# CHAPTER 1



We have recently received the shock of major backlash (or should we use Van Jones's term and call it "whitelash") to what had just begun to seem like an emerging appreciation of our nation's diversity. The dramatic increase of immigrants in the United States and of nonwhite[1], non-European citizens altogether, has been forcing us to come to terms with our multiculturality. We have always been a nation of immigrants, but never before, despite previous waves of immigration and increasing rates of cultural intermarriage, has our nation been as diverse as it is today. Our diversity is expanding exponentially, although the change is much more apparent on the coasts and the southern border of the United States than in the large but less populated areas of the interior of the country. The population changes of the past 50 years, along with the communication revolution with the Internet and social media, have been changing our nation dramatically and forcing us to challenge our unquestioned assumptions about who we are and what our values should be.

The true multicultural richness and complexity of our nation offer us the greatest possibilities for re-visioning who we are and who we can be. Our diversity can become our greatest strength. On the other hand, when we fear our diversity, our prejudices and rigidities as a nation are highlighted, and our systemic appreciation and potential to lead the way toward a future for our planet disappear. Our fears can bring out a pernicious ability to exclude and dehumanize those who are considered not to belong. Ultimately, this dehumanization would mean death to our civilization. As Bryan Stevenson (2015) so touchingly puts it:

> We are all implicated when we allow other people to be mistreated. An absence of compassion can corrupt the decency of a community, a state, a nation. Fear and anger can make us vindictive and abusive, unjust and unfair, until we all suffer from the absence of mercy and we condemn ourselves as much as we victimize others. The closer we get to mass incarceration and extreme levels of punishment, the more I believe it is necessary to recognize that we all need mercy, we all need justice, and—perhaps—we all need some measure of unmerited grace. (p. 18)

Those who are not of the dominant culture have always tended to experience our society from a multicultural perspective, which more easily appreciates the need for mercy and compassion. But the dominant culture, from the inception of our nation, has tended to deny and mystify our multiculturalism, articulating the magnificent promise of "liberty and justice for all" only for a very strict minority—white men—and obscuring at every level the insidious hidden misrepresentations of whom "all" would include.

But a multicultural lens can be the model for the ideals our forefathers set out, the model for the cultural flexibility we require as systemic therapists in this, the most culturally diverse society that has ever existed, for times when vindictiveness and cutoff are increasingly coming to the fore and trampling the ideals of democracy.

Appreciating our diversity as a nation transforms our awareness of what it means to be American. Except for Native Americans who immigrated here thousands of years before the thoughts of our nation began, the rest of us are all relatively recent immigrants. But the ideology put forth by all our governmental institutions has generally included a denial of our more complex heritage of injustice to those not part of the dominant group. To appreciate who we really are requires expanding our awareness of the truths of our heritage. As Sanford Ungar (1995) wrote about becoming conscious of the meaning of his family's migration for him, a third-generation grandchild of Eastern European Jewish immigrant ancestors, "I was no less American than ever before, of course, but now, in middle age, I had discovered my own immigrant consciousness. Indeed, in that sense, I could now feel more authentically American" (p. 18).

Only by attending to the multiplicitous voices that have until now been silenced in the dominant story of who we are as a nation can we become

"more authentically American." Although African Americans, Hmong refugees, and recent immigrants from Sri Lanka or Syria have their own cultures of origin and particular experiences of migration and dislocation, they need equally to feel themselves included in the definition of "American."

But our clinical models, training, and practice have ignored this multicultural dimension of our society. We have developed theories and conducted research to define working models for intervention without accounting for their cultural limitations. We have done research on the absurd assumption that we could manualize intervention and apply it to any clients, no matter what their history or context, on the assumption that everyone should be able to fit into the universalized category of middle-class white people (primarily men) in the United States. That is the standard by which we measure all others and usually find them failing. We have not even noticed that families from many cultural groups rarely come to our therapy and that, if they do, they do not find our techniques helpful. It is we who must change and expand to include them, not they who must learn to fit into our schemas.

The failure of our society to embrace and respect diversity is the greatest single threat to the survival of our civilization. We must break the constraints of our traditional monocular vision of families as white, heterosexual, and middle class. The boundaries of our field must be redefined to take into account our country's ever-expanding diversity and the way that societal oppression has silenced the voices and constrained the lives of individuals, families, and whole communities since our nation was founded. Racist, sexist, ethnocentric, classist, and heterosexist power hierarchies constrain our clients' lives and determine what gets defined as a problem and what services our society will support in response.

Systemic practice, like any set of ideas and practices, is always evolving, but it originally developed mostly in reaction to Freudian psychology, which had focused primarily on intrapsychic processes as the core of human psychology. Systemic theory and practice provided a kind of corrective perspective, focusing attention on interpersonal processes among family members as central to understanding psychological functioning. Although some family therapists eschewed any other level of analysis than the interpersonal/family level, most came to think in terms of multiple systemic levels, from the biological to the familial to the cultural and societal. However, it has been difficult to shift our thinking about therapy beyond the family to consider the therapeutic implications of the cultural context in which families are embedded, given that our dominant ideology about who defines the parameters of conversation in our society has not been seriously open to challenge or revision.

This third edition of this book continues our attempt to re-vision the dominant discourses within family therapy. We must examine the ways in which we have organized our theory and practice and analyze how they replicate the dominant value systems of our society. Such re-visioning will be a slow and difficult evolution and will not take place without a backlash.

In this introductory chapter, we want to map out a series of phases that describe both the past and the possible future of family therapy, a framework we hope will contribute to the transformation of theory and practice.

Our society is still organized to accommodate a type of family structure that represents a very small percentage of U.S. households—nuclear family units with employed fathers and homemaker mothers who devote themselves to the care of husbands and children. Family therapy, like our dominant social ideology in general, has tended toward a view of families as self-sufficient, nuclear units. However, our definition that two parents are critical for child development has always been a euphemism for a mother who is perpetually on call for everyone emotionally and physically and a distant, money-providing father. Families with such a structure cannot help being problematic.

Although poor families are the only ones seen as deficient, because of their obvious and critical dependence on systems beyond themselves for their survival, the reality is that all families are dependent for their survival on systems beyond themselves.

But those of us who are of the dominant groups fail to realize this because of the unseen ways the government and others support us. Our needs are met and taken for granted and thus rendered invisible to us (Coontz, 2016). Schools, courts, the police, and all other institutions of the society operate for the protection and benefit of the dominant groups. Thus those of us who make the rules and definitions are kept blind to our privilege (see McIntosh, Chapter 15, this volume) and to our dependence on those who take care of us. The problem is not the dependence of certain people on the society, but the delusion of autonomy of the rest of us.

The dominant groups are using up the world's resources with no awareness or accountability (Worldwatch Institute, 2017). The economic system, the prison system, the drug rehabilitation industry, the gun industry, and the legal and governmental systems make money for the dominant groups of our society on the backs of the poor and the disenfranchised, who serve us in our homes and factories, making our clothing and supplies, while we remain blind to our connection to them, not seeing our exploitation or the bias in our behavior. We seldom recognize the invisible workforce of the poor toiling tirelessly for our comfort. They come at night to hospitals, hotels, and the halls of academia. They are commissioned essentially to be our caretakers and to "keep America clean." We never even notice that they, like us, are parents, grandparents, beloved children, aunts, uncles, nieces, and nephews; they remain objectified, invisible, and known only by the services that they provide for us, such as "the janitor" or "the maid."

Paradoxically, the ideals stated, but not meant, in our Constitution could be the foundation of a truly egalitarian society, perhaps the first in human history, but only if we acknowledge the pernicious, unspoken exclusions on which it was founded. To do this, we must admit that our founders built slavery and the disenfranchisement of people of color and women into the

system and that these inequities remain in place today. Our history books still brag about the foundation of our nation, minimizing the slaughter, slavery, and forced invisibility of more than two-thirds of the population. This is hard to see, because what we espouse overtly mystifies the underlying facts of exclusion. Our society makes it difficult to notice the intersection between the spoken and the unspoken. So we continue to invest in the ideal that we are "the land of the free," even though some of us are and have always been free on the backs of others. We continue to believe that escaping the walls of poverty is simply a matter of personal will and hard work, denying that wealth and class are well-elaborated systems that negate the individual efforts of the poor while inflating the opportunities of the structurally, economically, and racially privileged.

We therapists need to revise our books to take into account the unspoken structures, the cultural, racial, and class- and gender-biased hierarchies that limit the lives of many of our potential or real clients and are the underpinnings of our society. It goes unacknowledged that African Americans, Latinos, Asians, and other racially oppressed people do not have the same entitlements to participate in our institutions, including in our world of family therapy. Just as our history books have told primarily the history of heterosexual white men, our family therapy models have been researched and developed by and for therapy primarily addressed to families of the dominant groups. Therapists must begin to think of families in terms of the communities they live in. We have ignored community, focusing on the interior of the nuclear family, while ignoring the larger context, as well as all the history of social exclusion of whole groups from participation in our institutions. It is impossible to understand or treat poor families without a comprehensive understanding of how stigma and limited access to resources affect their symptoms and presentation. We continually turn a blind eye to the pervasive impact of oppression on the poor, the racially subjugated, and other marginalized groups who behave in predictable ways, not because of who they are but because they have been forced to live in a context of ongoing devaluation and discrimination. Delivering more culturally competent services will require our field to consider the broader ecology in which families are embedded. Widening our lenses to take history, context, and community into account will require us to reconsider many of our assumptions.

Children need more than one or even two adults to raise them, and adults need more than one or two close relationships to get them through life. As therapists, we need to encourage our clients to go beyond the dominant culture's definitions of family, to pay attention to relationships with siblings, nieces and nephews, grandchildren, aunts, and uncles. And beyond this we must attend to friendships and to the health and safety of neighborhoods and community contexts in which families live. We need to consider the role of caretakers, housekeepers, maids, and nannies, as well as godparents, teachers, and other mentors, in the rearing of children and the care of the disabled and the elderly.

## THE PROBLEMS OF NAMING

In family therapy, we get paid by the names we give to the problems our clients present to us. The politics and economics of naming are powerful. Names mean money, and they mean status. Naming has become also big business. Robert Spitzer, one of the senior developers of the DSM-III (the diagnostic manual that contains the numbers by which we in mental health get paid), is among many who have criticized the most recent DSM-5 for having forced those who worked on the document to sign a nondisclosure agreement; this meant that the entire process of developing the manual was conducted in secret. Seventy percent of the task force members reported having direct industry ties (Cosgrove, Bursztajn, & Krimsky, 2009; Cosgrove & Krimsky, 2012)! Another major figure in the world of psychiatry, Allen Frances (2014), formerly head of the DSM-IV Task Force, has written a stiff critique of our diagnostic system in *Saving Normal: An Insider's Revolt against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life*. He has also written, "The work on DSM-5 has displayed the most unhappy combination of soaring ambition and weak methodology" (Frances, 2009, p. 1). He also has great concern about the incredibly secretive process of its development.

Clearly, the "evidence" of the DSM is driven by finances and race, social class, and gender privilege. DSM-5, which runs 900 pages, devotes about 20 pages to cultural issues in diagnosis and 1 page to gender differences. Perhaps this is not surprising, given the gender and cultural backgrounds of those who created the DSM. We are, for example, much more likely to diagnose the victims of abuse than the perpetrators. The perpetrators of violence against others go virtually unnamed in the DSM. Psychologists define with elaborated jargon practically the whole life course of those who have experienced trauma but leave out of their descriptions and nomenclature those who traumatize others, just as we do not consider issues such as racial or gender oppression or poverty in our discussion of diagnosis, even though we know well that these are major factors in psychopathology.

In the era of slavery, two mental disorders were described as prevalent among slaves (Tavris, 1992; DeGruy Leary, 2005):

1. *Drapetomania,* characterized by a single symptom: the uncontrollable urge to escape slavery. This disorder was literally called a "flight-from-home mania."
2. *Dysathesia aethiopia,* for which many symptoms were described: destroying property on the plantation, being disobedient, talking back, fighting with their masters, and refusing to work.

These diagnoses turned the desire for liberty into a sickness that was the problem of the slave, not the slave owner. There was, not surprisingly, no corresponding disorder characterized by the irresistible urge to possess slaves

or to mistreat them. The brutal acts of inhumanity that slavery involved were never considered reflections of mental illness. The diagnostic gaze focused instead on the so-called mental disorders of the slave for wanting to escape slavery. Such "disorders" were, incidentally, considered almost completely treatable by whipping or amputation of toes. The slave owner remained completely invisible in this nomenclature and thus as needing no treatment himself. Even today, racism is not only not a diagnosis, it is not even listed in the index of the DSM-5.

Using labels as a means of control is a long story in this country. As another example, homosexuality was considered a mental illness by the so-called "scientifically based" DSM, until it was *voted* out of existence in 1973. As with other oppressed groups, those who promote hatred and violence against homosexuals received no labeling then and still receive no labeling today. Even when homosexuality was finally removed from the DSM as a mental disorder, the decision masqueraded as a scientific decision (Spiegel, 2002; Tomm, 1990; Caplan & Cosgrove, 2004; Kutchins & Kirk, 1997). Robert Spitzer, the chief architect of the DSM for many years, played a key role in removing homosexuality from the category of mental illness, but he did not want to give it the stamp of "normalcy," viewing it as "suboptimal" behavior. His argument was that if DSM were to include suboptimal behaviors as "mental disorders," other phenomena, such as "celibacy, religious fanaticism, racism, vegetarianism, and male chauvinism," would have to be included as diagnostic categories (Kutchins & Kirk, 1997, p. 76). The organization went along with his wishes.

We as a society further obscure who does what to whom by labels, such as "alcoholic family," as if the whole family has the disorder, and "domestic violence" or "violent family," terms that obscure who are the agents and who are the victims of abuse.

Since a significant part of the supposed "scientific evidence" on which the DSM claims that its naming is based has been funded by drug companies (Cosgrove et al., 2009), the voting process of American Psychiatric Association committees is thus disguised as science.

Dominic Murphy (2015), who has been examining the attitudes toward culture in DSM-5, suggests that the problem of how culture is thought about begins with the problem that "Americans are WEIRD (Western, Educated, Industrialized, Rich, and Democratic; Henrich, Heine, & Norenzayan, 2010). If western, educated, industrialized, rich democratic people are the norm, cultural variation must refer to ways of being mentally ill that depart from the expectations of western medical schools" (Murphy, 2015, p. 98), what Hughes (1985) referred to as "deviant deviance" (p. 3).

To give just one more example, the latest DSM includes a diagnosis called "dependent personality disorder" for the person who is overly submissive and desires to be cared for, such that he or she fears separation and clings to others. However, the entire manual offers absolutely no way to assess how realistic that person's fears might be! Meanwhile, the DSM has no comparable

diagnosis for those who use their power to control and intimidate others. There is no diagnosis for those who are racist, misogynistic, homophobic, who have a need for sexual conquests, or who are emotionally or physically abusive. Indeed, it is not sufficient, according to the DSM, to have been physically or sexually violent to receive a diagnosis of conduct disorder or antisocial personality disorder. The latter diagnosis is only given if the person has had symptoms of a conduct disorder before the age of 15! And this lack of acknowledgment exists in a society in which a woman is beaten on the average every 18 seconds and in which physical abuse is the most common cause of injury for women, more widespread than breast cancer or car accidents ("DSM V codes," 2015).

Similarly, families of color, families of the poor, and immigrant families, whose norms and values are different from those of the dominant norms, remain marginalized, invalidated, and pathologized as deficient, dysfunctional, or, worse, invisible within the DSM naming system.

I (KVH) have suggested, only partly in jest (Hardy, 2007b), the development of a DSM-M (marginalization version) that would bring attention to the role that the oppressor plays in the life of the oppressed. The DSM-M would, for example, contain diagnostic categories such as:

1. *Addiction to domination disorder (ADD).* This category would be reserved for those who cannot resist subjugating others through use of force, domination, and a reliance on the establishment of rigid hierarchical boundaries.
2. *Privilege disorder.* This category would be for those who enjoy the unearned benefits afforded to them by virtue of living in a patriarchal, sexist, heterosexist, racist, Christian-oriented society. One of the major features of this disorder is to have privilege but claim not to know or feel it.
3. *Oppositional cop disorder (OCD).* This would be reserved for police and other individuals or groups who use excessive force, particularly toward the disadvantaged, without discernible provocation. A generalized, overly aggressive demeanor toward people of color, gays, Muslims, or the poor often characterizes the disorder.
4. *Clinical oppression disorder (COD).* This condition is often manifested in marginalized people who have lived their lives in the midst of sociocultural oppression. The major symptoms associated with COD are learned voicelessness, learned helplessness, suppressed anger and rage, and a generalized sense of suspicion, with ideas of persecution.

Years ago, but maybe even more relevant today, Karl Tomm (1990) suggested another diagnosis, "DSM Syndrome," characterized by a compulsive desire to objectify and label people according to predetermined psychiatric categories. Such satirical nosologies highlight the invisibility of the power of

systems of domination and oppression that have power to name and label people in ways that wreak havoc on the lives of oppressed people while remaining invisible under the guise of being based on scientific evidence.

## LABELS: MAKING ROOM FOR BOTH GROUP CONNECTIONS AND UNIQUENESS

Labels can be both reassuring and dangerous. They define boundaries—who is in and who is out. Labels of self-definition may be reassuring when we use them to specify a group to which we belong, thus overcoming our sense of isolation. But they also define the limits of that belonging. Coming to define myself (MM) as Irish American, for example, was an affirmation at the deepest level of my identity. It gave me a profound sense that neither I nor my family were alone in our ways of experiencing the world. I realized that much of what I thought was strange or eccentric made sense in the light of Irish history. At a certain point, however, when I define myself as "Irish American" or by any other fixed group identity, the boundary becomes exclusionary and distances me from others who are not in that group. I may be better served by emphasizing other identities to support my connections to them.

To receive a diagnosis, whether attention-deficit/hyperactivity disorder (ADHD), dyslexia, bipolar disorder, or something else, may provide reassurance that a person's experience of something being "wrong" has a name. There may also be some treatment that is useful, and it can be a relief to have a name for something we have struggled with. But the diagnosis can also easily become one's self-identity, and it may become difficult to get free of the label. Once people have been given a label of having a disability, for example, it may become a challenge to view themselves as "normal." Such labeling can be pejorative. The new discussion of whether grief is a disease is another case in point. If grief is a disease, one can have medication for depression reimbursed. But it also means that going through a normal grieving process becomes pathological.

As a society, we need to transform the way we think about sameness and difference and increase the flexibility of our thinking to include systemic perspectives that are more nuanced. The dichotomous definitions of "normal" and "pathological" should not be our only ways of thinking about mental health. If we take race, gender, sexual orientation, social class, ethnicity, and the life cycle into account, for example, we may expand our thinking depending on what each person's position is at a given moment in the life cycle and in his or her cultural context. Our survival as human beings depends on whether we can remove the blinders of denial that prevent our seeing past our differences to our human connectedness and, at the same time, make more room for tolerance of these differences.

If we look carefully enough, each of us is a hodgepodge. Developing "cultural competence" requires us to go beyond labels and the dominant values and explore the complexity of culture and cultural identity—not without

values and judgments about what is adaptive, healthy, or "normal," but without accepting unquestioningly our society's definitions of these culturally determined categories. We need to develop a perspective on our identities that allows for at least three levels:

1. Our uniqueness as individuals.
2. Our various group identities that give us a sense of "home"—of defining our relatedness to others.
3. Our common partnership with every other human being, without a sense of which we human beings will surely perish.

The goal is to create a world in which everyone can feel at home, a place in which everyone has a voice, in which our flowing sense of group identities gives us more a sense of boundaries that include than of divisions that exclude. The notion of culture is almost a mystical sense of connection with all the threads of which our human community is woven.

Dealing with the subject of cultural diversity is, therefore, a matter of balance between acknowledging and validating the differences among us and appreciating the forces of our common humanity. Group boundaries may make it difficult for people to define themselves in all their complexity. Members of a group may be pressed to emphasize exclusion of others over affiliation as part of their group definition. This negative way of defining group boundaries usually also incorporates covert power hierarchies—focusing on the power of "insiders" versus the powerlessness of "outsiders." The unacknowledged aspect of power can be especially harmful, as when ethnic differences are described in such a way that the status differences between groups go unnamed. As family therapists, we need to help our clients develop multiple dimensional group identities, which increase the flexibility of their lives, to help them adapt to ever-evolving circumstances. To do this we must expand our psychological theories of development to describe our identities with all their multiplicity (McGoldrick, Garcia Preto, & Carter, 2016; McGoldrick, 2016).

Our assessment and clinical work must help clients understand their cultural selves as fluid, ever-changing aspects of who they are. The narrator, Vivian Twostar, in *The Crown of Columbus* (Dorris & Erdrich, 1991), described brilliantly the complexity of her multicultural identity:

> I belong to the lost tribe of mixed bloods, that hodgepodge amalgam of hue and cry that defies easy placement. When the DNA of my various ancestors—Irish and Coeur d'Alene and Spanish and Navajo and God knows what else—combined to form me, the result was not some genteel indecipherable puree that comes from a Cuisinart. You know what they say on the side of the Bisquick box? . . . Mix with fork. Leave lumps. That was me. (p. 123)

Her amusing analogy to Bisquick is apt, because our cultural identities do not involve some clearly measured and thoroughly blended parts but rather an ever-changing mixture of identities, some of which may have particular prominence in a given context, whereas a different aspect may come to the fore under other circumstances. The narrator articulates the way we may identify ourselves in different contexts and the advantages of a multilayered identity:

> There are advantages to not being this or that. You have a million stories, one for every occasion, and in a way they're all lies and in another way they're all true. When Indians say to me, "What are you?" I know exactly what they're asking, and answer "Coeur d'Alene." I don't add, "Between a quarter and a half," because that's information they don't require, first off—though it may come later if I screw up and they're looking for reasons why. If one of my Dartmouth colleagues wonders, "Where did you study?" I pick the best place, the hardest one to get into, in order to establish that I belong. If a stranger on the street questions where [my daughter] gets her light brown hair and dark skin, I say "the Olde Sodde" and let them figure it out. (pp. 123–124)

This example beautifully illustrates the complexity of how a person handles the various "lumps" in his or her complex identities in different social contexts. She goes on to describe the special perspective of people at the margins, which is a primary insight regarding the re-visioning of our field—valuing the perspectives of those at the margins. They can see things people at the center do not see:

> My roots spread in every direction, and if I water one set of them more often than others, it's because they need it more. . . . I've read anthropological papers written about people like me. We're called marginal, as if we exist anywhere but on the center of the page. . . . But there are bonuses to peripheral vision. Out beyond the normal bounds, you at least know where you're not. You escape the claustrophobia of belonging, and what you lack in security you gain by realizing—as those insiders never do—that security is an illusion. . . . "Caught between two worlds," is the way we're often characterized, but I'd put it differently. We are the catch. (p. 124)

This brilliant illustration of our multifaceted cultural identities, composed of complex heritages, highlights the impact of one's social location and the need to underline one or another aspect of culture in a given context in response to others' projections. Barack Obama was a bit ahead of the curve in the complexities of his identity, but perhaps not by that much:

> I am the son of a black man from Kenya and a white woman from Kansas. I was raised with the help of a white grandfather who survived a Depression to serve in Patton's Army during World War II and a white grandmother who worked on a bomber assembly line at Fort Leavenworth while he was

> overseas. I've gone to some of the best schools in America and lived in one of the world's poorest nations. I am married to a black American who carries within her the blood of slaves and slaveowners—an inheritance we pass on to our two precious daughters. I have brothers, sisters, nieces, nephews, uncles, and cousins of every race and every hue. Scattered across three continents and for as long as I live, I will never forget that in no other country on Earth is my story even possible. (Obama, 2008)

Acknowledging our multiple identities is essential in helping us connect with different groups. We must, as family therapists who are necessarily always crossing cultural borders, amplify our understanding of these different cultural territories between and among people.

Clinically, we must find ways of working that hold each person accountable for his or her behavior, including intentional or unintentional sexism, racism, or other unjust behavior, at the same time that we must convey a message of respect, care, belonging, and empathy for the painful history that has involved all of us in both trauma and denial. This requires that we move beyond our denial that we are all connected to each other, the abuser, the victim of abuse, and the one who stands by in silence.

## SOCIAL CLASS

Whatever we keep secret about class—about how much or how little money we have, about class contempt and class elitism, about the pain of unacknowledged social class distance from our family members—costs us. It keeps us from being free and from learning about the experiences of those from different classes than our own. We should dare to put our prejudices on the table, to examine them, and to determine what they cost us. We believe we must radically change our family therapy training to help trainees have the courage to discuss these issues, as well as those pertaining to race, gender, ethnicity, religion, and sexual orientation. A first step is to acknowledge our prejudices and to know that we will make mistakes. We will blurt out comments that are indicators of our prejudice without realizing it. If we are lucky, someone will draw this to our attention, and we will move along in overcoming our silences about class privilege and oppression.

## BACKLASH WITHIN FAMILY THERAPY

In family therapy, as in every other structure of our society, we see repeated efforts to silence the marginalized voices that would speak up. For years the field stayed in a reactive stance to the feminist critique of the 1980s. Many men withdrew from professional meetings. More recently, as the issues of culture and race have begun to be asserted, people say that we must go slowly or

whites will retreat from our organizations. But we will not have a future if we have only a white future.

One aspect of the backlash is the accusation that those who advocate attention to oppression, culture, and diversity are stultifying us with a straitjacket of "political correctness" (Takaki, 1994) or the "fragility" of white people, focusing our attention on the discomfort of the privileged rather than on the pain of the oppressed (Diangelo, 2018). White people tend to be oblivious to the pervasive ways white supremacy operates at every level of our society. We (MM) get reactive when anyone tries to discuss our oppressive behaviors, saying the person is making us uncomfortable—thereby blocking discussion of our privilege. Those who draw our attention to such social phenomena as the absence of people of color in our professional organizations or inequities in the status of women or minorities in salary, power, and visibility in our institutions do make us white people uncomfortable. Asserting that we do not feel "safe" in an atmosphere that values "political correctness" is an expression of the privilege of feeling safe. Those who are marginalized are never safe.

Tamasese and Waldegrave (1994) have described how claims of injustice are often overtly acknowledged in "liberal therapeutic environments" but then subtly avoided. They describe three techniques by which accountability for injustice is undermined. People become so paralyzed by their own pain that, fearing the possibility that they might offend again, they feel impotent and do nothing. A response of overwhelming guilt can end up entrenching the status quo. Others respond in a *patronizing* way, taking on the issues of the oppressed to the extent that they inappropriately become self-appointed spokespeople for them. A third response is *individualizing,* through which a person denies the relevance of group norms and behaviors, making it impossible to discuss issues of power, privilege, and accountability:

> [This] cleverly sidesteps the institutional and collective reality of discrimination. It is the collective of men and the history of patriarchy, which has created the environment that privileges the decisions and actions of men over women. No matter how committed to women a man may be, he may still continue to benefit at every level in a patriarchal society, at their expense. (Tamasese & Waldegrave, 1994, p. 32)

Denial that one belongs to the category of privilege, such as denying that one is "white," for example, keeps one from having to be accountable for the privileges of whiteness and makes discussion of the problems of racism, sexism, and other discrimination impossible.

There are many signs of backlash within our organizations. People of color are often blamed for not wanting to join our associations. Faculty members may say, "We would love to hire a faculty person of color but we can't find any" or "We invited so-and-so, but she is a prima donna and didn't respond." Most do not question their standards for defining a "senior family therapist." Requirements such as having the "right" credentials, being in the field for

a long time, or having trained with the field's leaders set up a conundrum, because the very problem to be solved is that family therapy, like the society at large, has excluded and marginalized people of color from the beginning so they are unlikely to have the "right" credentials for centrality in the field. In the rare instances in which a person of color is recruited, it is often difficult for him or her to feel included and fully appreciated. Many institutions are oblivious to the subtle but persistent pressures that they apply to people of color to fit into the prevailing racial norms of the setting. Too often people of color are required to relinquish who they are racially to be "mainstreamed," which often translates into suppressing their identity as a person of color. To survive and be fully accepted within the field, many therapists of color have to become what I (KVH) have referred to as GEMMs (good, effective, mainstream, minority family therapists; see Hardy, 2007a).

It is not surprising that many clinicians of color have not defined themselves as family therapists, because they have not felt at home in our context. We have not realized that we have to change both our context and our requirements in order to welcome them. Dominant-culture therapists may say they would gladly mentor someone of color, but they fail to consider the reasons that a person from a marginalized group might not want to join with us. Our institutions themselves have to change. Would a white person feel comfortable as the only white person included in a group, expected to represent all others of his or her race? Probably not.

Some members of the dominant group make subtly disqualifying comments: "These issues just aren't relevant to my work. This topic doesn't interest me. I think we need to talk about trauma and evidence-based practice instead." Or they may say, "We did cultural diversity last year; we need something new this year." These attitudes assume that we can continue our old routines and business as usual, failing to analyze the systems of oppression built into our institutional structures that hold our dominant group in place.



## THE EVOLUTION OF FAMILY THERAPY

Peggy McIntosh (1983, 1990) described five phases of educational and personal "re-vision" with regard to both gender and race. Using these different lenses, we might broaden our perspective as family therapists to include the categories of culture, class, race, and gender in our thinking.

Starting with *Phase 1,* in which women and minorities were absent from academic discussions, McIntosh described several evolutionary stages of revisioning curricula to include a shifting consciousness of these dimensions. For example, exploring the discipline of history: In *Phase 1,* history may be thought of as about ordering of events of privileged white men's achievement, accomplishment, and success; wars, rulers, and so forth. An English course might be organized around "Man's Quest for Knowledge."

As notions of history first expand (*Phase 2*), the lens may be widened to include some women and minorities in the discussion of history by broadening our focus to include some "second stringers" who have also had an impact on history, science, or the arts—Elizabeth Cady Stanton, Mary Cassatt, Frederick Douglass, Clara Barton, and Sacagawea might be included, but the focus of interest remains the same—a chronological ordering of events and accomplishments of certain individuals.

As consciousness evolves (*Phase 3*), there begins to be a rethinking of the place of women and minorities in society. History courses may begin to focus on them as "a problem," discussing how women struggled to get the vote, the history of the antislavery movement, and so forth. In this phase there is a consciousness that prior curricula have ignored them. The question is asked, for example, "Did women have a Renaissance?" The answer is: "No, and neither did people of color, at least not during the Renaissance." Efforts to modify the exclusion of women or people of color now focus on social forces that have kept them invisible.

In *Phase 4,* conceptions of history undergo a more radical transformation. The historian is now included in the notion of history. Instead of being an "objective" ordering of the "facts" of the past, history becomes an interactive process, in which the historian influences the stories and there is an interactive fluidity in perspectives about history.

In *Phase 5,* a phase that McIntosh says she herself cannot clearly envision, history will itself be reconceived to include us all.

Following McIntosh, we propose several perspectives through which we might imagine the field of family therapy could evolve.

### *Traditional Universalist Perspective*

This was the primary perspective in family therapy in the 1960s and 1970s and continues in some quarters into the 21st century. The primary definers of families and family therapy in this era were such people as Bowen, Minuchin, Ackerman, Whitaker, Jackson, Watzlawick, Weakland, Bateson, Framo, Boszormenyi-Nagy, Lidz, Fleck, and Haley. There was one prominent woman in the field in this early era, Virginia Satir, who played a major role until a quadrennial meeting of the *Family Process* Advisory Editors in 1972, which set up a confrontation entitled "Is Virginia Satir Dangerous for Family Therapy?" In this meeting, Satir and her "second," Kitty LaPerriere, were pitted against Salvador Minuchin and his "second," Frank Pittman. The very idea of setting up a discussion of ideas as a duel with seconds obviously comes from an either/or worldview. Beyond that, if we add acknowledgment of the long history of patriarchy, it is hard to conceive that the field would have tolerated a plenary titled "Is Murray Bowen Dangerous for Family Therapy?" or "Is Sal Minuchin Dangerous for Family Therapy?" Satir never attended another major family therapy meeting and devoted more and more time after that to working abroad.

Within its traditional framework, family therapy was white male family therapy—invented by white men, whose theories implicitly defined "family" to mean intact, middle-class, heterosexual, white families, organized with the man as head of the household and the woman as primary caretaker of all family relationships. The theoretical focus was on family members interacting as systemic units, with no acknowledgment of their unequal power to influence interactions. Common concepts taught about the understanding of family relationships concerned complementarity, homeostasis, triangles, pursuer–distancer, recursive feedback loops, cognitive behavioral exchanges, enmeshment and disengagement, and over- and underfunctioning. One prime theoretician, Bowen, emphasized a scale of "differentiation" as the measure of human maturity, according to which those who define themselves primarily by the standards of others would be lower on the scale. The fact that this has been required of women and people of color was not mentioned, and therefore differentiation would be much harder to achieve for them than for heterosexual white men. Similarly, the structural approach, another leading approach to family therapy in this era, tended to hold women responsible for family problems without reference to their unequal power within the family and to explicitly promote men to take the role of "head" of the family. Men were expected to control their families, and women were expected to take care of the needs of all family members.

Within this traditionalist lens, neither racism nor sexism was considered as relevant to the understanding of systems. Problems were formulated and assessed according to unquestioned white male definitions, which were discussed as universal truths (as per the DSM categories). No reference was made to race, gender, or sexual orientation as categories requiring specific attention in the family therapy field. No one pointed out that there were no people of color in the field as either leaders or followers. Groups and individuals fitting into this perspective might include Ackerman, Boszormenyi-Nagy, Bowen, Haley, the Mental Research Institute–Palo Alto group (Jackson, Watzlawick, Weakland, Fisch); the Milan group; Whitaker, Bateson, Erickson, deShazer, and O'Hanlon. The structural group did train many people of color and focused a lot of their work around families of color, including several creative second-generation men of color, including Harry Aponte and Braulio Montalvo, but their training was one of the most conservative in advocating patriarchal gender arrangements.



### *Gender Perspective*

In the late 1970s and early 1980s a new gender perspective emerged, spurred by articles by Rachel Hare-Mustin (1978) and by Kerrie James and Deborah McIntyre (1983) in Australia and by the establishment in 1977 of the Women's Project (Marianne Walters, Betty Carter, Peggy Papp, and Olga Silverstein). Women began to notice that the field was defined primarily or exclusively

by men. A few women had risen to prominence before the feminist critique of the field: Virginia Satir, Peggy Papp, Mara Selvini, Kitty LaPerriere, and a few others. However, the majority of presenters at conferences were white men, the leading texts were authored by white men, and the primary research in the field was led by white men, who still assumed that a family was white, middle class, and intact unless otherwise noted. Individuals' or families' cultural backgrounds did not need to be mentioned in theoretical, research, or clinical publications. Women's lack of power in families was still overlooked.

At the beginning of the 1980s, the journals and professional organizations had a predominance of white heterosexual men at the helm. *Family Process* had only one woman on its board, and only 10% of its advisory editors were women. Almost all presenters at every quadrennial meeting were men. By the 1982 meeting, "Epistemology, Efficacy, and Ethics," a few "junior" women had become advisory editors, but the program was still very much in the hands of the men who ran the organization. One woman, Olga Silverstein, was invited by these men to critique Mara Selvini's ideas, and Selvini responded hotly. This conflict between the only two women on the program seemed to be constructed into it. The discussants for all the male presenters at the event were colleagues who were their supporters. Bell (1993) and others have written of how those without a voice in our society are pitted against each other in order to keep invisible the role of the dominant group in maintaining the status quo.

Although the ratio of male to female presenters was still about 14:1 at the next *Family Process* meeting in 1986, a panel of all women was arranged on gender issues, scheduled on the last morning of the conference—a Sunday. One person of color presented at the meeting—an African American epidemiologist, who was not a family therapist. "Women's issues" were still seen as a domain exclusive to women and separated from "regular" family theory and practice. There was almost no notice taken that all the participants remained white, so the feminist critique, without being acknowledged as such, was white-only feminist critique.

Two pivotal networking meetings of women family therapists in 1984 and 1986, called "Stonehenge," solidified a collaboration among women therapists that had been missing until then. A third international meeting of women family therapists in 1991 in Denmark expanded the networking of women family therapists with those in other countries. The consciousness raising of women's networking related initially more to gender than to race and culture, which took almost 10 more years to get on the table. A critique of the organization of the field began to evolve. But the primary ideas and readings in most family training programs were still those of white heterosexual men. In 1990, *Family Process,* under pressure from junior advisory editors, committed itself to having at least one-third women and 10% (!) people of color on its advisory editorial board.

As the Women's Project and others began to write about and to present on feminist family therapy, the absence of women and minorities in many

discussions was increasingly recognized as a problem. New areas of research emerged, bringing into focus the inequality of gender roles in families, the oppression of women, violence against women in families, and mother blaming in family therapy theorizing and other professional writing. Still, the first-ever plenary presentation on male violence, which laid out the most basic dimensions of the problem in society and called for the development of therapeutic models to address them, was criticized as an appallingly unjust, unbalanced attack on men because the issue of women's violence was not addressed. This issue has still not become a topic of mention by mainstream men in our field.

By the late 1980s, the American Family Therapy Academy (AFTA) for the first time had a predominance of white women in leadership positions. At the annual conference, the majority of presenters were women. White male leaders reacted with outrage. They had not noticed that during the first decades of family therapy most presentations had been made by and virtually all the key awards had been given to white men. In the mid-1980s, four women (the Women's Project) had to share one award, and the awards committee proposed that two others (Goldner and Hare-Mustin) share another, because neither had "quite done enough" to deserve a full award for her contributions to the field. By the 1990s, AFTA had a president and a vice president who were both women. The organization's programs dealt with cultural diversity for 3 years in a row, but its leadership worried that the emphasis on the concerns of women and culture were causing men to leave the organization. By the mid-1990s, some of the major texts began to include sections on feminist family therapy but still made no reference to gender inequities in couples or families. It was not until this time that there was any public acknowledgment of the heterosexist bias of the field, and books and articles began to appear then about gay, lesbian, bisexual, and transgender families.



### *Cultural Perspectives*

During the later 1980s, an expanded cultural perspective emerged, although one strong thread had developed from the 1960s with the work of a small minority of theoreticians and clinicians whose work focused on the poor. This group included the authors of *Families of the Slums* (Minuchin, Montalvo, Guerney, Jr., Rosman, & Schumer, 1967) and others, including Dick Auerswald, Harry Aponte, Braulio Montalvo, Carlos Sluzki; a very few others spoke and wrote about multiproblem, poor minority families. Others, such as Nancy Boyd-Franklin and Elaine Pinderhughes, wrote about African American families, racism, and the poor, but these were seen as special topics, not pertaining to family therapy itself. Similarly, writers on couple therapy, child abuse, the family life cycle, and other issues pertinent to family therapy continued to use white families as the norm, including myself (MM), and neglected to consider cultural differences and social inequalities. As time went

on, family therapy conferences began to include one or two presenters of color to present on issues of "minority families" as opposed to "families." By 1985 AFTA had given about 75 awards, but not one had gone to a man or woman of color. The two most well-known men of color in the early family therapy movement, Harry Aponte and Braulio Montalvo, did not receive awards until the 1990s.

The American Association for Marriage and Family Therapy (AAMFT), while claiming to represent family therapists throughout the United States and Canada, was as remiss as AFTA in its recognition of women and people of color. Although founded in 1942, the AAMFT did not elect its first woman president until the 1990s, and the first president of color was not elected until the 2000s. The organization moved from California to Washington, D.C., but did not have a person of color on its national staff until 1982, despite its location in two of the most culturally diverse regions in the country. The AAMFT guidelines and standards for practice did not mention a single word about "culture" or "diversity" until the early 1990s. Fortunately, from that time on, there was a gradual shift toward an emerging cultural perspective in family therapy.

However, notions of culture and class were still applied primarily to people of color, immigrants, or those with specific diagnoses. One could still discuss "couples," "child-focused families," "genograms," or "the family life cycle" without specific mention of gender, class, culture, or race. The term "family," unless otherwise qualified, still generally meant intact, once-married, heterosexual, white, middle-class couples and their children. Even a family's third generation was often referred to as an "extended family," as if "family" included only those living together in the present.

The emerging cultural perspectives did expand the ways in which families and family therapy were thought about to include the dimensions of gender and culture, although these dimensions were for a long time viewed as "special" features of certain families rather than as basic dimensions for understanding all families. Gradually, perspectives began to expand beyond just asking that more minorities be included in leadership positions. Some family institutes offered workshops, usually by visiting presenters of color, on poor Black families, although, again, these discussions were still generally marginalized rather than integrated into the main body of family therapy.

Gradually, beginning in the 1990s, cultural diversity workshops became more common at major family therapy meetings. African Americans appeared on panels, and more books and articles began to appear on Black families and other cultural minorities; there was some acknowledgement that researchers had ignored the experience of families of color. Accepted definitions in the field of family therapy now began to be questioned. These definitions had labeled both people of color and women as deficient—undifferentiated, enmeshed, or having high expressed emotionality.

A few institutions, to encourage change in the balance of white therapists, awarded a small number of minority scholarships in modest amounts.

However, when minorities did not sign up for family therapy training, it was seen as their problem. By the early 1990s the AAMFT, with much fanfare, gave out a mere $5,000 in minority scholarships.

The annual AFTA meeting had a plenary on culture, in which it was intended that people of privilege would begin to take some responsibility for their own part in cultural problems. Three white therapists presented three white cases and had a panel of discussants, including one African American (myself, KVH). I said that if I had been the therapist in these cases, race would have been an issue, because I rarely have the luxury of working with a case in which race is not an issue. This issue was not picked up by the other discussants, who moved on to other issues of more interest.

### *Transforming Our Vision*

A fourth perspective, requiring second-order change, began developing later in the 1990s. From this perspective, all families, not just "minorities," are seen as embedded in and bounded by class, culture, gender, and race. Using this perspective, how a society defines gender, race, culture, and class relationships is critical to understanding how *all* family processes are structured.

This phase of family therapy, which has not yet become mainstream, aims to meet the needs of people of all cultural backgrounds. Courses on couple therapy use theory developed on families beyond European American couples. These included Black[1] couples, Chinese couples, interracial couples, and gay couples, not just occasionally but as a core of the course. Theorists whose work has developed primarily in a context of work with non-dominant-culture families became core faculty in training programs. The faculty and students of training programs become more culturally diverse. It will require second-order change for the leaders of the field to make room for the inclusion of knowledge and teaching other than that of the dominant groups. Faculties of training programs will need to be reconstituted to reflect diversity, and subject matter will need to be rethought from more inclusive perspectives. Emphasis will need to shift from the teachings of a few highly valued leaders to experiential and reciprocal learning. The wisdom and strengths of American Indian, African American, and other nondominant cultures will become an integral component of family therapy theories.

Student training will need to expand to include home visits and studies of the cultural values and healing customs of Muslim, Asian Indian, and Latino families. Students should be encouraged to collaborate with indigenous cultural leaders in the community to help families. Questions about how families are located in their communities will need to become a routine aspect of assessment. Training should involve exploration of the assumptions of the theorists in the field, as well as of faculty, students, and clients. The field will expand to include study of healing in cultures around the world. Spiritual, physical, psychological, and biological solutions to problems will be increasingly employed in an integrated way.

## FAMILY THERAPY REDEFINED AND RECONSTRUCTED TO INCLUDE US ALL

This final phase is hard to envision, just as it has been for Peggy McIntosh in the field of education. Its description must await our learning to see around the next corner. Surely in this phase family intervention must occur in more flexible contexts with a more diverse array of helpers and a more flexibly defined "family." Intervention strategies need to draw from cultural healing the world over. Family therapy training will need to focus on how we understand those who are different from ourselves. It is so difficult even to picture a world not divided by our current hierarchical structures that it is hard to imagine what healthy families or therapy may come to look like. One thing seems sure: As we expand the boundaries of our field, we open up enormous possibilities for helping families in multiple contexts and with a great variety of healing tools, from music, meditation, prayer, and poetry to community meetings and empowerment.

## CODA: TAKING THE BROADEST POSSIBLE SYSTEMIC VIEW

We want to offer a coda or postscript to this introduction, hoping to inspire you, our readers, to keep thinking systems no matter how much the pressure becomes against it. We want to encourage you to keep paying attention to your own values and definitions of health and meaning in life as well as of evil and pathology in all our relationships—with each other and with the world around us.

We want to end this introductory chapter with a story that comes out of work done by Joanna Macy, a trainer and activist who worked with and was inspired by Gregory Bateson and other systemic therapists and whose work has inspired also the Virginia Satir Global Network to tell the story and encourage people to think systemically about the earth and about each other. Macy has trained groups and communities all over the globe in systemic perspectives. She had occasion to go to Russia to work with communities in their efforts to find ways forward after the horrendous nuclear catastrophe in Chernobyl in 1986. Macy and her husband, who had led the Peace Corps work in Russia for years, worked with many communities, but their pivotal experience was in the town of Novozybkov, a town of 50,000 people. As the nuclear cloud moved away from Chernobyl in the direction of Moscow, the government had decided to stop the radiation cloud by making it fall on the town of Novozybkov instead of on the large city of Moscow. No one was told what was being done, so when the ash began raining down, the people had no idea that the catastrophe was being turned on them. It was months before they learned the truth of what had happened, months of people mysteriously beginning to get sick and die. They were so traumatized by the effects of the nuclear disaster that even 6 years later they refused to discuss it. They referred to it as the "event," but refused to even say the words "Chernobyl" or "nuclear" or

"radiation." They knew they would be dealing with the horrendous effects for the rest of their lives and for generations to come—the cancers, the deaths, the people missing and dying early in their community. As Macy and the other trainers worked with a group of 50 who were participating in their workshop, they tried, as creatively as they could to think of, to strengthen the community.

Macy had been thinking that just as the radiation attacks the body, it assaults also society, eroding people's sense of community and wholeness. She thought they needed to remember who they were and where they had come from. She taught them a Latvian song and dance she had learned from a German colleague that had become a major song of resistance, revolution, and freedom when the Latvians were struggling against the Russians. The song, "Ka man Klages" or "The Elm Dance" (*www.youtube.com/watch?v=z8E1bOma_Ag*), was about strengthening the elms from the elm disease that was destroying elms around the globe. It was also a song and dance of intention, about spring and the trees blooming; and the swaying of the dance was symbolic of the community moving together somehow. The song had a special resonance for the people of Novozybkov, because the radiation stays in wood for generations more than anywhere else. And the people of the town had always loved the woods and saw it as a place of recreation, refuge, and home. But now they were forced to teach their children that the woods was a dangerous forbidden place.

Macy taught them the simple circle dance, and the group wanted to sing and dance to the music again and again.

Then Macy invited them to do an exercise where they would spiritually connect with their ancestors and draw from their strengths, moving forward in time as they moved toward the center of the circle and talking about the gifts they had received from each generation of ancestors. The group participated, sharing the gifts they had received from their ancestors, until they got to 1986. At that point they refused to speak or move any further. First they were silent, but then finally the horror of what they had lived through exploded.

The leaders also had the group draw pictures of the gifts they had received from their ancestors, but when they got to 1986 they just drew large *X*'s. When asked to explain, they conveyed their rage that nothing could move them forward. One woman turned her rage on Macy, blaming her for trying to make them face this horror. Silence followed. Finally, Macy spoke, saying: "I have no wisdom with which to meet your grief. But I can share this with you: After the war which almost destroyed their country, the German people determined that they would do anything to spare their children the suffering they had known. They worked hard to provide them a safe, rich life. They created an economic miracle. They gave their children everything, except for one thing. They did not give them their broken hearts. And their children have never forgiven them."

The next morning the group began again with the Elm Dance. The pictures they had drawn the previous days were still on the walls around the

room. When Macy asked how they were doing, one woman who had been most enraged the day before, whose daughters had cancer, said she had hardly slept. But, she said, she felt her heart was breaking open and though perhaps that would keep happening, she felt somehow it was right, because it connected her to everyone as if they were all branches of the same tree. Others spoke of feeling somehow cleansed and connected. Macy then made them a promise that she would tell their story and do the dance because she knew they felt the outside world had forgotten them. She knew that their woods, which was always their home, held the radioactivity and that they could never go there. But, she said, by sharing their story she would try to help connect them more broadly to others. Through their story and the Elm Dance, Macy would spread connections to others around the world to think about protecting each other and sharing their intention to hold on to each other. The song itself, like many African American spirituals, had a double meaning—to hide people's connection and to inspire and share their hope. This seems a powerful intervention, and we hope you will draw from this and many more such inspiring systemic suggestions throughout this book to help you creatively support your clients to find hope and healing in their lives.

## NOTE

1. In this chapter we have capitalized "Black" and lowercased "white," in spite of the convention to do the reverse, because it seems to us that "Black" is a word which at least to some extent was chosen by African Americans to refer to themselves, while "white" does not deserve the "specialness" of capitalization as an honor to the distinction.

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