CHAPTER 3
Culture in Family Therapy

New Variations on a Fundamental Theme

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The first thing you do is to forget that I am black. Second, you must never forget that I am black.
—from Pat Parker’s poem, “For the White Person Who Wants to Know How to Be My Friend” (1990)

HISTORICAL CONTEXTS FOR MULTICULTURALISM

The call for cultural sensitivity in mental health services is not new. The civil rights movement demanded that institutions be more responsive and less discriminatory toward minority clients, and the nationwide development of community mental health programs in the 1970s attempted to expand services to economically disadvantaged and culturally marginalized groups. The multicultural movement of the 1990s has revitalized these concerns within newer, postmodern epistemologies that stress a social constructionist lens, a strength-based orientation, and a collaborative engagement with clients.

Among health disciplines, family therapy has emphasized contextual issues since its earliest days. With its foundation in systems theory, family therapy has always regarded the behavior of families as contextual and ecological (Auerswald, 1968). Early research and scholarly writings that focused on economically disadvantaged families highlighted the importance of sociocultural context in understanding family life (Aponte, 1976; Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967; Montalvo & Gutierrez, 1983, 1988; Sluzki, 1969). Other notable contributions include the work of Spiegel (1971) and Papajohn and Spiegel (1975), which compared value orientations of various ethnic groups; McGoldrick, Pearce, and Giordano’s (1982) examination of ethnicity in families; Boyd Franklin’s (1989) multisystemic approach in Black Families in Therapy; the feminist critique of family therapy (Goldner, 1985; HareMustin, 1978; Luepnitz, 1988; McGoldrick, Anderson, & Walsh, 1989; Walters, Carter, Papp, & Silverstein, 1988); the attention paid to gay and lesbian families (Johnson & Keren, 1998; Laird, 1998); or the use of “cultural consultants” in the New Zealand “Just Therapy” approach (Waldegrave, 1990); and my own work, which proposes a more comprehensive definition of culture and challenges the assumed universality of family therapy concepts and interventions (Falicov, 1983, 1995, 1998a, 1998b). The historical progression of these concerns places
family therapy squarely within the multicultural movement.

Collective Identities: A World of Variation

Defining specific “collective identities,” such as ethnic, class, gender, or social identities, appears at first glance both possible and practical. We look at the worldviews, values, and customs of certain groups and assume these traits to be normative and stable. We talk about how Latinos value family closeness and interdependence, how Anglos are time-conscious and schedule-oriented, how the Irish like to tell stories and drink. However, on close examination, deciding about sameness and difference isn’t so simple.

Even if one could describe characteristics that make up something like “Jewishness” or “Mexicanness” or “blackness,” ethnic identities are profoundly modified by other variables that affect behavior, experience, and worldviews. The cultural experiences of African American women are very different from those of African American men. A Puerto Rican elder who practices espiritismo—a belief in the ability of invisible spirits to materialize—as a way of coping with the loss of her granddaughter to cancer, has a different connection to her heritage than does the Puerto Rican mother who trusts only her Roman Catholic priest for advice about her drug-addicted son.

Gender, race, class, religion, nationality, and even cohort (the historical generation into which a person is born) all contribute to cultural identities. Consistencies of language, meaning or belief systems, worldviews, and experiences often lend a sense of familiarity and community for people who share the same culture. But inconsistencies, variabilities, and novelties along some of those dimensions exist as well. Cultural identities are also influenced by the constructs supplied by the dominant discourses. Taking these influences into account, and the myriad cultural blends that result, helps us avoid treating cultures as static. Given this incredibly complex, moving construct that we vaguely call the “culture” of a person or a family, how do we address its relevance and place for families that seek psychotherapy?

MULTICULTURALISM AND PSYCHOTHERAPY

Two constructs encompass family therapy’s current focus on multiculturalism: (1) a cultural diversity practice that respects cultural preferences among clients and critically examines existing models of the family and theories and techniques used in psychotherapy; and (2) a social justice practice that focuses on the effects of power differentials (due to gender, economic, and racial inequities) on individual and family well-being and on the relationship between clients and therapists.

A Cultural Diversity Lens

One of the first effects of bringing culture into the therapy room is that it upsets our theoretical applecart. Multiculturalism challenges what traditional schools of thought—psychoanalytic, systemic, structural, strategic, and so on—consider universal. Views
about how families function, how problems develop, and how change is facilitated by those approaches may be “local” ideas originated by various “schools of thought” or “cultures” (Fancher, 1995) within the professional standard clinical practices. It follows from this that clients’ beliefs or behaviors that are part of a cultural meaning system other than the one in which the therapist has been schooled could potentially be judged as dysfunctional or at least problematic. In the newer modes of family therapy, where a respect for or a consideration of differences is at the core of the principle of therapeutic respect, we see families as all different, all uniquely organized, and all needing description, rather than categorization, in order for us to understand them (Anderson & Goolishian, 1992; Alexander & Sexton, 2002; Freedman & Combs, 1996; Madsen, 1999; Penn & Frankfurt, 1994; Sexton & Alexander, 2002; White, 1989).

To avoid confusing other cultural ways with dysfunction, a multicultural therapist needs to incorporate a critically questioning attitude toward the Euro-American biases inherent in most professional training. This means accepting that theories and interventions stem from one local cultural niche and are not the standard by which families can be evaluated. Instead, a practice based on curiosity and respect for cultural diversity explores the healing resources within the client’s culture and develops a stance of empathic “sociological imagination” (Wright Mills, 1959). When we attend to issues of race, ethnicity, social class, gender, religion, or sexual orientation, critical questions are raised about the customary assumptions of mainstream psychotherapy. In family therapy, issues of boundaries, hierarchies, communication styles, or life-cycle norms may come into question and lead to transformations and accommodations of taken-for-granted therapy concepts and techniques (Gergen, Gulerce, Lock, & Misra, 1996; Sampson, 1993; Taylor & Gutmann, 1994).

A Sociopolitical Lens

Multiculturalism consists of more than a respect for multiple meanings or diverse values about family life. A component of social justice is essential to the multiculturalist lens. Members of collective-identity political movements—African Americans, Latinos, gay rights advocates, or feminists—have been denied their own voice in determining the conditions of their lives and (Sampson, 1993; Young, 1990) seek redress not only by having the legitimacy of their own worldviews recognized but also by obtaining equal rights and access to resources.

In the clinical arena, this social justice position directs the attention to life conditions, power differentials, and prejudice that limit social and economic opportunities, promote internalized racism, and affect psychological development and mental health for those who are poor or marginalized. Without a lens that includes social inequities, cultural preferences may be used as “explanations” for economic failure, domestic violence, or poor school performance, whereas the larger negative effects of poverty and social discrimination are downplayed.

A sociopolitical lens is not limited to impoverished clients. For example, in the past, a case of anorexia nervosa was viewed as “idiosyncratically” linked to an “overinvolved” mother and a “peripheral” father, without awareness of the social demand for the gender
specialization of each parent and the social demands for thinness in young women (Bordo, 1997). More recently, a large number of therapists are considering cultural and sociopolitical discourses to be central to the treatment of anorexia and other eating disorders (Epston, 1993). A social justice practice connects mental health issues with experiences of social oppression and aims to empower families in their interactions with larger systems and cultural discourses, including those in the psychotherapy field. (Hardy & Laszloffy, 1994; Korin, 1994)

In addition to attending to cultural diversity and social justice issues, a fundamental part of the multicultural equation consists of the therapist attitudes that incorporate beliefs about individual and family resilience, and support clients' personal agency and creativity. Therapy must not become a form of social and cultural reductionism, whereby a client’s gender, race, or social class automatically explains that person’s beliefs, attitudes and behavior. Although interlaced with historical moments, cultural discourses, and sociopolitical forces, the client’s biography is always unique.

**MECA: A Multilevel/Multidimensional Approach**

One answer to the questions of how therapists can orient themselves in the array of issues related to cultural diversity and sociopolitical realities is provided by the MultidimensionalEcosystemic-Comparative Approach (MECA), (Falicov, 1995, 1998a). MECA encompasses the ability to hold various levels of consideration: the “universal” similarities, the idiosyncratic particulars, and the sociopolitical level. It offers a multidimensional definition of culture, a method for making meaningful comparisons across groups, and room for multiple and evolving cultural narratives. Rather than making culture marginal and an add-on to theory, practice, or training, a multidimensional-ecosystemic-comparative approach takes culture into the mainstream of all teaching, thinking, and intervening in therapy (Falicov, 1988, 1995).

MECA is based on the idea that we are all multicultural persons, rather than belonging to a single group that can be summarized with a single label: Latino, lesbian, Lutheran, or Black. In reality, each person belongs to, participates in, and identifies with multiple groups that provide particular experiences and bestow particular values. Furthermore, people are denied access or are excluded from certain settings, and these exclusions also shape their experiences.

**THE CONSTRUCT OF ECOLOGICAL NICHE**

Taken altogether, these participations and exclusions make up a client’s and also a therapist’s ecological niche. Including culture in therapy requires that therapists and other service providers locate individuals and families in terms of race, class, religion, sexual orientation, occupation, migration experiences, nationality, and ethnicity. Likewise, all service providers must locate themselves in the same variables. Describing an ecological niche is equally important for “mainstream” clients who are White, middle class, and Protestant. Cultural location should not be described only for minority groups and should not imply that culture and society influence only the marginalized groups, whereas the
dominant groups are regarded implicitly as the standard norm.

Another related idea underlying MECA is that the therapy encounter is really an encounter between the therapist’s and the family’s cultural and personal constructions. Therapists’ views about family and family problems and resources stem from their ecological niche, which includes their own cultural variables, as well as their preferred brand of theory and professional subculture.

The construct of ecological niche makes it apparent that human beings share cultural borderlands (Anzaldúa, 1987; Rosaldo, 1989) or zones of overlap with others. By virtue of sharing the experiences of contexts such as race, social class, occupation, religion, or ethnicity, discrete groups dissolve and partial groupings and bridges of human connectedness emerge. A middle-class first-generation Vietnamese agnostic biologist may have more in common with another university-educated biologist, even though the latter is White, than with a Vietnamese immigrant who is Roman Catholic and is employed in a beauty salon. The first two share a greater number of cultural borderlands than the second two, in spite of the fact that they are both Vietnamese. The notion of ethnic or racial matching between therapist and client becomes more complex within this framework, because therapists and clients can share other forms of connectedness through their cultural borderlands.

With MECA, therapists make a holistic assessment of all the contexts to which the family belongs and draw from the family members their understanding of the resources, the constraints, and the cultural dilemmas those multiple contexts create. These types of collaborative explorations render a picture closer to what the anthropologist Clifford Geertz (1973) dubbed a “thick” description, rather than relying on identity labels and a priori knowledge about collective groups. Aiming for thick descriptions, the observer draws conclusions based on the people’s descriptions of their own complex locations, using their own cultural categories of understanding, rather than utilizing the labels and categories of the observer.

A CULTURAL GENERALIST FRAMEWORK

MECA attempts to arrive at a “cultural generalist” framework because it focuses only on those dimensions that family therapists generally use to orient themselves about basic aspects of relational life to be taken into account when trying to understand a presenting problem. The four dimensions identified by MECA are migration, ecological context, family organization, and family life cycle. MECA is based on the belief that the contents of these dimensions are culturally constructed, but that the dimensions themselves as general categories probably exist in all societies. In the clinical situation, an assessment includes conversations about possible connections between the presenting concerns that bring the family to therapy and the various cultural dimensions covered in MECA. The assessment should be relevant to the family’s concerns, so the question revolves around the family’s and client’s views and theories about the problem, who is most affected, and what has been done about it. From these assessments a contextual picture of the family emerges that includes cultural dilemmas that may be connected with the presenting problems or cultural and personal strengths that may be helpful in finding solutions.
MIGRATION AND ACCULTURATION

Much of the current emphasis on cultural competence is based on the demographic changes of the past 20 years. Statistics show that 1 out of 6 people in the United States are foreign born and 1 out of 4 is the offspring of foreign-born parents. Many immigrants leave their countries reluctantly. Their motivations primarily include improving their desperate economic situation or escaping political oppression and organized violence. Another language was spoken in their homes when they were children, and cultural dissonance permeates their lives.

The Uprooting of Meaning Systems

Personal stories, views of reality, and adaptive behaviors are all anchored in the lived experiences of one’s race, ethnicity, or social class within national contexts. Perhaps the most fundamental dislocation of migration is the uprooting from known structures of cultural meanings tied to those national contexts. These structures of meanings and beliefs have been likened to the roots that sustain and nourish a plant (Marris, 1980). The uprooting of established meaning systems and exposure to new life constructs have been linked to various types of psychological distress for immigrants, including culture shock (Garza-Guerrero, 1974); marginality, social alienation, and psychological conflict (Grinberg & Grinberg, 1989; Shuval, 1982); psychosomatic symptoms, such as palpitations, dizziness, and insomnia; and anxiety and depression (Warheit, Vega, Auth, & Meinhardt, 1985). Post-traumatic stress may occur if migration involved trauma, for example, for asylum seekers or for political refugees who have witnessed or have been victims of mass destruction.

AMBIGUOUS LOSS

The experiences of loss, grieving, and mourning that accompany migration have been likened to the processes of grief that accompany other types of losses, particularly the death of loved ones. However, the experience of migration loss seems to be better captured by the construct of ambiguous loss (Boss, 1991, 1999). Migration is a stressful event that brings with it losses of all kinds: gone is the support of family, friends, and community; gone is the ease of the native language, the customs, the foods, and the multiple connections with one’s own country itself. These physical absences are real, yet unlike the losses of death, with migration it is always possible to fantasize an eventual return or a forthcoming reunion with loved ones. Immigrants also hope that the added burdens will be lifted when their hard work is rewarded with improved economic or educational conditions or new political or cultural freedoms. The contradictory elements create a persistent mix of emotions: sadness and elation, absence and presence, despair and new hope, which make grieving incomplete or postponed. Ambiguity becomes inscribed in immigrants’ lives, an ambiguity that they must constantly learn to live with.
A MIGRATION NARRATIVE

Obtaining a migration narrative provides the therapist entrée into the individual members’ migratory experiences, their dreams and hopes and their strategies for coping with massive changes. To assess the changes in family composition and the meaning of the migration, the therapist might ask how long each family member has resided in the United States; who immigrated first, who was left behind, who came later, or who is yet to be reunited; what motivated the migration and how they went about planning for it; what stresses and joys were experienced by various family members at various stages; and what strengths and resources they discovered. It is important to inquire about who was left behind and their reactions to the migration because they are also members of a social system in transformation, affected by and affecting those who migrated.

Although ambiguity permeates the immigrant’s experience, the degree of agency people experience in making the decision to migrate may have important consequences for psychological distress. The migration narrative should start temporally in the premigration stage, to clarify various members’ participation and feelings about the decision. Immigrants who feel coaxed, forced, or manipulated to migrate may display more symptoms of anxiety and depression than those who were fully cognizant and accepting of their decisions. In telling a migration narrative, family members may find meaning in their uprooting in terms of their unique personal history, which incorporates gains as well as losses.

RESILIENT ADAPTATIONS AND RITUALS

Most immigrants and refugees demonstrate enormous capacity for resilient adaptations. The need to reestablish a sense of coherence and make meaning out of adverse circumstances is manifested in the emergence of what may be thought of as spontaneous rituals, which renew presences across absences by recreating the familiarity of old spaces, sounds, faces, smells, and other cultural rituals in the new land (Falicov, 2002, and in press). These rituals of connection, recreation, memory, and preservation illustrate the ambiguous and conflictual nature of immigrants’ losses and continued attachments. Yet, embedded in these spontaneous rituals, there are resilient both/and dual visions or “solutions” that symbolize learning to live with the ambiguity of never putting a final closure to migration. Work with immigrants can greatly profit from an exploration of the place of rituals in their lives. It seems possible that the abandonment of cultural rituals or excessive reliance on their performance at the expense of new adaptations may signal difficulties around migration. The creation of therapeutic rituals to deal with migration issues holds promise of dealing with migration impasses (Falicov, 2002; Imber-Black, Roberts, & Whiting, 1988; Woodcock, 1995).

ACCULTURATION AND ALTERNATION THEORIES

In time, new cultural and social contexts generate new meanings and accommodations or hybrid mixes between the dominant and the local cultures. Acculturation theory assumes
that immigrants gradually shed their original culture and language in favor of a better “fit” that correlates with mainstream culture and mental health. Acculturation theory has been challenged recently, after several studies indicated that immigrants who try to “Americanize,” or assimilate, actually have more psychological problems and drug use than those who retain their language, cultural ties, and rituals, at least partially (Escobar, 1998; Portes & Rumbaut, 1990). Furthermore, social ills such as drugs, alcohol, teen pregnancy, domestic violence, gangs, and AIDS, which affect discriminated groups, appear more frequently in the second and third generations than in the first (Padilla, 1994), presumably because the initial protection of a firm cultural and family identity was still intact in the immigrant generation.

A recent model, alternation theory, is based on a different assumption than acculturation theory, in other words, that it is possible to know two languages and two cultures and to appropriately use this knowledge for different contexts (La Framboise, Coleman, & Geron, 1993), without giving up one for the other. Communications made possible by globalization have transformed immigration into a two-home, trans-context lifestyle for many immigrants (Bustamante, 1995; Schiller, Basch, & Blanc-Szanton, 1992; Turner, 1991). Studying Mexicans in Redwood City, California, Rouse (1992) observed a “cultural bifocality,” that is, the capacity to see the world through two different value lenses, such as maintaining language and ethnic values within the family, while also learning and using English and American values when dealing with larger systems. Intrafamily conflict may emerge as family members acquire the new values or retain the old ones at different rates. Dilemmas of cultural meanings, beliefs, and expectations are often the subtext of many individual and family consultations and may also cause misunderstandings with larger systems, including with therapists’ discourses. Dual visions of continuity and change or double discourses appear also in the sociopolitical arena. Double consciousness, DuBois’s (1903) description of the awareness of African Americans about who they really are in their own group, in contrast with the prejudicial ways in which they are seen by others, is helpful in understanding the feelings and experiences of living in two worlds.

STRUCTURAL DILEMMAS

In addition to dilemmas of cultural meanings, beliefs, and expectations, migration precipitates family structural dilemmas, primarily because of separations and reunions between extended and nuclear family members but also among nuclear family members, such as when the father or the mother migrates first alone, to be reunited later with the children (Suarez-Orozco & Suarez-Orozco, 2001). Both men and women experience difficulties during migration, and both use mechanisms that appear to follow gender socialization, such as depression or psychosomatic problems in women and alcohol dependency and violent behaviors in men.

Separations are tied to practical reasons and economic limitations, but there may be other powerful, less conscious, reasons, such as loyalty toward the family of origin. Regardless of the reasons, separations at migration may differentially affect individuals and families. For example, separations may increase closeness between some family subsystems, whereas it weakens bonds among other family groupings, both among those
who left and among those who stayed. Increased nuclear closeness cushions from culture shock and supplements role functions left vacant, but, ultimately, these reorganizations may limit the reincorporation of separated family members, as it happens with children who become closer to their grandmothers than to their biological parents. Individual development may also be curtailed through either excessive closeness or excessive distance from significant figures.

The process of reunification is often traumatic for all involved, especially children, who may present with stomach pains, sleep disturbances, and temper tantrums or defiant behaviors that become the precipitant for therapy consultations. A therapeutic ritual that can be used at the time of reunion to help the family bridge the absences and temporal gaps of the separations is a “catching-up life narrative” (Falicov, 1998a). It consists of a family storytelling, whereby all members present facts, anecdotes, photos, objects, or drawings of their lives apart. The therapist weaves all these elements into a written story form that is repeatedly read and modified until a final product is arrived at, sometimes adding a “feed-forward” section that predicts an affirming future family form. Apprehension about the future may be assuaged by previewing a possible more stable future, where the family will continue to be together rather than suffer new separations.

How immigrants cope with these separations and the ambiguities of losing so much, while hoping for a better future, is in part related to the meanings they attach to the separations. The attached meanings often reflect the culture’s preferred ways of dealing with adversity and losses that are beyond one’s control. The use of religion or spiritual resources is one example of a positive cultural mechanism for coping with suffering that should not be automatically attributed to passive fatalism (Boss, 1999; Comas-Díaz, 1989; Falicov, 1999a). Turning to spiritual solace can also be seen from a sociopolitical perspective. Fanon (1967) suggests that when self-determination is limited, as is the case with nondominant groups, placing oneself under the protection of benevolent and powerful figures may help counteract fear, powerlessness, and lack of agency.

Other structural dilemmas occur when wives remain isolated in their homes and do not learn English, or conversely, when they encounter economic and gender freedoms denied before. Both situations can unleash matrimonial conflicts. Generational hierarchies may also be overturned when children serve as language intermediaries with the host society and cultural translators for their parents. Often, this hierarchical reversal is limited to certain areas, but in some situations it may become pervasive and eventually weaken parental authority, particularly if the parents abdicate their cherished values.

A therapist who intervenes in these situations of cultural dilemmas or conflicts by quickly becoming an agent of acculturation into the mainstream may create more, rather than less, emotional distress. Maintaining continuity, that is, supporting the “wisdom of no change” and thus not overburdening an already unstable situation with more suggestions for “adaptive” change, may be more therapeutic for overstressed families (Falicov, 1993). Promoting acculturation goals may in effect colonize clients by “imposing” values without awareness of cultural biases, as, for example, when the therapist supports the “Americanized” second generation against “old-fashioned” parents.
ECOLOGICAL CONTEXT

Migration or social disadvantage transports families to a social terrain different from the exposure to the mainstream messages of the dominant cultural discourses. Bombarded with differences, families re-create elements of their own culture and class in urban ethnic neighborhoods that serve as a buffer against culture shock and discrimination, while providing a continuity of faces, voices, smells, and foods. But the illusion of a safe haven may be offset by the fear of persecution, physical threat, and social unrest in inner-city neighborhoods. Middle-class families have their own set of stresses in isolated suburbs, with pressures of competition and maintaining affluent and overworked lifestyles.

In the case of immigrants, relocation can disrupt the emotional support, advice, and material aid that social networks provide. Enduring intimate relationships, whether husband-wife or parent-child, are taxed with many more requests for companionship from each other than before (Sluzki, 1969). Lacking the watchful eye of nearby relatives, parents compensate with restrictions on adolescents’ activities, which may aggravate intergenerational conflicts. Because social networks are essential for physical and emotional well-being (Sluzki, 1993), particularly in situations of stress, therapists must assess the family’s social interactions and sources of support and community involvement.

Religion and spirituality are the most transportable elements in the immigrant’s knapsack. In fact, the performance of soothing rituals, such as prayer, may contain elements of resilience for many impoverished groups. The church or temple in the ethnic neighborhood also provides community support in the form of a sanctuary for undocumented immigrants, a center for crisis counseling, and a meeting place for activist groups and community celebrations. Priests, pastors, or rabbis who officiate at life-cycle celebrations, communions, baptisms, and weddings may become resources for stability and a sense of community.

For many ethnic groups, folk medicine and indigenous spirituality coexist with mainstream religion and medical practices. Folk healers are consulted for many maladies but are turned to the most for “folk illnesses,” which are often thought to have psychological roots. It is important that therapists develop nonjudgmental ways of inquiring about these sources of help and assume a collaborative attitude toward them.

The notion that little in life is under one’s control is a worldview more frequently attributed to cultural discourses other than the American view, which is that much in life can be modified through personal will or intervention. It is important for therapists to consider that the ecology of lower socioeconomic status can disempower individuals and limit their hopeful outlook. The belief in an external locus of control should not be taken as a deficit but rather as a realistic and philosophical form of coping by trying to accept circumstances that may be beyond one’s control.

Externalizing conversations, that is, separating a client from a problem and stimulating personal agency or choice (White, 1989), also may be used, particularly in the form of “inner” rather than “outer” externalization. According to Tomm, Suzuki, and Suzuki...
(1990), an outer externalization involves talking about a problem as if it eventually could be defeated or escaped. Therefore, the conversation tends toward discussion about conflict and control over the problem. An inner externalization, on the other hand, encourages talking about a problem as if it will be necessary to “live with it.” This latter formulation is more syntonic with cultural discourses that encourage accepting or being resigned to problems, rather than confronting or struggling against them.

Interactions with institutions, such as school, work, and health systems, are challenging experiences for many marginalized adults and children. They may experience incompatibility between home and institution in primary languages, difference in cognitive and relational styles, and meaning or belief systems, which may cause conflict, confusion, and a sense of inferiority. Teachers, employers, physicians, and therapists also experience dissonance when they struggle to understand and serve culturally diverse families. A shift from a positive to a disenchanted or oppositional attitude occurs after children and parents become aware of institutional marginalization or racism, increasing the possibility of school dropout or work unemployment (Ogbu, 1987; Suárez-Orozco & Suárez Orozco, 1995a, 1995b). Therapists need to explore the family’s experiences and evaluations of larger systems interactions, whether these are teachers, priests, medical doctors, therapists, or employers, and the impact of these experiences in the family’s outlook of the present help being offered.

Common constraints of immigrants are social and cultural isolation, ignorance about community resources, and tensions between home norms and those of the school, peer group, or work situation. To inquire about such ecological issues, the therapist may explore the family’s neighborhood (housing, safety, crime, gangs); racial acceptance; employment (income, occupation, job stability); extended family and friendship networks; school and parent-teacher relationships; church attendance or other spiritual practices; and experiences with helping professions, including the present referral source.

It is revealing for the family and for the therapist to draw an “eco-map” that depicts family-environment relationships (Hartman & Laird, 1983). If this map reveals that ecological constraints and tensions zap the family’s strengths to cope, the therapist may temporarily become a “social intermediary” or a “match-maker” between the family and various communal institutions (Falicov, 1988; Minuchin et al., 1967). The therapist can help the family mobilize to use existing networks or facilitate building new reciprocal ones. Priests may offer spiritual support, particularly when dealing with physical illness, old age, and death. Relatives or compatriots can be advocates for a child or for the family in dealing with institutions, as well as a temporary relief for parents. The aim is to collaborate in empowering the family to deal with larger systems and to insist on receiving adequate services.

Family Organization

Cultural preferences and limited financial resources have traditionally motivated families from impoverished countries (many Latin American and Asian countries) and discriminated groups (African Americans or single mothers) to live in close proximity to extended family networks that can provide emotional and practical support. They form a larger kin and kith network than the isolated nuclear middle-class family that has become
the prototype of family psychology depictions of normal family life. It is important for therapists to help draw a genogram that includes the current family composition and, in the case of immigrants, the family network clients had in their countries. It is important to explore multi-generational patterns that might be related to the presenting complaint. Although the migration narrative can become a powerful magnet that absorbs all elements of family history for the protagonists and their therapists, immigrant families, like other families, have complex past life stories that preceded migration and might be implicated in their current concerns.

In traditional settings, intergenerational lifelong connectedness and respect for parental authority are valued greatly, sometimes creating structural and meaning conflicts with the contemporary egalitarian democratic ideologies based on the husband-wife bond. Certain dyads, like mother-eldest son or father-eldest son, may be very strong and may also run against notions of egalitarianism from parents towards all of their children, complicating sibling relationships. Traditional family organization affects family bonds along several dimensions of interaction: (1) collectivism and individualism, (2) gender and generation hierarchies, and (3) communication styles and emotional expressivity. Cultural preferences along these dimensions may remain over several generations, in some fashion, and may stir up dilemmas when younger generations incorporate Anglo-American discourses, or when the family comes in contact with the institutions of mainstream culture, such as the values upheld by psychotherapists.

COLLECTIVISM AND INDIVIDUALISM

Family collectivism is embedded in the cultural discourse of many ethnic groups, such as Latinos, African Americans, Asians, and even many European groups, such as Italian or Greeks. Family inclusiveness may also be more typical among women than men. Under these values, family boundaries easily expand to include grandparents, uncles, aunts, or cousins. Children who are orphaned or whose parents have migrated or divorced may be incorporated into the family, along with adults who have remained single or have become widowed or divorced. Strong sibling ties are stressed from a young age and throughout life. Any member of this large network can be involved in the problem or can become part of the solution. A family may bring a relative to a psychotherapy session, providing an entrée for therapists to understand the social network around the family and expand their professional definitions of family composition and family life.

Family interdependence involves sharing the nurturing and disciplining of children, shared financial responsibility, companionship for lonely or isolated members, and communal problem-solving. Concomitantly, there is a low reliance on institutions and outsiders. The idea of a “familial self” (Roland, 1988) is useful in understanding many individuals’ dedication to family unity and family honor and the celebration of family rituals. Adult sons or daughters who may unwittingly curtail their chances for marriage in order to take care of an ailing parent may be responding to their familial selves and not necessarily be inappropriately self-sacrificing.

The process of separation/individuation, so highly regarded in American culture may be de-emphasized in other cultures in favor of close family ties. Deficit views tend to pathologize this type of family closeness and label it enmeshment. However, family
close-ness may reflect cultural interactional preferences that contribute to resilient adaptations. Furthermore, in traditional settings, individuation also takes place, along with family closeness, via marriage, work, or simply having personal opinions and a sense of personal self, along with a familial self. Therapists who insist on stressing the client’s individual, as pitted against family, needs may run counter to internalized cultural specifications.

**GENDER AND GENERATION HIERARCHIES**

When family loyalty and collective cooperation are culturally stressed, usually there is also an emphasis on clear family hierarchies. Child-rearing practices of ethnic or disadvantaged groups may reflect this emphasis on hierarchies. Punishment, shaming, belittling, deception, promises, and threats may be used in response to young people’s misbehavior.

Unquestioned respect for authority runs counter to the democratic, egalitarian discourses of psychotherapists, who may negatively judge parents who show concern and caring according to their cultural ways. The parents may also react and judge negatively the “permissiveness” of American society, perhaps unwittingly personified in the individualistic democratic discourses of the therapist. Transparency in the therapeutic dialogue helps clarify the benevolent intent on both sides. Even in patriarchal systems, a child’s well-being is the responsibility of both parents, and, therefore, even traditional men can be persuaded to participate in conversations about children’s well-being.

Although a patriarchal view of gender roles persists among many Asian, Latin American, and other immigrants, more complex transitional dynamics are evolving. For example, a double standard of gender socialization and sexuality persists (Falicov, 1992), yet decision making is often shared by both parents or involves a process in which the mother alone or the father alone commands much authority (Kutsche, 1983; Ybarra, 1982). Increasingly, immigrant and ethnic family life is characterized by a wide range of structures and processes, from patriarchal to egalitarian, with many combinations in-between. Given the centrality of the parent-child dyad and the generational conflicts that may take place in immigrant families with adolescent children, it is not unusual to encounter situations where the father tries to exert authority by disciplining the children and compelling them to obey the mother, whereas she tends to defend and protect them. This interactional pattern may generate father-mother-child triangulations that need to be seen culturally and contextually, rather than simply regarded as “pathological” (Falicov, 1998b). Often, triangulations may be successful in resolving conflicts indirectly, in ways that are culturally syntonic even if they run counter to family therapy notions about generational boundaries, as when a family member asks another to intercede in a conflict, rather than confronting her opponent directly.

**COMMUNICATION AND EMOTIONAL EXPRESSIVITY**

Indirect, implicit, or covert communication is consonant with some groups collectivistic emphasis on family harmony, on “getting along” and not making others uncomfortable. For other traditional groups, assertiveness and open differences of opinion may be the
norm. From their own cultural discourses about communication, therapists may regard the first cultures as too stifling of individual expression and the second as too dismissive of the feelings of others. Yet both are legitimate ways of handling interpersonal relationships.

Because of power differentials and respect for authority, clients may feel that it is impolite to disagree with the therapist. Encouraging the family members to express their reactions, both positive and negative, to the therapist’s opinions helps to establish a tone of mutuality. Manifesting real interest in the client, rather than gaining data via referral sheets or obtaining many behavioral details about a problem, is essential to build personal relationships that carry emotional expressivity. Similarly, a therapist who suggests an explicit contract about the number of sessions or the treatment goals may be too task-oriented, rather than person-oriented, increasing the cultural distance clients may already be feeling.

The three elements of traditional cultural discourses—collectivism, hierarchies, and indirect communication—discussed previously, can appear to be constraining to individual development, but therapists should not assume that a position of cultural resistance to those cultural preferences is in order. Professional discourses are often based on mainstream values, such as individualism, that should not be privileged or imposed. Changes in discourse are valid only if they stem from a true and informed collaboration with the clients.

**Family Life Cycle**

Families from diverse cultures may approach family and sociocultural life in ways that may differ from the dominant interpretations of the life cycle. The meaning of the stages and transitions, the developmental tasks, and the rituals of the individual and the family life cycle may all be heavily guided by culture, custom, and traditional practice (Falicov, 1998a, 1999b). Many groups may differ from the dominant culture’s view of the life cycle by experiencing a longer state of interdependence between mother and children and a more relaxed attitude about children’s achievement of self-reliance skills (these attitudes are often mistaken for overprotection); the absence of an independent living situation for unmarried young adults; the absence of an “empty nest” syndrome or a middle-age crisis and a refocusing on marital issues; and the continuous involvement, status, and usefulness of elders in the family. These traditional developmental expectations may persist alongside the new considerations of individual pursuits and romantic love espoused by the younger generations, sometimes causing intergenerational tensions.

For many traditional families, leaving home occurs primarily through marriage, and boundary or loyalty issues with families of origin are common, particularly because the second generation has begun to stress husband-wife exclusivity. The relationship between the mother-in-law and the daughter-in-law may enter into conflict, given the differences in cultural codes.

Some developmental impasses can be linked to the stresses of migration. Leaving home can become more problematic when parents have depended on their older children to be intermediaries with the larger culture. Younger siblings, too, may cling to an older
one who appears to be more culturally understanding than the parents are. Normal-life cycle events, such as the death of a loved one, either in the country of origin or the adoptive country, may precipitate additional stress by rekindling the ambiguities of migration and the questioning about the wisdom of being so far away from loved ones (Falicov, 2003).

Because professional discourses tend to be based in taken-for-granted but nevertheless culture-bound expectations about how to navigate life-cycle stages and transitions, therapists need to be aware and self-reflexive about their own normative evaluations about age-appropriate behaviors in their clients. Once the life-cycle dilemmas within the family or with other institutions are deconstructed and discussed, the therapist may attempt to become a “cultural mediator,” encouraging conversation between parents and offspring about de-velopmental expectations and their loyalties to both cultures.

The presence of two or three generations, each speaking a different language and holding different cultural values while partaking in some common customs and traditions, is both very enriching and resourceful. The challenge is how to merge and blend differing cultural codes about family life. It is not unusual for a Latino, a Greek, or an Italian group of adult siblings to have arrived at vastly different connections to their parents’ language and cultural rituals and to also have varied degrees of adherence to the mainstream culture and language.

Gender differences appear as well in perceptions of life-cycle meanings. Although studies of 20 years ago reported a slower pace of language-cultural change in immigrant women than in men, more recent studies indicate that women adapt to cultural changes faster than men do. Women are more likely to adopt new life-cycle values and gains in greater personal freedoms (Hondagneu-Sotelo, 1994).

A Method for Deconstructing Cultural Meaning Systems

In a rapidly evolving multicultural society many family problems may be related to several conflicting cultural experiences and perspectives, often those regarding generational and gender perspectives. The method is one attempt to deal with dilemmas of intersecting cultural views by constructing integration, alternations, and other hybrid solutions between cultural meanings (Turner, 1991; Falicov, 1998a; see Table 3.1).

The first step is to “draw attention to differences” in ideologies and meanings. It involves simply naming the differences: the husband may feel that women’s work is at home, whereas the wife feels ready and willing to work outside the home; the son may feel that the father is overly strict in his discipline, but the father feels that his disciplinary approach is correct.

The second step is to “contextualize the differences.” By inquiring about the experiences behind the differences, an appreciation emerges that each person’s thoughts, preferences, and feelings are influenced by his or her ecological niche—the combination of institutional contexts and social settings from which the person has been included or excluded. Polarizations soften and are replaced for greater respect or appreciation for each other’s views.

The third step is to “reframe the presenting concern as a dilemma of coexisting meanings.” The discussion focuses on how family members’ differences about
collectivism and individualism, gender and generation hierarchies, and communicative
directness and indirectness pose dilemmas for the adults, the children, the men, and the
women in the family. The presenting problem is looked at as being connected to the
stresses of these dilemmas.

**TABLE 3.1 Deconstructing Cultural Meaning Systems**

<table>
<thead>
<tr>
<th>1. Drawing attention to DIFFERENCES within the family and with larger systems (individualism and collectivism; gender and generational hierarchies)</th>
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<tbody>
<tr>
<td>2. CONTEXTUALIZING the differences (understand socialization forces and search for similarities that transcend differences)</td>
</tr>
<tr>
<td>3. DILEMMAS of coexistence of conflicting meanings (how these relate to the presenting problem)</td>
</tr>
<tr>
<td>4. Previewing FUTURE family shapes, narratives, solutions (alternation, integration, metatexts)</td>
</tr>
</tbody>
</table>

or as an attempted solution, albeit a problematic one.

The fourth step, that of “previewing future family patterns and cultural blends,” introduces a future-oriented dimension. What kinds of alternation or blends of meaning systems are possible? Can each be used, depending on the context at hand? Are there overarching meanings, such as universal needs for freedom or justice, that can transcend differences? Therapists have an opportunity here to be transparent with clients about their own personal or professional belief systems. Asking these questions can orient the family toward a future in which multiple cultural meanings coexist or are integrated. Each family will find its own solutions of blending and living with cultural differences.

The therapist might note similarities and contrasts with dominant cultural meanings, as well as the possible dilemmas and enrichments precipitated by the meeting of different beliefs and meaning systems. These explorations should set a tone of respect, curiosity, and collaboration in understanding the philosophical and behavioral consequences of a cultural way of life as part of American society.

**TOWARD BOTH/AND INTEGRATIVE ATTITUDES**

An ethnically focused position encourages therapists—though always mindful that families never fit stereotypes—to inform themselves of as many details as possible about particular cultures, views in family life, and beliefs about health and the process of change that lead to cures. This position can be contrasted to a “not-knowing” stance in therapy. “Not-knowing” approaches are based on curiosity and on dialogue that takes into account all meanings—cultural and personal—as they emerge in the therapeutic situation. Yet there are families where “credibility” and direction from a “knowing” agent “fits.”

These two positions seem to be unnecessarily polarized. A dialectic, both/and approach, which combines a “not-knowing” stance with “some-knowing” or information about specific cultures, including the therapist’s own, allows for more complexity and
effectiveness. This integration of attitudes can provide the most beneficial means of working with diverse client families, as the following case illustrates.

Behind the one-way mirror, an emerging power struggle was brewing between a family therapy trainee at a well-known training institution and the Bernals, a Puerto Rican immigrant family. The therapist insisted that the father’s delusions should be treated with psychotropic medication. But the family politely refused pharmaco-therapy and could not answer why. Suspecting there was a plausible cultural belief or practice behind the resistant behavior, I suggested to the therapist that she ask the family members if they had other health or religious resources that might be helpful to the husband’s condition. The wife then said she believed her husband would get better because prayer would help him. I suggested the therapist adopt a curious stance by asking the family, “How does prayer work?” To this, the mother replied that she met twice a week with her friends to pray at a local storefront church, and all of their prayers together swelled up to a powerful, luminous energy that could counteract the dark forces that had overtaken her husband’s psyche. The family’s refusal to accept could now be understood positively as linked to their belief systems about effective treatment of delusions. Furthermore, their “cure” connected the mother to her social network of co-nationals, which was clearly supportive and helpful. This new meaning decreased the polarization with the therapist and opened the door for collaboration in stages.

Having some knowledge of cultural details attuned the consultant to the possibility that religion and ecological context may be playing a role in the family’s resistance to the therapist’s “local” medical cure for delusions. A therapist with a “not-knowing” approach toward culture might have eventually arrived at the same place. The family members, meanwhile, conscious of difference with the dominant culture views, might not ever have volunteered their prayer practice unless asked. One might be tempted to say that the first therapist would have done better. Not necessarily. The ethnic-focused therapist may have stopped at simple respect for the family’s cultural solution once the family mentioned prayer. A “not-knowing,” curious stance was very helpful in taking the inquiry further by asking how prayer works concretely in the family’s particular subculture of religion. Weaving back and forth between these stances—one informed by some cultural knowledge and the other guided by curiosity—could clarify the family’s fears that medication would preclude the prayers from working. The therapist could then ally with the family members to better define what kind of help they needed and would be willing to accept from the clinic.

In a both/and position, involving “someknowing” and “not-knowing,” the therapist must be comfortable with other “double discourses”—an ability to connect with the universal human similarities that unite us beyond color, class, ethnicity, or gender—but simultaneously recognize and respect culture-specific differences due to color, class, ethnicity, and gender. This “double discourse” may be explicit or implicit, foreground or background, expanding or shrinking, the cultural emphasis depending on the case at
hand. Consistent with the reality of shifting multiple contexts, there is no list of “do’s” and “don’ts” when working with ethnic, gender, racial, or religious groups. There is only one “do” and one “don’t”—do ask, and don’t assume. Like the lines of the Pat Parker (1990) poem at the beginning of this chapter, we must relate to each other’s universal humanity, yet not forget about each other’s remarkable cultural contexts. The borderlands we share can be a meeting place for these conversations to begin.

REFERENCES


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