Biracial youth and families in therapy: Issues and interventions, 2000

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Empirical research and clinical resources focusing specifically on minority youth and families have increased tremendously in the last 2 decades. Despite this trend, certain groups continue to be relatively neglected. In particular, very few resources exist for understanding the unique challenges that often face biracial youth and their families. In this article, we use a nationally representative database to compare functioning in biracial youth to white adolescents and other minority adolescents. Results suggest that biracial/biethnic youth are a particularly vulnerable group in terms of self reported delinquency school problems, internalizing symptoms, and self regard. As a group, they are also more likely to receive some form of psychological intervention. Given these findings and the shortcoming of clinical resources for work with this population, we provide an in-depth discussion of why biracial youth may be particularly vulnerable from a socialconstructionist framework and offer several strategies based on narrative family therapy for working with biracial youngsters and their families.

Cultural pluralism is perhaps one of the greatest accomplishments of the modern era. In the past 2 decades, the field of psychology has responded to our changing demography with an increase in research and clinical literature focusing on various minority groups. Although the need for strengthened effort in this area is clear, therapists and researchers today are much better equipped to appreciate the challenges, strengths, and sociohistorical context associated with children and families from diverse backgrounds. Yet despite these gains, certain minority groups still remain relatively neglected within the literature. One such group is biracial youth and their families. Although the number of biracial individuals in the United States has grown steadily over the last 50 years, very little has been documented about the potentially unique aspects of individual development and family context within this population.

From professional and personal experience, we became interested in the unique developmental and clinical issues facing biracial children and their families. The existing literature, however, had very little to offer in understanding normative and problematic development within this population. Although a number of excellent literary works are available (e.g., Root, 1996), very little empirical research has been conducted specifically focusing on biracial youth. Thus, a first step in understanding adjustment in this population is to discern if biracial children are at particular risk for mental health problems. In order to address this question, we used data from the National Longitudinal Survey of Adolescent Health (Add Health; Udry, 1998). The survey was mandated by Congress to provide data measuring the impact of the social environment on adolescents' physical and mental health. Adolescents and their parents were asked both numerous questions assessing multiple domains of adjustment and detailed questions on racial/ethnic background. Because of the large sample size and diversity of areas assessed, Add Health is a unique source of data for generating a richer picture of biracial/ethnic youth.

The existing gap in the literature on biracial/biethnic youth is not limited to empirical research, however. There are also relatively few resources aimed at aiding practitioners in conceptualizing and addressing adjustment difficulties in clients that may be associated with biracial/biethnic status. Thus, the goal of this article is threefold. The first objective is to provide descriptive information from a nationally representative sample on the adjustment of biracial adolescents relative to white and monoracial minority youth. Next, we explore why biracial children may be particularly vulnerable from a social-constructionist perspective. Finally, we offer some guidelines for narrative-based family therapy specific to this population.

METHODS

Participants

Data are drawn from the core sample of the National Longitudinal Survey of Adolescent Health (Add Health; Udry, 1998). Add Health is a nationally representative study of students in the seventh through twelfth grades that is designed to measure the impact of social environment on adolescent health. The Add Health public-use data set includes interviews of 6,504 adolescents and 4,600 parents. On the Add Health survey, adolescents were asked multiple questions to assess their racial/ethnic background. Youngsters who self-identified as belonging to two different racial/ethnic groups were consolidated into a biracial/biethnic group (n = 272). All children who identified as White and non-Hispanic constitute the "Whites" group for the present study (n = 3,521). All children who identified as belonging to only one minority group (e.g., African American, Native American) constitute the "monoracial minority" group (n = 1,941). There is clearly considerable diversity within any of these groups; however, our overarching goal was to contrast children who identify with two different racial/ethnic groups to Whites and minorities identifying with only one group. Although this classification suited the present purposes, it is not to suggest that minority children-nor white children for that matter-an be considered a homogenous group in psychological research or practice.

In general, biracial children tended to fall between Whites and monoracial minorities on most demographic characteristics. For example, 78% of the white parents and 42% of the monoracial minority parents were married, while 67% of the biracial parents were married (Chi^sup 2^(2) = 439.8, p

Family income for white families was significantly higher than that for the monoracial minority families with the income for biracial families falling in between (F = 49.98, p

Measures

Items on the Add Health survey were culled from multiple measures with adequate psychometric properties in the existing literature. Existing measures were not taken in their entirety, however, so it was necessary to first develop appropriate variables. For the current purposes, the following variables were constructed: quality of mother-child relationship (five items), quality of father-child relationship (five items), depression (20 items), somatization (16 items), conduct problems (19 items), school-related behavioral problems (six items), self worth (five items). Items included in each of these constructed variables are listed in appendix A (items were interspersed throughout the actual interview). Items assessing relationship quality and self regard were based on a 5-point Likert scale. Items assessing adjustment (behavioral conduct, depression, somatization, school-related problems) were based on a 0-3 frequency scale.

Because measures were not included in the Add Health survey in their entirety, we took several steps to assess the psychometric properties of our variables. Alpha reliabilities for all of the constructed variables were above .8. Annual stability correlations ranged from .50 to .65 with an average of .60. Since all of the constructed variables come from adolescents' self-report, it is possible that these variables are better thought of as one general adjustment factor rather than as distinct aspects of adjustment. However, confirmatory factor analysis (Milan, van Eys, & Canon, 2000) indicated that the outcome variables loaded together in the conceptually expected manner. Specifically, a three-factor model (i.e., behavioral-conduct and school problems loading on one factor, depression and somatization loading on another factor, and self-regard as a separate item) provided the best fit to the data (Chi^sup 2^(1) _ .41, p = .52, normed fit index (NFI) _ .99, root mean square error of approximation (RMSEA) _ .00), whereas a one factor model did not fit the data well (Chi^sup 2^ (2) 7.46, p = .02; NFI = .95; RMSEA = .11).

Procedures

A complete account of sampling and procedural aspects of the Add Health survey are available from Udry (1998) and on line at http:l/www.cpc.unc.edu/addhealth. In brief, cluster sampling was conducted based on census demographic estimates in order to generate a nationally representative sample of sevenththrough twelfth-grade U.S. students. Participants were interviewed in their schools and homes at two time points. Data for the presented findings are based on time-1 interviews, conducted between 1994 and 1995.

RESULTS

Appropriate weights for generating unbiased parameter estimates of the U.S. school population between seventh through twelfth grade are provided by Add Health and were applied when appropriate in analyses. One-way analyses of variance (ANOVAs) were conducted on the demographic characteristics, family relationship variables, and adjustment variables. The means, standard deviations, F-tests, and post hoc LSD comparisons are presented in Table 1 for perceived quality of family relationships, and adolescent self reported adjustment.

Biracial children did not differ significantly from Whites or monoracial minorities in perceptions of family relationships. However, biracial adolescents reported more problems across multiple domains of functioning. Specifically, biracial adolescents report significantly more maladjustment than other youth in reports of behavioral conduct, school problems, somatization, and general self-worth. Although effect sizes are small (i.e, between .1 and .3), these consistent group differences provide support for the notion that selfidentified biracial children may be a particularly vulnerable group. Supportive of this view, biracial/biethnic youth were the most likely to be receiving some sort of therapy or counseling (Chi^sup 2^(2) = 14.34, p

DISCUSSION

In this article, we take a social-constructionist perspective in understanding the nature of psychological dysfunction. After first briefly highlighting what is meant by "social constructionism," we focus more specifically on why, from this perspective, biracial children and families in the United States may be particularly vulnerable to psychological dysfunction. One result of the social-constructionist movement over the last 2 decades has been the advent of narrative approaches to family therapy. Throughout the discussion, we offer strategies from a narrative family therapy framework for working with biracial youth and families.

From the social-constructionist perspective, problems do not reside within individuals but rather in language (Anderson & Goolishian, 1988) and in personal narratives (White & Epston, 1989). Individuals and families experience problems when

they interpret life experiences in ways that are personally undesirable. These interpretations are then formulated into a problem-dominated story that penetrates ongoing interpretations of past and present events. In other words, "stories organize, maintain, sustain, and substantiate problems" (Sluzki, 1992, p. 220). Thus, therapists working from a social-constructionist perspective are concerned with discerning the meaning of the presenting problem as understood by the client and with bringing into conversation the experiences that the client attends to or ignores in formulating his or her story. In this way, social constructionism is a move away from definitions of dysfunction in the mental health field that are grounded in locating internal deficits or deviations and labeling the individual vis-a-vis symptomotology. Moreover, defining dysfunctional behavior is no longer in the purview of the expert therapist; rather, deconstructing problematic interpretations held by the client is the collaborative task that constitutes therapy.

An essential element of social constructionism is a focus on the influence of sociocultural factors on the individual. Accordingly, the notion of a personal narrative is not meant to imply that we are free to live out or tell any story that we choose. Rather, every culture is viewed as having a particular set of storiessome contemporary and others passed down through generations-that constitute and constrain the actions and interpretations of individuals. Cultural stories are often so pervasive that they are interpreted by individuals as reflecting some natural order (i.e., as an objective truth) rather than as being culturally unique, socially constructed phenomena (Bruner, 1990). As Mair (1988, p. 127) states, "We inhabit the great stories of our culture. We live through stories. We are lived by the stories of our race and place." Many of the stories available to individuals, however, are determined largely by the norms and goals of those with power-those in the dominant culture. Consequently, members of marginalized groups may construct narratives that do not reflect their preferred way of being in their world either because they adopt a subjugating story of the dominant culture or because they interpret their experiences as being in conflict with pervasive stories (Howard, 1991; White, 1992). Thus, attending to external sociocultural messages is an important feature, at least in theory, of social-constructionist psychotherapies.

Social constructionists have criticized the practice of therapy-with its emphasis on the therapist's privileged ability to assess and diagnose-as being a disempowering event for the client (Anderson & Goolishian, 1988; Gergen, 1985). In this form of encounter, the potential exists for the client to leave the therapy room with a notion of him- or herself as defective in such a way as to require help from an expert. Narrative family therapy is one alternative form of psychotherapy rooted in social-constructionist philosophy. The overarching goal of the narrative therapist is to facilitate a transformation in an individual's or family's set of dominant stories. In order to do this, the therapist's first goal is to engage the clients) in a dialogue that illuminates both the meanings ascribed to events and the personal narratives constructed to encompass these meanings. Next, the therapist asks questions aimed at evoking alternative interpretations of events and the recollection of ignored occurrences that contradict the problem-dominated personal narrative. Finally, the therapist introduces a new story that reflects the client's preferred way of being in hopes that this alternative story will be adopted and carried forth by the client(s). The actual techniques utilized in achieving these goals will be discussed later in the context of providing services to interracial families.

The narrative approach views therapy as a collaborative effort between the therapist and client in which the client holds essential knowledge. In order to sustain this collaborative effort, the narrative therapist acts in a respectful and curious manner, through the use of questions, to bring the client's knowledge into the therapeutic conversation. Within the therapist-client relationship, all participants are recognized as having different stories about themselves and the presenting problem that have been shaped by their respective status, roles, and social experiences. Thus, in therapy, the clients) and the therapist are all participants in a collaborative process and must together negotiate meanings that seem acceptable and genuine to the client(s). Since much of the "expert" knowledge on what constitutes dysfunction is based on the perspective, theories, and research of the dominant culture, the behavior and beliefs of the members of certain groups (e.g., women, homosexuals, people of color) may be labeled dysfunctional in traditional therapy with little regard for the influence of the sociocultural context. In contrast, the perspective on dysfunction and intervention taken by narrative therapists, with its simultaneous emphasis on phenomenology and external social messages, may be particularly applicable in the treatment of individuals from subjugated groups.

The growing body of clinical, theoretical, and literary works on and by minorities, coupled with increased diversity in media representations, provides the opportunity for therapists to empathically experience some of the cultural stories that influence the lives of different minority groups. Nonetheless, certain groups, such as interracial families and biracial children, continue to be largely ignored and therefore marginalized. In providing services to these families, it is certainly important that therapists have knowledge of the cultural stories relevant to each parent; however, this knowledge may not be sufficient. Interracial families have an emergent quality; they are more than the sum of their parts. Thus, our purpose is to illuminate the particular cultural stories and discourse that may be potent in the lives of interracial families as a means of informing therapists treating this population and to suggest some possible intervention strategies based on the narrative approach for therapists providing services to this population.

For the purposes of this article, an interracial family is defined as any partnership between a white person, a person of color, and their offspring. This label is not without problems since it confounds the meaning of ethnicity and race; however, the difficulty in simply naming the population of interest is reflective of the flawed classification systems that pervade our society. Thus, we have chosen this label despite its limitations. In addition, the focus on interracial families is not meant to imply that families in which the parents are of different nationalities, classes, or religions do not also face unique challenges. In the current era in the United States, however, skin color continues to act as the great dividing

factor. Therefore, interracial families, as previously defined, will be the focus of the remainder of this paper.

The number of interracial families in the United States has been slowly increasing over the past 30 years. According to the 1990 U.S. Census, there are approximately 800,000 interracial marriages and one million biracial children in the country (Herring, 1995). Given the classification systems used to collect these data, however, these numbers are likely to underestimate the actual population. Despite the increase in the numbers of interracial families, societal acceptance is still limited. Indeed, in a 1997 Gallup Poll assessing attitudes toward interracial marriages, only 61% of respondents approved of such unions (Gallup Poll Organization, 1997). Although this number is a vast improvement over social attitudes 30 years earlier (4% of the population approved of interracial unions in 1953), it still suggests that the biracial child and family will meet with disfavor-if not outright prejudice-quite regularly (Gallup Poll Organization, 1997). Thus, although many interracial families who enter treatment will do so for reasons other than race (Brandell, 1988), most will have experienced social disapproval. Consequently, these clients are likely to possess some memories of unkind stares, questioning by others, family disapproval, feelings of uncertainty and discomfort, or outright racism. In addition, the children in these families are parented by monoracial individuals who cannot fully understand what it means to be biracial. Although these experiences may not constitute the family's stories of the presenting problem, they will certainly color these stories. Therefore, it is critical that the therapist be able to deconstruct the existing cultural discourse that emerges from the labels, laws, stories told, and stories withheld about interracial families.

Labels

Perhaps one of the greatest challenges facing biracial youth in America is in finding an acceptable name. We live in a society in which the classification of individuals by their ethnic heritage has taken on profound importance as a means of allocating social rewards. Nearly every governmental form-be it birth certificate, school registration, driver's license, voter's card, or census form-requires that respondents be classified, either by themselves or by others. Some of these forms have recently begun to include options for the biracial individual besides "other. " However, these options have been criticized by individuals who fear that a "multiracial" label will undermine minority-group struggles for solidarity and political power. For example, the chairman of the Census Bureau's Advisory Committee on African-American Populations has stated that "people who have been pushing for this option want somehow to deemphasize the racial component, the black component. They say they are multiracial which means `f m less black or somehow I can have a way of not having to check myself as black'." (Madu, 1997). At least for now, biracial children and their parents are faced with two choices every time they complete a seemingly important form: confront their "otherness" in our society or deny the heritage of one parent. Although biracial children may not deal directly with institutional forms, the societal emphasis on clear categorization is mirrored in many of the schoolyards and playgrounds throughout our country.

The need for ethnic and racial classification in our society has a long history-it is the history of oppression. For centuries, the racial identity of a child has had enormous implications for the both the rights and the opportunities of that child. Words such as mulatto (a young mule) or half-breed are remnants of the racial pollution ideology evident during slavery in which any African heritage made a person "officially" Black and therefore entitled to less. Although there are no longer laws explicitly demoting one's legal standing based on race, it is important that service providers, particularly those of the dominant culture, recognize that one's racial label is a critical feature of minority identity development (Gibbs, 1989; Root, 1992)

From a social-constructionist perspective, the failure of societal institutions to acknowledge biracial children has profound implications for the individual and family: If one does not exist in language, how important can one be to others? If language does not validate all elements of one's family, how valid can the family be? Thus, the first task of the narrative therapist working with the interracial family may be to negotiate a preferred label. (Although some may wish to put an end to our societal need to classify, such a formidable task cannot be the responsibility of the young child.) The family has several options-identification with the classification assigned by society based on appearance, identification with a chosen singular group, identification with both groups, or identification as a new group-none of which are mutually exclusive or permanent. The therapist should allow the family to negotiate this choice; however, he or she can suggest means by which to actualize the chosen label through language and dialogue such as asking teachers and relatives to use this term or creating certificates and declarations of ehnic identity.

Laws

In the late 1950s, Richard Loving and Mildred Jeter decided to get married. Both were residents of a small town in Virginia in which blacks and whites had been having sexual relations for years, and most of the residents were the same color (Spickard, 1989). Richard and Mildred traveled to Washington, D.C., to wed since interracial marriages were legal in the capital; however, on their return to Virginia, the couple was arrested, tried, and imprisoned. For the next 9 years, the case went back and forth on appeals with the help of the American Civil Liberties Union. Finally, in 1967, the Supreme Court ruled that antimiscegenation laws were unconstitutional by the Fourteenth Amendment (Loving v Commonwealth of Virginia). At that time, one-fourth of all states still had such laws in place (Spickard, 1989). Although antimiscegenation laws were repealed more than 30 years ago, the practice of denying interracial unions still occurs. For example, in 1991, the Texas Supreme Court heard two cases in which local justices refused to marry interracial couples (Spickard, 1995).

Laws are socially constructed mechanisms of exerting control that are created either by consensus or by those in power. Laws are also promulgated language, and as such, the meaning of a law can easily be construed as a reflection of the natural order, reality, or truth. Thus, the therapist may decide that it would be useful to discuss antimiscegenation laws with the interracial family for two reasons. First, the recentness of the Supreme Court decision may help members of interracial families to see themselves as pioneers or heroes of a new cause. Refraining the meaning of their uniqueness may buffer some of the negative experiences often associated with being a biracial child or an interracial family. Furthermore, understanding how recent and widespread the existence of antimiscegenation laws was may help families contextualize their experience within a larger cultural story in transformation. As Mair stated, "we are, each of us, locations where the stories of our place and time become partially tenable" (1988, p. 127). By placing themselves in historical context, members of the interracial family may also be able to place the reactions of others in historical context, thereby reducing the likelihood of their interpreting a negative social experience in a self-deprecatory manner. This alternate interpretation can be enhanced through the use of contextualizing questions such as:

1. Have you always been one not to yield to societal pressures?

2. Who from your past would not be surprised to learn about your willingness and strength to deal with unpleasant aspects of our society?

3. Looking back, what early experiences have you had that would foretell your strong commitment to the people you love?

4. In what other ways do you act as a person who models courage and acceptance to your children?

Children who seem to feel troubled or uncertain about their identity or that of their family may also benefit from hearing the story of the Loving case in a developmentally appropriate manner. For example, they can be told of how nine of the smartest people in our country, who knew the most about what was right or wrong in the United States, decided that families are allowed to look any way that they want.

Stories Told and Stories Withheld

Men and women of different races have joined together throughout history. Indeed, the Bible (Numbers 12:1) tells the story of a couple being punished after chastising Moses for having an Ethiopian wife. The telling of our nation's history, however, has included few stories of interracial coupling founded on love or choice. This is not surprising since during colonization, slavery, segregation, and wartime many interracial unions were the result of domination or a lack of potential same-race mates. In this way, history has provided the context in which many interracial couples are still viewed today. Specifically, this historical context foments several assumptions or societal myths as to why people of different races come together including sexual curiosity, status seeking, rape/domination, achieving citizenship, rebellion against society ox family, or an inability to do better (Root, 1992; Spickard, 1989).

Many of the existing myths about interracial unions, while grounded in historical events, are perpetuated through contemporary images in the media. These images will have different meanings for individuals depending on their race, ethnicity, gender, and life experiences. Consequently, it is not possible to attribute a specific meaning to each of these images. However, the therapist may want to explore the effect of these images on both his/her personal beliefs and those of the clients in terms of cultural myths about interracial couples (e.g., sexual curiosity, status, inability to do better, etc.). Although positive images of interracial couples have certainly existed in the media (e.g., "I Love Lucy;' "Guess Who's Coming to Dinner?"), there have been a number of potentially negative images of Black-White unions that epitomize the stereotyped myths of interracial families and children:

In the television show "The Jeffersons," a white man who is likable but somewhat of a dupe is married to an intelligent, attractive black woman. In addition, their television daughter shows no phenotypic signs of being biracial.

In the Clarence Thomas-Anita Hill hearing, Thomas was questioned by the Senate on accusations of sexually harassing an intelligent black female. Each day, Thomas was shown with his White wife. While the hearing was not designed to determine legal guilt, his appointment to the Supreme Court implies exoneration.

In the O. J. Simpson-Nicole Brown case, a famous black athlete was accused of brutally killing his white ex-wife. He was found not guilty of criminal wrongdoing. Many of the reactions to the case and actual defense strategies emphasized issues of race and interracial coupling.

Media images of professional athletes suggest that a disproportionate number of financially successful Black athletes are coupled with White women.

Tiger Woods, a prodigy golf player of black and Asian heritage, has received popular support in the media; however, he is most often identified and heralded as a black athlete.

In Spike Lee's movie Jungle Fever, the marriage of a black couple is nearly destroyed after the husband has an affair with his white secretary. His friends question if the affair was rooted in interracial sexual curiosity. In another scene, a character states, "Nine out of 10 brothers who be with a white woman, she ain't no penthouse pet. . she be a dog . . . with fleas . . . an outhouse pet" (Lee, 1991).

Interracial families are influenced not only by the cultural discourse about interracial unions but also by the stories salient in the culture of each monoracial parent. One obvious example is the story of white oppression, which constitutes a critical aspect of the cultural narrative of African Americans. This story has a different effect on individuals in the course of development, and many African Americans will go through developmental periods in which anger and mistrust at the oppressor are particularly salient (Gibbs, 1989). In the interracial family, this period is compounded since anger at the oppressor entails anger at loved ones/members of the family. Thus, the therapist must be prepared to help the family deal not only with the stories specific to interracial families but also the stories about each monoracial culture as they unfold in the context of the interracial family.

Perhaps just as influential as the cultural narratives available to members of interracial families is the lack of available stories. It is striking to consider that biracial children are likely to spend their entire school career without ever seeing a picture of a family resembling their own. In many cases, stories of interracial unions have been explicitly excluded from historical text (e.g., rarely will schoolbooks on Thomas Jefferson mention his having many biracial children with Sally Herrings). Being rendered invisible in this way is undoubtedly a form of marginalization. Consequently, therapists should attempt to counteract the potential ill effects of invisibility by increasing the interracial family's sense of validity and acceptability. From the social-constructionist perspective, promoting one's sense of positive identity can be facilitated through involvement in discourse that acknowledges personal validity: if one's identity exists in language then it becomes "real:' To that end, two sources may be particularly useful. Crohn (1995) provides a comprehensive list of organizations uniting interracial families, and Root (1992) offers a strength-based perspective on biracial individuals that cites a number of relevant books for both adults and children.

Other Intervention Strategies

To become aware of the distinct cultural narratives at play in the interracial family, it may be useful to have each parent construct a cultural genogram that focuses on the identity, coping strategies, childrearing practices, strengths of and adversities faced by their ancestors. Discussing these genograms in the therapeutic setting may facilitate greater understanding by all family members of the distinct cultural stories that are potent in their lives. This format is important since it allows the nonwhite partner to tell a family or cultural narrative from the perspective of a minority. The story of slavery or the Jim Crow laws, when told from the perspective of Whites, may be colored by guilt. The same story, told from a Black voice, is rarely one of guilt. The same could be said for the story of colonization as seen by Native Americans or the meaning of the World War I, the Korean War, or the Vietnam War for different Asian-American groups. Not only are events interpreted differently based on perspective, individuals are often completely unaware of the important experiences of culturally different groups. By way of illustration, Whites and Blacks in America have largely forgotten, or were never concerned with, the Sandinista-Contras warfare in the 1980s; however, this period of civil unrest is a constitutive event in the lives of many Central Americans living in the United States. The experience of prejudice is of course not limited to minority family members. As the example from Jungle Fever highlights, there are often ways in which Whites who choose to be with minority partners-whether temporarily or permanently-are also the victim of prejudice and assumption from both the majority and minority population. Thus, discussing each genogram may ensure that personal and cultural narratives are not distorted by being told from another's point of view.

Employing a cultural genogram also allows for the coconstruction of knowledge by family members. For instance, the parent from the dominant culture may learn about how minorities have dealt with discrimination. With this knowledge, he or she may be better equipped to help the child who is confronted with racist remarks or actions. For the adolescent in individual or family therapy, creating a more comprehensive and integrated view of the experiences of both lines of heritage may provide a richer context in which to understand his or her uniqueness. Finally, cultural genograms may help families mutually determine the strengths that each parent brings to the relationship and subsequently aid them in defining, for themselves and for their children, the uniqueness of their current family.

Two other techniques advocated by narrative therapists are the use of reflecting teams and externalizing language. The reflecting team consists of a group of therapists and therapists-in-training who watch a therapy session and then discuss, with each other and the family members, their reactions (Nichols & Schwartz, 1995). In treating the interracial family, it may be particularly useful to have a culturally diverse reflecting team that can bring their own relevant experiences into the therapeutic conversation. Externalization refers to the therapist's attempt to separate the presenting problem from the client by talking about the problem as an adversarial entity existing outside the client (Nichols & Schwartz, 1995). The therapist then discusses this adversarial entity (e.g., "bulimia;' "fear") as trying to gain control over the family and encourages members to recollect times they were victorious over the efforts of the identified problem (for discussion of this technique, see Zimmerman & Dickerson, 1996). When treating interracial families, it is of course important that therapists not unduly assume that clients' problems are rooted in cultural narratives. However, if clients do appear to have internalized social messages, therapists may externalize and label the presenting problem as "invalidity" or

"isolation" as a reflection of social marginalization.

Conclusions

It is not uncommon for service providers to assume that specific ethnic/racial groups are homogenous and that one theoretical approach or intervention strategy will therefore be invariantly applicable. In fact, all families are unique. Thus, the cultural narratives highlighted in this article may be potent in the lives of some families at some points in time and meaningless at different times or to different families. In addition, we have not addressed how the cultural stories about interracial unions may be compounded by stories of parental absence for families in which biracial children are being raised by a single parent or foster parents. Therefore, it would likely be ineffectual for therapists working with interracial families-or any family for that matter-always to focus on certain cultural narratives. Nevertheless, as long as the society we work in continues to restrain certain families through its stories, it is critical that therapists at least recognize the existence of these stories. Indeed, it may be only after the therapist thinks in terms of the family's cultural narratives that he or she can hear their personal narratives (McGill, 1992).

Interracial families should be expected and accepted in a multicultural, multiracial, egalitarian democracy. Consequently, cultural discourse that prohibits interracial coupling, whether explicitly or implicitly, must be seen as a mechanism of marginalization. These stories are part of a repertoire of cultural narratives that serve to keep people from stepping across constructed boundaries and are established largely to protect the interests of the socially advantaged. What are the consequences of deconstructing these stories? Perhaps the artificiality of the imposed hierarchy would be exposed; perhaps all individuals would have the opportunity to cast themselves as the hero or heroine of a narrative characterized by personal potency.

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