CHAPTER 1

MECA

A Meeting Place for Culture and Therapy

> How comes it, after all, that, beginning with glancing experiences and half-witnessed events, one ends, as one sometimes does, with formed, written, recounted fact? Mainly, it seems, by way of *summary figures somehow assembled along the way: worked-up images of how matters connect*.
>
> —Clifford Geertz (1995, p. 18, emphasis added)

At a time when human migrations continue to rise, we find ourselves crossing cultural borders to meet with families that are themselves crossing physical as well as cultural borders. In this two-sided crossing, families are not the only ones confronting cultural change. Practitioners—health and mental health care providers, researchers, teachers, and workers in many disciplines—are required to go beyond the confines of familiar European American theory and practice to examine the immensely rich and complex meaning systems of their immigrant clients. By placing the stresses and strengths tied to migration, culture change, and sociopolitical ecologies at the center of the clinical practice encounter, rather than as an add-on to treatments developed in the mainstream, we are better able to attend to the needs and to honor the wisdom brought by families from different cultures—in this case Latino families in transition. Seeking to incorporate complex sets of cultural and sociopolitical variables into clinical practice requires a clear recognition that clinical practice is, in itself, a cultural and sociopolitical encounter.

CLINICAL PRACTICE AS CULTURAL AND SOCIOPOLITICAL ENCOUNTER

A culturally attuned position on the part of the practitioner (and also the supervisor of clinicians in training) requires awareness of how theoretical

positions, sociopolitical perspectives, and professional values inform the clinical encounter. The practitioner also brings to this encounter the personal values acquired in the cultures and contexts of his or her own family. In spite of a psychoanalytic tradition of questioning clinicians' objectivity and encouraging self-examination, not much attention has been paid to "cultural countertransference" (Pérez Foster, 1998), a concept that takes into account clients' and therapists' perceptions of each others' cultures and sociopolitical contexts. Supervisors must recognize that clinicians' subjectivity is a vital component in the treatment of clients whose race, class, or ethnicity differs from those of the therapist. Clinicians' and clients' cultural histories and social contexts are neither neutral nor irrelevant to the therapeutic relationship and have a profound impact on treatment outcome and process (La Roche, 1999).

There have been various attempts to answer the questions of how, what, and when to articulate culture with clinical practice. Some approaches advocate a "knowing" or knowledge-rich position; that is, the need for a priori knowledge about ethnic or other cultural traits, such as that Puerto Ricans, Mexicans, and Cubans value very close family ties (McGoldrick et al., 2005). Others prefer to focus on universal invariants in families' predicaments (e.g., children need to be raised by adults) and consider cultural differences to be tangential to the clinical situation. There are also many in-between positions. Still others advocate a "not-knowing" position of curiosity and respect, making use of cultural values and social locations as they emerge during the treatment process, and thus relying minimally on a priori knowledge of the particular culture of the client (Lappin 1983).

Most cultural competence approaches focus on learning the values of various ethnic cultures as belonging to other people. In spite of the emphasis on culture-specific information, these approaches do not sensitize clinicians and supervisors to the cultural underpinnings of the theories they use—which of course, are not culture-free. Since the universality of mainstream theories and techniques is not questioned, practitioners are seldom encouraged to develop new, culture-specific theories and interventions (Falicov, 1995b, 2003b; 2012).

Incorporating culture and context into theory, assessment, treatment planning, and the therapeutic relationship is a challenging undertaking. One of the difficulties is that the broad generalizations about cultural norms and values found in anthropology or sociology may be valid at the societal level but need refinement, qualification, or rejection at the individual level. In fact, when we apply sociocultural norms to clients, we tend to use stereotypes that may hamper rather than facilitate clinical work. It may be equally problematic, however, to ignore cultural norms and sociopolitical contexts when they are relevant to assessment and intervention.

Let's examine the spectrum of choice available to practitioners in deciding when to include culture and context in their thinking and how these options are not only influenced by practitioner preference, but may also be dictated by the client's presenting problem.

THE PLACE OF CULTURE AND CONTEXT IN CLINICAL PRACTICE: A SPECTRUM OF CHOICE

In clinical situations culture and context can become either background or foreground depending on the issue at hand. Culture can also be an organizational reality, a defensive mask, or a powerful myth for the client. In addition, the practitioner has ideological positions relative to the place of culture and context. Hence, the practitioner and family need to explore the connections between the presenting problem and culture and context issues in a collaborative way.

Culture as central or tangential. Some practitioners consider cultural influences as tangential, whereas others see them as central to theory, practice, and training.

Culture as background. For some clinicians and clients, culture and context provide a background narrative seen as one of a multitude of forces that shape a family's predicament, and they have the choice to reflect upon these cultural forces or not.

Culture as foreground. At the other extreme, practitioners who view culture as an overpowering foreground narrative believe that many emotional problems are connected to (1) constraining self-definitions imposed by socialization, (2) alienation from one's ethnic traditions, or (3) disempowering social and political forces. For this latter group, the healing potential lies in either reconnecting clients with their cultural legacies and sense of belonging, or in the acknowledgment (or recognition) of a sense of exclusion from the mainstream or from cultural communities.

Clinicians are further guided in the way they approach culture by taking certain positions—more implicit than explicit—about the relationship between culture and therapy. It is possible to group these positions into four categories: the universalist, the particularist, the ethnic-focused, and the multidimensional ecological comparative. Each position has different implications for multicultural practice and training as outlined in Table 1.1.

TABLE 1.1. The Place of Culture in Clinical Practice and Training

Positions	Multicultural practice and training
Universalist	• No use
Particularist	• No use
Ethnic-focused	• "Cultural literacy" in a separate course or lecture with specific content
Multidimensional ecosystemic comparative	• Integrates culture with all learning • Distills diversity in basic systems domains • Generic comparative maps

The Universalist

This position maintains that families are more alike than different. A universal position emphasizes similarities rather than differences in both intrapsychic and interpersonal processes. Many classic psychoanalytic theories and traditional behavior therapy fall into this category. Some clinicians who believe in the stable universality of psychic and interpersonal processes claim that contextual variables such as race, gender, and ethnicity are irrelevant distractions from basic individual and family processes. Indeed, universalist assumptions underlie most psychological concepts and theories: object relations, multigenerational transmission, attachment, triangulation, and life-cycle transitions, to name a few. Those who assume a universalist position regard culture as tangential to therapy and not necessary.

It is undoubtedly correct that many shared biological and social imperatives create similarities across cultures. It is also crucial for practitioners and supervisors to appreciate the sameness between groups. The danger, however, lies in clinicians' commission of ethnocentric errors while believing their stance to be objective and impartial.

The Particularist

At the other extreme is the particularist position, which states that all individuals and families are more different than they are alike. A "not-knowing" position based on postmodern language-based collaborative practices approximates a particularist position (Anderson, 2001). From a particularist perspective, no generalizations can be made about the relationship between a family and the larger culture, and therefore each individual's predicament is a product of his or her personal history and the interior of the family. No focus on multicultural training is necessary.

The Ethnic-Focused

The third position stresses predictable diversity of thoughts, feelings, and behavior, as well as of customs and rituals, among different ethnic groups. This position might be illustrated by the tendency of Catholic Mexicans to shun divorce or by the importance of native healers such as *curanderos*. This approach has been pivotal in developing sensitivity in practitioners by requiring them to gain basic knowledge about the characteristics of different ethnic groups (McGoldrick et al., 2005). There is little room in an ethnic-based position for cultural inconsistencies, dilemmas, or contradictions, however. It also has largely assumed that the observer is culture-free. Still another limitation is that ethnic-focused generalizations tend to portray culture as static and stable rather than as changing and unstable.

The ethnic-focused approach advocates "cultural literacy" through education of the practitioner about specific features of the culture, grounded in a view of the client as "other." Although it has been useful to alert practitioners and supervisors to cultural differences, I believe that the ethnic-focused position needs to be counteracted with the practitioner's and the supervisor's knowledge of their own cultures and their prejudices along with a willingness to cede the role of cultural expert to the client.

MECA: A Multidimensional Ecosystemic Comparative Approach

The approach taken in the multidimensional ecosystemic comparative approach (MECA) integrates the three positions discussed above *and* goes beyond them. MECA offers a comprehensive definition of culture, a method for making meaningful comparisons, and room for multiple and evolving cultural narratives. Rather than making culture marginal to theory and practice, MECA takes the factor of culture into the mainstream of all teaching and learning. This framework maintains that it is possible and desirable to integrate cultural awareness at every step in the process of learning how to observe, conceptualize, and work therapeutically, regardless of theoretical orientation. For example, if the topic being considered is divorce or aging, the MECA approach asks, what are the ethnic, social-class, and religious differences one may expect to see in these events? And what are the universals that transcend group variations? Culture is then discussed in the context of a specific issue rather than in the abstract.

Every clinical encounter is really an encounter between the practitioner's, the client's, and the supervisor's cultural and personal life maps, as illustrated in Figure 1.1. A clinician's views about each client stem from

the clinician's cultural map, which includes his or her preferred brand of theory and professional subculture (Fancher, 1995). The clinician's maps are further affected and organized by personal values, views, and preferences acquired in his or her family of origin and through life experiences (Aponte, 2009).

In the introductory MECA diagrams (Figure 1.1 and later in Figure 1.2) I include the clinical supervisor because he or she is often part of the therapeutic system and has a great deal of influence on how issues are constructed. Supervisors must also become aware of their personal and professional ecological niche. In a different publication, I address the training of supervisors in the MECA approach and in migration-specific competencies (Falicov, 2014a, 2014b). I believe that supervisors will increasingly be called upon to self-reflect about their cultural and social locations to guide supervisees' work.

In presenting this generalist framework, my hope is that clinicians and supervisors, regardless of theoretical orientation, will find it both accessible and meaningful in their work with individual families that represent a wide variety of cultures, subcultures, and cultural blends. It will become apparent in my description of cases that the theoretical orientation I use is ecosystemic, structural, multicultural, and postmodern, and the practices that I implement are integrative and multidisciplinary.

In the rest of this chapter I introduce the salient ideas that underlie MECA, discuss each of its components, introduce its four domains, and use a case study to illustrate MECA's application to assess and treat

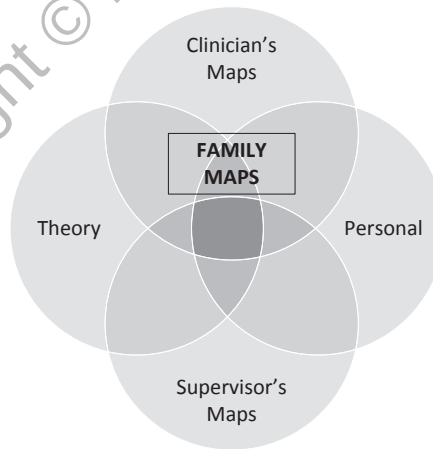

FIGURE 1.1. The overlapping maps of family, clinician, and supervisor.

a family, as well as to describe the clinician's and, in this case, also the supervisor's cultural positions.

MECA: SYSTEMIC AND POSTMODERN FOUNDATIONS FOR PRACTICE

A Multidimensional Ecosystemic Definition of Culture

One of the first challenges in introducing culture and context to clinical practitioners is to define these terms in a nonstereotypic or formulaic fashion. The following definition underlines the multidimensionality and fluidity of culture:

> Culture is those sets of shared world views, meanings, and adaptive behaviors derived from simultaneous membership and participation in a variety of contexts, such as language; rural, urban or suburban setting; race, ethnicity, and socioeconomic status; age, gender, gender identity, sexual orientation and sexual variance, religion, disability, nationality; employment, education and occupation, political ideology, stage of migration/acculturation, partaking of similar historical moments and ideologies. (Falicov, 1983, pp. xiv–xv)

Exclusion from various contexts is also part of the cultural experience (Falicov, 1995b, 2003b).

This multidimensional view reflects more fairly the meaning of the word *diversity* than any one dimension alone. Individuals and families partake of and combine features of the many contexts listed in the definition. The contexts provide particular experiences of inclusion and exclusion. It is the combination of multiple contexts and partial perspectives that shapes a person's culture, rather than any of those separately. Each person is raised in a plurality of cultural groups that exerts a multiplicity of influences, depending on the degree of contact with each context. Since individuals and families partake of and combine features of several contexts, it is necessary for practitioners to consider membership in all of the relevant contexts simultaneously.

The ecosystemic view endorsed in MECA was first brought to the field of family therapy and training by Edgar H. Auerswald (1968) when he proposed seeing individual and family issues in interaction with institutions and agencies. Two decades later I adapted Bronfenbrenner's classic 1977 ecological model of human development to the challenge of learning to think culturally in family therapy training and practice (Falicov, 1988). It seemed then, and is still, a fundamental way to regard all

families. The model proposed that individual and family relationships need to be understood in interaction with various levels of their social and cultural environments, such as extended family, community setting, institutional connection, and dominant cultural discourses. The adoption of multisystemic, ecodevelopmental, and structural ecosystems therapies, based on clinical research studies with Hispanic populations, attests to the importance of this way of thinking (Liddle, 2000; Muir et al., 2004; Szapocznik & Coatsworth, 1999; Coatsworth et al., 2002; Parra-Cardona, Cordova, et al., 2008).

Exploration of cultures and contexts should also include the critical examination of practitioners' racist, sexist, or classist views (Aldarondo, 2007; Burton et al., 2004). Recent studies acknowledge the intersections of race, gender, ethnicity, and class and thus stress multiple identities, while taking into account power issues in ecological contexts (Kosutic & McDowell, 2008; Watts-Jones, 2010). A supervisor's disclosure of personal and theoretical values or ideologies to the supervisee could serve both by modeling a way of thinking and to lay the groundwork for issues that might affect their relationship and the client's treatment. The construct of *ecological niche* is helpful in drawing points of connection and divergence.

Ecological Niche: Multiple Contexts and Cultural Borderlands

Each person has a cultural foundation comprised of multiple contexts that include a number of collective identities—groups of belonging, participation, and identification that make up his or her "ecological niche." Each person's ecological niche shares "cultural borderlands" or zones of overlap of similarity and difference with others by virtue of race, ethnicity, religion, occupation, or socioeconomic class (Anzaldúa, 1987). Borderlands give rise to internal inconsistencies and contradictions as well as to commonalities and resonances among groups and individuals. Borderlands occur at the edges of "officially" recognized cultural groups, such as in my case, being an Argentine, a Jew, and a U.S. citizen. Other borderlands occur at less formal intersections—being raised a traditional girl (gender) in a family of immigrants (class and migration) of limited schooling (education), encountering a different world (and values) through advanced education, and acquiring higher social status (economics) through marriage. The idea of *cultural borderlands* captures more accurately the multiculturalism of modern everyday life in urban settings.

With MECA, practitioners make a quick holistic assessment of all the contexts to which family members belong to understand the cultural resources, constraints, and dilemmas those multiple contexts may create. Points of contact and divergence also open up connections between

practitioner and client (and for supervisor, supervisee, and client) that go beyond ethnic and racial matching. A middle-class white Costa Rican therapist who is an agnostic Democrat may have more in common with a similarly politically and religiously minded Jewish Uruguayan client than with a rural Catholic conservative Costa Rican, because the first two share a greater number of cultural borderlands with each other. In Table 1.2, I illustrate the construct of personal and theoretical niche by using my example of self-reflection, an exercise that I suggest for all clinicians and supervisors. The process of investigating one's personal and theoretical ecological niche helps therapists and supervisors get in touch with their cultural ideologies as well as areas of privilege and areas in which they have either experienced "otherness" or need to acknowledge their own racism. These explorations can be used as the basis for conversations between supervisors and supervisees.

Beyond Cultural Stereotypes

The definition of culture above moves beyond cultural stereotypes based on a single dimension, such as ethnicity. In a pluralistic society such as the United States, persons are multicultural rather than belonging to a single ethnic group that can be summarized by a single label or even a hyphenated label. In attempting to provide culturally attuned practice,

TABLE 1.2. My Personal and Theoretical Ecological Niches

My personal ecological niche	My theoretical niche
• Argentine, naturalized U.S. citizen, bilingual/bicultural • Woman • Heterosexual • White • Second-generation in Argentina as daughter of Eastern European working-class Jews • Psychologist • Liberal Democrat • First-generation immigrant to the United States • Married for 30 years to a physician • Mother of three daughters • Grandmother of four • Widow	• Human development (lifespan development in social and cultural contexts) • Family psychology • Systemic • Postmodern • Family therapist (structural, ecosystemic, multicultural, strength-based)

professionals face the dilemma of acquiring sufficient cultural literacy to respect the cultural beliefs of the client, and yet not fall prey to stereotypical evaluations that rob clients of their particular individual histories and choices. In this process an inclusive and comparative both–and position is very helpful.

Both–And Stances

When making a generalization that describes some culture-specific aspect of a collective identity (e.g., "He is displaying Latino-style *machismo*"), it is possible to recognize similarities with other groups (e.g., "His protectiveness toward his daughter is not dissimilar to preferred masculinities in other patriarchal societies"), while also honoring individual differences by probing the person's interpretations or exceptions to these cultural generalizations (e.g., "He protects his daughter's reputation from premarital sexual activity but supports her college education because he does not want her to be dependent on a man").

Knowing and Not-Knowing Stances

Knowing and not-knowing stances are both necessary when embracing multidimensionality. The ethnic-focused position, which requires knowing as many details about particular cultures as possible, can be contrasted to a "not-knowing" stance in therapy. Not-knowing approaches are based on a valuing of curiosity and encourage a dialogue that takes into account all meanings—cultural and personal—as they emerge in the therapeutic situation (Lappin, 1983). In my opinion, a combination of knowing and not-knowing approaches can provide the most beneficial means of working, or supervising work, with diverse client families. It combines a not-knowing stance with an informed cultural foundation that could be used to raise questions with the family.

In a supervisory role from behind a one-way mirror, I witnessed an emerging power struggle between a family therapy trainee and a Puerto Rican family, the Castillos. The therapist insisted that the father's delusions should be treated with psychotropic medication, but the family politely refused pharmacotherapy.

I suggested to the therapist that she ask the family if they had other health or religious resources that might be helpful. The wife said that she thought her husband would get better because prayer would help him. I suggested to the therapist that she adopt a curious stance by asking the family, "How does prayer work?" 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 Castillo family believed in the power of the gradual accumulation of these positive forces through prayer, and they felt that medication would drastically interfere with this process.

My awareness about cultural preferences attuned me to the possibility that religion may be playing a role in the family's resistance to a "universal" medical cure for delusions and led me to encourage the therapist to inquire about the family's religious resources. A supervisor or a therapist with a not-knowing approach toward culture might have arrived at the same place, but more likely would have stayed close to the guarded information provided by the family. The family, conscious of their differences with the dominant culture's views, might not have volunteered their prayer practice. One might be tempted to say that a supervisor with knowledge about the culture tends to do better. Not necessarily. The ethnic-focused supervisor may have stopped at a simple respect for the family's cultural solution, while my adding a not-knowing, curious stance about how prayer works revealed something important for this family's adherence to treatment.

Weaving back and forth between these stances—one informed by cultural guesses and the other guided by curiosity—I helped the supervisee to clarify the family's fears that medication would preclude their prayers from working. I could then instruct the therapist to ask the family to better define what kind of help they needed and were willing to accept from the clinic. The family opted for giving their prayer approach 2 more weeks. One of the adult daughters suggested that she would observe the father's progress carefully and insist on returning to therapy and medication if there was no significant improvement.

The clinician must be comfortable with an ever-present "double discourse"—an ability to see the universal human similarities that unite us beyond color, class, ethnicity, and gender, while simultaneously recognizing and respecting culture-specific differences that exist due to color, class, ethnicity, and gender. This double discourse may be explicit or implicit, foreground or background, expanding or shrinking the cultural emphasis. It may come about from some basic knowledge about cultural differences or from a curious and respectful not-knowing stance, depending on the demands of the case. This *both–and* position and the *knowing and not-knowing* position also include a particularist view that recognizes the uniqueness of each family's story.

A Strength-Based Orientation

Latino families (particularly, economically disadvantaged immigrants) have been portrayed with a deficit model that points to problematic

areas in family relationships. Without minimizing the serious challenges and risks that Latino immigrant families face, I focus on their resilient responses and underline the importance of working with their many strengths. Among these are strong family and community bonds and systems of help, healthy maintenance of cultural rituals, capacity for hard work, and pride in good parenting.

A "relational resilience" lens proposed by Walsh (2006) is very helpful with Latino immigrants because it shifts the perspective from viewing distressed families as damaged to seeing them as challenged and it affirms their potential for growth. Many immigrant families demonstrate capacity to survive and even thrive; they have ethnic and network resources, situational triumphs, loving capacities, and courage to face racial or ethnic prejudice and economic injustice. Strength-based explorations offer a more solid, hopeful ground for trust in the practitioner's capacity to appreciate and help a family.

The practice ideas offered in the case illustrations in this book demonstrate clients' capacity to weather stress and draw out abilities for growth and adaptation. Later in this chapter, the Díaz Ortiz family shows us how they overcame a crisis situation connected to migration and abrupt cultural transition and managed to expand their newly gained knowledge of institutions to help other community members prevent a similar stressful event.

A Collaborative Stance: The Client as Cultural and Sociopolitical Expert

Consonant with seeing families as having complex and varied cultural identities, clients are seen as the experts on their cultures and contexts. Since the clinician is not the cultural expert and furthermore adds to the mix the complexities of his or her own cultural values, the clients are the only ones who can interpret the meaning of their personal and sociocultural experiences. The clinician may hold a rough map of inquiries that may help him or her construct a migration narrative, but clients are in charge of establishing what parts of their experiences they prefer to focus on and what kinds of solutions fit with their goals.

Another form of collaboration is also pivotal to this work. Multilevel collaborations that involve the services of folk healers, priests, family physicians, psychiatrists, social workers, teachers, or lawyers need to be part of clinical practice to create effective and coordinated change, as illustrated repeatedly in this book. For example, immigrant families commonly turn to the comfort and continuity of their health beliefs, such as the use of prayer and other traditional cultural cures. These rituals and traditions are a naturally occurring healing resource (see Chapters 6 and 7). Asking clients what they think is causing their ailments and what means they have

been using to overcome them can lead to meaningful collaborations with folk systems of care and with uses of religion (see Chapter 6, Angel Pérez Dominguez's case, p. 188).

A Reflective and Culturally Humble Stance

The notion that the clinician and the supervisor could benefit from cultural self-reflection and acknowledging their subjectivity fits with the construct of *cultural humility*. This concept, more common among physicians (Tervalon & Murray-García, 1998; Juarez et al., 2006) than among psychotherapists, captures more accurately than the concept of *cultural competence* how contemporary clinicians are called on to practice. From a stance of cultural humility, a practitioner recognizes that the client is the expert who is uniquely qualified to educate the practitioner about his or her multiculturalism—that is, his or her membership in multiple cultural groups and his or her life stressors and treatment priorities, rather than assuming cultural knowledge of the client based on preconceived identity labels. Many of the case illustrations and personal anecdotes in this book include the clinician's own ecological niche and positions about cultural diversity and social justice that influence the encounter with families.

MECA CONSTRUCTS: CULTURAL DIVERSITY AND SOCIAL JUSTICE

For over 15 years I have used MECA to provide a cultural and contextual framework focused on differences and similarities by using domains that are relevant to assessing and treating diverse clients (Falicov, 1995b, 2003b). MECA incorporates two major constructs about difference: cultural diversity and social justice.

1. *Cultural diversity* focuses on cultural preferences among clients based on their ethnicity, religion, nationality, profession, or political ideology and critically examines existing theories and techniques used in clinical work.
2. *Social justice* focuses on the effects of power differentials (due to gender, economic, and racial inequities) and related sociopolitical or contextual stressors on individual and family well-being. It also examines these issues in the relationship between minority clients and practitioners and between minority trainees and supervisors.[1]

Throughout this book, I cite many recent articles that integrate cultural differences and social justice concerns, often in the form of contextual

TABLE 1.3. MECA Multiculturalism Constructs: Cultural Diversity and Social Justice

Cultural diversity	Social justice
Meaning and belief differences tied to . . . • Ethnicity • Religion • Nationality • Profession • Political ideology	Power differences and contextual stressors tied to . . . • Gender • Sexual orientation, gender identity • Race • Social class • Minority status
Practice • Curiosity and respect • Culture-specific adaptations • Transformations of theory (attachment, individuation)	Practice • Empowerment • Cultural resistance • Social action • Legitimization of local knowledge

stressors in the study of Latino families. These two constructs have been conflated often, but I believe they have important different implications for practice, as I outline in Table 1.3. At the practical level, a notion of cultural diversity centers on curiosity and respect and on culture-specific adaptations of mainstream approaches; and less frequent but also important are transformations of theory in areas such as individuation concepts. A social justice lens encompasses the legitimization of local knowledge, cultural resistance, empowerment, and social action. Let's examine these distinctions further.

A Cultural Diversity Lens

In MECA, cultural diversity is explored primarily in the domains of family organization and family life cycle (see Figures 1.2 and 1.3). Clients' beliefs, communication styles, traditions, or rituals that are part of a culture different from the one with which the practitioner has had personal experience or has been schooled in, could unintentionally be judged as problematic. To avoid confusing cultural types of family organization or family life-cycle timings with problems, a practitioner must incorporate a critically questioning attitude toward the European American biases inherent in most professional training. The clinician's examination of his or her sociocultural background makes it evident that many theories and interventions may stem from cultural niches other than the client's, and therefore they cannot be the standard by which individuals and families can be evaluated.

A Social Justice or Sociopolitical Lens

With MECA, sociopolitical issues are explored primarily in the domains of migration and acculturation and ecological contexts (see Figures 1.2 and 1.3). A social justice position directs attention to life conditions, power differentials, and contextual stressors such as discrimination that limits opportunities and affect physical and mental health for those who are poor, marginalized, or discriminated against. 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 or racial discrimination are downplayed (Montalvo & Gutiérrez, 1983).

A social justice practice connects mental health with contextual stressors and experiences of social oppression and aims to empower families in their interactions with larger systems and cultural discourses, including those in the psychotherapy profession (McGoldrick & Hardy, 2008; Hardy & Laszloffy, 1994; Laszloffy & Hardy, 2000).

MECA: THE KEY GENERIC DOMAINS

The MECA framework offers a comparative way of thinking about similarities and differences that are relevant to clinical practice. MECA encompasses four generic domains: migration–acculturation, ecological context, family organization, and family life cycle. Parts II, III, IV, and V of this book cover these four domains. The choice of these domains is intended to transcend particular schools of psychotherapy and to reflect cultural and contextual variations relevant to family therapy theory and practice, but also to many other helping professionals who need to incorporate the impact of migration and culture change in their work.

Within this approach, the basic domains chosen represent my views of migration and culture. As noted in the quote at beginning of this chapter, they are *"summary figures somehow assembled along the way, worked up images of how matters connect"* (Geertz, 1995, p. 18, emphasis added) in areas of culture and contexts for practitioners. These views are inevitably influenced by my conceptual development as a family therapist and my personal experience as an immigrant and as a second-generation daughter of immigrants. Some of these personal cultural strands are shown in Table 1.2. Thus the ideas I express should not be taken as the "truth" about culture and therapy about Latinos; doubtless there are other accounts and constructions of culturally oriented work.

A crucial difference between MECA and other approaches is the proposal to use only four domains of description for all groups. Rather

than learning the special characteristics of separate and distinct cultural groups by using a different set of categories for each group, the use of the same four domains allows for a comparative approach that often captures the common ground as well as the differences among individuals or various groups, in this case Latino groups—thus the use of the term *comparative* in MECA. Further, examining cultural matches and comparisons between therapist and supervisor along MECA domains encourages better understanding of each other's perspectives. (See MECAmaps under Practice and Training tools later in this chapter.)

Migration and Acculturation

The first key generic domain, migration–acculturation, attends to when, why, and how a family migrated. Migration and acculturative stresses may have significant mental health reverberations for the internal and external workings of individuals and families over several generations. These stresses include individual symptoms such as somatization or nightmares, as well as family over- and underinvolvement caused by separations and reunifications. A number of clinical issues are tied to such experiences as coaxed migrations or traumatic crossings. Other relational migration stresses, from cultural gender gaps between husbands and wives to intergenerational conflicts between parents and children, emerge as cultural changes over time. Yet, there are also many migration stories of triumph gained through family unity, endurance, hard work, and determination to aspire to a better future for oneself and one's children.

Ecological Context

The second generic domain of ecological context examines diversity in where and how the family lives and fits in the broader sociopolitical context. It considers the family's total ecological field, including the racial, ethnic, class, religious, and educational communities in which each person lives; their living and working conditions; and their involvement with schools and social agencies. This domain sensitizes clinicians to ecological or contextual stresses: those psychosocial and mental health consequences of marginalized status; discrimination due to race, poverty, and documented or undocumented status; and other forms of powerlessness, lack of entitlement, and access to resources. Facing these injustices many families resist losing their cultures or isolating themselves from their communities. They protect their children from dangers in the streets and continue to instill positive values of dignity and integrity.

The constellation of beliefs about health, illness, religion, spirituality, and magic is relevant for understanding the client's attitudes toward

mainstream health care, psychotherapy, and complementary traditional medicine (Falicov, 2009a). This information is included under exploration of the ecological context because often the spiritual and health resources provided by priests, church congregations, and folk healers are part of the immediate neighborhood and community. Drawing out the themes of these first two domains—migration and ecological context—and their connection with the presenting concern is essential to engagement in social justice practices (see Figure 1.2).

Family Organization

The third generic domain of family organization considers diversity in family structure and in the values connected with different family arrangements. Many Latino and poor families tend to share a preference for collectivistic, sociocentric family arrangements that encourage parent–child involvement and parental respect throughout life. This perspective is in contrast to nuclear family arrangements that favor nonbiological relationships such as husband–wife (Falicov, 2006). The qualities or attributes of many family interactions are affected by these differential preferences, such as connectedness versus separateness, gender versus generational hierarchies, or styles of communication and conflict resolution among family members and outsiders. Latino families that come for clinical consultation in the throes of rapid cultural transformation may experience conflict and confusion over family models, obligations, and loyalties. It is common for immigrant and poor clients to need help in balancing emotional and pragmatic attachments to the family of origin and current loyalties to the family of procreation. These dilemmas are conceptualized as themes of cultural transition in family organization, as we discuss later.

Family Life Cycle

The fourth generic domain of family life cycle encompasses the dimension of time, and focuses on diversity in how developmental stages and transitions are culturally and contextually patterned. Although the sequence of developmental events has universal biological aspects, many elements are embedded in a cultural and ecological fabric: the timing of stages and transitions, the constructions of age-appropriate behavior, various growth mechanisms, and life-cycle rituals and rites, to name a few. It is valuable for practitioners to understand similarities and differences between themselves and their clients regarding life-cycle values and experiences. Based on European American life-cycle perspectives and developmental norms, a therapist may mistakenly assume a developmental individuation delay or a dysfunctional overattachment in a 25-year-old

married Nicaraguan American man who stops by his mother's daily to have a delicious *tamalito* and ask her opinions on many life issues. They may actually be a source of support and cultural family continuity to each other in ways that help with migration and contextual stresses.

The impact of migration and transnational connections needs to be considered, too, because new values may coexist with traditions, giving rise to bicultural codes (Falicov, 2011). These themes are part of cultural life-cycle transitions. The last two domains, family organization and family life cycle, encompass many cultural diversity variables.

Exploring the family's migration history and acculturation together with its ecological resources or constraints will help locate both the practitioner and the client in the family's "external cultural landscape." Conversations about culturally diverse values and themes in family organization and life-cycle processes highlight the family's "internal cultural landscape." In short, the stories of migration and culture change, the patterned space of ecological context, the shapes of family organization before and after migration, and the temporal transitions of the family life cycle must always be present in the multicultural practitioner's mind whenever he or she is conversing with clients.

Many immigrant family themes and processes embedded in the four MECA domains are summarized in Table 1.4. This table serves as a guide to the contents and processes covered under various topics in the chapters to follow.

Using MECA to Compare Cultural and Contextual Maps of Family, Clinician, and Supervisor

Each participant in the therapeutic encounter brings a unique "cultural map" to the table (see Figure 1.1). Awareness of these maps underscores the partial perspectives that color our cultural and contextual observations and ultimately influence our interventions.

Examining overlapping areas of maps reveals both the dissonance and the consonance between a family and a practitioner. For example, they may have different ethnic backgrounds and religions but similar education and social class; they may all have experienced prejudice and marginalization because of race, gender, sexual orientation, or political ideology, or they may have experienced relocation or migration; or they may share developmental niches, perhaps as parents of adolescents. The multidimensional, comparative approach builds cultural bridges of connectedness between a family and a practitioner and also between a supervisee and a supervisor. When there are areas of clear difference, the comparative approach stimulates interest in learning about the experiences and worldviews of others. This attitude can forge new mutual understanding and respect.

TABLE 1.4. MECA: Assesment Themes and Processes Covered

Transformations: Continuity and change	Migration and acculturation • Type of migration (e.g., undocumented) • Composition of separations (e.g., father alone) • Trauma pre-, during, postmigration • Losses and gains • Uprooting of meanings (physical, social, and cultural) • Transnationalism • Psychological or virtual family: those who stayed • Complex acculturation (e.g., alternation) • Spontaneous rituals • Second-generation transnational exposure • Adolescent–parent biculturalism	Social justice
	Ecological context • Poverty • Work/school • Neighborhood • Isolation • Ethnic community • Virtual community • Church and religion • Health and traditional healing • Racism and anti-immigrant reception • Gender and gender orientation discrimination • Contextual dangers (drugs, violence, gangs) • Contextual protections (language, social network)	

	Family organization
	• Separations and reunifications
	• Long-distance connections
	• Other people in household
	• Kin care: transnational triangles
	• Remittances
	• Relational stresses
	  ○ Gender evolutions
	  ○ Polarizations about migration
	  ○ Boundary ambiguity
		Cultural diversity

	Family life cycle • Cultural ideals • Meanings • Timings • Transitions • Rituals • Sociocentric and authoritative child-rearing practices • Developmental dilemmas (autonomy vs. family loyalty) • Suicide attempts and parent–adolescent conflicts • Gender variance and family acceptance • Pileup of transitions • Absences at crucial life-cycle markers	

MECA provides a framework for introducing conversations about diversity and social justice, which are generally awkward or difficult to broach. A clinician can explore with the family the four parameters and the extent to which these areas may be connected to the presenting issues or symptoms. Similarly, a supervisor can initiate conversations about cultural and sociopolitical issues with a supervisee, utilizing MECA as the points of comparison. A number of training and practice graphic and narrative tools can be used in conjunction with MECA applications, some of which are described here.

PRACTICE AND TRAINING TOOLS

Several graphic instruments are useful for training and for clinical assessments that can be adopted for use with immigrants. A *basic genogram* is a classic tool to gather historical and relational data for clients (McGoldrick et al., 2008). Over time, this standard genogram has been found to have significant limitations in depicting diversity in families. Watts-Jones (1997) proposed an African American genogram that can reflect a definition of family as a larger social and functional kin and non-kin entity than the mainstream definition of family as a biological entity—a critical observation that applies also to Latino families.

Culture-centered genograms have been proposed as ethnic and race-oriented instruments by Hardy and Laszloffy (1994) and Thomas (1998). Santiago-Rivera et al. (2002) add to the culture-centered genogram features relevant to immigrant families: immigration date, language usage, contact with native country, and bicultural characteristics. In some cases, I illustrate features of cultural genograms, such as language proficiency by indicating, for example, family members who are monolingual Spanish speakers and/or those who are bilingual or monolingual English speakers. McGoldrick et al. (2008) have used genograms to symbolize community and culture. Keily et al. (2002) suggests using cultural genograms in a self-reflective way to help trainees become more aware of their cultural background.

An *ecomap* (Hartman, 1978) is a tool that visually organizes the social and institutional world in which the client's life is embedded. Ecomaps are increasingly used as separate companions to genograms. In some cases, I draw connections to community members and institutions from the genogram itself (see Figures 8.1 and 8.2, pp. 230, 246).

Along similar lines of inclusion of social or cultural dimensions in graphic form, Congress (2004) has proposed the *culturagram*, which is basically an ecomap that includes reasons for relocation and immigration status, along with values about family organization. The *community*

genogram (Rigazio-DiGilio et al., 2005) is similar to an ecomap. It encourages clients to depict, as a free-form drawing, their community of origin and their current community. Recently, the notion of a *critical genogram* (CritG; Kosutic & McDowell, 2008) has been introduced as a training tool that promotes critical consciousness by focusing on intersecting forms of oppression (e.g., sexism, classism, racism).

Ecological Niche Exercise, MECAmaps, and MECAgenograms

As part of MECA, I have developed three basic tools that I use regularly for training and for clinical practice. The first tool is the Ecological Niche Exercise, for use by a clinician or a supervisor for cultural self-reflection. On the left side of a simple table drawn with pencil and paper, the clinician lists his or her PERSONAL NICHE—that is, multiple personal contexts of belonging and identity, such as age, race, class, immigrant story, language, and marital status. On the right side of the table, the clinician lists his or her THEORETICAL NICHE—that is, professional identity, level of experience, model preferences. Two ecological niche tables are illustrated in Table 1.2 (supervisor) and Table 1.5 (supervisee). The clinician or the supervisor can study his or her ecological niche as part of learning about one's own multiple contexts. The exercise can also be used to compare cultural and contextual similarities and differences—that is, cultural borderlands—with a specific family in treatment.

The second tool is the MECAmap (see Figure 1.2). It is primarily a training tool used to represent the cultural and contextual sociopolitical maps of the family or those of the clinician. It is simply constructed by placing the four domains (migration–acculturation, ecological context, family organization, and family life cycle) in four rectangles (always in the same order). In the center of the MECAmap, the clinician can draw circles indicating the family, or the clinician, or the supervisor.

The four rectangles representing each domain are filled with the information gathered in conversation with each family. It is helpful to use Table 1.4 to increase the amount of information and the complexity of the items covered in each parameter. To compare areas of similarity and difference with the family, a therapist can fill in his or her maps in each rectangle on a separate piece of paper and look at the maps with the family. This side-by-side viewing could alert all involved to possible areas of error or potential difficulties in the interaction that may need to be clarified to create a therapeutic alliance.

The third tool is the MECAgenograms. It combines the family genogram at the center, surrounded by the four rectangles describing the MECA domains. A template appears in Figure 1.3.

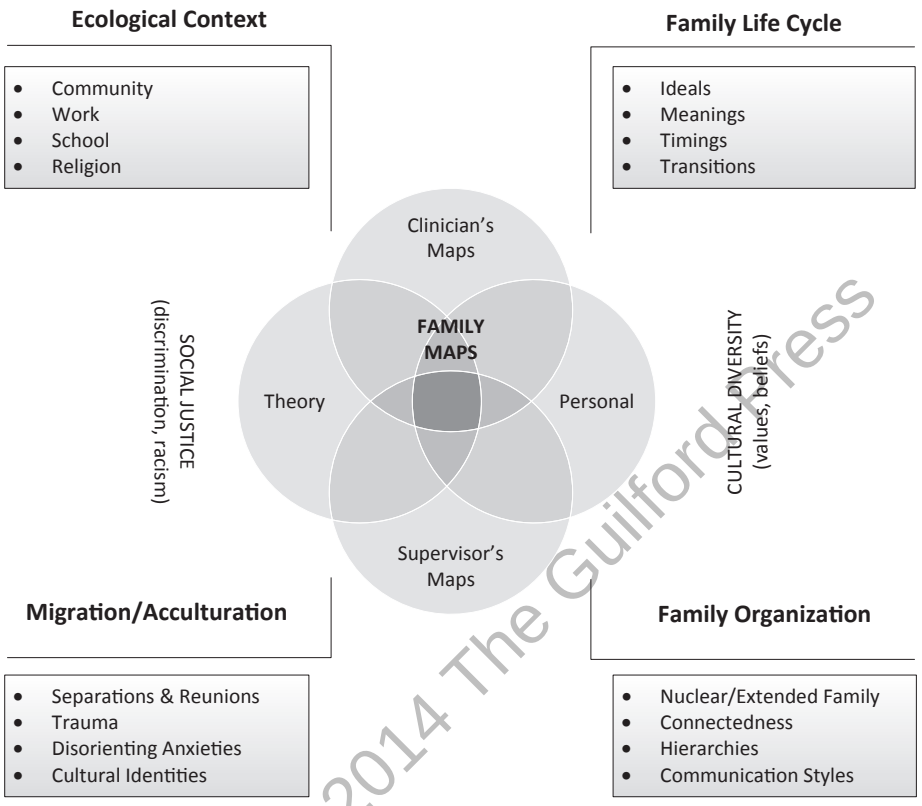

FIGURE 1.2. MECAmaps: The four generic domains of MECA.

This is a descriptive tool that appears filled out in several of the book's case illustrations (see for examples Figures 1.4 and 5.1 [pp. 41 and 143]). The four rectangles in this template figure can be filled out by the therapist with the family, and it covers the topics that appear in the four rectangles in Figure 1.2. The content of Table 1.4 can further enrich the topics covered in family assessment and serve as a guide for fruitful explorations with the family. A useful permutation is to put the elements of the therapist's MECAmap on the MECAgenogram. To do this, a second set of rectangles is drawn at the bottom of the first set on the same page to represent the therapist's maps in the same four domains as the family's and to provide a quick visual comparison. (See Figure 9.1, p. 280.) Consistent with a strength-based approach and similar to a culture-centered genogram, the MECAgenogram provides an opportunity to discuss individual stories of struggle and triumph (Santiago-Rivera et al., 2002).

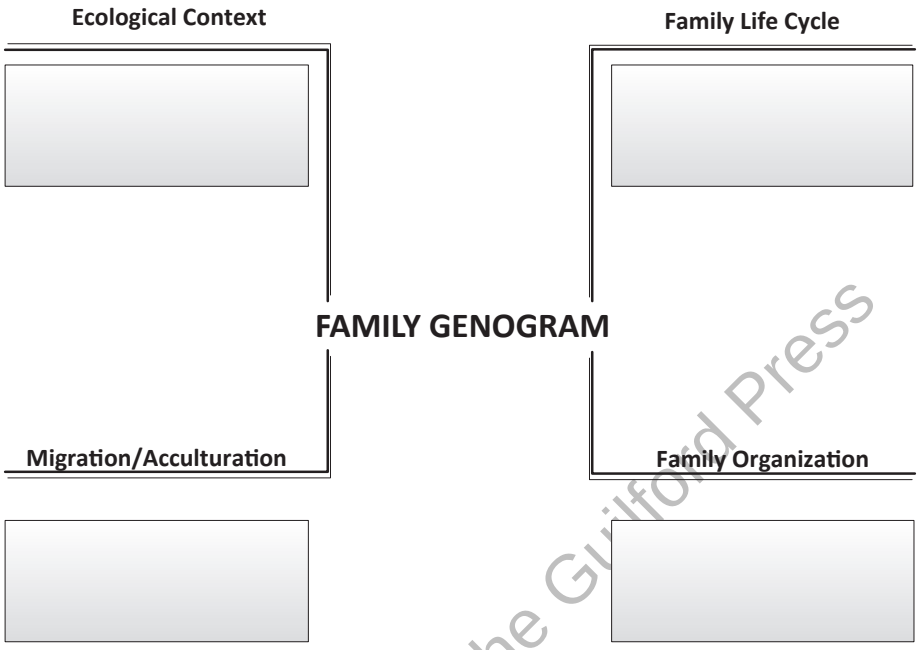

FIGURE 1.3. A template for a MECAgenogram

These stories can provide past and present positive role models for family members.

When possible, I draw the MECAgenogram on a poster-size paper on an easel or a wall and encourage clients to find their own fitting symbols to depict strengths and risks in their relationships with institutions, communities, and with individuals in their family. This search for fitting symbols is quite fascinating and more fun and accurate than imposing my symbols. Some clients have chosen to draw a flower (for a beautiful influence) or a stone (for a heavy burden) around a person or a place. Other clients have chosen wings (new attachments) and roots (old attachments), or wings (angelic) and horns (devilish) for significant persons and places. One client chose to draw a Pandora's box (for unpredictable neighbors whom she could not trust) and a golden box (for our clinic, where she felt she could trust everybody completely). An older sister wrote "Despair" for a brother in jail and "Hope" for a brother in school.

The process of building a MECAgenogram is an invaluable way to join with a family and to engage children and adolescents in finding out about their parents' lives. It gives youth a unique opportunity to reveal more about their own contexts than they may usually do. Often, the

generations find out a lot about each other that had never been discussed before. If possible, it is helpful to provide continuity by displaying the large paper that depicts the MECAgenogram on a wall or on a table during the family sessions.

The best way for trainees and clinicians or supervisors to learn how to use these tools with clients is to first apply them to themselves. A therapist can fill in the information for Figures 1.1–1.3 and bring these to supervision sessions to (1) relate his or her own family's migration history, (2) detect possible sources of relational and acculturative stresses and strengths, and/or (3) compare the congruence of these maps with the client's maps.

MECA ILLUSTRATION IN PRACTICE

The following case presents information about the four domains obtained through the migration narrative (see Chapter 3), the use of MECAgenograms, and the use of therapist's ecological niches and practice ideas that were utilized during treatment. The cases in other chapters contain similar domains and practices, but the latter vary to accommodate to the therapeutic needs of each case as it unfolds.

THE DÍAZ ORTIZ FAMILY: A CASE OF CHILD ABUSE AND/OR FAMILY REUNIFICATION STRESS?

The Díaz Ortiz family is composed of a 26-year-old mother, Isabel; a 29-year-old father, Victor; and two children, 6-year-old Yolanda and 2-year-old Magdalena (Figure 1.4). Victor had been accused of hitting Yolanda and was reported to Child Protective Services (CPS) by school authorities for investigation. Because the evidence was inconclusive, CPS referred the family for counseling at a local mental health center.

Collecting MECA Assessment Information

Migration

Seven years ago, Mr. and Mrs. Díaz Ortiz migrated from a small town near San Luis de Potosí, Central Mexico, to San Marcos, California, a small town north of San Diego, in search of a better economic future. Their migration narrative revealed that Victor had initially come to California alone, before he and Isabel had married. He found a number of small gardening jobs that paid him less than minimum wage. Nonetheless, Victor felt that, over time, he would be better able to support a family in the United States than in his

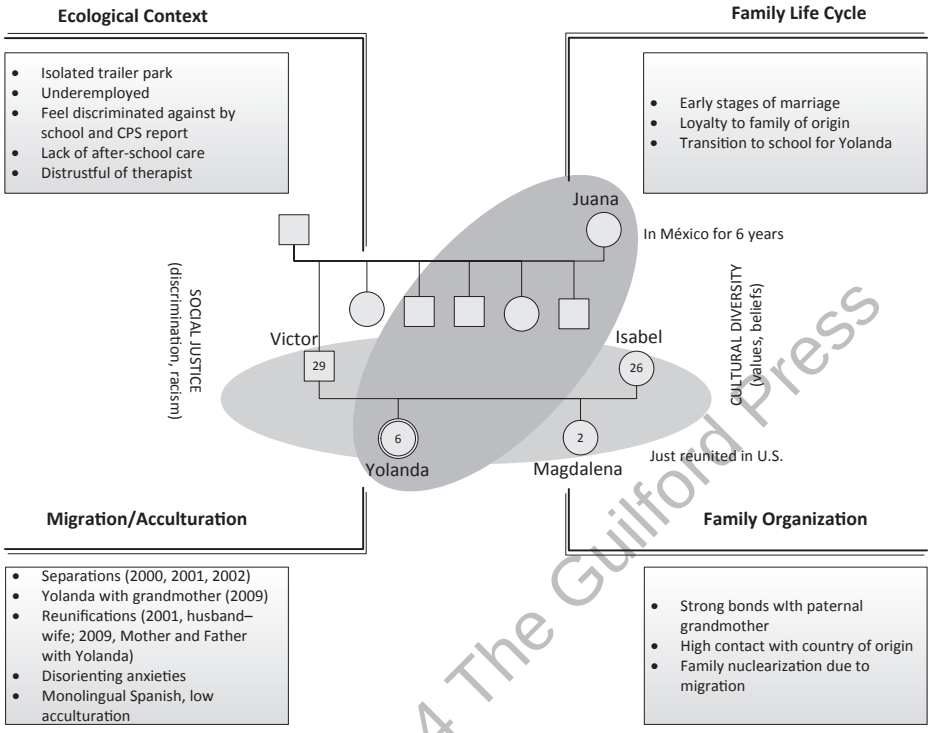

FIGURE 1.4. The MECAgenogram of the Díaz Ortiz family.

own country. He returned to his native town to marry Isabel and then came back with her to the United States. At that time, he poignantly described to her how comfortable the couches seemed to be in America, and how the TV programs advertised many wonderful household appliances that could be bought in easy installments. Isabel, who was only 19, worked as a maid the first year and became pregnant soon after. The couple was concerned that, without the help of their extended family, they would be unable to manage financially and emotionally once the new baby arrived. They returned to Mexico, where they lived with Victor's family. But their economic situation worsened, spawning a desire to return to the United States.

For practical and economic reasons, Victor urged Isabel to leave their baby, Yolanda, in Mexico with Juana, her paternal grandmother. Isabel was uncomfortable with this idea, but Victor argued that without the responsibility of caring for Yolanda, his wife could continue to work in the United States. Pressured by Victor (and Victor's mother), Isabel acquiesced. The arrangement was a common one from the standpoint of Mexican culture—children

may remain behind with extended family during the initial stages of migration and are reunited at a later date (see Chapters 3 and 4).

Four years later, when the couple was expecting another child, Isabel decided she would stop working and bring Yolanda to San Diego. The grandmother resisted. Yolanda resisted. The girl and the grandmother prevailed (with a little help from Victor, who continued to favor his mother's wishes over his wife's). A year later, as the time approached for Yolanda to start elementary school, Isabel renewed her campaign to bring her daughter to San Diego. Arguing that her child would get a better education in the United States, Isabel's choice prevailed.

The family came in contact with the mental health system 4 months after Yolanda's own difficult migration and reentry into the Díaz Ortiz family. As soon as the 6-year-old child arrived from Mexico, she began throwing tantrums during meal times. She disliked many foods and often refused to eat. She also resisted calling her parents *Mother* and *Father*, for she had learned to call her grandmother *Mother* and believed her parents to be her siblings.

Among the therapist's first hypotheses was that Yolanda must be missing the flavors of her grandmother's home-cooked Mexican food. This assumption turned out to be incorrect. On the contrary, Isabel was a superb Mexican cook, whereas the grandmother had indulged Yolanda's sweet tooth with commercial candy in Mexico.

Ecological Context

The Díaz Ortiz family lived in an isolated trailer park on the outskirts of San Diego with a few Latino neighbors and other working-class families. Given their precarious economic position, Isabel's wish to stay home was not possible. She found a job at a factory that had a nursery to care for her younger child, Magdalena. But Isabel and Victor had trouble finding after-school child care for Yolanda. Both parents were working, and neither was able to pick up Yolanda at 5 P.M. Victor was angry at the indifference of school authorities, who told him there was a long waiting list for later after-school care and that he had applied too late. The couple said that they suspected discrimination. The report to CPS confirmed the Díaz Ortizes' feeling that school authorities "had it in for them." Unfamiliar with American laws, they believed that a child abuse allegation was a ploy to invade their privacy, to close doors on them, and to send them back to Mexico. (I have witnessed this fearful response in other immigrants, including those with papers, as anti-immigrant climates pervade the lives of people daily.) Feeling scared, isolated, ashamed, and unaccustomed to asking for institutional help, the Díaz Ortiz family felt they had nowhere to turn. Initially, they probably saw the therapist as being in cahoots with the school officials, aiming to find fault so as to "get rid of them."

Family Organization

When asked about the meaning of his decision to leave his daughter in Mexico, Victor Díaz's responses opened the door to an exploration of the family's organization. His answer to that question was, "There is no greater love than a mother's love, blood of her blood." At first he confused the therapist and myself with what we thought to be a contradiction—he had worked hard to convince the child's mother, his wife, to leave Yolanda behind. The mother he was referring to, however, was not his wife, but his own mother. For Victor, the direct bloodline was between his mother and his daughter, without recognition of his wife. His allegiances and definition of mother revolved around his own mother, not Isabel. By virtue of his Mexican ethnicity and his Roman Catholic upbringing, his family had been organized such that loyalty to intergenerational bonds, particularly between mother and son, were stressed over marital allegiances, at least during the early stages of marriage.

Isabel understood the guilt and distress Victor felt at leaving his mother to come to the United States. She explained empathically that Victor was worried his mother would *morir de tristeza* (die of sadness) had he refused to leave Yolanda with her. This strong intergenerational bond typifies many extended family arrangements, in which family connectedness is valued (and needed) over autonomy.

After a few years alone in this country, however, and perhaps because Isabel was working outside the home, the Díaz Ortizes' conception of family was slowly transforming into an arrangement that focused more on the husband–wife tie and on more egalitarian views. Migration had made them rely on each other rather than on an extended family network for emotional and practical support.

Family Life Cycle

For the Díaz Ortiz family, migration precipitated a dramatic change in family organization. This change intersected with the normative life-cycle transitions of early marriage, creating a troubling combination of stressors. Victor and Isabel were still steeped in family-of-origin norms when they married and left Mexico. A sense of responsibility toward their families and guilt for leaving tormented the couple, creating a need for parental approval. This was especially true for Victor, who was the prime initiator of the migration. Had they stayed in Mexico, it is likely that both Victor and Isabel would have remained tied to their families of origin even after marriage. Greater autonomy may have come when the couple was older. Victor's loyalty to his mother would have been manifested more subtly, perhaps by paying daily visits, helping out financially, and bringing the baby to visit every weekend.

Leaving a child behind at the time of migration may have ensured some continuity of presence and served as a symbolic offering of family loyalty.

For Latino grandparents, involvement with caretaking of grandchildren is generally much more intense than the normative expectation for the white middle-class American family.

Thus, for this family migration truncated a stage of the life cycle that is shared collaboratively or conflictually, but almost always together, by the three generations. Both parents, but more so Isabel, attempted to retrieve Yolanda, but she was unsuccessful for several reasons: lack of support from her husband and his attachment to his mother, with which his wife empathized; practical and economic limitations; and the grandmother's and the child's own resistance. At a later point, two life-cycle transitions legitimized Isabel's attempts to reunite with Yolanda: first, the birth of another baby established Isabel as even more of a mother than before; and second, the forthcoming entrance to primary school for Yolanda supported the family's immigrant's dream—education and a better future for their offspring in a new country.

Clinician's Ecological Niche

Early in the supervision process, the therapist, Stephanie Santana, was encouraged to draw her ecological niche, both in terms of her personal, sociocultural location and also her theoretical perspectives (see Table 1.5). The intention was to understand better the unique cultural encounter between her and the family.

The therapist was a 24-year-old marriage and family therapy supervisee, a second-generation Mexican American whose parents had migrated about 30 years earlier and had raised five children before her. Her Spanish was laborious, but acceptable. She was definitely more comfortable speaking English.

TABLE 1.5. Clinician's Personal and Theoretical Ecological Niches for the Díaz Ortiz Family

Clinician's personal ecological niche	Clinician's theoretical niche
• Second-generation Mexican American • Woman, 24 years old • White • Middle class • Youngest of six siblings • Bilingual—English dominant • Raised traditional, prefers modern • Most acculturated in her family • Resents privileged treatment of men in her family of origin • Single • Heterosexual	• Marriage and family therapy program • Beginning practicum level • Learning schools of therapy • Favors systems orientation • Individualistic attachment models of development • Feminist orientation • Transition from deficit- to strength-based models

She had incorporated the dominant culture's models of mental health that value autonomy over interdependence and symmetry over complementarity, particularly in relations between men and women. I was her supervisor with my own ecological niche, personal and professional, which I shared with her early during the supervision sessions (see Table 1.1).

During the first sessions with the family, the supervisee felt overwhelmed by the task of evaluating the presenting problem, particularly because the family appeared to be uncooperative. Victor was articulate and very vocal about how upset he was by the school intervention and referral to CPS. He didn't deny hitting Yolanda, but justified it as a reaction to his, and his wife's, frustration with the girl's frequent whining and refusal to eat "her mother's food." He was indignant at what he considered an unjust violation of his rights and the intrusion of strangers into their family ambit. His wife, Isabel, was quiet and appeared tacitly to support Víctor's position.

Feeling scared, defensive, and suspicious, the parents may have united to fight off the "invaders"—Victor challenged the young therapist, asking her why and how she expected them to disclose so much personal information when she was unwilling to reveal anything about herself. The "attack" appeared to be an uncharacteristic deviation from customary cultural politeness: The family was reacting to a perceived threat.

Out of her cultural and sociopolitical story and her professional studies, the supervisee had developed three psychological hypotheses: First, the parents and Yolanda were insufficiently bonded with each other, given the history of separation at a critical developmental time; second, the father had a "pathological" attachment to his own mother and lacked empathy for his wife; and third, the wife was subservient to her husband and needed to become more assertive. As constructions they were plausible and could certainly become part of a conversation with the family.

The first hypothesis seemed to be the most promising place to start because it involved the three family members' history of migration. It also had a more blame-free emotional tone and could be more easily linked to Yolanda's eating problems and to her parents' disciplinary and protective reactions to those problems. The other two constructions were based, at least in part, on stereotypes (and the supervisee's personal biases) about Mexican men's relationships to their mothers and wives, and the women's complementary responses. These two latter hypotheses were charged with considerable irritation and disapproval, manifest in the young therapist's judgmental attitude toward Victor.

In supervision, the supervisee was encouraged to practice her "sociological imagination" about this family's culturally patterned life, particularly in terms of their family organization and life-cycle expectations, had they remained in their native village. The supervisee was also asked to imagine the couple and their families' state of mind then, and now, when the son departed and subsequently when he left again after marriage and again after

having a baby and lastly again after taking the child back with them(see Figure 1.3). This imaginative stance facilitated a more flexible, more empathic, more curious, and less critical view of the two young parents on the part of the therapist. Further, I asked her if thinking about her parents as young immigrants could be of some help in her understanding of the Díaz Ortizes.

The therapist told me about the family's feelings of isolation, anger, and vulnerability, and requested that I meet with them, which I agreed to do. As a supervisee, she was familiar with my ecological niche and correctly believed that my age would confer more authority and that I would also be more likely to find areas of consonance with the family.

PRACTICE IDEAS FOR THE DÍAZ ORTIZ FAMILY

Joining by Clarifying and Empathizing with Contextual Stressors

When we all met, I expressed my understanding of the Díaz Ortizes' outrage and fear in a new stressful context. I gave them information about child abuse laws in California, stressing that these applied to people of *all* ethnicities and social classes. I explained that being an immigrant myself, I had been unaware of these laws until I learned through examples of American parents who were undergoing severe scrutiny from CPS, cases in which children would most likely be removed from the home. Hearing this empathic clarification, and learning about the state's interpretation of "the best interest of the child," Isabel and Victor visibly relaxed their guard. This shift enabled them to be more open to taking the steps necessary to comply with the legal requirements, even when those steps appeared to be excessive from their vantage point.

Exploring the Frequency and Meaning of Physical Discipline

As it turned out, the physical discipline was the first time the father had intervened forcefully on his wife's behalf against the whining child. Neither parent had a history of being hit as children, except for some occasional light spanking. As therapist and supervisor, we were both also concerned about Mr. Díaz's anger, and wondered if Mrs. Díaz, and perhaps even Yolanda, could be concealing the extent of physical abuse for various reasons, such as protecting the family against outsiders who might discriminate against them or because they had been intimidated into silence by Victor's possible retaliation.

Creating Safety for Disclosure in Individual Sessions

We decided to hold individual sessions with the stated objective of understanding each person better and to use these encounters to explore possible

abuse. The private sessions did not unearth new information, but they gave the wife and child a chance to freely share their concerns.

Uncovering and Supporting Family Strengths

Individual sessions also improved the relationship between each parent and the therapist, who later used the information she had gathered to comment on many positive aspects of the family: their care for and interest in one another, their pride in their family, and their desire to do what was right for all members.

Increasing Empathy for Immigrant Child Symptoms of Distress

Using a cognitive approach, both parents were helped to co-develop, list on a blackboard, and discuss other possible reasons for Yolanda's eating problems and to move away from feeling that Yolanda was simply "bad" or "spoiled" by the grandmother. The therapist introduced guesses that Yolanda could be *nerviosa* (nervous or upset), reacting to the trauma of recent migration, which included the loss of many familiar faces, places, and objects, but especially her grandmother. Indeed, an eating disorder could be seen as a somatization of psychological stress, a connection that is culturally congruent (see Chapter 6) and that the parents could easily understand. Yolanda's parents became more sympathetic toward their daughter's situation. Isabel also began to disentangle her relationship with Yolanda from a web of rivalry with her mother-in-law.

Relabeling Physical Discipline as Issues of Cultural Transition and Family Reunification Stress

We labeled the parents' problems with Yolanda, the school, and child protection authorities as issues of "family reunification" and "cultural transition." We openly supported Victor's attempts to help Isabel get Yolanda to eat, while disapproving of the means he used.

Identifying Changes in Family Organization, Such as Movement toward Family Nuclearization

Though poorly handled, the husband had good intentions to help his wife establish her influence over their daughter because, as he put it, "She [Yolanda] is ours now." We felt that a better connectedness for the couple would require a shift in the husband's ability to support his wife, even at the risk of disappointing his own mother. This attempt to develop a stronger parental alliance could be construed as a move toward an adaptive husband–wife companionate model of family organization appropriate to the new

cultural and ecological context and consonant with life-cycle changes, such as parenting in a nuclear family.

Empowerment in the New Ecological Context: Social Action

The Díaz Ortiz family faced another common dilemma of minority parents. The state orders most families to take parenting classes after they have had encounters with CPS, but the therapist could find only English-speaking classes in the area where Victor and Isabel lived. Surprisingly, Mr. Díaz Ortiz wanted to turn this upsetting experience into a useful cause. He figured other Spanish-speaking parents were unaware of child protection laws and the psychological reasons behind them. Victor and Isabel asked us to find a Spanish-speaking expert to facilitate a parenting group, and they offered to help develop this group by inviting parents they met at work or at their trailer park.

This decision toward social action on the part of the parents was a proof of their creativity and hands-on practicality. The therapist had come to appreciate the family's resilience, inspiring her to offer to work with them to facilitate the group, which they managed to arrange to meet at a local church. Both family and therapist were empowered by this experience.

THE CASE STUDY AND INTEGRATIVE APPROACHES

Within a multidimensional ecosystemic definition of culture, each case represents a unique combination of cultural and contextual influences. The case study becomes a fundamental avenue for the family and the practitioner to discover the interplay of migration, cultural, and contextual forces with family processes.

The practice ideas in the clinical cases presented in every chapter illustrate various aspects of dealing with migration issues, ecological stresses and injustices, changes in family organization, or stressful family life-cycle transitions. Clients are viewed as experts on their communities and cultures, and therapy is essentially a collaborative endeavor that stresses clients' strengths.

Because this volume focuses on the specifics of working with immigrants and their children, I introduce many migration and culture-specific competencies, such as possible roles of clinicians as social or family intermediary, and present many particular practices, such as migration narratives, catching-up life narratives, certificate of legitimization, rebalancing contracts or transnational therapies, and reframing as cultural transition or empowering in the new ecological context, among others—all designed

to address issues relevant to the circumstances of minority immigrants. Similarities and differences between the culture and context of the practitioner and the clients are taken into account in every case, for two reasons. One, there is much validity to the notion of common factors in family therapy (Sprenkle & Blow, 2004), which stresses the role of empathy, motivation, and a working alliance with the clinician as the basis of all therapy and its application to Latinos (Gallardo, 2012). The second reason is that the same crucial relationship between the clinician and the client, given the possible culture and context differences, requires constant self-reflection on the part of the practitioner with mindfulness about possible cultural biases and errors of assessment.

Depending on the case, I make use of family therapy resources learned over many years of practice. My theoretical basis has always been Minuchin's (1974) structural family therapy for families of all socioeconomic levels and its applications to low-income families (Minuchin et al., 1967). I also incorporate many postmodern approaches, such as the use of therapeutic rituals, circular questions, feed-forward questions, as well as strategic techniques such as odd days–even days interventions. I also find the conceptual and practice aspects of the work of narrative therapists, such as externalizing the problem, well suited to working with some issues of oppressed minorities. Whenever I use these practices, I give the rationale for their application. Although each case is different and therefore no formulas are possible, consistent patterns of practice emerge, and these are highlighted in every case illustration.

In many of the clinical situations presented, it is noted that the clinical hour with a practitioner needs to be supplemented and integrated with multidisciplinary and multilevel collaborations that involve other community resources, such as support and empowering groups, folk and religious healing, parenting classes, medical consultations, teacher conferences, Alcoholics Anonymous (AA) groups, marital enrichment programs or family acceptance programs, and many others, as part of both clinical practice and prevention.

Cultural and sociopolitical meanings are explored through dialogue and conversations that are *not* based on presuppositions, a priori categories, or any other formulaic "knowledge" about the culture or context of a family. In spite of this exploratory stance, it can be helpful to carry along some "worked-up images of how matters connect" (Geertz, 1995, p. 18) when one goes into the uncharted territory of a family's culture. Without any sort of map, one might get lost and miss completely what could have been just around the corner. MECA can provide such guidelines. In the chapters that follow, I delve more deeply into each of its four domains, offering new constructs and integrating findings from research

studies and many practice ideas based on my years of clinical experience with Latino immigrant families. But first we turn to a general orientation about the cultural and sociopolitical forces at work on a large diversity of Latino clients as a helpful and necessary background for clinical practice, whether it is conducted by Latinos or by non-Latino professionals.

NOTE

1. The family therapy literature has burgeoned with work focused on cultural diversity and social justice with various populations (McGoldrick et al., 1999, 2005; Boyd-Franklin, 2003; Santiago-Rivera et al., 2002; S. López, 1997; Comas-Díaz, 2007; Flores-Ortiz, 1999; Aldarondo, 2007; Almeida et al., 2007; Hernandez-Wolfe, 2008; Kosutic & McDowell, 2008; McGoldrick et al., 2008; Baumann et al., 2011).

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