

CHAPTER

3

Critical Challenges

Ethnicity, Gender, Violence, and Sexual Orientation in Families

INTRODUCTION

In the late 1970s and early 1980s, marriage and family therapy was well established and had become a legitimate profession. Once this occurred, it turned its critical lens on itself and became self-reflective. As a profession, marriage and family therapy has had a long history of being critical of established theories of psychotherapy. It was family therapy's criticism of the linear perspective that helped establish family therapy as a legitimate endeavor. When the profession did turn its critical lens inward, the focus was on issues of diversity, specifically gender and ethnicity. In the 1990s, the profession looked at issues of sexual orientation and domestic violence. These critiques led several theorists to question some of the core ideas of general systems theory. While these questions are being discussed in literature and at professional meetings, systems theory remains the foundation for specific schools of family therapy. The field still concerns itself with the study of homeostasis as maintained through feedback. The critiques have sent many theorists back to the drawing board, but they have not produced a paradigm shift. This chapter examines issues of diversity, gender, violence, and sexual orientation.

Periodically, it is healthy for a profession to look at its context, and yet family therapy largely ignored its own context for several decades. This seems to have occurred for two reasons. First, the context of the profession was missed by most theorists as they tried to describe the context of their clients. Second, during the early period, the profession was struggling with legitimacy.

Focusing a self-critical lens on a fledgling discipline might have been seen as dangerous when the profession was receiving criticism from the outside. Only with the profession's increased status and legitimacy as a mental health discipline was the field mature enough to take a long, hard look at itself.

These views include minority issues. As members of the dominant culture, the founders of the profession were mostly white, middle-class males who developed theories with their culture in mind. As the field developed and women and minorities became involved in the profession, theories and techniques were taken to the margins of our society. It was in these margins of society that the theories broke down. It was also at the margins that the critiques of family therapy took hold.

A CRITIQUE OF ETHNOCENTRICITY IN MARRIAGE AND FAMILY THERAPY

Until the 1980s, this country was seen as a melting pot of cultures. The dominant story was of settlers moving from their native lands to America, the land of freedom and opportunity. Driven from their homelands by oppression, the new settlers in America were eager to adapt to American culture. This mythology prevailed for a significant portion of the past century.

Part of this mythology is that America was a democratic society that, by shedding the tyranny of a monarchy, was able to create a meritocracy. A meritocracy is a society where social position is based on the contribution of the holder of that position. This is a Darwinist view of the wider social hierarchy that tends to miss the role of class in American society. Issues of race and class have a large impact on one's opportunities, but racism and ethnocentrism, though dominant forces in American history, were largely ignored. Slowly, the melting pot ideal has been replaced by a pluralistic, multicultural view. One significant factor in this evolution has been the social movements that started in the 1960s and have been raising our consciousness since. Also, the proliferation of the mass media has made this a smaller world by bringing many cultures and experiences into our homes.

Family therapy seemed to be off to a good start in recognizing the role of class in a family's experience with the 1967 publication of *Families of the Slums* (Minuchin, Montalvo, Guerney, Rosman, & Schumer). Minuchin brought his ideas and experiences of working with urban New York families to Philadelphia when he became the director of the Philadelphia Child Guidance Center. There, he started to train members of the local black and Latino populations to be paraprofessional therapists. These therapists had an easier time establishing credibility with their clients because the perceived differences between them were not as great.

In 1982, McGoldrick, Pearce, and Giordano brought ethnicity to the forefront of family therapy with the edited volume *Ethnicity and Family Therapy*. In her opening essay, McGoldrick (1982) eloquently sums up the state of family therapy:

It seems so natural that an interest in families should lead to an interest in ethnicity. 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. (p. 3)

She argues that an ethnically sensitive therapist must have an understanding of the shades of meaning a culture presents in order to understand a family's situation. From this perspective, the therapist's role "will be that of a cultural broker, helping family members recognize their own ethnic values and to resolve the conflicts that evolve out of different perceptions and experiences" (p. 23). The therapist works from within the family system.

To facilitate the understanding of different cultures, the first edition of *Ethnicity and Family Therapy* (McGoldrick et al., 1982) presented essays on some 20 different cultural groups. These essays were designed to provide therapists with an overview of the significant issues one might face when working with a family from a particular cultural group. In recognizing the potential limits of one's ability to understand different cultural groups, McGoldrick (1982) states that one cannot understand all family types. She also states, "What is essential for clinicians to develop is an attitude of openness to cultural variables and to the relativity of their own values" (p. 27). The second edition of *Ethnicity and Family Therapy* (McGoldrick, Giordano, & Pearce, 1996) expanded on the already significant contribution of the first edition and provides 47 essays on different ethnic groups. This resource belongs in every family therapist's library.

To further your willingness to examine your own culture openly, let us start to develop a cultural awareness by looking at African American families, Latino families, and Asian American families. These three groups represent the largest ethnic groups in America. As you will see below, these groups are collections of different nationalities. If one thinks about differences further, it is possible to see the national view of ethnicity as inadequate. Regions of nations have rather different cultures. In fact, people of different socioeconomic means have different experiences, even when they are from the same ethnic background. In no way is this list exhaustive, but it will serve as a beginning of cultural knowledge for family therapists.

African American Families

African American families are unique in that, by and large, their immigration to this continent was not by choice. They were brought out of Africa in slavery and pressed into unpaid labor. While slavery has been outlawed for over a hundred years, oppression and exploitation still prevail. Consistently, African Americans have less average income, nearly double the unemployment rate, an increased number of deaths due to homicide, a lower rate of college and university enrollment, and a decreased life expectancy when compared to their white counterparts (Hines & Boyd-Franklin, 1996).

Given the long history of oppression, early researchers viewed the African American family pejoratively as disorganized and pathological (Deutsch & Brown, 1964; Frazier, 1966; Moynihan, 1950). Starting in 1970 with Carol Stack's ethnography *All Our Kin*, researchers studying African American families have focused on the families' initiative in the face of adversity. More recently, Boyd-Franklin (1989), Hines and Boyd-Franklin (1982), McAdoo (1981), and Staples (1994) have continued to question the deficit view of African American family life. Clearly, when viewed in the context of their history and current oppression, the accomplishments of African American families are exemplary. The sense of kinship and pride in "Blackness" is a testimony to the strength of families.

African American families are also noted for strong kinship ties. According to Nobles (1980), a tribal mentality prevails in African philosophy where the phrase "We are; therefore, I am" contrasts with more European notions of family. Relatives often live close to one another and share child rearing responsibilities. Kinship ties often go beyond blood ties to include family friends, who are referred to as aunts and uncles; boyfriends; girlfriends; deacons; preachers; and others. To the majority of African Americans, kinship means that one can expect support from others and is expected to give support in times of adversity. There is a great sense of obligation to one's kin. Children can be transferred to relatives when situations become problematic. For example, when a teenager gets in trouble with gangs, the family may send the child to live on an aunt's farm in a rural area, thus effectively cutting off the gang influence.

It will often take a degree of detective work on the part of a non-African American therapist to find all significant nonblood kin ties. Too much curiosity on the part of the therapist can make the family suspicious. (Suspiciousness is understandable when one considers the significance of the "Tuskegee study." Over a period of four decades, the government studied syphilis in black males by withholding treatment from the subjects without their knowledge or consent.) While a genogram (McGoldrick & Gerson, 1985) is a useful tool for collecting data on a client's kin network, Hines and Boyd-Franklin (1996) caution that "genogram information should be gathered only after the therapist feels that he or she has a bond of trust with the family" (p. 71).

In African American families, the identity of a man is often a function of his ability to provide for the family. Thus, many black men work several jobs. While it is important for therapists to include the family's significant males in the therapy process, the therapist must be flexible in scheduling appointments so the male clients can attend. Hines and Boyd-Franklin (1996) suggest using phone contact and letters to keep the father apprised of progress in therapy, thereby reducing the likelihood of sabotage.

Eye contact is another issue one should be aware of when working with African American men. In this ethnic group it is a sign of deference not to make eye contact, especially with other men. Often, they will choose to wear sunglasses during a session. A therapist who confronts them about their lack of eye contact or insists that they remove their glasses will be viewed

with suspicion. Likewise, an African American man is likely to be very quiet during a session. This may be due to deference, but can be easily misinterpreted. A home visit where a seemingly mute client has a home turf advantage may go a long way toward opening up dialogue between client and therapist (Jones & Seagull, 1977). Franklin (1993) talks of an “invisibility syndrome,” where, out of fear, whites treat African Americans as if they are invisible, further marginalizing them. This speaks to the need for white therapists to be aware of and overcome this tendency.

In contrast to their male counterparts, African American women are often seen as central to the family and often have identities tied to the roles of mother and grandmother. Work outside of the home is no stranger to these women. Frequently, they have been the sole breadwinners for a period of time. Willie (1981) and Willie and Greenblatt (1978) credit this to the fact that African American families tend to have more egalitarian relationships than Caucasians. Furthermore, African American women tend to identify to a great degree with their spiritual life, and church can be a central influence in their lives.

African American families often seek therapy out of concern for their children (Hines & Boyd-Franklin, 1996). Problems with children are often identified at school, on which African American families put a great deal of emphasis. Recognizing the decreased opportunities for their children, African Americans are often very strict and commonly use corporal punishment to control them. “Sparing the rod” and rearing a child that is ill prepared for the challenges of the world are often central concerns. A therapist who responds negatively to the parenting style can drive a family from therapy. Hines and Boyd-Franklin (1996) suggest that, “rather than argue for the elimination of physical punishment, the therapist can expand upon parents’ understanding that this practice is a residual of slavery, as well as teach and emphasize the benefits of positive, alternative approaches” (p. 80).

Latino Families

The Latino population has grown at an incredible rate over the past few decades. At the time of the 2000 census, there were over 35 million people of Hispanic origin in the United States (Guzmán, 2001). This number is much higher if one considers that there are many more Latinos who have entered the United States illegally and are undocumented and uncounted. According to Garcia-Preto (1996), Latinos are the fastest-growing ethnic group in America. However, as Garcia-Preto points out, this increase in number does not result in an increase in status. In fact, oppression is increasing as public assistance is discontinued for people without legal standing and as bilingual education is being threatened.

Mexicans, Puerto Ricans, and Cubans are the three largest Latino groups in the United States. Latinos from nations in Central and South America have immigrated for economic opportunity or, more recently, as war and civil unrest refugees. We will review some of the therapeutic issues

facing Mexican, Puerto Rican, and Cuban clients. In no way will this be an exhaustive review, and there is a need to recognize differences in these groups. I encourage family therapy students to read further on the specific Latino groups. The second edition of *Ethnicity and Family Therapy* (McGoldrick et al., 1996) contains a comprehensive review of Cuban (Falicov, 1996), Puerto Rican (Garcia-Preto, 1996), Brazilian (Korin, 1996), and Central American (Inclan & Hernandez, 1992) people.

Mexico's borders originally contained what is today New Mexico, Texas, California, Nevada, and Utah and part of what are now Arizona, Colorado, Kansas, Oklahoma, and Wyoming (Calvert & Calvert, 1993). Many of the early missions have become major Southwestern cities. As Mexico lost land to the United States, the inhabitants found themselves foreigners in their own land, and lost civil rights and private property (Falicov, 1982). Most Mexican Americans are a mix of the early Caucasian settlers and Native American tribes, including Mayan, Aztec, and Hopi (Novas, 1994). The first major wave of immigrants came around 1900 as an attempt to escape the Mexican Revolution of 1910 (Shorris, 1992). According to the 2000 census, there are 8.4 million Mexican Americans living in California alone (U.S. Census Bureau, n.d.). While some Mexican Americans have become financially successful, the majority live below the poverty line (Garcia-Preto, 1996).

Puerto Ricans are the second-largest Latino group in the United States. At the time of the 2000 census, there were 3.4 million Puerto Ricans living in the United States (Guzmán, 2001). The largest concentration resides around New York City. Puerto Rico is an island possession of the United States, and as a result, Puerto Ricans have been U.S. citizens since 1917. Despite citizenship, the majority of Puerto Ricans in the United States live in poverty. According to Garcia-Preto (1996), "Drug addiction, alcoholism, and AIDS have plagued the Puerto Rican population at home and on the mainland" (p. 147).

Cubans are the third-largest Latino group in the United States and the most recent immigrants. At the time of the 2000 census, there were 1.2 million Cubans in the United States (Guzmán, 2001). Concentrations are in Florida, New Jersey, California, and New York. They started to emigrate to the United States in the early 1960s after Castro came to power. The first immigrants were mainly of European ancestry and came from upper-class backgrounds. Later immigrants were of mixed race and economically disadvantaged. While Cubans are some of the most economically successful of the Latino groups, their average family income still falls short of the national average (Novas, 1994).

For the most part, Latinos are members of the Roman Catholic Church. According to Garcia-Preto (1996), "there is an emphasis on spiritual values and expressed willingness to sacrifice material satisfaction for spiritual goals" (p. 151). This is related to a deep sense of family and commitment to the honor of the family. This family connection can be confusing to a non-Latino therapist, who might view this strong connectedness as a pathology by labeling it enmeshment. Related to Latinos' loyalty to the Catholic Church is a general respect for authority. This can lead

to difficulty in asserting their rights, which is more pronounced for those who are here illegally, as there is political backlash against those without legal status (Garcia-Preto, 1996).

Latino families have a strong extended structure where several generations may live together. They have a more pronounced division of labor based on gender and, as a result, have stronger gender roles than white, middle-class Americans. It is this extended family that first comes to the aid of a Latino family. Formal therapy is often not sought before the situation becomes desperate, and, even when presented to the therapist, the problem is minimized out of respect for authority. Korin (1994) suggests that eliciting, listening to, and validating stories about the family's life in this country helps contextualize their struggles. Garcia-Preto (1996) suggests that families' sense of culture shock and lack of context be addressed as a therapeutic issue.

Asian American Families

White, middle-class people tend to identify Asian Americans as one cultural group. However, Lee (1996) identifies Asian Pacific Americans as being divided into 43 distinct ethnic groups. Like other ethnic groups, these groups are experiencing a period of rapid growth in the United States, from 1 million in 1960 (Lee, 1996) to over 10 million in 2000 (Barnes & Bennett, 2002). Each of these 43 ethnic groups has a unique immigration history. Some came to the United States seeking economic opportunity, while others came as war refugees seeking to escape persecution. There are at least 32 languages spoken by Asian Americans, with even more dialects, making this an even more diverse group (Lee, 1996). Asian Americans practice many religions of Eastern and Western origin. Despite the great degree of diversity within this group, common characteristics can be identified that lead to some suggestions for treatment.

According to Lee (1996), "in traditional Asian families, the family unit—rather than the individual—is highly valued" (p. 230). This belief is highly ritualized in cultural and family customs. Given this, a person's acts reflect not only on himself or herself, but also on the family and all ancestors (Shon & Ja, 1982). Thus, shame and obligation are a social control mechanism to keep family members in their prescribed social role. These roles are based on age, gender, birth order, and social class. Role reversal is a common stressor in Asian American families. It is often the children who first learn English, making the parents dependent on their children for assistance in dealing with issues of acculturation. In addition, role reversal can occur when women are more able to find employment than their husbands.

In many traditional Asian families, marriages are arranged. The Western notion of marriage for love is not an issue in Asian families. Despite this, divorce is not common in Asian American families. Parent-child relationships are more dominant than the husband-wife relationship (Lee, 1996).

Traditional Asian American families have role structures similar to stereotypical American families of the post-World War II era. Males assume roles as authoritarian, provider,

protector, and disciplinarian. Females assume roles of homemaker, child bearer, and nurturer. According to Lee (1996), “most parents demand filial piety, respect, and obedience from their children” (p. 231). Most families are extended in structure, including members from three or more generations.

Uba (1994) has shown that Asian Americans have occurrences of mental illness at rates equal to or higher than those of Americans of European descent. According to Lee (1996), Asian American families commonly present with parent–child problems, marital discord, in-law problems, and other domestic problems. Asian American individuals are likely to present with somatic complaints, depression and anxiety, adjustment disorder, schizophrenia, alcoholism, drug addiction, gambling, and suicidal ideation (Lee, 1996). Uba (1994) has identified six factors that predict mental health problems in Asian Americans: (1) financial status, (2) being a woman, (3) old age, (4) social isolation, (5) recent immigration, and (6) postmigration adjustment. Sue and McKinney (1975) have found that Asian Americans who use mental health services are more disturbed than their European counterparts. This is an indication that Asian Americans are likely to delay getting help until problems have become quite intense. Lee (1996) identifies five types of data that should be collected when assessing an Asian American family: (1) demographics, (2) data on the family system, (3) data on the community system, (4) pre-immigration history, and (5) immigration history.

There are several ideas to keep in mind when working with Asian American families. First, many Asian Americans do not accept a Western biopsychological explanation of mental illness (Lee, 1996). Thus, it is important to discuss with the family what they see as the cause of difficulty. Second, it is essential to keep in mind the role of shame in Asian American families. Questions asked about men may be seen as an attempt by the therapist to shame the family. Third, it is best not to use children as interpreters in families where the children speak English (Lee, 1996). Using the children as interpreters would further invert the system. Finally, it is necessary to keep in mind that the Western notions of self-disclosure and verbal expression may counter Asian American values (Lee, 1996).

Several authors have recommended specific approaches when working with Asian American families in therapy. Kim (1985) has developed an approach based on an integration of strategic and structural therapy. Ho (1987), in an approach based on the theories of Satir and Bowen, teaches families to recognize unspoken rules. Paniagua (1994) and Sue and Zane (1987) do an outstanding job laying out the fundamentals of working with Asian Americans.

Table 3.1 summarizes key points to keep in mind when working with African American, Latino, and Asian families.

TABLE 3.1**Summary of Key Differences in Working With Three Ethnic Groups**

<i>Issue</i>	<i>African American</i>	<i>Latino</i>	<i>Asian</i>
Immigration pattern	History of slavery	Fastest-growing ethnic group, both legally and illegally	Diverse immigration pattern
Gender roles	Egalitarian roles	Traditional gender roles; pronounced division of labor by gender	Traditional gender roles
Spirituality	Strong spiritual orientation	Predominantly Catholic	Diverse Western and Eastern religious practices
Child rearing practices	Strict parenting style	Often the responsibility of females	Practices focus on obedience to family and ancestors
Clinical issues	<ul style="list-style-type: none"> • Therapist needs to be flexible to get men to attend • Men may not make eye contact • Therapy often focuses on children 	<ul style="list-style-type: none"> • Addiction • HIV/AIDS • Strong family connection can be confused for enmeshment • Therapy may not be sought until family is in crisis 	<ul style="list-style-type: none"> • Extreme pressure not to shame family • Western view of mental illness may not be accepted • Using children as interpreters inverts family structure
Strengths	Strong kinship ties	Deep sense of family	Low divorce rates

LEARNING EXERCISES

1. Talk to a member of an ethnic group that is different from yours. Pretend you are an anthropologist trying to understand the person's culture. Ask her to tell the story of how her family came to live in this country. As she is telling the story, pay attention to themes that emerge. Ask the person how she maintains her culture in this country. How does she try to fit in with mainstream American culture? As you ask the person questions, be sure to probe for as much detail as possible. Pay attention to the types of questions that open up the flow of information.

2. Trace the ethnic ancestry of your family of origin. Talk to the most senior members of your family that live in this country. How did the ancestors who immigrated reach the decision to come to this country? How did they get here? If your family is of mixed ancestry, ask how the family mixes the cultures. Ask what works for the family and what is difficult.
3. Attend a religious service at a church, synagogue, mosque, or temple that is not familiar to you. Observe the rituals and try to infer their meaning. After the service, talk to a member of that religious group. Ask him to interpret the meaning of the symbols in the rituals. How similar or dissimilar are they from the symbols and rituals in your own religion? After you have an understanding of the key beliefs of that religion, reflect on how your life would be different if you had these fundamental beliefs. Spend a day reflecting on this at different times.

A CRITIQUE OF GENDER BIAS IN MARRIAGE AND FAMILY THERAPY

Unlike the ethnic critique of family therapy that came about over time, the gender critique of family therapy struck like a whirlwind. A single article published in *Family Process* 30 years ago triggered this critique of family therapy. Rachel Hare-Mustin (1978), an associate professor and director of a community counseling training program at Villanova University, published an article titled “A Feminist Approach to Family Therapy” that set off a rethinking of the role of gender in family therapy.

Two features differentiate feminist family therapy from other forms of therapy, such as the gestalt and humanistic therapies, which seek to enhance the self-esteem of the client by exploring his or her social roles. Although “these approaches may encourage individual development free of gender-prescribed behaviors, . . . they do not (a) examine nor (b) seek to change the conditions in society that contribute to the maintenance of such behaviors” (Hare-Mustin, 1978, p. 182).

Family therapy initially moved the focus off of the individual and onto the society. With the feminist critique, society has become the patient in family therapy. This view calls on experts educated in the behavior of societies, such as sociologists and anthropologists, to provide information relevant to therapy. Not only has the profession of family therapy come under critique, but American society has also undergone scrutiny.

Historically, changes in the family that occurred during the industrialization of America set the stage for the current structure of the family. Families became dependent on work outside of the home for their economic means. This increased the family’s need to divide labor. As Hare-Mustin (1978) points out, “where productivity was rewarded by money, those who did not earn money, such as women, children, and old people who were left at home, had an

ambiguous position in the occupational world” (p. 182). Given this, the roles of women shifted to being almost exclusively responsible for child rearing and household labor. Not only was there an increase in the division of labor, but the gender roles became more rigid.

This gender-based division of labor was described as early as 1955 by Parsons and Bales. Taking a structural functional stance, Parsons and Bales (1955) described the division of labor in a family where women engaged in expressive roles and men engaged in instrumental roles. Expressive roles allowed for the expression of emotion in the family environment. Parsons and Bales saw this role as necessary to provide for the maintenance of family cohesion and for nurturance of the children. This left men to provide labor outside of the home in exchange for money. Men provided for the instrumental needs of the family, such as food, clothing, and shelter. This labeling set up two conditions that are of concern to feminists. First, it put women in charge of emotional expression in the family, making them increasingly susceptible to emotional distress. Second, it set up a situation where it became very easy to blame mothers for the emotional distress of their children.

Gender and Mental Illness

Women are much more likely to suffer from a mental illness than men. If we look at the text revision of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR;* American Psychiatric Association, 2000), we see that, except for sexual disorders that are specific to men, there is an increased frequency in mental disease among women relative to men. This is also the case for the class of diagnostic criteria called personality disorders. Unlike mental disorders, personality disorders are seen as long-standing flaws in character that are dysfunctional. Save for antisocial disorder, the personality disorders all have an increased rate of prevalence in females. From this, one can conclude that being a woman in our society is bad for mental health. To a feminist, this is seen as the cost of gender roles where the woman is responsible for the emotional expression and functioning in her family.

Feminists noticed that since women were assigned the role of child socialization, they were often blamed for emotional difficulties in children. This phenomenon is referred to by feminists as “mother blaming.” A classic example of this is Fromm-Reichmann’s (1948) theoretical construct, “schizophrenogenic mother.” In this, the mother was seen as the cause of her child’s schizophrenia. In a study by Caplan and Hall-McCorquodale (1985), clinical journal articles were researched from 1970, 1979, and 1982 to discover the rate of mother blaming for children’s problems. They found very little difference in the rate of mother blaming across the years or according to the gender of the author presenting the theory. It is as if mental health theory reasons that the mother’s natural instinct of nurturance is the cause of any problems developed in her children.

Gender-Sensitive Treatment

The systemic functional model of the family leads family therapy to ignore issues of gender and equality in our society. By correcting for individual biases of traditional psychology, family therapy developed what could be called a systemic bias. As Braveman (1988) points out, family therapists considered themselves far ahead of traditional linear psychology. As a result, she asserts, family therapists “had [their] heads buried in the sand” while others addressed issues of gender.

The machine-like view of simple cybernetics gave way to a machine-like view of family and family functioning. Included in this was the Batesonian view that opposed the use of a power metaphor. In this view, all parties contribute to problems by participation in the system. Not only was the family a machine, but it was a political machine, where all members had equal participation and blame was a linear and irrelevant term.

Goldner (1985) points out that, to a feminist, the idea of equal responsibility seems “suspiciously like a hypersophisticated version of blaming the victim and rationalizing the status quo” (p. 33). James and MacKinnon (1990) point out that blaming the victim is particularly marked in crimes and violence against women. Explanations by psychologists of battery, rape, incest, and the like have included women’s provoking or consenting to the crime. For this reason, feminist family therapists are suspicious of the neutrality implied in the systems metaphor.

Feminist family therapy, like the constructionist approach and the ethnicity critique, is more a set of values than a collection of therapeutic interventions of family functioning. Osmond and Thorne (1993) state, “It is not our impression that feminist family therapists call for abandoning general systems theories; rather they are critical, specifically, of non-contextual cybernetic approaches” (p. 604). Feminist family therapy is a set of values used to influence the course of treatment.

Central to feminist family therapy is the idea that gender should be a central organizing component of family theory. Goldner (1988, 1993) and Luepnitz (1988) argue that gender should be given at least the same consideration that generations are given in family theory. Furthermore, by looking at gender as an important factor, therapists can stop blaming mothers for problems in the family. Feminists recognize that, given the role of women and mothers in our society, women are most often interested in change. Many therapists call on the most motivated members of families to do the largest share of the work in therapy. To the feminist, having the woman do the majority of the work in the therapy room is another form of oppression.

LEARNING EXERCISES

1. List all of the rites of passage that occurred in your socialization into your gender. How were these marked by members of your family? Describe in detail how you became a man or woman in the form of a developmental history. Be sure to pay attention to transitions from various stages of your gender development. Which stages were more difficult than the others?

2. Pair up with a classmate of opposite gender. Share your developmental history with this person. Try to develop an understanding of the rites of passage of members of the opposite gender. Ask questions that will help you develop an understanding.
3. Spend time in a public place observing the interaction of men and women. Try to observe how intimacy is expressed in these situations. How do men show intimacy with other men? How do women show intimacy with other women? How is intimacy displayed between men and women?

A STANCE AGAINST VIOLENCE AND ABUSE IN RELATIONSHIPS

The treatment of violence and abuse that occurs in significant relationships is an issue that has not come to the forefront of marriage and family therapy until very recently. It was not until feminism was well enough established in the field that the focus could shift to issues as dark as violence and abuse in relationships.

Like the feminist movement, the antiviolence movement seemed to arrive suddenly. In 1991, Avis, Bograd, and Kaufman presented a Plenary session titled *Abuse and Violence: The Dark Side of the Family* at the annual meeting of the American Family Therapy Association, later published in a special section of the *Journal of Marital and Family Therapy* (Avis, 1992; Bograd, 1992; Kaufman, 1992). This session caused the profession to look at basic assumptions of therapy and to consider the role of therapy as a means of social control.

Sexual abuse is a common occurrence in North America. Between 18% and 44% of women report being sexually victimized during their lives (Casey & Nurivis, 2006; Russell & Bolen, 2000; Tjaden & Thoennes, 1998). Abuse of women also occurs with alarming frequency in former intimate relationships. Russell (1982) found that, in a nonclinical sample, 14% of women reported being raped by their ex-husbands.

It is clear that there is a strong association among violence and abuse and gender. By far, the vast majority of violence is perpetrated by men. In North America, 95% of incest (Finkelhor, 1986; Rogers, 1990) and 95% of marital violence (Brown, 1987; Dobash & Dobash, 1979) is perpetrated by men. Every year in the United States, one out of six women is abused by a man she lives with (Avis, 1992). In their review of relationship violence, Simpson, Doss, Wheeler, and Christensen (2007) state that relationship aggression exists in 25% to 75% of distressed couples. Dutton (1988) found that violence occurs in 1 of 14 marriages, and on average, 35 incidents of violence occur before it is reported. Avis (1992) summarizes these and other statistics:

These data lead us to the unavoidable conclusion that male violence and abuse directed against women and children in families is extremely common in Canadian and American families and that the consequences are highly destructive for individuals, families, and our collective well-being as societies. (p. 228)

Not only is violence an issue directly involving the victim of violence, but the whole family and the children's future family may be victims as well. A male child who watches a parent being abused is more strongly associated with being a future perpetrator of interpersonal violence than a victim is (Graham-Bermann, 1998). Girls who witness abuse have increased tolerance for being abused themselves in future relationships (Edleson, 1999). Likewise, mothers who are abused themselves are more likely to be abusive to their own children (Appel & Holden, 1998; Bancroft & Silverman, 2002). Thus we see that the total damage of violence in families is greater than the sum of its parts.

Treating Family Violence

Family therapists who have taken an antiviolence position criticize the views of individual psychology, cycle-of-violence theories, and cybernetics systems thinking. In psychodynamic explanations, abuse is reduced to acts taken out of context and violence reinterpreted as "an ineffective attempt to meet ordinary human needs" (Herman, 1990, p.182). Writers from this perspective call attention to the abuser's psychological need for "recognition, acceptance, validation, affiliation, mastery, and control" (Groth, Hobson, & Gary, 1982, p. 137). This minimizes the impact on victims and increases the need to accept responsibility.

Cycle-of-violence theories view perpetrators as responding to violence acted upon them as a child. This theoretical model postulates an intergenerational effect of the violent lifestyle. However, the data do not bear out such a view. Of all the women who are victims, only a small minority are recruited into the cycle of violence. This theory cannot explain the "virtual male monopoly" on sexually violent behavior (Herman, 1990, p. 181). In addition, this perspective often calls for the relationship in which the violence occurs to be terminated. This happens when the victim is counseled in a shelter and the perpetrator is sent off to work on anger management issues. However, this approach often derails when, despite therapeutic recommendations, the couple continues the relationship.

Systems theories do not fare better in their treatment of violence. The act of abuse can be easily lost in the idea of recursion. The homeostatic view of equal responsibility can place blame on the victim by calling attention to the role of the victim in the violence. Perhaps Kaufman (1992) best summarizes this critique:

Constructivists and systems theorists who are enamored of speaking of the recursive sequences and the arbitrariness of punctuation in relationships, of cybernetic and Heisenbergian and other new-physics explanatory systems, should know this violence follows the old Newtonian physics of mass, velocity, momentum and inertia—as in a fist hitting a face breaking bones. (p. 236)

This critique is similar to that of feminist family therapists and is applied to systems theory in general.

As we take a deep look at domestic violence issues, we see that we must consider more complex conceptualizations of the issues. Greene and Bogo (2002) discuss the need for different approaches to treating intimate violence based on the style of violence. These types are (1) violence involving power and control by one (usually the male) partner, and (2) violence involving mutual conflict between partners. To make this clinical picture more complex, a study by Blasko, Winek, and Bieschke (2007) showed that marriage and family therapists' assessment of domestic violence situations varied as a function of the sexual orientation of the clients. In this research, therapists were asked to identify domestic violence in scenarios that were identical except for the sexual orientation of the couple. In the heterosexual scenario, therapists perceived the man as perpetrator, while in the same-sex scenarios, both partners were perceived to be both victim and perpetrator.

Safety is the key issue in treating family violence. The best approach is to assess violence perpetrated against children and in intimate relationships at intake. By asking about violence on intake forms, clients are alerted to your antiviolence stance. It may not present at first, but over time clients may feel comfortable discussing their concerns about violence. When faced with violence, it is important to emphasize both the safety of the victim and the responsibility of the perpetrator. Most states mandate child abuse reporting and provide penalties for professionals who fail to report as well as protection under the law for those who make good-faith reports. When making a report, it is often useful to include the family in the process. If the therapist supports the perpetrator in self-reporting, making the report can become part of his or her healing process.

While we recognize the risks and controversies in treating domestic violence conjointly, we find that there is some benefit to this approach when it can be done safely. Rosen, Matheson, Stith, McCollum, and Locke (2003) discuss the positive aspects of working with both partners when using the common technique of time-outs for de-escalation. When both parties are present and when the time-out technique is taught, the couple will have a better chance of using the technique appropriately and effectively.

Now that family therapists are aware of issues of abuse, there have been specific recommendations on how to address the issue. First, there is a need for recognition of the problem. Second, Avis (1992) reminds us,

we must recognize and address power dynamics in family relationships and avoid conceptualizations which view violence and abuse as systems dysfunctions rather than as abusive acts committed by one individual against another, or which in any way hold women and children responsible for the behavior of abusive men. (p. 230)

This relationship perspective allows for systemic treatment of domestic violence. Avis (1992) proposes three specific guidelines for the effective treatment of violence in families. First, abusive and controlling men must be seen as responsible for their violent,

coercive, and abusive behavior and must be held accountable for it. The therapist must not minimize the acts of violence and should not apply a psychological or systemic theory that lets the perpetrator escape responsibility for his or her actions. Second, the primary focus of any therapeutic efforts must be on changing the violent behavior itself. Treatment should focus on details of the behavior's impact on others, and on the belief system that supports it. The focus when working with violence is always the removal of violence and the safety of the victims. The therapist must establish the goal of safety prior to addressing any personal or relational issues. Third, therapists should work in conjunction with the police and courts to use legal sanctions and mandated treatment. Because violence is such a difficult problem to overcome, the therapist must be willing to use as much leverage as possible to stop the violence. In some cases, the power of public institutions can be successfully used to force the termination of violence.

More recently, Stith, Rosen, and McCollum (2003) revived the literature on couple treatment of spousal abuse and drew some important conclusions. They concluded that there is some sparse empirical support for couple treatment for spousal abuse being at least as effective as traditional treatment while posing no greater risk of injury to the woman. In addition, they find four key ingredients in effective treatment. These are as follows:

1. Clients are carefully screened into the program. Clients who have seriously injured their partner are excluded. Both clients (in separate interviews) must report that they want to participate in couple treatment and that they are not afraid to express their concerns to their partners.
2. The primary focus of treatment is on eliminating all forms of partner abuse (physical, emotional, verbal), not on saving marriages.
3. Most programs emphasize taking responsibility for one's own violence and include a skill building component including teaching such skills as recognizing when anger is escalating, de-escalating, and taking time outs.
4. Effectiveness in all the successful programs reviewed here is measured by reduction or elimination of violence. (p. 422)

LEARNING EXERCISES

1. Research the resources available in your community for addressing violence in families. Does your state mandate reporting the abuse of children? How is spousal abuse dealt with by the legal system? Is there a domestic violence shelter and prevention program? How do clients get access to these programs?
2. Devise a personal safety plan. Ask yourself the question, "If I had to get away from my partner to be safe, how could I do it?" What are the resources that would be available to you? Where could you stay that would be safe? Would you have money to support yourself, and if you could,

how long could you support yourself? Discuss your plan with your peers. What did others include in their plans that could help you? As a group, try to develop elements that go into a good safety plan.

3. Become familiar with child abuse reporting laws in your state. Who takes child endangerment reports, and how are they processed?

GAY AND LESBIAN FAMILIES

Issues facing gay and lesbian families were brought to consciousness at about the same time as family violence was being addressed in marriage and family therapy literature. Just as family therapy has been slow to look at the other issues discussed in this chapter, it has a long history of ignoring the issues faced by gay and lesbian families. The profession had to reach a level of maturity before it was able to address these issues. The awareness of issues of sexual orientation started in the late 1980s, but it was not until 1991 that the *Family Therapy Networker* published a special article on gay and lesbian issues. It was clear that this topic had arrived when a chapter on gay and lesbian issues was included in the second edition of Froma Walsh's classic text *Normal Family Processes* (1993). More recently, Bigner and Gottlieb (2006) coedited a book titled *Intervention With Families of Gay, Lesbian, Bisexual, and Transgender People: From the Inside Out*, also published as a special edition of the *Journal of GLBT Family Studies*.

Issues of sexual identity in the development of healthy families are too complex to be addressed by a simple conceptualization of heterosexuality versus homosexuality. We need to consider sexual identity to include persons who have a bisexual or transgender orientation. We also have to consider these issues in their historical context. There is a long history of oppression of people who deviate from the heterosexual assumption. As late as 1973, homosexuality was categorized as a mental illness in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. This occurred one year after Weinberg (1972) first introduced the term *homophobia*. Homophobia is actions or attitudes based on a fear of homosexuality.

Like the melting pot mythologies of race and the ethnocentricity of American culture that led to oppression of people who were different from the Caucasian norm, the normative sexual orientation is heterosexual. Given that segments of our society still see people with alternative lifestyles as deviant, mentally ill, or sinners, it is hard to articulate how families can accept and support their members who are not heterosexual. Likewise it can be difficult for people of gay, lesbian, bisexual, or transgender (GLBT) orientation to accept themselves. According to Palma and Stanley (2002), gay and lesbian persons can be homophobic themselves, having lived in a broader heterosexual and homophobic society.



Froma Walsh

Given that, unlike gender and race, sexual orientation can be invisible to others, throughout history people with a GLBT orientation have chosen to remain hidden and as a result suffered discrimination. The stress of being closeted inhibits personality development. There is also a double discrimination for people who are a minority both sexually and racially. This double-minority position can place additional stress on that person.

Families with GLBT members are in many ways like other families, and like all families they face issues from time to time that need to be addressed in therapy. As Long, Bonomo, Andrews, and Brown (2006) point out, these families are not inherently unhealthy. "In fact, the problems faced by these families are mainly reflective of the heterosexist, homophobic world in which we live" (p. 9). The question for us is how family therapists can support families with GLBT members.

One way family therapists can help families with these issues is in the area of coming out. Sexual minorities are now self-identifying at a younger age and while living with their parents (Long et al., 2006). This is despite the fact that the process of coming out is emotionally complex (Waldner & Magruder, 1999). The person coming out can fear consequences ranging from being abused or being forced into therapy to simply disappointing his or her family (Coenen, 1998). In fact, some adolescents have chosen to run away after being emotionally, verbally, or physically abused following their disclosures (Savin-Williams, 1994; Savin-Williams & Cohen, 1996). Despite the possible negative consequences, Bepko and Johnson (2000) and LaSala (2002) argue that GLBT people suffer when they keep part of their life hidden from their family and therefore should come out to their family. It can be useful for family therapists to help people with GLBT orientation weigh the costs and benefits of coming out. Once a decision is made, the family therapist can help the client with that process to maximize the benefits and reduce trauma.

Families need support in dealing with feelings and issues associated with their teen's coming out (Long et al., 2006). They need to reconcile their assumption that their child is heterosexual with the child's orientation while continuing to love and support him or her. They have to deal with the social stigma associated with having a GLBT family member. According to Long and colleagues (2006), "many parents are extremely fearful that their children will be seriously injured or killed because of their identity" (p. 14). Likewise, there are a variety of stressors for siblings of GLBT children. They suffer from a stigma and on some occasions become jealous of the extra attention their sibling receives to support him or her through the coming-out process.

An additional area where family therapists can assist families is in parents' coming out after they have children. When and how GLBT parents talk to their children can have an impact

on the relationship (Long et al, 2006). Long and colleagues conclude, “Researchers have demonstrated that younger children have a smoother adjustment than older ones when learning about their parent(s) being gay or lesbian” (p. 15).

Helping GLBT families is a complex process that the field is just starting to address. There is very little written on how each theory can be modified to assist these families. Long and colleagues (2006) provide a brief theoretical analysis of several theories. Since this area is on the cutting edge of development, there is need for well-trained clinicians to apply models of family therapy to sexual minority families and publish on their findings (Long et al., 2006).

LEARNING EXERCISES

1. Most openly gay or lesbian people engage in a process of acceptance and “coming out.” This process involves disclosing their sexual orientation to significant people in their lives. Think about what a coming-out process would look like in your life. Who would be supportive of you? Who would reject you?
2. Research resources available on your campus to support GLBT students. As you review these services, think about additional services that you think could or should be offered.

SUMMARY

This chapter traces some more recent challenges that the field of family therapy has been wrestling with in recent years. Unlike the challenges discussed in the first two chapters, these challenges did not lead to a shift in epistemology. However, they were great enough to raise the consciousness of the profession.

First we looked at the ethnocentric position of the early family therapy movement. By recognizing the cultural context of our clients, we are able to move to a therapy that considers the cultural context of each client’s family. Through an awareness of the impact of culture on family, we can hopefully avoid a family therapy that is culturally inappropriate. A cultural awareness also allows therapists to assist families in adapting to the broad and diverse American culture without sacrificing their own cultural identity.

Like ethnicity, gender is a contextual factor that was largely overlooked by the early family therapy movement. By examining the often invisible influence of gender, we are able to embrace a more equal division of labor between the genders. We also see that historically women have taken more of the responsibility and ultimately more of the blame for child rearing. Gender awareness in family therapy allows us to look more closely at issues of power and control in families.

Interest in power and control led family therapy to take a stance against violence and abuse in relationships. No longer could we have an idealistic view in which families are not violent

toward each other. By taking a stance against violence and abuse and encouraging safety and responsibility, family therapists seek to break the cycle of violence.

Most recently family therapy has addressed issues of sexual orientation. As family structure has evolved to include families not based on a heterosexual marital bond, our views of families have had to be modified. New views of families need to be developed so we can understand and support these alternative forms of family.

DISCUSSION QUESTIONS

1. Describe the social change processes that allow society as a whole to address its biases toward groups of people.
2. Do you feel it is important to make self-disclosures about your ethnicity, race, or sexual orientation when working with clients who are different from you in terms of their ethnicity, race, or sexual orientation? If so, when and how best are the self-disclosures made?
3. To what degree do you think family therapy should take a leadership role in social change? Should family therapy follow the lead of broader society?