

CHAPTER 1



Overview

Ethnicity and Family Therapy

Monica McGoldrick

Joe Giordano

Nydia Garcia-Preto

The future of our earth may depend on the ability of all [of us] to identify and develop new . . . patterns of relating across difference.

—LORDE (1992, p. 502)

What would it be like to have not only color vision but culture vision, the ability to see the multiple worlds of others?

—BATESON (1995, p. 53)

Cultural identity has a profound impact on our sense of well-being within our society and on our mental and physical health. Our cultural background refers to our ethnicity, but it is also profoundly influenced by social class, religion, migration, geography, gender oppression, racism, and sexual orientation, as well as by family dynamics. All these factors influence people's social location in our society—their access to resources, their inclusion in dominant definitions of “belonging,” and the extent to which they will be privileged or oppressed within the larger society. These factors also influence how family members relate to their cultural heritage, to others of their cultural group, and to preserving cultural traditions. Furthermore, we live in a society in which our high rates of cultural intermarriage mean that citizens of the United States increasingly reflect multiple cultural backgrounds. Nevertheless, because of our society's political, economic, and racial dynamics, our country is still highly segregated; we tend to live in communities segregated communities by race, culture, and class, which also have a profound influence on our sense of ethnic identity.

It is now more than two decades since the first edition of *Ethnicity and Family Therapy* was published; in these decades our awareness of cultural diversity in our society and

world has changed profoundly. We have witnessed amazing attempts at transforming ethnic group relationships in South Africa, Northern Ireland, the Middle East, and the former Soviet Union, as well as tragic ethnic devastation in the Sudan, Rwanda, Kosovo, Russia, the Middle East, and Latin America. Meanwhile, the United States is being transformed by rapidly changing demographics and has played a most ethnocentric role in going to war in Iraq. This is a role it has unfortunately played in many other regions at other times, most especially in Central and South America, in some of the Caribbean island nations, the Philippines, and Vietnam (see Chapters 11–19, 23, and 27).

THE MEANING OF ETHNICITY

Why have we as a people been able to continue to exist? Because we know where we come from. By having roots, you can see the direction in which you want to go.

—JOENIA BATISTE DE CARVAHLO, first Indian woman lawyer in Brazil,
who is fighting for the rights of her people.
(*New York Times*, November 13, 2004, p. 7)

Having a sense of belonging, of historical continuity, and of identity with one's own people is a basic psychological need. Ethnicity, the concept of a group's "peoplehood," refers to a group's commonality of ancestry and history, through which people have evolved shared values and customs over the centuries. Based on a combination of race, religion, and cultural history, ethnicity is retained, whether or not members realize their commonalities with one another. Its values are transmitted over generations by the family and reinforced by the surrounding community. It is a powerful influence in determining identity. It patterns our thinking, feeling, and behavior in both obvious and subtle ways, although generally we are not aware of it. It plays a major role in determining how we eat, work, celebrate, make love, and die.

The subject of ethnicity tends to evoke deep feelings, and discussion frequently becomes polarized or judgmental. As Greeley (1969) has described it, using presumed common origin to define "we" and "they" seems to touch on something basic and primordial in the human psyche. Irving Levine (personal communication, February 15, 1981) observed: "Ethnicity can be equated along with sex and death as a subject that touches off deep unconscious feelings in most people." When there has been discussion of ethnicity, it has tended to focus on nondominant groups' "otherness," emphasizing their deficits, rather than their adaptive strengths or their place in the larger society, and how so-called "minorities" differ from the "dominant" societal definitions of "normality."

Our approach is to emphasize instead that ethnicity pertains to everyone, and influences everyone's values, not only those who are at the margins of this society. From this perspective cultural understanding requires examining everyone's ethnic assumptions. No one stands outside the category of ethnicity, because everyone has a cultural background that influences his or her values and behavior.

Those born White, who conform to the dominant societal norms, probably grew up believing that "ethnicity" referred to others who were different from them. Whites were the definition of "regular." As Tataki (1993, 2002) has pointed out, we have always tended to view Americans as European in ancestry. We will not be culturally competent until we let go of that myth. Many in our country are left with a sense of cultural homelessness because their heritage is not acknowledged within our society.

Our very definitions of human development are ethnoculturally based. Eastern cultures tend to define the person as a social being and categorize development by growth in the human capacity for empathy and connection. Many Western cultures, in contrast, begin by positing the individual as a psychological being and define development as growth in the capacity for autonomous functioning. Even the definitions “Eastern” and “Western,” as well as our world maps (Kaiser, 2001), reflect an ethnocentric view of the universe with Britain and the United States as the center.

African Americans (see Chapter 6; Boyd-Franklin, 2003; Carter, 1995; Franklin, 2004) have a very different foundation for their sense of identity, expressed as a communal sense of “We are, therefore I am,” contrasting starkly with the individualistic European ideal: “I think, therefore I am.” In the United States, the dominant cultural assumptions have generally been derived from a few European cultures, primarily German (Chapter 40), Dutch (Chapter 38), and, above all, British (Chapter 37), which are taken to be the universal standard. The values of these few European groups have tended to be viewed as “normal,” and values derived from other cultures have tended to be viewed as “ethnic.” These other values have tended to be marginalized, even though they reflect the traditional values of the majority of the population.

Although human behavior results from intrapsychic, interpersonal, familial, socioeconomic, and cultural forces, the mental health field has paid greatest attention to the first of these—the personality factors that shape life experiences and behavior. DSM-IV, although for the first time considering culture in assessing and treating patients, allows one to conduct the entire course of diagnosis and therapy with no thought of the patient’s culture at all. Much of the authors’ work on culture was omitted from the published manual, and the “culture-bound” syndromes they did mention tended to “exoticize the role of culture” (Lopez & Guarnaccia, 2000). Indeed, the authors decided to exclude disorders seen as primarily North American disorders (anorexia nervosa and chronic fatigue syndrome) from the glossary of culture-bound syndromes because they wanted to restrict the term to problems of “ethnic minorities” (Lopez & Guarnaccia, 2000)!

As things stand now, most mental health record-keeping systems do not even record patients’ ethnic backgrounds, settling for minimal reference to race as the only background marker. No other reference is generally made to immigration or heritage. In the broader mental health field, there was a great increase in attention paid to ethnicity in the 1980s. However, since then there has been a distinct retreat from attention to culture as managed care, pharmaceutical, and insurance companies took control of most mental health services and intentionally minimized attention to family, context, and even service for those who cannot afford to pay. Since the early 1990s, the mental health professions in general pay only lip service to the importance of cultural competence. The study of cultural influences on human emotional functioning has been left primarily to the cultural anthropologists. Yet they have preferred to explore remote cultural enclaves, rather than examining culture within our own diverse society.

Even mental health professionals who have considered culture have often been more interested in examining international, cross-cultural comparisons than in studying the ethnic groups within our own society. Our therapeutic models are generally presented as having universal applicability. Only recently have we begun to consider the underlying cultural assumptions of our therapeutic models and of ourselves as therapists. And even now, reference to “cultural competence” varies from complete acceptance to outright derision (Betancourt, 2004).

We must incorporate cultural acknowledgment into our theories and into our therapies, so that clients not of the dominant culture will not have to feel lost, displaced, or mystified. Working toward multicultural frameworks in our theories, research, and clinical practice requires that we challenge our society's dominant universalist assumptions, as we must challenge our other societal institutions as well in order for democracy to survive (Dilworth-Anderson, Burton, & Johnson, 1993; Hitchcock, 2003; Pinderhughes, 1989).

It is unfortunate that society's rules have made it difficult for us to focus our vision on ourselves in this way, but it is essential if we are to become culturally effective clinicians. As Bernard Lewis (2002) has put it:

When things go wrong in our society, our response is usually to place the blame on external or domestic scapegoats—foreigners abroad or minorities at home. We might ask a different question: What did we do wrong? (pp. 22–23)

This question, which leads us to look in every situation to see what we contribute to misunderstandings, is essential to expanding our cultural awareness. We must understand where we have been and the cultural assumptions and blinders our own history has given us before we can begin to understand those who are culturally different from us.

This book presents a kind of “road map” for understanding families in relation to their ethnic heritage. The paradigms here are not presented as “truth,” but rather as maps to some aspects of the terrain, intended as a guide for the explorer seeking a path. They draw on historical traits, residues of which linger in the psyche of families many generations after immigration, long after its members have become outwardly “Americanized” and cease to identify with their ethnic backgrounds. Although families are changing very rapidly in today's world, our focus here is on the continuities, the ways in which families retain the cultural characteristics of their heritage, often without even noticing these patterns. Of course, the clinical suggestions offered by the authors of this book will not be relevant in every case, but they will, it is hoped, expand the readers' ways of thinking about their own clinical assumptions and the thinking of the families with whom they work. Space limitations have made it necessary for us to emphasize characteristics that may be problematic. Thus, we do not always present families in their best light. We are well aware that this can lead to misunderstandings and feed negative stereotypes. We trust the reader to take the information in the spirit in which it is meant—not to limit our thinking, but to expand it.

There has been a growing realization since this book's first edition that a positive sense of ethnic and racial identity is essential for developing a healthy personal and group identity, and for effective clinical practice. So far, more in the field of health care than in mental health, the concept of “cultural competence” has begun to become an accepted value. In recognition of the overwhelming evidence of racial and ethnic disparities in health care, there is a beginning acknowledgment that with every illness and on virtually every measure of functioning, the cultural disparities in health care are staggering and it is time to rethink our cultural attitudes and to address these realities. A new field of “cultural competence” in health care has been emerging, a field that defines the “culturally competent health care system” as one that acknowledges the importance of culture throughout the system and is vigilant in dealing with the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003).

This field of culturally competent health care seeks to identify sociocultural barriers to health care and to address them at every level of the system, including the cultural congruity of the interventions provided and the degree to which the leadership and workforce reflect the diversity of the general population (Betancourt et al., 2003).

Within the mental health field, recognition of the importance of culture has been much slower. Family therapy, which was rocked to its foundations by the feminist critique (Luepnitz, 1992; McGoldrick, Anderson, & Walsh, 1989; Wheeler, Avis, Miller, & Chaney, 1985), has been moving toward an awareness of the essential dimension of culture as well as gender. Unfortunately, most of the institutions in the field, such as the major training programs, the publications, and the professional organizations, still view ethnicity as an “add-on” to family therapy, a “special topic,” rather than as basic to all discussion. Reactions to the upsurge in “diversity” presentations at the annual Family Therapy Academy meetings have included a frequently articulated request by members to “get back to basics.” In our view there is no such thing as moving “back” to basics. Rather, we must re-envision the “basics” from more inclusive perspectives, so that the cultural underpinnings of all therapeutic endeavors will inform our work, allowing us to deal theoretically and clinically with all our clients (see the Appendix on cultural clinical assessment).

For many, the earlier editions of *Ethnicity and Family Therapy* provided an “ah ha!”—a recognition of their own cultural background or that of spouses, friends, or clients. Still, when it was first written, we were all fairly naive about the meaning of culture in our complex world. Some feared that our book reinforced cultural stereotypes, but we believed then, and believe now, that exploring cultural patterns and hypotheses is essential to all our clinical work.

We also recognize that ethnicity is not the only dimension of culture. In this book we illustrate how gender, socioeconomic status, geography, race, religion, and politics have influenced cultural groups in adapting to American life. Knowing that no single book could possibly provide clinicians with all they need to know to work with those who are culturally different, we gave the authors of the chapters the following instructions:

We have become increasingly convinced that we learn about culture primarily not by learning the “facts” of another’s culture, but rather by changing our attitude. Our underlying openness to those who are culturally different is the key to expanding our cultural understanding. Thus, cultural paradigms are useful to the extent that they help us recognize patterns we may have only vaguely sensed before. They can challenge our long-held beliefs about “the way things are.” Thus, we ask you to write your chapter with the following aims in mind:

1. Describe the particular characteristics and values of the group with some context of history, geography, politics, and economics as they are pertinent to understanding the patterns of the group.
2. Emphasize especially values and patterns that are relevant for therapy—those an uninformed therapist might be most likely to misunderstand (e.g., related to problems, help seeking, and what is seen as the “cure” when people are in trouble).
3. Describe patterns that relate to clinical situations, especially couple relationships; parent-child issues, sibling relationships, three-generational relationships; how families deal with loss, conflict, affection, homosexuality, and intermarriage.
4. Include relevant information on the impact of race, class and class change, religion, gender roles, sexual orientation, and migration experiences.
5. Offer guidelines for intervention to facilitate client well-being, demonstrating respect for both the historical circumstances and the current adaptive needs of families in the United States at the beginning of the 21st century.

Clinicians should never feel that, armed with a small chapter about another cultural group, they are adequately informed to do effective therapy. The chapters that follow are not intended as recipes for relating to other ethnic groups, which is far more influenced by respect, curiosity, and especially humility, than by “information.” It has been said that some individuals are blessed with a certain magic that enables them to break down the natural reserve we all feel toward those of another language, another culture, another economic stratum. This is the blessing we wish to impart to our readers.

THE COMPLEXITY OF ETHNICITY

If we look carefully enough, each of us is a “hodgepodge.” Developing cultural competence requires us to question the dominant values and explore the complexities of cultural identity. All of us are migrants, moving between our ancestors’ traditions, the worlds we inhabit, and the world we will leave to those who come after us. The consciousness of ethnic identity varies greatly within groups and from one group to another. Many people in the United States grow up not even knowing their ethnicity or being descended from many different ethnic backgrounds. Our clinical work of healing may entail helping clients to locate themselves culturally so that they can overcome the sense of mystification, invalidation, or alienation that comes from not being able to feel culturally at home in our society. But everyone has a culture. As family therapists, we work to help clients clarify the multiple facets of their identity to increase their flexibility to adapt to America’s multicultural society. We help them appreciate and value the complex web of connections within which their identities are formed and which cushion them as they move through life. Our clients’ personal contexts are largely shaped by the ethnic cultures from which they have descended.

For most of us, finding out who we are means putting together a unique internal combination of cultural identities. Ethnicity is a continuous evolution. We are all always in a process of changing ethnic identity, incorporating ancestral influences while forging new and emerging group identities, in a complex interplay of members’ relationships with each other and with outsiders. Every family’s background is multicultural, and all marriages are, to a degree at least, cultural intermarriages. No two families share exactly the same cultural roots. Each of us belongs to many groups. We need to find a balance that allows us to validate the differences between us, while appreciating the common forces that bind us together, because the sense of belonging is vital to our identity. At the same time, the profound cultural differences between us must also be acknowledged. It is when the exclusion of others becomes primary to group identity that group identity becomes negative and dysfunctional, based on exclusion of others through moral superiority, such as White supremacy groups, or on elite social status, such as secret societies. The multiple parts of our cultural heritage often do not fit easily into the description of any one group. In addition, to define oneself as belonging to a single ethnic group, such as “Irish,” “Anglo,” “African American,” is to greatly oversimplify matters, inasmuch as the process of cultural evolution never stands still. We are always evolving ethnically. We offer ourselves as illustrations:

Monica: My Irish ancestors had roots in Celtic tribes, who probably came from what is now Switzerland, and Viking communities in what is now Norway. My husband emigrated from Greece at age 19, his family having lived in Turkey for generations until the

1920s. Our son speaks some Greek, but no Gaelic, and has had to struggle to put together the differences between Greek patriarchy and Irish matriarchal values.

Joe: My grandparents came from Italy—grandpa from Naples and grandma from Genoa. (Some would say that was a mixed marriage!) I married a Puerto Rican-Italian woman; my second wife's mother was Scots Irish, and her father was born in Holland of a Jewish mother and a Protestant father. I also have three grandchildren whose mother is African American with roots in the Baptist South.

Nydia: My ancestors were Spanish colonizers, African slaves, Corsicans, and Taino Indians who met in Borinquen, the island known today as Puerto Rico. I came with my interracial parents and brother to Columbus, Georgia, in 1956, for my father was in the U.S. Army. I married a second-generation Italian, and my two children identify themselves mainly as Puerto Rican. My grandson's mother is African American.

Each generational cohort also has a different “culture,” shaped by the historical forces that defined it (the Depression, World War II, Vietnam, etc.), as do people of different geographic regions, urban and rural areas, socioeconomic contexts, and religious affiliations. Upper-middle-class Jewish families in Northeast cities, middle-class German and Scandinavian families on Midwestern farms, African Americans and Anglo families in small Southern towns, poor Mexican migrant farm workers in rural Texas, and Asian Indian and Iranian professionals in California suburbs all have had very different experiences. In addition, we are all being influenced by the “culture” of the Internet and television, which is replacing family and community relationships to an ever increasing extent.

So when we ask people to identify themselves ethnically, we are really asking them to oversimplify, to highlight a part of their identity in order to make certain themes of cultural continuity more apparent. We believe that ethnically respectful clinical work helps people to evolve a sense of whom they belong to. Thus, therapy involves helping people clarify their self-identities in relation to family, community, and their ancestors, while also adapting to changing circumstances as they move forward in time.

We need to go beyond many of our cultural labels and develop a more flexible language that allows people to define themselves in ways that more accurately reflect their heritage and cultural practices. Such labels as “minorities,” “Blacks,” and “Americans,” and one of the more recent additions to our lexicon, “non-Hispanic Whites,” reflect the biases embedded in our society's dominant beliefs. The term “minority” marginalizes groups whose heritage is not European. The term “Black” obliterates the ancestral roots of Americans of African heritage altogether and defines them only by their color. And the use of the term “American” to describe people of the United States makes invisible Canadians, Mexicans, and all other people of the Western Hemisphere. We might use the term “United Statesan,” but we have instead claimed only for ourselves the descriptor for people of all the Americas. The term “non-Hispanic White” for people of European origin forces them to define themselves always in relation to “Hispanics.” Hispanics are defined as a cultural group, although they thought of themselves as a racial group in the 2000 census, but were forced to define themselves by races that included Filipino and Guamanian but not Hispanic or Latino.

Ethnicity is, indeed, a complex concept. Jewish ethnicity, for example, is a meaningful term to millions of people (Chapter 48). Yet it refers to people who have no single country of origin, no single language of origin, no single set of religious practices. Jews in the United States may come from Argentina, Russia, Greece, or Japan and have Ashkenazic roots. Or they may be Sephardic Jews from North Africa or Spain, who have

very different cultural traditions and migration patterns within the United States. There are similar difficulties with definitions of Arabs (Chapter 31), who may be Eastern Orthodox Syrians, Roman Catholic Lebanese (Chapter 34), or Turkish, Jordanian, Egyptian, or Palestinian Muslims (Chapter 35). There is, however, some sense of cultural connection between these groups. Moreover, the shared ethnic history of families of these backgrounds is not irrelevant to their adaptation in the United States.

We may feel negative toward, or proud and appreciative of, our cultural heritage, or we may be unaware of which cultural groups we even belong to. But our relationship to our cultural heritage will influence our well-being, as will our sense of our relationship to the dominant culture. People's sense of their ethnicity is affected by their relationship (unaware, negative, proud, appreciative) to the groups they come from, and their relationship (a sense of belonging, feeling like an outsider, or feeling inferior) to the dominant culture. Are we members of it? Are we "passing" as members? Do we feel like marginalized outsiders? Or are we outsiders who have so absorbed the dominant culture's norms and values that we do not even recognize that our internalized values reflect its members' prejudices and attempts to suppress cultural difference? Individuals should not have to suppress parts of themselves in order to "pass" for normal according to someone else's standards. Being "at home" means people having a sense of being at peace with who they really are, not being assigned to rigidly defined group identities, which strains people's basic loyalties. Maria Root (2003) has developed a "Bill of Rights" for racially mixed people, which includes the right

- to identify myself differently than strangers expect
- to identify myself differently than my parents identify me
- to identify myself differently than my brothers and sisters identify me
- to identify myself differently in different situations
- to create a vocabulary to communicate about being multiracial
- to change my identity over my lifetime and more than once
- to have loyalties and identify with more than one group of people

As family therapists, we believe in helping clients understand their ethnicity as a fluid, ever-changing aspect of who they are. Louise Erdrich (Erdrich & Dorris, 1991), has described the complexity this entails through one of her characters:

I belong to the lost tribe of mixed bloods, that hodgepodge amalgam of hue and cry that defies easy placement. When the DNA of my various ancestors—Irish and Coeur d'Alene and Spanish and Navajo and God knows what else—combined to form me, the result was not some genteel indecipherable puree that comes from a Cuisinart. You know what they say on the side of the Bisquick box, under instructions for pancakes? Mix with fork. Leave lumps. That was me. There are advantages to not being this or that. You have a million stories, one for every occasion, and in a way they're all lies and in another way they're all true. When Indians say to me, "What are you?" I know exactly what they're asking and answer Coeur D'Alene. I don't add, "Between a quarter and a half," because that's information they don't require, first off—though it may come later if I screw up and they're looking for reasons why. If one of my Dartmouth colleagues wonders, "Where did you study?" I pick the best place, the hardest one to get into, in order to establish that I belong. If a stranger on the street questions where [my daughter] gets her light brown hair and dark skin, I say the Olde Sodde and let them figure it out. There are times when I control who I'll be, and times when I let other people decide. I'm

not all anything, but I'm a little bit of a lot. My roots spread in every direction, and if I water one set of them more often than others, it's because they need it more. . . . I've read anthropological papers written about people like me. We're called marginal, as if we exist anywhere but on the center of the page. We're parked on the bleachers looking into the arena, never the main players, but there are bonuses to peripheral vision. Out beyond the normal bounds, you at least know where you're not. You escape the claustrophobia of belonging, and what you lack in security you gain by realizing—as those insiders never do—that security is an illusion. . . . "Caught between two worlds," is the way we're often characterized, but I'd put it differently. We are the catch. (pp. 166–167)

This brilliant expression of a multifaceted cultural identity, composed of complex heritages, illustrates the impact of one's social location on the need to highlight one or another aspect of one's cultural background in a given context, in response to others' projections. The illustration also points out what those who belong have to learn from those who are marginalized.

Most of us are somewhat ambivalent about our ethnic identification. But even those who appear indifferent to their ethnic background would be proud to be identified with their group in some situations and embarrassed or defensive in others. Those most exposed to prejudice and discrimination are most likely to internalize negative feelings about their ethnic identity. Often ethnicity becomes such a toxic issue that people do not even want to mention it, for fear of sounding prejudiced, even in situations where it is primary. Some families will hold onto their ethnic identification, becoming clannish or prejudiced in response to a perceived threat to their integrity. Others use ethnic identification to push for family loyalty. They might say: "If you do that, you're betraying the Jews." For other groups, for example, Scots, Irish, or French Canadians, such an emotional demand for ethnic loyalty would probably not hold much weight.

Awareness of ethnicity within a United States context is always associated with loss. In the case of the indigenous peoples of the Americas, their cultures were destroyed by the European immigrants or by the illnesses they brought, or they were uprooted and great efforts were made to destroy them, so the preservation of their ethnicities has been a profound struggle (Tataki, 2002; Zinn, 2003). Those who came from elsewhere came because of political or religious oppression in their original culture, economic need, or, as in the case of African Americans, enslavement. For many, the memories and associations with their own cultural group or homeland are fraught with pain for their ancestors or relatives left behind or for the plight of their group, which may lead them to distance themselves from this history and perhaps even hide it from their children and grandchildren.

Stuart Hall (1987) has said that every immigrant must face two classic questions: "Why are you here?" and "When are you going back home?"

No migrant ever knows the answer to the second question until asked. Only then does she or he know that really, in the deep sense [he or she is] never going back. Migration is a one-way trip. There is no "home" to go back to. There never was. (p. 44)

What Hall is referring to is that those who come, especially from poor, war torn, or oppressive situations can never really go back, because the circumstances in the culture of origin remain devastating, but also because they will never again have the same relationship to the culture of origin they left; so the connection with their heritage necessarily

involves pain, and their homeland is a place where that pain often continues. Thus, connecting to one's ethnic roots has a different meaning, depending on the situation in the culture of origin. The Irish who are now 150 years away from the poverty and desperation that led to their migration may look to their ethnic roots with nostalgia and find in them a source of strength for their ancestors' courage, while feeling supported by our society's social institutions when they need assistance (Chapter 43). Immigrants of Latino origin rarely feel that their cultural values are supported by the community institutions on which they become dependent when in need. Their experience is often of ineffective, inadequate, and at times blatantly hostile, antifamily social service bureaucracies (Ortiz, Simmons, & Hinton, 1999; Chapter 11).

Given the harsh circumstances many immigrants face, and the painful, traumatic history they have left behind, it is not surprising that many people ignore or deny their ethnicity by changing their names and rejecting their families and social backgrounds, but they do so to the detriment of their sense of themselves. Those who have experienced the stigma of prejudice and racism may attempt to "pass" as members of the more highly valued majority culture. Groups that have experienced prejudice and discrimination, such as Jews, Latinos, Asians, and African Americans, may absorb the larger society's prejudice and become conflicted about their own identities, internalizing racial or ethnic hatred.

Family members may even turn against each other, with some trying to "pass" and others resenting them for doing so. Those who are close enough in appearance to the dominant group's characteristics may experience a sense of choice about what group to identify with, whereas others have no choice, because of their skin color or other physical characteristics. Examples of ethnic conflict include some group members' attempts to change their appearance through plastic surgery or other means to obtain "valued" characteristics. Families that are not of the dominant culture are always under pressure to give up their values and conform to the norms of the more powerful group. Intrafamily conflicts over the level of accommodation should be viewed not just as family conflicts, but also as reflecting explicit or implicit pressure from the dominant culture.

A few years ago Ann Fadiman wrote a book about the experience of a Hmong family in Merced, California, with the health care system, which may serve as a primary guide to cultural competence for family therapists and other health care professions. Fadiman (1997) shows how an understanding of culture challenges all our assumptions, beginning with our decisions on how far back in history we go to assess the presenting problem:

If I were Hmong, I might feel that what happened when Lia Lee and her family encountered the American medical system could be understood fully only by beginning with the first beginning of the world. But since I am not Hmong, I will go back only a few hundred generations to the time when the Hmong were living in the river plains of north-central China. (p. 13)

Here, in two simple sentences, Fadiman expresses a most profound understanding of "cultural competence" as she refers to the astounding difference in worldview between the dominant culture's managed care values, whereby an impersonal health care professional is expected to do an assessment in 15 to 30 minutes, focusing almost exclusively on current symptoms, whereas the Hmong patient's framework includes a history going back a thousand years:

For as long as it has been recorded, the history of the Hmong has been a marathon series of bloody scrimmages, punctuated by occasional periods of peace, though hardly any of plenty. Over and over again, the Hmong have responded to persecution and to pressures to assimilate by either fighting or migrating—a pattern that has been repeated so many times, in so many different eras and places, that it begins to seem almost a genetic trait, as inevitable in its recurrence as their straight hair or their short, sturdy stature. The Chinese viewed the Hmong as fearless, uncouth, and recalcitrant. . . . The Hmong never had any interest in ruling over the Chinese or anyone else; they wanted merely to be left alone, which, as their later history was also to illustrate, may be the most difficult request any minority can make of a majority culture. (p. 14)

Here too is a profound insight into cross-cultural understanding, demonstrating the main problem: how to see past our assumptions in order to understand the experience of others. The Lee family experienced repeated violations by well-meaning but ethnocentric health care personnel who saw this loving family as uncaring, abusive, negligent, and ignorant, only because the yardstick they used to measure the family's values and relationships was that of the dominant U.S. psychological theories. The health care system's unwitting imposition of its own values on this family shows us how limited our perspectives are, unless we add a cultural lens to our psychological assessments.

Sukey Waller, one of the few clinicians who managed to connect with the Lee family, demonstrated an amazing natural creativity as a culture broker:

Psychological problems do not exist for the Hmong, because they do not distinguish between mental and physical illness. Everything is a spiritual problem. I've made a million errors. When I came here everyone said you can't touch people on the head, you can't talk to a man, you can't do this, you can't do that, and I finally said, this is crazy! I can't be restricted like that! So I just threw it all out. Now I have only one rule. Before I do anything I ask, Is it okay? Because I'm an American woman and they don't expect me to act like a Hmong anyway, they usually give me plenty of leeway. (quoted in Fadiman, 1997, p. 95)

Waller's guidelines urge openness to others and reflect the certain knowledge that we will make mistakes. But the dominant culture makes it hard to open oneself to the possibility of mistakes, our only hope for increasing our learning about groups that are different.

In the 1990s, Robert McNamara, defense secretary during the Vietnam War, met with his Vietnamese counterpart of 30 years earlier. He reports that it was in that conversation that he for the first time understood the cultural misunderstanding between the United States and the Vietnamese. The United States viewed the Vietnamese as pawns of the Chinese communists in the Cold War. The Vietnamese leader said to McNamara:

Haven't you ever read a history book? Don't you know we've been fighting the Chinese for 1,000 years? We saw you as coming to dominate us as everyone else always had and were willing to fight to the death. (Morris, 2002)

Here was a lesson in cultural humility that corresponds completely with the message of this book for family therapists: We must work to see the limitations of our own view so we can open our minds to the experience of others.

Cultural meanings may persist many generations after migration and after people have ceased to be aware of their heritage. Indeed, the suppression of their cultural history

may lead to cultural patterns they themselves fail to appreciate. They may perceive their behavior as resulting purely from intrapsychic or familial factors, when, in fact, it derives from hidden cultural history. Tom Hayden, co-founder of the Students for a Democratic Society in the early 1960s, a fourth-generation Irish American, who became a committed spokesperson for the power of the hidden cultural identity, discussed the experience of so many in our country who have had to live with their deepest cultural history denied:

What price do we pay when those who pull the curtains of history allow us to know our history only dimly or with shame. [Ours is a] . . . story . . . of identity forever blurred by the winds of silence and the sands of amnesia. It is also a universal story of being rooted in uprootedness. . . . Themes of personal identity being threatened first with destruction and later by assimilation appear throughout our literature. . . . Themes that reverberate in each story are those of near destruction and survival, shame and guilt, the long fuse of unresolved anger, the recovery of pride and identity. (1998, pp. 8–9)

Hayden himself grew up experiencing himself as Catholic, but not Irish, thinking that he was “post-ethnic in an ethnic world,” only to realize years later that he carried his suppressed ethnicity within:

I had no historic rationale for why I was rebelling against my parents’ achievement of respectability and middle-class comfort. There was no one teaching the Irish dimension of my radical discontent, in contrast to Jews and blacks who were instilled with values of their ancestors. . . . The Irish tradition . . . seemed more past than present, more sentimental than serious, more Catholic than political. (2001, pp. 68–69)

It was years until Hayden realized that his family had sought “respectability” as a way to “pass” for the dominant group. It had required his family, and indeed his whole cultural group, to appear to assimilate into the melting pot, but it had cost them their sense of who they were. Feeling himself an outsider in young adulthood, he joined the civil rights movement. His first task was to bring food to Black sharecroppers who had been evicted from their lands in Tennessee.

Was it only coincidental that I responded to a crisis reminiscent of my evicted, starving Irish ancestors? So effective was the assimilation process that my parents couldn’t comprehend why I would risk a career to prevent hunger, eviction and prejudice. I was Irish on the inside, though I couldn’t name it at the time. (2001, p. 68)

Hayden grew up mystified about his identity. His father too was mystified about what made Tom do what he did, saying, “I don’t know what influenced him when he went away, but it’s not the way he was raised.” Hayden’s example illustrates the mystifying effect that attempts to deny or ignore cultural history have on people’s sense of their own identity. Cultural competence requires not a cookbook approach to cultural differences, but an appreciation for the often hidden cultural aspects of our psychological, spiritual, and social selves, a profound respect for the limitations of our own cultural perspective, and an ability to deal respectfully with those whose values differ from our own.

Maya Angelou (1986), who, as a young African American, not surprisingly found it hard to feel culturally at home in the United States, went to live in Africa, hoping in some way to find home. What she found there was that who she was could not be encompassed by that important part of her heritage:

If the heart of Africa still remained elusive, my search for it had brought me closer to understanding myself and other human beings. The ache for home lives in all of us, the safe place where we can go as we are and not be questioned. It impels mighty ambitions and dangerous capers. . . . We shout in Baptist churches, wear yarmulkes and wigs and argue even the tiniest points in the Torah, or worship the sun and refuse to kill cows for the starving. Hoping that by doing these things, home will find us acceptable or that barring that, we will forget our awful yearning for it. (p. 196)

Those who try to assimilate at the price of forgetting their connections to their heritage are likely to have more problems than those who maintain their heritage. Simpson (1987) has said that:

The United States, which has been called the home of the persecuted and the dispossessed, has been since its founding an asylum for emotional orphans. . . . Many who have assimilated by changing their names and forgoing their roots, have no way of estimating their spiritual loss. (pp. 221, 225)

We often see people in therapy who have become disconnected from their history and don't even know it, because belonging to your context is not a value in the dominant culture. When people are secure in their own identity, they tend to act with greater flexibility and openness to those of other cultural backgrounds. However, if people receive negative or distorted images of their ethnic group, they often develop a sense of inferiority, even self-hate, that can lead to aggressive behavior and discrimination toward outsiders.

STEREOTYPING

Although generalizing about groups has often been used to reinforce prejudices, one cannot discuss ethnic cultures without generalizing. The only alternative is to ignore this level of analysis of group patterns, which mystifies and disqualifies the experience of groups at the margins, perpetuating covert negative stereotyping, as does the failure to address culture explicitly in our everyday work. Yet many have eschewed the value of discussing ethnicity per se, considering socioeconomic, political, and religious influences more important. Others avoid discussion of group characteristics altogether, in favor of individual family patterns, maintaining, "I prefer to think of each family as unique" or "I prefer to think of family members as human beings rather than pigeonholing them in categories." Of course, we all prefer to be treated as unique human beings. But such assumptions prevent us from acknowledging the influence of cultural and group history on every person's experience. Some have the privilege to belong, with access to society's resources and the ability to trust that society's institutions will work for them. Others are disqualified by society at every turn, because they are judged not as human beings, but by particular group characteristics such as culture or race.

The values, beliefs, status, and privileges of families in our society are profoundly influenced by their socioeconomic and cultural location, making these issues essential to our clinical assessment and intervention. Discussing cultural generalizations or stereotypes is as important as discussing any other norms of behavior. Without some concept of norms, which are always cultural norms, we would have no compass for our clinical work at all.

OUR EVOLVING CONCEPT OF ETHNICITY

We live in the most ethnically diverse society that has ever existed on the planet and have struggled since its beginning over issues of ethnicity. It has not been only since September 11, 2001, and the massive reactivity against people from Middle Eastern and Asian Indian cultures that ethnicity has been a source of great conflict. Our nation was founded by people seeking change from their ancestors' cultures. But it was also built on conflict, prejudice, and attempts to oppress and destroy ethnic groups that were perceived as "other," even as we attempted to set up the most culturally tolerant society that had ever been imagined. Tataki (1993) states:

Indians were already here, while blacks were forcibly transported to America, and Mexicans were initially enclosed by America's expanding border. The other groups came here as immigrants: for them, America represented liminality—a new world where they could pursue extravagant urges to do things they had thought beyond their capabilities. Like the land itself, they found themselves "betwixt and between all fixed points of classification." No longer fastened as fiercely to their old countries, they felt a stirring to become new people in a society still being defined and formed. (p. 6)

Conflicts between different groups in the United States have been built into our nation from the beginning. The Naturalization Law of 1790 restricted citizenship to Whites (Tataki, 1993). We attempted to destroy Native American cultures (see Chapters 2, 3, and 11), and we built into the interior of our governmental institutions, the dehumanization and disqualification of many cultural groups that had been brought here from Africa as slaves (see especially Chapters 5 and 6). When, only a few years after our own revolution, the slaves in Haiti fought for their freedom in a revolt very similar to our own, we saw them as dangerous and did everything we could to hinder it (see Chapter 9). The idea of "liberty and justice for all" was never more than an idea that we found impossible to truly believe. Benjamin Franklin, like so many of the founders of our democracy, owned slaves and advertised slave sales in his newspaper, though he later became president of the first abolition society. His ethnic prejudice extended also to Europeans. Dismayed by the mass immigration of Germans, he expressed fear that "this will in a few years become a German colony: Instead of their learning our language, we must learn theirs, or live as in a foreign country" (cited in Morgan, 2002, p. 77).

Why should Pennsylvania, founded by the English, become a colony of Aliens, who will shortly be so numerous as to Germanize us instead of our Anglifying them, and will never adopt our language or customs, any more than they can acquire our complexion? Which leads me to add one remark: That the number of purely white people in the world is proportionably very small. All Africa is black or tawny. Asia chiefly tawny. America (exclusive of the new comers) wholly so. And in Europe, the Spaniards, Italians, French, Russians and Swedes are generally of what we call a swarthy complexion; as are the Germans also, the Saxons only excepted, who with the English make the principal body of white people on the face of the earth. I could wish their numbers were increased. And while we are, as I may call it, scouring our planet, by clearing America of woods, and so making this side of our globe reflect a brighter light to the eyes of inhabitants on Mars or Venus, why should we in the sight of superior beings, darken its people? Why increase the sons of Africa, by planting them in America, where we have so fair an opportunity, by excluding all blacks and tawnys, of increasing the

lovely white and red? But perhaps I am partial to the complexion of my Country, for such kind of partiality is natural to Mankind. (1918, cited and discussed in Malcomson, 2000, p. 177)

Franklin's attitudes help us understand the pervasive yet unacknowledged way racism and prejudice have been embedded in our nation. Alexis de Tocqueville, the great 19th-century observer of American ethnic traits, found it striking how Whites were able to deprive Indians of their rights and exterminate them "with singular felicity, tranquility, legally, philanthropically, without shedding blood, and without violating a single great principle of morality in the eyes of the world." Tocqueville wryly remarked that no other people could destroy men with "more respect for the laws of humanity" (Tocqueville, 1835, reprinted 1945, pp. 352–353, cited in Tataki, 1993, p. 92).

Over the centuries we have greatly expanded the category of "White" cultures to include Europeans previously considered "ethnic," such as Poles, Italians, Irish, and Jews. People of mixed heritage are often pressed to identify with a single cultural group, rather than being free to claim the true complexity of their cultural heritage (Chapter 31; Root, 1992, 1996).

The majority group has often asserted its power through an assimilationist "melting pot" ideology, and we have remained ambivalent about the value of ethnic pluralism, as indicated also in recent attempts to roll back affirmative action, which have decreased the diversity of the college population even as the nation is becoming more diverse. Yet ethnicity remains a major form of group identification and a major determinant of our family patterns and belief systems. The American premise of equality required us to give primary allegiance to our national identity, fostering the myth of the melting pot—the notion that group distinctions between people should ultimately disappear. The idea that we were all equal led to pressure to see ourselves as all the same. But we have not "melted." Some have said that ethnicity, especially among European Americans, the only ones always free to become "American," is more symbolic than real (Alba, 1990). Indeed, some research on ethnicity lumps all European Americans together into one group. This book asserts a different view, that it will be a long while before ethnicity disappears as a factor relevant to understanding European Americans as well as other groups (Chapter 36).

The way our census counts people has always been a volatile issue in the United States. The reason is, said former bureau chief Kenneth Prewitt, that "throughout American history, starting with the 1790 Census, a classification of racial groups has been used to regulate relations among the races and to support discriminatory policies designed to protect the numerical and political supremacy of white Americans of European Ancestry" (Roberts, 2004, p. 143). In the 2000 census people were asked to identify themselves ethnically/racially and to list up to two ancestries. Some 7.6 million people nationwide answered simply "American" or "USA," and millions more left the question blank (Roberts, 2004). In our definition, however, everyone is ethnic, whether they choose to identify with their background or not. Not acknowledging our ethnic background is like not acknowledging our grandparents; it is a fact of identity over which we have no choice.

The 2000 census was the first to allow people to acknowledge mixed heritage at all, though it was done in a completely inadequate way. Many have feared that the reason was only that the United States is in need of further expansion of the category of "White," which will otherwise soon become a minority of the population. The cen-

sus, which has enormous power to determine the dominant cultural definitions of race and ethnicity, has severe limitations in its cultural categorizations. A glaring illustration is its definition of “White,” which includes all those who have origins in Europe, the Middle East, and North Africa. The term “Asian” is used to include a wide spectrum of groups, ranging from Hmong to Pakistani. Cultural groups from Middle Eastern countries such as Afghanistan or Iraq are classed as White, although they are much more closely related to cultural groups in Pakistan that we have labeled “Asian,” making one wonder whose interests it serves to use the categorization “White” at all. The only ethnicity explored at all by the latest census was “Hispanic.” This is a very problematic category (Chapter 11), which many consider racist, since it emphasizes the connection to Spain. It is so general that it is about as relevant as using “American” to describe people of so many heritages. Second, the census forced “Hispanics” to define themselves racially using categories that did not include Hispanic, Latino, or Native American. Their only choices were Black, White, American Indian, Asian, or Other, the last of which they generally saw as their only option. Furthermore, this categorization by the U.S. Census Bureau forced Brazilians (Chapter 12) to label themselves “White” rather than “Hispanic,” even though the cultural history of Puerto Ricans (Chapter 18), Cubans (Chapter 15), Dominicans (Chapter 16), Colombians (Chapter 14), and other groups in Latin America (Chapter 13) undoubtedly have much more in common with Brazilian cultures than with “White” cultures.

The census has been a conservative force within our society for 200 years, putting people in categories that oversimplify their heritage and cultural connections to each other and to their ancestors. People have been pressed into racial categories that have no basis whatsoever except to stratify people by the meaningless difference of skin color. These categorizations have been developed to promote White supremacy in our society (Malcomson, 2000). Racial categorization was first articulated in Germany by Johann Blumenbach (Frederickson, 2002), an anatomist who divided the world into four racial categories by geography (Gould, 1994):

- The Caucasian variety for the light-skinned people of Europe and the adjacent parts of Asia and Africa.
- The Mongolian variety for the other inhabitants of Asia, including China and Japan.
- The Ethiopian variety for the dark-skinned people of Africa.
- The American variety for most native populations of the “New World.”

In his second edition he added a fifth Malay category for the Polynesians and Melanese of the Pacific and the aborigines of Australia. This clarified a hierarchy with White at the apex and the American variety on the way to the Mongolian extreme on one side, and, quite illogically, labeled the Malay as in the direction of the other extreme, the Ethiopian. Blumenbach’s categories had no basis whatsoever in science. They were based on his judgment of the beauty of the people of the Caucasus! He said:

I have taken the name of this variety from Mount Caucasus, both because its neighborhood, and especially its southern slope, produces the most beautiful race of men, I mean the Georgian, and because . . . in that region, if anywhere, it seems, we ought with greatest probability to place the autochthones (original forms) of mankind. (cited in Gould, 1994, p. 1)

During the 18th century, Europeans and Americans were in serious need of a categorization of races that would provide justification for Whites to treat people of color as not human. This was especially important at a time when, with the Enlightenment, there was a focus on the “inalienable” rights of human beings. Having a hierarchy of races helped rationalize slavery. This insidious categorization persists to this day and continues to promote White power because unlike the definition of ethnicity, U.S. official definitions of race have no scientific or historically cultural basis. Maria Root (1992, 1996, 2001), one of the prime researchers on ethnicity and multiculturalism, has defined a special bill of rights for people of mixed race, asserting their right to define themselves for themselves and not be limited by society’s racial and ethnic stereotypes and caricatures.

THE CHANGING FACE OF ETHNICITY IN THE UNITED STATES AT THE START OF THE 21ST CENTURY

The late 20th century saw the greatest rise in immigration in 100 years. More than one million legal and undocumented immigrants came annually, most from Asia and Latin America. And although there has been a great upturn in negativity toward immigrants since September 11, 2001 (Gallup Organization, 2004), the 2000 census counted about 28 million first-generation immigrants in the United States, equaling 10% of the population—not the highest percentage of foreign born in the overall population, which occurred in 1907, when the percentage was 14% (Martinez, 2004). With streams of new immigrants imparting their unique cultures, American society has become characterized by unparalleled diversity. Asians, Latin Americans, and other newcomers have become “the new face of America.”

Respect for ethnic diversity has flourished during certain periods in American history and has been stifled at others. The backlash against multiculturalism has also waxed and waned, depending on the economics and politics of the moment. Anti-Arab and Anti-Muslim feelings escalated to an extreme degree in the wake of September 11, 2001, and various governmental initiatives related to Homeland Security and the Patriot Act increased fear and negative feelings about certain nondominant groups in our society. White extremist skinheads and neo-Nazi groups periodically escalate their fostering of racial and ethnic hatred, and we experience periodic increases of anti-immigrant reactions, depending on the labor needs of the country.

The impact of ethnicity varies geographically. In the Pacific region, for example, one fifth of Americans are foreign born, whereas in the Midwestern farm belt, this is true of only one person in 50. In Los Angeles, 4 in 10 residents are foreign born; in New York, 3 in 10. Before the end of this century, White Americans will be a minority. In 1900, outside of the South, all states but Arizona had a population that was more than 90% White. Roberts (2004) reports that, by 2000, only 10 states had that ratio and 5 states beyond the South had a population that was less than 70% White. African Americans have increased to 12.3% of the population, with record-high proportions in the Northeast, Midwest, and West, and record lows in the South (Roberts, 2004). Latinos have increased dramatically to become 13.4%, in contrast to 9% in 1990, whereas Asians have increased to 3.6% of the population, one third of whom live in California. Only about 69% of Americans are “non-Hispanic Whites,” a decrease of more than 6% in a decade, although fully one in 4 Americans believe they were descended from the Pilgrims!

However, this includes almost 50% of Hispanics who, as stated earlier, had no way to identify themselves in the 2000 census except as White, Black or “Other race.” They could not identify themselves racially as “Hispanic.” Of the 31 million foreign-born Americans, only 15% are European, 26% are Asian, and 51% are Latino. Thirty-three ancestry groups reported populations of over 1 million in 2000. The Arab population rose by 41% in the 1980s and by 38% in the 1990s, but still accounts for only 0.5% of the general population.

Concomitantly, there has been a rapid rise of multicultural consciousness in the United States. When Queens, New York, the most diverse county in the nation, launched its new telephone information line, it boasted providing service in 170 different languages (Roberts, 2004).

The changing ethnic demographics are having a significant impact on all aspects of our society. Of new workers entering the workforce, 80% are women, minorities, or new immigrants. In other words, our workforce is becoming culturally diverse in ways we never imagined. This reality in the context of a growing global economy and the presence of many international corporations helps explain the upsurge in business literature on managing a culturally diverse workforce (Jamieson & O’Mara, 1991, Thiederman, 1991; Thomas, 1991). Twenty percent of the nation’s children have at least one foreign-born parent! The foreign-born population has increased to more than 31 million, making the United States now the least “American,” by conventional definitions, or the most American it has ever been when we consider Latinos as Americans (Roberts, 2004). Twenty percent of schoolchildren speak a language other than English at home, mostly Spanish, although more than 150 languages are represented in America’s schools (Roberts, 2004). Multicultural education, although controversial, is increasingly being included in school curricula (Banks, 1991).

FACTORS INFLUENCING ETHNICITY

Essential to understanding culture is learning about the interaction between ethnicity, gender, sexual orientation, class, race, religion, geography, migration, and politics and how they have together influenced families in adapting to life in the United States. All these components are also influenced by the length of time since migration, a group’s specific historical experience, and the degree of discrimination its members have experienced in this society. Generally, people move closer to the dominant value system the longer they remain in the United States and the more they rise in social class. Families that remain within an ethnic neighborhood, that work and socialize with members of their groups, and those whose religion reinforces ethnic values, will probably maintain their ethnicity longer than those who live in heterogeneous settings. When family members move from an ethnic enclave, even several generations after immigration, the stresses of adaptation are likely to be severe. The therapist should learn about the community’s ethnic network and, where appropriate, encourage the rebuilding of social and informal connections through family visits, letters, or creating new networks.

Those who are systematically excluded from the dominant group, or from the groups to which they belong because of racism, anti-Semitism, sexism, homophobia, or other institutionalized bias, will continue to show the effects of this exclusion in their psychological and social makeup.

MIGRATION

No one leaves his or her world without having been transfixed by its roots, or with a vacuum for a soul. We carry with us the memory of many fabrics, a self soaked in our history, our culture; a memory, sometimes scattered, sometimes sharp and clear, of the streets of our childhood.

—FREIRE (1994, p. 32)

All Americans have experienced the complex stresses of migration. And the hidden effects of this history, especially when it goes unacknowledged, may linger for many generations. Families' migration experiences have a major influence on their cultural values. Why did the family migrate? What were they seeking (e.g., survival, adventure, wealth)? What were they leaving behind (e.g., religious or political persecution, or poverty)? An immigrating family's dreams and fears become part of its heritage. Parents' attitudes toward what came before and what lies ahead will have a profound impact on the expressed or tacit messages they transmit to their children. Families that have migrated before tend to adapt more easily, such as the Jews who migrated first to South America and later to the United States. Their previous migration probably taught them something about flexibility. Those who come as refugees, fleeing political persecution or the trauma of war and who have no possibility of returning to their homeland, may have very different adaptations to American life than those who come seeking economic advancement with the idea of returning to their homeland to retire. The political history surrounding migration may intensify cultural traits for a particular group, strengthening their tendency to hold onto cultural traits if they experienced the threat of cultural annihilation, as happened for Cubans, African Americans, Poles, Native Americans, and Jews, for example.

Adaptation is also affected by whether one family member has migrated alone or whether a large portion of the family, community, or nation has come together. Frequently, educated immigrants who come for professional opportunities move to places where there is no one with whom they can speak their native language or share family customs and rituals. Families that migrate alone usually have a greater need to adapt to the new situation, and their losses are often more hidden. On the other hand, when a number of families migrate together, as happened with the Scandinavians who settled in the Midwest (Chapter 46), they are often able to preserve much of their traditional heritage.

When members of a large part of a population or nation come together, as happened in the waves of Irish (Chapter 43), Polish (Chapter 54), Italian (Chapter 44), and Jewish migration (Chapter 48), discrimination against the group may be especially intense. The newest immigrants always pose a threat to those who came just before, who fear losing their tenuous economic security. Sometimes more recent immigrants of the same background have conflicts with their older compatriots because of class differences, as has been true for Cubans, Iranians, Poles, and other groups. Some groups have a back-and-forth pattern of migration, like Puerto Ricans and Mexicans, and are more transnational, meaning that they are always incorporating two cultures rather than only adjusting to the new one.

The East and West coasts, the entry points for most immigrants, are likely to have greater ethnic diversity and defined ethnic neighborhoods, and people in these areas are more often aware of ethnic differences. The ethnic neighborhood provides a temporary

cushion against the stresses of migration, which are likely to surface in the second generation. Those immigrant families that moved to an area where the population was relatively stable, for example, the South, generally had more trouble adjusting or were forced to assimilate very rapidly.

RACE AND RACISM

Racial bars build a wall not only around . . . [people of color] but around white people as well, cramping their spirits and causing them to grow in distorted shapes.
—BRADEN (1999, p. 24)

Prejudice is a burden which confuses the past, threatens the future, and renders the present inaccessible.
—ANGELOU (1986, p. 155)

Race, reality and relationships are often complexly entangled in ways that are difficult to discern. The volatility of race as a phenomenon, the acute silence that often accompanies racial interactions, and the general lack of attention devoted to the intricacies of relationship development and maintenance all contribute to the difficulty of deconstructing this entanglement, which is a powerful and pervasive force in our personal lives and in our clinical practices.
—HARDY (2004, p. 87)

Race, unlike culture, is not an internal issue, but rather a political issue, operating to privilege certain people at the expense of others. It is a bogus construct, created and kept in place by White people, and it creates walls that lock us all in. Ann Braden (1999), one of the White sheroes of the antiracism movement, puts it this way: Racism “is the assumption that everything should be run by white people for the benefit of white people” (p. 340). Unlike culture, which operates from the inside out, influencing us because it represents values that have been passed down to us through generations of our ancestors, race is a construct which imposes judgment on us from the outside in, based on nothing more than our color or physical features. Many who come to the United States are deeply troubled when they experience racism here for the first time. Over time reactions to our society’s racism, which stratifies people by skin color, tends to be internalized. As Hardy (2004) puts it, “although seldom explicitly acknowledged, race is often one of the factors that determines who participates in certain interactions, and how” (p. 87). Expectations of privilege and entitlement or invalidation tend to become internalized assumptions in response to this social force. For people of color, race becomes “like the invisible fences that pet owners use to keep their dogs contained within a given circumscribed space. After a very short while, dogs learn where the boundaries are that should not be crossed unless they are willing to be shocked” (Hardy, 2004, p. 88). Race is an issue of political oppression, not a cultural or genetic issue. Ignatiev (1995) has said, “No biologist has ever been able to provide a satisfactory definition of ‘race’—that is, a definition that includes all members of a given race and excludes all others.” Categorizing people by race serves, rather, to justify reducing all members of one group to an undifferentiated social status, beneath that of all members of another group. Racism operates like sexism, a similar system of privilege and oppression, justified within the dominant society as a biological or cultural phenomenon, which functions systematically to advantage White members

of society at the expense of members of color (Chapter 36; Hardy & Laszloffy, 1992; Hitchcock, 2003; Katz, 1978; Mahmoud, 1998).

Although racism may be more subtle and covert today, the politics of race continue to be complex and divisive, and, unfortunately, Whites remain generally unaware of the problems our society creates for people of color. Just as patriarchy, classism, and heterosexism have been invisible structural definers of all European groups' ethnicity, race and racism have also been invisible definers of European groups' cultural values. The invisible knapsack of privilege (McIntosh, 1998) granted to all White Americans, just by the color of their skin, is something that most White ethnics do not acknowledge (Chapter 36).

Although there is a rapidly increasing rate of intermarriage among European groups and of Whites with people of color, the percentages are still small. And the level of segregation in the United States between European Americans and people of color, especially African Americans, remains profound, a problem that most Whites do not notice. Racism and poverty have always dominated the lives of ethnic minorities in the United States. Race has always been a major cultural definer and divider in our society, inasmuch as those whose skin color marked them as different always suffered more discrimination than others. They could not "pass," as other immigrants might, leaving them with an "obligatory" ethnic and racial identification.

Racial bigotry and discrimination continue to be terrible facts of American life, from college campuses to corporate boardrooms. Although Blacks are no longer forbidden to drink from the same water fountains as Whites or to attend integrated schools, we still live in a highly segregated society. The racial divide continues to be a painful chasm, creating profoundly different consciousness for people of color than for Whites (Tatum, 2003). People find it even more difficult to talk to each other about racism than about ethnicity. Each new racial incident ignites feelings and expressions of anger and rage, helplessness and frustration. Exploring our own ethnicity is vital to overcoming our prejudices and expanding our understanding of ourselves in context, but in our pursuit of multicultural understanding, we must also take care not to diminish our efforts to overcome racism (Hitchcock, 2003; Katz, 1978; Kivel, 2002).

RELIGION

The United States is a very religious country. Normally, such an advanced society would over time become more secular, but this has not been the case. About 95% of Americans profess a belief in God, most of them belong to a church or synagogue, and most say that they pray on a daily basis (Gallup & Lindsay, 1999). According to the 2001 American Religious Identity Survey (Kosmin & Lackman, 2001), 76.5% of Americans, or 159 million people, identify themselves as Christians; 13.2%, or 27.5 million, identify themselves as nonreligious or secular. In order, the major Christian denominations are Catholic, Baptist, Methodist, Lutheran, Presbyterian, Pentecostal (charismatic or evangelical), Episcopalian, Mormon, Church of Christ, and Congregationalist. Other major religious groups include Jews, 2.8 million; Muslims, 1 million; Buddhists, 1 million; Hindus, 766,000; and Unitarian Universalists, 629,000. There are also an estimated 991,000 agnostics and 902,000 atheists. There are indications that public interest in spirituality is increasing (Miller & Thoreson, 2003). Religion, for many groups, roots its participants in the fam-

ily and community, and thus in their own histories and cultural traditions (Aponte, 1994; Boyd-Franklin & Lockwood, 1999; Walsh, 1999; Walsh & Pryce, 2002).

For many ethnic groups, their religion has been a major force for transmitting their cultural heritage, even where, as with African Americans (Jones, 1993), Haitians (Chapter 9), Cubans (Chapter 15), Puerto Ricans (Chapter 18), and others, they had to hide their ancestral beliefs in a new religion. Many Latino groups, for example, maintained their earlier gods hidden in the guise of Catholic saints. Religion and cultural tradition have been largely intertwined, although there are cultural groups, such as Koreans (Chapter 26), that may practice very different religions (Buddhism, Methodism, Catholicism) even within the same family. Walsh (Walsh & Pryce, 2002) notes:

Spirituality . . . like culture and ethnicity, involves streams of experience that flow through all aspects of life, from family heritage to personal belief systems, rituals and practices, and shared faith communities. Spiritual beliefs influence ways of dealing with adversity, the experience of pain and suffering and the meaning of symptoms. (p. 337)

Most Europeans share the dominant American Judeo-Christian belief in one God, and in the separation of church and state. Today, however, with the flood of new immigrants coming to the United States, other religions are making an impact on established religious institutions. Islam, the third great monotheistic faith, while expanding through immigration and African American conversions, will soon supplant Judaism as this country's third largest faith, including people of widely different ethnic backgrounds: African Americans with roots in the southern United States and Africa (Chapter 10), Pakistanis (Chapter 30), Asian Indian families (Chapters 28 and 29), Arab families from many different countries (Chapters 31 and 32), Albania, Turkey, and Indonesia, the world's largest Muslim nation (Chapter 24).

The Catholic Church, which has absorbed floods of immigrants, is particularly feeling the impact of the new immigration. Today mass is heard in 30 languages in New York City. Millions of Latinos with a fervent approach to worship are challenging the church hierarchy. The Catholic Church also has contingents of African immigrant families and African Americans, Filipinos, Latinos and others. These groups are also increasingly being attracted to the Pentecostal and Baptist faiths, creating new competition for the Catholic Church. Likewise, Koreans are changing the nature of both Protestant and Catholic church communities, with their evangelical zeal and religious traditionalism. And many Jews and former Catholics of European heritage are embracing Buddhism and altering the practice of this and other religious communities of Asian origin. Thus, the interaction between religion and ethnicity is profound, and it is essential to understand the interplay as one explores families' cultural contexts.

People use religion as a means of coping with stress or powerlessness, as well as for spiritual fulfillment and emotional support. Institutionalized religion also meets social needs. Unfortunately, clinicians often fail to utilize appropriate religious tenets and support systems that give comfort and meaning to the family (Hodge, 2001; Miller & Thoresen, 2003; Walsh, 1999). Given Americans' strong spiritual beliefs and their religious institutions' social service networks, it is surprising that many family therapists treat faith as a private affair that has little or no impact on treatment; we hope that this book will help clinicians appreciate that spiritual values are fundamental to healing for most of the cultural groups in the United States.

SOCIAL CLASS AND SOCIOECONOMIC STATUS

Social class and socioeconomic status increasingly organize the United States in very insidious ways, including structuring the relationships between ethnic groups, often pitting less powerful groups against each other, or members of a less powerful group against one another. The distance between the very rich and everyone else has been increasing dramatically in the last two decades. It has been estimated that the richest 20% of American households now own more than 80% of our country's wealth (Vermeulen, 1995). With this trend continuing, poor as well as middle-class families will find themselves in more vulnerable and precarious situations. These class differences will have a serious impact on family relations. The top one million people in the United States make as much money as the next 100 million put together. And the share of wealth of the top 1% of the population (40% of the nation's wealth) has doubled since 1970 (Thurow, 1995). Twenty years ago, the typical CEO made 40 times the amount of the typical American worker. That ratio has swelled to 190 times as much (Hacker, 1995). Inequalities in earnings between the top 20% of wage earners and the bottom 20% doubled in the last two decades (Thurow, 1995). Derrick Bell (1993) has suggested that intergroup conflicts, especially racial conflicts, are promoted by those at the top to keep everyone not at the top from realizing their commonalities and shared interests, because, if they did, it would create a revolution. It is much safer for the dominant group to promulgate the myth that it is the Black man we really have to fear, rather than the power structure that holds our dominant class in place.

Class intersects powerfully with ethnicity and must always be considered when one is trying to understand a family's problems. The influence of class on the cultural position of groups in the United States is extreme. Of the 1,000 people who have ever appeared on *Forbes* magazine's list of the 400 richest people in America, only 5 have been Black (Hacker, 1995). Some have maintained that class, more than ethnicity, determines people's values and behavior. Class is important, but not all differences can be ascribed to class alone. Boyd-Franklin (2002) makes extremely clear the powerful interaction between race and class in the case of African Americans. Ethnic distinctions generally play a less powerful role among the most educated and upwardly mobile segments of a given group, who are more likely to dissociate themselves from their ethnic roots. This may create hidden problems in a family, pitting one generation against another, or one segment of a group against another. It is also more difficult to rise into the upper classes if your skin is dark, because of the institutionalized racism in this country.

Upward mobility is part of the "American dream." Although you cannot change your ethnicity, changing class is even an expectation in our society. You may deny your gender or culture, you may not conform to stereotypic patterns of your gender or cultural group, but you cannot change who you are on these dimensions. Yet changes in class, which are among the most profound we experience, are generally not talked about, even among people within the same family. Silence about class transitions can become very painful. Parents and children or siblings from the same family often end up in different socioeconomic groups when the children are either highly successful or disabled and dysfunctional.

Groups also differ in the extent to which they value education or "getting ahead." Family members may feel compelled to make a choice between moving ahead and loyalty to their group, which can be a major source of identity or intrafamilial conflict. For

important historical reasons, certain groups, such as Irish, Italians, Poles, and African Americans, may have a distinct ambivalence or discomfort about moving up in class, whereas others embrace it wholeheartedly.

CULTURAL DIFFERENCES IN WORLDVIEW AND BASIC VALUES

It is almost impossible to understand the meaning of behavior unless one knows something of the cultural values of a family. Even the definition of “family” differs greatly from group to group. The dominant American (Anglo) definition focuses on the intact nuclear family, whereas for Italians there is no such thing as the “nuclear” family. To them, family means a strong, tightly knit three- or four-generational family, which also includes godparents and old friends. African American families focus on an even wider network of kin and community. And Asian families include all ancestors, going all the way back to the beginning of time, and all descendants, or at least male ancestors and descendants, reflecting a sense of time that is almost inconceivable to most other Americans.

Ethnic groups’ distinctive problems are often the result of cultural traits that are conspicuous strengths in other contexts. For example, British American optimism leads to confidence and flexibility in taking initiative. But the same preference for an upbeat outlook may also lead to the inability to cope with tragedy or to engage in mourning. Historically, the British have perhaps had much reason to feel fortunate as a people. But optimism becomes a vulnerability when they must contend with major losses. They have few philosophical or expressive ways to deal with situations in which optimism, rationality, and belief in the efficacy of individuality are insufficient. Thus, they may feel lost when dependence on the group is the only way to ensure survival.

Families from different ethnic groups may experience diverse kinds of intergenerational struggles. British American families are likely to feel that they have failed if their children *do not* move away from the family and become independent, whereas Italians generally believe they have failed if their children *do* move away. Jewish families often foster a relatively democratic atmosphere in which children are free to challenge parents and discuss their feelings openly. Greek and Chinese families, in contrast, do not generally expect or desire open communication between generations and would disapprove of a therapist’s getting everyone together to discuss and “resolve” their conflicts. Children are expected to respect parental authority, which is reinforced by the distance parents maintain from their children.

Cultural groups vary greatly in the emphasis they place on various life transitions (Carter & McGoldrick, 2005; Dilworth-Anderson et al., 1996). Irish and African Americans have always considered death the most important life cycle transition (McGoldrick et al., 2004). Italians, Asian Indians, and Poles tend to emphasize weddings, whereas Jews often pay particular attention to the bar or bat mitzvah, and Puerto Ricans to the *Quinceanero*, the 15th birthday, celebrating transitions from childhood, which other groups hardly mark at all. Families’ ways of celebrating these events differ as well. The Irish tend to celebrate weddings (and every other occasion) by drinking, the Poles by dancing, the Italians by eating, and the Jews by eating and talking. Mexican Americans (Chapter 17) may see early and middle childhood as extending longer than the dominant American pattern, while adolescence is shorter and leads more quickly into adulthood than in the dominant American structure, in which courtship is generally longer and mid-

Older age extends into what Americans generally think of as older age. Any life cycle transition can spark conflicts in regard to ethnic identity, because it puts a person in touch with his or her family traditions (Carter & McGoldrick, 2005). A divorce, marriage, childbirth, illness, job loss, death, or retirement can exacerbate ethnic identity conflicts, causing people to lose a sense of who they are. A therapist who tries to help a family to preserve cultural continuities will assist its members in maintaining and building upon their ethnic identity (Cushing & McGoldrick, 2004).

MIGRATION AT DIFFERENT PHASES OF THE LIFE CYCLE

Migration is so disruptive that it seems to add an entire extra stage to the life cycle for those who must negotiate it (Hernandez & McGoldrick, 2005). Adjusting to a new culture is not a single event, but rather a prolonged developmental process (Falicov, 2002) that affects family members differently, depending on their life cycle phase when they are going through the process.

Young Adult Phase

When individuals immigrate during the young adult phase, they have the greatest potential for adapting to a new culture in terms of career and marital choice, but they may also be most vulnerable to cutting off their heritage.

Families with Young Children

Families that migrate with young children are often strengthened by having each other, but they are vulnerable to the reversal of hierarchies. Parents may acculturate more slowly than their children, creating a problematic power inversion. When children interpret the new culture for their parents, parental leadership may be threatened, as children are left without effective adult authority to support them and without a positive ethnic identity to ease their adaptation to life in the new culture. If the parents are supported in their cultural adjustment, through their workplaces or extended family and friends, their children's adjustment will go more easily, since young people generally adapt well to new situations even when doing so involves learning a new language. But in adolescence, when the children are drawn toward their peer culture, problems may surface. Coaching the younger generation to show respect for their elders' values is usually the first step in negotiating such conflicts.

Families with Adolescents

Families migrating with adolescents may have more difficulty, because they will have less time together as a unit before the children move out on their own. A family can struggle with multiple transitions and generational conflicts at once. Families' distance from the grandparents in their home country may be particularly distressing as the grandparents become ill, dependent, or die, and their children may experience guilt or other stresses in not being able to fulfill their filial obligations. At times adolescents develop symptoms in reaction to their parents' distress.

Launching Phase

Families with young adult children are less likely to migrate seeking a better way of life. More often, if families migrate at this phase, it is because circumstances in the country of origin make remaining there impossible. Migration at this phase may be especially hard, because it is much more difficult for the parents to adapt to a new language, job situation, relationships, and customs. Again, if their aging parents are left behind, the stresses of migration will be intensified. This phase may be more complex if children date or marry individuals from other backgrounds. This is naturally perceived as a threat by many, if not most, parents, because it means a loss of the cultural heritage in the next generation. One cannot underestimate the stress parents experience in their children's intermarriage when they themselves have lost the culture in which they grew up.

Later Life

Migration in later life can be especially difficult because at this point families are leaving a great deal of their life experience and sociocultural resources behind. Even those who might migrate at a young age have a strong need to reclaim their ethnic roots at this phase, particularly because they are losing other supports. For those who have not mastered English, it can be extremely isolating to be dependent on strangers for health care services when they cannot communicate easily. When older immigrants live in an ethnic neighborhood, acculturation conflicts may be postponed. Members of the next generation, particularly during adolescence, are likely to reject their parents' "ethnic" values and strive to become "Americanized." Intergenerational conflicts often reflect the families' struggles over values in adapting to the United States. The third and fourth generations are usually freer to reclaim aspects of their identities that were sacrificed in previous generations because of the need to assimilate.

CULTURAL AND RACIAL INTERMARRIAGE

The degree of ethnic intermarriage in the family also plays a role in the evolution of cultural patterns (Crohn, 1995; Kennedy, 2003; McGoldrick & Garcia-Preto, 1984; Petsonk & Remsen, 1988; Root, 2001). Although, as a nation, we have a long history of intercultural relationships, until 1967 our society explicitly forbade racial intermarriage, and discouraged cultural intermarriage as well, because it challenged White supremacy. But traditional ethnic and racial categories are now increasingly being challenged by the cultural and racial mixing that has been a long submerged part of our history. Intimate relationships between people of different ethnic, religious, and racial backgrounds offer convincing evidence that Americans' tolerance of cultural differences may be much higher than most people think (Alibhai-Brown & Montague, 1992; Crohn, 1995; McGoldrick & Garcia-Preto, 1984; Petsonk & Remson, 1988; Schneider, 1989). Intermarriage is occurring at triple the rate of the early 1970s. More than 50% of Americans are marrying out of their ethnic groups; 33 million American adults live in households where at least one other adult has a different religious identity. Intermarriage greatly complicates those issues that partners from a single ethnic group face.

Generally, the greater the cultural difference between spouses, the more trouble they will have in adjusting to marriage.

Knowledge about ethnic/cultural differences can be helpful to spouses who take each other's behavior too personally. Typically, we tolerate differences when we are not under stress; in fact, we may find them appealing. However, when stress occurs, tolerance for differences diminishes. Not to be understood in ways that conform with our wishes and expectations frustrates us. For example, when upset, Anglos tend to move toward stoical isolation to mobilize their powers of reason. In contrast, Jewish spouses seek to analyze their experience together. Italians may seek solace in food or in emotionally and dramatically expressing their feelings, and Asians may become very silent, fearing loss of face. Members of these groups sometimes perceive each other's reactions as offensive or insensitive, although, within each group's ethnic norms, such reactions make perfect sense. Much of therapy involves helping family members recognize each other's behavior as largely a reaction from a different frame of reference.

Many cultural and religious groups have prohibitions against intermarriage, which is seen as a threat to group survival. Until 1967, when such laws were declared unconstitutional, 19 states prohibited racial intermarriage. Until 1970, the Catholic Church did not recognize out-marriages, unless the non-Catholic partner promised to raise the couple's children in the Catholic faith. Members of many Jewish groups have also feared that intermarriage would threaten the group's survival. In earlier generations the intermarriage rate in Jewish families was very low, though it has increased dramatically for the current generation. According to the 1990 National Jewish Population Studies, 52% of new marriages were to non-Jews. The likelihood of ethnic intermarriage increases with the length of time individuals have lived in this country, as well as with higher educational and occupational status.

Couples who choose to "marry out" are usually seeking to rebalance their own ethnic characteristics, moving away from some values as well as toward others. During courtship, a person may be attracted precisely to the loved one's differentness, but when he or she is in a marital relationship the same qualities can seem grating.

Consider an Anglo Italian couple in which the Anglo husband takes literally the dramatic expressiveness of the Italian wife, whereas she finds his emotional distancing intolerable. The husband may label the Italian "hysterical" or "crazy" and in return be labeled "cold" or "catatonic." Knowledge about differences in cultural belief systems can help spouses who take each other's behavior too personally. Couples may experience great relief when they can come to see the spouse's behavior fitting into a larger ethnic context rather than as a personal attack. Yet cultural traits may also be used as an excuse for not taking responsibility in a relationship: "I'm Italian. I can't help it" (i.e., the yelling, abusive language, impulsiveness), or "I'm a WASP. It is just the way I am" (lack of emotional response, rationalization, and workaholism), or "I can't help being late. We Puerto Ricans have a different conception of time."

CLINICAL INTERVENTION FROM A CULTURAL PERSPECTIVE

Appreciation of cultural variability leads to a radically new conceptual model of clinical intervention. Helping a person achieve a stronger sense of self may require resolving

internalized negative cultural attitudes or cultural conflicts within the family, between the family and the community, or in the wider context in which the family is embedded. A part of this process involves identifying and consciously selecting ethnic values we wish to retain and carry on. Families may need coaching to distinguish deeply held convictions from values asserted for dysfunctional emotional reasons.

What is adaptive in a given situation? Answering this requires an appreciation of the total context in which a behavior occurs. For example, Puerto Ricans may see returning to the island as a solution to their problems. A child who misbehaves may be sent back to live with an extended family member. This solution may be viewed as dysfunctional if the therapist considers only that the child will be isolated from the immediate family, or that the relative in Puerto Rico may have fewer resources to meet the child's developmental needs. Rather than counter the parents' plan, the therapist may encourage them to strengthen their connectedness with family members in Puerto Rico with whom their child will be staying, for they will be using a culturally sanctioned network for support. The therapist's role in such situations may be that of a culture broker, helping family members to recognize their own ethnic values and to resolve the conflicts that evolve out of different perceptions and experiences.

There are many examples of such misunderstood behavior. Puerto Rican women are taught to lower their eyes and avoid eye contact, which American therapists are often taught to read as indicating an inability to relate interpersonally. Jewish patients may consider it essential to inquire about the therapist's credentials; many other groups would perceive this as an affront, but for these patients it is a needed reassurance. Iranian and Greek patients may ask for medication, give every indication of taking it, but then go home and not take it as prescribed. Irish families may not praise or show overt affection to their children for fear of giving them "swelled heads," which therapists may misread as lack of caring. Physical punishment, routinely used to keep children in line by many groups, including, until recently, the dominant groups in the United States, may be perceived as idiosyncratic pathological behavior, rather than as culturally accepted behavior, albeit a violation of human rights. This is not to justify child beatings, which have been widely accepted by many cultures. Rather, we must consider the cultural context in which a behavior evolves, even as we try to shape it, when it does not reflect humanitarian or equitable values. The point is that therapists, especially those of dominant groups, who tend to take their own values as the norm, must be extremely cautious in judging the meaning of behavior they observe and in imposing their own methods and time table for change.

Almost all of us have multiple belief systems to which we turn when we need help. Besides medical or psychotherapeutic systems, we turn to religion, self-help groups, alcohol, yoga, chiropractors, crystals, special foods, and remedies our mothers taught us or those suggested by our friends. Various factors influence our choice of solutions that we will rely on at any given time. Many studies have shown that people differ in the following:

1. Their experience of pain.
2. What they label as a symptom.
3. How they communicate about their pain or symptoms.
4. Their beliefs about its cause.
5. Their attitudes toward helpers (doctors and therapists).
6. The treatment they desire or expect.

Yet a group whose characteristic response to illness is different from that of the dominant culture is likely to be labeled “abnormal.” For example, one researcher found that doctors frequently labeled Italian patients as having psychiatric problems, although no evidence existed that such disorders occurred more frequently among them (Zola, 1966). Another classic study (Zborowski, 1969) found that Italian and Jewish patients complained much more than Irish or Anglo patients, who considered complaining to be “bad form.”

CULTURAL ATTITUDES TOWARD “TALK” AND THERAPY

Another obvious and essential variable is the family’s attitude toward therapy. The dominant assumption is that talk is good and can heal a person. Therapy has even been referred to as “the talking cure.” Talking to the therapist or to other family members is seen as the path to healing. A high level of verbal interaction is expected in Jewish, Italian, and Greek families, whereas Anglo, Irish, and Scandinavian families have much less intense interaction and are more likely to deal with problems by distancing. Therapists need to take these potential differences into account in making an assessment, considering carefully their own biases and their clients’ values. Clients may not talk openly in therapy for many different reasons related to their cultural background or values. Consider various cultures and the value they assign to talk:

- African American clients may be uncommunicative, not because they cannot deal with their feelings, but because the context involves a representative of a traditional “White” institution that they never had reason to trust (Chapter 6).
- In Jewish culture, analyzing and discussing one’s experience may be as important as the experience itself for important historical reasons. Jews have long valued cognitive clarity. Analyzing and sharing ideas and perceptions help them find meaning in life. Given the anti-Semitic societies in which Jews have lived over the centuries, with their rights and experiences often invalidated, one can understand that they came to place great importance on analyzing, understanding, and acknowledgment of what has happened (Chapter 48).
- In families of English descent, words tend to be used primarily to accomplish one’s goals (Chapter 37). They are valued mainly as utilitarian tools. As the son says about his brother’s death in the movie *Ordinary People*: “What’s the point of talking about it? It doesn’t change anything.”
- In Chinese culture, families may tend to avoid the dominant American idea of “laying your cards on the table” verbally. They have many other symbolic ways of communicating, such as with food, rather than with words, so the talking cure, as we have known it, would be a very foreign concept (Chapter 22).
- Italians often use words primarily for drama, to convey the emotional intensity of an experience. They may be mystified when others, who may take verbal expression at face value, hold them to their words, because for them it is the interaction and the emotional relationship, not the words, that have the deepest meaning (Chapter 44).
- An Irish client’s failure to talk may have to do with embarrassment about admitting his or her feelings to anyone, most especially to other family members. The Irish were forced by the British, who ruled them for centuries, to give up their language, which

they found a cruel punishment. They are perhaps the world's greatest poets, using words to buffer experience—poetry and humor somehow make reality more tolerable. They have tended to use words not particularly to tell the truth, but often, rather, to cover it up or embellish it. The Irish have raised poetry, mystification, double meanings, humorous indirection, and ambiguity to an art form, in part, perhaps, because their history of oppression led them to realize that telling the truth could be dangerous (Chapter 43).

- Norwegians may withhold verbal expression out of respect and politeness, which for them involves not openly stating negative feelings they have about other family members. Such a custom may have nothing to do with guilt about “unacceptable” feelings or awkwardness in a therapy context, as it might for the Irish (Chapter 46).

- In Sioux Indian culture, talking is actually proscribed in certain family relationships. A wife does not talk directly to her father-in-law, for example, yet she may experience deep intimacy with him, a relationship that is almost inconceivable in our pragmatic world. The reduced emphasis on verbal expression seems to free Native American families for other kinds of experiences of each other, of nature, and of the spiritual realm (Chapters 2 and 3).

CULTURAL DIFFERENCES IN WHAT IS VIEWED AS A PROBLEM

Concomitantly, groups vary in what they view as problematic behavior. Anglos may be uncomfortable with dependency or emotionality; the Irish are distressed by a family member “making a scene”; Italians, about disloyalty to the family; Greeks, about any insult to their pride or *filotimo*; Jews, about their children not being “successful”; Puerto Ricans, about their children not showing respect; Arabs, about their daughters' virginity. For Chinese families harmony is a key dimension, and for African Americans bearing witness and testifying about their suffering is a central concept.

Of course, cultural groups also vary in how they respond to problems. Anglos see work, reason, and stoicism as the best responses, whereas Jews often consult doctors and therapists to gain understanding and insight. Until recently, the Irish responded to problems by going to the priest for confession, “offering up” their suffering in prayers, or, especially for men, seeking solace through drink. Italians may prefer to rely on family support, eating, and expressing themselves. West Indians may see hard work, thrift, or consulting with their elders as the solution, and Norwegians may prefer fresh air or exercise. Asian Indians may focus on sacrifice or purity, and the Chinese, on food or prayer to their ancestors.

Groups differ as well in attitudes toward seeking help. In general, Italians rely primarily on the family and turn to an outsider only as a last resort. African Americans have long mistrusted the help they can receive from traditional institutions, except the church, the only institution that was “theirs.” Puerto Ricans and Chinese may somatize when under stress and seek medical rather than mental health services. Norwegians, too, often convert emotional tensions into physical symptoms, which they consider more acceptable; thus their preference for doctors over psychotherapists. Likewise, Iranians may view medication and vitamins as a necessary part of treating symptoms. And some groups tend to see their problems as the result of their own sin, action, or inadequacy (Irish, African Americans, Norwegians) or someone else's (Greeks, Iranians, Puerto Ricans).

CULTURAL DIFFERENCES IN SOCIAL ORGANIZATION AND GROUP BOUNDARIES

Cultures differ also in their attitudes about group boundaries. Many Puerto Ricans, Italians, and Greeks have similar rural, peasant backgrounds, yet there are important ethnic differences among these groups. Puerto Ricans tend to have flexible boundaries between the family and the surrounding community, so that informal adoption is a common and accepted practice. Italians have much clearer boundaries within the family and draw rigid lines between insiders and outsiders. Greeks have very definite family boundaries, are disinclined to adopt children, and have deep feelings about the “bloodline.” They are also strongly nationalistic, a value that relates to a nostalgic vision of ancient Greece and to the country they lost after hundreds of years under Ottoman oppression. In contrast, Italians in the “old country” defined themselves first by family ties, second, by their village, and, third, if at all, by the region of Italy from which they came. It was only within a U.S. context that defining themselves by their ethnicity became relevant as they experienced discrimination by others. Puerto Ricans’ group identity has coalesced only within the past century, primarily in reaction to the United States’ oppression. Each group’s way of relating to therapy will reflect its differing attitudes toward family, group identity, and outsiders, although certain family characteristics, such as male dominance and role complementarity, are similar for all three of these groups.

Groups differ in other patterns of social organization as well. African Americans and Jewish families tend to be more democratic, with greater role flexibility, whereas Greeks (Chapter 41) and Asian cultures (Chapter 20) tend to be structured in a much more hierarchical fashion. Such differences will significantly influence how a person may respond to meetings of the whole family together versus individual coaching or meeting with same-sex subgroups of family members. Therapists need to be aware of how their methods of intervention fit for clients of different backgrounds.

NOT ROMANTICIZING CULTURE

Just because a culture espouses certain values or beliefs does not make them sacrosanct. All cultural practices are not ethical. Mistreatment of women or children, or gays or lesbians, through disrespect, as well as physical or sexual abuse, is a human rights issue, no matter in what cultural context it occurs. Every intervention we make is value laden. We must not use notions of neutrality or “deconstruction” to shy away from committing ourselves to the values we believe in. We must have the courage of our convictions, even while realizing that we can never be completely certain that our perspective is the “correct” one. It means we must learn to tolerate ambiguities and continue to question our stance in relation to the positions and values of our clients. And we must be especially careful about the power differential if we are part of the dominant group, since the voices of those who are marginalized are harder to hear. The disenfranchised need more support to have their position heard than do those who feel they are entitled because theirs are the dominant values.

In addressing racism, we must also deal with the oppression of women of color and of homosexual, bisexual, and transgender people. This cannot be blamed solely on White society, for patriarchy and heterosexism are deeply embedded in African, Asian, and

Latin American cultures. We must work for the right of every person to a voice and a sense of safety and belonging. We must challenge those who argue that cultural groups should be allowed to “speak for themselves.” This ignores the issue of who speaks for a group, which is usually determined largely by patriarchal and class factors. Helping families define what is normal, in the sense of healthy, may require supporting marginalized voices within the cultural group that express liberating possibilities for family adaptation. This requires making a careful cultural assessment (see the Appendix).

ETHNICITY TRAINING

Although there has been a burgeoning literature on ethnicity since the first edition of this book was published in 1982, integration of material on ethnicity in mental health professional training remains a “special issue,” ignored for the most part in research, taught at the periphery of psychotherapy training, and rarely written about or recognized as crucial by or for therapists of European origin (Chambless et al., 1996; Murry, Smith, & Hill, 2001). For this perspective to become truly integrated into our work will require a transformation of our field, which has barely begun (Green, 1998a, 1998b).

In our view, the most important part of ethnicity training involves the therapist coming to understand his or her own ethnic identity (Hardy & Laszloffy, 1992, 1995a; Laszloffy & Hardy, 2000). Just as clinicians must sort out the relationships in their own families of origin, developing cultural competence requires coming to terms with one’s own ethnic identity. Ideally, therapists would no longer be “triggered” by ethnic characteristics they may have regarded negatively, or caught in the ethnocentric view that their own cultural values are more “right” or “true” than those of others. Ethnically self-aware therapists achieve a multiethnic perspective, which opens them to understanding values that differ from their own, so that they neither need to convert others to their view, nor give up their own values. Our underlying openness to those who are culturally different is the key to expanding our cultural understanding. We learn about culture primarily not by learning the “facts” of another’s culture, but rather by changing our own attitudes about cultural difference. Indeed, David McGill (Chapter 37) has suggested that the best training for family therapists might be to live in another culture and learn a foreign language. That experience might best help the clinician achieve the humility necessary for respectful cultural interactions that are based on more than a one-way hierarchy of normality, truth, and wisdom. The best cultural training for family therapists may be to experience what it is like to not be part of the dominant culture.

Cultural paradigms are useful to the extent that they help us challenge our long-held beliefs about “the way things are.” But we cannot learn about culture cookbook fashion, through memorizing recipes for relating to other ethnic groups. Information we learn about cultural differences will, we hope, expand our respect, curiosity, and humility regarding cultural differences.

Our experience has taught us repeatedly that theoretical discussions about the importance of ethnicity are practically useless in training clinicians (McGoldrick, 1998). We come to appreciate the relativity of values best through specifics that connect with our lived experience of group differences. Thus, in our training we try to fit any illustration of a cultural trait into the context of historical and cultural experiences in which that value or behavior evolved. We ask trainees to think about how their own groups, and

perhaps those of their spouses or close friends, differ in responding to pain, in their attitudes about doctors, and in their beliefs about suffering. Do they prefer a formal or informal style in dealing with strangers? Do they tend to feel positive about their bodies, about work, about physical, sexual, psychological, or spiritual intimacy, or about children expressing their feelings? Then we try to help them broaden this understanding to other groups through readings, films, and conversations that illustrate other ways of viewing the same phenomena.

When beginning cultural training, it is extremely important to set up a safe context, which allows for generalizing about cultural differences. Of course, all generalizations represent only partial truths. We begin by personal sharing, conveying that everyone has grown up influenced by culture, class, race, gender, and sexual orientation. We discuss the problem of stereotyping (e.g., becoming stuck in an overgeneralization) and the problem of not generalizing (e.g., that it prevents culture from being discussed at all).

As the training evolves, we discuss the implications of people's social location, which becomes a core part of our assessment of each case, both for ourselves and the client. A power analysis of cultural, racial, class and gender politics becomes a core part of all training, so that clinicians can see how power affects all clinical interactions (Hardy & Laszloffy, 1992, 1995b; Laszloffy & Hardy, 2000).

The training usually proceeds from the personal, to the theoretical, to the clinical implications. We frequently use an exercise in which trainees discuss their own social location and how it has shifted over the course of their own and their family's cultural journey in the United States since immigration. We do this by actually spreading index cards on the floor showing a hierarchical listing of social locations by class (from the upper class—those who live on inherited wealth, to the poor—who may grow up without even the hope of employment), with subhierarchies for gender, race, and sexual orientation. Trainees take turns moving along this hierarchy on the floor as they describe their personal and family evolution. As they do this, they explore the influence of ethnicity and religion on the hierarchies of class, race, gender, and sexual orientation. They also show how education, migration, employment, finances, health, and marital status have influenced their positions. This exercise helps trainees understand that cultural dimensions are not individual issues, but are socially structured within the sociopolitical context.

We have found that to organize training only around “minority” ethnicities, as has so often been done, is not helpful. Such training perpetuates the marginalization of groups that are already at the periphery, because they continue the myth that Western theories (developed by Europeans and White Americans) are the norm from which all other cultures deviate. Instead, training entails considerable deconstruction of “Western” ways of thought to challenge the dominant psychological structures as an essential part of freeing people to become more culturally competent.

We have found a number of common pitfalls in discussions of diversity:

1. The discussion may become polarized, particularly in regard to the Black experience of White racism, leaving other people of color feeling invisible or excluded. People get lost in arguments over which oppression is the worst or most important. This typically leads to the withdrawal of those who feel that their own issues of oppression are marginalized in such a dialogue.

2. People tend to think much more easily about their oppression than about their privilege, and are thus likely to move quickly from acknowledgment of racism and White

supremacy to talk about the impact of sexual abuse, sexual orientation, poverty, or some other disadvantage. This has the effect of short-circuiting the discussion of racism. As other differences are discussed, racism becomes submerged and sidelined.

3. We believe that staying at the table is everything, and we make great efforts to explain that if we are to succeed in moving conversations about race and other oppression forward, staying in the conversation is the primary requirement. We try to emphasize that the conversations may get sticky, uncomfortable, or intense and that we will all make mistakes as we go along. But persevering with the conversation is everything—not letting the issues get resubmerged, which, as Ken Hardy puts it, always leads to cutoff, war, destruction, and, ultimately, death (Hardy & Laszloffy, 2000).

We consider it essential to keep a multidimensional perspective that highlights the overwhelming reality of institutionalized racism while also including other forms of oppression. At the same time we have found that it helps to let the group know about the dynamics of power, privilege, and oppression early in the conversation and to say that in terms of social location, all of us have privilege on certain dimensions and experience oppression on others. We then share guidelines that may help trainees notice how these power dynamics work and how people can monitor themselves. They can notice their own inclination to shift a discussion from a dimension on which they have privilege to one on which they are oppressed. The following are some of the guidelines we lay out in training to help participants monitor their own reactions and increase their sensitivity to others:

The impact of privilege on our vision

- The more privilege we have, the harder it is to think about how our own actions have affected others with less privilege.
- We take our privilege for granted—our right to safety, acknowledgment, being heard, being treated fairly, being taken care of; our right to take up the available time, space, and resources, etc.
- The more power and privilege we have, the harder it is to think about the meaning of the rage of the powerless.

How Whites often respond to attempts to discuss racism

- They distinguish themselves from those with power and privilege by emphasizing their other oppressions: They refer to their great-grandfather, who was Cherokee, their own history of oppression as Irish, Jewish, gay, poor, disabled, or being from an abusive or mentally ill family. We experience oppression ourselves, they say, why focus only on racism?
- They shift the discussion to the internalized racism of people of color against themselves or of one group against another: the issue of skin color within African American families, conflicts between Latinos or Koreans and African Americans, etc.).
- They resist group categories, saying, “We’re just human beings.” “We do not think of people by color, culture, or class, but as unique human beings.” “You’re creating the problem by forcing us into categories. It’s stereotyping.” “I don’t identify as White. It’s not fair to force me into this categorization. It’s reverse racism.”

- “How can you blame a whole race for a few individuals? My ancestors weren’t even here during slavery. It’s not fair for you to blame me for these problems.”
- They say they feel “unsafe” in an atmosphere of “political correctness,” that it makes them feel they are walking on egg shells, which focuses the discussion on their discomfort, implicitly blaming those who are attempting to discuss oppression for making them uncomfortable. Such assertions make it impossible to have a discussion about their privilege.
 - They accept criticism, but then assume a talking position, refocusing the discussion on their feelings of shame. By doing so, they are implicitly asking others to listen or to take care of their pain about their racist behavior, and thus keep the focus on themselves.
 - They disqualify the issue or the one who raises it, by saying things like:
 - “Why do people always have to bring up the past? Slavery ended 140 years ago.”
 - “People of color get so angry when they talk about these issues that it’s impossible to talk with them. I don’t want to talk until they can deal with these issues in a more appropriate way.”
 - “They never point out the clinical implications of these issues.”
 - They feel confused, thinking, “I’m certainly not a racist. I can’t think of anything to say on this topic.”

African American responses to a discussion of racism

- “It’s too painful and overwhelming. I feel so weary always having to lead Whites in these discussions, and they never get it anyway.”
- “Even when they claim to acknowledge racism, they always go back to individual thinking when they assess the behavior of a person of color. They don’t get excited about Rodney King or Amadou Diallo, but are appalled about O. J. Simpson.”
- “Racism makes me feel so much rage. I hate to get into it. I have to choose my battles. Why should I go into it here?”
- “When I was a child we could not even eat next to a White person or use the Whites’ drinking fountain, and they still don’t get it.”
- “I wish I knew how to protect my children from racism. I worry about how I will handle it the first time my child comes home having experienced a racist insult.”

What White people need to do in response to people of color discussing their experiences of racism (Hardy, 2004)

- Resist the temptation to equalize the experience with a description of their own suffering.
- Resist refocusing the conversation on their good intentions.
- Listen and believe. Resist any response that could negate the experience that is being described. The only reasonable position for people of privilege to take is to “listen and believe.”

Guidelines for accountability in training

- Racist patterns are most likely to be replicated when there is only one member of a traditionally oppressed group present. Whites are more likely to learn about

oppression and privilege in a group where the majority are people of color, a context that rarely occurs for White people.

- The most culturally competent structure has people of color at every level of the hierarchy.
- If that is not possible, consultation to the upper levels of the hierarchy from an outside group with experience in dealing with racism, and partnerships at other levels with consultants of color, can help the organization move in this direction as well.
- It helps to have at least three perspectives present in any discussion to minimize polarization.

In our experience presentations on a single group are rarely successful, because participants tend to focus on the exceptions to the “rule.” We find that presenting two groups is also problematic, because it leads to polarizing so-called opposites. Discussion becomes more meaningful when three or more groups are discussed together, at least until there is a general acceptance by the trainees of the importance of culture in clinical discussions. This is especially important because of our society’s tendency to polarize: Black/White, male/female, gay/straight, rich/poor. It is always valuable to create a context in which overlapping and ambiguous differences cannot easily be resolved, because that fits better with the complexities of human experience. Presenting several groups also tends to help students see the pattern, rather than the exception. Thus, although not all Dominicans may be alike, they may have certain similarities when compared with Haitians, Russians, or Greeks.

In training groups we often ask participants to (1) describe themselves ethnically, (2) describe who in their families influenced their sense of ethnic identity, (3) discuss which groups other than their own they think they understand best, (4) discuss the characteristics of their ethnic group they like most, and which they like least, and (5) discuss how they think their own families would react to having to go to family therapy and what kind of approach they would prefer.

CONCLUSION

The following guidelines, based on our years of clinical experience, suggest the kind of inclusive thinking necessary for judging family problems and normal adaptation in a cultural context (Giordano & Giordano, 1995; McGoldrick, 1998):

- Assume that the family’s cultural, class, religious, and political background influences how its members view their problems until you have evidence to the contrary.
- Assume that having a positive awareness of one’s cultural heritage, just like a positive connection to one’s family of origin, contributes to one’s sense of mental health and well-being.
- Assume that a negative feeling or lack of awareness of one’s cultural heritage is probably reflective of cutoffs, oppression, or traumatic experiences that have led to suppression of the person’s history.
- Assume that no one can ever fully understand another’s culture, but that curiosity,

humility, and awareness of one's own cultural values and history will contribute to sensitive interviewing.

- Assume that clients from marginalized cultures have probably internalized society's prejudices about them and that those from dominant cultural groups have probably internalized assumptions about their own superiority and right to be privileged within our society.

Respectful clinical work involves helping people clarify their cultural identity and self-identity in relation to family, community, and their history, while also adapting to changing circumstances as they move through life.

REFERENCES

- Alba, R. D. (1990). *Ethnic identity: The transformation of white America*. New Haven, CT: Yale University Press.
- Alibhai-Brown, Y., & Montague, A. (1992). *The colour of love: Mixed race relationships*. London: Virago Press.
- Angelou, M. (1986). *All God's children need traveling shoes*. New York: Vintage.
- Aponte, H. (1994). *Bread and spirit*. New York: Norton.
- Banks, J. A. (1991). *Teaching strategies for ethnic studies* (5th ed.). Boston: Allyn & Bacon.
- Bateson, M. C. (1995). *Peripheral vision: Learning along the way*. New York: Perennial.
- Bell, D. (1993). *Faces at the bottom of the well: The permanence of racism*. New York: Basic Books.
- Betancourt, J. R. (2004). Cultural competence: Marginal or mainstream movement? *New England Journal of Medicine*, 351(10), 953–954.
- Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and healthcare. *Public Health Reports*, 118(4), 293–302.
- Boyd-Franklin, N. (2002). Race, class and poverty. In F. Walsh (Ed.), *Normal family processes: Growing diversity and complexity* (3rd ed., pp. 260–279). New York: Guilford Press.
- Boyd-Franklin, N. (2003). *Black families in therapy: Understanding the African American experience* (2nd ed.). New York: Guilford Press.
- Boyd-Franklin, N., & Lockwood, T. W. (1999). Spirituality and religion: Implications for psychotherapy with African American clients and families. In F. Walsh (Ed.), *Spiritual resources in family therapy* (pp. 90–103). New York: Guilford Press.
- Braden, A. (1999). *The wall between*. Knoxville: University of Tennessee Press.
- Carter, B., & McGoldrick, M. (Eds.). (2005). *The expanded family life cycle: Individual, family and social perspectives* (Classic ed.). Boston: Allyn & Bacon.
- Carter, R. T. (1995). *The influence of race and racial identity in psychotherapy*. New York: Wiley.
- Chambless, D. L., Crits-Cristoph, P., Baker, M., Johnson, B., Woody, S. R., Sue, S., et al. (1996). An update on empirically validated therapies. *Clinical Psychologist*, 49, 5–18.
- Crohn, J. (1995). *Mixed matches: How to create successful interracial, interethnic, and interfaith relationships*. New York: Fawcett Columbine.
- Cushing, B., & McGoldrick, M. (2004). The differentiation of self and faith in young adulthood. In F. B. Kelcourse (Ed.), *Human development and faith*. St. Louis, MO: Chalice.
- Dilworth-Anderson, P., & Burton, L. M. (1996). Rethinking family development: Critical conceptual issues in the study of diverse groups. *Journal of Social and Personal Relationships*, 13(3), 325–334.
- Dilworth-Anderson, P., Burton, L., & Johnson, L. (1993). Reframing theories for understanding race, ethnicity and families. In P. G. Boss, W. J. Doherty, R. LaRossa, W. R. Schumm, & S. K. Steinmetz (Eds.), *Sourcebook of family theories and methods: A contextual approach*. New York: Plenum Press.

- Erdrich, L., & Dorris, M. (1991). *The crown of Columbus*. New York: Harper.
- Fadiman, A. (1997). *The spirit catches you and you fall down*. New York: Farrar, Straus & Giroux.
- Falicov, C. J. (2002). Immigrant family processes. In F. Walsh (Ed.), *Normal family processes: Growing diversity and complexity* (3rd ed., pp. 280–300). New York: Guilford Press.
- Franklin, A. J. (2004). *From brotherhood to manhood: How Black men rescue their relationships and dreams from the invisibility syndrome*. Hoboken, NJ: Wiley.
- Frederickson, G. M. (2002). *Racism: A short history*. Princeton, NJ: Princeton University Press.
- Freire, P. (1994). *The pedagogy of hope*. New York: Continuum.
- Gallup, G., Jr., & Lindsay, D. M. (1999). *Surveying the religious landscape: Trends in U. S. beliefs*. Harrisburg, PA: Morehouse.
- Gallup Organization. (2004, July 22). *Americans divided on immigration*. Princeton: Gallup Poll News Service.
- Giordano, J., & Giordano, M. A. (1995). Ethnic dimensions in family therapy. In R. Mikesell, D. Lusterman, & S. McDaniel (Eds.), *Integrating family therapy*. Washington, DC: American Psychological Association.
- Goldner, V. (1988). Generation and gender: Normative and covert hierarchies. In M. McGoldrick, C. Anderson, & F. Walsh (Eds.), *Women in families*. New York: Norton.
- Gould, S. J. (1994, November). The geometer or race. *Discover*, p. 1.
- Greeley, A. (1969). *Why can't they be like us?* New York: American Jewish Committee.
- Green, R.-J. (1998a). Race and the field of family therapy. In M. McGoldrick (Ed.), *Re-visioning family therapy: Race, culture, and gender in clinical practice* (pp. 93–110). New York: Guilford Press.
- Green, R.-J. (1998b). Training program: Guidelines for multicultural transformation. In M. McGoldrick (Ed.), *Re-visioning family therapy: Race, culture, and gender in clinical practice* (pp. 111–117). New York: Guilford Press.
- Hacker, Andrew (1995, November 19). Who they are. *New York Times Magazine*, pp. 70–71.
- Hall, S. (1987). Minimal selves. In H. K. Bhabha et al. (Eds.), *Identity: The real me: Post-modernism and the question of identity* (ICA Documents, No. 6, pp. 44–46). London: Institute of Contemporary Arts.
- Hardy, K. V. (2004). Race, reality, and relationships: Implications for family therapists. In S. Madigan (Ed.), *Therapeutic conversations 5: Therapy from the outside in* (pp. 87–98). Vancouver, BC, Canada: Yaletown Family Therapy.
- Hardy, K. V., & Laszloffy, T. A. (1992). Training racially sensitive family therapists: Context, content and contact. *Families in Society*, 73(6), 363–370.
- Hardy, K. V., & Laszloffy, T. A. (1995). The cultural genogram: Key to training culturally competent family therapists. *Journal of Marital and Family Therapy*, 21(3), 227–237.
- Hardy, K. V., & Laszloffy, T. A. (1995). Deconstructing race in family therapy. *Journal of Feminist Family Therapy*, 5(3–4), 5–33.
- Hayden, T. (Ed.). (1998). *Irish hunger*. Boulder, CO: Roberts Reinhart.
- Hayden, T. (2001). *Irish on the inside: In search of the soul of Irish America*. New York: Verso.
- Hernandez, M., & McGoldrick, M. (2005). Migration and the family life cycle. In B. Carter & M. McGoldrick (Eds.), *The expanded family life cycle*. Boston: Allyn & Bacon.
- Hitchcock, J. (2003). *Lifting the white veil: An exploration of white American culture in a multiracial context*. Roselle, NJ: Crandall Dostie & Douglass Books.
- Hodge, D. R. (2001). Spiritual genograms: A generational approach to assessing spirituality. *Families in Society: The Journal of Contemporary Human Services*, pp. 35–48.
- Ignatiev, N. (1995). *How the Irish became white*. New York: Routledge.
- Jamieson, D., & O'Mara, J. (1991). *Managing workforce 2000*. San Francisco: Jossey-Bass.
- Jones, A. C. (1993). *Wade in the water: The wisdom of the spirituals*. Maryknoll, NY: Orbis.
- Kaiser, W. L. (2001). *A new view of the world: Handbook to the Peters projection world map*. New York: Friendship Press.

- Katz, J. H. (1978). *White awareness: Handbook for anti-racism training*. Norman: University of Oklahoma Press.
- Kennedy, R. (2003). *Interracial intimacies: Sex, marriage, identity, and adoption*. New York: Pantheon.
- Kivel, P. (2002). *Uprooting racism: How White people can work for racial justice*. New York: New Society.
- Kosmin, B., & Lachman, S. (2001). *American Religious Identity Survey (ARIS)*. New York: Graduate School of the City University of New York. www.gc.cuny.edu/studies/aris_index.htm
- Laszloffy, T. A., & Hardy, K. V. (2000). Uncommon strategies for a common problem: Addressing racism in family therapy. *Family Process*, 39(1), 35–50.
- Lewis, B. (2002). *What went wrong: Western impact and Middle Eastern response*. New York: Oxford University Press.
- Lopez, S. R., & Guarnaccia, P. (2000). Cultural psychopathology: Uncovering the social world of mental illness. *American Review of Psychology*, 51, 571–598.
- Lorde, A. (1992). Age, race, class, and sex: Women redefining difference. In M. Anderson & P. H. Collins (Eds.), *Race, class, and gender: An anthology* (pp. 495–502). Belmont, CA: Wadsworth.
- Luepnitz, D. (1992). *The family interpreted*. New York: Basic Books.
- Mahmoud, V. M. (1998). The double binds of wisdom. In M. McGoldrick (Ed.), *Re-visioning family therapy: Race, culture, gender, and clinical practice* (pp. 255–267). New York: Guilford Press.
- Malcomson, S. (2000). *One drop of blood. The American misadventure of race*. New York: Farrar, Straus & Giroux.
- Martinez, R. (2004). *The new Americans*. New York: The New Press.
- McGoldrick, M. (Ed.). (1998). *Re-visioning family therapy: Race, culture, and gender in clinical practice*. New York: Guilford Press.
- McGoldrick, M. (2002). Culture: A challenge to concepts of normality. In F. Walsh (Ed.), *Normal family processes: Growing diversity and complexity* (3rd ed., pp. 235–259). New York: Guilford Press.
- McGoldrick, M., Anderson, C., & Walsh, F. (Eds.). (1989). *Women in families*. New York: Norton.
- McGoldrick, M., & Garcia-Preto, N. (1984). Ethnic intermarriage. *Family Process*, 23(3), 347–362.
- McGoldrick, M., Gerson, R., & Schellenberger, S. (1999). *Genograms: Assessment and intervention*. New York: Norton.
- McGoldrick, M., Marsh Schlesinger, J., Hines, P., Lee, E., Chan, J., Almeida, R., et al. (2004). Mourning in different cultures: English, Irish, African American, Chinese, Asian Indian, Jewish, Latino, and Brazilian. In F. Walsh & M. McGoldrick (Eds.), *Living beyond loss* (2nd ed.). New York: Norton.
- McGoldrick, M., & Rohrbaugh, M. (1987). Researching ethnic family stereotypes. *Family Process*, 26, 89–98.
- McIntosh, P. (1998). White privilege: Unpacking the invisible knapsack. In M. McGoldrick (Ed.), *Re-visioning family therapy: Race, culture, and gender in clinical practice* (pp. 147–152). New York: Guilford Press.
- Miller, W. R., & Thoresen, C. E. (2003). Spirituality, religion and health. *American Psychologist*, 58(1), 24–35.
- Morgan, E. S. (2002). *Benjamin Franklin*. New Haven, CT: Yale University Press.
- Morris, E. (Producer & Director). (2003). *The fog of war* [Film]. Available from Sony Pictures.
- Murry, V. M., Smith, E. P., & Hill, N. E. (2001). Race, ethnicity and culture in studies of families in context. *Journal of Marriage and the Family*, 63(4), 911–914.
- Ortiz, A., Simmons, J., & Hinton, W. L. (1999). Locations of remorse and homelands of resilience: Notes on grief and sense of loss of place of Latino and Irish-American caregivers of demented elders. *Culture, Medicine and Psychiatry*, 23, 477–500.
- Petsonk, J., & Remsen, J. (1988). *The intermarriage handbook: A guide for Jews and Christians*. New York: William Morrow.

- Pinderhughes, E. (1989). *Understanding race, ethnicity and power*. New York: Free Press.
- Roberts, S. (2004). *Who we are now: The changing face of America in the 21st century*. New York: Times Books.
- Root, M. P. P. (Ed.). (1992). *Racially mixed people in America*. Thousand Oaks, CA: Sage.
- Root, M. P. P. (Ed.). (1996). *The multiracial experience: Racial borders as the new frontier*. Thousand Oaks, CA: Sage.
- Root, M. P. P. (2001). *Love's revolution: Interracial marriage*. Philadelphia: Temple University Press.
- Root, M. P. P. (2003). Bill of rights for racially mixed people. In M. P. P. Root & M. Kelley (Eds.), *Multiracial child resource book*. Seattle, WA: Mavin.
- Schneider, S. W. (1989). *Intermarriage: The challenge of living with differences*. New York: Free Press.
- Simpson, E. (1987). *Orphans: Real and imaginary*. New York: New American Library.
- Tatum, B. D. (2003). "Why are all the Black kids sitting together in the cafeteria?": *And other conversations about race* (rev. ed.). New York: Basic Books.
- Tataki, R. (1993). *A different mirror: A history of multicultural America*. Boston: Little, Brown.
- Tataki, R. (2002). *Debating diversity: Clashing perspectives on race and ethnicity in America* (3rd ed.). New York: Oxford.
- Thiederman, S. (1991). *Profiting in America's multicultural marketplace: How to do business across cultural lines*. New York: Lexington.
- Thomas, R. (1991). *Beyond race and gender*. New York: American Management Association.
- Thurow, L. (1995, November 19). Why their world might crumble. *New York Times Magazine*.
- Vermuelen, M. (1995, June 18). What people earn. *Parade Magazine*, pp. 4–6.
- Walsh, F. (Ed.). (1999). *Spiritual resources in family therapy*. New York: Guilford Press.
- Walsh, F., & Pryce, J. (2002). The spiritual dimension of family life. In F. Walsh (Ed.), *Normal family processes: Growing diversity and complexity* (3rd ed., pp. 337–372). New York: Guilford Press.
- Wheeler, D., Avis, J., Miller, L., & Chaney, S. (1985). Rethinking family therapy training and supervision: A feminist model. *Journal of Psychotherapy and the Family*, 1, 53–71.
- Zborowski, M. (1969). *People in pain*. San Francisco: Jossey-Bass.
- Zinn, H. (2003). *A people's history of the United States* (rev. ed.). New York: Harper.
- Zola, I. K. (1966). Culture and symptoms: An analysis of patients' presenting complaints. *American Sociological Review*, 5, 615–630.

PART I



AMERICAN INDIAN
AND PACIFIC ISLANDER
FAMILIES

CHAPTER 2



American Indian Families

An Overview

CharlesEtta T. Sutton
Mary Anne Broken Nose

An objective of the Decade is the promotion and protection of the rights of indigenous people and their empowerment to make choices which enable them to retain their cultural identity while participating in political, economic and social life, with full respect for their cultural values, languages, traditions and forms of social organization.

—GENERAL ASSEMBLY RESOLUTION 50/157 (December 21, 1995)

You were born here, she was born here, and so was I. We are all Native Americans. My relatives were here when Columbus and other explorers discovered the Americas. I like to be called an Indigenous person belonging to an Indigenous Nation, the Poncas, in North America.

—PARRISH WILLIAMS, Ponca Elder, personal communication (December 3, 2002)

Since the time of Columbus, inaccurate and conflicting images have characterized the dominant culture's concept of American Indians. Europeans thought of Indians as either, innocent savages living in a primitive paradise or as heathens and bloodthirsty fiends. Explorers, settlers, missionaries, and political leaders all exploited these images for their own purposes. When viewed through the lens of European beliefs and customs, Europeans saw Indian culture generally as barbaric. Even the design of "humanistic" policies of Indian advocates, such as those of 18th-century reformers, was to "educate the Indian out of the Indian." In retrospect, their impact was almost as devastating as the U.S. army's genocidal policies (Berkhoffer, 1978).

Early Spanish explorers first gave one name, "Indios," to all the indigenous peoples living in America, rather than seeing them as diverse ethnic groups. When the Europeans first sailed to this land, at least "two thousand cultures and more societies practiced a multiplicity of customs and life styles, held an enormous variety of values and beliefs, spoke numerous languages mutually unintelligible to the many speakers, and did not con-

ceive of themselves as a single people—if they knew about each other at all” (Berkhoffer, 1978, p. 3).

Europeans’ concern was that the new people they encountered were neither Christian nor culturally familiar. By labeling these aboriginal people as “uncivilized,” they were able to make decisions concerning them more easily, as well as to justify the atrocities they committed. This blurring of distinctions between tribal groups continues today.

The entertainment industry has offered a distortion of American Indian customs and culture. The images created by the early dime novelists and, later, by movies had little to do with reality. They sometimes placed tribes in the wrong parts of the country or had a character who was supposed to be Cherokee speak Lakota and practice Mohawk ceremonies. What they often portrayed was not an Arapaho, Cheyenne, or Ute, but a generic “Indian.” Unfortunately, most Americans having very little day-to-day contact with American Indians and often obtain their main and largely inaccurate impressions through the media.

Indians are changing this view by using the very institutions that have done so much to malign them to portray a more accurate picture of their history and society. Many school systems are developing curricula featuring Indian history. Documentaries produced by American Indians tell the stories of their individual nations. There are now Indian-owned and operated radio stations, TV networks, newspapers, and publishing companies. A new respect for Indians’ positive influences on the dominant culture is replacing old concepts and stereotypes (Adams, 2002).

Environmental groups applaud Indians’ respect for nature. Theologians, as well as New Age spiritualists, embrace Indian ceremonial life. Feminists and sociologists study many of the first nations’ democratic social structures. Educational and behavioral health care settings are incorporating Native American teachings and rituals, such as sweat lodge ceremonies and talking circles, into their practices. More dominant culture and mixed-race people are searching their family histories for Indian roots.

NATIVE AMERICANS IN HISTORICAL AND CULTURAL CONTEXT

Demographics

The terms “Native American” and “American Indian” are labels that encompass a diversity of languages, lifestyles, religions kinship systems, and community structures (Polacca, 1995). Many tribes are sovereign nations, both in law and through treaties.

There are many ways of defining “Indian”: by genetic definition—having a certain percentage of Indian blood as established by the Federal Register of the United States; by community recognition—being recognized as Indian by other Indians is paramount, because federal and state governments do not recognize all tribes; by enrollment in a recognized tribe; and by self-declaration, the method used by the Census Bureau.

According to the 2000 Census, 2.5 million people identified themselves being American Indian, with another 1.6 million reporting they were Indian and of another race. (U.S. Bureau of the Census, 2000). There are 562 federally recognized tribes (U.S. Department of the Interior, 2004). Many tribal members live in urban areas, and those on the reservations may spend time away looking for work, education, and other opportunities. Most major cities have a substantial Indian population, with New York and Los Angeles having the largest.

There is a wide range of cultural identification among Indians. Some consider themselves American Indian because they have a great-grandparent who was Indian. Others are born on reservations and enter school speaking a mixture of their native language and English. Still others grow up in the city and have no knowledge of tribal language or customs. A large group, however, move in and out of both worlds, trying to maintain a precarious balance between their Indian and American identities.

Family Structure and Obligations

Family represents the cornerstone for the social and emotional well-being of individuals and communities.

—RED HORSE (1981, p. 1)

The ultimate aim of Dakota life, stripped of accessories, was quite simple: One must obey kinship rules; one must be a good relative. No Dakota who has participated in that life will dispute that. In the last analysis every other consideration was secondary—property, personal ambition, glory, good times, life itself. Without that aim and the constant struggle to attain it, the people would no longer be Dakota in truth. They would no longer even be human. To be a good Dakota, then, was to be humanized, civilized. And to be civilized was to keep the rules imposed by kinship for achieving civility, good manners and a sense of responsibility toward every individual dealt with. Thus only was it possible to live communally with success, that is to say, a minimum of friction and a maximum of good will.

—DELORIA (1944, cited in Gunn, 1989, p. 11)

Although the extended family is typical of American Indians, its core is quite different from that of the dominant culture. Family therapist Terry Tafoya (1989) explains: “In many Native American languages, cousins are all referred to as brother and sister. The primary relationship is not the parents, but rather that of grandparents” (p. 32). This reflects the grandparents’ role as caregiver and provider of training and discipline.

The grandparent role is not limited to what is called a “grandparent” in English, but is opened up to include other relations such as a “grand aunt,” and could be extended to include . . . a “Godparent.” Parent roles include not only the biological parents, but also those who have a sibling relation to the biological parents. The biological parents of the central siblings would then have specific responsibility over their nieces and nephews. . . . (pp. 32–33)

Many Indian cultures do not have a term for in-law; rather, a daughter-in-law is a daughter; a sister-in-law, a sister. Families make no distinctions between natural and inducted by marriage family members once one marries into an Indian family. This concept is foreign to White Anglo-Saxon, Protestant family norms. Thus, families blend, not join, through marriage. Medicine people¹ and non-blood relatives are sometimes made part of the family. This is similar to what happens in African American and Latino families, where the relationship, not blood, determines the family role.

A therapist working with a Lakota Sioux couple obtained an initial family history. When Joseph, the father, learned that one of his grandfathers had died, the therapist pulled out the genogram and did not find his name listed as a grandfather. For the non-Indian therapist, the deceased was the client’s paternal great-uncle. The client explained that all his grandfather’s brothers were his grandfathers. “So, you call your great-uncles ‘grandfather’?” inquired the therapist. “No,” replied Joseph, “I don’t call them that; that

is what they are, my grandfathers.” At this moment, the therapist understood that the client’s emotional relationship and sense of respect was to a grandfather, not a great-uncle.

The individual tribe determines roles and family obligations. For example, in Hopi society, an uncle is a family leader who provides guidance, nurturance, and support to other family members. A person unable to meet these role obligations can experience a great deal of anxiety and guilt. Two-Spirit is the contemporary name for lesbian, gay, bisexual, and transgender Native Americans. This contemporary term, adopted in 1990 from the Northern Algonquin word *niizh manitoag*, proposes to signify the embodiment of both feminine and masculine spirits within one person (Anguksuar, 1997). Traditionally, many Indian cultures respect lesbian, gay, bisexual, and transgender (LGBT) persons and believe these persons hold sacred and ceremonial roles. Healer is often one of such roles. Many scholars believe the suppression of these traditional indigenous values of acceptance and honor is another result of compulsory Christianity and colonization. According to Walters (1997), most LGBT Native Americans face homophobic oppression from both mainstream U.S. society and their own tribes and communities, especially those who live off their reservations and in urban areas. Adopting the label Two-Spirit for many LGBT Native Americans is an act of decolonization and reclamation of tradition for future generations.

A non-Indian therapist may have difficulty recognizing these different roles. It helps to take a good family history, a nonthreatening activity with which an American Indian client usually feels comfortable and which demonstrates the therapist’s concern for the extended family. Traditionally, when strangers meet, they often identify themselves through their relatives: “I am a Navaho. My name is Tiana Bighorn. My hometown is Tuba City, Arizona. I belong to the Deer Springs Clan, born for the Rocky Gap Clan” (Benet & Maloney, 1994, p. 9). As therapy proceeds, the professional who is sensitive and willing to listen intently will gradually learn more about the family structure and dynamics. Therapist–client rapport, does not happen in one session but gradually develops over time. The therapist might begin by modeling the process. It is very important to say who you are and where you come from in an accessible, nonthreatening way. Napoli (1999) and Warner (2003) stress the importance of the clinician’s self-disclosure in establishing a working alliance and trust with the family.

The Spiritual Relationship of Man and Nature

Mitakuye Oyasin, Lakota for “To all my relations,” is a salutation and a saying one commonly hears at the end of prayer. It acknowledges the spiritual bond between the speaker and all people present. It affirms the importance of the relationship of the speaker to his or her blood relatives, the forbears’ tribe, the family of man, and Mother Nature. It bespeaks a life-affirming philosophy that all life forces are valuable and interdependent. Western civilization’s orientation is toward control over nature, whereas traditional Indian culture sees harmony with natural forces as a way of life. A belief is that only a few human beings have control over nature’s forces, those gifted with a special bond to and an unusual understanding of nature. The acceptance of overwhelming, uncontrollable natural events is an integral part of life.

For the American Indian, sacred beings may include animals, plants, mountains, and bodies of water, which are part of the universal family and, as such, involved in a reciprocal system; we care for Mother Earth and she nurtures us. Just as a person strives to be in harmony with his or her human relatives, so should that person try to be in harmony with his or

her spiritual and natural relatives: “My mother told me, every part of this earth is sacred to our people. Every pine needle. Every sandy shore. Every mist in the dark woods. Every meadow and humming insect. The Earth is our mother” (Jeffers, 1991, p. 3).

Genocide

Contact with Europeans was devastating for North America’s indigenous peoples. Millions died through disease and genocidal warfare that destroyed entire communities and tribes. They subjected survivors to an insidious plan of coerced assimilation and cultural genocide, with many tribes forced to live on reservations distant from their native lands. They tore thousands of Indian children from their families and placed them in boarding schools. White authorities denigrated Indian languages, customs, and religions and forbade their practice. These policies led to a profound cultural trauma, because American Indian cultures are rooted in family ties, a unique attachment and respect for their natural surroundings, and a distinct spirituality (La Due, 1994).

Efforts at forced assimilation did not end in the 1800s. During the 1950s and 1960s the federal government developed a termination and relocation plan, taking many Indians from their homes and families and relocating them to urban centers (Tafoya & Del Vecchio, 1966). Alcoholism rates soared. One scholar concluded: “This was another significant loss heaped upon the already present losses of language, elders, family and culture. Suicide, violence, and homicide all increased to epidemic proportions. School dropout rates, teen pregnancies and high rates of unemployment all became markers of a legacy of trauma experienced throughout this country by Indian people” (La Due, 1994, p. 99). The implications of this “soul wound” are far-reaching, passed down through each generation (Duran, Duran, Brave Heart, & Yellow Horse-Davis, 1998).

Today, Indian cultures continue to survive in a hostile environment, as evident in the controversy over court cases that adjudicate treaty rights, the unapologetic use of Indian mascots for sports teams, and the need for civil rights investigations in areas that border reservations. Contrary to the typical pattern of violence in which most acts are committed between members of one ethnic group, the members of another group, primarily Whites, victimize American Indians (Greenfield & Smith, 1999). The therapist should be aware of such phenomena as suicide, depression, and alcoholism within the context of ongoing oppression combined with a genocidal history. Labeling and naming are powerful methods of creating subjectivity and “life worlds,” which may “be contributing to the invalidation of the pain and suffering that is directly connected to generations of genocide” (Duran et al., 1998, p. 346).

Tribal Identity

Although many may think of Indians as a homogenous group, Indians identify themselves as belonging to a particular tribe, band, or clan. Each tribe’s customs and values are critical to individual identity and affect family dynamics (Red Horse, 1981). This tradition of thinking in terms of “we” instead of “I” is a great strength of Indian culture.

All tribes, even those in the same geographic area, have distinctive worldviews and practices. For example, the Hopi, Dine’h (Navaho), Havasupai, Pima, Yaqui, and Apache all share the desert of the Southwest, but differ in terms of religious practices, customs, and family structures. When a Hopi or Dine’h man marries, he usually moves in with his wife’s family. However, the opposite is true of the Havasupai; the woman lives with her husband’s

relatives. The particular American Indian worldview has major implications for therapy. The Dine'h have a legend indicating that epileptic seizures result from a brother and sister being involved in incest. Recent studies comparing attitudes of Apaches, Dine'h, and Hopis toward epilepsy reveal that Dine'h Indians with epilepsy feel more stigmatized, are more ashamed of their illness, and are less likely to seek treatment (Levy, 1987). The Mvskoke Creek believe that animals cause all illnesses and diseases (P. Coser, personal communication, February 26, 2004).

American Indian tribes' diversity sometimes leads to conflict. For example, the Sioux and the Ponca are both Plains Indian Nations that may seem similar to outsiders, but they are traditional enemies. Each nation has legends about its own warriors, heroes, medicine men, and medicine women. Each has its own horror stories about encounters with Whites and tales of military, moral, or spiritual triumph. Through tribal traditions, Indian people are offered a radically different view of themselves than that created by the dominant culture. This view helps sustain them in their encounters with White society.

Families succeeding best in this migration (into the White culture) have two characteristics. Not surprisingly, one is openness to learning and to using the social and technical skills of the White culture. A second, more startling characteristic is the interest that these families show in keeping alive the language, folkways, crafts, and values associated with their tribal identities. (Attneave, 1982, p. 82)

Some Indians struggle to maintain their cultural identity in a foreign environment, and others may try to recapture nearly extinct languages and customs. Because a therapist cannot be familiar with all the nuances of a particular Indian culture, when on unfamiliar ground he or she might ask the client such questions, "What particular cultural traits do you value most and wish to maintain: language, spirituality, family ties?" The therapist might explore such practical resources as a language class, participation in local ceremonies and traditional events such as Pow Wow, Sun Dance, and Sweat Lodge, or involvement with Indian organizations and centers. The therapist would do well to acknowledge the depth of a client's loss of his or her culture, even for those who have assimilated and are yearning for what they never had.

Communal Sharing

"When I was little, I learned very early that what's yours is mine and what's mine is everybody's" (Ivern Takes the Shield, traditional Oglala Lakota, personal communication, June 1989). Traditionally, Indians accord great respect to those who give the most to other individuals and families, and then to the band, tribe, or community. "Give-aways," an ancient custom whereby many gifts are presented to others for their help or achievements, persist in many tribes. They are a way of marking climactic events in the life cycle such as birth, naming, marriage, and death. On a day-to-day basis, Indians share material goods. Each traveler and visitor is always fed, housed, and even clothed and transported (Attneave, 1982, p. 69).

This value of sharing contrasts sharply with the dominant culture's capitalist emphasis on acquisition and can make it difficult for Indians on reservations to operate businesses. For example, a cafe started by a Dine'h (Navaho) couple should have been very successful, given the lack of competition and the availability of patrons. Nevertheless, the

owners felt an obligation to provide food gratis for family members. Because “family” often includes in-laws and their families, it was difficult to find paying customers. People who are either part Indian or nontraditionalists, however, run many successful businesses on reservations.

Similar issues often arise when the head(s) of an urban Indian family finds steady work or a student receives a stipend or fellowship. Whereas White culture focuses on carefully managing cash flow and savings, American Indians are prone to share liquid assets. “Unemployed parents may move in; siblings consume food, wear out clothing, and take up time needed for study. Students realize they can hardly pay tuition or study in this kind of environment. However, they feel that they cannot be Indian, yet be selfish about helping others whose needs are greater” (Attneave, 1982, p. 69).

THERAPY ISSUES

Many family therapy models are akin to the “Indian way,” which consists of extended families and often entire tribal groups working together to resolve problems. Family therapy, with its emphasis on relationships, is particularly effective in working with Indians, whose life cycle orientation blends well with the life cycle approach of family therapy. We suggest that the therapist use culturally sensitive, nondirective approaches. It is helpful to incorporate the use of storytelling, metaphor, and paradoxical interventions. Networking and the use of ritual and ceremony are favored over strategic interventions and brief therapy models.

Studies show that Indians come to treatment hoping that the therapist is an expert who can give them concrete, practical advice about their problems and be sensitive to their cultural beliefs and differences (Attneave, 1982; DuBray, 1993; La Fromboise, Trimble, & Mohatt, 1990; Polacca, 1995; Tafoya, 1989). Historically, racism has marred the relationship between American Indians and the helping professions. Missionaries, teachers, and social workers usually try to “help” Indians by changing their value systems, thus alienating them from the strength and support of their own people and traditions (La Fromboise et al., 1990). This has understandably led many to feel wary of therapists and therapy.

Professionals with impeccable credentials have victimized American Indians, who sometimes judge therapists by who, not what, they are. When Indian clients enter a clinician’s office, they will more likely look for behavioral indications of who the therapist is rather than for a particular diploma on the wall. Personal authenticity, genuine respect, and concern for the client are essential.

There are three important elements for successful therapy with American Indians. The first is to be aware of the impact of genocide. The second is to understand the differences between the dominant culture and that of American Indian clients. The third is to consider each individual client and family’s level of assimilation.

Who Comes to Therapy and Why?

American Indians come to therapy for the same reasons other Americans do, including marital problems, chemical dependency issues, and depression. An American Indian family’s underlying racial and cultural characteristics may resemble those of an immigrant

family that has acculturated for several generations. Nevertheless, the Indian client may still be very close to his or her reservation roots (Attneave, 1982). Yet, as in Oklahoma, many Native families of mixed-blood ancestry have no connection to their communities (P. Coser, personal communication, February 26, 2004).

The stress of intermarriage often brings couples to therapy. Working out the details of everyday life can result in the collision of Indian and dissonant cultural values.

Ruben, a Cheyenne, and his wife Angie, a Hungarian, were at an impasse. Living on the East Coast and childless, with financial problems, they came to therapy when Ruben was offered an apprentice job with a large manufacturer, a position arranged by a member of Angie's family. Angie worked as a secretary, while Ruben held a series of temporary jobs. Instead of being happy about the new position, Ruben was depressed and even was thinking of turning it down. Furious, Angie was threatening to leave him.



In this case, the therapist and clients explored how problems were resolved in their families of origin. Angie came from a family in which women typically made decisions about work and finances and thus helped to direct the family's mobility (socioeconomic and/or upward mobility). For her, financial stability was critical.

In Ruben's family, asking for guidance and direction through healing rituals was a way to begin to find answers to problems. Before he and Angie married, Ruben had made a commitment to Sun Dance, a religious purification and peace ceremony of his tribe, which sometimes requires a year or more of preparation. The sun dancer fasts, prays, and dances in the hot sun under the guidance of a medicine man. Sun Dance grounds are usually located on reservations. As in most Indian ceremonies, the sun dancer's family and community participate and provide emotional and spiritual support. The time, travel, and expense involved in keeping this kind of commitment often conflict with the demands of employment or education in the non-Indian world.

Ruben wished to sun dance to provide blessings for his family and as a way of promising himself that although he was moving into the dominant culture, he would not abandon his ceremonial ways. He felt that if he did not keep this commitment, something bad might happen to someone he loved or he might lose the marriage he valued so highly. He thus found himself caught in a difficult conflict.

Here is a classic example of the counterpoint between the American Indian value of spirituality expressed through ceremonial life versus financial security, as well as the Indian way of thinking in terms of "we" instead of "I." Ruben fears that not fulfilling his commitment will hurt someone he loves. If Ruben does not perform the Sun Dance and his father subsequently dies, he may well feel responsible. However, if he tells his non-Indian therapist this, the therapist is likely to think that Ruben is overreacting and will try to diffuse his guilt. That will not work, for Ruben has a culturally defined problem that requires a culturally acceptable solution. The therapist's primary task is to allow him to talk about his feelings and explore acceptable ways for him to resolve the situation. The therapist may also encourage Ruben to seek support from family and friends who may want to pray with him. Angie also needs support in learning about the sacredness of the Sun Dance and its significance for Ruben. Understanding this ritual may make her feel more comfortable about discussing possible alternatives with her family.

Living in the dominant society can make following culturally prescribed solutions difficult. The therapist can help by supporting such values and rituals and assisting the client in determining ways of using them to become “unstuck.” “Until traditional indigenous therapies are implemented and considered legitimate, there will be a struggle” (Duran et al., 1998, p. 341).

Communicative Style

My grandmother always told me that the white man never listens to anyone, but expects everyone to listen to him. So, we listen! My father always told me that an Eskimo is a listener. We have survived here because we know how to listen. The white people in the lower forty-eight talk. They are like the wind, they sweep over everything.

—COLES (1978, cited in Nabokov, 1991, p. 431)

Native cultures value listening. Long periods of silence during a session can be confusing for the therapist. Yet silence may connote respect, that the client is forming thoughts, or that the client is waiting for a sign that it is the right time to speak. Indians can be very indirect. Some native cultures consider it disrespectful for one relative to mention the name of another. A Lakota woman may refer to her father-in-law as “he” rather than speak his name.

The non-Indian therapist may treat silence, embellished metaphors, and indirectness as signs of resistance, when in fact they often represent important forms of communication (Attneave, 1982). The professional needs to monitor his or her feelings about these differences and resist the urge to interrupt. Otherwise, Indians may experience the therapist as disrespectful, insensitive, and opinionated. The therapist can counter this perception by joining with the client and following his or her directive and by being willing to admit to confusion and misunderstanding.

Professionals also need to be especially aware of nonverbal communication, particularly when “nothing is taking place.” For an Indian client, everything one does, no matter how subtle, communicates something (Sutton & Mills, 2001). How the therapist enters a room, what is in that room, and how the therapist responds to silence reveals something about him or her to the client. Everything influences the therapy. In addition, having coffee and food available for clients can make an office seem more welcoming and comfortable.

Treatment: Native and Western

Until the passage of the American Indian Freedom of Religion Act (1978), Indians who practiced their own religion through Sun Dance ceremonies, Native American Church practices, Sweat Lodge rituals, and the like, risked, and sometimes suffered, imprisonment. Despite such hardships, Indian religion endured and is thriving today. Some traditional American Indians seek the guidance of medicine people in times of crisis or major decision making, or when seeking spiritual growth. Others may not even know what a medicine person is, much less have contact with one (Polacca, 1995). Often we assume that a family follows traditional cultural practices. However cultural orientation can vary on a continuum ranging from the traditional to the contemporary (Weibel-Orlando, 1987).

“Indian medicine refers to a traditional and specific cultural approach to health and life for a person, rather than a treatment for a disease or illness” (DuBray, 1985). Gen-

erally, a medicine person's approach is holistic, involving healing the body and the troubled soul. Therapists should be alert to any contact that their clients may have with medicine people and should usually consider it beneficial.

In 1980, the American Medical Association revised its code of ethics, giving physicians permission to consult, and to take referrals from and make referrals to, non-physician healers, including American Indian medicine people (Polacca, 1995). Even practicing Christians may have an ongoing relationship with medicine people, which may positively or negatively affect a therapist's work with a family, as the following case reveals:

The Shields are a Navajo family who relocated to a large city from a rural reservation on a mesa; they are practicing Catholics, with three children: Tony, 16; Kensil, 12; and Shell, 9. The children attend a parochial school system with a large Indian population. The school's guidance counselor referred them because Tony clearly had a substance abuse problem affecting his school performance. After initially feeling that things were going well, the therapist began to sense that the family had become resistant, particularly after placing Tony in a juvenile detention facility because of a drinking episode. The therapist instructed the family to keep Tony in the detention center, as an intervention designed to allow him to experience the consequences of his actions. Without notifying the therapist, the family withdrew Tony from the detention facility and took him to the reservation to stay with an aunt and uncle. When the therapist contacted the family about this action, they scheduled an appointment, but did not show up. When Tony returned to school, the family resumed therapy, only to have the same pattern repeat itself.



In this case, the Shields brought their son home to be with an uncle, a person who traditionally plays an important role in a son's upbringing. They also utilized the services of a medicine man and were involved in the Native American Church. The Native American Church is a recognized religion that uses peyote as a sacrament instead of wine or juice and wafers or bread. The Shields were reluctant to discuss these involvements with the therapist, feeling that she would not understand their decision and would reject their ceremonial approach. Rather than having to explain why they had not followed her instructions, the family tried to avoid her. The therapist began to explore the reasons behind the missed appointments instead of assuming the family was rejecting treatment. Upon discovery of the family's reason, she began to integrate some of their healing methods into therapy.

Many Indians utilize traditional and Western practices, viewing both as vital to the healing process. Using the clients' own language, the therapist can strongly support such approaches as prayer meetings and the use of herbal medicines, as well as encourage American Indian healing rituals. With regard to the Shields, the therapist might say something like, "The ceremonies you are performing to get rid of these bad spirits, while Tony is in treatment, are helpful. It is good that you are helping him in this way."

Family therapists must also examine their own personal values. How do their religious beliefs affect those of their clients? Therapists need to respect and value cultural differences and help clients to use their own traditions for personal or familial healing.

Today, American Indians are developing their own approaches to treatment and to preventing alcohol, drug abuse, and suicide. They are also incorporating recovery tech-

niques used in the broader society. The Native American Church, for example, described as “the most important pan-Indian movement in this country, is political, cultural and spiritual, a source of pride, power, and psychological health” (Hammerschlag, 1988, p. 60). The Native American Church has many members throughout the country.

CONCLUSION

Therapists wishing to work effectively with American Indian clients not only need to discard the stereotypes perpetuated by our Eurocentric historical legacy and by the media, but must also be willing to suspend their assumptions regarding family roles, relationships, and what is considered as an appropriate style of communication. Therapists must fully understand and respect each native client’s degree of identification with his or her own tribe. Therapists should listen carefully, ask questions, and assume nothing when gathering information about American Indian clients, all of which will provide them with important information. In addition, this helps to foster the trust of American Indian clients, who often are wary of non-Indian therapists. To become more effective in understanding and determining the best course of treatment, we encourage therapists to read the literature about individual tribes, about historical trauma, about rituals and ceremonies, and about the religion, beliefs, and customs of the client family. When invited, the therapist should take the opportunity to participate and attend the ceremonies, rituals, and other events important to a family.

ACKNOWLEDGMENTS

We both would like to express our gratitude to Mona Polacca, Hopi-Havasupai; Pete G. Coser, Mvskoke Creek; Parrish Williams, Ponca; and Helen Rende, Kahnawke-Mohawk, for their reviews and suggestions regarding this chapter.

NOTE

1. *Medicine people* refers to men or women who practice indigenous healing that focuses on physical or spiritual health or both. Practitioners may also be members of the mainstream medical community.

REFERENCES

- Adams, J. (2002). Coast Indian film festival highlights banner year. *Indian Country Today*. Retrieved March 4, 2002, from www.indiancountry.com/?1038415793
- Anguksuar, L. R. (1997). A postcolonial perspective on Western [mis]conceptions of the cosmos and the restoration of indigenous taxonomies. In S. E. Jacobs, W. Thomas, & S. Lang (Eds.), *Two-spirit people: Native American gender identity, sexuality, and spirituality* (pp. 217–222). Chicago: University of Illinois Press.
- Attneave, C. (1982). American Indians and Alaska Native families: Emigrants in their own homeland. In M. McGoldrick, J. K. Pearce, & J. Giordano (Eds.), *Ethnicity and family therapy* (pp. 55–83). New York: Guilford Press.

- Benet, N., & Maloney, S. (1994). Keeper of the culture. *Intertribal America*. Collectors Edition.
- Berkhoffer, R. (1978). *The White man's Indian: Images of the American Indian from Columbus to the present*. New York: Vintage Press.
- DuBray, W. (1985). American Indian values: Critical factors in casework. *Social Casework: The Journal of Contemporary Social Work*, 66(1), 30–38.
- DuBray, W. (1993). *American Indian values: Mental health interventions with people of color*. St. Paul, MN: West.
- Duran, E., Duran, B., Brave Heart, M., & Yellow Horse-Davis, S. (1998). Healing the American Indian soul wound. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 341–354). New York: Plenum Press.
- Gunn, P. A. (Ed.). (1989). *Spider Woman's granddaughters: Traditional tales and contemporary writing by Native American women*. New York: Fawcett Columbine.
- Hammerschlag, C. (1988). *The dancing healers: A doctor's journey of healing with Native Americans*. New York: HarperCollins.
- Jeffers, S. (1991). *Brother Eagle, Sister Sky: A message from Chief Seattle*. New York: Dial Books.
- La Due, R. (1994). Coyote returns: Twenty sweats does not an Indian expert make, bringing ethics alive. *Feminist Ethics in Psychotherapy Practice*, 15(1), 93–111.
- La Fromboise, T., Trimble, J., & Mohatt, G. (1990). Counseling intervention and American Indian tradition: An integrative approach. *Counseling Psychologist*, 18(4), 628–654.
- Levy, J. (1987). Psychological and social problems of epileptic children in four Southwestern Indian tribes. *Journal of Community Psychology*, 15(3), 307–315.
- Nabokov, P. (Ed.). (1991). *Native American testimony: A chronicle of Indian–White relations from prophecy to the present*. New York: Penguin.
- Napoli, M. (1999). The non-Indian therapist working with American Indian clients: Transference-counter transference implications. *Psychoanalytic Social Work*, 6(1), 25–47.
- Polacca, M. (1995). *Cross cultural variation in mental health treatment of aging Native Americans*. Unpublished manuscript, School of Social Work, Arizona State University.
- Red Horse, J. (1981, April). *American Indian families*. Paper presented at the conference on American Indian Family Strengths and Stress, Tempe, AZ.
- Sutton, C., & Mills, J. (2001) *Take hart (healing and recovery after trauma): An emergency response to terrorist the United States—A training manual*. Piscataway, NJ: University of Medicine and Dentistry of New Jersey.
- Tafoya, N., & Del Vecchio, A. (1996). Back to the future: An examination of the Native American holocaust. In M. McGoldrick, J. Giordiano, & J. K. Pearce (Eds.), *Ethnicity and family therapy* (2nd ed., pp. 45–54). New York: Guilford Press.
- Tafoya, T. (1989). Coyote's eyes: Native cognition styles. *Journal of American Indian Education* [Special issue], pp. 29–40.
- U.S. Bureau of the Census. (2000, February). *The American Indian and Alaska Native population: 2000*. Washington, DC: U.S. Department of Commerce, Economics and Statistics Administration.
- U.S. Department of the Interior. (2004). Bureau of Indian Affairs. Retrieved March 2, 2004, from www.doi.gov/bureau-indian-affairs.html
- Walters, K. L. (1997). Urban lesbian and gay American Indian identity: Implications for mental health service delivery. *Journal of Gay and Lesbian Social Services*, 6(2), 43–65.
- Warner, J. C. (2003). Group therapy with Native Americans: Understanding essential differences. *Group*, 27(4), 191–202.
- Weibel-Orlando, J. (1987). Culture-specific treatment modalities: Assessing client-to-treatment fit in alcoholism programs. In W. M. Cox (Ed.), *Treatment and prevention of alcohol problems: A resource manual* (pp. 261–283). Orlando, FL: Academic Press.

CHAPTER 3



Back to the Future
*An Examination
of the Native American Holocaust Experience*

Nadine Tafoya
Ann Del Vecchio

NATIVE AMERICANS TODAY: ROSE P.'S STORY

What is it like to be an Indian in today's society? I live in shame and feel oppressed. I know that the stress and strain of oppression takes its toll on my psyche, on my sense of self, and on my ability to live a good life.

"When I was thinking about this question, I remembered a time when my son was about 4 years old. He was angry at me. He wasn't ready to come in from playing outside. He was very angry and crying in his rage. I sternly told him to go to his room until he could calm down. As he headed for his room, he narrowed his eyes at me and whispered something under his breath. He stood before his bedroom door and raised his little fist in the air and shook it wildly at me. I will always picture that raised fist clearly in my mind.

"That raised fist is what comes to mind first when I think about being a Native American in America today. I have been scorned and squashed down because my culture, my traditions, and my identity are different from mainstream America's. My son raised his fist to me. To whom do I shake my fist in rage at the daily frustration of being humiliated for simply being Native American? My boss? My husband? My teacher? My tribal leaders?

"I learned very young that I was different. In school, I learned not to try to answer the teacher's questions. The teacher only called on the blond children. When she looked at me, I saw disgust, or worse, pity. I felt dirty and stupid. If I had tried once in the past to raise my hand and offer my answers, I learned to stop trying. I hid my pride, my pain, and my tears. I didn't talk to the other Native kids about it. We all kept quiet.

"As an adult, I don't try much. I don't shake my fist but the pain is still there. I see the teacher's look of disgust on my boss's face. I drink alcohol. I gamble. One of my cous-

ins killed herself. I think about how easy it would be to kill myself too. The pain would be gone then.

“For 500 years my people have been told in so many ways, ‘You’re no good. You’re a savage. You’re ways are not Christian.’ My parents met in boarding school and relocated from their reservations (they came from different tribes) to Los Angeles after they were married. The government promised them training and jobs, housing, and education. These promises, like the federal treaties made years before, never materialized and my father began to drink, beat my mother and us kids. We grew up away from our tribal reservation, languages, and culture. We never spoke the language of my mother or father, we never spent enough time with our grandparents to learn the old ways. This bitter legacy is mine to pass on to my own children and grandchildren today.

“We have found systematic oppression and racism. We have found depression and anxiety. We have lost ourselves again in alcohol, drugs, and suicide. We are survivors of multigenerational loss and only through acknowledging our losses will we ever be able to heal.”

DOCUMENTING OUR HISTORICAL LOSS AND THE DYNAMICS OF UNRESOLVED GRIEF

Memories are all we have. And when the memories are dreadful—when they hold images of the pain we have suffered or, perhaps even worse, inflicted—they are what we try to escape.

—CORLISS (1993, p. 110)

In a review of the movie *Schindler’s List* in the popular press, Corliss makes the point that the movie is essentially a plea to remember, and that to remember is to speed the healing. This is the case for Native Americans in the United States today. We are at a crossroads, and actively remembering our past and the historic trauma that is our legacy is one way we can recover a happy, healthy, and productive existence as a separate and distinct ethnic/cultural group.

As a result of the genocidal U.S. policies toward native peoples, unresolved grief is a day-to-day dynamic that affects the lives of Native Americans. Historical trauma involves the impact and social transmission of one generation’s trauma to subsequent generations. As a result of federal boarding school policies, this trauma included the destruction of native language and culture.

The dynamics of unresolved grief include symptoms and manifestations that affect every aspect of an individual’s life, including:

- Somatic symptoms such as migraines, stomachaches, joint pain, dizziness, and chronic fatigue
- Physical stress and vulnerability to chronic health problems, such as Type II diabetes
- Depression
- Substance abuse
- Preoccupation with death
- Suicidal ideation and gestures
- Chronic, delayed, or impaired grief process, including searching and pining behaviors

Trauma response, as documented in survivors of the Nazi Holocaust, among Vietnam veterans, and the survivors of war, involves both psychological and physical responses (DeBruyn & Brave Heart, in press). Duran and colleagues (2004) identified the prevalence and correlates of mental health disorders among Native American women in primary care, and although they did not find a direct link between boarding school experiences and mental health disorders, they did posit that the high prevalence of anxiety disorders in this group may be effected by a complex interaction of individual and community-level variables. The following list of trauma response behaviors was derived from the literature:

- Psychic numbing
- Hypervigilance
- Disassociation
- Intense fear, free-floating anxiety
- Survivor guilt
- Fixation on the trauma
- Victim identity, death identity, and identification with the dead
- Low self-esteem
- Anger
- Self-destructive behavior
- Weakened immune system and chronic disease processes
- Depression
- Substance abuse

These processes, signs, and symptoms of both unresolved grief and the trauma response are endemic on reservations and among urban Indian populations in the United States. No family is untouched by these problems, and the manifestations are evident community-wide. A lack of public infrastructure on reservations compounds the problem with a lack of critical behavioral health services and providers to address this multigenerational holocaust.

It has been only within the last two decades that historians have begun to detail the legacy of oppressive and racist federal policies that were aimed at forcibly and nonnegotiablely assimilating and/or annihilating the indigenous peoples of the North American continent. Ethnohistorical methods of inquiry have helped to paint a picture of the historical trauma visited upon Native Americans without further victimization. “Ethnohistory enables scholars to move beyond traditional methods in providing a balanced assessment of cultures meeting in the arena of contact” (Axtell, 1981, p. 5). Ethnohistory has allowed a more balanced and complete rendering of the historic trauma to enter mainstream America through video, audio, and other forms of commercial mass media (television and movies), as well as through history and social studies textbooks and the popular press.

LIFE BEFORE CONTACT BETWEEN NATIVE AMERICAN AND EUROPEAN CULTURES

Prior to any contact with Europeans, the tribes of North America existed with an intact community self-awareness and purpose that included a complete educational system for raising their children. Each tribal group lived in relative isolation from the other native

peoples, and most tribes had a name for themselves in their own languages that, translated loosely, meant “the people” or “the true people.” Some groups—for example, members of the Tewa-speaking San Juan Pueblo—had ritual precautions and purification ceremonies that were used when they returned from hunting or foraging expeditions that put them in contact with “other people” (Szasz, 1988). These other native groups were not always recognized as people; rather, they were identified as a source of contamination or sometimes as a source of trade goods, slaves, different foods, and other ways of life. Some tribes were more receptive to the cultural ways and innovations of other people.

Although each tribal group used distinct linguistic and cultural methods to educate their children, all tribes required that certain skills be mastered before a youth was accepted as an adult member of the tribe. These knowledge requirements and skills can be loosely categorized in three areas: (1) knowledge of cultural heritage, (2) spiritual/religious practices, and (3) economic survival skills (Szasz, 1988). This tripartite emphasis provided an effective educational system for child rearing and the transmission of indigenous languages and cultures. The child’s special skills, temperament, or proclivities might shape his or her role in the community. However, each child was expected to be knowledgeable and competent in all three areas. A child who was an exceptionally good hunter might spend more time hunting and supplying meat to the community, but that child was also expected to know the tribe’s ethics, values, and religion and to practice them accordingly.

These competencies were interwoven. Religious rituals were performed to ensure abundant harvests and hunts. Storytelling during cold winter months entertained the adults and youth confined because of the weather, simultaneously passing on the traditions and beliefs of the tribe. Cultural ideals, mundane lessons, and moral instruction were passed on through a rich oral tradition (Szasz, 1988). Cultural continuity was ensured by the accumulation of stories told each winter as a child grew up. Economic/survival skills were passed on through stories and through direct, hands-on instruction with supervised practice throughout the year. When the European explorers first encountered Native Americans, they were exposed to these traditions, beliefs, and skills, but most viewed indigenous ways of life as primitive, and only a few explorers were able to experience and understand the Native American ways of life as complete, elaborate, practical cultures that were intact and not in need of “civilization.”

LIFE AFTER CONTACT BETWEEN NATIVE AMERICANS AND EUROPEANS

Traditional history books are full of details about the conquest of the New World by European immigrants. However, the French, Spanish, English, and other European settlers who arrived in the New World were rarely referred to as immigrants in the history books. To the indigenous cultural groups who lived in the New World, these settlers were immigrants to begin with, and later, interlopers and usurpers.

Ethnohistory documents the persistent pressure from the European immigrants on the Native Americans to give up their land. Once the homelands were usurped by the Europeans, pressure was exerted on Native Americans to conform to the immigrants’ European customs. With a loss of traditional lands as the foundation of Native American economic survival, and with associated policies and pressure to assume European ways

and means of economic survival, Native Americans were caught in a vise that crushed the traditional tripartite educational systems for the transmission of tribal cultures and ways of life.

By the 1800s, the press of European immigrants had become massive in scale and was reaching the Great Plains west of the Mississippi River. Pushed into the domains of neighboring tribes, which resulted in bloody conflict between tribes, attacked by Old World diseases such as smallpox, exposed to the insidious corruption of alcohol abuse, ravaged by starvation and malnutrition, the Native American population of the New World was decimated; Native Americans numbered some 600,000 in the 1840s, and the population dropped again to about 250,000 by 1850. European “civilization” resulted directly in more Native American deaths than the actual warfare between the immigrants and the North American tribes (New, 1964).

THE MISSIONARY SYSTEM OF ASSIMILATION

A concomitant of the European immigrants’ greed for the tribes’ lands was the need to Christianize the heathens. The underlying assumption was that Native Americans would fit better with the immigrants’ schemes for the New World if they practiced a “real” religion and gave up their savage religious customs. The U.S. government approached the Indian pragmatically by encouraging missions.

Missionaries cost the government little beyond minimal military support to suppress any hostility on the part of the indigenous population, and the missionary system of education bought the government a ready means of annihilating the rest of the tripartite tribal system of educating children. Through missionary schools, Indian children lost their languages, their tribal customs and beliefs, and came home strangers to their parents, clans, and tribal communities. Szasz (1988) provides an excellent ethnohistorical description of the missionary system of schooling Indians from 1607 to 1783. Beyond 1783 missionary schools continued to educate Native American children and can be found today on reservations throughout the United States. However, the missionary schools proved to be insufficient as a means of assimilation and annihilation of the tenacious Native American cultures.

THE BOARDING SCHOOL PHENOMENON

It was 1915, during the harvest season. I was a little girl. I remember it was in October and we had a pile of red chile and we were tying chile into fours. And then my grandfather was putting them onto a longer string. We were doing that when they came to get me. Then right away my grandmother and mother started to cry, “Her? She’s just a little girl! She’s just a little girl, you can’t take her” . . . I was 5 years old.

—HYER (1990, pp. 5–6)

The boarding school method of removing the Indian from the child was implemented toward the end of the 1800s. Tribal leaders were informed that all Indian children were required to be formally educated, and that this would be accomplished through boarding schools. The Carlisle School in Carlisle, Pennsylvania, was established in 1879. By 1902 a total of 25 Indian boarding schools had been established in 15 states. The schools were

often located in old army forts and commonly staffed by ex-military personnel (old army types).

Native American children, parents, and tribes were not given a choice or a voice in the matter of the education of Indian children. The aim of this system was twofold: (1) to remove all traces of Indian from the child and (2) to immerse the child totally in Western culture, thought, and tradition. Thus, the Indian problem would be solved by raising the children in a Western, civilized manner and away from their wanton, savage ways. The boarding school system was one of the most ruthless and inhumane methods of assimilation available to the U.S. government. All-out warfare, with associated atrocities, was a much more humane method of dealing with Native Americans. McLaughlin (1994) included this description from a 40-year-old Navajo parent who was left at boarding school at 7 years of age. At the time, she spoke only Navajo, no English.

It was the first time I've seen a brick building that was not a trading post. The ceilings were so high and the rooms so big an empty. There was no warmth. Not as far as "brrrr, I'm cold," but in a sense of emotional cold. Kind of an emptiness, when you're hanging on to your mom's skirt and trying hard not to cry. Then when you get up to your turn, she thumbprints the paper and she leaves and you watch her go out the big metal doors . . . you see her get into the truck and the truck starts moving and all the home smell goes with it. . . . Then the women takes you by the hand and takes you inside and the first thing they do is take down your bun. The first thing they do is cut off your hair and you been told your whole life that you never cut your hair recklessly because that is your life. . . . And you see that long, black hair drop, and it's like they take out your heart and they give you this cold thing that beats inside. And now you're gonna to be just like them. You're gonna be cold. You're never gonna be happy or have that warm feeling and attitude towards life anymore. That's what it feels like, like taking your heart out and putting in a cold river pebble. When you go into the shower, you leave your squaw skirt and blouse right there at the shower door. When you come out, it's gone. . . . They cut your hair, now they take your squaw skirt. They take from the beginning. When you first walk in there, they take everything that you're about. They jerk it away from you. They don't ask how you feel about it. They never tell you anything. They barely speak to you. They take everything away from you. . . . (pp. 47–48)

The trauma described in this passage was typical of the boarding school experience. The boarding school system was inhumane by virtue of the fact that children as young as 5 years of age were separated from their parents and transported far from home. As most Native American families lived on poverty-level incomes, traveling to these schools to visit was impossible. A multifaceted process of assimilation commenced as soon as the children reached their destination. The process involved the following features:

- English language immersion with punishment for speaking tribal languages.
- Destruction of traditional garments and replacement with alien, Western clothing.
- Braids and traditional hairstyles shaved and replaced with Western-style haircuts.
- Buildings, dormitories, campuses, and furnishings of Western design.
- Forced physical labor in the kitchens, stables, gardens, and shops, necessary to run the schools.
- Corporal punishment for the infraction of rules or for not following the work and school schedules.

- Immersion in a Western educational curriculum with associated alien goals and philosophy.
- Regimented, time-bound schedules.

This list is not exhaustive. Szasz (1977) described the boarding school experience as one in which the physical conditions were almost always inadequate. Food was scarce, children were overcrowded, and the improper treatment of sick children led to frequent epidemics. Preadolescent children worked long hours to care for the facilities and produce food, because congressional appropriations were woefully inadequate. Staff were usually not prepared with any understanding of the children, their languages, and traditions. In addition, boarding school staff members and teachers lacked coping strategies and skills for working with confused and sometimes defiant children. At times, the staff disciplined the children brutally.

As a result of the boarding school system, several generations of Native Americans were raised without family ties. Nurturing, the most essential element of healthy development for young children, was nonexistent and was replaced with forced assimilation, hard physical labor, harsh discipline, and physical, sexual, and emotional abuse. A variety of negative coping strategies have been adopted by Native Americans as a result of the historical trauma and internalized oppression. These survival skills include some of the same behaviors itemized earlier as features of unresolved grief and trauma response. Substance abuse, depression, and suicide are endemic on our reservations are resorted to in order to cope.

The boarding school generations of Native Americans survived, but at the cost of thousands of lives lived in the misery and doubt of damaged self-esteem and linguistic and cultural annihilation. This is the legacy of Native American communities today.

It is the fallout from the historical trauma of the boarding school system with which we, as mental health professionals, must contend. Our awareness of this trauma and our ability to assist Native American clients to become aware of it must be used as a foundation to *speed the healing*.

IMPLICATIONS FOR TREATMENT

Middelton-Moz (1986) describes some of the emotional and psychological scarring produced by forced assimilation. She states that children who were sent to boarding school institutions became strangers to their parents. The children gave up their traditional cultural values and ways and assumed the values of the majority culture. The children found themselves ill prepared to cope with either culture and often felt confused and alienated from both the Western and the Indian ways of life. Middelton-Moz found that adults in the therapeutic setting who had been educated through the boarding school system suffered from a pervasive sense of low self-worth, powerlessness, depression, and alienation from the power and strength of cultural values. Indian adults in therapy were confused about their family roots and traditions and felt abandoned. The young adults who had not been raised by their own parents felt increased confusion when faced with the need to parent their own children.

DeBryun and Braveheart (in press) have extended work in the area of historical trauma to encompass four principal elements for dealing with the trauma response and

for addressing the symptoms of unresolved grief and historical trauma. These authors suggest that, as mental health professionals, we can assist Native American individuals and communities to develop positive methods and models, using the following framework.

1. Treatment must provide for cathartic release of affect during the initial process. Some discussion of the history of genocide against Native Americans and the boarding school experience may be necessary to orient clients to the effect that trauma has had on the families and communities. Repression and racism should be identified as concomitant to the trauma process, and the impact of racist behavior on daily life should be investigated.

2. Treatment must provide an emotional container so that the client feels safe and competent to handle the feelings that emerge. Therapists must acknowledge the impact historical trauma has had on Native people and must act as educators and resources when necessary. Therapists must guard against judgmental statements and affect and should cultivate nonjudgmental acceptance.

3. Timing is critical to ensuring that the client can cope with the feelings and knowledge associated with multigenerational trauma. Sessions should end with a debriefing time, and during this time the clinician can impart hope and confidence that the client is capable of handling the negative feelings that arise in the process. It is important to reflect on the accomplishments of the client, who may need to be reminded of what he or she has achieved.

4. Traditional ceremonies and healing processes provide a grounding for clients linked to their culture and history. The client should be encouraged to access the cultural ways that will facilitate healing and to become involved in traditions that provide anchoring and emotional support. The traditional ways and ceremonies help to facilitate the cathartic release of unresolved grief and feelings as well.

This framework is a simple beginning to use with Native American clients who seek professional mental health care for problems or for growth and wellness. However, on a larger scale, it is important to apply the framework's principles to the larger context of whole communities, reservations, and pueblos. As our tribal governments, social service workers, religious leaders, and other community members have all been through the historical trauma and the fallout from oppressive racist policies to one degree or another, healing must occur at the level of the whole community. Remembering and acknowledging the impact of our past is the first step on our road back to the future.

REFERENCES

- Axtell, J. (1981). *The European and the Indian: Essays in the ethnohistory of colonial America*. New York: Oxford University Press.
- Corliss, R. (1993, March 14). Schindler comes home. *Time*, p. 110.
- DeBruyn, L. M., & Brave Heart, M. Y. H. (in press). Suicide as a manifestation of historical trauma. In M. Y. H. Brave Heart, B. Segal, L. M. DeBruyn, J. Taylor, & R. Daw (Eds.), *Historical trauma within the American experience: Roots, effects, and healing*. New York: Haworth Press.

- Duran B., Sanders, M., Skipper, B., Waitzkin, H., Halinka Malcoe, L., Paine, S., & Yager, J. (2004). Prevalence and correlates of mental disorders among Native American women in primary care. *American Journal of Public Health, 94*(1), 71–77.
- Hyer, S. (1990). *One house, one voice, one heart: Native American education at the Santa Fe Indian School*. Albuquerque: University of New Mexico Press.
- McLaughlin, D. (1994). Critical literacy for Navajo and other American Indian learners. *Journal of American Indian Education, 33*(3), 47–59.
- Middelton-Moz, J. (1986). Wisdom of the elders. In R. J. Ackerman (Ed.), *Growing up in the shadow: Children of alcoholics* (pp. 57–70). Deerfield Beach, FL: Health Communications.
- Szasz, C. M. (1977). *Education and the American Indian: The road to self-determination since 1928* (2nd ed.) Albuquerque: University of New Mexico Press.
- Szasz, C. M. (1988). *Indian education in the American colonies, 1607–1783*. Albuquerque: University of New Mexico Press.

CHAPTER 4



Nā ‘Ohana:
Native Hawaiian Families

Valli Kalei Kanuha

Ola nā iwi.

The bones live.

(Said of a respected older person who is well cared for by his family.)

—PUKUI (1983)

The 2000 U.S. Census marked the first time national population data were collected about Native Hawaiians, who are the indigenous people of Hawai‘i (Greico, 2001). The Hawai‘i Revised Statutes define “Hawaiian” as “any descendant of the aboriginal peoples inhabiting the Hawaiian Islands which exercised sovereignty and subsisted in the Hawaiian Islands in 1778, and which peoples thereafter have continued to reside in Hawai‘i” (Office of Hawaiian Affairs, 2002). The terms “native Hawaiian,” “Hawaiian,” *Kanaka Māoli* (first or original people) (Blaisdell & Mokuau, 1990), and *Nā ‘Ōiwi* or *Kanaka ‘Ōiwi*, literally, “the bones” or ancestors, are used interchangeably.

According to the U.S. Census Bureau, 874,000 or 0.3% of Americans claim Native Hawaiian or Pacific Islander (NH/PI) as their primary racial/ethnic category (United States Census Bureau, 2003). The largest subcategory chose Native Hawaiian as their only ethnicity (141,000 or 16%), with an additional 261,000 (30%) who identified themselves as Native Hawaiian and other Pacific Islander (Greico, 2001). Fifty-eight percent of NH/PIs live in Hawai‘i or California, with the majority residing in Hawai‘i (283,000; 23%). Native Hawaiians also live in major U.S. cities such as Seattle, New York, Salt Lake City, and Chicago. The majority of NH/PIs have at least a high school diploma (79%), but only 17% have baccalaureate degrees. Although almost 50% of NH/PIs own their own homes, 18% lived below the poverty line in 1999. It is important to note, however, that most U.S. Census-based statistics on the NH/PI population are aggregated and therefore do not accurately describe Native Hawaiians as a separate ethnic group from the broader Pacific Island category.

As with many indigenous peoples, 79% of Hawaiians and Pacific Islanders live in families (U.S. Census Bureau, 2003). Families, or *nā ‘ohana*, are fundamental to Native Hawaiians because, as many Hawaiians learn from an early age, “‘*ohana* is the center of all things Hawaiian” (Santos, 2002). This chapter on Kanaka Maoli families begins with a brief historical overview of pre- and post-Western contact Hawai‘i, describes central values, beliefs, and customs associated with traditional Native Hawaiian society, and presents key issues of practice for clinicians working with Native Hawaiians today.

A HISTORY OF NATIVE HAWAIIANS

The area known as the Polynesian Triangle, “the largest nation on Earth” (Polynesian Voyaging Society, 2004) covers 10 million square miles of the eastern Pacific Ocean. The triangle is composed of three island points, with Hawai‘i at the northernmost apex, New Zealand to the west, and Easter Island, or Rapa Nui, in the east. The peopling of the Hawaiian Islands is attributed to forbears from the Marquesas, one of the largest island groups of French Polynesia, located about 500 miles south of the equator almost midway between Rapa Nui and Hawai‘i, and 3,000 miles from California. Around 500 A.D., skilled navigators from this island group sailed double-hulled canoes almost 2,000 miles to the north for Hawai‘i, guided only by the stars, tides, and their highly advanced knowledge of “wayfaring” passed on orally by their ancestors (Finney, 1994; Kyselka, 1987). The first Europeans who traveled to Hawai‘i in the late 1700s described the native people as

radiantly healthy and of near physical perfection. They were genial, affectionate and generous. A highly developed agricultural system and skillful and intensive fishing methods provided the food needed for a relatively large population. (Mitchell, 1992, p. 250)

Ancient Hawaiian social life centered on a complex cosmology linking human beings, animal and plants, the skies, sea, and land, as well as ancestral spirits, in a holistic existence ruled by gods (*akua*) and spiritual powers/forces (*mana*). Various estimates put the population of precontact Hawai‘i at 400,000 to almost one million (Nordyke, 1977; Smith, 1978; Stannard, 1988). However, after the first foreign arrival to Hawai‘i by English explorer Captain James Cook in 1778, exposure to contagious diseases to which the people had no natural immunities reduced the Kanaka Maoli population to 40,000 in just 100 years.

Following this decimation of the Native Hawaiian race, Caucasian industrialists designed a land-registration policy known as the Great Mahele of 1848, a single act that many Kanaka Maoli historians believe marked the end of Hawaiian self-rule (Kame‘eleihiwa, 1986). Hawaiians who had resided for generations on land tracts with deeply spiritual origins not only lost their homesteads because they did not understand the concept of land ownership, but were subsequently forbidden from fishing, gathering, planting, or engaging in other cultural practices. These prohibitions, coupled with the influx of Protestant missionary doctrines in the mid-1800s, resulted in the condemnation and subsequent deterioration of the Kanaka Maoli belief systems and traditions so integral to the social stability of Hawaiian life. Over a brief century untold numbers of

Native Hawaiian practices and sacred sites were lost through Western colonization, however many values and beliefs still prevail today.

STRUCTURE, VALUES, AND TRADITIONS OF HAWAIIAN FAMILIES

The literal translation of the Hawaiian word for “family,” *‘ohana*, has its origins in the taro plant, the staple of ancient Kanaka Maoli. An indigenous plant of Hawai‘i, taro (*kalo*) is one of the few edible sources from which the emerging shoots, or *‘oha*, sprout from the mature corm, or *makua*, which is also the Hawaiian word for “parent.” When joined with *nā* to form the plural “many,” *nā ‘ohana* attests to the symbolic meaning of the family as a collective that gives life, nourishment, and support for the growth and prosperity of blood relatives as well as extended family, those joined in marriage, adopted children or adults, and ancestors living and deceased (Pukui, Haertig, & Lee, 1972, 1979).

Young (1980) suggests that the emphasis on the family is inherently linked to the necessity for and significance of the connection between people, not only to those who are biologically related, but to the community of Native Hawaiians as a people. The foundation of *nā ‘ohana* is its children and their relationship to elders (*kūpuna*), their ancestors, and their physical, spiritual, and material surroundings. Core values that maintain the necessary balance between family members and their natural environment include *aloha* (love and affinity), *mālama* (care), *kokua* (help, aid), *lōkahi* (unity, connection), *lokomaiika’i* (generosity), *ha‘aha‘a* (humility), *ho‘omana* (spirituality), and *pono* (righteousness or “right”) (Blaisdell & Mokuau, 1990; Pukui et al., 1972, 1979; Rezentes, 1999).

Traditional Hawaiian families functioned within a well-defined structure based on “generation, genealogical superiority, and sex” (Handy & Pukui, 1998 p. 43). Therefore, older Hawaiians were viewed as more deserving of respect than the younger generations, Hawaiians of royal lineage were accorded higher status than commoners, and males and females were assigned distinct roles and tasks in family and social life. *Kūpuna* (elders or grandparents) were so revered that the first-born child in a family was often given to grandparents to be raised with indigenous Hawaiian beliefs and traditions (Kamakau, 1991).

As in other Pacific Islander cultures, in early adolescence males and females were relegated to sex-designated residences to learn expected sex and gender roles. Hawaiian men fished or dived from reefs far out in the ocean, and women and children gathered mollusks and seaweed near the shore. Both men and women cultivated plants and animals for eating; however, foods were prepared and consumed according to clearly delineated sex/gender customs. For example, only males could eat pork, bananas, coconuts, and turtle, because these foods were thought to represent male gods and characteristics. Food preparation was solely the domain of Hawaiian men, a function carried out separately for males and females, who were not permitted to eat together until 1820, when one of the most powerful Hawaiian queens, Ka‘ahumanu, abolished the practice along with many other then-sacred rules of behavior, or *kapu* (Kamakau, 1992; Kame‘eleihiwa, 1999b).

Ancient Hawaiians espoused a joyous and open attitude toward sexuality. Historian Kame‘eleihiwa states: “Sexual possession was rare in Hawai‘i, where marriage did not

exist, where men and women did not ‘own’ one another because they were lovers” (1999b, p. 5). Sex and mating with blood kin was not only allowed but preferred among members of the royal class—“for how could a high chief be sure of passing on equally high *mana* (supernatural powers) unless he conceived a child with his own kin?” (Pukui et al., 1979, p. 86). Couples could have more than one sexual and intimate partner as long as all parties agreed to the arrangement. Among Hawaiian royalty same-sex relationships were well known; however, there are conflicting accounts about whether such relationships were socially accepted across different social strata, such as among commoners (Handy & Pukui, 1998; Kame‘eleihiwa, 1999a; Pukui et al., 1979).

Caring for family members over the lifespan was a key value and practice for the Kanaka Maoli. The ancients believed, as do many modern-day Hawaiians, that because humans are related to all elements in nature, we are required to care for the land, plants, and oceans as we would our own families. When ill health befell a family member, the ailment might be attributed to possession by spirits, failure to abide by social rules of conduct (*kapu*), or the harboring of negative thoughts such as jealousy or anger toward others (Pukui et al., 1979).

To facilitate healing, Hawaiians used herbs, physical treatments such as massage (*lomilomi*), and prayer to ancestors and gods. They also employed *ho‘oponopono* (Ii, 1959; Kamakau, 1991; Mitchell, 1992; Rezentes, 1999), an indigenous family conflict-mediation strategy, which is described in more detail later in this chapter.

CRITICAL ISSUES IN INTERVENTION WITH KANAKA MAOLI FAMILIES

There are two basic requirements in any clinical intervention with Native Hawaiian individuals, couples, or families. The first is to have a working knowledge of the key events in the history of the Kanaka Maoli and the islands of Hawai‘i as unique cultural and geographic entities. Clinicians must also acknowledge the importance of Hawaiian values and traditions to which most Kanaka Maoli have access, whether or not they actively believe in or practice them. Whether having lived for many generations in the islands or having been raised exclusively elsewhere, most Hawaiians maintain some bond to their cultural roots. There are Hawaiian social clubs, community associations, and cultural activities (traditional Hawaiian dance or *hula* schools; annual *lū‘au* or parties) in almost every major U.S. city. These gatherings of primarily expatriate Native Hawaiians, their families, and friends are crucial to maintaining Hawaiian values and traditions for those who live away from the islands (Dudoit, 1997; Halualani, 2002).

Cultural Conflict between Traditional and Contemporary Belief Systems

For Hawaiians, the notion of family, or *‘ohana*, has always been central to their worldview. However, the rapid evolution of American life due to expanding technologies and the impact of globalization has resulted in some daunting challenges for Native Hawaiians, as for all families. Long-established customs regarding child–parent relations, sex/gender roles, and even how family life was prioritized within other social relationships (such as work) have transformed traditional Hawaiian families into modern-day Hawaiian families.

Peter is a 16-year-old Native Hawaiian–Japanese American youth, born and raised in Hawai‘i. Two years ago Peter’s father, Clyde, a Hawai‘i-born Japanese American and career Marine, transferred his family from Hawai‘i to North Carolina. Peter was always described as “a sensitive boy” who was very close to both of his parents. In the past 6 months, Peter has begun wearing makeup on weekend outings to clubs, laughing it off to his parents as “something all the kids are doing these days.”

Peter’s Hawaiian mother, Pua, has long thought that Peter might be *māhū*, Hawaiian for transgendered. Pua grew up in a predominantly Native Hawaiian community, where *māhū* were well accepted by most families. Her husband, Clyde, grew up in a more traditional Japanese American household in a rural area of Hawai‘i where sexuality was not discussed.

Peter has begun to have arguments with his father about his makeup and “girly” mannerisms, much of the conflict focused on Clyde’s embarrassment about Peter being seen around the base. Tensions are rising between Clyde and Pua about Pua’s support for Peter’s gender development versus the impact Peter’s behavior might have on Clyde’s status with his Marine peers and supervisors.

Peter has finally begun talking to his mother about his emerging sexual and gender identity and asking Pua to tell him more about her *māhū* relatives. He is afraid of being “different” and is already being taunted in school. He is also worried about the discord with his father and between his parents. Over the past few weeks Peter has started to distance himself from his parents and has been staying out late with his friends. More recently Peter has asked to move back to Hawai‘i to live with Pua’s extended Hawaiian family.

A key developmental issue for adolescents coming of age focuses on individual emancipation and the simultaneous reconfiguring of family roles and expectations. Sexual and gender identity development is a critical issue for teens, and particularly for Native Hawaiians who traditionally were much more tolerant of sex and gender variability than those of many other cultures. Clinicians working with Hawaiian families in which homosexuality, transgender, and/or other sexual issues are present must be knowledgeable about how Hawaiian families once and still do understand sex and gender. Many contemporary Hawaiians accept *māhū* in their families, partly because of being socialized to the belief that the special nature of *aloha*, or love, is unconditional, particularly in regard to *‘ohana* (Anbe & Xian, 2001; Matzner, 2001). Hawaiian families are taught to value the enduring connection of family members with each other, no matter what conflicts, disagreements, or hurts transpire between them.

Over the past two decades there have been many changes in societal norms and attitudes in response to the long-standing bigotry and discrimination against gay men, lesbians, and transgendered persons. However, homophobia, sexism, and oppression of anyone with an alternative sexual or gender identity are still rampant in Hawai‘i and throughout the United States. Even in the relatively tolerant environment of Hawai‘i, in which vestiges of Hawaiian open-mindedness about sexuality still exist, a recent constitutional amendment to allow same-sex marriage was roundly defeated (Goldberg-Hiller, 2002). The “don’t ask, don’t tell” policy of the U.S. military is especially relevant in Peter’s case, as it foreshadows the challenges ahead for Peter and his Marine father.

In this case study, conflicting belief systems about sex/gender are highlighted against the Hawaiian cultural background of Peter and his mother’s family, the deeply entrenched nature of homophobia in today’s Hawaiian and American societies, and the already exist-

ing challenge of launching adolescents in the family life cycle (Carter & McGoldrick, 1999). Practitioners working with Hawaiian families such as Peter's should not only acknowledge the historical culturally positive view toward *māhū*, particularly with an already supportive Hawaiian parent, but should also encourage the mobilization of Hawaiian values such as *aloha* and *lōkahi* from Hawaiian family traditions to mediate those tensions resulting from "culture clashes" in today's Kanaka Maoli families.

Cultural Conflict Related to Multiethnic/Multicultural Identity

Alika is a 20-year-old college student in Wisconsin who has never lived in Hawai'i. His Native Hawaiian father and Caucasian mother left the islands in the mid-1970s but maintain family ties in Hawai'i, where they both grew up. Alika has always felt out of place in the Midwest, particularly because of mispronunciations of his name and questions about his racial/ethnic background. Alika recently sought counseling at the student health center for anxiety, resentment, and anger after taking a sociology course on minority ethnic identity. As the only Native Hawaiian in the class, Alika was subject to many questions about Hawaiians and Pacific Islanders and was also expected to be a "spokesperson" about contemporary topics such as Hawaiian sovereignty and the movement for Native Hawaiian political and economic self-rule, about which other students knew more than he did.

During the early stage of therapy, Alika reported ambivalence about his Hawaiian identity, in part because his father had always been reluctant to share much about his own family history. His father was sometimes disparaging of Hawaiians, saying, "We left Hawai'i for a new life so we wouldn't have to be poor and on welfare like other Hawaiians at home." In addition, Alika described conflicting feelings about being Hawaiian and Caucasian, particularly given the negative history of White colonization in Hawai'i. The sometimes racist situations he experienced as a part-Hawaiian male growing up in the Midwest only exacerbated his social and emotional detachment from his Native Hawaiian heritage. However, although he did not often admit it to others, he also yearned to know more about his Native Hawaiian roots and culture.

Like many indigenous and First Nations peoples in the United States, Hawaiians are overrepresented in negative indices of health, education, and crime (Office of Hawaiian Affairs, 2002). According to the Office of Hawaiian Affairs:

- Native Hawaiian students in 8th to 12th grade use more tobacco, alcohol, and other drugs than any other ethnic group in Hawai'i.
- Only half of Kanaka Maoli who reside in the state complete high school, and of those who attend college, only 15% graduate.
- Native Hawaiians are among those with the highest rates of obesity, diabetes, hypertension, and cancer-related deaths in the United States.
- Hawaiians make up 39% of the inmate population in Hawai'i correctional facilities, more than any other ethnic group in the state.

The long-standing stigma associated with being Native Hawaiian is evidenced among Kanaka Maoli in Hawai'i, who report anxiety about seeking help because of the shame associated with being "another Hawaiian" with problems (Bell et al., 2001;

Crabbe, 1998; Mokuau, 1996; Nahulu et al., 1995). Hawaiians who are multiracial, particularly those who are part Caucasian, also struggle, as all mixed-race peoples do, with having to “choose identities” and never feeling a sense of belonging to any of their racial/ethnic communities (Root, 1995). In addition, some Native Hawaiians who are raised away from Hawai‘i and who lack knowledge of or, especially, direct experience with their own indigenous cultural practices sometimes reject or distance themselves from their Hawaiian heritage (Ahlo, 1996; Dudoit, 1997).

This psychosocial dynamic of denying the cultural norms or practices associated with one’s stigmatized or oppressed identity group is often referred to as internalized oppression. Internalized oppression has been conceptualized as a mechanism wherein those of an oppressed class assume and enact the negative characteristics and stereotypes of their class as defined by those classes with more social power (Lipsky, 2004; Pheterson, 1990). In the preceding case study, Alika’s father, as a Hawaiian himself, has expressed disdain for other Hawaiians, resulting in Alika’s confusion about his own Hawaiian identity. Particularly in this post-civil rights era of racial pride, it is not uncommon for people of color to condemn those who reject their own minority racial/ethnic heritage.

I suggest, however, that internalized oppression is a survival mechanism resulting solely from living in oppressive conditions reinforced by societal institutions and norms (Kanuha, 1999). In Alika’s case, rather than attribute his ambivalence and shame about his Hawaiian identity to his negative self-concept, our focus should be on the courage and resiliency required for any subjugated person to keep his or her spirit alive in the face of oppression. Internalized oppression is an indictment of societal racism, sexism, classism, and all systems of oppression that force persons such as Alika to assume a persona and belief system that daily results in self-hatred and rejection of others similar to oneself. As clinicians, we need to be cautious about not revictimizing survivors of racism by accusing them of consorting with the beliefs and behavior of their oppressors when they, like many of us, must sometimes choose to act against their true selves under circumstances of subjugation and fear of retaliation.

Family therapists working with Hawaiians must understand the historical milieu in which coping mechanisms such as distancing from one’s ethnic heritage emerge. That is, when deluged with abysmal social, health, and economic data about Native Hawaiians, as reported here, it should not be surprising that some Kanaka Maoli might reject their own cultural values, beliefs, and traditions. In a therapeutic situation, Hawaiians, like all minority groups, require culturally skilled practitioners to help them utilize the resiliency and strengths of their values and traditions to overcome the health and mental health consequences of centuries-old colonization.

Cultural Conflict between Traditional and Contemporary Helping Approaches

A challenging aspect of working with Kanaka Maoli families is the balancing of traditional Hawaiian understandings and strategies with modern-day therapeutic approaches. For example, because of the disconnect between many Native Hawaiians and their lands, language, and cultural practices, they may lack familiarity with values and traditions that are sometimes more accessible to a well-informed family therapist (Hawaiian or not) than to the Native Hawaiian client him- or herself.

As introduced earlier, an ancient Native Hawaiian approach to family conflict is *ho‘oponopono*, which is translated as “to make right” (Meyer & Davis, 1994; Mokuau,

1990; Omuro-Yamamoto, 2001; Pukui et al., 1972; Shook, 1992). This unique Hawaiian family intervention includes a fundamental spiritual overlay, clearly delineated process stages, and well-defined roles and functions for all participants, which are performed in the context of Hawaiian values such as *aloha* (love and affinity), *mālama* (care), *lōkahi* (unity, connection), *loko maika'i* (generosity), and *pono* (righteousness or “right”). The goal of *ho'oponopono* is to address pain and hurt among family members through a structured process in which those who have offended make amends to others, and aggrieved family members accept those acts of contrition through forgiveness.

In traditional *ho'oponopono* sessions, all interactions are grounded in spirituality. Guidance is sought from a Christian deity and/or Hawaiian ancestral gods throughout each session. There is a pivotal role played by the facilitator, or *haku*, who was traditionally a respected family *kupuna* (elder) but who now may be a community member or social worker trained in the process and chosen by consensus of all family members. Although similar in function to a Western family therapist, in *ho'oponopono* the *haku* assumes a more directive and prescribed role during sessions. For example, all interaction and dialogue are mediated through the *haku*; that is, at no time do participants speak directly to each other. *Ho'oponopono* may be employed deftly by a parent to quickly resolve disagreements between children or may involve sessions that extend for hours over a period of months. Sharing a meal upon completion of a session is a tradition that continues to be fundamental to the process.

The ideal outcome of *ho'oponopono* is healing and reconciliation among family members, but occasionally an impasse that cannot be resolved can result in banishment, or *mō ka piko*—literally, the severing of the umbilical cord. According to renowned scholar Mary Kawena Pukui (1979) this most extreme consequence “was not pronounced lightly” (p. 221) because “the ultimate heartbreak came with the total severance of family ties” (p. 220).

Until recently, this approach was not promoted in clinical settings. The present-day availability and use of *ho'oponopono* may sometimes produce anxiety among some Native Hawaiian clients who are not only unfamiliar with the practice, but are more comfortable with “talking therapy” led by Western-trained family therapists. With the growing acceptance of indigenous approaches to address many types of health and social issues, practitioners must be cognizant of the variety of traditional Native Hawaiian clinical approaches now available, as well as how, when, where, and with what types of social problems those strategies might complement or supplant Western models of healing.

CONCLUSION

Native Hawaiian families today only vaguely resemble Kanaka Maoli of ancient times. Whereas the lives of most Native Hawaiians were traditionally defined by bloodline, many Hawaiians today have no knowledge of nor interest in their genealogy. It is inconceivable that Hawaiian women were once not allowed to eat with men and that certain foods were *kapu* (forbidden) to them. Men slept with men without fear of homophobic retribution. And, most important, elders and grandparents were once integral to family life, not cast off to nursing homes or regarded as long-forgotten memories.

As the case examples illustrate, Native Hawaiian families today not only have culturally specific traditions that distinguish them from other ethnic groups, but are equally diverse within Hawaiians as a subgroup. Software developers of Hawaiian ancestry living

in Seattle may still listen to Hawaiian music and dance the *bula*. Multiethnic offspring of African American and Hawaiian parents who've lived most of their lives in Chicago may wish one day to return to Hawai'i or may be disinterested in Hawaiian culture. A Native Hawaiian youth living in Honolulu may know a few Hawaiian words, or as a graduate of a Hawaiian language immersion school be equally adept in English and Hawaiian.

Clinicians working with Native Hawaiians are not necessarily required to be "competent" in their knowledge of *nā mea Hawai'i* (Hawaiian things), but should think and practice with understanding, sensitivity, and openness to Hawaiian culture. All Native Hawaiians, whether they reside in Hawai'i or elsewhere, have some connection to their Hawaiian cultural roots. For some, a deep understanding of their Hawaiian ancestry may be elusive because of the stigma attached to Native Hawaiians and Hawaiian culture in a colonial context. For others, who have the opportunity and/or support to retain and, most important, practice their Hawaiian heritage, "Hawaiian pride" may be the predominant aspect of their lives. Clinicians who work with Native Hawaiians today must acknowledge the historical losses associated with colonization of the Hawaiian Islands, as well as the challenges that contemporary Hawaiians face in realizing what it means to reclaim and live those belief systems and traditions of old.

As this chapter is being written, Kanaka Maoli are poised at a critical juncture in U.S. history. Today, Native Hawaiian sovereignty and the legal relationship of the Hawaiian people to the American government are being hotly and passionately debated in the U.S. Congress and, especially, among Native Hawaiians everywhere (Kelly, 2003; Office of Hawaiian Affairs, 2004; Sai, 2004). Shall Native Hawaiians establish legal status with the United States similar to other First Nations people? What type of self-governance should Hawaiians, now Americans, expect when until 1893 Hawai'i was an independent nation with distinct diplomatic ties to other countries?

Sovereignty as an issue of self-determination for the Native Hawaiian people is also reflected at the individual and family levels. Native Hawaiians must determine for themselves how they will nurture their relationships with each other, with non-Hawaiians, and with their global brothers and sisters in the broadest sense of *'ohana*. They must learn how to preserve and practice such values as *lokomaiika'i* (generosity), *ha'aha'a* (humility), and *pono* (righteousness or "moral right") in their families and communities just as they did in ancient times. Self-determination means that, as a people, they must grapple with the conundrums of determining how to balance the "old ways" with the new.

The role of family therapists and clinicians is to support, empower, and facilitate healing for Native Hawaiian individuals and *nā 'ohana* through acknowledgement and affirmation of indigenous cultural values and beliefs, coupled with present-day "best practices."

REFERENCES

- Ahlo, M. N. (1996). *Aloha spirit past and present: Two generations of Native Hawaiians discuss the issue of aloha in the context of cultural crisis*. Unpublished master's thesis, University of Hawaii, Honolulu.
- Anbe, B., & Xian, K. (2001). *Ke kulana he māhū* (Film). Honolulu, HI: Zang Pictures.
- Bell, C. K., Goebert, D., Miyamoto, R. H., Hishinuma, E. S., Andrade, N. N., Johnson, R. C., &

- McDermott, J. F. J. (2001). Sociocultural and community factors influencing the use of Native Hawaiian healers and healing practices among adolescents in Hawaii. *Pacific Health Dialog*, 8(2), 249–259.
- Blaisdell, K., & Mokuau, N. (1990). Kanaka Maoli: Indigenous Hawaiians. In N. Mokuau (Ed.), *Handbook of social services for Asian and Pacific Islanders*. Westport, CT: Greenwood Press.
- Carter, B., & McGoldrick, M. (1999). *The expanded family life cycle: Individual, family and social perspectives* (3rd ed.). Needham Heights, MA: Allyn & Bacon.
- Crabbe, K. M. (1998). Etiology of depression in Native Hawaiians. *Pacific Health Dialog*, 5(2), 341–345.
- Dudoit, M. R. (1997). *Cultural identity and cultural practices of Hawaiians and part-Hawaiians in Southern California and Hawai'i*. Unpublished master's thesis, California State University, Long Beach.
- Finney, B. R. (1994). *Voyage of discovery: A cultural odyssey through Polynesia*. Berkeley: University of California Press.
- Goldberg-Hiller, J. (2002). *The limits to union: Same-sex marriage and the politics of civil rights*. Ann Arbor: University of Michigan Press.
- Greico, E. M. (2001). *The Native Hawaiian and other Pacific Islander population: Census 2000 Brief*. Washington, DC: U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau. Retrieved March 2, 2004, from www.census.gov/prod/2001pubs/c2kbr01-14.pdf
- Halualani, R. T. (2002). *In the name of Hawaiians: Native identities and cultural politics*. Minneapolis: University of Minnesota Press.
- Handy, E. S. C., & Pukui, M. K. (1998). *The Polynesian family system in Ka'u Hawai'i*. Honolulu, HI: Mutual.
- Ii, J. P. (1959). *Fragments of Hawaiian history* (M. K. Pukui, Trans.). Honolulu, HI: Bishop Museum Press.
- Kamakau, S. M. (1991). *Ka po'e Kabiko: The people of old* (M. K. Pukui, Trans.). Honolulu, HI: Bishop Museum Press.
- Kamakau, S. M. (1992). *Ruling chiefs of Hawai'i* (rev. ed.). Honolulu, HI: Kamehameha Schools Press.
- Kame'elehiwa, L. (1986). *Land and the promise of capitalism: A dilemma for the Hawaiian chiefs of the 1848 Māhele*. Honolulu, HI: University of Hawaii Press.
- Kame'elehiwa, L. (1999a, September 20–22). *Le'ale'a o na kupuna (The pleasures of our ancestors)*. Paper presented at the *Lei Ānuenuē: Community Building with Groups at Risk for HIV* conference, Honolulu, HI.
- Kame'elehiwa, L. (1999b). *Nā wahine kapu: Divine Hawaiian women*. Honolulu, HI: 'Ai Pohaku Press.
- Kanuha, V. K. (1999). The social process of “passing” as a stigma management strategy: Acts of internalized oppression or acts of resistance? *Journal of Sociology and Social Welfare*, 26(4), 27–46.
- Kelly, A. K. (2003). From Native Hawaiian to Native American? *Hawai'i Island Journal*. Retrieved September 24, 2004, from www.hawaiiislandjournal.com/stories/8a03a.html
- Kyselka, W. (1987). *An ocean in mind*. Honolulu: University of Hawaii Press.
- Lipsky, S. (2004). Internalized racism: A major breakthrough has been achieved. *FUSE*. Retrieved September 24, 2004, from focusonfreedom.org/resources/consciousness/breakthrough.html
- Matzner, A. (2001). *'O au no kēia: Voices from Hawai'i's māhū and transgender communities*. Philadelphia: Xlibris.
- Meyer, M., & Davis, A. (1994, Fall). Talking story: Mediation, peacemaking and culture. *American Bar Association Dispute Resolution Magazine*, pp. 5–9.
- Mitchell, D. D. K. (1992). *Resource units in Hawaiian culture* (rev. ed.). Honolulu, HI: Kamehameha Schools Press.
- Mokuau, N. (1990). Family-centered approach in native Hawaiian culture. *Families in Society: Journal of Contemporary Human Services*, 71(10), 607–613.
- Mokuau, N. (1996). Health and well-being for Pacific Islanders: Status, barriers, and resolutions. *Asian American and Pacific Islander Journal of Health*, 4(1–3), 55–67.
- Nahulu, L. B., Andrade, N. N., Makini, G. K. J., Yuen, N. Y. C., McDermott, J. F. J., Johnson, R. C., &

- Waldron, J. A. (1995). Psychosocial risk and protective influences in Hawaiian adolescent psychopathology. *Cultural Diversity and Mental Health*, 2(2), 107–114.
- Nordyke, E. C. (1977). *The peopling of Hawaii*. Honolulu: University of Hawaii Press.
- Office of Hawaiian Affairs. (2002, June). *Native Hawaiian data book*. Honolulu: Author.
- Office of Hawaiian Affairs. (2004). *The Hawaiian federal recognition bill*. Honolulu: Author. Retrieved May 20, 2004, from www.nativehawaiians.com/fedrecindex.html.
- Omuro-Yamamoto, L. K. (2001). *Ho'oponopono: A phenomenological investigation of a Native Hawaiian harmony restoration process for families*. Unpublished doctoral dissertation, University of Wisconsin, Madison.
- Pheterson, G. (1990). Alliances between women: Overcoming internalized oppression and internalized domination. In L. Albrecht & R. Brewer (Eds.), *Bridges of power: Women's multicultural alliances*. Philadelphia: New Society.
- Polynesian Voyaging Society. (2004). *History of the Polynesian Voyaging Society: 1973–1998*. Retrieved September 21, 2004, from www.pvs-hawaii.com/about_pvshistory.htm
- Pukui, M. K., Haertig, E. W., & Lee, C. A. (1972). *Nānā i ke kumu (Look to the source)* (Vol. 1). Honolulu, HI: Queen Lili'uokalani Children's Center.
- Pukui, M. K., Haertig, E. W., & Lee, C. A. (1979). *Nānā i ke kumu (Look to the source)* (Vol. 2). Honolulu, HI: Queen Lili'uokalani Children's Center.
- Rezentes, W. C. (1999). *Ka lama kukui (Hawaiian psychology): An introduction*. Honolulu, HI: 'A'ali'i Books.
- Root, M. P. P. (Ed.). (1995). *The multiracial experience*. Thousand Oaks: Sage.
- Sai, D. K. (2004). *The Hawaiian kingdom*. Retrieved September 25, 2004, from hawaiiankingdom.org
- Santos, B. (2002). *'Ohana: Hawaiian proverbs and inspirational quotes celebrating family in Hawai'i*. Honolulu, HI: Mutual.
- Shook, V. E. (1992). *Ho'oponopono*. Honolulu: University of Hawaii Press.
- Smith, R. C. (1978). *Historical statistics of Hawaii*. Honolulu: University of Hawaii Press.
- Stannard, D. E. (1988). *Before the horror: The population of Hawai'i on the eve of Western contact*. Honolulu: University of Hawaii Press.
- U.S. Census Bureau. (2003). *Minority links: Facts on the Native Hawaiian and other Pacific Islander population*. Retrieved March 20, 2003, from www.census.gov
- Young, B. B. C. (1980). The Hawaiians. In J. F. McDermott, W.-S. Tseng, & T. W. Maretzki (Eds.), *People and cultures of Hawaii: A psychosocial profile*. Honolulu: John A. Burns School of Medicine and University of Hawaii Press.