

Feminist Therapy with Ethnic Minority Populations: A Closer Look at Blacks and Hispanics*

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The integration of a feminist philosophy into the theory, practice, and ethical standards of traditional psychotherapies with ethnic minorities deserves close examination, for it offers a potentially rich, philosophical orientation from which to conduct therapy. Most theories of human behavior and methods of therapeutic practice have failed to take into account cultural variables relevant to ethnic group members (Solomon, 1982). Traditional clinical intervention strategies have had varying degrees of effectiveness with Black (see Jackson, 1983, for review) and Hispanic clients.

Increasingly, ethnic minority practitioners have questioned the application of traditional theory and methods to ethnic group members because traditional approaches lack congruence with their experiences, life-styles, and culture (Jackson, 1983; Mays, 1985). The authors believe that there is a definite need for developing theories and methods appropriate to the culture and life-style of the various ethnic groups. Until these theories have been developed and empirically tested, it is necessary in current practice to take into account the unique experiences of ethnic minorities, considering the influence of the external social world on their personalities (Lerman, 1985; Solomon, 1982). This

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orientation must modify traditional theory and practice to accommodate the interaction between the social world and inner reality and the consequent impact on the etiology, presentation, and approach to treatment of ethnic group members. Feminist philosophy offers the potential of such a perspective.

FEMINIST PHILOSOPHY

Early feminist philosophy was questioned and in many instances rejected by ethnic scholars (Smith, 1985). Rejection was based explicitly on the primacy of gender division in feminist philosophy, which was most strongly expressed in two tenets. The first was the belief that the oppression of women was the most fundamental oppression. The second was a belief in a sisterhood in which a woman has more in common with another woman of a different ethnic, racial, or class group than with a man of the same ethnic, racial, or class group. Primacy of gender division tended to ignore the strong realities of ethnicity, race, culture, and class bonds in the lives of ethnic minority group members. It relegated to second class status the racial and ethnic bond that many ethnic minorities perceive as critical to the continuation of their groups.

However, as feminist philosophy has grown and has continued to prioritize the pluralistic and integrative aspects of its philosophy, its relevance as a philosophical foundation for psychotherapeutic treatment of ethnic minorities has increased. The greatest asset of current feminist philosophy is its belief in a dialectical relationship between its theory and practice. As experiences occur that challenge its theory, the theory is refined to adapt to those experiences, keeping both theory and practice accountable to each other (Stanley & Wise, 1983). This dialectical process within feminist therapy challenges the practitioner to examine those aspects of theoretical and applied traditional therapies that are speculative and concerned primarily with abstract knowledge. A feminist philosophy mandates the practitioner to engage in ethical therapeutic practices grounded in experiences that reflect the client's social reality. Inherent in this philosophical orientation is the demand that practitioners monitor ways in which their individual, internalized value systems operate on the outer world of their clients' lives (Gilbert, 1980). The necessity for social change as well as inner psychological changes in order to promote well-being among ethnic groups is an implicit challenge of a feminist perspective (Lerman, 1985). For the ethnic client, feminist therapy encourages understanding the intricate and complex social realities and the effect of economic, social, and biological systems in their lives.

SOCIALIZATION AND DEVELOPMENTAL ISSUES

A great deal has been written about the impact of the differential socialization of women and men on the development of personality, character traits, styles of relating, and sense of self in relation to the world (Chodorow, 1978; Gilligan, 1982; Schlachet, 1984). However, the impact of differential socialization among ethnic minorities has been examined very little; instead, it has been assumed that the same detrimental effects have been suffered. This volume espouses that feminist philosophy recognizes the process whereby the socialization of women differs from that of men and regards the process and effects as destructive and oppressive to women. Let's examine the application of this premise to two specific ethnic minority groups: Blacks and Hispanics.

Blacks

The socialization process of Blacks originates in a value base that has been transmitted from generation to generation. It is characterized by a strong ethnic identity, a sense of community, the rejection of materialism and competition as basic values, and a strong sense of spirituality (Ward, 1981). In Black culture individuals belong to a racial/ethnic community by virtue of skin color and may feel that they owe their survival to other people, both past generations and contemporaries who sacrifice and strive each day to make their lives better (Mbiti, 1969). The community is responsible to a large extent for the individual's sense of identity; it instills attitudes and beliefs regarding the self, the community, and the larger society that ensure development and survival of the self.

For Black Americans the family and the community are critical to the individual's physical and emotional survival. Blacks live in a community under attack by the values, beliefs, and attitudes of an Euro-American culture. Hence, the socialization of Blacks has been shaped by an antagonistic environment (Ward, 1981). In maintaining their culture in the face of antagonism, Black women and men have developed cultural/gender-specific patterns of socialization in order to lighten their feelings of oppression, enhance group solidarity, sustain hope and build self-esteem and satisfying survival-based interpersonal relationships (Billingsley, 1976). The sex role demarcations in Black culture are often confusing to nonethnic minorities as they do not follow those of Anglo culture and in some ways differ from those of other ethnic groups.

Black women are described by such characteristics as: self-reliant (Robinson, 1983), self-assertive, independent, strong, possessive of a

fighting spirit, contrary, and erotic (Christian, 1985). At the same time Black women have suffered from the stereotypical images of Sapphire, Aunt Jemima, the Black mammy, the sex kitten, and evil woman; although the labels are not overtly in use, Black women continue consciously to refute them in their physical appearance, manner of dress, and behavior. In attempts to help disprove these images, Black men, particularly believers in Nationalism, idealized the Black woman and her relationship to Black men by viewing her as Queen or Mother of the Universe, responsible for the survival of the Black race (Christian, 1985). Indeed, in the past the Black community would not have survived if Black women had not taken on the roles of supportive wives and mothers. Black women are the keepers of the moral conditions of Blacks and hold the key to physical survival by bearing children to create a new nation.

Clearly, sexism and racism have critically affected the social and psychological spheres of Black women and men's lives. The impact for both is felt most strongly in their identities as men and women. The Black man is often characterized as sexually promiscuous, macho, lazy, slick, handsome, experienced in the ways of life, a protector and endangered (Gary, 1981). Some Black men, in struggling to live the role of a man in American society, are filled with anger, self-hatred, or depression for they are powerless, instead of powerful, as men are expected to be. The Black man's displays of his (limited) power, or rather his maleness, most often must rely on the cooperation of the Black woman. His mate becomes a visual representation of his financial success and access to power and resources in society. Her appearance, her sophistication and savvy in social spheres, her level of education, her employment, and other signs of achievement are benchmarks for his success in the world. The Black woman is critical to his display because racism limits his physical and economic access to other displays of power, such as owning property in exclusive neighborhoods and the ability to participate in leisure activities that require private membership or prestigious employment. Hence racism by its restrictions reinforces the need of some Black men to imitate the white man's conventions for power displays (Christian, 1985).

When a Black woman opposes this symbolic role in a relationship, a Black man feels betrayed and not supported in his efforts to be "a man." Other Black women, conditioned by years of selfless behavior (Mays & Howard, 1986a) and responsibility for the survival of the race, often feel a part of the failure that Black men experience when denied their status as men (Christian, 1985). In a true ethnic/gender-appropriate mode, some Black women compromise their own dreams and ambitions to assist the men who, because of society's sexism, are

more likely to bring in greater resources and status to their families than are the women. But the struggle by Black women not to subjugate their individual selves to family or community survival is an old one. Women often have been caught between their own personalities and desires and the life expected of them as Black mothers in a racist and sexist society.

The Black women who refuse this role, who define themselves outside of the gender, class, and racial/ethnic definitions of the Black society, are viewed as *contrary*, a term used in Black culture (Christian, 1985). "Contrariness" in Black women often reflects attempts at self-definition and maintenance of integrity in the face of race, class, and gender definitions by the larger society and gender and class restrictions of behavior within the Black community.

Black women not only bear the traditional definition of women in their culture but also must confront the limiting sexist myths of another race that oppresses them (Christian, 1985). The conventions that are expected to hold are not even conventions of their own communities (Christian, 1985). Black women fall especially short of fulfilling the role of woman when the model is the Southern white woman. As Christian (1985) points out, it is no wonder that these Black women seem mad or their behaviors irrational whenever they are being themselves. Their contrariness is an insistence on being spontaneous, "characteristically themselves, momentarily human beings without the societal constraints of either the Anglo or Black community, which have planned their paths regardless of their individual personalities, dreams, or desires (Christian, 1985).

The Black woman who chooses not to be a wife or mother, who chooses to be in an interracial relationship, who fights with others regarding their assessment of her, or who places her self-development as a priority before the many needs of her family or the Black community is "contrary." The Black woman who says "no" to a Black man regarding his expectations of her relationship to him is "contrary" (Christian, 1985). The Black woman who chooses a path of development not typical of most Black women's planned destinies is "contrary" and her behavior is dismissed as irrational. The further she moves from society's prescribed roles for her the more she is viewed as angry or, from the Black male's perspective, as having a "chip on her shoulder." Black women are viewed by whites as different because they are Black and by Black men as different because they are female. Consequently, this "other" status often leads to dismissal of attempting to truly understand their behavior (Christian, 1985). Instead, such behavior is dismissed as the woman's own problem.

Although these "contrary" women maintain a sense of integrity, they can pay a price for it ranging from loneliness to being targets of physical violence. Solace and empowerment are often found in relationships with other Black women, from which a new perspective in self-identity and roles within the Black community emerges. The amount of courage to challenge the Black woman's limiting role in a society with a racist and sexist definition of her is tremendous. Yet seldom within the therapeutic context of assessing psychological strengths is this acknowledged.

In understanding the life of the Black American, a therapeutic paradigm that encourages exploring the role of culture and the impact of migration is important. Many of the cultural mores and ethos embraced by Black Americans find their roots in a Southern tradition—a culture that flowed from a rural life-style—where societal conventions have much to do with the conduct of relationships between man and woman, young and old, and Black and white (Christian, 1985). Memories linger of a united community which sustained its members even under the hardest times. It was a culture where mobility was restricted, work was for survival, motherhood usually occurred within the confines of marriage, and pain and sorrow were trivialized as legitimate states for Christians.

Movement to the urban life-styles of the present challenged the notions which were passed on as legacies by previous generations. Stories of suffering, hard times, the necessity of struggle, the placement of the family (and, thus, the race) above all else by the Black woman and the equation of Black manhood with a well-paying, steady job are legacies creating present-day "ghosts" for many Blacks.

Myths, memories, and folklore combine with the events of the present to cause some Blacks to live constantly in the shadow of these "ghosts." For those never explicitly told the myths that everyone else operates from they strive to intimately understand the nuances of Black culture. In a time in which a steady, paying job is unobtainable by a large segment of the Black male community and when Black women who constantly give of themselves suffer depression from the lack of respite from their roles, these legacies are significant factors in current intrapsychic states. Even those not knowing their history or understanding the intricacies of Black culture wrestle with the ghosts of invalid stereotypes from 100 years ago (Christian, 1985). Practitioners need to understand that the legacies of the past which help form identity are best handled by neither denying them nor becoming fixated on the past, but rather by renewing those aspects of heritage that are nurturant, sustaining, and culturally defining. Practitioners must help their ethnic clients not allow their cultural or ethnic heritage to function as an

abstraction to which they subordinate their individual lives. Instead, they should grasp the past as a living idea that helps to chart the future.

The Southern tradition taught many Blacks, especially Black women, an "I-can-do" ethos, in which righting a wrong means attacking the problem head on, not waiting, and not "meeting to meet" about the problem, but rather naming the problem and solving it (Mays, in press). Such strategies may conflict with those of an urban, Euro-American tradition.

As generations live their lives in urban, Northern culture, moving into new cultures and transcending the old class structures, tensions have developed as to the existence of a Black culture or identity among the heterogeneous Black population. The questions, as posed by Christian (1985), are:

whether there is a functional Black culture in the present day society, a contemporary Black community that is held together by bonds that work. Are Blacks essentially upwardly mobile and taking on an amalgamated cultural identity? Is color merely camouflage? Or is race/ethnicity in America operating as a communal bond, a source of rich support and positive identity or is it merely a marker of a past history once functional but no longer perceived by contemporary blacks as operative in their response to each other? (p. 69)

These are crucial questions with which many Black Americans struggle intimately today. The questions manifest in many disguises in the therapy room. For example, a typical issue is how to be assured that children of professional Blacks who have lived and attended primarily white and middle-class schools can be given a Black identity and the skills and experiences to interact positively with other Blacks from less privileged backgrounds. Another disguise is feelings of frustration and depression among professional Black women whose occupations propel them into a middle-class environment where they find few eligible Black men for long-term relationships. Feelings proud of their career achievements nagging feeling sometimes loom that this achievement was at cost of potential Black male marriage partners. Or there is the issue of the young, Black, teen-age gang members who rob and assault other Blacks and express no sense of common fate with their victims. The sense of community based on ethnic identification appears lost.

As Blacks struggle against the racist, sexist, classist definitions that society has promulgated for Black men and women, it is critical that we have a therapeutic philosophy that examines behavior as it relates to the social structure. There is movement to a new class with few

role models showing how to maintain elements of the Black culture, which seem out of place in certain class activities. Given the changing realities of Blacks, a therapeutic philosophy is necessary in which heterogeneity is viewed as positive. In the 1980s there are many lifestyles and ways of approaching issues that confront Blacks as Blacks, as Americans, and as individuals. This creates a real struggle for Blacks facing a legacy passed on by parents and the community—a dream and mandate for the survival of that family or community's image.

HISPANICS

Hispanics like Blacks embrace cultural values that often differ from those of White Americans. Within the traditional Hispanic culture, sex roles are clearly demarcated. Men are expected to be cold, intellectual, rational, profound, strong, authoritarian, independent, and brave, while women are expected to be sentimental, gentle, intuitive, impulsive, docile, submissive, dependent, and timid (Senour, 1977). These attributes are encouraged early in the socialization process, where boys and girls are taught two very different codes of sexual behavior. Boys are given greater freedom of movement, are encouraged to be sexually aggressive, and are not expected to share in domestic or household responsibilities. On the other hand, girls are expected to be passive, obedient, and homebound. Furthermore, men are seen as strong by nature and not needing the protection required by women, who are perceived as weak by nature and vulnerable to the sexual advances of men. This rigid demarcation of sex roles encourages a double moral standard for the sexes and is epitomized in the concept of machismo.

Machismo literally means maleness or virility and stipulates that by virtue of their gender, men are superior and are to be treated as authority figures. Culturally, it means that the man is the provider and the one responsible for the welfare of the home and the family. Machismo tends to be manifested in a man's sexual freedom, affective detachment, physical dominance over women, and excessive alcohol consumption (Giraldo, 1972). Although it has been argued that machismo is more prevalent among lower socioeconomic classes (Kinzer, 1973), it is nevertheless believed to influence behavior in all strata of Hispanic society (Giraldo, 1972).

The cultural counterpart of machismo is marianismo. Based on the Catholic worship of the Virgin Mary, who is both a virgin and a madonna, the concept underlying marianismo is that women are spiritually superior to men and, therefore, capable of enduring all suffering inflicted by men (Stevens, 1973). Using the Virgin Mary as their role

model, unmarried Hispanic women are expected to be chaste and virginal, and not to demonstrate interest in sex even once they are married. When they become mothers, Hispanic women attain the status of madonnas and, accordingly, are expected to deny themselves in favor of their children and husbands. The image of the "Mater Dolorosa" is quite prevalent among Mexican-American women by arguing that these women, without being masochistic, appear to get satisfaction and fulfillment from suffering. Stevens (1973) associates this with Catholicism, which offers guidance on how to suffer and emphasizes its benefits. In noting the high incidence of somatic complaints among low-income Hispanic women in psychotherapy, Espin (1985) suggests that these complaints may well be a reaction to the self-sacrificing dictum, especially since somatization is a culturally accepted mode of expressing needs and anxieties.

At first sight, these sexual codes seem to condone the oppression of one group (women) by another (men) and thus coincide with the feminist precept that the socialization process is destructive and oppressive to women. However, the dynamics involved in male-female relationships are very complicated and as a consequence, the power relationship between the sexes is not straightforward. For example, Stevens (1973) asserts that the marianista code rewards women who adhere to it. Due to the sacredness of motherhood, women who bear children enjoy a certain degree of power despite the outward submissiveness of their behavior. Stevens further posits that as women grow older, they attain a semidivine status. Adult offspring tend to fight their mothers' struggles, especially against their fathers. Furthermore, the children are manipulated into doing what their mothers want. Hence, power is achieved through passivity and conformity to the marianista role.

Another way in which Hispanic women obtain power is by emphasizing their culturally ascribed feminine role. Historically, women in most cultures have resorted to healing and magic as a means of empowerment (Bourguignon, 1979). Similarly, Hispanic culture assigns the healing role to women: *curanderas* among Mexican-American women, *espiritistas* among Puerto Ricans, and *santeras* among Cubans are overrepresented by females. Espin (1985) states that Hispanic female healers obtain power through the use of supernatural forces that cannot be resisted. She asserts that Hispanic female healers are transformed, by virtue of their healing powers, from powerless members in the family (due to cultural sex role expectations) to powerful members. Moreover, they obtain control over their lives, performing behaviors that are usually associated with women who espouse feminist values. These behaviors include leaving their family in order to pursue their healing

"careers" and, as a consequence, achieving social mobility, financial independence, and community prestige.

Furthermore, Comas-Díaz (in press) asserts that within the Puerto Rican culture, women enjoy a powerful, albeit passive position, because the task of communicating with the spirits is still a predominantly female one, dating back to the Taino Indian society, characterized by the belief in spirits, where women had the power of invoking the spirits. Similarly, Canino (1982) found that when she studied sex roles among Hispanics, both husband and wife reported traditional patriarchal attitudes. However, when the same couples were interviewed extensively and observed during decision making, the most prevalent marital transaction was a shared process. Thus, this suggests that the cultural context needs to be taken into consideration when denoting a "socialization process that is oppressive to women."

Feminist philosophy can be useful in assessing Hispanic women's behaviors. For example, cultural dynamics discourage women's direct expression of their feelings and rights. As a consequence, feelings of inferiority, premature marriages, and motherhood among Hispanics have been related to their traditional female roles (Canino, 1982). Moreover, Lopez-Garriga (1978) describes the use of indirect and/or covert manipulation among Puerto Rican women in order to exert power in a culturally acceptable manner. She indicates that these manipulative strategies are characteristic of oppressed people of different sexes and ethnicities. Clearly the feminist paradigm can properly address these issues.

Oppression is a relevant paradigm in using a feminist framework with Hispanics. Hispanic women are observed to defend and perpetuate machismo as a way of coping with the oppression that ethnic minorities face in the United States. For example, Senour (1977) claims that Chicanas reinforce machismo in their men to compensate them for their lack of status in the majority society. Similarly, Steiner (1974) cites Puerto Rican women who defend machismo as an understandable response to socioeconomic deprivations as well as to racism: Men take their frustrations out on women because they are oppressed. In utilizing a feminist perspective, the therapist needs to take these issues into consideration.

Another paradigm that the feminist therapist needs to observe while working with the Hispanic population is acculturation. Hispanics in the United States exhibit diverse degrees of acculturation, which is directly related to gender roles. Traditional sex roles are undergoing change among Hispanic emigrés. The Hispanics' native culture, including its machismo/marianismo codes, is not reinforced by the new dominant culture, which is more influenced by the impact of the

women's liberation movement. However, cultural transition itself often presents Hispanic men and women with a sex role reversal in terms of public interactions. For example, studies of immigrant families reveal that the family member who most often deals with the dominant culture assumes the instrumental role, thus becoming autonomous and more acculturated, while the one who assumes the affective role becomes increasingly isolated (Sluzki, 1979).

In many cases, the instrumental role is filled by the man and the affective one by the woman. However, among Hispanics instrumental/affective role taking is not always respectively male/female. The pressures of economic survival in the United States, as well as the types of skills that are in demand, have contributed to the role reversal among Hispanics. This role reversal is common, as it is often easier for low-income female immigrants to obtain employment in the United States than it is for male immigrants. Indeed, the woman may have no choice but to assume the instrumental role because she is able to sell her sewing and domestic skills, while her partner's ability to farm is not marketable and therefore is irrelevant in the city. This situation is typical among most ethnic minorities who immigrate to the U. S. (Immigrants, 1985). Ethnic minorities may present themselves in therapy struggling with the consequences of sex role reversal. Feminism, with its emphasis on power-balanced relationships, can be used effectively to address these issues.

First-, second-, and even third-generation Hispanics continue to face acculturation conflicts. For example, sex roles among Hispanic women can be complicated by the expectations imposed by the two different cultural contexts in which they live. The Anglo culture tends to apply masculine criteria to the evaluation of women's performance, ascribing the greatest value to those who distinguish themselves occupationally or professionally. Yet this tendency is contradicted enough to send mixed messages to the women. For example, a consequence of this is that the Chicana is far surer of her role within traditional Mexican culture than she is in the mainstream, where her role is ambivalent (Senour, 1977). Apparently, this sureness of role that her ethnic culture provides has not stopped the Chicana, nor other Hispanic women, from exploring the behavioral alternatives available to her. This exploration can lead to conflict within the nuclear unit as well as within the extended family. Again, feminist therapy is equipped to best deal with these contradictions and help the woman separate the societal pressures of her ethnocultural reality from her personal dynamics.

The degree of acculturation needs to be carefully monitored. For instance, a first-generation Hispanic woman would present a different clinical picture than a third-generation one, who in turn would be

placed at a different point of the acculturation spectrum from the recent immigrant. In addition, regardless of acculturation, gender roles should be assessed and the socioeconomic context considered. For instance, it is common to see a middle-class, second-generation Hispanic woman professing progressive and even feminist views regarding education and employment of women, while holding traditional values on family and marital relationships. The following vignette illustrates some of these issues.

Susana is a 22-year-old Cuban-American woman. She lives at home with her parents and a younger brother 18 years old. Susana is enrolled in a nearby college, where she pursues a bachelor's degree with plans to later become a lawyer. She is a first-generation Hispanic within an upper-class family. Her father, a physician who emigrated from Cuba with his family, has a successful practice in the United States. Her mother, a college professor in literature, was unable to find a comparable job and decided to "stay home and take care of things." Susana is fully bilingual and highly acculturated to the mainstream. Both parents have reinforced her nursing a professional career and allowed her a significant amount of autonomy.

Susana was referred to psychotherapy after a suicide attempt with an overdose of pills (Valium from her father's supply). This was her first contact with the mental health system. The whole family was seen in evaluation. The family assessment revealed a patriarchal system, with the mother bearing indirect influence and power. Although Susana was the elder, she was treated as a child by all family members, including her younger brother.

Individual sessions revealed that the precipitant event for Susana's suicide attempt was the anniversary of her abortion. Susana became pregnant by her boyfriend, a Black American classmate, during her first year at college. Susana had wanted to get married and establish her own nuclear family. Her parents, however, stated that Susana's pregnancy would impede her future career as a lawyer. Thus, they pressured Susana into having an abortion. Later Susana realized that her parents' real motivation for the abortion was a racial one; they did not want Susana to have a Black child. Susana, who was raised as Catholic and viewed motherhood as sacred, had extreme difficulties dealing with these inconsistencies.

During therapy Susana was able to mourn the loss of her pregnancy and to work through her guilt. Feminist orientation was used in therapy aiming at empowering Susana by expanding her options. Treatment also addressed Susana's coping with cultural inconsistencies.

CLINICAL ISSUES

Basically, ethnic minorities function psychologically similar to any other group of people (Block, 1981). What differs and what the practitioner needs to take into account is their manner of expression or intensity of symptoms (Block, 1981). Because of the racial, ethnic, cultural, class, and gender struggles of ethnic minorities, they do develop different personality structures, defense hierarchies, and symptomatologies in response to their social, political, and individual life conditions (Block, 1981). These differences have clear implications for help-seeking behavior, clinical presentation in therapy, and the client's attitudes and expectations of mental health services.

Help-Seeking

Ethnic minorities continue to underutilize traditional mental health services (Kitano, 1969; Mays, Howard, & Jackson, 1988; Neighbors, 1984; Neighbors & Jackson, 1984). When they do enter the traditional service system, they tend to receive inpatient treatment, more crisis intervention services, and fewer psychotherapy sessions, and they fail to keep appointments and terminate therapy early (Griffith, 1977; Jackson, 1976; Jones, 1974, 1978; Sue, McKinney, Allen, & Hali, 1974; Warren, Jackson, Nugaris, & Farley, 1973; Yamamoto, James, & Palley, 1968). The fault for this underutilization is often placed on demographic characteristics (such as lower income and less education) of the ethnic group. Some believe that it is a mistake to focus on these factors in isolation from the total context of how ethnic group members define mental health problems, where they go for help, and when it is deemed appropriate to seek professional treatment (Mays, Howard, & Jackson, 1988; Snowden, Collinge, & Runkle, 1982). It is a mistake that may cause practitioners to overlook valuable opportunities for interventions that may reduce or eliminate low utilization or early terminations by ethnic group members (Snowden, Collinge, & Runkle, 1982). The pluralistic orientation of feminist therapy may have some impact in changing this pattern.

For the most part ethnic minorities do not perceive mental health services as the most relevant avenue for coping with their problems unless those problems have reached the stage of a "nervous breakdown" (Block, 1981; Neighbors, 1984). Coping styles within most ethnic group communities follow a tradition of independence and self-reliance (Robinson, 1983) in which intrapsychic problems are handled alone, within the family, or in extended kinship/friendship networks (Block, 1981).

For example, in the Black culture there is an emphasis on accomplishing tasks with "no sweat" (Block, 1981). The no-sweat attitude is particularly characteristic of ethnic men, who in times of stress may display a cool indifference toward their problems. Complaints or attitudes of "can't" are viewed as inappropriate according to the legacy of a people who have sacrificed and overcome many apparently dramatic traumas.

Even in everyday occurrences, the number of serious survival based problems that some segments of the ethnic community struggle with cause the seriousness of intrapsychic conflicts to pale in comparison. Seeking treatment in a formal setting for such problems is viewed as a self-serving luxury that is not appropriate. When problems are encountered, informal networks are the primary choices for help seeking. Among Black Americans informal networks (e.g., friends, minister) are used to a greater extent in coping with problems than are the traditional mental health services (Mays, Howard, & Jackson, 1988; Neighbors & Jackson, 1984). The young Black man who after a marital disagreement calls his friends to play basketball may be viewed as indifferent or not upset by the marital dispute. But within a cultural/gender-appropriate perspective, this behavior reveals that he is seeking informal help. This young Black man will discuss his marital problems within a context that is informal but typical of Black male, help-seeking strategies.

Asians follow a pattern somewhat different from that of Blacks as they are less likely than Blacks to handle problems alone or to seek the services of a community mental health center. They are less inclined than Blacks or Hispanics to utilize ministers. They rely most often on family, friends, physicians, and hospitals for help with emotional or personal problems (Ossirio, Aylesworth, & Lasater, 1979). The Chinese help-seeking pattern is one in which there is persistent family involvement, extensive use of general health care systems, and extreme delays in mental health contact and entry (Lin, Inui, Kleinman, & Womack, 1982; Lin & Lin, 1981). In most Asian cultures, the family rather than the individual is viewed as the basic social unit. The mental illness of an individual is taken as a threat to the homeostasis of the family unit (Lin, Inui, Kleinman, & Womack, 1982). Therefore the involvement of the family in seeking help and the attempts at containing the problem within the family tend to be persistent (Lin, Inui, Kleinman, & Womack, 1982). According to Lin et al. (1982), because the shame and failure is shared by all of the family, the family promotes denial of the problem as a psychiatric one. The individual is more likely to somaticize, which allows the behavioral aberrations and psychological suffering to be viewed more comfortably as having a medical basis. Hence, it is important to recognize how cultural norms and networks that are often presumed to be supportive may influence the symptoms presented.

In addition, the therapist may need to take into account the conflict, feelings of shame, and embarrassment or traitor status that ethnic group members feel when they turn to professional sources. These feelings may be exacerbated when the therapist is Anglo. Sensitivity regarding how the cultural dynamics may impact the entry into treatment of ethnic group members may help in maintaining them in treatment.

Typically, ethnic group members do not enter the formal mental health system until their problems are severe or symptoms are very distressing (Howard, 1984; Mays, Howard, & Jackson, 1988; Neighbors, 1984), which may account for why they more often need crisis intervention.

Symptoms and Presenting Factors

Somaticization is one culturally acceptable mode used by ethnic minorities to express some of their psychological distress. For some segments of the ethnic community there is little differentiation between physical and mental concerns (Lin & Lin, 1981; Padilla & Ruiz, 1973). Among Asians this lack of differentiation has much of its origin in East Asian (especially Chinese and Japanese) language in which there is somatopsychic terminology for psychological problems, psychocultural coping processes that emphasize suppression and denial of emotion, and the traditional Oriental (Chinese) medical concepts (Lin, Inui, Kleinman, & Womack, 1982). Examples are yin-yang imbalance, obstruction of the circulation of vital energy (ch'i), and disturbances of harmony, with natural as well as supernatural powers being regarded as reasons for physical problems, the somatic bases for psychological disturbances.

Blacks tend to express psychological stress through such problems as headaches, stomach ailments, backaches, and general nervousness, with little understanding of the psychological determinants of these ailments (Block, 1981). Hispanics follow much the same pattern as Blacks, with the same gender pattern of greater prevalence of somaticization among women. Hispanic women tend to report somatic complaints as a means of expressing their needs and thereby obtaining support from significant others (Hynes & Werbin, 1977). A study by Comas-Diaz, Geller, Melgoza, and Baker (1982) revealed that, despite this cultural tendency, Hispanics requesting services at a community mental-health clinic did present complaints of a psychological nature: depression, anxiety, concentration problems, obsessions and compulsions, fears, and sleep problems. In addition, they also complained of physical and financial problems.

It is not unusual that when ethnic minorities enter therapy their major complaints are disguised (Block, 1981). In fact, Black clients may verbally deny the depth of the problem and their need for help (Block, 1981) because of their cultural style of not being dependent and helpless in the face of problems. As Block (1981) points out, what the therapist must remember is that they do *not* feel under control and *do* sense that something is seriously wrong. Thus, in examining the presenting symptoms of ethnic clients it is important to remember that their life situations may result in somewhat different styles of coping and psychosocial competence (Evans & Tyler, 1976; Tyler & Gatz, 1976). A feminist paradigm for therapy of ethnic minority group members would be highly appropriate, for feminist philosophy regards individual behavior as best understood by examining the social structure.

Expectations

Many ethnic groups are more accustomed to a style in which directive help is given by telling the person the necessary course of action to quickly remedy a problem (Carter, 1979; Sue & Sue, 1972; Vontress, 1971). Ethnic minorities live in an environment in which mistakes are more costly to them because of society's negative expectations. Due to the racist, sexist, and classist tendencies to homogenize ethnic subgroups, a mistake by one individual may have repercussions for all members of that subgroup. Because it is so important to "get it right" the first time, the authority will often spell out exactly what is to be done. Mothers concerned about the welfare of their children are very directive in explaining what the child's behavior is to be if that child is to survive successfully in a racist society. The child also learns that this authoritative approach comes from love and caring. Thus, Blacks, for example, when entering mental health services for their physical problems, experience impatience and frustration at the lack of direct intervention aimed at their medical problems.

Unaccustomed to the therapy process and consistent with cultural experiences, they expect the therapist to be assertive, to ask questions, and to come up with an answer as a physician does when physical symptoms are presented (Carter, 1979). In talking about a problem, a client may expect that the therapist will label the seriousness of the problem and the degree to which it is affecting the client. A study conducted by the second author (Comas-Diaz et al., 1982) revealed that Hispanics expected the therapist to be decisive and give advice while viewing themselves as active participants and assuming an active

personal responsibility for the outcome of therapy. Therapists who were not assertive, directive, and decisive were viewed as uncaring.

In establishing a therapeutic relationship it is necessary for practitioners to understand in what way individuals will give them permission to be an influence in their lives (Solomon, 1982). Solomon (1982) describes urban middle-class individuals as relating to others out of a *gesellschaft* orientation in which they look at a person's place in the hierarchy of social statuses and decide what is appropriate behavior in relationship to that status or position. Therefore they become more concerned with the credentials, location, and looks of the office. On the other hand, Solomon views ethnic group members as relating to others from a *gemeinschaft*, a highly personal orientation. This orientation sanctions roles based on personal attributes, so the client's interest is in the attributes identifying the practitioner in the role of person, not therapist. Hence questions arise as to the marital or parental status of the therapist. Differences in orientation call for an involvement of the personal self rather than the professional self as usually advocated by traditional therapies.

Many American psychotherapies emphasize self-disclosure, active participation, openness, decision making, and growth in independence (Wong, 1983). These culturally laden goals may not be the best approach within some ethnic groups such as Asians (Sue & Sue, 1977). For the new Vietnamese immigrant accustomed to a structured society in which one is often the passive receiver of knowledge dispensed by an authority, pushing for active participation, decision making, and independence in the treatment setting would be contrary to cultural expectations (Wong, 1983). Ethnic minorities require culturally informed and relevant services addressing the complex nature of their expectations and attitudes toward treatment (Comas-Diaz et al., 1982). These issues should be carefully examined when delivering psychotherapy within a feminist perspective. Again, feminist therapy, with its pluralistic and integrative orientation, can accommodate and address the complexity of ethnic group members' attitudes and expectations of mental health services.

APPLICATION OF FEMINIST THERAPIES

Blacks

The philosophy of feminist therapy allows for a positive view of the cultural life-styles of Blacks, which promote kinship and friendship patterns, the exchange of favors and gifts, and the ethic of mutual obligation (Bailey & Perkins, 1982). It promotes insight into the in-

terdependence of the past in both its historical and personal realms in coping with the present and moving adaptively into the future.

While there is a multitude of therapies aimed at helping individuals with psychosocial problems, several have common goals: increased skills in coping with everyday events, greater self-insight into the consequences of one's actions in the world, and greater willingness to accept responsibility for one's feelings and actions (Solomon, 1982). It is likely that for Black Americans problems in these areas may be due in part to feelings of powerlessness induced by the negative valuation they experience in society (Solomon, 1982). Thus effective therapy with many Black Americans may need to be directed toward empowerment. Solomon (1982) defines empowerment as "a process whereby the individual is assisted in utilizing interpersonal relationships effectively to enhance self-esteem and obtain basic social supplies, such as health care, employment, or financial assistance" (p. 177). Within the context of psychotherapy she sees this accomplished by:

1. Helping clients to perceive themselves as causal agents in reaching solutions to their problems or problems;
2. Helping clients to perceive the practitioner as having knowledge and skills which they can use;
3. Helping clients to perceive the practitioner as a peer and a collaborator in the problem-solving effort; and finally,
4. Helping clients to perceive opportunities to change the responses from the wider society. (p. 177)

It is also crucial to deal with Black anger and experiences of self-hatred and degradation imposed on Black Americans (Trotman, 1984). Both legacies and current climates have left psychic wounds and scars that have a tremendous influence on the psychological well-being of Blacks in this country. Intra- and intergroup conflicts regarding gradations of skin color, hair texture, and physical features often leave deep pains and feelings of rejection and self-hatred.

Practitioners must be sensitized to the "cultural depression" often brought into therapy by Black clients (Trotman, 1984). In a Black culture which stresses the ability to "do it" and manage difficult situations without showing signs of stress (Block, 1981), the typical presentation signs of psychomotor retardation, weight loss, increases in sleep, and inactivity may not be present. Instead one is more likely to see weight gain from overeating, greater activity, and in the case of Black women, an increase in selflessness behaviors (Mays & Howard, 1988).

Inclusion of the content of Black Americans' experiences may demand a reordering of the thinking and procedures of traditional therapies (Ward, 1981). The collective orientation of feminist therapy will result in the most effective mental health services because it recognizes the need for weighing the Black individual's own goals as well as family responsibilities and obligations against the consequences for the global Black community and against reactions in wider society (Jackson, 1983; Ward, 1981).

Hispanics

Feminist therapy that incorporates an orientation cognitive of Hispanic culture can be successful. It has been argued that when mental health services are culturally relevant, Hispanics utilize them (Abad, Ramos, & Bryce, 1974). Several theoretical orientations and modalities have successfully been employed with Hispanics (Acosta & Yamamoto, 1984). The common denominator of successful treatments is the integration of a sociocultural perspective. For example, all-female groups have been used successfully with Hispanic women, due to the women's willingness to confide in an all-female group matters that they would not discuss elsewhere (Hynes & Werbin, 1977). In a similar format, assertiveness training has been effectively used with Hispanic women (Boulette, 1976). Moreover, a cultural component has been incorporated into assertiveness training in order to "translate" culturally the concept to Puerto Rican women (Comas-Diaz & Duncan, 1985). These attempts have been used by the therapist while applying a feminist perspective to Hispanics.

Feminist therapy, with its precepts of empowering the client, can help Hispanics to better identify and utilize their resources. For instance, support systems are available within the Hispanic culture. The extended family, for example, can be a source of both frustration and support. Feminist therapy, with its emphasis on the collective, can help individuals negotiate this complex network. Feminist therapy, with its aim of achieving meaning in the individual's life, allows Hispanics to examine their ethnocultural identity in the treatment process. This is crucial because regardless of ethnicity, race, or gender, cultural identification is a process that is pervasive (Helms, 1985). Furthermore, the dialectic of feminist therapy enables Hispanic clients to address the dynamic and evolving process of acculturation and its subsequent impact on identity. Many Hispanics have a bicultural identity. Feminist therapy can help Hispanic women, who have multiple, often conflicting

roles, to negotiate conflictive demands and achieve meaning through an awareness of increased choices.

SUMMARY

A therapeutic approach that integrates the interpersonal politics of race, ethnicity, culture, and class into its perspective will be most useful for effectively treating ethnic minority group members. This therapeutic approach, rather than focusing on self-awareness and the ego in abstraction, ought to center on family, community obligations and responsibilities, and the cultural/socioeconomic realities of ethnic group members (Wong, 1983). Feminist therapy is such a perspective. It recognizes the legitimacy of healing that can occur through examining how the outer realities of the social world influence intrapsychic feelings. Other cultural considerations that are important in the treatment of ethnic minorities include attention to the heritage of the client, degree of acculturation or migration experiences, age (generation), circumstances surrounding departure from the client's homeland and separation from loved ones, presence or absence of family, extended family, friends, and community supports, and proximity of these sources of support (Wong, 1983).

As long as traditional theories and methods of application in psychology continue to be predicated on philosophical orientations that are inconsistent with the social and inner realities of ethnic minorities, they remain invalid, and their use is unethical in the treatment of these individuals (Pedersen & Marsella, 1982). Practitioners are facing ethnic minority clients who present patterns of behavior inadequately addressed by many traditional theories of behavior. Practitioners are duty-bound to embrace a philosophy that can help them integrate the experiences of ethnic group members into their behavior theories. Feminist philosophy offers such an opportunity and may be the catalyst for new empirically derived theories of personality and psychotherapy that will result in effective mental health services for ethnic group members.

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