**Ethnicity and Family Therapy: An Overview**

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It seems so natural that an interest in families should lead to an interest in ethnicity, that it is surprising this area has been so widely ignored. Ethnicity is deeply tied to the family, through which it is transmitted. The two concepts are so intertwined that it is hard to study one without the other, and yet we have done just that.

The mental health field has paid most attention to the intrapsychic factors that shape life experiences. The study of cultural influences has been left primarily to sociologists and cultural anthropologists. And even they have tended to focus on distant cultures or other sociological trends, paying scant attention to the variety of cultural groups from all over the world that have coexisted for over 200 years in the United States. As Andrew Greeley, one of the few sociologists who has been studying ethnicity, has observed, future historians will be amazed that we have stood in the midst of such an astonishing social phenomenon and taken it so much for granted that we did not bother to study it.

They will find it especially astonishing in light of the fact that ethnic differences, even in the second half of the 20th Century, proved far more important than differences in philosophy or economic system. Men who would not die for a premise or a dogma would more or less cheerfully die for a difference rooted in ethnic origins. (Greeley, 1969, p. 5)

Ethnicity remains a vital force in this country, a major form of group identification, and a major determinant of our family patterns and belief systems. The premise of equality, on which our country was founded, required us to give primary allegiance to our national identity, fostering the myth of the "melting pot," the notion that group distinctions between people were unimportant. Yet, we have not "melted." There is increasing evidence that ethnic values and identification are retained for many generations after immigration (Greeley, 1969, 1978, 1981) and play a significant role in family life and personal development throughout the life cycle (Lieberman, 1974; Teper, 1977; Gelfand & Kutzik, 1979). Second, third, and even fourth generation Americans, as well as new immigrants, differ from the dominant culture in values, lifestyles, and behavior.

Gradually we have begun moving toward a more complex view of ourselves, which allows us to consider group differences within the whole. For family therapists this means shifting our thinking up a level to the consideration of the cultural system of families who share common history and traditions. Just as family therapy itself grew out of the myopia of the intrapsychic view and concluded that human behavior could not be understood in isolation from its family context, family behavior also makes sense only in the larger cultural context in which it is embedded. Perhaps family therapists needed, for a time, to block out other system levels in order to gain understanding of the nuclear family and then the extended family, but the time is past now when that is sufficient context. There are many specific clinical implications of shifting to this broader perspective, as we hope the chapters in this book will demonstrate.

**ETHNICITY: WE AND THEY**

An ethnic group has been defined as "those who conceive of themselves as alike by virtue of their common ancestry, real or fictitious, and who are so regarded by others" (Shibutani & Kwan, 1965, p. 23). Ethnicity describes a sense of commonality transmitted over generations by the family and reinforced by the surrounding community. It is more than race, religion, or national and geographic origin (which is not to minimize the significance of race or the special problems of racism). It involves conscious and unconscious processes that fulfill a deep psychological need for identity and historical continuity (Giordano & Giordano, 1977). Ethnicity patterns our thinking, feeling, and behavior in both obvious and subtle ways. It plays a major role in determining what we eat, how we work, how we relax, how we celebrate holidays and rituals, and how we feel about life, death, and illness.

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Our cultural values and assumptions are generally outside of our awareness. We see the world through our own "cultural filters," often persisting in established views despite even clear evidence to the contrary (Watzlawick, 1976).

The subject of ethnicity evokes deep feelings, and discussion frequently becomes polarized or judgmental. According to Greeley, using presumed common origin to define "we" and "they" seems to touch on something basic and primordial in the human psyche (Greeley, 1969). Similarly, Irving Levine (1981) has observed: "Ethnicity can be equated along with sex and death as a subject that touches off deep unconscious feelings in most people."

Indeed, there is a common tendency for human beings to fear, and therefore to reject, that which they cannot understand. The ancient Greeks called all non-Greek "barbarians," considering them to be without culture. And the Russian word for a German is nemetz, which means "one who is mute," reflecting the belief that those who could not be understood could not speak at all. We tend to label that which is different as "bad" or "crazy." Thus, in more modern usage, U German may label the Italian "hyster-ical," while the Italian may label the German "obsessive-compulsive."

ETHNICITY

Ethnicity is a powerful influence in determining identity. A sense of belonging and of historical continuity is a basic psychological need. We may ignore it or cut it off by changing our names, rejecting our families and social backgrounds, but we do so to the detriment of our wellbeing.

Even Freud, in his later works, began to look into the role of culture in identity formation. As Erikson has noted, Freud took certain principles of cultural identity for granted (Erikson, 1950). He described Freud's own deep sense of ethnic identification as consisting of many obscure emotional forces, which were all the more powerful the less they could be articulated. According to Erikson, Freud conceived of ethnic identity as suggesting a deep commonality, known only to those who share in it, and only expressible in works more mythical than conceptual.

Erikson, in his classic work on identity in 1950, began to develop a framework for understanding how the individual is linked to the ethnic group and society. He defines identity as a process located in the core of the individual, and yet also in the core of his or her communal culture. In his description the final stage of human development concerns coming to terms with our cultural identity: "For only an identity safely anchored in the "patrimony" of a cultural identity can produce a workable psychosocial equilibrium" (p. 412).

The work of Klein (1980) with Jews, Cobbs (1972) with Blacks, and Giordano and Riotta-Sirey (in press) with Italians demonstrated the fact that if people are secure in their identity, then they can act with greater freedom, flexibility, and openness to others of different cultural backgrounds. However, if people receive negative or distorted images of their ethnic background or learn values from the larger society that conflict with those of their family, often develop a sense of inferiority and self-hate that can lead to aggressive behavior and discrimination toward other ethnic groups.

ETHNICITY AND THE MEDICAL MODEL

Until now, the medical model, with its emphasis on "diagnosing" and "curing" disease, has been the major influence on the psychotherapeutic system. This leads to a systematic inattention to "illness" that is, to the patient's or family's perception of what is wrong and is partly responsible for noncompliance, dissatisfaction with clinical care, and treatment failure. There is much evidence that this model is inadequate for understanding illness and the help-seeking behavior in our society. Problems (whether physical or mental) can be neither diagnosed nor treated without understanding the frame of reference of the person seeking help as well as that of the helper. Many studies (Giordano & Giordano, 1977; Tseng & McDermott, 1981; Rabkin & Struening, 1976; Harwood, 1981; Rakel, 1977) have shown that people differ in:

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 the cause of their illness
5. their attitudes toward helpers (doctors and therapists)
6. what treatment they desire or expect.
Kleinman, a prominent physician-researcher, has explored the culturally determined nature of the entire health care system:

Illness behavior is a normative experience governed by cultural rules; we learn "approved" ways of being ill. . . . And doctors' explanations and activities, as those of their patients, are culture-specific. (Kleinman, Eisenberg, & Good, 1978, p. 252)

Symptoms differ so much among ethnic groups that it brings into question the usefulness of our diagnostic nomenclature (Fattl & Shiro, 1959; Opler & Singer, 1956; Singer & Opler, 1956; Tseng & McDermott, 1981). The language and customs of a culture will influence whether or not a symptom is labeled a problem. Having the diagnosis or label may even help to create the problem. For example, the absence of stuttering among certain groups of American Indians is associated with their less stringent demands for fluent speech (Eisenberg, 1977). In fact, their language has no word for stuttering.

As Tseng and McDermott (1981) have stated:

We need to continue to examine ourselves to see on what grounds, and for what purposes, we recognize, label, and conceptualize certain emotional behavior disturbances as mental disorders and what are the so-cio-cultural implications of our conclusions. (p. 36).

Patients' "illness" (the experience of being ill) is very different from the course of their "disease" (a physically identifiable dysfunction) and is strongly influenced by cultural beliefs (Stoeckle, Zola, & Davidson, 1964).

Almost all of us have multiple belief systems to which we turn when in need of help. We use not only the official medical or psychotherapeutic system, we turn also to religion, self-help groups, alcohol, yoga, chiropractors, and so on. We utilize remedies our mothers taught us and those suggested by our friends. Many factors influence our tendency to rely on one system or another at any given time.

Thus, patients vary markedly in their use of the health care system. Although it is estimated that more than 90% of the population experience some physical symptoms of illness at any given time, the vast majority (70-80%) of those believing themselves ill manage their problems outside the formal health care system (Zola, 1972). Of those who do seek professional attention, only about 50% are found to have any diagnosable disease (Kleinman et al., 1978).

Attitudes toward health and illness are strongly influenced by ethnic factors, and studies of ethnic differences in response to physical illness (Sanua, 1960; Zborowski, 1969; Zola, 1966) have clear implications for family therapy practice. In Zborowski's classic study (1969) of physically ill patients of Jewish, Italian, Irish, and White Anglo-Saxon Protestant (WASP) descent, the Jewish and Italian patients tended to complain about their pain, while the Irish and WASPs did not. When it came to describing their pain experience, the WASPs and Jews were accurate, while the Irish and Italians were conspicuously inaccurate. The Italian patients dramatized their pain, and the Irish blocked or denied theirs. When the researchers looked at patients' expected solutions, the results again showed striking differences. The Italians worried about the effects of their pain on their immediate situation (work, finances, family), but once the pain was relieved, they easily forgot their suffering. While they wanted an immediate remedy to stop the pain, the Jewish patients found this unacceptable. They feared anything, such as a pill, that stopped the pain, because they felt it would not deal with the real source of their problem. They worried about the harmful, long-range effects of drugs on their general health. Instead, they sought a full explanation of the meaning of their pain and of its relief. The Irish patients did not expect a cure for their ailments at all. They were fatalistic and usually did not complain of or even mention their pain. Rather, they tended to view pain as the result of their own sinfulness and held themselves responsible for it. The WASP patients, on the other hand, were optimistic, future oriented, and confident in the ability of technology and science to cure disease. Operating on the "work ethic," they sought control over their pain by their own efforts.

Emotional expressiveness can lead to problems since the dominant culture tends to value emotional expressiveness less than many minority groups within it. "Americanized" medical per-sonnel in Zborowski's study (1969) distrusted the uninhibited display of suffering exhibited by Jewish and Italian patients and saw their reactions as exaggerated. Another researcher found that doctors frequently labeled their Italian patients as having "psychiatric problems," although there was no evidence that psychosocial problems were more frequent among them (Zola, 1966). We would
suppose that Jewish and Italian medical staffs would also have difficulty understanding the silence of Irish and WASP patients.

One of the first to move beyond the medical model in the psychoanalytic movement was Karen Horney, who recognized that human problems were incomprehensible apart from their cultural context:

Thus the term neurotic, while originally medical, cannot be used now without its cultural implications. . . . One would run a great risk in calling an Indian boy psychotic because he told us that he had visions in which he believed. . . . The conception of what is normal varies not only with the culture, but also within the same culture in the course of time. (Horney, 1937, pp. 14-15).

In Horney's view, therapy was aimed at helping the patient adapt to the environment, which implied that some theory of social order, such as cultural anthropology, needed to be added to the concepts of psychoanalysis.

However, others did not follow Horney's lead in awareness of cultural relativity in psychotherapy. Even when mental health professionals have considered culture, they, like sociologists and cultural anthropologists have more often focused on international cross-cultural comparisons than on the ethnic groups in our own culture (Carpenter & Strauss, 1974; Giordano & Giordano, 1977; Kiev, 1972).

A number of important collections on ethnic differences that have appeared in the sociological literature (Glazer & Moynihan, 1975; Mindel & Habenstein, 1976; Sowell, 1981) have not, for the most part, become part of the knowledge base of family clinicians. Recent growing interest and awareness may change this pattern. New works are appearing frequently, filling in many gaps. The new *Harvard Encyclopedia of American Ethnic Groups* (Thernstrom, Orlov, & Handlin, 1980) will surely become a classic. Tseng and McDermott's *Culture, Mind and Therapy* (1981) takes a careful and much needed look at di-agnostic labeling from a cultural perspective, and Harwood's (1981) collection on seven medically under-scored groups is another important addition.

In recent years there has been a burgeoning literature on work with a few minority groups, notably Black (see Hincs & Boyd-Franklin, Chap. 4; Pinderhughes, Chap. 5; Boyd, 1980; Block, 1981; Staples & Miranda, 1980; Allen, 1978) and Hispanic (see Falicov, Chap. 7; Garcia-Preto, Chap. 8; Bernal, Chap. 9; Levine & Padilla, 1980). Unfortunately, in the past when these groups have been studied, they have too often been presented singly or as a group representing "third world" cultures. The focus on the harmful effects of racism, poverty and political powerlessness often so dominate, that positive aspects of ethnicity - traditions, coping skills, belief systems - are ignored. While racism and poverty are enormous issues in our culture and have great impact on behavior in the health care system (Thomas & Sillen, 1972; Jacobs, Charles, Bocobs, Weins, & Man, 1972), focusing on them exclusively, rather than within the broader context of a pluralistic society, may obscure perspective on the relativity of all value systems.

Just as there is a paucity of material on the impact of ethnicity in individual therapy, very little has appeared in the family therapy literature on the subject. An exception is the work of Spiegel and Papajohn (1971, 1975) who have made a major advance in our conceptualizations about cultural differences by developing a framework for analyzing value orientations of a culture (see Chap. 2). They have used their schema, which is based on Kluckhohn and Strodtbeck (1961), to analyze the cultural conflicts of a number of ethnic groups (Irish, Italian, Greek, Mexican American, and Puerto Rican) as they adapt to the dominant American value structure. For example, in analyzing the time orientation (past, present, or future) of different groups, none of the ethnic groups valued the future to the extent it is valued in the dominant American value system. Clearly those who value the past or present over the future will find themselves at odds with the dominant culture and are likely to be labeled as "deviant" for this difference. In addition to the comparative value analysis of Spiegel and Papajohn, a few family articles have appeared, on Black Americans (Boyd, 1980; Foley, 1975; McAdoo, 1977), Jewish Americans (Zuk, 1978), Slovak Americans (Stein, 1978), and Irish Americans (McGoldrick & Pearce, 1981). Also, Minuchin, Montalvo, Guerney, Rosman, and Schumer (1967) focused on the multiprob-lems families and developed specific techniques to deal with poor Black and Hispanic families. But the other major family models (Bowen systems, strategy, Communications), while emphasizing the importance of the family context, have not made explicit reference to ethnic differences. Many family therapists view ethnicity as a superficial overlay, irrelevant in relation to more "basic" family process (Bowen, 1981; Satir, 1981).

While interest in ethnicity has grown in recent years, there has been very little systematic integration of material on ethnicity in the training of any mental health professionals (Giordano & Giordano,
Ethnicity relates family process to the broader context in which it evolves. Just as individuation requires that we come to terms with our families of origin, coming to terms with our ethnicity is necessary to gain a perspective on the relativity of our belief systems. For example, if young people experience their parents as cold, distant, and unfeeling, it may be hard for them, even with the appreciation that their grandparents were the same, to feel sympathetic to their lifestyles. However, if we recognize in that "distance" the determined individualism on which the pioneers forged ahead in this country, we become connected with a fuller, more complex and accurate picture of our heritage, which may be easier to appreciate and to renegotiate. Even the definition of "family" differs greatly from group to group. The dominant American (WASP) definition focuses on the intact nuclear family. Black families focus on a wide network of kin and community. 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. The Chinese go beyond this and include in their definition of family all their ancestors and all their descendants. [Their conception of time is very different, and death does not create the same distinction it does for Westerners (Shon & Ja, Chap. 10).]

The family life cycle phases also vary for different groups. For example, Mexican Americans have a longer courtship period and sec early and middle childhood as extending longer than the dominant American pattern (Falicov & Karrer, 1980). Adolescence is shorter and leads more quickly into adulthood than in the dominant American structure, while middle age extends longer going into what Americans generally think of as older age.

Cultural groups vary also in the emphasis they place on different transitions. The Irish have always placed most emphasis on the wake, viewing death as the most important life cycle transition. Italians, in contrast, emphasize the wedding, while Jews often give particular attention to the Bar Mitzvah, a transition most groups hardly mark at all. Families' ways of celebrating these events differ also. As Greeley has noted, 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 (Greeley, 1969).

Some groups celebrate Christmas most elaborately (e.g., Poles, Germans, Scandinavians, WASPs), where others emphasize Easter (Greeks and Slavs), and others the Jewish New Year, the Chinese New Year, and so forth. These customs evoke deep feelings in people that relate to the continuity of the rituals over generations and centuries.

The occupations that groups choose also reflect their values, as well as necessity. The Irish are overrepresented in politics and police work; Jews, in small businesses, medicine, and, above all, in mental health specialties; Germans, in engineering; Greeks in the restaurant business; and so on.

Every culture generates characteristic problems for itself. These problems are often consequences of cultural traits that are conspicuous strengths in other contexts. For example, WASP optimism leads to confidence and flexibility in taking initiative, an obvious strength when there are opportunities to do so. But the one-sided preference for cheerfulness also leads to the inability to cope with tragedy or to engage in mourning (McGill & Pearce, Chap. 21). Historically, WASPs have perhaps had less misfortune than most other peoples. But optimism becomes a vulnerability when they must contend with tragedy. They have few philosophical or expressive ways to deal with situations in which optimism, rationality, and belief in the efficacy of individuality are insufficient. The WASP strengths of independence and individual initiative work well in some situations, but WASPs may feel lost when dependence on the group is the only way to ensure survival.

Naturally, what behavior groups see as problematic will differ as well. WASPs may be concerned about dependency or emotionality, the Irish about "making a scene," Italians about disloyalty to the family, Greeks about any insult to their pride, or Jilotimo, Jews about their children not being "successful," or Puerto Ricans about their children not showing respect. Groups differ also in what they see as the solution to problems. WASPs tend to see work, reason, and stoicism as...
the best solutions. Jewish families often consult with doctors and therapists and seek understanding and insight. The Irish, until recently, solved problems by going to the priest for confession, "offer-ing up" their suffering in prayers, or (especially 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 might prefer surgery, fresh air, or exercise.

Groups also differ in attitudes toward seeking help. In general, Italians rely primarily on the family and turn to an outsider only as a last resort (Gambino, 1974; Fandetti, 1976; Rotunno & McGoldrick, Chap. 16; Zborowski, 1969). Black Americans have long mistrusted the help they can receive from traditional institutions except the church, which was the only one that was theirs (Hines & Boyd-Franklin, Chap. 4; Pinderhughes, Chap. 5; McAdoo, 1977). Puerto Ricans (Garcia-Pretol, Chap. 8), Greeks (Wells, Chap. 13), and Chinese (Kleiman, 1975; Tseng & McDermott, 1981; Lee, Chap. 25) are likely to somatize when they are under stress and may 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 the surgeon rather than the psychotherapist (Midelfort & Midelfort, Chap. 20).

Likewise, Iranians often view medication and vitamins as a necessary part of treating symptoms, regardless of their origin (Jalali, Chap. 14). Many potential patients, perhaps even the majority, experience their troubles somatically and strongly doubt the value of psychotherapy. And many groups may tend to see their problems as the result of their own sin, action, or inadequacy (Irish, Blacks, Norwegians) or somebody else's (Greeks, Iranians, Puerto Ricans).

Cultural differences are often ascribed to class rather than ethnicity. Class is also a major aspect of family life experience, but all differences cannot be ascribed to this factor alone. For example, Puerto Ricans, Italians, and Greeks all have similar rural, peasant back-grounds, and yet there are important ethnic differences among these groups. Puerto Ricans (see Chap. 8) tend to have flexible boundaries between the family and the surrounding community, so that child lending is a common and accepted practice. Italians (see Chap. 16) tend to have much more clear boundaries between the family and the surrounding community and extremely tight boundaries against outsiders. You can be taken in as a member of the extended family by long and close association, but the boundaries remain quite rigid between insiders and outsiders. Greeks have very definite family boundaries, are disinclined to adopt children, having deep feelings about the "blood line" (Wells, Chap. 13). Greeks are also nationalistic - a value that relates to a nostalgic vision of ancient Greece and to the country they lost under hundreds of years of Ottoman oppression. (Poles and Irish, who experienced similar foreign domination after a period of nationhood, also have intense nationalistic feelings.) By contrast, Italians, until coming to this country, defined themselves primarily by family ties, second, by their village, and, third, if at all, by the region of Italy from which they came. Puerto Ricans as a group have coalesced only within the past century or so and have developed their awareness of their group identity primarily in reaction to experiences with the United States. These differences have important implications for treatment. Each group's way of relating to a therapy situation will reflect its differing attitudes toward family, group identity, and outsiders, even though certain family characteristics such as male dominance and role complementarily are somewhat similar for all three groups.

FACTORS INFLUENCING ETHNICITY

Many factors will influence the ways ethnic patterns surface in a family.

Migration

Therapists need to be attuned to the stresses of migration even several generations later (Sluzki, 1979; Cassim, 1982). All families in this country have experienced the complex stresses of migration; they may be "buried" or forgotten, but they will continue, albeit at times subtly, to influence the family's outlook. Under the pressure of accommodating to the new situation, and because of the pain of what was left behind, many immigrant groups have been forced to abandon much of their ethnic heritage (Greeley, 1979; Winawer-Steiner & Wetzel, Chap. 12; Hines & Boyd Franklin, Chap. 4) and thus have lost a part of their identity. The effects of this cutting off of the past may be all the more powerful for being hidden. Families will be more vulnerable in the present, the more they have repressed their past.
How the family adjusts to the new culture depends a great deal on whether one family member migrated alone or whether a large portion of the family, community, or nation came together.

Families who migrate alone have a greater need to adapt to the new situation, and their losses are often more hidden. Frequently, educated immigrants, who come for professional jobs, are in this situation of moving to places where there is no one with whom they can speak their native language or share customs and rituals.

When a number of families migrated together, as often happened with the Scandinavians who settled in the Midwest, they brought their network with them and were able to preserve much of their traditional heritage.

When a large part of the population or nation came together, as happened in the waves of Irish, Polish, Italian, and Jewish migration, the situation was again different, in that our nation as a whole tended to react to these large groups with prejudice and discrimination. The newest immigrants became the biggest threat to those just ahead of them, who feared losing their tenuous hold on economic security.

The reasons for migration will also play an important role, including what the family was seeking and what it was leaving behind - religious or political persecution, poverty, wish for adventure, and so forth.

A family's dreams and fears in coming to the United States become part of its heritage. Their attitudes toward what came before and what lies ahead will have profound impact on the messages given to their children, although the subject may never be mentioned directly.

The hope of returning to the country of origin may impede the family's efforts to adapt to the new situation. The film *El Super* depicts this touchingly in a Cuban family who kept hoping the revolution would be over so that they could return to Cuba. The state of permanent uncertainty or uprootedness is in itself profoundly stressful and will have a long-range impact on family adjustment.

Often the pain of the situation from which family members fled plays a dominant role in the family for generations, as the children of Holocaust survivors are now demonstrating.

*The Languages Spoken in the Home*

Family members vary in the extent to which they retain their heritage, though clearly the impact of the past diminishes as families have new experiences. The language of the country of origin will serve to preserve its culture. Often family members vary in the rate at which they learn English (Lappin & Scott, Chap. 22). It is important to learn what language(s) were spoken while the children in the family were growing up.

A 45-year old Greek man, raised in Astoria, Queens, where his parents, who migrated in their teens, never learned to speak much English, described his mother as uninterested in his life, "ignorant and in-capable of much emotional response/" His marital difficulties seemed a clear reflection of his feelings about his mother, so he was asked to bring her in for one session. (The father had died some years earlier).

It turned out that his parents had known three languages (Greek, Russian, and Bulgarian). The mother spoke English with difficulty. She had never needed to learn it, as she lived in a traditional family, where women did not go beyond the home sphere. Her husband had been her translator when necessary, since he had needed English in his business. The son had spoken Greek throughout his childhood, but had lost much of it by now, so that he and his mother could barely communicate. When given the opportunity to speak in Greek, the mother showed an astonishing understanding of the problems her son was experiencing, in spite of the fact that he practically never spoke to her, and even when he did, never discussed anything in depth.

In the session, which was conducted in part in Greek, the mother's rich traditions and complicated childhood were discussed. The family had been prominent before being forced to emigrate, a loss from which they had never recovered. They had placed all their hopes on their only son, who had done very well academically and professionally. However, he was personally isolated, unable to get in touch with the wealth of his family heritage. He was shocked to realize how much he himself had let the language barrier prevent him from making emotional contact with his mother over the years and how much that had influenced his sense of identity, in spite of having the outward trappings of success.
Race and Country of Origin

Race has also been a major factor here since those whose skin color marked them as different always suffered more discrimination than others - they could not "pass" as other immigrants might try to do. This has left immigrants who are noticeably different physically from the dominant norm with no choice about their ethnic and racial identification.

Often those who look physically similar join or are lumped together as one group, even when they are not. Certain ethnic groups who were, in fact, historical strangers, if not enemies, may be identified with each other in the United States since that is how they are perceived. A Pakistani therapist will be expected to work better with an Indian family, in spite of generations of animosity; or an Argentinean Jew, raised in a situation of anti-Semitic prejudice in the country of origin, may be named administrator of the Hispanic section of a clinic because of language and geographic background. Often groups who are perceived as identical feel pressure to distinguish themselves from each other. West Indians, for example, whom Americans tend to identify with American Blacks, have had a different history and usually do not perceive themselves as the same group ethnically (Brice, Chap. 6). Or, on the other hand, groups from different backgrounds may join together for common needs as Hispanic groups have tended to do.

The Family's Place of Residence

Whether or not they live in an ethnic neighborhood will influence the impact of the family's cultural her-itage on their lives.

The East and West coasts, which tend to be the points of entry for most' immigrants, are likely to have greater ethnic diversity and ethnic neighborhoods, and people in these areas are more often aware of ethnic differences (the East more than the West). The ethnic neighborhood provided a temporary cushion against the stresses of migration that usually surface in the next generation. Those immigrant families who moved to an area where the population was relatively stable, for example, the South, gener-ally have had more trouble adjusting (and were pressured to assimilate very rapidly).

The therapist should be informed about the ethnic network in the community and, if it is lacking, encourage the rebuilding of connections, through family visits or letters or crating new networks. Also, when family members move from the ethnic enclave, even several generations after immigration, the stresses of adaptation are likely to be severe.

The Socioeconomic Status, Educational Achievement, and Upward Mobility of Family Members

Even though there is evidence that ethnic distinctions play a less powerful role among the most educated and upwardly mobile segments of our population, ethnicity is still often a hidden stress. Upward mo-bility may lead families to dissociate themselves from their ethnic roots. In addition, groups differ in the extent to which they value education or "getting ahead," and this may cause intergroup prejudice as well as intergenerational conflict.

An Italian medical student reported great frustration with his father who had high blood pres-ure. When the father was finally persuaded to consult a physician, he was given medication. He de-cided he would take it during the week, but weekends were his own and he would take a vacation from the medication. The son had great difficulty appreciating his father's need to assert that he would not let scientific regimens take complete control of his life - his living came first.

Family members may feel compelled to make a choice between moving ahead and loyalty to their group (Lee, Chap. 25). This in itself can be a source of severe identity conflict for family members.

Emotional Process in the Family

Emotional factors will also influence the role ethnicity plays in the family (see Friedman, Chap. 24). Some families will hold onto their ethnic identification, becoming clannish or prejudiced in response to perceived threat to their integrity. They use ethnic identification as a pull for family loyalty. For other groups, for example, Scots, Irish, or French Canadians (see Langelier, Chap. I I ) , such an emotional demand would not be likely to hold much weight.

Most of us have some ambivalence about our ethnic identification. It is rarely a matter of indiffer-ence. It may appear to be, but we can all imagine situations where we would be proud to be identified.
with our group, others where we would be embarrassed, and situations where criticism would make us feel defensive. Those most exposed to prejudice and discrimination are obviously most likely to inter-nalize negative feelings about their ethnic identity.

Frequently traits create such toxic reactions that they can barely be mentioned for fear of sounding prejudiced. Again, the groups that have experienced the most external discrimination are under the most pressure regarding their "negative" traits.

As in any emotionally determined situation, objective discussion of ethnic characteristics becomes impossible under stress. The therapist should be sensitive to this factor. Children who have not been exposed to the same ethnic discrimination their parents have lived through may have difficulty appreciating the emotional intensity with which the parents hold to their ethnic values.

The Political and Religious Ties to the Ethnic Group

As many sociologists have observed, politics is an area strongly influenced by ethnic identification. Americans join together on the basis of various similarities: class, union affiliation, economic interests, sex, geography, or ethnicity. Since our country's beginning, politicians have been extremely sensi-live to the dynamics of the ethnic vote (Winawer-Steiner & Wetzel, Chap. 12). The more a person feels ethnically identified politically, the more the sense of ethnicity will be strengthened. This factor may lie dormant at once time and be aroused at another. Similarly, religion is a force that often strengthens ethnic identification. Generations of Irish children were strengthened ethnically not only by being the most political of all American ethnic groups (Greeley, 1981; Glazer & Moynihan, 1975), but by participating in a religion that was dominated by Irish clergy. (Generations of Italian, German, and, at times, Polish children also got a fair dose of Irish ethnicity along with their catechism.) Greeks have also been unified ethnically by the Greek church, which became the center of most Greek community activities and of "Greek school," where the next generation was indoctrinated not only about religion, but also about the ancient Greeks and pride in their ethnic heritage. Politics and religion are commonly ignored by therapists, but they are aspects of people's lives, which may be important sources of strength in times of stress. Therapists must assess the role they may play and their interface with ethnic values.

The Family Life Cycle

All of life is motion from and toward. Families who become symptomatic have become fixed in time. In the most basic sense, therapy aims to get the family back in motion. When ethnic stresses or transitions interact with life cycle transitions, the stresses inherent in all change are compounded.

Ethnicity interacts with the family life cycle at every stage. Migration is so disruptive in itself (Hinkle, 1974), that we could say it adds an entire extra stage to the life cycle for those families who must negotiate it. The readjustment to a new culture is by no means a single event, it is a prolonged developmental pro-cess of adjustment, which will affect family members differently, depending on the life cycle phase they are in at the time of the transition. When family members come in the young adult phase, they may have the greatest potential for adapt-ing to the new culture in terms of career and marital choice. However, they are perhaps the most vulner-able to cutting off their heritage, leaving themselves vulnerable to disconnection at later phases of the life cycle.

Jack Johnson was admitted to the hospital for depression and alcohol withdrawal at age 58. He had migrated alone to the United States from Norway at age 24. He lived in a rooming house for several years, sent money back to his family in Norway, but never visited, and no family members ever vis-ited him. At age 32 he married Mary, a third generation Irish American, and became a peripheral member of her extended family. He worked hard as a carpenter, raised five children, and rarely spoke about his background. His family rarely asked. His father had died when Jack was in his teens, and his brother wrote that his mother died after Jack had been here for about 10 years. After that he gradually gave up the minimal correspondence he had kept up with his two brothers. He brought home his earnings, and his wife managed the family. Shortly before his admission to the hospital, Jack's wife had left him. She said that after the children were gone she found the relationship with him empty and could not stand his spending his weekends drinking. Jack moved into a rooming house, did not see much of his children after the separation, and drank increasingly. His landlady finally called the police when she found him passed out on the stairs.
While it would obviously be an oversimplification to attribute all of Jack's difficulties to his immigration and being cut off from his extended family, his vulnerability to later family stress seems to have been much increased by his distance from his family in early adulthood. The distance from parents that is appropriate at that phase could not be repaired at later phases, when the need for cultural support and identification tends to increase (Gelfand & Kutzik, 1979). This left him permanently cut off, unable to maintain continuity between his heritage and his children.

Therapy involved questioning Jack in detail about his background, not only about his family but about Norway, the meaning of Norwegian customs, his attitudes about his ethnicity, and helping him re-connect with his brothers. The following year he made the first trip back to his country of origin since leaving in 1946. He took with him his youngest daughter, who was particularly excited about the recon-nection, feeling she had found a part of her father she had never even known about.

Families that migrate with young children are perhaps strengthened by having each other, but they are vulnerable to the parental reversal of hierarchies. If the family migrates with small chi-l-dren (even more so with teenagers), there is a likelihood that the parents will acculturate more slowly than their children, creating a problematic power reversal in the family (sec Lappin & Scott, Chap. 22). If the children must take on the task of interpreting the new culture for the parents, parental lead-ership may be so threatened that children are left without effective adult authority to support them and without the positive identification with their ethnic background to case their struggle with life in this new culture. If the parents have support in their cultural adjustment - through their work place or extended family and friends - the children’s adjustment will be facilitated and may go more easily since children generally adapt well to new situations, even when it involves learning a new language. Problems may surface, however, in adolescence, when the children move out toward their peer culture (sec Bernal, Chap. 9). Coaching the younger generation to show respect for the values of the older generation is usually the first step in negotiating such conflicts.

Families migrating when their children are adoles-cents may have more difficulty because they will have less time together as a unit before the children move out on their own. Thus the family must struggle with multiple transitions and generational conflicts at once. In addition, the distance from the grand-parental generation in the old country may be particularly distressing as grandparents become ill, de-pendent, or die. The parents may experience severe stress in not being able to fulfill their obligations to their parents in the country of origin. It is not uncommon for symptoms to develop in adolescents in reaction to their parents' unexpressed distress. For example:

John was admitted to an adolescent psychiatry unit in an acute psychotic state at age 17, two weeks after a visit to Greece with his parents and younger sister. He had begun acting strangely while in Greece, where the paternal grandfather had died two months previously. John's grandmother was in good health, but according to John, was severely depressed and lonely. In his psychotic talking he spoke often of taking care of her and of bridging the two worlds of Greece and the United States. John's father had begun a successful restaurant business in the United States, into which he had brought his younger brother, brother-in-law, and two cousins. John's mother had no immediate family in the United States, and missed her own parents and sisters a great deal. However, her husband had told her before they came to this country that she must never think of returning, and she obeyed.

John's dilemma, reflected, at least partially, his concern that his parents were in an impossible di-lemma - cut off from their families in Greece, unable to give up the strivings they had in the United States or to reconcile themselves with what they had left behind. He felt that his paternal grandfather's death symbolized for his mother that her own parents would die without her support. He worried about her almost continuously. Therapy involved helping the family sort through their cultural conflicts. The worry and concern for the family in Greece was reframed as a sign of their loving sensitivity, while their struggle to achieve in this country was also for the family's benefit. The mother was encouraged to stay in close touch with her parents and sisters in Greece but also to develop contacts with the Greek women in her church, which she had been avoiding in her preoccupation • with her own family members in Greece.

When families migrate in the launching phase, it is less often because they seek a better way of life and more often because circumstances in the country of origin make remaining there impossible. This phase causes particular difficulties for families because it is much more difficult for the middle generation to break into new work and friendship networks at this phase. Again, if aging parents are left behind, the stresses will be intensified.
The launching phase may be made more complex when children date or marry spouses from other backgrounds. This is naturally perceived as a threat by many, if not most, parents since it means a loss of the cultural heritage in the next generation. One cannot underestimate the stress it creates for parents, who themselves have had to give up their country of origin, to fear the loss of their traditions when their children intermarry.

Migration in later life is often especially difficult because families are leaving so very much behind. There is evidence that even those who migrate at a young age have a strong need to reclaim their ethnic roots at this phase, particularly because they are losing other supports around them (Gelfand & Kutzik, 1979). For those who have not mastered English, life can be extremely isolating at this phase. The need to depend on others may be particularly frustrating, as when one is forced to be in a nursing home where one cannot communicate easily.

Sometimes if the first generation is older at the time of immigration and lives in an ethnic neighborhood in the new country, its conflicts of acculturation may be postponed. The next generation, particularly in adolescence, is likely to reject the ethnic values of their parents and strive to become "Americanized" (Suzuki, 1979). Intergenerational conflicts often reflect the value struggles of families in adapting to the United States.

The third or fourth generations are usually freer to reclaim aspects of their identities that were sacrificed in the previous generations because of the need to assimilate (Rotunno & McGoldrick, Chap. 16).

Families from different ethnic groups may have very different kinds of intergenerational struggles. WASP families are likely to feel they have failed if their children do not move away from the family and become independent (McGill & Pearce, Chap. 21), while Italian families are likely to feel they have failed if their children do move away. Jewish families will expect a relatively democratic atmosphere to exist in the family, with children free to challenge parents and to discuss their feelings openly (Herz & Rosen, Chap. 17). Greek families, in contrast, do not expect or desire open communication between generations and would not appreciate the therapist getting everyone together to discuss and "resolve" their conflicts. Children are expected to respect parental authority, which is maintained by the distance parents preserve from their children (Welts, Chap. 13). Irish families will be embarrased to share feelings and conflicts across generations and cannot be expected to do so to any great extent.

Any life cycle transition can trigger off ethnic identity conflicts since they put families more in touch with the roots of their family traditions. How the rituals of transition are celebrated can make an important difference in how well the family will adjust to the changes (Friedman, 1980). All situational crises - divorce, illness, job loss, death, retirement - can compound ethnic identity conflicts, causing people to lose a sense of who they are. The more a therapist is sensitive to the need to preserve continuities, even in the process of change, the more he or she can help the family to maintain maximum control of its context and build upon it.

**Interruption**

Obviously intermarriage complicates geometrically the picture presented by a family of a single ethnic group. Generally, the greater the difference between spouses in cultural background, the more difficulty they will have in adjusting to marriage.

For example, a WASP/Italian couple might run into conflicts because the WASP takes literally the dramatic expressiveness of the Italian, while the Italian finds the WASP's emotional distancing intolerable. The WASP may label the Italian "hysterical" or "crazy" and be labeled in return "cold" or "catatonic." Knowledge about differences in cultural belief systems can be helpful to spouses who take each other's behavior personally. In the extreme, of course, it 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" (the lack of emotional response, the rationalization and workaholics). Or, "I can't help being late, we Puerto Ricans have a different conception of time."

Cultural and religious groups have always had prohibitions against intermarriage. Until 1967 when the laws were declared unconstitutional, 19 states had laws prohibiting racial intermarriage. Until 1970 the Catholic Church prohibited intermarriage with non-Catholic unless the latter promised to raise all children as Catholic. Intermarriage is feared because it threatens the survival of the group.
The likelihood of intermarriage obviously increases with the length of time an ethnic group is in this country, as well as with educational and occupational status. For example, in a nationwide survey of Catholics, 80% said their parents were from the same ethnic background, but only 55% of this generation were married to someone from the same ethnic background (Heer, 1980).

Just as understanding of family systems (family patterns, sibling positions, life cycle stages, etc.) is important for couples, so is understanding of ethnic differences (McGoldrick, 1980). Couples may have a sudden and remarkable shift in response when they can come to see the spouse's behavior fitting into a larger ethnic context rather than as a personal attack. Couples who choose to marry are usually sacking a rebalance of the characteristics of their own ethnic background. They are moving away from some values as well as toward others. As with all systems, the positive feelings can, under stress, become negative. The extended families may stereotype the new spouse negatively - often a self-protective maneuver - reassuring themselves of their superiority, when they feel under threat. During courtship, a person may be attracted precisely to the fiancé's different ness, but when entrenched in a marital relationship the same qualities often become the rub.

Friedman, in his discussion of the "Myth of the Shiksa," describes what he calls "cultural camouflage": the universal tendency of family members everywhere to avoid responsibility for their feelings, their actions, and their destiny by attributing their cause either to factors in their own background, or to aliens (shiksa) from a background that is foreign (goyische). Friedman's point is a very important one. Families may use their ethnic customs or religious values selectively to justify an emotional position within the family or against outsiders (Friedman, Chap. 24).

But our experience is that the opposite problem is equally difficult. That is, couples often react to each other as though the other's behavior were a personal attack rather than just a difference rooted in ethnic-nity. Typically, we tolerate differences when we are not under stress. In fact, we find them appeal-ing. However, when stress is added to a system, our tolerance for difference diminishes. We become frustrated if we are not understood in ways that fit with our wishes and expectations. WASPs tend to withdraw when upset, to move toward stoical isolation, in order to mobilize their powers of reason (their major resource in coping with stress). Jews, on the other hand, seek to analyze their experience together; Italians may seek solace in food, emotional and dramatic expression of their feelings, and a high degree of human contact. Obviously these groups may perceive each other's reactions as offensive or insensitive although within each group's ethnic context their reactions make excellent sense. In our experience, much of therapy involves helping family members recognize each other's behavior as a reac-tion from a different frame of reference (McGoldrick, 1980, 1982).

Example:

The Carbones applied for therapy after seven years of marriage. Tony was third generation Italian American, the youngest of three sons, from a very close-knit family. He was the first to attend college, where he did very well and where he met Ann, the middle of three daughters from a Boston Brahmin family, whose ancestors had come over on the Mayflower. Ann's father was a banker, who ruled his family tyrannically. Her mother was a qui-et, soft-spoken woman, who filled her life with social activities and hostessing for her husband's business friends. She suffered chronic headaches, which she never mentioned to anyone. Tony's career plans had changed when his oldest brother was injured in a car accident and the family needed him to take over the family business. (The middle brother was considered "weak" by the family and could not be given the job.) Tony and Ann had had a romantic courtship. Tony saw Ann as the ideal American woman: blond, beautiful, wealthy, sophisticated, and quietly charming. Ann was attracted to him for his dark good looks, humor, and easy outgoing manner. She appreciated that he was not a "stuffed shirt" like her father and that he liked to have a good time and to say what he thought. However, after they moved to Tony's hometown, Ann became unhappy. She felt uncomfortable at all of the family gatherings. Tony insisted she attend with him on weekends. He often went off with his brothers and father and left her with his mother and aunts. In Ann's view he became angry, impulsive, and abusive when things did not go his way. She looked to having headaches like her mother and gradually became quietly addicted to painkill-ers and alcohol.

A major part of therapy with this couple revolved around helping each of them to understand the other's behavior in an ethnic context. Tony came to realize that Ann's withdrawal and non-response were not aimed directly at him but were part of a general way she had learned at home of coping with stress. Ann came to appreciate that Tony's style, far from indicating that he did not love her, reflected his deep frustration that he was not able to stay in control of her happiness as his family obligation. Both of them were relieved to learn that the other's behavior was not meant to be destructive as it appeared. And both were relieved to realize that their own behavior was not as disturbed as they were coming to feel through their mutually escalating cycles. Each spouse gradually moved to more accommodation of
their differences in perception: Tony by allowing Ann the space to solve her addiction for herself, and Ann by accepting Tony's expressions of frustration as a sign of his caring. She learned to respond to him rather than withdrawing from what she perceived as rejection.

**Therapy**

Appreciation of cultural variability leads to a radically new conceptual model of clinical intervention. Restoring a stronger sense of identity may require resolving 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 differentiation involves selecting from our ethnic traditions those values we wish to retain and carry on. Families may need coaching to sort out deeply held convictions from values asserted for emotional reasons. This requires raising one's consciousness beyond the level of family to a perspective on the cultural relativity of all value systems.

Defining what response is adaptive in a given situation is not an easy task. It involves appreciation of the total context in which the behavior occurs. For example, Puerto Ricans in this country may see returning to Puerto Rico as a solution to their problems. A child who misbehaves may be sent back to live with family members. This solution may not be functional from the perspective that the child will then be isolated from the immediate family. The living situation in Puerto Rico may also not be adequate to provide for the child's needs. However, it is advisable for the clinician not to counter the parents' plan but to encourage them to strengthen their connectedness with the family members in Puerto Rico with whom their child would be staying in order to make the most of their wish to rely on their own network for support.

The therapist's role in such situations, as in all therapy, will 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.

Often it is very difficult to understand the meaning of behavior without knowing something of the value orientations of the group. The same behavior may have very different meaning to families of different backgrounds.

For example, clients may not talk openly in therapy for many different reasons. Black clients may be uncommunicative, not because they cannot deal with their feelings, but because the context involves a representative of a traditional "White" institution, which they never had reason to trust. The Irish client's failure to talk might have nothing whatsoever to do with resisting the institutional context, but rather with embarrassment about admitting feelings to anyone, most especially to other family members. Norwegians might be withholding out of respect and politeness not to state openly certain less than positive feelings they have about other family members. It is a courtesy having nothing to do with either the therapy context or guilt about "unacceptable" feelings.

There are many examples of such misunderstood behavior. Puerto Rican women are taught to lower their eyes and avoid eye contact. American therapists are taught to read lack of eye contact as an indication of inability to relate to others. Jewish patients routinely inquire about the therapist's credentials, which many groups would perceive as a challenge and affront but is for them a needed reassurance. Iranian and Greek patients may ask for medication and give every indication of taking it and then go home and not take it as prescribed. Irish families may not praise or show overt affection for their children, for fear of giving them a "swelled head." Therapists may misread this behavior as lack of caring. Physical punishment, commonly used by many groups (Black, Greek, Iranian, Puerto Rican), may be misread as child abuse by American therapists unfamiliar with the norms of these groups. The list of possible misunderstandings is endless. The point is that therapists must never be too quick to judge the meaning of behavior they observe.

For example, an Italian therapist who did an excellent evaluation of an Irish family, came for supervision to discuss his "failure," because in his view he had not managed to engage them, or "put them at ease." He misunderstood their awkwardness as resulting from his failure as a therapist to establish a congenial setting. Their stiffness and embarrassment in the situation had to do with their feelings about their son's misbehavior and not with the therapist at all. This trainee had to remind himself continuously throughout his work with this family that their emotional distance did not have the same meaning for them that it did for him.
Ethnicity Training

There are many who believe that cross-fertilization from one ethnic group to another is the best antidote to the "stuckness" families experience when their cultural adaptations fail. It is often said that Irish re-serve is a good balance for Italian impulsiveness, while Italian expansiveness counters Irish repression. Jewish families who become stuck in their analyzing, may be helped by the WASP ethic that pushes to resolve the matter and move on. On the other hand, the constriction of WASP methods in dealing with emotional distress may be greatly helped by the Jewish value of sorting through the painful experiences and sharing the suffering. The recent movie Ordinary People was an excellent demonstration of the ways in which the values of one culture (in this case the values of a Jewish therapist) may be an excel-lent antidote to the rigidities of another culture (in this case a WASP family trapped in its inability to deal with tragedy).

We believe the best way we can learn is by being open to new possibilities and that this is much more likely when the training takes a positive point of view. It does not help therapists to be told only what they are doing wrong, what does not work, and how inappropriate traditional therapies are for the clients they see. They need to be offered something new to try. We make it a point in these chapters and in our training to emphasize what can be done over what will not work.

This model requires clinicians to struggle consciously with their own subjectivity and to recognize the limitations of any belief system in their work. We do not mean to imply that culture is the only or even the most important contextual factor to be considered in assessing problems and behavior. Social class and religious and regional identities are also extremely important. In addition, the impact of gender on personality, development, and illness behavior, though largely ignored until recently, cannot be over-estimated (Silverstein, 1981; Carter & McGoldrick, 1980; Gluck, Dannefer, & Milea, 1980; Mechanic, 1978). Only when we come to realize the context determined roots of our values can we shift to a system-ic view of ourselves as part of a helping context. Only then will we leave behind the dichotomized my-thology of the doctor "diagnosing" and labeling the patient as though by some objective measures of reality. We are always a part of the systems we are trying to observe, and our participation affects our observations. This perspective is a prerequisite for understanding and intervening in the complexities of interacting systems.

In our view the most important part of ethnicity training involves the therapist coming to understand his or her own ethnic identity in a differentiated way. Similar to the emphasis that Bowenites place on the therapists' working out the relationships in their own families or origin, we think that differentiation requires going a step beyond this to a resolution of our own ethnic identity. This means, ideally, that therapists would no longer be "triggered" by ethnic characteristics they may have regarded negatively nor be caught in an ethnocentric view that their groups values are more "right" or "true" than others. No group has a corner on truth. Resolving the psychological issues of ethnic identity involves achieving a multiethnic perspective where we are open to understanding values that differ from our own and no longer need to convince others of our values or give in to theirs.

We try to teach a way of thinking more than specific information about different ethnic groups, but our experience has taught us repeatedly that theoretical discussions about the importance of ethnicity are practically useless in training clinicians. We come to appreciate the relativity of values best through specifics. Thus in our training we work a great deal through detail. How do groups differ in their re-sponses to pain, in their attitudes about doctors, in their beliefs about suffering? Do they prefer a for-mal or informal style in dealing with strangers? Do they tend to feel positive about their bodies? about work? about marital intimacy? about children expressing their feelings? In other words, we try to offer rules of thumb.

Obviously the study of ethno cultural factors in therapy could hardly be based on encouraging therapists to learn the differences in values, family patterns, life cycle rituals, and attitudes toward therapy of all groups. It would be a big mistake to suggest that therapists need to be-come cultural anthropologists in order to be effective clinicians. So what do we expect? Even if many of us (about half) marry into another ethnic group, have close friends from other back-grounds, or live in another culture, we are still not likely to have too keen an understanding of the world view of more than a few groups. The best approach is probably for clinicians to focus on a few groups with whom they have considerable exposure as a way of training themselves to be more aware of the cultural relativity of all norms and values. Ethnicity, like family systems, may at times be a very loaded issue for trainees. Even an objective discussion of cultural differences may trigger off disturbing feelings or memories of early ethnic experiences. The psychological scars
of negative stereotyping and discrimination are often still there - the cultural memory can readily come alive with a seemingly harmless joke or ethnic reference.

In our experience there are two major resistances to ethnicity training. The first is the attitude that ethnicity is a subject we all understand, it is common sense, and there is no particular need to develop a special program to study it when there are so many other critical priorities to be covered in training. We think this issue can best be responded to through concrete, useful clinical suggestions.

The second resistance, which is more difficult to address, is an active reluctance to define ethnic differences. At times this may come from minority groups who fear that in a discussion of ethnic differences in general their own group will be lost. More often the resistance comes from deep-seated fears about labels. It is usually predictable that those who are the most upset about discussion of ethnic differences, have charged personal reasons for their reactions.

Once in doing a presentation about the Irish I began to discuss their high tolerance for drinking, and the many functions that drinking serves in Irish culture. Suddenly a very Irish-looking woman stood up in the audience and began in a barely controlled manner to challenge me for stereotyping. I was taken quite by surprise since the Irish attitudes about drinking have been much discussed and are not particularly a matter for debate. It was not until some while later that it came out in working with this young woman that her Irish father's drinking had been the central fact of her childhood. She heard the characterization of the Irish as drinkers as a pronouncement of doom on her family, which was very painful to her.

It is extremely important in beginning ethnicity training to set up a safe context. We must make the training situation safe for stereotyping, that is, for generalizing about cultural differences. Nothing would make failure more likely than to begin training with a description of characteristics of different ethnic groups without making clear to the group the need to use generalizations, which will reflect at best only partial truths.

One of the best ways we know to do this is by describing our own reluctance to stereotype - our fears of being labeled as prejudiced or racist and the alternative possibility of not talking about differences at all.

Presentations of one group alone are rarely successful because they lead the audience to think of the exceptions to the rule. Once a number of cultures are presented together it is easier to recognize, for example, that while all Irish are not alike, they probably are, indeed, a good deal more like each other than they are like Greeks or Russians.

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

CONCLUSION

It is hard for us to remain open to the wide range of cultural possibilities. Ambiguity and difference are threatening, and we tend to close down emotionally when confronted with too much of them. Understanding the relativity of our own ethnic biases is the best insurance against such rigidity. Yet this insight is hard to gain.

For us as therapists there are particular difficulties in stepping outside our belief systems. Not all cultures value the pursuit of insight, truth, "getting ahead," or sharing problems and feelings. By exploring our ethnic assumptions, we are led to question our primary therapeutic techniques. It is no wonder we are threatened.

The extensive geographical and class mobility in American culture, while often cutting individuals off from their ethnic heritage, increases their contact with different ethnic groups. The high rate of interethnic marriage means that many Americans will learn about ethnic differences from marriage partners.

But, at best, most Americans probably come to understand well only three or four groups in the course of a lifetime. Obviously, no therapist can become an expert on all ethnic groups. What is
essential for clinicians is to develop an attitude of openness to cultural variability and to the relativity of their own values.

Some potential negative consequences of emphasizing ethnicity must also be recognized. Overly strict adherence to a particular way of doing things, under the supposition that it is an "ethnic" value, can make an ethnic group resist change and thereby impede its development. Values that were functional in another place and time often become dysfunctional when translated into modern America. Ethnocentrism, clannishness, prejudice, fear, and distrust of outsiders can prevent cooperation, reinforce exclusivity, and deepen intergroup conflicts (Giordano & Giordano, 1977; Kolm, 1973). However, the solution to these problems lies not in eradicating cultural differences but in developing their potential to become a source of cultural enrichment.

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