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THE MULTICULTURALISM AND DIVERSITY OF FAMILIES

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The widespread impact of globalization around the world challenges practitioners everywhere with understanding and integrating gender, race, social class, ethnicity, sexual orientation, and other diversity variables in clinical practice. This challenge has never been greater than now since, increasingly, psychotherapists provide mental health care to a wider and more diverse range of families in many countries. The fit between the culture of therapy and the culture of the clinician and even the clinical supervisor must be considered with the recognition that psychotherapy is a cultural and sociopolitical encounter. This chapter presents a systemic and postmodern framework to guide a diversity approach to psychotherapy theory and practice. Most of the conceptual and practical applications presented are based on clinical experiences with diverse groups of clients within North America, but it is likely that the framework itself applies to other client groups in the Western hemisphere.

Historical Attention to Multiculturalism and Diversity

Attention to diversity and multiculturalism and the call for cultural sensitivity or competence in mental health services are not new. The civil rights movement demanded that institutions be more responsive and less discriminatory toward minority clients, and the nationwide development of community mental health programs in the 1970s attempted to expand services to economically disadvantaged and culturally marginalized groups.

Early on, family therapy, as other forms of psychotherapy, tended to look at the patterns of family life as universal. Furthermore, the particular approach promoted by each school or brand of theory and practice was regarded by its proponents as universally valid. Nevertheless, family therapy also emphasized contextual and ecological issues in family life (Auerswald, 1968). Early research and scholarly writings that focused on economically disadvantaged families highlighted the importance of sociocultural context in understanding family life (Aponte, 1976, 1994; Minuchin, Montalvo, Guernsey, Rosman, & Schumer, 1967; Montalvo & Gutiérrez, 1988; Sluzki, 1969). Other notable contributions include the work of Papajohn and Spiegel (1975) that compared value orientations of various ethnic groups.

The enduring emphasis on contexts made family therapy particularly poised to question universality and to incorporate diversity and multiculturalism. Over time, this task has been undertaken in a variety of ways: McGoldrick and colleagues' (McGoldrick, Giordano, & Pearce, 1996; McGoldrick, Giordano, & Garcia-Preto, 2005) examination of ethnicity in families; Boyd-Franklin's (2003) multisystemic approach for black families; the feminist critique of family therapy (Hare-Mustin, 1978; Walters, Carter, Papp, & Silverstein, 1988); the attention paid to gay and lesbian families (Green, 2012); and my own work, which proposes a comprehensive integrative definition of culture (Falicov, 1983, 1988, 1995, 2014a) to incorporate cultural diversity perspectives in all aspects of training and clinical work.

Starting in the mid-1990s, attention to diversity became further influenced by incorporating newer, postmodern epistemologies that stress a social constructionist lens, a strength-based orientation, and a collaborative engagement with clients along with a greater emphasis on self-reflexivity for the clinician (Falicov, 2014a; McGoldrick & Hardy, 2008).

The historical progression of diversity concerns places family therapy squarely within the multicultural movement. This position requires a constant navigation between the perils of relying on stereotypical generalizations about collective identities that do not capture intergroup variation, or the opposite, that is, remaining only at the level of individual description case by case. The latter could be acceptable were it not for the ever-present risk of ignoring that clinicians have cultures derived from their professional and personal values and they also have culture-specific methods of assessment and intervention which could lead to errors of treatment with diverse families. Without the benefit of self-reflection that acknowledges those biases, injustices may be committed by lack of awareness of what could be cultural and sociopolitical in clients as well as in practitioners' values and behaviors.

In the past decade, significant contributions have also come in the form of the introduction and testing of cultural adaptations of mainstream approaches (i.e., cognitive-behavior therapy) for the treatment of individuals and families from diverse cultural groups (Bernal & Domenech Rodríguez,

2009, 2012; Falicov, 2009b; Parra-Cardona et al., 2012). Family-oriented clinical researchers stress the importance of searching for compatibility between treatment and clients' cultures by using bilingual-bicultural professionals whenever possible and including cultural diversity factors and contextual stressors. The interest in adapting treatments to cultural and contextual differences reflects the necessary and desirable integration of modernist, scientific-oriented views with the social constructionist, postmodern perspectives inherent in incorporating cultural perspectives to clinical theory and practice as proposed in this chapter.

Collective Identities: A World of Variation

Defining specific "collective identities" such as ethnic, class, gender, or social identities appears at first glance both possible and practical. We look at the worldviews, values, and customs of certain groups, and assume these traits to be normative and stable, albeit in a rather stereotypical way. We talk about how Latinos value family closeness and interdependence, how Anglo-Americans are time-conscious and schedule-oriented, how the Irish like to tell stories and drink. However, on close examination, deciding about sameness and difference is not so simple.

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

Gender, race, class, sexual orientation, religion, nationality, disability, and even cohort (the historical generation into which a person is born) all contribute to cultural and sociopolitical identities. Consistencies of language, meaning or belief systems, worldviews, and experiences often lend a sense of familiarity and

community for people who share the same culture or contextual location. But inconsistency, variation, and novelty exist along those dimensions as well. Transnational lifestyles made possible by the existence of increasingly sophisticated global technologies of communication have made cultural exchanges and influences much more prevalent than it was possible in the past (Falicov, 2007, 2008). Identities are also influenced by the constructs supplied by the dominant discourses, which often discriminate and marginalize cultural differences.

Taking the variations in cultural and sociopolitical influences into account, and the myriad cultural blends that result, helps avoid treating cultures and contexts as static. Given this incredibly complex, moving construct we vaguely call the “culture” of a person or a family, how do we address its relevance and place for families that seek psychotherapy? How do we arrive at a framework generic enough and specific enough to encompass similarities and differences germane to clinical theory, research, and practice?

The framework presented in this chapter is based on systemic and postmodern foundations. It attempts to acknowledge wide variation within collective identities and yet allow for some generalizations in the culture of clients and the culture of practitioners useful for their encounter in clinical theory, research, and practice. The framework is intended to be applicable to a large variety of groups on the basis that the parameters of comparison issued are more universal than culturally specific, although specific aspects may emerge precisely by drawing comparisons among groups.

The answer proposed here to the questions of how clinicians can orient themselves in the array of issues related to cultural and sociopolitical diversity is provided by MECA, the Multidimensional-Ecosystemic-Comparative Approach (Falicov, 1995, 1998a, 2012, 2014a)

Systemic and Postmodern Foundations of MECA as an Approach to Diversity

MECA is based on the idea that we are all multicultural persons rather than belonging to a single group that can be summarized with a single label: Latino, lesbian, Lutheran or black. In reality,

each person belongs, participates, and identifies with multiple groups that provide or impede particular experiences and bestow particular values. Furthermore, persons are also denied access or are excluded from certain settings and these exclusions also shape their experiences.

The following definition of culture underlines the multidimensionality and fluidity of culture:

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

(Falicov, 1983, pp. xiv–xv)

Exclusion from various contexts can also be part of the cultural and sociopolitical experience (Falicov 1995, 1998, 2014a).

This multidimensional view reflects more fairly the meaning of the word “diversity” than any one dimension alone. Individuals and families partake of and combine features of the many contexts listed in the definition. It is the combination of multiple contexts and partial perspectives that shapes and defines each person’s culture, rather than any of those separately. Nor does some monolithic “culture” exert an inexorable influence upon the individual. Each person is raised in a plurality of cultural subgroups that exert a multiplicity of influences depending on the degree of contact with each subcultural context. Cultural similarities and differences reflect inclusion in or exclusion from various groups.

MECA Embedded Constructs: A Cultural Diversity Lens, a Sociopolitical Lens and an Ecological Niche

Embedded in the definition of culture above are several important constructs (i.e., a cultural

diversity lens, a sociopolitical lens, and the construct of ecological niche). A *cultural diversity lens* promotes respect for clients' cultural locations and preferences and critically examines existing models of families, theories and techniques used in psychotherapy with a view to their application to minority clients; a *social political lens* focuses on the effects of power differentials in societal discrimination (due to gender, economic, and racial inequities and to gender orientation and variance) on individual and family well-being and on the relationship between clients and therapists; and the construct of *ecological context* stirs practitioners toward a complex cultural and sociopolitical description of each client and each clinician by taking into account the multiplicity of contexts to which each one belongs and their areas of overlap or cultural consonance and dissonance between them.

A Cultural Diversity Lens

One of the first effects of bringing culture into the therapy room is that it upsets our theoretical applecart. It challenges what traditional schools of thought—psychoanalytic, systemic, structural, strategic, and so on—consider as universal. Views about how families function, how problems develop, and how change is facilitated by those approaches may be “local” ideas originated by various “schools of thought” or “cultures” (Fancher, 1995) within the professional standard clinical practices. It follows from this that clients' beliefs or behaviors that are part of a cultural meaning system other than the one in which the therapist has been schooled could potentially be judged as dysfunctional or at least problematic. Consideration of differences is at the core of the newer principle of therapeutic respect whereby the client's life requires description rather than categorization (Anderson & Goolishian, 1992; Freedman & Coombs, 1996; Madsen, 2007; Sexton & Alexander, 2003; White, 1993).

To avoid confusing other cultural ways with dysfunction, a multicultural therapist incorporates a critically questioning attitude toward the Euro American biases inherent in most professional training. This means accepting that theories and interventions stem from one local

ecological niche and are not the standard by which all families can be evaluated. Instead, a practice based on curiosity and respect for cultural diversity (Lappin, 1983) explores the healing resources within the client's culture and develops a stance of empathic “sociological imagination” (Wright Mills, 1959). When we attend to issues of ethnicity or religion, critical questions are raised about the customary assumptions of mainstream psychotherapy. For example, in family therapy, issues of boundaries, hierarchies, communication styles, or life-cycle norms may come into question and lead to transformations and accommodations of taken-for-granted concepts and techniques (Gergen, Gulerce, Lock, & Misra, 1996).

A Sociopolitical Lens

Diversity-oriented theory and practice comprises more than respect for multiple meanings or diverse cultural values about family life. A sociopolitical or social justice component is also essential. Members of minority groups—African Americans, Latinos, LGBT—have been consistently marginalized and denied their own voice in determining the conditions of their lives (Aldarondo, 2007; Young, 1990) in ways that cause health and mental health distress.

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

A sociopolitical lens is not limited to impoverished clients. For example, in the past, a case of anorexia nervosa was viewed as “idiosyncratically” linked to an “overinvolved” mother and a “peripheral” father without awareness of the social demand for the gender specialization of each parent and the social demands for thinness in young women (Bordo, 1997). More recently, a number of therapists are considering cultural

and sociopolitical discourses to be central to the treatment of anorexia and other eating disorders (Epston, 1994). A social justice practice connects mental health issues with experiences of social oppression and aims to empower families in their interactions with larger systems and cultural discourses, including those in the psychotherapy field (Hardy & Lazzloffy, 1994; Korin, 1994).

An Ecological Niche

Taken altogether, cultural and social participations and exclusions make up a client's and also a therapist's "ecological niche." Including culture and sociopolitical issues in clinical practice requires service providers to locate themselves and their clients in terms of race, class, religion, sexual orientation, occupation, migration experiences, nationality, and ethnicity. Describing an ecological niche is equally important for "mainstream" clients who are white, middle class and Protestant. Cultural location should not be described only for minority groups and imply that culture and society influence only marginalized groups while dominant groups are regarded implicitly as the standard norm.

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

With the Multidimensional Ecosystemic Comparative Approach (MECA), therapists make a holistic assessment of all the contexts to which

the family belongs and draws from the family their understanding of the resources, the constraints, and the cultural dilemmas those multiple contexts create. These types of collaborative explorations render a picture closer to what the anthropologist Clifford Geertz (1973) dubbed a "thick" description, rather than relying on identity labels and a priori knowledge about collective groups. Aiming for "thick descriptions," the observer draws conclusions based on each person's descriptions of their own complex locations using their own cultural categories of understanding rather than utilizing the labels and categories of the observer. Underlying MECA is the idea that the therapy encounter is really an encounter between the therapist's and the family's cultural and personal constructions. A therapist's views about family and family problems and resources stems from his/her ecological niche, which includes their own cultural and contextual variables as well as their preferred brand of theory and professional subculture.

Toward Postmodern Integrative Attitudes

A social constructionist postmodern approach enhances the integration of multiculturalism and diversity to the work with families. Two salient features are the adoption of a not-knowing stance and a focus on the strengths of diverse and multicultural families.

A Knowing and Not-Knowing Stance

An ethnically focused position encourages clinicians to inform themselves of many details about particular cultures. This position can be contrasted to a "not-knowing" stance in therapy. "Not-knowing" approaches are based on curiosity, and on dialogue that takes into account all meanings—cultural and personal—as they emerge in the therapeutic situation. Yet there are families where "credibility" and direction from a "knowing" agent "fits," particularly in more hierarchical cultures than the United States as people may turn to experts for concrete guidance and advice.

These two positions seem to be unnecessarily polarized. A dialectic, both/and approach, which combines a "not-knowing" stance with

“some-knowing” or information about diversity and specific cultures, including the clinician’s own diversity and culture, allows for more complexity and effectiveness. This integration of attitudes can provide the most beneficial means of working with diverse and multicultural clients, as the following case illustrates.

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

Having some knowledge of cultural details attuned the consultant to the possibility that religion may be playing a role in the family’s resistance to the clinician’s mainstream medical cure for delusions. A therapist with a “not-knowing” approach toward culture might have arrived eventually at the same place. The family, meanwhile, conscious of difference with the dominant culture views, might not have ever volunteered their prayer practice unless asked. One might be tempted to say the

first therapist would have done better. Not necessarily. The ethnic-focused therapist may have stopped at simple respect for the family’s cultural solution once the family mentioned prayer. A “not-knowing”, curious stance was very helpful in taking the inquiry further by asking how prayer works concretely in the family’s particular subculture of religion. Weaving back and forth between these stances—one informed by some cultural knowledge and the other guided by curiosity—could clarify the family’s fears that medication would preclude their prayers from working. The therapist could then ally with the family to better define what kind of help they needed and would be willing to accept from the clinic.

In a both/and position, involving “some-knowing” and “not-knowing,” the therapist must be comfortable with other “double discourses”—an ability to connect with the universal human similarities that unite us beyond color, class, ethnicity, or gender, while simultaneously recognizing and respecting diversity due to color, class, ethnicity, or gender. This “double discourse” may be explicit or implicit, foreground or background, expanding or shrinking the cultural emphasis depending on the case at hand. Consistent with the reality of shifting multiple contexts, there is no list of “dos” and “don’ts” when working with ethnic, gender, racial, or religious groups. There is only one “do” and one “don’t”—*do* ask, and *don’t* assume. We must relate to each other’s universal humanity, while not forgetting about each other’s remarkable cultural contexts.

A Focus on Strengths

Multicultural and diverse families, such as economically disadvantaged immigrants, have been portrayed with a deficit model that points to problematic areas in family relationships. Without minimizing the serious challenges and risks that such families face, I focus on their resilient responses and underline the importance of working with their many strengths. These may include strong family and community bonds and systems of help, healthy maintenance of cultural rituals, capacity for hard work, and pride in good parenting.

A “relational resilience” lens proposed by Walsh (2006) is very helpful with multicultural and diverse families because it shifts the perspective

from viewing distressed families as damaged to seeing them as challenged and it affirms their potential for growth. Many immigrant families demonstrate capacity to survive and even thrive; they have ethnic and network resources, situational triumphs, loving capacities, and courage to face racial or ethnic prejudice and economic injustice. Strength-based explorations offer a more solid, hopeful ground for trust in the practitioner's capacity to appreciate and help a family.

MECA Generic Domains

MECA focuses on dimensions that family therapists generally use to orient themselves about basic aspects of relational life to be taken into account when trying to understand presenting problems. The four domains identified in MECA are migration and acculturation, ecological context, family organization, and family life cycle. MECA is based on the belief that the contents of these domains are culturally constructed but that the domains themselves as general phenomena probably exist in all societies. In the clinical situation, an assessment includes conversations about possible connections between the presenting concerns and the various domains covered in MECA. From these conversations a contextual picture of the family emerges that includes cultural dilemmas that may be connected with the presenting issues, or cultural and personal strengths that may be helpful in finding solutions. Clinicians who become familiar with these four domains acquire *migration and culture-specific competencies* as described in the following sections.

Migration and Culture-Specific Competencies

Migration and Acculturation

Many immigrants leave their countries reluctantly. Their motivations include primarily improving their desperate economic situation or escaping political oppression and organized violence. A number of consequences ensue from the migration experience. These include uprooting of various meaning systems, ambiguous losses and gains, resilient adaptations and rituals, forms of acculturation and family organization dilemmas.

The Uprooting of Meaning Systems

Personal stories, views of reality, and adaptive behaviors are all anchored in the lived experiences of one's race, ethnicity, or social class within national contexts. Perhaps the most fundamental dislocation of migration is the uprooting from known structures of cultural meanings tied to those national contexts. These structures of meanings and beliefs have been likened to the roots that sustain and nourish a plant (Marris, 1980).

The uprooting of established meaning systems and exposure to new life constructs have long been linked to various types of psychological distress for immigrants, including culture shock (Garza-Guerrero, 1974); marginality, social alienation, and psychological conflict (Grinberg & Grinberg, 1989; Shuval, 1982); psychosomatic symptoms such as palpitations, dizziness, insomnia, anxiety and depression (Warheit, Vega, Auth, & Meinhardt, 1985). Post-traumatic stress may occur if migration involved trauma; for example, for asylum seekers or for political refugees who have witnessed or have been victims of mass destruction.

Ambiguous Losses and Gains

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

inscribed in immigrants' lives, an ambiguity that must be constantly learned to live with.

Resilient Adaptations and Rituals

Most immigrants and refugees demonstrate enormous capacity for resilient adaptations. The need to reestablish a sense of coherence and make meaning out of adverse circumstances is manifested in the emergence of what may be thought of as spontaneous rituals which renew presences across absences by recreating the familiarity of old spaces, sounds, faces, smells, and other cultural rituals in the new land (Falicov, 2002, 2012, 2014a, b). These rituals of connection, recreation, memory, and cultural preservation illustrate the ambiguous nature of immigrant's losses and continued attachments. Yet, embedded in these spontaneous rituals there are resilient both/and dual visions or "solutions" that symbolize learning to live with the ambiguity of never putting a final closure to migration. Work with immigrants can greatly profit from an exploration of the place of rituals in their lives. It seems possible that either the abandonment of cultural rituals or an excessive reliance on their performance at the expense of new adaptations may signal difficulties around migration. The creation of therapeutic rituals to deal with migration issues holds promise of dealing with migration impasses (Imber-Black, Roberts, & Whiting, 2003; Falicov, 2002, 2014a, b; Woodstock, 1995).

Acculturation and Biculturalism Theories

Acculturation theory assumes that immigrants gradually shed their original culture and language in favor of a better "fit" that correlates with mainstream culture and mental health. Acculturation theory has been challenged recently after several studies indicated that immigrants from several countries who try to "Americanize," or assimilate rapidly, actually have *more* psychological problems and drug use than those who retain their language, cultural ties, and rituals, at least partially (Escobar, 1998; Falicov, 2014a; Organista, 2007; Portes and Rumbaut, 2006).

Furthermore, social ills such as drugs, alcohol, teen pregnancy, domestic violence, gangs, and

AIDS, which affect discriminated groups, appear more frequently in the second and third generations than in the first (Smorowski, David-Ferdon, & Stroupe, 2009), presumably because the initial protection of a firm cultural and family identity was still intact in the immigrant generation.

Biculturalism, a different model involving cultural alternation and hybridization is based on a different assumption than acculturation theory, that is, that it is possible to know two languages and two cultures, and to appropriately use this knowledge for different contexts without giving up one for the other, or that it is possible to integrate parts of cultures (LaFramboise, Coleman, & Gerton, 1993; Schwartz Unger, Zamboanga, & Szapocznik, 2010; Smorowski & Bacallao, 2011). Communications made possible by globalization have transformed immigration into a two-home, trans-context life style for many immigrants (Falicov 2007, 2008; Turner, 1991). Studying Mexicans in Redwood City, CA, Rouse (1992) observed a "cultural bifocality," that is, the capacity to see the world through two different value lenses, such as maintaining language and ethnic values within the family, while also learning and using English and American values when dealing with larger systems. Intrafamily conflict may emerge as family members acquire the new values or retain the old ones at different rates.

Dilemmas of cultural meanings, beliefs, and expectations are often the subtext of many individual and family consultations and may also cause misunderstandings with larger systems, including therapists' discourses. Dual visions of continuity and change or double discourses appear also in the sociopolitical arena. Double consciousness, Du Bois' (1903) description of the awareness of African Americans about who they really are in their own group in contrast with the prejudicial ways in which they are seen by others, helps to understand the feelings and experiences of living in two worlds.

Family Organizational Dilemmas

In addition to dilemmas of cultural meanings, beliefs, and expectations, migration precipitates family organization dilemmas, primarily because of separations and reunifications between extended

and nuclear family but also among nuclear family members, such as when father or mother migrates first alone to be reunited later with the children (Falicov, 2014a, b). Both men and women experience difficulties during migration and both use mechanisms that appear to follow gender socialization, such as depression or psychosomatic problems in women and alcohol dependency and violent behaviors in men.

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

Reunifications are often traumatic for all involved, especially children that may present with stomach pains, sleep disturbances, temper tantrums, or defiant behaviors that become the precipitant for clinical consultations. Among many migration-specific practice ideas are therapeutic rituals that can be used at the time of reunification to help the family bridge the absences and temporal gaps of the separations is a “catching up life narrative” (Falicov, 2014a, b). It consists of a family story-telling whereby each member presents facts, anecdotes, photos, objects, or drawings of their lives apart. Therapist and family weave all these elements in a written story form, which is repeatedly read and modified until a final product is arrived at, sometimes adding a “feed-forward” (Penn, 1985) section that predicts an affirming future family form. Apprehension about the future may be assuaged by previewing a possible more stable future where the family will continue to be together rather than suffer new separations.

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

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

Ecological Context

Paying attention to ecological context entails examining the stresses that ensue from interactions with the immediate milieu and the societal institutions. It also requires our appraisal of social networks, spiritual supports and cultural belief systems, such as locus of control about dealing with life situations.

Ecological Stresses

Bombarded with differences from the main culture, diverse minority families tend to gravitate toward elements of their own ethnicity, race, and class in urban enclaves that serve as a buffer against culture shock and discrimination. But the illusion of a safe haven may be offset by the fear of detection and deportation in the case of

undocumented immigrants, and of physical threat and social unrest in inner-city neighborhoods. Middle-class families have their own set of stresses in isolated suburbs, with pressures of competition and maintaining affluent and over-worked lifestyles.

Interactions with institutions, such as school, work, and health systems are challenging experiences for many marginalized adults and children. They may experience incompatibility between home and institutions in primary languages, difference in cognitive and relational styles, and meaning or belief systems that may cause conflict, confusion and a sense of inferiority. Teachers, employers, physicians, and therapists also experience dissonance when they struggle to understand and serve culturally diverse families. A shift from a positive to a disenchanting or oppositional attitude occurs after children and parents become aware of institutional marginalization or racism, increasing the possibility of school dropout or work unemployment (Falicov, 2014a; Ogbu, 1987; Suárez-Orozco and Suárez-Orozco, 1995; Suárez-Orozco, Suarez-Orozco, & Todorova, 2008). Practitioners need to explore the family's experiences and evaluations of larger systems interactions, whether these are teachers, priests, medical doctors, therapists, or employers and the impact of these experiences on their outlook about the present help being offered.

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

Disruption and Reconstruction of Social Networks

Relocation can disrupt the emotional support, advice, and material aid that social networks

provide for all families but particularly for impoverished families. Enduring intimate relationships, whether husband-wife or parent-child, are taxed with many more requests for companionship from each other than before (Sluzki, 1969). Lacking the watchful eye of nearby relatives, parents compensate with restrictions on adolescents' activities, which may aggravate intergenerational conflicts (Smith, 2006; Smowrowski and Bacallao, 2011). Because social networks are essential for physical and emotional well-being (Sluzki, 2008), particularly in situations of stress, therapists must assess the family's social interactions and sources of support and community involvement.

Religion, Spirituality and Traditional Healing

Religion and spirituality are the most transportable and least costly elements in the immigrant's and the minority family's knapsack. In fact, the performance of soothing rituals, such as prayer, may contain elements of resilience for many impoverished groups. The church or temple in the ethnic neighborhood also provides community support in the form of a sanctuary for undocumented immigrants, a center for crisis counseling, activist groups and community celebrations. Priests, pastors, or rabbis who officiate at life-cycle celebrations, communions, baptisms, and weddings may become resources for stability and a sense of community (Aponte, 1994; Falicov, 2009a).

For many ethnic groups, traditional healing practices and indigenous spirituality coexist with mainstream religion and medical practices. Folk healers are consulted for many common and uncommon maladies but are turned to primarily for "folk or traditional illnesses," which are often thought to have psychological or interpersonal roots. It is important for clinicians to develop non-judgmental ways of inquiring about these sources of help and assume a collaborative attitude toward them.

The use of religion or spiritual resources is one example of a positive cultural mechanism for coping with suffering that should not be automatically attributed to passive fatalism

(Boss, 1999; Comas-Díaz, 1989; Falicov, 2009a). Turning to spiritual solace can also be seen from a sociopolitical perspective. Fanon (1967) suggests that when self-determination is limited, as is the case with non-dominant groups, placing oneself under the protection of benevolent and powerful figures may help counteract fear, powerlessness, and lack of agency.

Locus of Control

The notion that little in life is under one's control is a worldview quite different than the Euro-American belief that much in life can be modified through personal will or intervention. It is important for clinicians to consider that the ecology of lower socioeconomic status can disempower individuals and limit their hopeful outlook. The belief in an external locus of control should not be taken as a deficit but rather as a realistic and philosophical form of coping by trying to accept circumstances that may be beyond one's control. This may mean an attitude of learning to live with a problem rather than insisting on resolution, a notion that may be foreign to practitioners who have internalized an optimistic positive action outlook.

Assessment and Practice Tools

A Migration Narrative

Obtaining a *migration narrative* provides the clinician an entrée into the individual members' migratory experiences, their dreams and hopes, and their strategies for coping with massive changes (Falicov, 2012; 2014a). To assess the changes in family composition and the meaning of the migration, the therapist might ask how long each family member has resided in the United States; who immigrated first, who was left behind, who came later, or is yet to be reunited; what motivated the migration and how they went about planning for it; what stresses and joys were experienced by various family members at various stages, and what strengths and resources they discovered. It is important to inquire about who was left behind and their reactions to the migration because they are also members of a social

system in transformation, affected by and affecting those who migrated.

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

MECA Maps and MECA Genograms

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

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

The MECA genograms combines the family genogram at the center, surrounded by the four rectangles describing the MECA domains as in the MECA maps. A useful permutation is to put the elements of the therapist's MECA map on the family's MECA genogram. To do this, a second set of rectangles is drawn at the bottom of the first set on the same page to

represent the therapist maps in the same four domains as the family's and to provide a quick visual comparison. Consistent with a strength-based approach, the MECA genogram provides an opportunity to discuss individual stories of struggle and triumph. These stories can provide past and present positive role models for family members. More detailed and graphic illustrations of these instruments appear in Falicov (2014a). One illustration (Figure 5.1) appears later in this chapter.

If these maps reveal that ecological constraints and tensions sap the family's strengths to cope, the clinician may temporarily become a "social intermediary" or "matchmaker" between the family and various communal institutions (Falicov, 1988, 2013; Minuchin, 1974). The clinician can help the family mobilize to use existing networks or facilitate building new reciprocal ones. Priests may offer spiritual support, particularly when dealing with physical illness, old age, and death. Relatives or compatriots can be advocates for a child or for the family in dealing with institutions and a temporary relief for parents. The aim is to collaborate in empowering the family to deal with larger systems and insist on receiving adequate services.

Family Organization

Cultural preferences and limited financial resources have traditionally motivated families from impoverished countries (many Latin American and Asian countries) and discriminated groups (African Americans, or single mothers) to live in close proximity to extended family networks that can provide emotional and practical support. They form a larger kin and kith network than the isolated nuclear middle-class family, that is, the prototype of family psychology depictions of normal family life. Family compositions and definitions of who is a family member may differ from the mainstream (Watts-Jones, 2010) and in the case of immigrants it is useful to explore the family network they had in their countries.

Traditional family organization affects family bonds along several dimensions of interaction: a) collectivism and individualism; b) gender and

generation hierarchies; c) communication styles and emotional expressivity (Falicov, 2014a).

Collectivism and Individualism

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

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

The process of separation/individuation, so highly regarded in American culture, may be de-emphasized in other cultures in favor of close family ties. Deficit views tend to pathologize this type of family closeness and label it as enmeshment. However, family closeness may reflect cultural interactional preferences that contribute to resilient adaptations. Furthermore, in traditional settings, individuation may take place while blending with family closeness, via marriage,

work, or simply having personal opinions and a sense of personal self along with a familial self. Therapists who insist on stressing the client's individual needs as pitted against family needs may run counter to internalized cultural preferences.

Gender and Generation Hierarchies

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

Unquestioned respect for authority runs counter to the democratic, egalitarian discourses of psychotherapists, who may negatively judge parents who are showing concern and caring according to their cultural ways or they are simply using the only repertoire of childrearing practices to which they have been exposed. The parents may also react and negatively judge the "permissiveness" of American society, perhaps unwittingly personified in the individualistic democratic discourses of the clinical practitioner. Transparency in the therapeutic dialogue helps clarify the benevolent intent on both sides. Even in patriarchal systems, a child's well-being is the responsibility of both parents and therefore even traditional men can be persuaded to participate in conversations about children's well-being.

While a patriarchal view of gender roles persists among many Asian, Latin American, and other immigrants, more complex transitional dynamics are evolving. For example, a double standard of gender socialization and sexuality persists (Falicov, 1992, 2010, 2014a), yet it has long been documented that decision-making often is shared by both parents, or it may involve a process in which the mother alone, or the father alone commands much authority (Kutsche, 1983; Ybarra, 1982).

Immigrant and ethnic family life is increasingly characterized by a wide range of structures and processes, from patriarchal to egalitarian, with many combinations in between. It is not

unusual to encounter situations where the father tries to exert authority by disciplining the children and compelling them to obey the mother, while she tends to defend and protect them. This interactional pattern may generate father-mother-child triangulations that need to be seen culturally and contextually, rather than simply regarded as "pathological." Triangulations may be successful in resolving conflicts indirectly in ways that are culturally syntonetic even if they run counter to family therapy notions about generational boundaries, as when a family member asks another to intercede in a conflict rather than confronting her or his opponent directly (Falicov, 1998).

Communication and Emotional Expressivity

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

Because of power differentials and respect for authority, clients may feel that it is impolite to disagree with the therapist. Encouraging the family to express their reactions, both positive and negative, to the therapist's opinions helps to establish a tone of mutuality. Manifesting real interest in the client, rather than gaining data via referral sheets, or obtaining many behavioral details about a problem is essential to build personal relationships that carry emotional expressivity.

Cultural preferences along three elements of traditional cultural discourses, namely, collectivism, hierarchies, and indirect communication, may stir up dilemmas when younger generations incorporate Euro-American discourses, or when the family comes in contact with the institutions of mainstream culture such as the values upheld

by psychotherapists. The appropriate role for clinicians is to become a *cultural family intermediary* (Falicov, 1988, 2013). Traditional value preferences can appear to be constraining to individual development, but clinicians should not assume that their cultural preferences are objectively better. Professional discourses are often based on mainstream values, such as individualism, that should not be privileged or imposed. Working toward changes in family organization discourse is only valid if it stems from informed collaboration with specific clients.

Family Life Cycle

Families from diverse cultures and socioeconomic levels may differ from the dominant interpretations of the life cycle. The meaning of the stages and transitions, the developmental tasks and the rituals of the individual and the family life cycle may all be heavily guided by culture, custom, and traditional practice (Falicov, 2005, 2014a). How the life cycle is lived is highly dependent not only on cultural mores but also on the totality of a family or individual ecological niche. For example, the timing of procreation may be significantly different for gay men and women who, given societal discrimination, may need to arrive to an older and settled period of the life cycle to engage in parenting when compared to heterosexual couples, who readily meet societal approval for their union and procreation.

Many groups may differ from the dominant culture's view of the life cycle by experiencing a longer state of interdependence between parents and children and a more relaxed attitude about children's achievement of self-reliance skills (these attitudes are often mistaken for overprotection); the absence of an independent living situation for unmarried young adults; the absence of an "empty nest" syndrome or a middle-age crisis and a refocusing on marital issues; and a continuous involvement, status, and usefulness of elders in the family. Any of these traditional developmental expectations may persist alongside the new considerations of individual pursuits and romantic love espoused by the younger generations, sometimes causing intergenerational tensions.

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

Some developmental impasses can be linked to the stresses of migration. Leaving home can become more problematic when parents have depended on their older children to be intermediaries with the larger culture. Younger siblings, too, may cling to an older one who appears to be more culturally understanding than the parents. Normal life-cycle events, such as the death of a loved one, either in the country of origin or the adoptive country, may precipitate additional stress by rekindling the ambiguities of migration and the questioning about the wisdom of being so far away from loved ones (Falicov, 2014a).

Because professional discourses often embody different cultural expectations about how to navigate life-cycle stages and transitions, therapists need to be aware and self-reflexive about their own normative evaluations about age-appropriate behaviors in their clients. Once the life-cycle dilemmas within the family or with other institutions are deconstructed and discussed, the clinician may attempt to become a "cultural mediator," encouraging conversation between parents and offspring about developmental expectations and their loyalties to both cultures.

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

Gender differences also appear in perceptions of life-cycle meanings. While studies of twenty years ago reported a slower pace of language cultural change in immigrant women than in men, more recent studies indicate that

women adapt to cultural changes faster than men. Women are not only more likely to adopt new life-cycle values, particularly those that grant them greater personal freedoms such as employment or divorce, but they also may become more inclined to settle in this country than they did in the past even against their spouses' wishes (Hondagneu-Sotelo, 1994).

Case Illustration of MECA Assessment and Clinical Practices

The clinical case that follows illustrates the use of MECA domains for assessment and intervention relevant to the issues the family presented. The MECA genogram in Figure 5.1 summarizes the main issues found in the four MECA domains.

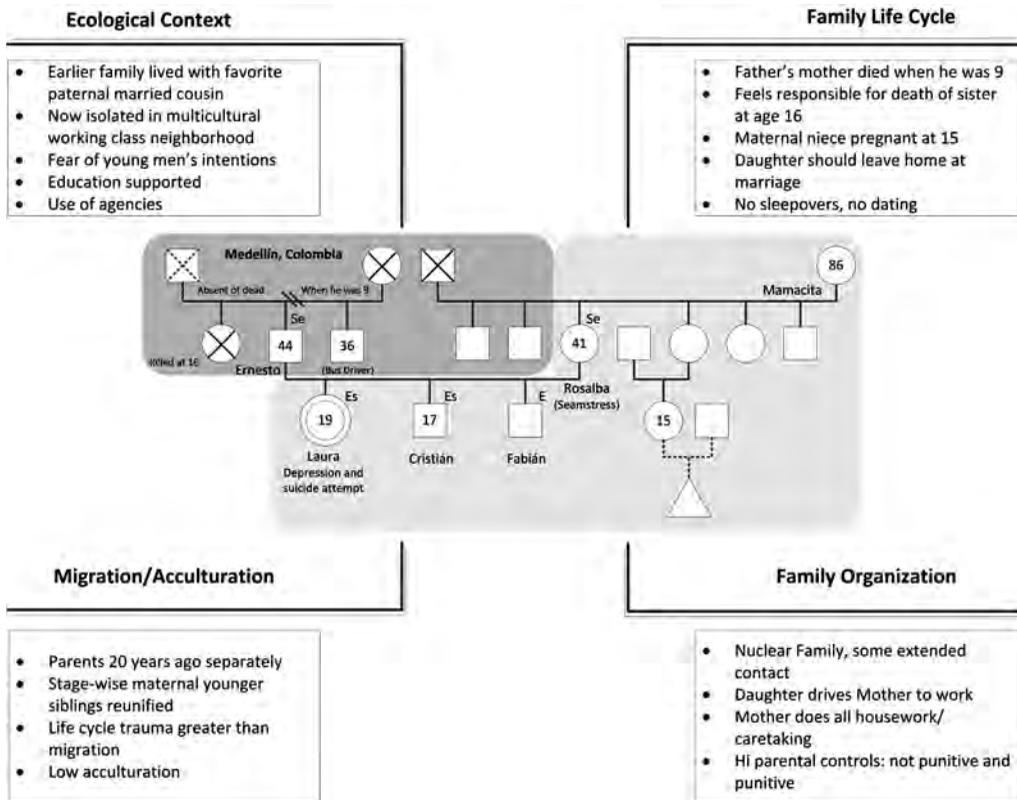


Figure 5.1 MECA Genogram of Gordillo-Ríos Family

Presenting Problem and Precipitant. The Gordillo Ríos, a Colombian family, came to therapy for depression in their 19-year-old daughter, Laura. She had recently made a suicide attempt by ingesting a bottle of aspirin and a box of Sudafed pills. This attempt had followed an altercation with the parents when they prohibited Laura from spending a planned night at a friend's house, allegedly because the friend's parents had gone out of town. Laura appeared as an obedient

daughter who always said yes to her father's rules of arriving home before 10pm and always said yes to her mother's request that she call to let her know where she was and at what time she was returning home. Yet, she not always truly complied, as she often came later than agreed upon, forgot to call and avoided answering her cell phone when called by her mother. Sometimes she came in at 2 or 3am, staying chatting with friends in a car or at somebody's home.

Migration. From the migration narrative we learned that the parents had migrated in their late teens separately twenty years ago, the mother with other family members, the father alone. The families had reconstituted in the migration trajectory and therefore there was little contact and sense of loss related to the country of origin. The children were all born in the United States but Laura had been more steeped than her brothers in the parents' extended family, particularly because the maternal grandmother lived with them and shared a room with Laura for many years.

Ecological Context. When asked about their controls on Laura, the parents said the neighborhood had many dangers. Being a bus driver in this neighborhood, the father gave many negative examples of young men's bad behavior toward young women. Laura's mother argued that when she was Laura's age, she would only occasionally go to a dance and only if she was chaperoned and did not understand why Laura wanted to be out so much. Money was tight particularly in a precarious economy and the parents felt that Laura's phone and car gasoline were additional unnecessary expenses.

Ecological Fears. The parents had many examples of dangers in the neighborhood, humiliation, and dating violence in the lives of girls. They did not feel that they had a protective social network to rely on either. Their cultural preferences were certainly exaggerated by their ecological fears.

Family Organization. The father tended to dominate the session by lecturing the daughter about why she needed to come home earlier. In a condescending way, he also lectured the mother and the daughter about how to manage their relationship and how the mother could be more clear about rules regarding Laura's activities. The parents believed that Laura should know the rules about a girl's appropriate behavior, and did not believe that Laura's depression could be related to the parental controls.

Parent-Adolescent Cultural Differences. Laura found the gender treatment differences between

Cristián, her 17-year-old brother, and herself to be intolerable. He was allowed to come home late at night after drinking, going to dances, and spending time in the back of cars with girls. To add to the controls, this younger brother had been designated by the parents to supervise Laura's activities when boys were around. When Laura would finally express her frustration to her parents over the obvious "double standard," her parents would get mad at her for her "disobedience" along with intimations that she was on the brink of becoming a woman of ill repute, "una loca" (a somewhat loose or crazed woman) for wanting to go out with her friends at night. One time they gave her a slap in the face. But these accusations were not typical, more frequently the parents said they distrusted others, such as her friend's parents for going out of town and leaving the young women unsupervised. The parents' rigid stance was compounded recently by the fact that Laura's cousin, Gloria, had recently become pregnant at 15. One time Laura wanted to develop a friendship with a male coworker in her summer job, and invited him to the house to watch TV with everybody. But the parents became uncomfortable because they thought that they were touching the sides of their arms when sitting in the couch. In their estimation, the most minimal physical contact would stimulate a young man's temptations and therefore work against Laura's safety. Parents recognized that "our mentalities are different than hers," but believed that it was Laura who needed to comply.

Family Life Cycle. Later on, the father revealed that his life-cycle trauma related to migration was not as "significant as his own mother's death," in Medellín, Colombia when he was nine years old, a loss of a different magnitude that was followed by other family losses. At that time, his father became more intensely involved with alcohol and eventually abandoned the children. Being the oldest child, Laura's father took over the enormous responsibility to raise his siblings. At age 16, his sister who was a year younger than him stayed out for the night and suffered a violent street

death. He was devastated and could never forgive himself.

Thus, personal narratives and realistic ecological context risks, along with aspects of cultural family organization, all were converging on the father's fears and controlling behavior toward Laura.

Separation Anxiety. Laura was going to community college and the parents did not predict that she might leave San Diego after school. Rather they thought she would always be around to help them. The mother had never learnt to drive and Laura drove her everywhere, having to plan her schedule according to the mother's. Both parents could not sleep at night if Laura was out and many of their interactions revolved around worrying over their daughter being out. They both complained bitterly about their anxiety caused by not knowing where Laura was, but were not aware of the possibility that their deeper anxiety over a future separation and over past family losses may have been playing a significant role.

Practice Ideas for the Gordillo Ríos Family

The MECA domains assessment of the Gordillo Ríos family revealed that migration issues were no longer at the forefront of family concerns, but were now represented in ecological context, family organization, and family life-cycle stressors. In a recent publication (Falicov, 2014a), I have described how immigrant parents, through a combination of cultural differences, ecological fears and separation anxiety with their adolescent children, exert very tight controls when the time approaches for a major developmental shift toward granting more autonomy to the teenager. I have shortened these three elements to the acronym CEFS (Culture, Ecological Fears, and Separation Anxiety), three elements that are highlighted in this case description.

Laura's depression could be interpreted in the context of parental constant surveillances that were blocking her desires for greater autonomy. Later, Laura said that "everything" could

be resolved "if only they [her parents] would give me some space." Laura could be thought as *encerrada* or "lockdown" (Smith, 2006). Her parents were concerned and involved, caring in many ways and supportive of her studies, so she wanted to please them. But they also treated her with such immutable controls that she felt she could not have a normal life like all the young adults she knew (Zayas, 2011).

The clinical practices for this case included the therapist acting as a *cultural family intermediary* and labeling their difficulties as issues of cultural transition that besieged them. I articulated the legitimacy of the parents' concerns and of Laura's need for more space to grow up. They were all encouraged to reach compromises between polarized positions with specific tasks such as the parents allowing Laura more freedom than they had been giving her. In exchange, Laura will let the parents know her whereabouts and her friendships, stressing *quid pro quo*s and the notion of reciprocity. In relation to the issue of cultural differences within the family, Laura was able to find online helpful self-help books for Latina teens that shared her predicament. Family strengths were emphasized, such as caring, wanting the best for each other, and having raised very good children that were torn between pleasing parents and/or responding to societal preferences outside the family.

Summary

Deciding about sameness and difference between cultures, races, and ethnicities is not so simple because gender, class, sexual orientation, religion, nationality, and even cohort (the historical generation into which a person is born) all contribute to an individual's identity. A Multidimensional-Ecosystemic-Comparative Approach (MECA) assists clinicians to orient themselves to this array of factors related to an individual's cultural and sociopolitical diversity. There are three constructs embedded in the definition of multiculturalism and diversity, they are: a cultural diversity lens, a sociopolitical lens, and an ecological niche. A *cultural diversity lens* promotes respect for clients' cultural preferences and critically examines

existing models of families and theories and techniques used in psychotherapy with a view to their application to minority clients. A *social political lens* focuses on the effects of power differentials in societal discrimination on individual and family well-being and on the relationship between clients and therapists. The construct of *ecological context* stirs practitioners toward a complex cultural description of each client and each clinician by taking into account the multiplicity of contexts to which each one belongs and their areas of overlap or cultural consonance and dissonance.

The four domains identified in MECA are migration and acculturation, ecological context, family organization, and family life cycle. MECA is based on the belief that the contents of these domains are culturally constructed but that the domains themselves as general phenomena probably exist in all societies. It is important for clinicians to obtain information about the four domains in MECA throughout therapy in order to fully understand an individual's identity and culture and how presenting issues may be connected with cultural dilemmas and contextual sociopolitical stressors.

A more beneficial approach when using MECA with diverse clients is combining a "not-knowing" stance with "some-knowing" or information about specific cultures, including the clinician's own culture as this may allow for more complexity and effectiveness. A focus on family strengths complements this approach. This chapter also includes suggestions for clinical assessment and interventions and an extensive clinical case illustration.

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