is focused and not a conversation or therapy (Creswell, 1998). Telephone interviews are preferable to surveys because I could ask the participants follow-up questions. They can also go into more depth about a question, which the participant might only answer in a few lines in a web-based survey. Also I could clarify any questions the participants had at that time.

Feminist research emphasizes calling the researched as “participant” as opposed to “subject.” Also Oakley (1981) suggests a more egalitarian and equal relationship between the researcher and participant. He also discusses how interviews that are conducted in a participant friendly way with researcher’s emotional involvement are one way of doing feminist research. This was very important for me to keep in mind especially when I conducted interviews, to bond with the participants and was able to share with them her passion for India’s fight against HIV/AIDS.

*Drawbacks of phone interviews.* Phone interviews do not elicit responses as thoroughly as the more intimate face-to-face interviews. One of the major drawbacks is not being able to connect as well with the respondents because the interview is more impersonal and I was unable to read facial expressions and the body language of the participant (Patton, 2002).

The overarching research question was “What are the marriage and family therapy interventions that work best with HIV positive clients and their families in an Indian setting? This research question guided the following interview questions.
Interview Questions

To determine interventions which will work best with HIV positive Indian clients, I asked open ended questions to the participants. The participants received the interview questions in advance so that they could prepare for the interview. Below are the interview questions:

1. Can you please elaborate on your practice as a marriage and family therapist?
2. In your clinical practice have you ever done therapy with an HIV positive person? Can you elaborate on that particular case?
3. How did you handle that case and what marriage and family therapy interventions did you use?
(Skip to question 5 if the case was in India)
4. How would you handle that scenario differently if it was in India using marriage and family therapy theories?
5. What metaphor would you apply to Eurocentric theories/interventions applied to the Indian context?
6. What are the unique issues a family therapist might face in the Indian culture specifically relating to HIV?
7. How might family therapy be adapted in India to deal with HIV issues?
8. What one family therapy intervention or technique do you think will best fit an Indian culture? Why?
9. Can you tell me one family therapy intervention or technique or model you think will not fit an Indian culture? Why not?
10. What difficulties do you see yourself facing when you apply Eurocentric theories
of family therapy in an Indian setting?

11. What can you recommend that should change before we apply Eurocentric interventions to Indian families?

A vignette reflecting typical HIV/AIDS challenges that a mental health provider might face in India was read to the participants. This vignette was intended to provide concrete issues for participants to reflect on whether or not they have worked with an HIV positive person in the past. By giving a concrete issue like in the vignette, the participants can exactly tell what family therapy interventions they can use in India with an HIV positive person. The interventions that were collected from the vignette were sorted into different models of family therapy which the participants thought were culturally appropriate for India clients. This vignette has been drawn from my clinical experience in India.

12. I will read a scenario to you. After I have read it I have a few questions I would like you to answer:

• A couple is pressured by the wife’s mother-in-law to have a child. The couple has two girls already, but the mother-in-law wants a boy to inherit their lineage. She insists her son and daughter-in-law should have a boy child. The son is HIV positive but has not disclosed his status to his mother and other family members except his wife. The mother-in-law has threatened her daughter-in-law that she would ask her son to divorce her and marry another woman if she did not give her a grandson.

The questions are:

Q a. What marriage and family therapy interventions would you use in the above vignette
which will be most adaptable in the Indian context?

Q b. What interventions would you use to address the gender and power issues involved in the scenario?

*Transcripts.* The interviews were audio taped and transcribed verbatim (Schlosser, Hill, Kox & Moskovitz, 2003). All the identifying information of the participants was removed and the participants were assigned pseudonyms.

*Data Analysis*

The data was analyzed systematically. For data analysis, I used qualitative methods of analytic induction and constant comparison to learn from the Indian marriage and family therapists experience how they would apply family therapy interventions to clients affected by HIV in India.

Analytic induction and constant comparison offer analysis that begins inductively by first collecting data and, in doing so, formulating partial propositions or hypotheses. I revised the hypotheses into emerging categories and themes as more data was collected (Patton, 2002). The findings were examined both within and across cases to search for both unique and common findings. The constant comparison analysis helped me to support, modify and collapse emerging themes. I went back and forth between the data and previous themes to develop a final list of themes that summarize the data (Glaser and Strauss, 1967).

The data analysis followed these steps.

a. *Open coding:* The data was analyzed and gathered in iterations which are consistent with grounded theory analytic procedures (Strauss & Corbin, 1990). I read and reread the transcript to become familiar with participants’ responses.

While reading I wrote words in the margins which captured different topics. I then
took this list of topics and went back to the data and abbreviated the topics as codes and wrote the codes next to the appropriate segments of the text. By sorting and grouping the open codes, certain themes emerged. Since I used the constant comparison method of grounded theory I, (1) Compared different participants (views, experiences and interventions), (2) Compared the data from the same individuals with themselves at different points in time, (3) Compared data with a category and (4) Compare categories with other categories (Echevarria-Doan & Tubbs, 2005).

b. **Axial coding**: After the open coding, axial coding was employed. That is, themes were related to each other to see which categories were created. Axial coding also serves to make connections and compare sub-categories and categories. The text segments of different categories were cut and placed on note cards. There were many note cards placed into emerging categories. Axial coding is considered to be an intermediate step of interpretation, since categories are formed in comparison to patchy open codes (Strauss & Corbin, 1990).

c. **Selective coding**: According to Strauss and Corbin (1990), in the selective coding phase the core variable emerged. First patterns (descriptive statements) were identified. This led me to develop major categories and sub-categories. When possible, the actual words of participants were used as category labels. Also when possible, two to three categories were combined together into a category that captured the essence of those two or three categories (Piercy & Deacon, 1998). I asked one of her marriage and family therapy colleagues to play the devil’s advocate and question her on her procedures and the categories she decided upon.
Identifying the Core Variable: I reflected on and tried to look for the larger picture within or between the categories. I was able to get a theoretically saturated and centrally relevant category which was the core variable (LaRossa, 2005). For further validity check, general descriptions were applied back to individual interviews to see how well the analysis held up (Piercy & Deacon, 1998). Also the categories were contrasted to the existing literature related to international family therapy.

Researcher Reaction Memos. During the study I kept a journal to record all my personal thoughts, ideas, speculations, reflections, prejudices and feelings towards the research or participants. Thus during data collection and data analysis, I was mindful of my own biases and wrote memos in order to bracket my personal biases.

Trustworthiness, Credibility and Transferability

Trustworthiness is the confidence one has in one’s research (Patton, 2002). The trustworthiness of one’s research is important (Merriam, 1998). The rigor with which one conducts research helps to assure others that the research is trustworthy (Firestone, 1987). This process of assuring trustworthiness and credibility took place throughout the data collection, data analysis and report writing phase (Creswell, 1998). There are several strategies suggested by Creswell (1998) to increase the trustworthiness and credibility of one’s research, which are given below but I actually used a few of them like devil’s advocate, reflexive journal, and field notes.

1. Triangulation: Multiple sources of data are used to increase the understanding of and confidence in one’s findings (Creswell, 1998). Triangulation occurs through
2. **Member checks:** When the participants are given the opportunity to provide feedback about the findings (Creswell, 1998).

3. **External Audits:** An external expert examines the process and the product of the study to verify the integrity of the study (Lincoln and Guba, 1985).

4. **Thick description:** The use of enough detail in writing up the results to allow the reader to know the participants, setting, and study as if they were present (Patton, 2002).

5. **Devil’s Advocate:** The devil’s advocate is an expert/collaborator of the researcher who can ask questions to the researcher about the categories they have constructed in the research and how they have constructed them (Piercy & Deacon, 1998). I asked a marriage and family therapy colleague to examine and discuss the process and the themes of her study.

6. **Negative Case Analysis:** When a case does not support the hypothesis of research it is called a negative case. Negative case analysis allows further thinking to occur, and possibly an expansion or revision of the results (Patton, 2002).

7. **Saturation:** This is a process where the researcher keeps collecting data until no more categories or themes emerge (Creswell, 1998).

8. **Reflexive Journal:** These are reports or notes that the researcher writes about his/her feelings, experiences and thoughts. The researcher writes about how his/her feelings have affected his/her observation and how the observations have affected him/her. The reflexive journal also reports the origins and implications of researchers own perspective on the research (Patton, 2002). I used a reflexive
journal to keep track of my biases during the process of the study. It was also an outlet for me to reflect on my personal thoughts and prejudices. I could bracket my thoughts and feelings so that they were not in the way of my participants stories (Patton, 2002).

9. Field Notes: I took down field notes during the telephone interview in case my audio recorder failed. I also recorded field notes after the completion of each interview to ensure that her observations about the participants and interview would not be forgotten (Strauss & Corbin, 1990).

In quantitative research internal validity, external validity and reliability are salient concepts. In qualitative research parallel terms of credibility, transferability and dependability/consistency are used.

Credibility: If the results of the study are consistent with the data collected then the research has credibility. Merriam (1998) states that “A researcher only wants an outsider to confirm that the results match the data collected, rather than wanting the outsider getting the same results.” In qualitative research the primary goal is not generalizability, but transferability.

Transferability: If the reader decides that the findings of the study can relate to other studies, the research is said to have transferability (Merriam, 1998). I incorporated reflexive journaling and field notes to enhance the credibility, transferability and dependability of this study. See the following table listing the procedures that are used to assure credibility, transferability and dependability/consistency.
Table 2: Given below is the table of how researchers build on trustworthiness, but I only employed a few of them.

<table>
<thead>
<tr>
<th>Qualitative Term</th>
<th>Quantitative Term</th>
<th>Strategies Used</th>
</tr>
</thead>
</table>
| Credibility      | Internal Validity | • Triangulation of transcribed interviews, journal, memos, Reflexive journal during the phone interview  
                   |                   | • Reporting of researcher’s biases through assumptions and theoretical orientation  
                   |                   | • Reflexive journal (Used in this study)  
                   |                   | • Devil’s advocate (Used in this study) |
| Transferability  | External Validity | • Thick description  
                   |                   | • Purposive sampling (snowball)  
                   |                   | • Triangulation of transcribed interviews, journal, memos, Reflexive journal during the phone interview (Used in this study)  
                   |                   | • Member check  
                   |                   | • Peer review |
| Dependability/Consistency | Reliability | • Triangulation of transcribed interviews, journal, memos, Reflexive journal during the phone interview  
                                         |                   | • Reporting of researcher’s biases through assumptions and theoretical orientation (Used in this study)  
                                         |                   | • Member check |

(Adapted from Yorgerson, 2003)
To ensure trustworthiness of her findings, I asked one of my colleagues to each cross code one interview. My colleague has a Ph.D. in marriage and family therapy and has done research in qualitative methods. This colleague also served as a peer examiner and devil’s advocate to help ensure the credibility and transferability of my study. I talked to my colleague over the phone and compared initial codes that they thought emerged from the interviews and came up with a coding scheme. I kept all the coded interviews and each of the coding schemes to provide an audit trail so that other researchers can understand how I reached the final list of themes. This also ensured credibility and transferability.

Finally, the transcripts were read one last time with the final coding scheme. Then I highlighted every theme and sub-theme in each transcript and compared them across participants. Once this was done I saw themes which seemed most significant to my research questions and this helped me to broaden my understanding of the participants’ experiences.
Chapter IV

Results

The main research question was “What are the marriage and family therapy interventions which work best with HIV positive clients and their families in Indian settings according to the perceptions of Indian family therapists?” To answer this main research question interview questions were asked (see Appendix 7). The participants discussed what they would do in therapy with an HIV positive client or his/her family in response to the vignette question. The different techniques and models were identified (through open coding). Some that were related were collapsed (axial coding). The resulting categories were the different family therapy interventions, models and techniques which Indian therapists thought would work in the vignette (case scenario). Some of the resulting categories are psychoeducation, directive therapy, couples therapy and strategic family therapy. The participants also discussed what family therapy interventions fit best or would not fit at all in an Indian setting. These sub-categories were again collapsed, resulting in a major category which was called interventions. This major category and sub categories are mentioned in detail later under the heading ‘Interventions’.

The next question asked to the participants was “Why do you think certain family therapy interventions work or not work in India?” To explain this, the participants discussed the Indian cultural issues in the context of therapy. For example, one participant said that “I do not think family therapy will work with the poor people in India. Most of them have to worry about food, shelter and do not want to concentrate on emotional problems and go for therapy.” There were many such themes that were
collapsed to form the more inclusive category, ‘Class and marriage and family therapy’.

The different sub-categories, like class and marriage and family therapy, social stigma, fluid boundaries but strict hierarchies fell under a major category called ‘Cultural Issues’.

This major category and sub categories are mentioned in detail below.

The participants discussed what unique cultural issues they faced as therapists in India due to their unique cultural context. Some of the categories falling under this major category included insider-outsider issues, how there is a lack of resources (money and man power), the form supervision would take, and the need for therapist flexibility (for example, a therapy session in India may not be a 50 minute session in the therapists office but could take place standing at a bus stop with the client waiting for a bus, or waiting in the court room for the judge to arrive.

The participants also discussed confidentiality and lack of accountability in some of the medical systems in India especially with respect to HIV/AIDS as a unique issue that a therapist faces. But confidentiality is very important with respect to HIV, especially in the therapist-client and doctor-patient relationship. Many participants discussed how clients did not open up because their confidentiality had been broken earlier by either a doctor or a counselor. Since the issue of confidentiality, especially with respect to HIV/AIDS and duty to warn the third party and accountability are very important, I decided to collapse these categories into the major category called ‘Ethical Issues’.

After discussing with the participants which interventions work best due to different cultural issues, and because of these cultural issues what unique issues a therapist faces, the next logical step was to discuss what therapists would do to adapt family therapy to an Indian setting, which was the next major category. In this category,
participants discussed the issue of doing culturally sensitive therapy and the need for more research and articles in the field of Indian family therapy. Some participants also said that there is a need for more awareness of family therapy. Some participants discussed that the word ‘Eurocentric’ was very polarizing and they believed that humans are humans and even though they look different and live in different cultures we all have similar emotions, and a mother’s love in India is not greater or substantially different from a mother’s love in France.

Finally, the metaphor question was asked. The metaphor is an example of an aesthetic form of data representation that captured the themes the participants were trying to articulate their thoughts about, adapting Eurocentric theories to Indian settings. The metaphors were divided into two categories. One reflected the thinking of those who thought that Eurocentric theories needed to be adapted and the other emphasized the essential humanness and transferability of therapy across cultures. These participants believed that the very term ‘Eurocentric’ was polarizing. Some of the sub-categories represented included British rule and human emotions. All the metaphors are explained in detail below.

The core variable was that due to the unique Indian culture, some family therapy interventions and models work better than others and to implement these culturally appropriate interventions the therapist faces distinctive challenges.

*Interventions*

The analysis of the clinical interventions that the participants shared regarding how they would mediate as the therapist in the vignette resulted in the categories below. The findings emerged from the data in that many participants volunteered the models of
family therapy discussed in their responses.

_Psychoeducation._ All the participants unanimously agreed that psychoeducation is the most important and first thing a therapist needs to do in a therapy session with and Indian client, especially if that client is infected with or affected by HIV/AIDS. Firstly, the client needs psychoeducation about what therapy is. Clients also need psychoeducation on HIV/AIDS stigma, medication, impact on family, and clearing myths and misconceptions about the transmission and spread of HIV. Secondly, client couples need education about the transmission of HIV to the unborn child or to the woman if they plan to have another child. Also, they need education about genetics (XX and XY), the chances of infection of a male child or a female child, and the male partner’s responsibility for the sex of the child.

_Directive therapy._ Many participants felt that a therapist needs to do directive therapy with Indian clients. The reason behind this was that most Indians come to therapy seeking advice from the therapist, like a follower would ask a guru. One participant said, “If the therapist was not going to be directive with Indian clients then he or she would be butting heads and it would defeat the purpose of meeting the clients where they are.”

_Strategic therapy._ Some participants believed that strategic family therapy is a good fit with Indian clients. One of the participants said, regarding the vignette, that,

I will use strategic family therapy and tell the daughter-in-law to tell her mother-in-law that we are trying for a baby but I didn’t conceive. I will kind of make it a joke kind of things between mother-in-law and daughter-in-law. I would not go any further since the husband has revealed to his wife and does not want to reveal it to his mother and it is well within his rights. I would not get into a power
struggle in the sense you are complying with it by saying that you are joining with her (mother-in-law) even though in reality you are not but by saying so you are maintaining the status-quo of power that the therapist is in charge and I am trying in reality but I am not.

The participant said that since she could not challenge the power of the mother-in-law, at least she could redirect it to something else. Similarly, another participant said that it was difficult to confront a family member with high status in front of other family members. One participant said that he felt that strategic family therapy was a good fit and that he could use strategic therapy (presumably through reframing) with the husband to remove the husband’s misconception that girls (his daughters) cannot be successful. This participant would help him (the husband) to bond better with his daughter and thus think about the daughter’s future and not plan another child, which would put his wife’s life at risk. Another participant felt that strategic intervention is a good way to disclose the spouse’s HIV status to the other spouse. The therapist could explain to the husband the double bind that he puts his wife into. On the other hand, some participants felt that strategic family therapy is not a good fit for Indian clients.

Narrative therapy. Most of the participants felt that narrative therapy would be a good fit in the Indian context because most Indian people love to tell stories about their life. Externalizing the problem in narrative therapy would be helpful since the focus is no longer on the client being bad, but instead on a negative condition like HIV. Narrative therapy has been a good fit in different cultures such as the Aborigines in Australia (White, & Epston, 1990) and so it may be adaptable in India too. Also participants indicated that narrative therapy can be therapeutic with women who are
victims because it asks them to re-author their life stories and shows them patterns which they need to break to lead a better life.

*Couples Therapy.* Most of the participants felt that couple therapy is essential and a good fit with Indian clients. They said that couples therapy could be used to strengthen the bond between couples, to enhance communication between them, to help the husband to support his wife in front of his mother, and to help the wife to share her feelings and story as a victim with her husband. The husband could be encouraged to tell his wife about his HIV status once the trust between the couple has been built through couples therapy. Emotionally-focused couples therapy could be used with couples to increase compatibility and intimacy, to strengthen the marital bond, and to make boundaries around them instead of between them. Couples therapy also can help empower the bond between the individuals in the couple so that they have a united front in front of the wife’s mother-in-law, especially when she (the mother-in-law) is making traditional demands like producing a grandson to carry on the family name. The therapist also can encourage the couple to think about adopting a boy child.

*Spirituality.* Most of the participants said that spirituality is a part of their therapy. The said that they use passages from the Bhagwad Gita, the Bible, the Buddhist philosophy and the Quran. One participant said,

I give the example of a Hindu goddess and tell the women that Hindu dharma gives importance and equality to both the sexes. In any temple and scriptures where there is Ram there is Sita and where there is Shiva there is Parvati and where there is Krishna there is Radha and so devi (goddess) has same power and religion treats them equal. So (it is the) same way in real families. There has to be
equity and man and woman have to work back to back to share responsibilities.

One participant talked about how she would not preach but would involve the clients in the process of understanding their religious beliefs: with the help of Gita Sar, this participant would explain that we did not come with anything into this life and that we would not leave with anything, so therefore, being possessive and jealous would not lead to any happiness. Another participant said that she uses the examples of Mary Magdalene and Jesus, the Buddhist philosophy of suffering and karma, and the principle of determination to stick through suffering to empower her Indian clients. Clearly, religious and spiritual tradition provided a strong source of metaphor and advice that Indian clients could relate to. Another participant explained how creating an extended locus of control in which the therapist asks clients to put forth their best effort and leave the rest to God would help clients.

*Family reconstruction/ Virginia Satir.* There was disagreement on the use of family reconstruction. One participant said that she found family reconstruction effective in her therapy, especially sculpting and family mapping. She could ask the client to map his/her sexual behavior. She would ask them questions like, “How many people have been in your bed and how many other people have been in your sexual partner’s bed?” This would make the client aware of the risk to HIV to which she/he was putting his/her family. On the other hand, two other participants said that they did not find family reconstruction appropriate in the Indian culture since the families would laugh during sculpting and make fun of the therapist—saying that it was the job of an actor to act, not theirs. Also most women clients would feel shy switching roles and acting as their husbands. Another reason that some gave for family reconstruction not working in India
is the technical difficulty or time constraint. It would be difficult for all the family members to come at the same place and time for sculpting.

_Solution focused therapy._ Most of the participants believed that solution-focused therapy would work in India. The reason behind this is mainly that people in India like practical solutions to their problems. The participants said that clients like the prescription of solutions and that they look up to their therapists for tasks to do or solutions, rather than introspecting about their forefathers or their problems. Also, solution-focused therapy does not directly work on changing structure of the family or changing hierarchal roles of some members.

Two participants felt that solution-focused therapy would not work, especially with the lower socio-economic group because of their fatalistic belief in Karmic philosophy. They also said that because of the lower educated clients’ inability to visualize, it would be hard for them to use solution-focused therapy. One participant said,

>I really love solution-focused work that I do but the Indian mind or the Indian psyche is influenced a lot by Karmic philosophy, so when I ask a client to visualize the future without the negative experience, it is difficult for them because they say that there can never be a future without trouble since we have already committed sins in our past life.

Some participants said that it was important that the therapist focus on coping strategies, especially with HIV-positive clients, and at the same time let them talk about their insecurities and vent their problems and frustrations.

_Structural Family Therapy._ There was a difference of opinion regarding whether structural family therapy is a good fit in Indian society. Some participants felt that
structural family therapy is not a good fit since most Indians do not know their boundaries clearly, and structural therapy works towards breaking certain family structures that are firmly set in India. On the other hand, two participants felt that Minuchin’s structural family therapy worked well with Indian street children and people from lower socio-economic status since Minuchin also used this therapy with clients from lower SES in USA (Minuchin, 1967). Another participant liked structural family therapy since it takes into account the various roles that people get stuck in and it gives a panoramic view of the family, including husband, wife, children, grandparents, uncles and other extended family. Another participant said that it was really important that the client understands boundaries and draw them so that nobody encroaches on his/her happiness. The participant added that most professors who teach family therapy in India were trained in structural and strategic family therapy from National Institute of Mental Health and Neuro Sciences (NIMHANS), in Bangalore. Consequently, a number of participants gave structural interventions for the questions asked in the vignette. They said that they would use structural therapy to strengthen the couple structure, and to identify boundaries and dynamics in the family. Also structural therapy could empower the husband to develop his own sense of individuality and manhood and his sense of right and wrong. This would encourage him to tell his mother about his HIV status and also give him the courage to withstand inappropriate pressure from his mother. This approach could also ease the pressure from the wife. One participant said,

The husband needs to be given support so that he realizes that it is in his mind that he is sinning against his mother or not doing his filial duties by standing up against her to protect his wife from getting HIV. He should be made to understand
that he is a good son. Even if he moves out of the house with his wife and children temporarily or builds another room upstairs for his family, he can still send money to his parents and not be cutting off all ties with his mother. Thus structural therapy can help him think about his family role and he will realize that he should not blindly obey his mother.

Bringing extended family to therapy, like the mother-in-law or brother or sister, to support the husband may ease the pressure from the wife. Still, it is the couple’s decision, according to some participants, whether or not to involve the extended family. Some participants were of the opinion that the therapist should not challenge the hierarchy in the family since it may jeopardize the position of the daughter-in-law. Sometimes it can help to validate the position of the mother-in-law by making her understand her boundary. Structural family therapy, according to the participants, also promotes restructuring family systems along healthy lines. For example, it can challenge the belief that man is superior to woman.

Bowen Systems Therapy. There were different views about Bowen Systems Therapy. Some participants said that Bowen Systems Therapy would work because it focuses on multi-generation patterns and triangles (e.g. mother-in-law, son and daughter-in-law) and family secrets. On the other hand, some participants felt that although systems works well for conceptualizing a problem in a systemic way, it may not work overall since people in India want a quick fix. Some participants also disagreed about the differentiation explained by Bowen. One participant felt that differentiation really helps, especially when the husband is not stepping up to his duties to his wife since he fears not being a dutiful son to his parents. Another participant said that,
The way Bowen defines differentiation, if I use it for myself, an American would think I am enmeshed with my family, which is very far from the truth in the Indian context. I am independent but also attached to my family, but from an American viewpoint it may look like I am enmeshed. So I don’t think Bowen’s theory is culturally sensitive.

Another participant agreed and felt that it is very difficult for Indians to differentiate from their families of origin and to create boundaries. Some participants felt that the genogram works well with families because families can see how certain traditions and issues in their family are passed down from generation to generation, regardless of the changing society. The participant added:

I would ask the mother-in-law about how things were done when she was a daughter and daughter-in-law and I would ask her if she is behaving in a certain way because she does not know any better. Also, I will point out to the mother-in-law that the traditions of boy and girl not being equal are long gone. Just like how sons carry on the family name, many girls today are also carrying on the family name.

Some participants said that depending on the couple, they would involve external family like mothers-in-law or brothers- and sisters-in-law, but definitely wanted to involve the children in therapy at a later stage to educate them about HIV and how to deal with their feelings of living with a parent who is HIV-positive. One of the participants felt that Bowen or insight-oriented therapy might not work with average Indian families, but might work with professionals like doctors and other families who are used to introspection or analysis. The reason this participant gave was:
The Indian mind-set is to go for therapy and get advice or solutions and not want a lecture on what their grandfather did and what relevance it has on him since he does not understand the relevance. All he wants is a prescription to feel better.

One of the participants said that she would use Bowen to make the mother-in-law understand how she was influencing the life of the granddaughter and whether she was teaching her to be assertive or to become submissive after she got married.

*Social Construction.* Two participants were strong proponents of social construction and said that social construction is the best fit for the Indian context. One said:

A therapist becomes culturally competent when she or he deconstructs what are culture, therapy, and competency and reconstructs them with the context and situation that the person is going to be in. I think India not only needs a marriage and family therapy but also social constructional changes in the system.

*Feminist Family Therapy.* Some participants said that they would use feminist theory, especially in couple therapy, to address the gender and power issues between men and women. One participant said, “I would use the feminist lens to explain to the man that if he wants his wife to be Sita then he needs to be Ram and not have sex outside of marriage and respect her”.

Also, some wanted to use feminist therapy to explain to the husband that he needs to balance his duty towards his mother and his wife since they were both women, and that he should not give more respect and love to his mother while neglecting his wife. Some participants felt that using feminist theory meant only addressing the gender issue in the Indian context and not addressing other important social issues (e.g. economic,
Some participants felt that they would not use feminist therapy. That is, they would not approach the issue of a woman’s mother-in-law wanting a grandson since this reflected an old cultural and social issue which they did not have the social structure to deal with. Also, some said that empowering a woman to stand up against her in-laws and husband with no financial or social support herself was not realistic or practical. The woman would then not have anywhere to go since shelters in India are scarce and women living in shelters are not given respect. So these participants felt that it was best to simply work with the family in a subtle but respectful way without disturbing the harmony.

Some participants felt that if they used the feminist lens and discussed the equality in the relation of the couple, they might offend the man and then, he may forbid his wife from coming to therapy. Also, if the mother-in-law is offended, she may decide not to come for therapy and then stop the couple from coming. McGoldrick (1998) asked therapists to go a step further by not only being sensitive to different cultures but also to support values of social justice. I is not sure whether I can support this because most of the participants did not want to stir up trouble by questioning the power of the mother-in-law or any other hierarchy.

Cognitive Behavioral Therapy (CBT). Some participants felt that cognitive behavior therapy is a good fit with Indian clients because it is a more hands-on approach, and the therapist can give tasks to the clients which are more structured. Using tools like questionnaires and behavior modification makes it easier for clients to understand. One of the participants felt that although CBT could work in India, it would not work with the lower socio-economic group because of their difficulty at introspection.
Group therapy. Some participants saw that group therapy and support groups would be a good fit in the Indian context. One participant said:

I use group therapy with my domestic violence clients and it works very well.

When one woman gives her example of how she left her abusive husband and is taking care of her child on her own, it gives courage to the other women to leave abusive spouses.

Another participant said that he used group therapy with parents to get examples of how the other persons’ children had changed, which provided motivation to the group.

Other comments. It is important for the therapist to know the belief system of the client, such as how she feels about the mother-in-law interfering in her life. Most of the participants felt that they were eclectic therapists and they were comfortable using whichever theories suit a situation and client at a particular time. Thus, they said that there was not just one theory that best suited Indian clients since there were differences among Indian clients themselves. Also one participant added,

We (Indian therapists) do not have the luxury to be rigid and follow just one theoretical orientation because we do not have many schools or professors who are training in one pure theory and secondly we do not have many services or therapists in India to say I will only see these clients.

Another participant added,

I do not think in terms of interventions. I think of it as techniques which I co-create with my clients. I may do genograms not because I am doing family-of-origin work but it is more of pictorially collecting of their family material and connects with them. One of the participants felt that pure-psychoanalysis would
not fit the Indian setting.

Yet another participant said, “I need not be a behavioral therapist all my life. I use some techniques in my tool box that I have and apply what works”.

Cultural Issues

Class and marriage and family therapy: Most of the participants said they felt that family therapy in India depends on the class of the client. Some participants felt that family therapy best suits the middle class and the upper class that live in metropolitan cities, speak English, and are exposed to the western culture. The reason given was that clients who come from the lower or poor classes have other major issues like poverty, no food, ill health, no shelter, no water or no employment to worry about before they can think about family emotional disputes. On the other hand, most clients from the upper or middle class backgrounds have their basic necessities of food, clothing and shelter taken care of, so they may concentrate on the emotional and family problems that they are facing. Most women in the upper classes are more emancipated and empowered compared to the disempowered women in the lower classes. Some participants felt that community work is more essential than family therapy in the lower income groups. Also a participant said that insight-oriented therapies such as Bowen family therapy are more effective for middle-class than for lower-class families. In the lower class, more advice or prescription therapy, visual aids and questionnaires work better. The power and gender issues also are differently addressed among classes because the attitudinal changes are different depending on one’s belief system. One participant said, “If I talk to a lower-income couple or uneducated traditional couples then they resist change and say, “Yeh mera naseeb hai” (This is my fate and destiny). Middle class and educated clients are at
least more open to change.

While on the other hand, one participant had a different opinion. She said that clients of lower socio-economic status easily accepted therapy compared to clients of the rich or elite class---who are considered pillars of the society---because those in the elite class would be ashamed to admit that there was a problem in the marriage or with a child. Also, clients from the lower income groups are more subdued in front of a therapist whom they perceive as having a large power differential. Conversely, clients from the middle class treat the therapist as an equal.

*Social Stigma.* All the participants talked about the many potential social stigmas that a client may experience. These stigmas may relate to coming for therapy, being HIV-positive, being divorced, leaving one’s husband, being gay/ bisexual, not living in an intact family, talking about sexuality, or being mentally ill. One of the participants explained that since there is a taboo on therapy, she spent the first session explaining the role of the therapist and what therapy is. This participant stated:

> I come from a small town where people come in and ask about the package deal on therapy sessions and ask the number of sessions they or their family would be cured in. Also most of them think that therapy is meant only for people who are crazy.

Another participant discussed how clients are resistant to come for therapy until another family member is identified as the patient or trouble maker. This is especially true of husbands and women’s mothers-in-law who are in powerful positions. According to one participant, due to the stigma attached to therapy, it is sometimes easier to just tell family members of the client that they were being called by a doctor for advice. Due to
the stigma of therapy, there are often many secrets among family members.

*Interdependence in society and defining families in India.* Most participants agreed that there is a great importance placed on family cohesion in India. This is reflected in the collectivist approach to life. Clients usually come with their spouses or extended family members or a neighbor or friend. One participant said, “I think most of us do not consider marriage as ‘me’ and ‘you’ but ‘my family and ‘your family’ together. Thus, the pressure is on not only making decisions for the nuclear family but taking into consideration about the joint family in whole.”

Thus it is very important for a therapist to be culturally aware and sensitive towards what the client brings into therapy. In India, marriages that are less than five years old involve many adjustment issues, especially for the newlywed bride. This is because she not only has to adjust to her husband but also to her extended family that lives with them. One participant who is a doctor and a therapist explained,

A therapist or doctor has to be sensitive to the beliefs of the clients. For example, if a couple who are highly educated software professionals but come from a small village in India decide to bring the wife’s mother-in-law to help deliver the baby, and if the mother-in-law believes that cow dung should be applied to the umbilical cord of the baby, the doctor/therapist cannot just say ‘no.’ This is not correct. The couple may have asked the mother-in-law to come and help for six months. If I as a professional just reject the mother-in-law’s idea and so do the couple, she (the mother-in-law) may decide not to help and go back to her village.

*Importance of having a son.* Most of the participants concurred about the importance of having a male child in an Indian family. Indians believe that sons carry the
family name and lineage and would take care of them in their old age. This is because principally, it is a male-dominated society, and secondly, girls once married become a part of the husband’s family and are not entitled to take care of their own family of origin. And due to this importance of having a son, the girl child is often discriminated against. One of the participants mentioned the difference between India and America in this regard. In India, even after having four or five girl children, the parents would still want to have another child just because they want a boy. On the other hand, in America, parents are happy with whatever sex a child is. Sometimes, for example, after having two sons, American parents might try for another child just to have a daughter.

**Sexuality.** Many participants discussed the taboo of talking about sex. They said that people in India have sex but do not want to talk about it. One participant said,

I am from Calcutta and it has the largest number of prostitutes in the country. They are surviving and living, so somebody is going to them, but when I talk to clients, they say that we are not going to them. So nobody wants to talk about having sex with prostitutes.

There is much debate on sexual immorality and HIV and most people in India believe that people who are HIV-positive are immoral people (i.e., have sex with multiple partners). Consequently, the HIV-positive people are stigmatized in Indian society. Another taboo area is talking about sex among couples. As one participant said, “My male clients say that why would they want to communicate with their wife about fulfilling their sexual desires when they can get a blow job from a prostitute for Rupees 30 only.”

Promiscuity was another difficult problem to talk about, especially for one of the
female participants. Another participant uses a metaphor. She explained,

> When I explain to an illiterate client I tell him, ‘If you try a new shoe, what does it do? It hurts you for a few days when you try it. But when you use it for three, four days or weeks, you feel comfortable with the new shoe and it becomes a part of your life. The same way you will feel comfortable using the condom.’

**Being Directive.** Most participants felt that therapists need to be directive with their clients. This was because most Indian clients would not like to critically analyze their problem. Being indirect, as in using psychoanalysis, is too abstract for their understanding. One participant said, “I think in the Indian context you are going to run into people who want their therapist to be directive.”

**Fluid boundaries.** Some participants mentioned the fluid boundaries in the Indian families. They explained how sometimes clients come in for therapy with a neighbor and call her ‘masi’ (mother’s sister/aunty) when she is not even related to them. Boundary, respect and privacy mean different things in India and America. The participant explained, “When my mother had come to visit me and stayed she did not knock on my bedroom door before opening. I told her that it was not respectful and she said that ‘you are my child, I do not have to respect your privacy.’”

Some of the clients are also comfortable with triangulating the child in their marriage or couple life. On the other hand, some participants mentioned that clients are not comfortable taking family matters outside the family, so they may not mention their family problems to anyone outside the family like neighbor and extended family.

**Strong hierarchies.** Even with fluid boundaries, there is very strong hierarchy in Indian families. A woman’s mother-in-law and father-in-law have high and powerful
positions in the family. Some participants mentioned that it is common in the Indian context for the mother-in-law to threaten the daughter-in-law that she would force her son to marry another woman if the daughter-in-law did not give her a grandson. Thus the role of the therapist would be to encourage openness among the couple and mother-in-law.

*Why Indians drop out of therapy and the sources for resistance.* Most participants mentioned the taboo of going to therapy and the stigma attached to being mentally ill. Also they mentioned that Indians always want to look good in front of outsiders, which prevents them from taking family problems outside the family to therapists. Clients also have a fatalistic attitude, the traditional culture feeding the notion that an individual does not have any power to change anything and reinforcing the operation of an external locus of control. Indian therapists have to fight against this idea and explain to their clients that they have to put in some effort to change and do their best and to leave the rest to God. Another important reason for dropping out of therapy is that clients often have greater problems, like no food, shelter or medications, and these needs have to be met before clients come to therapy. Sometimes a client stops coming to therapy if she or he does not see progress in four or five sessions. Sometimes the prejudice against and the resistance to go for therapy is greater among the richer- or higher-class clients because they think problems are only among lower-income-group clients.

Some of the participants mentioned how important it is for therapists to prove themselves first by fixing something initially in the therapy. Many participants were concerned about clients not coming back for therapy once they saw progress. The participants felt that the drop-out rate among Indian clients is high irrespective of their class and education. A highly educated young professional who could analyze and
logically think about the solutions of his or her problems would also drop-out of therapy after he or she felt symptom-free, or felt that progress had been made or felt that they had received enough advice from the therapist. Thus some participants felt that their biggest challenge is to motivate their clients to continue therapy. One participant felt that this challenge was different from the one he had experienced in the United States.

*Difficulty in doing conjoint therapy in India.* A few participants mentioned the difficulty in doing family therapy or conjoint therapy in India. One participant said that the difficulty in doing family therapy is that the dominant person in the relation, usually the husband, would dominate the session and the other family members would not even open their mouths. Another participant felt that doing conjoint therapy is difficult because she said that the family members would break the ground rules set by her and usually talk at the same time or fight among themselves, making intervention very difficult. She added that meeting with each family member separately for therapy and meeting with all of them only for 5 -10 minutes in the end would be more effective.

*Guru-Chela attitude/ leader-follower attitude.* Many participants said that clients have a tell-me-what-to-do attitude and want the therapist to give them a prescription and tell them directly what to do. They added that a therapist should fix something to gain the confidence of a client and then employ other approaches to therapy. The therapist also should be aware not to make a client dependent on them. One of the reasons for this could be often, the clients think that a therapist is an expert like a teacher, professor or medical doctor and gives the therapist full power over their family situation.

*Gender in therapy.* A therapist comes across the issue of gender in therapy worldwide. Likewise, many participants felt that in India, gender is an important cultural
issue. This difficult and intricate subject matter of gender underlies many of the categories in the research such as the importance of having a son. Gender in therapy is present at two levels: the level of the client and the level of the therapist. Regarding the level of the client, due to the male-dominated society, the female client may not be allowed to come for therapy. Instead, she may be expected to do both housework and an outside job. While at the level of the therapist, if the therapist is a woman, she may find that some of the male clients are not giving her respect or she may not be treated equal to a male therapist. One of the participants who was a 32-year-old said,

When most Indian clients go to an expert in India and they assume that the expert is a male and if the expert is a female they will obviously look up to somebody only if they have 20 yrs of experience in the field or if they are married and have ½ dozen children themselves or something like that. So I think one of the barriers that I have is that I look very young---only 21 years---which makes it very hard for most of my clients to take me seriously, especially when I am telling parents that you know they need to change their behavior when it comes to their children.

Some participants said that it was difficult for them as a female therapist since some male clients do not want to listen to them. Also in couple’s therapy, the male may feel that the female therapist is aligning with his wife and may discontinue therapy. Some participants felt that most of their clients find it normal that their mother-in-law is powerful and that their husband would give his priority to his family of origin rather than to his wife. Thus, the therapist found it difficult to call this a problem when the client did not find it to be a problem. One participant said,

There may be gender differences in the way the man and woman are treated
differently but until and unless the client does not feel the pinch or says, “I don’t like being discriminated against,” then why should I (the therapist) call it a problem and try to work on it?

Doing therapy in India with a woman is mostly seen as giving her a forum to express her feelings freely without being judged about what kind of mother, daughter or daughter-in-law she is. One of the difficulties that therapists saw is that Eurocentric theories ignored the gender imbalance. For example, although the mother-in-law and daughter-in-law are both women, the mother-in-law is given more power and respect by the son. Also, even though women are working outside the home and bringing home money, they are expected to do the housework, while the role of the man never changes. That is, he is expected only to bring home the money and not asked to contribute to the housework. Because of HIV, the burden of cooking fresh food and taking care of a sick spouse might increase the burden on the caregiver, who in most cases is the wife. There are both pluses and minuses to this role. One participant explained,

There are gender and power issues in India and there are pros and cons to that because it does mean that she does not have the power to make decisions but in turn she is taken care of and she does not have to be on welfare. She is taken care of by the family so it is different in India. The daughter-in-law would just not be thrown out just because things have gone wrong, she and her children will be taken care of by the joint family system. So I do not think therapists should upset the status-quo in the sense you would want to continue to deal with the mother-in-law to change her ways if she decides to come for therapy.

*Power.* It is very important to be aware of the power in a client-therapist
relationship. Most participants discussed how Indian clients come into therapy with the mindset that someone will give advice or that an expert will fix things. Thus a therapist in India should be aware, if the client is giving power to the therapist, the therapist needs to explain to the client how the relationship needs to work. Participants mentioned that if they are not able to empower clients to think for themselves and to treat the therapist as an equal rather than as a guru, then they (therapists) cannot expect the clients to be able to fight the power differences in their marriages or families.

*Posterity (More importance given to children and to future generations than to oneself).* Many participants saw that their clients focused more on the well-being of their children than on themselves. For example, one participant said,

Although there is stigma on therapy, people in India are more willing to come for therapy and get help if the identified patient is the child. Also school counseling is becoming more common and is better accepted today. There is a lot of pressure and people believe that children reflect their parents and their upbringing so a child’s failure is a reflection on his or her parents. Parents do not want to be blamed by the society for not raising a good child. Also it is easier for parents to come in saying there is something wrong with my child and then open up about their troubled marriage or other issues they are facing.

Another participant who is currently practicing in Mumbai said that due to dual-earning parents and more income, there is more pressure on children to not only do well in school, but also to learn karate, swimming, skating and other activities, which has led to stress among children. She said,

Parents come to me complaining that ‘I have given everything to my child from
Game Boys to taking them to pizza and McDonald’s but they have no value for these things. I had nothing growing up but my child does not understand that.’

Some of the participants in response to the vignette said that they would like to empower the woman, but in reality, since it would not be possible, they would ask the mother what kind of role model she were going to be to her daughters. The therapists felt that if the therapy tapped into the mother’s emotions and if they could show the mother how she could either be a good role model or a bad role model for her daughter, the mother might take positive action and choose not to suffer at the hands of her husband or mother-in-law. The woman might decide to change and stand up for the rights of her and her daughters.

Additional issues. Another important issue which most of the participants discussed was the variations of Indian culture across families. There were differences with regards to religion, caste, region, urban versus rural living, economic background, education, etc. Thus it is important for Indian therapists to become culturally competent and sensitive, rather than to become narrow-minded and think that, since I am Indian, I know everything. We have to understand problems from an individual’s standpoint. Also, this is important since India is changing every day---both economically and culturally---and with the economy changing and more western ideas coming in, there is much emphasis on dating and an increase in divorce.

It is important for clients to understand therapy since, unlike in the United States, we do not have a history of people going for therapy. Also, Indian television and movies do not portray what a therapist does, so clients do not really understand what activities therapy entails.
A participant who was trained as a medical doctor in India and also now has a marriage and family therapy degree said that she had faced much resistance from colleagues and clients because of her bold and outspoken ideas of equality. Another therapist said that she faced corruption in the corporate sector as an organizational therapist.

Unique issues a therapist faces in India

Some of the unique issues that therapists face in Indian culture are as follows:

*Insider- Outsider issues.* A number of participants mentioned the insider-outsider issue as a unique issue that they face doing therapy. If, for example, a therapist has studied abroad (e.g., in the United Kingdom or the United States) and then comes back home to practice therapy, he or she often encounters difficulty being accepted. Similarly, when the therapist is from a middle class background and is seeing clients from a lower socio-economic background he or she may be considered an outsider. One participant explained:

I come from a well-educated middle class background while my clients are mostly from a lower socio-economic status and illiterate or low level of education. I also face challenges since I work with communities that are not mainstream. I have to work with slum community empowerment. This is because even if I work on parenting issues with the slum community, their world view’s subjective understanding of how life is or how life should be is very different than mine. So I need to understand what they need.

Another participant explained,

I grew up in urban India but the issues I faced when I worked in tribal India, I
could never imagine in urban India, and yet the kind of issues I would face in Delhi were not the same experience as a woman in Mumbai. In Mumbai I would travel by train late at night but in Delhi a woman cannot step out of her house after 7:00 pm or sunset.

Therapists need to know the community in which he or she works and its culture. The cultural implications of illness, for example, often involve shame; patients are isolated and rejected by society. The psychological, biological and interrelation factors in medicine and disease are important to know. A good knowledge of culture may also give the therapist knowledge about a patient’s senses of guilt and responsibility for the disease. Also the patient’s dependence on the caregiver and caregiver’s burden is different in each culture, so it is importance to know that about the Indian context. The therapist also needs to find out about the personal belief system of the client.

**Supervision.** Some of the participants commented on supervision in India. One of the participants who received her Master’s degree in the United States and is currently working in India in a hospital said that she really missed supervision, especially when she was dealing with a difficult case or an ethical dilemma. She said that my interview questions were like supervision for her and she felt good about it. Another professor in India commented that in India, supervision may not be available so peer consultation becomes very important.

**Emotion in therapy.** Some participants discussed how it was easier to explain issues to clients in an emotional way rather than in a logical way. One participant said, I have found at least in my practice that there are things that are very logical that I might understand, but for my Indian clients somehow when you talk about
things in an emotional way it somehow appeals to them a little more than if you just talk about giving them a very logical way. Because if you tell the lady in the vignette that she can’t give in to her mother-in-law like this and it is not practical and she can’t have another child because she knows that her husband has HIV, they will say, now what to do, I am like this and I can’t live any other way and I really do love my husband and I will put up with violence or whatever it is to be in the marriage. But instead if you (therapist) try and get kind of emotional and tell her (client) that if she gets pregnant and becomes HIV-positive and dies, no one will take care of her living daughters and her new baby may also get infected with HIV and die. Then I think for at least some people it has a little more of an effect. In the USA this may be called emotional blackmail/manipulation, but in India since we understand emotion more than logic, it is really the best way to go.

I would not call use of emotions in therapy as negative term like emotional blackmail, but instead I think for lack of words the participant said ‘manipulation’. I think the participant used reframing through a cultural context and explained the logical consequences of having sex with an HIV positive husband to the client. This would help the client get a clear understanding of her future.

Lack of resources. Many participants mentioned the disparity of resources that a therapist may face. They discussed the lack of resources and services in India and the abundance of the same in western countries. One participant who had worked in Australia for some time said,

I remember in Australia there were four street kids and there was a bungalow for those four and there were two staff members for those kids. And in India there are
millions of street kids and there are hardly any staff to look after them, so I was a bit overwhelmed by the difference in terms of services that are available there or by the lack of services here in India.

Another participant who was trained as a medical doctor in India and also now has a marriage and family therapy degree said that when she worked in a government hospital in India, she would check 80 patients in three hours and had learned to be very proficient in her skills since she would also have to be able to detect a heart murmur in a child in the midst of other crying children. She added that she had become very good in her clinical skills and senses due to the unbelievable work load and very little technology working. She said that this also helped her to become a very good crisis counselor because she could just jump into a disaster situation and be able to handle it well. Another participant explained, “There are no or very few resources/ shelters for battered women, and stigma attached if she leaves her husband and goes to a shelter.”

*Time.* Some participants mentioned that it is difficult for the entire family to come for a session, especially if they are working, and when they do, the therapist must work creatively. It is difficult for the man to miss work to come for therapy, or for the woman to skip housework, especially if water comes only 2 hours in a day or if she does not have childcare during the time of therapy. One of the participants said that especially during in-home therapy, the session could carry on for 2 hours and could be very exhausting. Some participants said that few therapists in India actually had private practice and did 50 minute sessions. Most of them worked in NGOs or hospitals or as social workers where the definition of time was totally different.

*Age/ Experience/Flexibility of therapist.* Some therapists felt that there are
definitely issues regarding the age of the therapist, especially if they are 22-23 years or look young. Clients wonder how their therapist will be able to tell them what to do. There are other concerns with regards to the therapist’s experience as well as the concern about talking to a stranger about family issues. In India, when a therapist does in-home therapy, there is a thin line between being a guest, a visitor or a therapist, since the client will offer tea or coffee and the therapist does not know whether to accept it or not. A therapist in India has to be more flexible and open. One participant said, “You should be prepared that the client will be late a few minutes because they could not get the bus on time or it was time for them to fill water or they had to walk for 3 miles just to come and see you.”

Another participant who was educated in the United States but is now working in India said that she would modify certain techniques she learned in the United States to make them adaptable in India. The example she gave was to bring positive emotions into therapy. She would facilitate the couples to express their positive feelings for each other by kissing or holding hands in the therapy session while she (therapist) would wait outside the therapy room to give them privacy.

*Where family therapy is done.* One participant said, “Family therapy might be done traveling in an auto or on the way to family court. That is something I felt I have done quite a bit in my field work, doing most of the talking while waiting for the bus or going in the auto or waiting in the family court for our names to be called.” Some of the participants said that they do therapy in their clients’ home.

*Personal vs. professional.* Some of the participants said that in the USA as a professional there is a clear demarcation between one’s personal and professional life, so clients do not usually have their home phone or cell phone numbers. But in India, several
participants had to give out their cell phone and home phone numbers since there are no
voice mails. One of the therapists said that many of the clients even knew where she lived
since she worked and lived in the same building. Another example of blurring of the
personal and professional spheres was mentioned by one participant. She recounted
seeing many therapists printing their wedding invitation with their qualification and
business information on it to get more clients. She added,

There are a lot of people who see clients at home, which I know happens in the
USA but it is a lot less frequent. I know a colleague who saw clients at home (in
the USA), but she had a separate area that was her office and you could not even
get a glimpse of her family. But in India you could have your servants walking in
and out and you could still have your counseling session going on.

Another participant believed that boundaries do not apply in India for a therapist
since the therapist could be, at the same time, the financial advisor, social worker and
confidante to the client. Sometimes many people live together and some are not even
related. For example, one participant mentioned that when she deals with a family, she
asks about the family influences and has the clients draw family maps. By doing family
mapping or making a home visit, she (therapist) finds out who lives in that house and
who influences whom. One of her clients, for example, was a child whose mother worked
all day and was given shelter by a prostitute. Although the therapist would have expected
to ask only about the mother’s influence on the child, by doing a home visit, she realized
that the child was taken care of all day by a prostitute and spent time with her mother
only in the night. Thus she included the prostitute in her work with the child.
Role of therapist in India

Many participants said that a therapist has to wear multiple hats---of a therapist, social worker, financial advisor, confidante, and psycho-educator. Some said that it is to the advantage of the therapist if she/he networks with different nongovernmental organizations and can provide resources like food, medication, employment, and support groups for clients with the help of different agencies. Sometimes the therapist is the one who even takes the patient to the hospital since she/he is the only one the patient has to depend on. Some participants were of the opinion that the therapist should be a liaison between the client and medical system or doctors. Some of the participants mentioned that they did not only therapy, but also, for empowering women in the community, they taught women tailoring or sewing skills to help their financial conditions. One of the participants said that he had started a savings group (Bachat Ghat) with women groups. One of the participants said that sometimes therapists should be willing to have dual or multiple relationships. Most participants mentioned that since people in India come to a therapist for advice, sometimes the therapist is a Guru (leader) for his/ her client (guru chela technique).

Four participants said that they thought combining medicine and therapy has its advantages. One participant said, “It is more systemic since you are looking at so many systems, it is important to have knowledge about what is going on medically since most people come for therapy in such crisis mode that something is affecting them physically and they have somatized it and there is anxiety or depression or some other physical or mental illness they are suffering from”.
Ethical issues

Some of the ethical issues that therapists in India face are discussed as follows:

Confidentiality. Most of the participants found that their clients are very skeptical about confidentiality and would only open up gradually to the therapist about their problems. This was because of no previous experience with a therapist and because confidentiality within the medical system is not maintained well in India. One of the participants was concerned that if a client revealed his/her HIV status to the extended family, then the word may go out of the family, and then the family members may not support the HIV-positive person and may even ostracize him or her. One participant said,

If I ask the son to reveal his HIV status to his mother, and the mother tells his sister who in turn tells an aunt since she wants someone to disclose to and support from, we are not revealing HIV status to the nuclear family but to everyone.

Another participant said that confidentiality is a gray area in India. Some participants felt that it is difficult to maintain confidentiality about HIV status, especially if the client lives in a joint family. Another issue of confidentiality occurs when the client is asked to reveal his/her HIV status to his or her spouse. If the client decides not to share his or her HIV status, the therapist can break confidentiality and reveal to the client’s spouse or partner the client’s status. However, it may not be as easy as it sounds. One of the participants said, “I cannot go and tell the spouse because the client may not give me the right address or phone number.”

On the other hand, the participant said that she would encourage her clients in the USA to tell their extended families, since the clients understand the pros and cons of divulging such information and the clients will do so if they think they will get support
from family members. However, in India, it is important to be more cautious about telling
the extended family because of the taboo and stigma still attached to HIV. Another
participant said that, “In India there are very few laws and you (therapist) cannot enforce
laws on the client (husband) if he decides not to tell his wife.”

_No Accountability_. One participant mentioned that in the USA the doctors,
therapist and nurses have to always be worried about being sued and therefore
accountable to the client. But in India, the fear of getting sued is not very high, especially
among low-income clients. This encourages a health system with little accountability.
One of the participants, now a professor in the United States, stated while reflecting on
clinical experiences in India,

> When it comes to confidentiality and privacy we suck. I do not fault clients and
> patients not feeling like they want to reveal something like this because I
> remember that for one of our field experiences (internship) we were taken to a
general hospital and the doctor brought us into a ward where there were patients
who had genital herpes/STD and the doctor just walked up to the women who had
genital warts and asked her to show us her warts. Firstly we were aghast and we
thought, oh my god, what is wrong with this doctor. We all thought that this
doctor was an extreme case. There is no privacy and no respect, human dignity
ceases to exist. So there is no accountability.

Another participant was concerned about the lack of supervision in India. Another
participant, a professor and therapist in India, said that although it is difficult to find a
supervisor, she has found that peer supervision or consultation helps her and her
colleagues.
How to adapt family therapy to India / What to change in Eurocentric theories

Most of the participants said that there is a lack of Indian literature on family therapy and that more articles and text-books on family therapy in the Indian context should be written by Indian family therapists. Most of the therapists felt that India is so diverse that a therapist has to cater to the needs of different individuals in different ways. So the participants felt that there is no one particular theory that would fit all Indians. The differences among Indians, due to class, education, family background, and where they live all play an important role in their life and each of them comes to therapy with a unique experience. Indians from a tribal village would have different experiences than an Indian in a larger city or an Indian who lives in America. So some said that therapy has to be adapted from textbooks while others felt that there needs to be more research in India about the culture and how it impacts therapy. One participant said that, “It is important to Indianize the theories by including Indian family structure, values, and a multi-generational approach---what are the strengths of Indian families and what are the things that stop them from making healthy decisions.”

Another participant said, “Eurocentric theories help you understand the psyche of the person, but we need to understand the Indian cultural context and dynamics to solve issues or develop interventions for Indian clients.” Some participants discussed the importance of integrating several approaches. One said, “Depending on who comes to therapy I can do therapy, say for example, if the wife comes for therapy then I can do strategic therapy indirectly through the wife for the husband and tailor an intervention to help her.”

There is no one size that fits all. Some therapists felt that therapy worked better
in the rich and middle classes than with the poor because the poor were worried about basic necessities like food, water and shelter and not so much about the emotional conflicts and hierarchy structures at home. Thus, interventions to address poverty and unemployment issues for the poor in India are needed so that therapy can be adapted to India. On the other hand, the rich may be acculturated to the west and probably, for them, the western theories might work better.

One common theme among all the participants was to be culturally sensitive and know the rights and the wrongs in the culture. One participant said that she had to comment on a published article in a journal as part of a class assignment. She said,

The couple had come with infidelity issues and there the mistress and the wife and the husband all 3 of them said that they were bound up in this lifetime because they were bound up in a previous lifetime so it was karma. And the mistress and wife were very upset but did not know how to deal with it and the husband did not know whom to choose and it was becoming a very tangled up situation with stress. So the therapist worked with the framework that we are bound by karma so let us find a karmic solution and what could be the possibilities that would work them through that difficult triangle? So I think we have to take every client as a unique person with a unique set of circumstances and work saying that this is a unique person and I cannot have my one size fits all formula for them. I have to work with what the client brings in to me, really study them, and really understand their position.

Another therapist said that it is important to work from the context of the client. She further explained that when an Indian client believes in ‘Jadu dala’ or ‘Bhoot chad
gaya’ (black magic or possessed by an evil spirit), then the therapist has to be sensitive to
the client’s feelings. The therapist cannot tell the client that his or her (client’s) belief is
wrong, and that it is mental illness rather than a demon possession. She said that
becoming multi-culturally competent and sensitive to the ideas of the clients is critical.

Most participants felt that family therapy can be adapted to India since we live in
families and we are very family-oriented. Another reason was the religious aspect; for
example, Hinduism teaches about living together in harmony in a family. Another theme
is that there are many family and personal problems in India as well as in the United
States. It is just the context that is different----- humans are still humans. One participant
stated, “To adapt family therapy to India, we need to learn everything about Eurocentric
theories and remember that although the cultures are different, basic human nature is just
the same, and as long as a person knows the do’s and don’ts of a culture, they cannot go
wrong.”

Similarly, another participant added that there could not be a universal theory,
but all theories could apply to a different culture if the therapist were culturally sensitive.
She said that it is important to meet the client where the client is. Another participant felt
that the concept of individualism is the only concept that would be difficult to adapt to
Indian clients.

Strategies used to adapt the theories. One of the participants said that school
counseling is a good way to make people more aware of therapy. Also, more talk shows
about therapy should be produced to make the masses sensitive to therapy. Media like TV
and radio could popularize counseling. Another participant felt that more therapists who
have studied in the United States should return to India and start their practices to see
Conceptualizing themes of framing or seeing problems

Some participants discussed the importance of language. One participant said that certain words like “empower,” “boundaries,” “validate,” and “vulnerable” did not have equivalent terms in the Indian language, and even if similar words were used in the colloquial language, they sounded strange. Some participants found the word “Eurocentric” very polarizing and believed that therapeutic concepts were universal, and thus cut across cultures and should not be considered Indian or American.

Metaphor

When the participants were asked what metaphor came to mind when they thought of applying Eurocentric theories to India, they came up with interesting insights that appear to capture certain themes that were presented earlier in a more traditional fashion. These visual metaphors are categorized by themes. Some participants felt that family therapy interventions were human theories that could work for all humans. These participants, for example, stated that all humans have a backbone, skin color, and height and weight. The point of such metaphors was the essential sameness underneath the differences in theories. This is represented in these metaphors: the stand for a dress, human emotions, skeletal structure or backbone, fish and chips, turmeric, mental tool box, and knowledge. For example one participant said that the core ingredient in a fish dish is the fish. However, the fish may be prepared in different ways in different countries to suit the tastes of different people. In India, it is served as fish curry with spices and fried in mustard oil, while in the United Kingdom fish is dipped in batter and fried. Each of these metaphors is explained below. Other participants believed that these
family therapy theories are indeed “Eurocentric” and must be adapted to make them culturally sensitive to the Indian context or they would not fit.

Some examples of these metaphors were the Mac Aloo Tikki burger, car, British rule, dishwasher, gas station, big bottle cap for a small bottle, round peg in a square hole. Some participants mentioned the difficulties they see facing as a therapist working within the Indian culture. For example, patriarchy and the expectation of receiving advice are two such culture constraints. Such cultural values are reflected in the metaphors of guru-chela, psychological-judo, faded jeans and stranger in the dark. Each of the metaphors is explained in detail below.

**Mac Aloo Tikki Burger** The participant said that the metaphor that came to his mind when he thought of applying Eurocentric theories to India was that of a Mac Aloo Tikki Burger (a potato vegetarian burger served at McDonald’s in India). He explained that McDonald’s is a worldwide chain and sells meat burgers. The beef burger is known to be the highest selling in many countries. Since the cow is sacred to Hindus, and most Indians are Hindu and thus do not eat beef, McDonald’s came up with a vegetarian burger which is the highest selling burger in India. Thus participant explained that just as a big multinational company like McDonald’s has had to make changes like developing the vegetarian, spicy Mac Aloo Tiki Burger, family therapists should similarly make Eurocentric theories culturally sensitive to India.

**Water.** Another participant said that therapy is like water in that it could take the shape of its container. In America, it (therapy) takes the form of American culture and in India, the Indian culture. But even therapy in the United States is not the same for everyone. For every family therapy takes a different form.
**Big bottle cap.** One participant said that “If there was a big bottle and a small bottle and you tried to put the big bottle cap on the small bottle it would cover the area, but would not fit properly.” That is, though these theories are constructed from a western perspective, some of the factors that they address are true about family systems throughout the world. The aim is to not reject a theory totally, but to look for how it might fit Indian families better. There are many families that have been helped by these different orientations over the years. Still, we need to be more conscious of what we do in the Indian context – the fit. So, in terms of the metaphor, the participant stated, the smaller bottle is covered but it is not airtight. The part that the cap covers in the smaller bottle is the part that probably we can adopt from the western theories and the rest we can leave out, and construct a cap which is right size for the bottle.

**Square peg in a round hole.** One of the participants said that applying Eurocentric theories to India would be like putting a square peg into a round hole. The participant explained that a square peg would not fit in a round hole, but if it were banged and worked around, it would fit. She said that in the same way, until a theory which was developed in one country takes into account the culture of the country to which it is going to be applied, the theory could not be adapted in that country. Thus, adapting theories and tweaking them to fit the culture are important.

**Dishwasher.** One of the participants explained that the dishwasher is applicable in both India and America. In America, it is used to wash crockery made of porcelain or china, but in India, dishes are made mainly of steel. The dishes made of porcelain and china is easy to wash in the dishwasher, but we need to tailor-make a dishwasher which will wash Indian dishes.
Gas station. One of the participants felt that Indians are more interdependent compared to people living in the United States. She explained that in India, there are people at the gas station who fill gas; maids who help clean the house, and vegetable vendors and milkmen who come to the house to sell their goods. But in America, people were independent and responsible and would do housework, fill gas and buy groceries on their own, and did not depend on others to come and do it.

Ram Sita. Ram and Sita are Hindu deities that represent an ideal relationship. One participant said that she thought of the metaphor of Ram and Sita. She explained that she thought of couples like Ram and Sita and their back-to-back partnership, where one would take care of the outside world while the other one the inside duties of home and children. Then they would communicate to each other about their respective duties.

Jigsaw puzzle. One participant said that she thought of the metaphor of a jigsaw puzzle. She added that fitting Eurocentric theories to Indian context is like fitting a jigsaw puzzle piece from a United States map to another jigsaw puzzle with a piece from an Indian map. Thus the two pieces would not fit.

Car. One participant said that the metaphor that came to her mind was that of a car. She said that cars made in India are specific to Indian road conditions, and have different tires, steering wheel, and speedometer (one is because India uses the metric system and the other because Indians do not travel at such high speeds). She added that, due to the heavy traffic and traffic laws, it is difficult to drive an automatic car in India and cars are modified to fit the Indian clientele. She then said that a multicultural aspect and cultural sensitivity are needed to modify certain Eurocentric theories and fit them to the Indian culture.
**British rule.** One participant said that she felt that if the theories were just taken from America and transposed to India without adapting them, it would be like British colonization. She also added that since Indians were so good at imitating and not recreating the wheel, they would be easily able to adapt the Eurocentric theories in the Indian context.

**Stranger in the dark.** One of the participants said that the metaphor she could think of was that of a stranger in the dark, especially because she is a woman. She said that in a patriarchal society like India, many clients, especially men clients, would not respect women therapists. She said that especially after being educated in the United States, where she learned about equality and equity between men and women, it would be difficult for her to go back to India and apply theories where she may not be respected as a therapist, and where even the concept of therapy is not clearly understood.

**Mental toolkit.** Another participant said that therapy is like a mental toolkit in that problem-solving skills, and family therapy theories are all different tools in the toolbox and the therapist should not be too attached to any one of the tools. The therapist should use whichever tool would be most effective in a particular situation.

**Guru-Chela.** One of the participants said that her metaphor was that of guru chela (leader–follower). She said that every therapist in India should know the guru chela technique, allowing Indian clients to be dependent on the therapist and then gradually making them independent by helping them to think for themselves and to make decisions for themselves rather than always being dependent on the therapist’s advice.

Another metaphor a participant mentioned was **Psychological judo.** The therapist was in the ring while the clients were watching. The therapist can handle resistance by
“going with it” rather than fighting it. Many traditional family therapies have techniques that will help Indian therapists deal with resistance.

**Faded Jeans.** One of the participant said that she thought that the concept of going for therapy should be made cool, just like the concept of faded jeans which is cool in the West. A fashion statement should be accepted by Indian youngsters that same way. They should find going for therapy to be hip and the in thing to do.

Some of the participants did not find the wording of the question appropriate since they do not see theories as Eurocentric. They maintained that although the theories were developed in the western world, knowledge is knowledge and all humans have the same emotions. Only their experience is different. Some of the examples that go along with this kind of thinking are presented below.

**Human emotions.** One of the participants expressed that human emotions could not be categorized as Vietnamese loneliness or American boredom or Indian joy or Swedish anger. In the same way, becoming culturally aware and culturally and contextually sensitive and then applying Eurocentric ideas to the clients would be appropriate. She added that it is actually detrimental to think that Eurocentric ideas could not be applied and had to be changed.

**Stand for a dress.** One participant said that she felt that marriage and family therapy theories were human theories which would work for all humans. She said that the theories were like a backbone, a structural skeleton like a stand that any dress could be put on. She added that just as the human backbone is similar, irrespective of skin color, theories would hold true with all humans.

**Turmeric.** One of the participants said that she thought of the metaphor of
turmeric (spice used in Indian curry). She added that turmeric is used all over the world such as in India, China and the USA, but some people in specific countries have had time and energy to write turmeric’s medicinal values and uses in a book and patent it. But she said that this in no way proved that turmeric was the sole propriety of that nation. In the same way, she said that families have had problems ever since they existed and in different cultures. Guru, elders, and family members have helped to solve these issues. Although western countries made the first move in identifying and giving theories their shape, the knowledge and wisdom inherent in the theories do not exclusively belong to the western world.

**Backbone or skeleton.** One participant felt that the crux of therapy is the same and we are all the same structure----that is why we do not need to think of people as Indians and Americans, but just as humans. She added that color of the skin and shape of the eyes may tell the country that a person is from and it may tint the way that the therapist thinks about them.

**Fish and chips.** One participant said that she thought of fish and chips. She said that fish and chips are especially famous in the United Kingdom. She said,

Fish is the same here in India and in UK. It is just that we deep fry the fish in a different manner in mustard oil with spices, while in UK they batter the fish and fry it in a different manner. So the content and the foundation is the same. Similarly, the base ideas in family therapy theory are the same but we apply it differently in India.

**Knowledge is knowledge.** Another participant said that knowledge is knowledge and that wherever it was discovered, it still existed. She added that even though family therapy was developed in particular countries, the good from those theories could still be
applied to other countries; and what does not apply can be researched further and the
effectiveness of the theories put to the test. She said that it is important for Indian
academic practitioners to write more books on family therapy and to test them on Indian
soil. Then any theory that emerges will be universal and not Eurocentric.
Chapter V
Discussion

The purpose of this study was to understand which Eurocentric marriage and family therapy theories and interventions (i.e., those developed in a western setting) can be applied in India, in a culturally appropriate way. To provide a clinical focus to this question, the interview questions largely related to issues concerning HIV/AIDS. To address the purpose of the study, I interviewed Indian therapists.

The demographic form was filled out by 31 respondents. Five of the 31 were not born in India so they could not participate in the study. Three more did not provide contact information and one lived in India for nine years only. One of these five who was not born in India, but was of Indian descent, was interviewed for instrument development. Thus, out of the 31 respondents only 22 of them fit the profile criteria. I conducted semi-structured interviews over the phone with the participants. I used a modified form of grounded theory to derive useful theoretical knowledge from the Indian family therapists about how to conduct culturally sensitive therapy with HIV positive Indian clients. The interview data were transcribed and analyzed using analytic induction and constant comparison.

The overarching research question was “What are the marriage and family therapy interventions that work best with HIV positive clients and their families in an Indian setting?” This research question guided the development of the interview questions. Through this research, I have tried to understand the marriage and family therapy interventions and models that Indian therapists think they can use with their clients in India. By asking about how the Indian family therapists would address HIV (a
particular interest of mine), I was able to raise concerns of culture, family dynamics, class, and the relevance to the caste system which are unique to Indian culture. Clinical issues related to HIV are at the intersection of death, sexuality, illicit drugs use, spirituality, oppression, race, class and region. Since HIV/AIDS is such a grave issue, it amplifies the other problems HIV creates. That is, the family therapy interventions discussed in this study may be applicable to other mental or physical health problems. Also, problems associated with HIV magnify because they are related to HIV/AIDS. For example there is stigma attached with being mentally ill but the stigma increases more when a person is found to be HIV positive. I will expand on this below.

This discussion includes the marriage and family therapy interventions that were identified in this study, the cultural beliefs that Indian therapists need to be aware of while doing therapy, and some of the ethical issues Indian therapists face in adapting Eurocentric theories to the Indian milieu. I also reflected on the ideas generated in this study that may be significant for further analysis or may function as a key component in future studies. The strengths, limitations and research application of this study also are mentioned in this discussion. The major categories that were found are given below. The first major category explains the family therapy interventions and models that Indian family therapists thought would work well with Indian clients. This category answers the first part of my research question.

Interventions

Research has shown the need for professional family therapy in India (Natrajan, & Thomas, 2003, Mittal, & Hardy, 2005, Sonpar, 2005, Baptiste, 2005, Carson and Chowdhary, 2000, & Singh, Nath, & Nicholas, 2005). These researchers think that family
therapy is flexible enough to be applicable to different cultures. The results of the present study also suggest the flexibility of family therapy, which is why all the participants agreed that they could use various family therapy interventions, depending on the needs of the different Indian clients.

The results of the study indicate that the participants used many different marriage and family therapy interventions and models to address issues in Indian families. But the results also reflected considerable disagreement among the participants, especially regarding the interventions that would best suit the Indian clients infected or affected by HIV/AIDS as they were presented in a clinical vignette. Some participants thought that strategic family therapy was the best intervention, others thought Bowen’s model of family therapy would work best, while still others thought narrative or solution focus or feminist family therapy were preferable, and so on. Such disagreement among participants appears to underlie the multiplicity of family therapy, which further indicates that the flexible nature of family therapy, rather than a cookie cutter, one-size-fits-all-approach, may be preferable in India due to the fact that not all families are the same. Also, this disagreement could be because of the youth of family therapy in India. The results of Shah, Vargese, Kumar, Bhatti, Raguram, Shobhana, & Juva, (2000), Prabhu, (2003), Nath, & Craig, (1999), Natraj, Karuppayswamy, Thomas, & Ramadoss, (2005), Singh, Nath,& Nicholas, (2005), Sonpar, (2005), Mittal & Hardy, (2005), Rastogi, Natraj & Thomas, (2005) similarly suggests that professional family therapy is in its infancy in India.

However, there were similarities and common overarching themes among the interventions, including the importance of psychoeducation, directive therapy,
spirituality, addressing the presenting problem and making sure that the therapy was consistent with cultural practices. Most of the interventions mentioned can be used to address any problems or issues that an Indian family faces. However psychoeducation has been found to be one of the most important techniques used by therapists with HIV positive clients and their families. Participants in this research also agreed with this. Macklin (1993) suggests how important it is for therapists to work with families and communities and to educate them about HIV so that they can provide a supportive environment for people infected with HIV. Most of the therapists reported an eclectic approach since they felt comfortable using different theories, models and interventions to fit their clients and specific situations at particular times. Thus, overall, it appears that the participants believe that interventions of family therapy developed in western countries can work with HIV positive Indian clients and their families as long as the therapist understands the cultural context and belief systems of their clients and applies the family therapy interventions in a manner consistent with that cultural context. Due to this belief it is important to understand the cultural issues the participants identify which will impact the use of family therapy in India.

*Cultural Issues*

Bhattacharya (2004) explains the cultural beliefs about transmission of HIV, dominating patriarchal society, and hierarchy, while Bharat (1995), has commented on the lower status of women compared to men. The results of this study authenticate that patriarchy, power, and hierarchy are some of the major issues that an Indian woman faces, whether she is a client or a therapist. Karasic and Dilley, (1999) found that people infected with HIV may suffer from depression and anxiety disorders. Krishna, Bhatti,
Chandra, & Juva (2005) have demonstrated that HIV has a major impact on family systems. The results also corroborates that HIV takes a toll, not only on the individual, but also the family, especially women.

But the social stigma attached to going to therapy is another cultural issue a therapist faces which prevents many Indians from seeking professional therapy. Also, unlike in America, therapy is fairly new in India and can generate resistance because of rigid traditions. Thus, the results of this study are consistent with those of Juthani (2001) and Davar (1999) who found that people are more likely to go to priests, gurus, shamans and local healers than to therapists for their emotional, mental and marital problems. Also, most people do not understand what therapy is or whether people go for therapy only if they are mentally or physically ill. Due to these false impressions of therapy, some Indian people think that going to the therapist is like going to a doctor or a guru who can magically make their problems go away. Because of this thinking most Indian clients tend to give their therapist a ‘one up’ position. This means that clients usually think that the therapist knows the best and that the therapist will make his or her or the client’s problems go away and that they (clients) do not have to work on their problems themselves. The results of the presented study also underline the stigmas attached with discussing sexuality as well as being gay, and HIV positive.

Other cultural issues that came across in the results involved the class (which constitutes income and education) of the client and its bearing on whether therapy would be effective to the client, and whether the client would seek therapy. Participants agreed that poor clients would need to focus on bare essentials like food and shelter before addressing their emotional problems. As for wealthy clients from the elite class may be
ashamed to come for therapy.

*Some cultural norms are universal.* Some cultural issues, according to the participants, are actually manifestations of universal issues. Whether it is a small village in India or a small town in the USA, a therapist is bound to face challenges related to issues such as gender and power. In India there is the caste system but the western world experiences power and aggression, for example, through racism and sexism. As long as someone has power there is the potential for oppression. A person who is gay, poor, colored or female can be discriminated against in both developed nations and third world countries. I have worked as a therapist both in India and in America and have come across the issue of gender bias in therapy. Being a female therapist, I have faced sexist attitudes by some of her American and Indian male clients. Similarly, she has found that many Indian female clients are at the mercy of their husbands or in-laws to either come in for therapy or continue therapy, but she has felt lesser resistance from most American female clients. Because America is a more developed society, most women are more educated and less dependant on their parents, spouses and in-laws to take care of them. Most American women make their own decisions, although after working with domestic violence victims in the USA, and seeing them in abusive restrictive relationships, the problem of oppression exists for both Indian and American women.

Through this research, and living as both an oppressor and an oppressed person, I have come face to face with realities of how important it is to challenge the universal issues of gender and power biases while at the same time respecting cultural boundaries and hierarchies. I have seen through the results that doing both is definitely possible. The participants generally respected cultural norms but did not approve of practices that were
socially unjust, even though they were culturally sanctioned. Some participants on the 
other hand felt that family therapy was universal. As one said, “People are people. 
Human emotions are the same, and there is nothing like Swedish joy and British anger or 
American sorrow.”

*Differences in culture.* Although there are many differences between the two 
cultures, a small part can be attributed to the western belief in leaving the family of origin 
and connecting with the new family after marriage. Hindus believe in the marriage of one 
family to the other, and living in large, multiple family units. But this does not mean that 
there are no Indian nuclear families or no American joint families. Living in large 
multiple families create unique cultural issues especially for the new daughter-in-law. 
Layered upon this is the importance of having a male child, which could lead to other 
problems like discrimination against a girl child, female infanticide and genital 
mutilation, which is seen in some Asian and African counties. Most Indian families also 
have fluid boundaries but strong hierarchies. Fluid boundaries here mean that some 
Indian clients would bring a friend or a neighbor to therapy or invite them to accompany 
them to the doctor. Also using the term ‘uncle’ or ‘aunty’ to an unrelated person like a 
neighbor or a taxi driver is common in India. Strong hierarchies’ mean that doctors, 
professors, guru, therapists and family members like parents or in-laws are given 
unquestionable power and authority in some Indian families.

The results also support the Natrajan and Thomas (2002), study that most Indians 
have a fatalistic attitude which makes it difficult for them to come in for family therapy, 
even if they need it. If one believes his or her future is set based on past behavior it makes 
little sense to try to change. Such cultural issues will be a unique challenge in India.
Based on the results, I believe that although we are of the human race, living in one world under one sky, we still have our differences. These differences between Americans, Africans, Asians, and Indians can be seen from their outer appearance. Even though earlier I have said that we have the same blood running inside us and experience emotions of pain and joy similarly, there is something which makes us unique. This uniqueness comes from our own individual experiences. That is the reason why two siblings, from the same parents brought up in the same home, may turn out quite differently: one turns out to be policeman while the other a thief. The only way I can explain this irony is because of the experiences the two have had. When two siblings could have such diverse experiences, there are going to be differences among Indians families depending on the class, region, caste, urban rural and environment, to address a few. To be a competent therapist, one has to appreciate and respect these differences of hierarchies, boundaries, extended family members, yet keep in mind the similarities of being a human being. Theories of family therapy can work as long as they show respect to some hierarchies while challenging others. Due to the cultural issues, Indian therapists face certain unique issues which they may not face in the western context. This became the third major category of the results.

*Unique issues a therapist faces in India*

As I read and analyzed the data from this study, I realized differences and similarities, the concave and convex lens through which she was trying to see through. There are certain unique issues that an Indian therapist faces while working in India. Although therapy is becoming common in metropolitan cities, there still needs to be a move towards of psychoeducation done on the part of the therapists to remove the stigma
attached with seeking therapy.

Another unique issue that many therapists in India face involves being an outsider inside their own culture. This observation was made by several participants who felt that even though they were Indians, because of either a higher education abroad or their socioeconomic status, it was difficult to fathom the complexities of clients who live a hand-to-mouth existence or come from a rural part of tribal India as compared to the urban India that was home to most of the participants. This supports the results of Rothbaum, Rosen, Ujiie, and Uchida, (2002) who ask therapists who work with families from other countries to be aware of their own cultural lens.

Knowing the culture and background of the client and accepting the differences is one of the unique challenges a therapist faces in India. This may be a challenge because of the different religions, languages, customs, regions, and belief systems. To illustrate this better I will give a simple example of the wedding dress in a Hindu marriage. In most of north India, a traditional Indian bride wears a gold embroidered red or orange sari, because red is considered an auspicious color for a long married life, while white is mostly worn by widows in north India and is absolutely inappropriate for a newly wed bride. But in some parts of south India the traditional Hindu bride wears a white sari, which symbolizes purity. This is a simple example, but I remember how much chaos and disagreement it caused between my parents and in-laws when my in-laws asked me to wear white on the day of marriage while my family of origin thought of white as inappropriate and bringing bad luck to the bride and groom.

Another unique challenge an Indian therapist faces is the lack of supervision and the lack of resources as compared to those in the western countries. Also the concept of
time and place in therapy, and the taboo related to talking about sexuality are much more pronounced to the Indian culture than in the West. Some other issues that differed in India versus the West included the high drop out rate from therapy, the difficulty in doing conjoint family therapy and the bureaucracy and corruption at different levels in the system in India. A good therapist would need to not only do good therapy, but also navigate such challenges.

I agree with some participants in saying that, while corruption is certainly present in US government, the common people are generally not deprived of basic necessities. On the other hand, in India corruption is at all levels of government, which leads to not only depriving the common people of basic necessities, but also depriving doctors and health care staff in government health care systems from basic protection like gloves and new injection needles to work on patients. This corruption leads to mandatory HIV testing of all patients in most of the government hospitals in India for staff protection, which is an unethical, vicious cycle that would require a social movement or policy to lift this type of oppressive corruption.

Role of the therapist

The therapists can do their best to bring about more awareness among HIV positive clients about the mandatory testing, doctors about confidentiality and become a liaison between clients and medical doctors. The results are consistent with other research conducted on how marriage and family therapists can help HIV positive clients disclose their status to their spouse and help improve poor relationships (Serovich, Kimberly, & Greene, 1998) and how therapists can work in collaborative partnership with patients and physicians (Yarhouse, 2003). Because therapists sometimes have to play the role of a
social worker, that may also include being an activist lobbying for rights of their clients.

Clearly, in India therapists play various roles.

*Ethical Issues*

Due to the complexities that HIV brings with it like stigma, morality, and death, there are a number of ethical issues that the participants discussed. Participants reported that confidentiality, duty to warn the third party and accountability were some major concerns they faced. Thus this became the third major category of the results. Some of the other themes that were noted were difficulty to change the bureaucracy and corruption in the government, presence of hierarchies, patriarchy, and old traditions which have been drilled into the heads of most Indians for centuries. The therapist needs to know ways to work through the system and he or she will come across many ethical quandaries along the way. Two of these quandaries are confidentiality and accountability. Many therapists said that they had been in a position where there was a breach of confidentiality by the family member, the client, or by the medical system. By this the therapists meant that when a client was told that he or she was HIV positive and disclosed his or her status to his or her spouse, he or she may reveal the HIV status to other family members without the permission of the infected person.

Some times, especially when the HIV positive client would refuse to share his or her status with their significant partner, thus endangering the life of another person, the therapist found herself or himself in a difficult situation where he or she could not tell the spouse because of the lack of knowledge about the whereabouts of the home or telephone number of the client. Also, sometimes a callous mistake on the part of the health system may jeopardize the client’s confidentiality. One of the main reasons for not maintaining
confidentiality may be because of the lack of accountability and absence of a system that supports treating clients with human dignity.

*How to adapt family therapy to India? / What to change in Eurocentric theories?*

Once we have considered the cultural and ethical issues that a therapist in India faces, it is important to discuss how family therapy might be used with Indian clients, particularly around issues of HIV/AIDS. The participants suggested a number of interventions related to the HIV epidemic that may be helpful to practicing clinicians in India. Several participants reported using cultural values to bring about change. One example included calling for parents to consider the best interests of their children, (e.g., asking elders what their hopes are for their grandchildren). Another involved using their religious values to support change (e.g., Just as Ram and Sita supported each other, and completed each other, so can you and your spouse complete and support each other).

Some participants identified interventions that addressed specific family issues in India (e.g., using structural therapies to strengthen boundaries between the son and mother, and support greater connection between husband and wife).

Some participants felt that therapy should be directive, brief, solution oriented and provide more information and education to the clients about the problem and appropriate solutions. The reason behind this was because most Indian clients prefer to get quick solutions rather than analyze their problems and critically think about their mistakes. Since the drop out rate is statistically so high it is better to do brief therapy, rather than expecting clients to come for therapy for a year. Since the concept of therapy is new to many clients think that they are going to a doctor and will get a prescription of therapy (just like a prescription of medication from a physician) and feel better. Hence expecting
that the client-therapist relationship would be egalitarian and the client would do all the thinking and analyzing and find answers for his or her problems is a false expectation.

Some participants also felt that using group therapy and community work would be more powerful, especially with clients who came from the lower economic status since they were more concerned with basic needs like food and shelter than emotional problems. Acknowledging the belief of clients in the fatalistic attitude, and working with the belief rather than against it was another important adaptation that therapists needed to be aware of. Another important issue was the belief in the collectivist approach of life for most Indian clients. As one participant said that the clinician needs to be aware that a client would not make a decision only for his or her nuclear family (couple and children) but had to take into consideration the impact that the decision would have on his or her joint family as a whole (grandparents, sisters, brothers and their families).

Some of the other issues that a clinician in India needed to be aware of were the strong hierarchies yet fluid boundaries in the family system, taboos attached to sexuality and being gay and the strong patriarchy hence the importance of having a male child. Some adjustments made by Indian therapists were meeting with each family member individually and then meeting with the entire family only for the last 10 minutes. Also working with the medical and government system is important for the therapist to bring out the most change. One important issue that all clinicians in India should remember is the diversity and variations of the Indian culture across families with regards to religion, caste, urban or rural environment, economic status, and education.

Certainly, more Indian researchers and therapists should write articles and textbooks on their applications of family therapy to the Indian context. The participants
also suggested familiarizing lay people through media about therapy and helping to remove the stigma of therapy. The participants also suggested coming up with equivalent terms for ‘vulnerable’, ‘empower’, ‘validate’ and ‘boundaries’. This is because there are no equivalent terms for the above mentioned words and even if there are they seem absurd and currently do not make sense in the culture. The importance of cultural sensitivity in selecting interventions mirrors the results of Rastogi, Natrajan, & Thomas (2005), Mittal, & Hardy, (2005), Natrajan, Karuppaswamy, Thomas, Ramadoss, (2005), and Dattilio, & Bahadur, (2005).

**Metaphor**

I asked all the participants, “What metaphor comes to your mind when you think about Eurocentric theories being applied to India?” The answers brought out the essence of what the participants were trying to convey in their answers to other questions. The metaphors included the ‘Mac Aloo Tikki burger’ reflecting how one concept (a McDonald’s hamburger) could be enlarged to be culturally sensitive. The participant said that the way a big corporation like McDonald’s could adapt themselves and bring in a vegetarian burger to satisfy the predominant vegetarian Hindu population, the same way Indian therapists needed to make Eurocentric theories and intervention culturally appropriate. Another metaphor ‘stand for a dress’ reflected one participant’s suggestion that although we look different and wear different things we have the same core foundation of being a human beings.

Another participant gave the metaphor of the British rule. She said that if theories were transposed directly from America to India without adapting them it would be like the British rule of colonization. Another metaphor of ‘fish and chips’ was reflected by
one participant that fish was the same in India and the UK. It was just that in India the fish was deep fried with mustard oil and spices while in the UK they battered the fish and fried it. So the content and the foundation is the same but we apply it differently in the two different counties. The richness of the responses to the metaphor question suggests the importance of aesthetic data to capture themes and to connect with both the heart and head of participants (Piercy & Benson, 2005).

**Important Learnings**

From this study, I found that different family therapy theories, models and interventions could be used in India as long as the therapist was culturally sensitive and knew what was right and wrong for this particular culture. Particularly, psychoeducation, directive therapy, addressing the presenting problem and systems therapy particularly focusing on the couple (husband-wife system) are interventions that most of the participants (Indian therapists) use with their clients. Psychoeducation was found to be especially useful with families and clients who are HIV positive. The reason behind these interventions or models being more successful than others was because of the Indian culture. The Guru-chela attitude, patriarchy, poverty, need for being directive, low literacy and awareness levels, and strong hierarchies in a families were some of the cultural reasons why the participants would use the above mentioned interventions more often than other interventions. These cultural issues also caused unique and ethical concerns for Indian therapists. These concerns related to limits to confidentiality, less access to resources, feelings of being an outsider in one’s own culture, and the need to take on flexible roles in a professional setting. These unique issues seems to have caused a need for the therapist to take on different roles as an educator, a financial advisor, a
friend and a confidant who can transport the client to a medical doctor. The participants felt that by doing more research on applying certain family therapy models to Indian families and finding out what works and what does not within the cultural context of India, and by subsequently writing more articles and creating more awareness about therapy, family therapy can be more easily applied to Indian families.

Policy implications

The results of this study would be helpful to people who work with Indian HIV positive clients and their families. The results may also be useful for marriage and family therapy educators, so that they can include the need for therapists to be culturally sensitive and mindful of their own biases. The research is especially valuable for Indian marriage and family therapists, who want to practice in India.

This is particularly true for therapists who have studied marriage and family therapy in a western country, like the USA, UK or Australia. The suggested interventions provide resources to help them (Indian marriage and family therapists) become more comfortable to go back home (India) and work more effectively. I also hope that, by reading this study, therapists will get a clearer picture of the unique cultural and contextual issues he or she would face in India. I also hope that the study will raise awareness and insight in the minds of Indian therapist who plan to go back to India making them mindful of their western lens and education, thus making them an outsider inside their own homeland.

Strengths of the study

As mentioned earlier, many studies have shown the need for family therapy in India and how it is in its early years of development. I also hope that this research has
contributed to the development of marriage and family therapy in India by identifying the challenges to be faced, and ways that therapists, practicing with cultural sensitivity, might address these challenges. There is a dearth of research and articles on family therapy in India. This study fortunately adds to the scarcity of the knowledge base too.

The methodology was another strong point of the study. Modified grounded theory used with knowledgeable Indian family therapists has helped to achieve an in-depth understanding of some of the subtle and not so-subtle cultural and contextual issues that a therapist faces, as well as the interventions that best suit Indian clients infected and affected by HIV/AIDS.

Yet another strength of this study is the differences noted among the participants, some of whom were practicing in India, while others had their education in the USA and were practicing in the USA. This variety helped me capture a rich data. Another strength is that I was born and raised and worked with HIV positive clients in India, and I could appreciate some of the unique issues that the participants discussed.

Limitations of the study

I encountered many problems collecting data, especially since there are few practicing Indian marriage and family therapists. Some refused to participate because they felt that they had taken part in many studies and were over sampled. The resulting number of 22 participants, while adequate for a qualitative study, must be considered a limitation since statistical generalization is not possible.

Although all the participants had some training in marriage and family therapy, not all of them were trained in an accredited program or school. I made sure that the participants had enough training to answer the interview questions. Even though training
for some of the participants was only a few courses in marriage and family therapy while studying to become a psychologist or social worker, the participants knew a range of family therapy theories and interventions and were using them with their current clients. Another limitation is that there were only three male participants and 19 female participants. Also, all the participants had not worked in the field of HIV/AIDS. While all the participants had worked with clients at least for two years, not all of them were currently working in India. Even though the participants were not working in India, most of them had previous experiences working with clients.

Directions for future research

In the future, I want to interview Indian therapists who are trained in the USA but currently working in India. It would be useful to interview only participants who have worked with HIV positive clients in India. Specifically, I would like to research more fully on two topics that arose from the present research. The research questions for these two topics would be (a) Are family therapy theories ‘Eurocentric”? If so then how do we adapt them, and if not, could they be called universal theories? and (b) Can the metaphors given in this research be used cross culturally? That is, how can metaphors be used to better understand clinical issues in the USA such as how American family therapists view blurring their personal and professional roles? Another example might involve metaphors female and male therapists used for describing domestic violence and its treatment. Also, I would like to research more Indian male therapists and understand how they would address the issue of patriarchy in India.

Reflexive Comments

This research has not only helped me understand better how therapy can be
applied in India but has helped me understand myself more. When I came to the USA I thought it would not be difficult to adapt. When anybody asked me questions of how I was adapting I said “fine” and responded that I was taking the best of both worlds. Through my research I have come to more clearly understand better the struggle that I have gone through being an Indian in a foreign land. There is a constant struggle in balancing doing what Americans do or doing what is traditional for me. I have always thought of myself as a very open minded Indian who did not believe in certain Indian superstitions or traditions. But the longer I reside in the USA, the more I come to realize that I am not as open minded as I thought. When my mother or friend’s mother would do ‘Nazar’ or ‘Sutti’ (i.e. take salt and put it over the head of person and pray that any evil eye on the person should be removed), whenever I achieved something, I never thought that I would do ‘Sutti’ as well, but I do. At least once a month I do ‘sutti’ for my young daughter (Similarly, the results of this research study indicate how parents will go to any lengths for the well being and posterity of their children). I was going through the “hiccups of marriage” while I was studying, not realizing why I had made certain decisions. This research has given me a certain new perspective of myself as an Indian and why I have made certain decisions (e.g. I have seen that a lot of women in my family called their husbands “suniye” (listen to me) or “Jotika ke papa”, and never by their husbands first name, out of respect given to the man by his wife. But the man always calls his wife by her first name. I found it totally strange and had thought that I would call my husband by his first name. After marriage, I found myself calling my husband by all the other names like ‘suniye’ and ‘Tulsi ke papa’ rather than his first name. The pressure on calling him with respect was even more when I was living with my in-laws). I too
have an embedded fatalistic attitude. Belief in the importance of my child’s happiness comes before my own, and awareness for myself of the stigma of divorce, and the fear of being alone without a man in my life is much more prominent in my understanding of myself and my beliefs. It is an irony that I feel that I have learned about myself and my culture more in this foreign land than I did in my 23 years in India. This research has enriched me personally and professionally. I wonder if I actually hold on to my culture more here in the USA than I did in India because of the fear of not being accepted. Even if my daughter, who is an American citizen and I are not accepted here in this country at least we will be in India if we adhere to Indian values and hold on tight to Indian traditions.

Throughout my research, recognizing my roles as therapist and researcher I have addressed my own stigma about going for therapy. It never occurred to me that I too had accepted the Indian belief that only ‘crazy’ or weak people go for therapy. It has been a huge step in my life to realize that if an educated therapist like me cannot go for therapy then I cannot expect other less educated Indians to seek therapy for themselves. I also feel that although there are many things that make people different from one another, there are also many similarities too, like the red blood that runs between us, the love that we feel for our children, and possibly our hopes and dreams. This research has reminded me of this fact, too.
References


Cell for AIDS Research Action and Training (CARAT) (Eds.) (2001). Care Services for


Davar, B. V. (1999). Mental health of Indian women: A feminist agenda. New Delhi,
India: Sage Publication.


http://news.bbc.co.uk/1/hi/health/5030184.stm


Kim, E. Y., Bean, R. A., & Harper, J. M. (2004). Do general treatment guidelines for Asian American families have application to specific ethnic groups? The case of


Books.


Nath, R., & Craig, J. (1999). Practicing family therapy in India: How many people are

Natrajan, R., Thomas, V. (2002). Need for family therapy services for middle class families in India. Contemporary Family Therapy, 24, 483-503.


Paxton, S., Gonzales, G., Uppakaew, K., Abraham, K. K., Okta, S., Green, C., et al.


Ramsundaram, S. (2002). Can India avoid being devastated by HIV? Yes, by scaling up
local prevention efforts targeted at the most vulnerable groups. *British Medical Journal*, 324, 182-183.


Serovich, J. M., & Mosack, K. E. (2000). Training issues with supervisors of marriage and family therapists working with people living with HIV. *Journal of Marital and Family Therapy, 26*, 103-111.


New York: Routledge.


Cutoff: Bowen Family Systems Theory Perspectives. Thrice-Told Tales: Married

thinking. In M. McGoldrick (Ed.), *Re-visioning family therapy* (pp. 404-413).
New York: Guilford Press.


Whitaker, C.A. (1975). Psychotherapy of the absurd: With special emphasis on the
psychotherapy of aggression. *Family Process, 14*, 1-16.

& D. P. Kniskern (Eds.), *Handbook of family therapy* (pp. 187-225). New York:
Brunner/Mazel.

Norton and Company.

3.


American Association for Marriage and Family Therapy. Retrieved on November 22,
2006 from [www.aamft.org](http://www.aamft.org)

Journal of Family Therapy, 31*, 125-137.
Yorgerson, J. (2003). Table documenting the credibility of his data. From his dissertation at Virginia tech. (1 page).
APPENDICES

Appendix A: IRB form submitted to Review Board
Appendix B: Copy of IRB form sent to participants
Appendix C: IRB Approval (Scanned copy of original approval)
Appendix D: Letters, emails to the President of Indian Association of Family Therapy (IAFT).
Appendix E: Letters, emails to the directors of CO-AMFT accredited programs in USA universities.
Appendix F: Letters, emails to the moderator of the Indian marriage and family therapists yahoo list serve.
Appendix G: Letters, emails to the Indian MFT (referred by president of IAFT) to invite them to participate in my study.
Appendix H: Letters, emails to the Indian MFT (referred by director of CO-AMFT program) to invite them to participate in my study.
Appendix I: Letters, emails to the Indian MFT (referred by moderator of Indian MFT yahoo list serve) to invite them to participate in my study.
Appendix J: Second emails to the Indian MFT (referred by president of IAFT) to invite them to participate in my study.
Appendix K: Second emails to the Indian MFT (referred by director of CO-AMFT program) to invite them to participate in my study.
Appendix L: Second emails to the Indian MFT (referred by moderator of Indian MFT yahoo list serve) to invite them to participate in my study.
Appendix M: Third emails (final emails) to the Indian MFT (referred by president of
IAFT) to invite them to participate in my study.

Appendix N: Third emails (final emails) to the Indian MFT (referred by director of CO-AMFT program) to invite them to participate in my study.

Appendix O: Third emails (final emails) to the Indian MFT (referred by moderator of Indian MFT yahoo list serve) to invite them to participate in my study.

Appendix P: Demographic profile

Appendix Q: Interview questions
Appendix A:

IRB form submitted to Review Board

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Informed Consent for Participants in Research Projects Involving Human Subjects

Title of Project: Culturally Appropriate Indian Applications of Marriage and Family Therapy Interventions addressing HIV

Principal Investigator: Jotika Jagasia

I. Purpose of this Research/Project

The purpose of the study is to explore marriage and family therapy interventions which work best with HIV positive clients and their families in an Indian setting according to the perceptions of Indian family therapists.

II. Procedures

I will interview 15-20 Indian family therapists. I will secure email addresses of the Indian therapists from either the Directors of family therapy programs or president of Indian Association of Family Therapy (IAFT) or directory of members of American Association for Marriage and Family Therapy (AAMFT). I would appreciate your help in this study by agreeing to be interviewed over the telephone. Your participation is voluntary. You may refuse to participate and/or stop participating at any time.

You will be asked to fill out demographic information on an electronic survey. Once you have completed the survey, I will interview you briefly over the telephone.
III. Risks

There are no more than minimal risks associated with participation in the study. On rare occasions, discussing therapeutic intervention which addresses HIV may cause the participant some psychological discomfort. If at any time during or after participating in the interview you experience psychological discomfort, you may contact me at the number below. The principle investigator and co-investigator have been trained on how to recognize emotional distress and ensure that any participants experiencing emotional distress receive appropriate support. Should you have other concerns than those which you feel comfortable disclosing to the researcher, you can contact the Institutional Review Board with those concerns at the number listed below.

IV. Benefits

No promise or guarantee of benefits has been made to encourage you to participate. However, you will have the satisfaction of knowing that you have contributed important information to a study of how Indian marriage and family therapists apply Eurocentric family therapy interventions to their Indian HIV positive clients and their families. You can contact the researcher and request the results of the research.

V. Extent of Anonymity and Confidentiality

The information regarding your participation in the study will be kept confidential by using pseudo-names for each person instead of real names. Social security numbers or any personal information will not be used in place of names. At no time will the researchers release the results of the study to anyone other than individuals working on
the project without your written consent. The researcher will audio tape the telephone interviews only if you consent to it. The tapes will be kept in a locked box in a secure place. Only the researcher will have access to the tapes. If you wish to participate in the study but do not give consent to audio-tape, the researcher will interview you without audio-taping. The researcher will transcribe the data herself. It is possible that the Institutional Review Board (IRB) may view this study’s collected data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research. In some situations, it may be necessary for an investigator to break confidentiality. If child abuse is known or strongly suspected, investigators are required to notify the appropriate authorities. If a subject is believed to be a threat to herself/himself or others, the investigator should notify the appropriate authorities. These are the conditions under which the investigator may break confidentiality must be described.

VI. Compensation

There will be no compensation for the participants involved in this study.

VII. Freedom to Withdraw

You have the freedom to withdraw from the project at any time without being penalized in any capacity.

VIII. Approval of Research

This research project has been approved, as required by the Institutional Review Board
for Research Involving Human Subjects at Virginia Tech, by the Department of Human Development.

5/15/2007 4/30/2008 (option for renewal)
IRB Approval Date Approval Expiration Date

IX. Subject's Responsibilities

I voluntarily agree to participate in this study. I have the following responsibilities:

To fill out the demographic profile on the internet survey.

To participate in a ½ hour telephone interview with the researcher.

Ask questions of the researcher about the study at any time.

IX. Subject's Permission

I have read the Consent Form and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent to take part in the study. Submission of the demographic profile form is evidence of my voluntary willingness to participate.

Should I have any pertinent questions about this research or its conduct, and research subjects' rights, and whom to contact in the event of a research-related injury to the subject, I may contact:

Jotika Jagasia_________  jotika@vt.edu
Investigator Telephne/e-mail

162
This informed consent is valid from 5/15/2007 to 4/30/2008 (option for approval) with option for renewal.
IRB Approval Number: #07-272

[NOTE: Subjects must be given a complete copy (or duplicate original) of the signed Informed Consent.]
Appendix B

Copy of IRB form sent to participants

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Informed Consent for Participants in Research Projects Involving Human Subjects

Title of Project: Culturally Appropriate Indian Applications of Marriage and Family Therapy Interventions addressing HIV

Principal Investigator: Jotika Jagasia

I. Purpose of this Research/Project

The purpose of the study is to explore marriage and family therapy interventions which work best with HIV positive clients and their families in an Indian setting according to the perceptions of Indian family therapists.

II. Procedures

The researcher will interview 15-20 Indian family therapists. The researcher will secure email addresses of the Indian therapists from either the Directors of family therapy programs or president of Indian Association of Family Therapy (IAFT) or directory of members of American Association for Marriage and Family Therapy (AAMFT). The researcher would appreciate your help in this study by agreeing to be interviewed over the telephone. Your participation is voluntary. You may refuse to participate and/or stop participating at any time.

You will be asked to fill out demographic information on an electronic survey. Once you have completed the survey, the researcher will interview you briefly over the telephone.
III. Risks

There are no more than minimal risks associated with participation in the study. On rare occasions, discussing therapeutic intervention which addresses HIV may cause the participant some psychological discomfort. If at any time during or after participating in the interview you experience psychological discomfort, you may contact the researchers at the number below. The principle investigator and co-investigator have been trained on how to recognize emotional distress and ensure that any participants experiencing emotional distress receive appropriate support. Should you have other concerns than those which you feel comfortable disclosing to the researcher, you can contact the Institutional Review Board with those concerns at the number listed below.

IV. Benefits

No promise or guarantee of benefits has been made to encourage you to participate. However, you will have the satisfaction of knowing that you have contributed important information to a study of how Indian marriage and family therapists apply Eurocentric family therapy interventions to their Indian HIV positive clients and their families. You can contact the researcher and request the results of the research.

V. Extent of Anonymity and Confidentiality

The information regarding your participation in the study will be kept confidential by using pseudo-names for each person instead of real names. Social security numbers or any personal information will not be used in place of names. At no time will the
researchers release the results of the study to anyone other than individuals working on the project without your written consent. The researcher will audio tape the telephone interviews only if you consent to it. The tapes will be kept in a locked box in a secure place. Only the researcher will have access to the tapes. If you wish to participate in the study but do not give consent to audio-tape, the researcher will interview you without audio-taping. The researcher will transcribe the data herself. It is possible that the Institutional Review Board (IRB) may view this study’s collected data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research. In some situations, it may be necessary for an investigator to break confidentiality. If child abuse is known or strongly suspected, investigators are required to notify the appropriate authorities. If a subject is believed to be a threat to herself/himself or others, the investigator should notify the appropriate authorities. These are the conditions under which the investigator may break confidentiality must be described.

VI. Compensation

There will be no compensation for the participants involved in this study.

VII. Freedom to Withdraw

You have the freedom to withdraw from the project at any time without being penalized in any capacity.

VIII. Approval of Research
This research project has been approved, as required by the Institutional Review Board for Research Involving Human Subjects at Virginia Tech, by the Department of Human Development.

5/15/2007

IRB Approval Date

4/30/2008 (option for renewal)

Approval Expiration Date

IX. Subject's Responsibilities

I voluntarily agree to participate in this study. I have the following responsibilities:

To fill out the demographic profile on the internet survey.

To participate in a ½ hour telephone interview with the researcher.

Ask questions of the researcher about the study at any time.

X. Subject's Permission

I have read the Consent Form and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent to take part in the study. Submission of the demographic profile form is evidence of my voluntary willingness to participate.

___________________________________________ Date

Signature of Participant

XI. Subject's Consent to Audiotape

Please check one: I choose to _________ choose not to _________ be audio taped for the
purpose of this study. I understand I am to use pseudo names (not actual names) in
talking about myself or others.

________________________________________ Date_________________
Signature of Participant

Should I have any pertinent questions about this research or its conduct, and research
subjects' rights, and whom to contact in the event of a research-related injury to the
subject, I may contact:

Jotika Jagasia          jotika@vt.edu
Investigator          Telephone/e-mail

Fred Piercy, PhD          piercy@vt.edu/540-231-6110
Faculty Advisor        Telephone/e-mail

_________________________________________ ________________________
Departmental Reviewer/Department Head Telephone/e-mail

David M. Moore 540-231-4991/moored@vt.edu
Chair, Virginia Tech Institutional Review
Board for the Protection of Human Subjects

Office of Research Compliance

1880 Pratt Drive, Suite 2006 (0497)

Blacksburg, VA 24061

This informed consent is valid from 5/15/2007 to 4/30/2008 (option for approval) with option for renewal.

IRB Approval Number: #07-272

[NOTE: Subjects must be given a complete copy (or duplicate original) of the signed Informed Consent.]
Appendix C

IRB Approval

DATE:      May 15, 2007

MEMORANDUM

TO:        Fred P. Piercy
           Jotika Jagasia

FROM:      David M. Moore

SUBJECT:   IRB Expedited Approval: “Culturally Appropriate Indian Applications of Marriage and Family Therapy Interventions Addressing HIV”, IRB # 07-272

This memo is regarding the above-mentioned protocol. The proposed research is eligible for expedited review according to the specifications authorized by 45 CFR 46.110 and 21 CFR 56.110. As Chair of the Virginia Tech Institutional Review Board, I have granted approval to the study for a period of 12 months, effective May 15, 2007.

As an investigator of human subjects, your responsibilities include the following:

1. Report promptly proposed changes in previously approved human subject research activities to the IRB, including changes to your study forms, procedures and investigators, regardless of how minor. The proposed changes must not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
2. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.
3. Report promptly to the IRB of the study's closing (i.e., data collecting and data analysis complete at Virginia Tech). If the study is to continue past the expiration date (listed above), investigators must submit a request for continuing review prior to the continuing review due date (listed above). It is the researcher's responsibility to obtain re-approval from the IRB before the study's expiration date.
4. If re-approval is not obtained (unless the study has been reported to the IRB as closed) prior to the expiration date, all activities involving human subjects and data analysis must cease immediately, except where necessary to eliminate apparent immediate hazards to the subjects.

Important:
If you are conducting federally funded non-exempt research, this approval letter must state that the IRB has compared the OSP grant application and IRB application and found the documents to be consistent. Otherwise, this approval letter is invalid for OSP to release funds. Visit our website at http://www.irb.vt.edu/pages/newstudy.htm#OSP for further information.

cc: File
Appendix D

Letters, emails to the President of Indian Association of Family Therapy (IAFT).

Dear President of Indian Association of Family Therapy (IAFT),

I am a doctoral candidate at Virginia Tech in marriage and family therapy. My dissertation research will focus on how Indian marriage and family therapists would adopt family therapy interventions to address issues related to HIV-positive clients and their families in India. Consequently, I would like to invite your Indian graduate students and alumni to take part. **Would you please send me the names and contact information/email addresses of members of your organization (I.A.F.T.)?**

Thank you for your help.

Sincerely,

Jotika Jagasia, M.S.W.

Doctoral candidate

Virginia Polytechnic Institute and State University

Fred Piercy, Ph.D.

Professor of Family Therapy

Doctoral Advisor

Virginia Polytechnic Institute and State University
Appendix E

Letters, emails to the directors of CO-AMFT accredited programs in USA

universities Dear MFT Program Director,

I am a doctoral candidate at Virginia Tech in marriage and family therapy. My dissertation research will focus on how Indian marriage and family therapists would adopt family therapy interventions to address issues related to HIV-positive clients and their families in India. Consequently, I would like to invite your Indian graduate students and alumni to take part. Would you please send me the names and contact information/email addresses of Indian graduate students or alumni in your program?

Thank you for your help.

Sincerely,

Jotika Jagasia, M.S.W.
Doctoral candidate
Virginia Polytechnic Institute and State University

Fred Piercy, Ph.D.
Professor of Family Therapy
Doctoral Advisor
Virginia Polytechnic Institute and State University
Appendix F

Letters, emails to the moderator of the Indian marriage and family therapists yahoo list serve.

Dear Moderator of Indian Association of Marriage and Family Therapy Yahoo List Serve,

I am a doctoral candidate at Virginia Tech in marriage and family therapy. My dissertation research will focus on how Indian marriage and family therapists would adopt family therapy interventions to address issues related to HIV-positive clients and their families in India. Consequently, I would like to invite your Indian graduate students and alumni to take part. Would you please send me the names and contact information/email addresses of members of the Indian marriage and family therapy yahoo list serve?

Thank you for your help.

Sincerely,

Jotika Jagasia, M.S.W.
Doctoral candidate
Virginia Polytechnic Institute and State University

Fred Piercy, Ph.D.
Professor of Family Therapy
Doctoral Advisor
Virginia Polytechnic Institute and State University
Appendix G

Letters, emails to the Indian MFT (referred by president of IAFT) to invite them to participate in my study.

Dear Indian Marriage and Family Therapist,

I am a doctoral candidate in marriage and family therapy at Virginia Tech. I got your reference from the president of the Indian association of family therapy (IAFT). For my dissertation research I will be learning from Indian family therapists like yourself how family therapy interventions might be applied in culturally appropriate ways to HIV positive clients and their families in India. For the purpose of this study, I need to interview Indian marriage and family therapists like you. I know that you are busy, but because of the lack of research on how Eurocentric theories might be applied back home in India, I would greatly appreciate it if you would complete a short survey and interview. Your responses will remain completely anonymous.

To participate in this study, please click here:
https://survey.vt.edu/survey/entry.jsp?id=1161203291185
If that doesn't work, try cutting and pasting the address into the web browser. It will only take 5 to 8 minutes. Filling and submission of the demographic profile survey is evidence of your voluntary willingness to participate in the study. The second part of my study will involve a short (about 30 minutes) telephone interview. To show my appreciation, I will be happy to share a summary of my findings with you. I hope you will agree to take part in my study.

Also, please send me your telephone number and the day; date, time I can call you for a telephone interview. During this interview I will ask you a few questions on adapting Eurocentric marriage and family therapy interventions related to HIV issues that many professionals are facing in India. The interview questions that I will ask you during the phone interview is given below.

1. Can you please elaborate on your practice as a marriage and family therapist?
2. In your clinical practice have you ever done therapy with an HIV positive person? Can you elaborate on that particular case?
3. How did you handle that case and what marriage and family therapy interventions did you use? (Skip to question 5 if the case was in India)
4. How would you handle that scenario differently if it was in India using marriage and family therapy theories?
5. What metaphor would you apply to Eurocentric theories/interventions applied to the Indian context?
6. What are the unique issues a family therapist might face in the Indian culture specifically relating to HIV?
7. How might family therapy be adapted in India to deal with HIV issues?
8. What one family therapy intervention or technique do you think will best fit an Indian culture? Why?
9. Can you tell me one family therapy intervention or technique you think will not fit an Indian culture? Why not?
10. What difficulties you see yourself facing when you apply Eurocentric theories of family therapy in an Indian setting?
11. What can you recommend that should change before we apply Eurocentric interventions to Indian families?
12. Please read the following vignette and answer the following questions:
   • A couple is pressured by the wife’s mother-in-law to have a child. The couple has two girls already but the mother in law wants a boy to inherit their lineage. She insists her son and daughter-in-law should have a boy child. The son is HIV positive but has not disclosed his status to his mother and other family members except his wife. The mother in-law has threatened her daughter-in-law that she would ask her son to divorce her and marry another woman if she did not give her a grandson.

The questions are:
Q a. What marriage and family therapy interventions would you use in the above vignette which will be most adaptable in Indian context?
Q b. What interventions would you use to address the gender and power issues involved in the scenario?

Thank you for your cooperation and help.
Sincerely,

Jotika Jagasia, M.S.W.
Doctoral candidate
Virginia Polytechnic Institute and State University

Fred Piercy, Ph.D.
Professor of Family Therapy
Doctoral Advisor
Virginia Polytechnic Institute and State University
Appendix H

Letters, emails to the Indian MFT (referred by director of CO-AMFT program) to invite them to participate in my study.

Dear Indian Marriage and Family Therapist,

I am a doctoral candidate in marriage and family therapy at Virginia Tech. I got your reference from the director of your program. For my dissertation research I will be learning from Indian family therapists like yourself how family therapy interventions might be applied in culturally appropriate ways to HIV positive clients and their families in India. For the purpose of this study, I need to interview Indian marriage and family therapists like you. I know that you are busy, but because of the lack of research on how Eurocentric theories might be applied back home in India, I would greatly appreciate it if you would complete a short survey and interview. Your responses will remain completely anonymous.

To participate in this study, please click here:
https://survey.vt.edu/survey/entry.jsp?id=1161203291185
If that doesn't work, try cutting and pasting the address into the web browser. It will only take 5 to 8 minutes. Filling and submission of the demographic profile survey is evidence of your voluntary willingness to participate in the study. The second part of my study will involve a short (about 30 minutes) telephone interview. To show my appreciation, I will be happy to share a summary of my findings with you. I hope you will agree to take part in my study.

Also, please send me your telephone number and the day; date, time I can call you for a telephone interview. During this interview I will ask you a few questions on adapting Eurocentric marriage and family therapy interventions related to HIV issues that many professionals are facing in India. The interview questions that I will ask you during the phone interview is given below.

1. Can you please elaborate on your practice as a marriage and family therapist?
2. In your clinical practice have you ever done therapy with an HIV positive person? Can you elaborate on that particular case?
3. How did you handle that case and what marriage and family therapy interventions did you use?
(Skip to question 5 if the case was in India)
4. How would you handle that scenario differently if it was in India using marriage and family therapy theories?
5. What metaphor would you apply to Eurocentric theories/interventions applied to the Indian context?
6. What are the unique issues a family therapist might face in the Indian culture specifically relating to HIV?
7. How might family therapy be adapted in India to deal with HIV issues?
8. What one family therapy intervention or technique do you think will best fit an Indian culture? Why?
9. Can you tell me one family therapy intervention or technique you think will not
fit an Indian culture? Why not?
10. What difficulties you see yourself facing when you apply Eurocentric theories of family therapy in an Indian setting?
11. What can you recommend that should change before we apply Eurocentric interventions to Indian families?
12. Please read the following vignette and answer the following questions:
   • A couple is pressured by the wife’s mother-in-law to have a child. The couple has two girls already but the mother in law wants a boy to inherit their lineage. She insists her son and daughter-in-law should have a boy child. The son is HIV positive but has not disclosed his status to his mother and other family members except his wife. The mother in-law has threatened her daughter-in-law that she would ask her son to divorce her and marry another woman if she did not give her a grandson.

   The questions are:
   Q a. What MFT interventions would you use in the above vignette which will be most adaptable in Indian context?
   Q b. What interventions would you use to address the gender and power issues involved in the scenario?

Thank you for your cooperation and help.
Sincerely,

Jotika Jagasia, M.S.W.
Doctoral candidate
Virginia Polytechnic Institute and State University

Fred Piercy, Ph.D.
Professor of Family Therapy
Doctoral Advisor
Virginia Polytechnic Institute and State University
Appendix I

Letters, emails to the Indian MFT (referred by moderator of Indian MFT yahoo list serve) to invite them to participate in my study.

Dear Indian Marriage and Family Therapist,

I am a doctoral candidate in marriage and family therapy at Virginia Tech. I got your reference from the moderator of the Indian marriage and family therapists yahoo list serve. For my dissertation research I will be learning from Indian family therapists like yourself how family therapy interventions might be applied in culturally appropriate ways to HIV positive clients and their families in India. For the purpose of this study, I need to interview Indian marriage and family therapists like you. I know that you are busy, but because of the lack of research on how Eurocentric theories might be applied back home in India, I would greatly appreciate it if you would complete a short survey and interview.

Your responses will remain completely anonymous.

To participate in this study, please click here:
https://survey.vt.edu/survey/entry.jsp?id=1161203291185

If that doesn't work, try cutting and pasting the address into the web browser. It will only take 5 to 8 minutes. Filling and submission of the demographic profile survey is evidence of your voluntary willingness to participate in the study. The second part of my study will involve a short (about 30 minutes) telephone interview. To show my appreciation, I will be happy to share a summary of my findings with you. I hope you will agree to take part in my study.

Also, please send me your telephone number and the day; date, time I can call you for a telephone interview. During this interview I will ask you a few questions on adapting Eurocentric marriage and family therapy interventions related to HIV issues that many professionals are facing in India. The interview questions that I will ask you during the phone interview is given below.

1. Can you please elaborate on your practice as a marriage and family therapist?
2. In your clinical practice have you ever done therapy with an HIV positive person? Can you elaborate on that particular case?
3. How did you handle that case and what marriage and family therapy interventions did you use?
(Skip to question 5 if the case was in India)
4. How would you handle that scenario differently if it was in India using marriage and family therapy theories?
5. What metaphor would you apply to Eurocentric theories/interventions applied to the Indian context?
6. What are the unique issues a family therapist might face in the Indian culture specifically relating to HIV?
7. How might family therapy be adapted in India to deal with HIV issues?
8. What one family therapy intervention or technique do you think will best fit an Indian culture? Why?
9. Can you tell me one family therapy intervention or technique you think will not fit an Indian culture? Why not?
10. What difficulties you see yourself facing when you apply Eurocentric theories of family therapy in an Indian setting?
11. What can you recommend that should change before we apply Eurocentric interventions to Indian families?
12. Please read the following vignette and answer the following questions:
   • A couple is pressured by the wife’s mother-in-law to have a child. The couple has two girls already but the mother in law wants a boy to inherit their lineage. She insists her son and daughter-in-law should have a boy child. The son is HIV positive but has not disclosed his status to his mother and other family members except his wife. The mother in-law has threatened her daughter-in-law that she would ask her son to divorce her and marry another woman if she did not give her a grandson.

The questions are:
Q a. What MFT interventions would you use in the above vignette which will be most adaptable in Indian context?
Q b. What interventions would you use to address the gender and power issues involved in the scenario?

Thank you for your cooperation and help.
Sincerely,

Jotika Jagasia, M.S.W.
Doctoral candidate
Virginia Polytechnic Institute and State University

Fred Piercy, Ph.D.
Professor of Family Therapy
Doctoral Advisor
Virginia Polytechnic Institute and State University
Appendix J

Second emails to the Indian MFT (referred by president of IAFT) to invite them to participate in my study.

Dear Indian Marriage and Family Therapist,

I am from India and currently a doctoral candidate in marriage and family therapy at Virginia Tech. I got your name from the president of the Indian Association of Family Therapy. For my dissertation research I will be learning from Indian family therapists like yourself how family therapy interventions might be applied in culturally appropriate ways to HIV positive clients and their families in India. I appreciate your time. For the purpose of this study I need to interview Indian marriage and family therapists like you. I know that you are busy, but because of the lack of research on how Eurocentric theories might be applied back home in India, I would greatly appreciate your thoughts and experiences in this area. My study consists of a short survey and a telephone interview.

Your responses will remain completely anonymous.

To participate in this study, please click here: https://survey.vt.edu/survey/entry.jsp?id=1161203291185
If that doesn't work, try cutting and pasting the address into the web browser.

It will only take 5 to 8 minutes. Filling and submission of the demographic profile survey is evidence of your voluntary willingness to participate in the study. The second part of my study will involve a short (about 30 minutes) telephone interview. To show my appreciation, I will be happy to share a summary of my findings with you at the completion of my research. I hope you will agree to take part in my study.

Also, please send me your telephone number and the days, dates, and times I could call you for a telephone interview. During this telephone interview I will ask you a few questions on adapting Eurocentric marriage and family therapy interventions related to HIV issues to Indian culture and practice. I have provided you with the interview questions I will use during the telephone interview. Please feel free to review them.

13. Can you please elaborate on your practice as a marriage and family therapist?
14. In your clinical practice have you ever done therapy with an HIV positive person? Can you elaborate, generally, on some of the details of that particular case?
15. How did you handle that case and what marriage and family therapy interventions did you use?
(Skip to question 5 if the case was in India)
16. How would you handle that scenario differently if it was in India using marriage and family therapy theories?
17. What metaphor would you apply to Eurocentric theories/interventions applied to the Indian context?
18. What are the unique issues a family therapist might face in the Indian culture specifically relating to HIV?
19. How might family therapy be adapted in India to deal with HIV issues?
20. What one family therapy intervention or technique do you think will best fit an Indian culture in working with families in general in India, HIV
21. Can you tell me one family therapy intervention or technique you think will **not** fit an Indian culture? Why not?

22. What difficulties you see yourself facing when you apply Eurocentric theories of family therapy in an Indian setting?

23. What can you recommend that should change before we apply Eurocentric interventions to Indian families?

24. Please read the following vignette and answer the following questions:

- A couple is pressured by the wife’s mother-in-law to have a child. The couple has two girls already but the mother in law wants a boy to inherit their lineage. She insists her son and daughter-in-law should have a boy child. The son is HIV positive but has not disclosed his status to his mother and other family members except his wife. The mother in-law has threatened her daughter-in-law that she would ask her son to divorce her and marry another woman if she did not give her a grandson.

The questions are:

**Q a.** What MFT interventions would you use in the above vignette which will be most adaptable in Indian context?

**Q b.** What interventions would you use to address the gender and power issues involved in the scenario?

Thank you for your cooperation and help.

Sincerely,

Jotika Jagasia, M.S.W.
Doctoral candidate
Virginia Polytechnic Institute and State University
Phone: 510-386-4006
Email: jotika@vt.edu

Fred Piercy, Ph.D.
Professor of Family Therapy
Doctoral Advisor
Virginia Polytechnic Institute and State University
Appendix K

Second emails to the Indian MFT (referred by director of CO-AMFT program) to invite them to participate in my study.

Dear Indian Marriage and Family Therapist,

I am from India and currently a doctoral candidate in marriage and family therapy at Virginia Tech. I got your name from the director of your program. For my dissertation research I will be learning from Indian family therapists like yourself how family therapy interventions might be applied in culturally appropriate ways to HIV positive clients and their families in India. I appreciate your time. For the purpose of this study I need to interview Indian marriage and family therapists like you. I know that you are busy, but because of the lack of research on how Eurocentric theories might be applied back home in India, I would greatly appreciate your thoughts and experiences in this area. My study consists of a short survey and a telephone interview.

Your responses will remain completely anonymous.

To participate in this study, please click here: https://survey.vt.edu/survey/entry.jsp?id=1161203291185

If that doesn't work, try cutting and pasting the address into the web browser.

It will only take 5 to 8 minutes. Filling and submission of the demographic profile survey is evidence of your voluntary willingness to participate in the study. The second part of my study will involve a short (about 30 minutes) telephone interview. To show my appreciation, I will be happy to share a summary of my findings with you at the completion of my research. I hope you will agree to take part in my study.

Also, please send me your telephone number and the days, dates, and times I could call you for a telephone interview. During this telephone interview I will ask you a few questions on adapting Eurocentric marriage and family therapy interventions related to HIV issues to Indian culture and practice. I have provided you with the interview questions I will use during the telephone interview. Please feel free to review them.

25. Can you please elaborate on your practice as a marriage and family therapist?
26. In your clinical practice have you ever done therapy with an HIV positive person? Can you elaborate, generally, on some of the details of that particular case?
27. How did you handle that case and what marriage and family therapy interventions did you use?

(Skip to question 5 if the case was in India)
28. How would you handle that scenario differently if it was in India using marriage and family therapy theories?
29. What metaphor would you apply to Eurocentric theories/interventions applied to the Indian context?
30. What are the unique issues a family therapist might face in the Indian culture specifically relating to HIV?
31. How might family therapy be adapted in India to deal with HIV issues?
32. What one family therapy intervention or technique do you think will best fit an Indian culture in working with families in general in India, HIV
related or other wise? Why?

33. Can you tell me one family therapy intervention or technique you think will not fit an Indian culture? Why not?

34. What difficulties you see yourself facing when you apply Eurocentric theories of family therapy in an Indian setting?

35. What can you recommend that should change before we apply Eurocentric interventions to Indian families?

36. Please read the following vignette and answer the following questions:

- A couple is pressured by the wife’s mother-in-law to have a child. The couple has two girls already but the mother in law wants a boy to inherit their lineage. She insists her son and daughter-in-law should have a boy child. The son is HIV positive but has not disclosed his status to his mother and other family members except his wife. The mother in-law has threatened her daughter-in-law that she would ask her son to divorce her and marry another woman if she did not give her a grandson.

The questions are:
Q a. What MFT interventions would you use in the above vignette which will be most adaptable in Indian context?
Q b. What interventions would you use to address the gender and power issues involved in the scenario?

Thank you for your cooperation and help.

Sincerely,

Jotika Jagasia, M.S.W.
Doctoral candidate
Virginia Polytechnic Institute and State University
Phone: 510-386-4006
Email: jotika@vt.edu

Fred Piercy, Ph.D.
Professor of Family Therapy
Doctoral Advisor
Virginia Polytechnic Institute and State University
Appendix L

Second emails to the Indian MFT (referred by moderator of Indian MFT yahoo list serve) to invite them to participate in my study.

Dear Indian Marriage and Family Therapist,

I am from India and currently a doctoral candidate in marriage and family therapy at Virginia Tech. I got your name from the moderator of the yahoo Indian family therapy list serve. For my dissertation research I will be learning from Indian family therapists like yourself how family therapy interventions might be applied in culturally appropriate ways to HIV positive clients and their families in India. I appreciate your time. For the purpose of this study I need to interview Indian marriage and family therapists like you. I know that you are busy, but because of the lack of research on how Eurocentric theories might be applied back home in India, I would greatly appreciate your thoughts and experiences in this area. My study consists of a short survey and a telephone interview.

Your responses will remain completely anonymous.

To participate in this study, please click here: https://survey.vt.edu/survey/entry.jsp?id=1161203291185

If that doesn't work, try cutting and pasting the address into the web browser.

It will only take 5 to 8 minutes. Filling and submission of the demographic profile survey is evidence of your voluntary willingness to participate in the study. The second part of my study will involve a short (about 30 minutes) telephone interview. To show my appreciation, I will be happy to share a summary of my findings with you at the completion of my research. I hope you will agree to take part in my study.

Also, please send me your telephone number and the days, dates, and times I could call you for a telephone interview. During this telephone interview I will ask you a few questions on adapting Eurocentric marriage and family therapy interventions related to HIV issues to Indian culture and practice. I have provided you with the interview questions I will use during the telephone interview. Please feel free to review them.

37. Can you please elaborate on your practice as a marriage and family therapist?
38. In your clinical practice have you ever done therapy with an HIV positive person? Can you elaborate, generally, on some of the details of that particular case?
39. How did you handle that case and what marriage and family therapy interventions did you use?
(Skip to question 5 if the case was in India)
40. How would you handle that scenario differently if it was in India using marriage and family therapy theories?
41. What metaphor would you apply to Eurocentric theories/interventions applied to the Indian context?
42. What are the unique issues a family therapist might face in the Indian culture specifically relating to HIV?
43. How might family therapy be adapted in India to deal with HIV issues?
44. What one family therapy intervention or technique do you think will best fit an Indian culture in working with families in general in India, HIV
related or otherwise? Why?
45. Can you tell me one family therapy intervention or technique you think will **not** fit an Indian culture? Why not?
46. What difficulties you see yourself facing when you apply Eurocentric theories of family therapy in an Indian setting?
47. What can you recommend that should change before we apply Eurocentric interventions to Indian families?
48. Please read the following vignette and answer the following questions:
   • A couple is pressured by the wife’s mother-in-law to have a child. The couple has two girls already but the mother in law wants a boy to inherit their lineage. She insists her son and daughter-in-law should have a boy child. The son is HIV positive but has not disclosed his status to his mother and other family members except his wife. The mother in-law has threatened her daughter-in-law that she would ask her son to divorce her and marry another woman if she did not give her a grandson.

The questions are:
Q a. What MFT interventions would you use in the above vignette which will be most adaptable in Indian context?
Q b. What interventions would you use to address the gender and power issues involved in the scenario?

Thank you for your cooperation and help.
Sincerely,

Jotika Jagasia, M.S.W.
Doctoral candidate
Virginia Polytechnic Institute and State University
Phone: 510-386-4006
Email: jotika@vt.edu

Fred Piercy, Ph.D.
Professor of Family Therapy
Doctoral Advisor
Virginia Polytechnic Institute and State University
Appendix M

Third emails (final emails) to the Indian MFT (referred by president of IAFT) to invite them to participate in my study.

Dear Indian Marriage and Family Therapist,
Please disregard this letter if you have already filled out the survey and given me a time for the phone interview.

I am from India and currently a doctoral candidate in marriage and family therapy at Virginia Tech. I got your name from the president of the Indian Association of Family Therapy. For my dissertation research I will be learning from Indian family therapists like yourself how family therapy interventions might be applied in culturally appropriate ways to HIV positive clients and their families in India. I appreciate your time. For the purpose of this study I need to interview Indian marriage and family therapists like you. I know that you are busy, but because of the lack of research on how Eurocentric theories might be applied back home in India, I would greatly appreciate your thoughts and experiences in this area. My study consists of a short survey and a telephone interview.

Your responses will remain completely anonymous.

To participate in this study, please click here: https://survey.vt.edu/survey/entry.jsp?id=1161203291185
If that doesn't work, try cutting and pasting the address into the web browser.

It will only take 5 to 8 minutes. Filling and submission of the demographic profile survey is evidence of your voluntary willingness to participate in the study. The second part of my study will involve a short (about 30 minutes) telephone interview. To show my appreciation, I will be happy to share a summary of my findings with you at the completion of my research. I hope you will agree to take part in my study.

Also, please send me your telephone number and the days, dates, and times I could call you for a telephone interview. During this telephone interview I will ask you a few questions on adapting Eurocentric marriage and family therapy interventions related to HIV issues to Indian culture and practice. I have provided you with the interview questions I will use during the telephone interview. Please feel free to review them.

49. Can you please elaborate on your practice as a marriage and family therapist?

50. In your clinical practice have you ever done therapy with an HIV positive person? Can you elaborate, generally, on some of the details of that particular case?

51. How did you handle that case and what marriage and family therapy interventions did you use?
(Skip to question 5 if the case was in India)

52. How would you handle that scenario differently if it was in India using marriage and family therapy theories?

53. What metaphor would you apply to Eurocentric theories/interventions applied to the Indian context?

54. What are the unique issues a family therapist might face in the Indian culture specifically relating to HIV?

55. How might family therapy be adapted in India to deal with HIV issues?
56. What one family therapy intervention or technique do you think will best fit an Indian culture in working with families in general in India, HIV related or otherwise? Why?
57. Can you tell me one family therapy intervention or technique you think will not fit an Indian culture? Why not?
58. What difficulties you see yourself facing when you apply Eurocentric theories of family therapy in an Indian setting?
59. What can you recommend that should change before we apply Eurocentric interventions to Indian families?
60. Please read the following vignette and answer the following questions:
   - A couple is pressured by the wife’s mother-in-law to have a child. The couple has two girls already but the mother in law wants a boy to inherit their lineage. She insists her son and daughter-in-law should have a boy child. The son is HIV positive but has not disclosed his status to his mother and other family members except his wife. The mother in-law has threatened her daughter-in-law that she would ask her son to divorce her and marry another woman if she did not give her a grandson.

The questions are:
Q a. What MFT interventions would you use in the above vignette which will be most adaptable in Indian context?
Q b. What interventions would you use to address the gender and power issues involved in the scenario?

Thank you for your cooperation and help.
Sincerely,

Jotika Jagasia, M.S.W.
Doctoral candidate
Virginia Polytechnic Institute and State University
Phone: 510-386-4006
Email: jotika@vt.edu

Fred Piercy, Ph.D.
Professor of Family Therapy
Doctoral Advisor
Virginia Polytechnic Institute and State University
Appendix N

Third emails (final emails) to the Indian MFT (referred by director of CO-AMFT program) to invite them to participate in my study.

Dear Indian Marriage and Family Therapist,

Please disregard this letter if you have already filled out the survey and given me a time for the phone interview.

I am from India and currently a doctoral candidate in marriage and family therapy at Virginia Tech. I got your name from the director of your program. For my dissertation research I will be learning from Indian family therapists like yourself how family therapy interventions might be applied in culturally appropriate ways to HIV positive clients and their families in India. I appreciate your time. For the purpose of this study I need to interview Indian marriage and family therapists like you. I know that you are busy, but because of the lack of research on how Eurocentric theories might be applied back home in India, I would greatly appreciate your thoughts and experiences in this area. My study consists of a short survey and a telephone interview.

Your responses will remain completely anonymous.

To participate in this study, please click here: https://survey.vt.edu/survey/entry.jsp?id=1161203291185

If that doesn't work, try cutting and pasting the address into the web browser.

It will only take 5 to 8 minutes. Filling and submission of the demographic profile survey is evidence of your voluntary willingness to participate in the study. The second part of my study will involve a short (about 30 minutes) telephone interview. To show my appreciation, I will be happy to share a summary of my findings with you at the completion of my research. I hope you will agree to take part in my study.

Also, please send me your telephone number and the days, dates, and times I could call you for a telephone interview. During this telephone interview I will ask you a few questions on adapting Eurocentric marriage and family therapy interventions related to HIV issues to Indian culture and practice. I have provided you with the interview questions I will use during the telephone interview. Please feel free to review them.

61. Can you please elaborate on your practice as a marriage and family therapist?
62. In your clinical practice have you ever done therapy with an HIV positive person? Can you elaborate, generally, on some of the details of that particular case?
63. How did you handle that case and what marriage and family therapy interventions did you use?
(Skip to question 5 if the case was in India)
64. How would you handle that scenario differently if it was in India using marriage and family therapy theories?
65. What metaphor would you apply to Eurocentric theories/interventions applied to the Indian context?
66. What are the unique issues a family therapist might face in the Indian culture specifically relating to HIV?
67. How might family therapy be adapted in India to deal with HIV issues?
68. What one family therapy intervention or technique do you think will best fit an Indian culture in working with families in general in India, HIV related or otherwise? Why?

69. Can you tell me one family therapy intervention or technique you think will not fit an Indian culture? Why not?

70. What difficulties you see yourself facing when you apply Eurocentric theories of family therapy in an Indian setting?

71. What can you recommend that should change before we apply Eurocentric interventions to Indian families?

72. Please read the following vignette and answer the following questions:

- A couple is pressured by the wife’s mother-in-law to have a child. The couple has two girls already but the mother in law wants a boy to inherit their lineage. She insists her son and daughter-in-law should have a boy child. The son is HIV positive but has not disclosed his status to his mother and other family members except his wife. The mother in-law has threatened her daughter-in-law that she would ask her son to divorce her and marry another woman if she did not give her a grandson.

The questions are:

Q a. What MFT interventions would you use in the above vignette which will be most adaptable in Indian context?

Q b. What interventions would you use to address the gender and power issues involved in the scenario?

Thank you for your cooperation and help.

Sincerely,

Jotika Jagasia, M.S.W.
Doctoral candidate
Virginia Polytechnic Institute and State University
Phone: 510-386-4006
Email: jotika@vt.edu

Fred Piercy, Ph.D.
Professor of Family Therapy
Doctoral Advisor
Virginia Polytechnic Institute and State University
Appendix O

Third emails (final emails) to the Indian MFT (referred by moderator of Indian MFT yahoo list serve) to invite them to participate in my study.

Dear Indian Marriage and Family Therapist,
Please disregard this letter if you have already filled out the survey and given me a time for the phone interview.

I am from India and currently a doctoral candidate in marriage and family therapy at Virginia Tech. I got your name from the moderator of the yahoo Indian family therapy list serve. For my dissertation research I will be learning from Indian family therapists like yourself how family therapy interventions might be applied in culturally appropriate ways to HIV positive clients and their families in India. I appreciate your time. For the purpose of this study I need to interview Indian marriage and family therapists like you. I know that you are busy, but because of the lack of research on how Eurocentric theories might be applied back home in India, I would greatly appreciate your thoughts and experiences in this area. My study consists of a short survey and a telephone interview.

Your responses will remain completely anonymous.

To participate in this study, please click here: https://survey.vt.edu/survey/entry.jsp?id=1161203291185
If that doesn't work, try cutting and pasting the address into the web browser.

It will only take 5 to 8 minutes. Filling and submission of the demographic profile survey is evidence of your voluntary willingness to participate in the study. The second part of my study will involve a short (about 30 minutes) telephone interview. To show my appreciation, I will be happy to share a summary of my findings with you at the completion of my research. I hope you will agree to take part in my study.

Also, please send me your telephone number and the days, dates, and times I could call you for a telephone interview. During this telephone interview I will ask you a few questions on adapting Eurocentric marriage and family therapy interventions related to HIV issues to Indian culture and practice. I have provided you with the interview questions I will use during the telephone interview. Please feel free to review them.

73. Can you please elaborate on your practice as a marriage and family therapist?
74. In your clinical practice have you ever done therapy with an HIV positive person? Can you elaborate, generally, on some of the details of that particular case?
75. How did you handle that case and what marriage and family therapy interventions did you use?
(Skip to question 5 if the case was in India)
76. How would you handle that scenario differently if it was in India using marriage and family therapy theories?
77. What metaphor would you apply to Eurocentric theories/interventions applied to the Indian context?
78. What are the unique issues a family therapist might face in the Indian culture specifically relating to HIV?
79. How might family therapy be adapted in India to deal with HIV issues?
80. What one family therapy intervention or technique do you think will best fit an Indian culture in working with families in general in India, HIV related or otherwise? Why?

81. Can you tell me one family therapy intervention or technique you think will not fit an Indian culture? Why not?

82. What difficulties you see yourself facing when you apply Eurocentric theories of family therapy in an Indian setting?

83. What can you recommend that should change before we apply Eurocentric interventions to Indian families?

84. Please read the following vignette and answer the following questions:
   - A couple is pressured by the wife’s mother-in-law to have a child. The couple has two girls already but the mother in law wants a boy to inherit their lineage. She insists her son and daughter-in-law should have a boy child. The son is HIV positive but has not disclosed his status to his mother and other family members except his wife. The mother in-law has threatened her daughter-in-law that she would ask her son to divorce her and marry another woman if she did not give her a grandson.

   The questions are:
   Q a. What MFT interventions would you use in the above vignette which will be most adaptable in Indian context?
   Q b. What interventions would you use to address the gender and power issues involved in the scenario?

Thank you for your cooperation and help.

Sincerely,

Jotika Jagasia, M.S.W.
Doctoral candidate
Virginia Polytechnic Institute and State University
Phone: 510-386-4006
Email: jotika@vt.edu

Fred Piercy, Ph.D.
Professor of Family Therapy
Doctoral Advisor
Virginia Polytechnic Institute and State University
Appendix P

Demographic Profile

Submission of the demographic profile is evidence of my voluntary willingness to participate in the study.

I give my voluntary consent to take part in the study.

a. Yes
b. No

1. Please indicate your gender
   a. Male
   b. Female

2. Were you born in India?
   a. Yes
   b. No

3. How long have you lived in India (in years)?

4. How strongly do you identify yourself as being an Indian? (1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree)

5. Have you received graduate training in marriage and family therapy:
   a. Through an marriage and family therapy graduate program in USA.
   b. Through a graduate program in another mental health discipline in the USA.
   c. Through a graduate program in India.
   d. Through any Indian training agency.
   e. Through NIMHANS, Bangalore.
f. Other (please specify)

6. Describe your clinical experience?

7. How long (in years) have you done therapy with clients?

8. How many hours a week do you provide direct client contact?

9. How long (in years) have you done therapy with clients in India?

10. Have you done therapy with any clients who are infected or affected by HIV/AIDS?
    
   a. Yes
   
   b. No

11. If yes how many?

12. Are you a member of American Association for Marriage and Family Therapy (AAMFT)?
    
   a. Yes
   
   b. No

13. Are you a member of Indian Association for Family Therapy (IAFT)?
    
   a. Yes
   
   b. No

14. Have you published any articles on marriage and family therapy in a journal?
    
   a. Yes
   
   b. No

15. If yes how many?

16. Have you presented a paper on marriage and family therapy in a conference?
    
   a. Yes
b. No

17. Indicate the highest degree you have earned.
   a. Master’s degree
   b. Ph.D.
   c. Other (please specify)

18. If your answer for question 17 was “other” please specify what “other” is?

19. In what field is your degree?
   a. Marriage and family therapy
   b. Social Work
   c. Psychologist
   d. Psychiatry
   e. Counseling Education

20. Where did you get your Marriage and family therapy degree from?
   a. USA (please specify the university)
   b. Other (please specify the country and university)

21. Which of the following best represents your clinical orientation
   a. Experiential
   b. Strategic
   c. Structural
   d. Systemic (Milan)
   e. Solution-Focused
   f. Emotionally focused therapy
   g. Social constructivist (Narrative)
h. Behavioral

i. Bowen

j. Metaframeworks

k. Experiential

l. Other (please specify)

22. Which part of India are you from? (please specify the state)

23. What religion do you practice?
   a. Hindu
   b. Muslim
   c. Catholic Christian
   d. Protestant Christian
   e. Other (please specify)
   f. No religion practiced

24. What languages do you speak fluently?

25. Marital Status
   a. Single, never married
   b. Single, divorced
   c. Married
   d. Divorced, but remarried
   e. Widowed, but remarried
   f. Widowed, but not remarried
   g. Separated

26. I give voluntary consent to be interviewed for the purpose of this study.
a. Yes

b. No

27. If you have given consent for the interview, then please give your contact phone number: Phone number: (nnn-nnn-nnnn, For India please specify your number after country code 91).

28. If you have given consent for the interview, then please give your preferred timings:

Date and time: Option 1: (mm/dd/yy, hh:mm AM/PM)

Date and time: Option 2: (mm/dd/yy, hh:mm AM/PM)

Please provide your time zone information: (Eastern, Central, Mountain, Pacific, Indian Standard Time)

29. I give voluntary consent to be audio-taped during the interview for the purpose of this study.

Thank you for your help.
Appendix Q

Interview questions for participants

1. Can you please elaborate on your practice as a marriage and family therapist?

2. In your clinical practice have you ever done therapy with an HIV positive person? Can you elaborate on that particular case?

3. How did you handle that case and what marriage and family therapy interventions did you use?

(Skip to question 5 if the case was in India)

4. How would you handle that scenario differently if it was in India using marriage and family therapy theories?

5. What metaphor would you apply to Eurocentric theories applied to the Indian context?

6. What are the unique issues a family therapist might face in the Indian culture specifically relating to HIV?

7. How might family therapy be adapted in India to deal with HIV issues?

8. What one family therapy intervention or technique do you think will best fit an Indian culture? Why?

9. Can you tell me one family therapy intervention or technique you think will not fit an Indian culture? Why not?

10. What difficulties you see yourself facing when you apply Eurocentric theories of family therapy in an Indian setting?

11. What can you recommend that should change before we apply
Eurocentric theories to Indian families?

12. I will read out a scenario to you. After I have read it out please answer the
questions given below:

• A couple is pressured by the wife’s mother-in-law to have a child. The
couple has two girls already but the mother in law wants a boy to
inherit their lineage. She insists her son and daughter-in-law should
have a boy child. The son is HIV positive but has not disclosed his
status to his mother and other family members except his wife. The
mother in-law has threatened her daughter-in-law that she would ask
her son to divorce her and marry another woman if she did not give her
a grandson.

The questions are:

Q a. What marriage and family therapy interventions would you use in the above
vignettes which will be most adaptable in Indian context?

Q b. What interventions will you use to address the gender and power issues involved in
the scenarios?
Curriculum Vitae

Jotika S. Jagasia

Business Address:
840 University City Blvd, Suite 1
Family Therapy Center, Virginia Tech
Blacksburg, VA 24061
Phone: (540) 231-7261, (540) 231-7209
Cell Phone: (510) 386-4006
Email: jotika@vt.edu, jotika19@hotmail.com

Education

2008 Virginia Polytechnic Institute and State University, Blacksburg, VA. Doctoral candidate in Marriage and Family Therapy, Department of Human Development. (Expected date of graduate May 2008). Dissertation Topic: Culturally Appropriate Indian Applications of Marriage and Family Therapy Interventions Explored Through an HIV Example


2000 St. Xavier's College, Bombay, India. Bachelors of Science, Life Science, Environmental Science & Pollution

Clinical Experience

2005/06 Marriage and family therapist (in training), Second Chance, Inc. Community Counseling Services, Fremont, CA. Duties: Counsel, couples, families, individuals, experiencing relational or personal problems due to alcohol or drug addiction and co-dependency, Survivors group therapy with women who have been sexually abused as children.

2005/04 Marriage and family therapist (in training), Virginia Polytechnic Institute and State University, Family Therapy Center, Blacksburg, VA. Duties: Counsel couples, individuals, and families experiencing a wide range of personal or relational problems.

2003/02 Social Worker, Aastha Counseling Center of TATA Institute of Social Sciences, Bombay India.
Duties: Counsel patients and families; provide outreach and referral services; conduct workshops and trainings for staff; develop programs for UNICEF and agency fundraising for treatment of HIV/AIDS; held workshops in schools, colleges, and communities on sexuality, STI, and HIV/AIDS.

2002

Social Work Intern, Psychiatric Diseases Hospital, Srinagar, Kashmir (India).
Duties: Counsel patients and families using psychiatric and family therapies; conduct research on understanding the psycho-social impact of insurgency (terrorism) on people of Kashmir. Clinical Experience continued

2002/01

Social Work Intern, Savera Counseling and Testing Center-- Shatabdi Hospital, Govandi, Mumbai (India).
Duties: Counseled individuals who tested for HIV/AIDS; served as liaison between medical profession and community; provided community outreach and educational services.

2001/00

Duties: Counseled senior citizens and their families; provided psycho-education and community outreach.

2000/1999

Counselor and Community Educator, Akanksha Foundation. Mumbai (India).
Duties: Counseled adolescent boys and girls who live in the slums about drug abuse, safer sex practices and teen pregnancy; conducted social advocacy; provided community education to children who come from low income households.

Research Experiences

2007/08
Graduate Research Assistant, Virginia Polytechnic Institute and State University, Blacksburg, VA.
Working on the literature review of protective factors of smoking among adolescent.
Supervisors: Dr. Peggy Meszaros

2006/07
Graduate Research Assistant, Virginia Polytechnic Institute and State University, Blacksburg, VA.
Working on the Add-health data set and research for child and development center for learning and research (CDCLR): conducting interviews, literature review. Computer skills in SPSS, SAS and STATA.
Supervisors: Dr Christine Kaestle and Dr Isabel Bradburn.

201

2004/05  **Graduate Research Assistant**, Virginia Polytechnic Institute and State University, Blacksburg, VA. Worked on two research teams using the *International Marriage and Family Therapist Survey* and *Experiences with Awareness of Diversity*; conducted qualitative data analysis; developed the survey, find articles for literature review, data collection, and open coding. Computer skills in In-Vivo and web-based survey.  
**Supervisors:** Dr Margaret Keeling, Dr Fred Piercy.

**Supervisors:** Dr Fred Piercy.

2003  **Graduate Research Assistant**, Virginia Polytechnic Institute and State University, Blacksburg, VA. Worked on research team focused on *Business Consultation in Marriage and Family Therapy*; find articles to write the literature review, and develop survey. Completed certification in training in Human Subject Protection. Computer skills in SPSS and SAS.  
**Supervisors:** Dr Annabeth Benningfield and Dr Scott Johnson.

**Teaching Experience**

2004  **Graduate Teaching Assistant**, Virginia Polytechnic Institute and State University, Blacksburg, VA.  
**Duties:** Served as a Teaching Assistant for HD 4374, Parent Education and Practice and HD 3324, Family Relationships; prepared student handouts; posted materials in Blackboard, an online instructional tool; proctored exams; assisted with class administration. Received a *Certificate of Appreciation* for outstanding performance and lasting contribution as a Graduate Teaching Assistant for *HD 4374, Parent Education and Practice*.

2005/04  **Graduate Instructor**, Virginia Polytechnic Institute and State University, Blacksburg, VA.  
**Duties:** Taught a class of 155 undergraduate students HD 3314, Human Sexuality, Spring 2005, Fall 2004, and 55 students in Spring 2004; prepared lectures and class assignments and guest presentations; wrote exams; developed activities for class, graded the exams and assignments. Supervising undergraduates and developed a good relation with them, and this bonding helped them confide their problems to me.
2003/02  **Instructor**, TATA Institute of Social Sciences, Bombay, India.  
**Duties:** Taught social work proficiency to hospital administration students; prepared lectures, and exams. This helped me understand the perspective of hospital administrators and doctors about social work.

2003-present  **Graduate Assistant**, Virginia Tech, Blacksburg, VA.  
**Duties:** Assistant to the Director of the Family Therapy Center and faculty of the College of Liberal Arts and Human Sciences’ Human Development department.

**Professional Affiliations**

2004-present  Member of the national honor society Kappa Omicron Nu, Omicron Beta Zeta Chapter.

2003-present  Student Member of the American Association for Marriage and Family Therapy.

2002-present  Member of the Mumbai Thalassaemia Society (Thalassaemia is a blood disorder; this organization supports individuals with this disorder)

**Presentations**

Jotika, J. (2007). Held a round table discussion on “Marriage and Family Therapy Theories used by Indian Therapist to Address Challenges in HIV in Culturally Appropriate way in India” at the Quint State conference, Virginia Tech, Blacksburg, VA.


Keeling, M., Piercy, F., Jagasia, J., Glass, V. (2005, 17-18 March). Round Table discussion on “International Approaches in Marriage and Family Therapy” at Mid-Atlantic Conference on the Scholarship of Diversity held at Hotel Roanoke and Conference Center Roanoke, V.A.


Jagasia, J. (2004). Presentation given on “Teaching a large class” given to 500 Graduate teaching assistants in a workshop organized by Dr. Don McKein, Virginia Tech.

Conferences Attended

Jotika, J. (2007). Held a round table discussion on “Marriage and Family Therapy Theories used by Indian Therapist to Address Challenges in HIV in Culturally Appropriate way in India” at the Quint State conference, Virginia Tech, Blacksburg, VA.


Keeling, M., Piercy, F., Jagasia, J., Glass, V. (2005, 17-18 March). Round Table discussion on “International Approaches in Marriage and Family Therapy” at Mid-Atlantic Conference on the Scholarship of Diversity held at Hotel Roanoke and Conference Center Roanoke, V.A.


Professional Interests

HIV/AIDS, women’s issues especially violence, grand parenting, children of divorce, substance abuse/ addiction, diversity/ethnicity, and sexual identity development.

Other Skills
Multilingual: Read, write, and speak English, Marathi, Hindi, and Sindhi Devnagari; competent using SPSS and SAS, statistical software programs; proficient with word processing and spreadsheet programs

References

Available upon request.