CHAPTER 13

Family Therapy in a Multicultural Society

The Case of Israel

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In his introduction to a special issue of Contemporary Family Therapy on the state of family therapy in Israel, the editor, William C. Nichols wrote:

Israel represents one of the more interesting places in the world in which to examine the development and current status of family therapy theory, practice, and research. The emergence of Israel as a new state occurred only a few years before the advent of family therapy in the United States of America as a revolutionary approach to dealing with human problems. Today, Israel provides a setting in which not only the "hot issues" of culture and ethnicity are part of the everyday scene, but also one in which immigration and continuing rapid change are abundantly evident. (Nichols, 1995, p. 351)

Indeed, one cannot fully grasp the development of family therapy in this country without being aware of its unique characteristics. Therefore, this chapter begins with a brief overview of Israeli society. The rest of the chapter provides a description of the development and current status of family therapy in Israel and a discussion of some specific issues for family therapists in this country.

THE CONTEXT: ISRAEL AND THE ISRAELI SOCIETY

Israel is a small country in the Middle East (slightly smaller than New Jersey), flanked by the Mediterranean Sea on the west, Jordan and Syria on the
east, Lebanon on the north, and Egypt on the south. The population numbers approximately 6 million, of whom about 80% are Jewish and the rest are non-Jewish, primarily Arabs (Central Bureau of Statistics, 2000). In addition to its mix of Jewish and Arab populations, Israel is home to immigrants coming from more than 70 countries around the world and speaking many different languages. It is a land of contrasting cultures, lifestyles, and family patterns: traditional family patterns alongside modern lifestyles, the influence of Western culture together with Middle Eastern heritage, values and practices ranging from secular to ultraorthodox religions among both Jews and Arabs.

As a young and dynamic country, Israel has always been characterized by a rapid rate of increase in population, with the demographic composition of the Jewish population constantly changing as a consequence of massive immigration waves. In the last 50 years there has been a sixfold increase in the population. In 1948, when the State of Israel was established, the population amounted to 873,000. Two large influxes occurred shortly thereafter: Holocaust survivors from Europe and Jews from Islamic countries (mainly North Africa, Iraq, Syria, and Yemen). The 1950s saw a relatively large wave of immigrants arrive from Europe and North Africa, whereas the 1960s were characterized by immigration from the affluent West (the United States, Canada, and the United Kingdom), and the 1970s and 1980s by immigration from the USSR. In the 1990s there was massive immigration (about 700,000) from the former Soviet Union. Jews from Ethiopia (about 56,000) immigrated in two waves: first in the mid-1980s and again in the early 1990s (Central Bureau of Statistics, 2000).

For both Jews and Arabs, different ethnic and religious groups coexist, with immigrants from various countries of origin living alongside veteran Israelis. The Jewish majority today is composed of two main ethnic clusters: "Orientals," or Sephardim (meaning Spanish), who themselves or their ancestors originated from the Near East, North Africa, Yemen, Ethiopia, the Balkans, Iran, Iraq, and Israel, and the Muslim republics of the former Soviet Union; and Ashkenazim, whose origin is in American or European countries. At present, 33.5% of the Jewish population is Asian-African—born or children of Asian-African origin; 40% are European-American—born or children of European-American origin; and 26.5% were born in Israel to Israeli-born parents. In addition, the Arab population is composed of several religious groups—Moslems (75%), Christians (16%), and Druze and others (9%) (Central Bureau of Statistics, 2000).

The diversity and pluralistic nature of the population make for a wide variety of family patterns and lifestyles, including different types of couples formation and marital dynamics, gender relations within families, intergenerational relationships, and ways of coping with internal and external sources of stress (Lavee & Katz, in press). Another important aspect of Israeli life is its continuous state of conflict with the neighboring Palestinian people and Arab countries. Wars, terrorist acts, and security threats are at the core of Israel's existential reality. In its 50 years of existence, Israel has fought seven wars and suffered a ceaseless chain of hostilities, including repeated shelling on border settlements and random terrorist activities inside the country, such as suicide and car bombings. The armed conflict between Jews and Arabs in Palestine has resulted in thousands of military and civilian casualties. The percentage of Israeli families who have suffered injury or loss themselves, or who have close relatives or personal friends who have experienced this suffering approaches 100% (Milgram, 1993). Besides the loss of life and serious injury caused by terrorist attacks, they also disrupt the routine life of families, put limitations on leisure activities, and increase the anxiety level of children and adults alike. Yet, at the same time, most Israelis live their lives normally, going about their daily business. Israelis enjoy all of the institutions that characterize modern democratic states: a well-developed health care and social welfare system, a vibrant art and literary community, and an advanced educational system. Within this context of Israeli society, we now move on to describe the development and place of family therapy in Israel.

THE HISTORY OF FAMILY THERAPY IN ISRAEL

The development of the field of family therapy in Israel was strongly influenced by the development and growth of family therapy in North America, which coincided with the need of Israeli professionals for more effective intervention modalities with multiproblem families. However, as in other revolutions, the "family therapy revolution" in Israel cannot be separated from its leaders—psychiatrists, psychologists, and social workers—who took a lead in introducing family therapy, establishing family therapy clinics, and educating generations of new family professionals.

The beginning of family therapy in Israel can be traced to the early 1960s, when Mordechai Kaffman, a child psychiatrist, introduced systemic assessment and family intervention in treating a variety of emotional and behavioral problems. Kaffman, who was trained in family therapy with Nathan Ackerman in New York, began practicing and teaching family therapy at the Kibbutz Child and Family Clinic (KCFC), which he headed, and at the mental health department of Kupat Holim (a major HMO) in Haifa. In 1963, Kaffman published the first account of the short-term family intervention that he developed in these two centers (Kaffman, 1963). The model consisted of an intake process, including an interview with the entire family...
in order to assess relationship patterns, followed by 10 sessions focusing on family dynamics related to the child's symptoms, and a closing assessment. The introduction of this mode of intervention initially faced many difficulties and objections from the psychiatric establishment (Kaffman, 1985). However, the rate of success of this model has influenced many professionals to adopt systemic therapy, first at the KCF centers (which by the mid-1970s consisted of two major clinics and a number of smaller ones throughout the country) and later in other institutions. The pioneering work of Kaffman and his colleagues was described in a number of publications in international family therapy journals (Kaffman, 1965, 1972). Kaffman was later joined by Avner Barcai, who was trained with Salvador Minuchin at the Philadelphia Child Guidance Clinic. Barcai joined the Kibbutz Child and Family Clinic and began teaching family therapy by introducing the one-way mirror, in which he first served as a model therapist and later as a teacher of live supervision. Psychologists and social workers at the KCF, trained by Kaffman and Barcai, were the first generation of family therapists who later continued to practice, teach, and develop MFT into a well-respected mode of treatment in this country.

A second major force in the development of family therapy in Israel consisted of social workers in social welfare agencies. In the late 1960s, social workers were disillusioned by the child-centered ideology and began adopting the idea that "children live in families" (Wertheimer & Wertheimer, 1988). Social workers also needed new solutions for families in distress other than taking children out of their families and placing them in institutions. Thus began the trend of dynamically oriented family intervention, catalyzed by Wertheimer, a social worker who was trained with Nathan Epstein in Canada. In the early 1970s, Wertheimer developed a family therapy program at the Institute for the Training of Social Workers. The program included courses of family dynamics, sociology of the family, psychopathology in the family context, and treatment of multiproblem families. It also included field experience in family therapy and supervision. In the first 10 classes, more than 200 social workers were trained, which helped spread the approach in the social welfare system.

The application of family therapy by the young graduates of the Institute was not without its difficulties, however. Not only was the new way of treating families perceived as a threat to the established system, but heavy case loads and lack of adequate physical conditions presented serious obstacles to the conduct of long-term family therapy (Slonim-Nervo & Wagner, 1991; Wertheimer, 1979). Nevertheless, the steadfast enthusiasm and interest in developing family therapy in social welfare agencies have proven worthwhile. Today, more than 70 public family therapy clinics are spread throughout the country.

The next phase in the development of family therapy training was the establishment of academic family therapy programs within major universities. The first program was established at Tel Aviv University in 1984 by Israel Charny as an extension of the Institute for the Training of Social Workers program. This program was developed as postgraduate family therapy training. It was interdisciplinary in content as well as in its faculty and student makeup. In 1987, the program led to the development of a family therapy specialization within the masters program in social work at Tel Aviv University. A year later, a masters program in family studies and family therapy was established in the School of Social Work at the University of Haifa, and in 1993 a program was opened in integrative marital and family therapy and individual psychotherapy at the Hebrew University of Jerusalem (Charny & Friedlander, 1996).

THE ISRAELI ASSOCIATION FOR MARITAL AND FAMILY THERAPY

The Israeli Association for Marital and Family Therapy and Family Life Education (IAMFT) was established in 1977. It is an interdisciplinary association, composed of psychologists, social workers, family physicians, psychiatrists, lawyers, educational counselors, and other helping professionals who conduct marital and family therapy, divorce mediation, systemic consultation, and family life education. The IAMFT maintains professional contacts with other marriage and family therapy associations worldwide, is a member of the European Family Therapy Association (EFTA), and was among the founding group of the International Family Therapy Association (IFTA).

The IAMFT conducts a range of professional activities in order to continue the development of family therapy in Israel. These include an annual conference, training workshops, and mini-conferences with Israeli and international family professionals, a bimonthly newsletter, Inyan Mishpat (Family Matters), and a journal, BaMishpacha (Inside the Family). In addition, professional meetings are held by three regional branches in Jerusalem, Haifa, and Rehovot. The Association has also hosted six international family therapy conferences since 1977, gathering thousands of family professionals from around the globe.

Five ongoing committees are in operation to promote family therapy in Israel, to enrich family therapists and maintain professional standards. These include the Professional Training Committee, Public Relations Committee, Accreditation Council, Ethics Committee, and Audit Committee. A divorce mediation council is also affiliated with the IAMFT, conducting
miniconferences and workshops for family professionals and lawyers who engage in divorce mediation.

The IAMFT is governed by a board, composed of the association’s president, secretary-general, executive director, treasurer, legal advisor, committee chairpersons, branch chairpersons, a representative of the divorce mediation council, and the editors of the newsletter and journal. The board meets regularly (usually every 6 weeks) to discuss professional and executive matters. With the exception of the executive director, all members of the board, as well as all committee members, are volunteers. The IAMFT assembly, in which all members have voting power, meets once a year to approve the financial report, make changes in the Association’s bylaws, and discuss plans for the development of the organization.

The IAMFT certifies family therapists and approved family therapy supervisors through the Accreditation Committee. Those eligible to become Certified Marriage and Family Therapists include helping professionals (e.g., psychologists, social workers, and school counselors) who hold a master’s or doctoral degree; graduates of MFT graduate programs abroad; and physicians with an adequate specialty (e.g., psychiatrists and family practitioners). In addition to their respective professional training, candidates for Certified Marriage and Family Therapists should have a graduate or postgraduate training in marital and family therapy. Specific requirements for training include courses in theoretical models of marriage and the family; transitions and crises across the family life cycle; individual dysfunction from a systemic perspective (e.g., sexual dysfunction, eating disorders, learning disabilities, family violence); family therapy intervention methods, skills, and techniques; theory and practice of marital therapy; and ethical issues in marriage and family therapy. In addition to these courses, candidates are required to have at least 750 hours of direct client contact in family and marital therapy conducted over a 3-year period, and to have received at least 250 hours of supervision from two or more approved supervisors. In order to be eligible for an Approved Supervisor status, family therapists must have at least 3 years of experience after receiving Certified MFT status. Requirements for this certification include advanced courses in family therapy and family therapy supervision, 200 hours of supervising two supervisees, and at least 75 hours of supervision from two or more Approved Supervisors.

FAMILY THERAPY TRAINING

Today, family therapy training is provided by academic institutions, public clinics, and private clinical institutes. Within the Israeli academic infrastructure, there are no academic departments specializing in marital and family therapy. Instead, family therapists are trained within master’s programs in schools of social work (at the universities of Tel Aviv and Haifa) or in a program affiliated with the department of psychology (at the Hebrew University of Jerusalem).

The programs at the University of Haifa and Tel Aviv University have both a general family studies component (family theory, research, and methodology; family policy; and courses on a variety of family issues, such as violence, parenting, aging, and others) and a heavy emphasis on family therapy. Courses in the latter area cover various marital and family therapy approaches, the therapist’s own family of origin, assessment and diagnosis, as well as a structured program of practicum and supervision. These programs make use of public family therapy clinics as field sites for gaining experience in family therapy, and all students are supervised by approved supervisors, both at the university (as part of their course of study) and in the field site. The Program for Advanced Studies in Integrative Psychotherapy at the Hebrew University of Jerusalem (Charny & Friedlander, 1996) is an integrative, interdisciplinary diploma program that emphasizes the integration of different modalities of intervention at the individual, family, and community levels. It consists of core and elective courses in psychotherapy, theories, and techniques of marital and family therapy, clinical seminars, and a clinical practicum under supervision.

In addition to the academic programs described in the preceding, family therapy courses are taught in schools of social work and psychology departments at other major universities in Israel (such as Bar Ilan and Ben Gurion University of the Negev). Family therapy training programs, including clinical courses, practicum, and supervision, are also provided by a number of public family therapy clinics as well as private family therapy institutes around the country (Slonim-Nevo & Wagner, 1991).

FAMILY THERAPY AND FAMILY THERAPISTS IN ISRAEL

Family therapy is alive and well in this country. There are currently about 980 members in the Israeli Association for Marital and Family Therapy, that is, one family therapist per 7,000 population (as compared with one per 10,000 in the United States). Family therapists are employed both in public services and in private institutes, as well as maintain private practice. Small private clinics and a number of larger family therapy institutes have been established throughout the country.

One of the most convincing indications for the place of marital and family therapy in Israel is the widespread existence of public clinics. Today, there are 71 such clinics available around the country. These clinics are run
under the auspices of the Ministry of Labor and Social Affairs and are staffed primarily by social workers who are certified family therapists or family therapists in training. All of these clinics offer therapy on a sliding-scale basis, making it affordable to all. Many of the clinics provide training and supervision for family therapy students, including family therapy courses and live supervision.

In addition to clinics specializing in family therapy, family counseling units are included within other public agencies. There are six agencies that provide counseling for family courts and eight drug-and-alcohol treatment centers that include family counseling in their program. Family therapy is also provided as part of adult and youth probation services; units for family support and counseling exist in medical centers; and many school psychologists trained in family therapy provide counseling and intervention for families within the system of municipal psychological services.

Family therapy has gained widespread public acceptance owing, in part, to radio talk shows and television programs, as well as regular columns in daily newspapers and weekly magazines that focus on family and marital relationships. These media programs and columns regularly feature family practitioners who discuss parent–child interactions and interpersonal couple relationships. Given the high value placed on family integrity in Israel and the high reliance on the media in this country, these programs have been significant in bringing family therapy to the public’s awareness and enhancing the visibility of family therapy as a mode of assistance for families (Halpern, 2001).

RESEARCH ON FAMILIES AND FAMILY THERAPY

Dozens of Israeli family professionals—researchers and therapists—regularly conduct research and publish theoretical and practice-related articles on marriage and family functioning as well as on intervention with couples and families. Most of the research is conducted by family scholars in various fields (psychology, social work, education) in the five research universities: the Hebrew University of Jerusalem, Tel-Aviv University, the University of Haifa, Bar-Ilan University, and Ben-Gurion University of the Negev. A number of family research institutes serve as host for interdisciplinary research on marriage and the family, including the Center for Research and Study of the Family at the University of Haifa, the Peleg-Bilg Center for Research on Family Well-Being in Bar-Ilan University, and the Bandy Steiner’s Center for Family Life at Ben-Gurion University. In addition, research is conducted and theoretical and clinical essays are published by scholars in a number of public academic colleges (e.g., Yezreel Academic College and Tel-Hai College), mental health institutes (e.g., Eitanim, Talbich, and Shalvata), and psychiatric departments in medical centers (e.g., Kaplan, Hadassah, and Rambam). Research is also conducted by practitioners in public agencies (Kibbutz Child and Family Clinic, Youth Aliyah Psychosocial Service, and the Israel Defence Forces Mental Health Department) and private family therapy institutes (e.g., Shiluv Institute for Family and Couple Therapy, Shimi Institute for Family and Personal Change, Barzai Institute for Family Therapy, and Tomer Institute for Medical Psychology).

Because of the small size of the academic community in this country, Israeli family researchers and practitioners most often publish their work in international journals to make it available to family scholars worldwide. However, a sizable amount of research is also published in Hebrew in a number of Israeli journals (Siho, Society and Welfare, Psychologia, and B'Mishpacha), research monographs, and master’s theses and doctoral dissertations.

A review of family treatment studies in Israel, in both Hebrew and English (Rabinowitz, 1996), shows the breadth of topics researched by Israeli family scholars. My own review of the literature indicates that the most frequently studied phenomena are those that relate to family effects of the Israeli–Arab conflict (security and war-related problems, terrorist activities, loss, and trauma), families of Holocaust survivors, immigrant families, and special considerations of treatment of Arab families in Israel. These issues, which are perceived as relatively unique to Israeli society (Good & Ben-David, 1995; Halpern, 2001; Lavee & Katz, in press) are addressed in more detail in the next section.

In addition, research has been conducted on more universal family issues, such as life-cycle transitions and life events (e.g., transition to parenthood, fertility problems, divorce and remarriage, neonatal death, and death of a child); families with special needs (e.g., parents with children with mental retardation or Down’s syndrome, multiproblem families, families in extreme economic distress, and prisoners’ families); families with members suffering from a range of mental disorders (e.g., depression, paranoid disorders, psychosomatic illnesses, eating disorders, alcoholism, and drug abuse); families with children and adolescents who have emotional problems (e.g., school phobia, elective mutism, stuttering, or conduct disorders); families with chronic illnesses; and family violence, primarily child abuse and wife battering. Researchers have also studied “normal” couple and family functioning, including support and coping within couples, management of work and home conflicts, patterns of parent–child attachment, parenting stress, adult attachment, and marital relationships.

Family researchers and practitioners also report on intervention methods and models (e.g., dialectical approach in couple therapy, use of biofeed-
back and hypnosis in couple and sex therapy, psychodrama and play therapy, use of art and photography in therapy, cognitive family therapy, enrichment programs for newlyweds, and psychoeducational programs for couples), as well as treatment effectiveness. Finally, reports have also been published on marriage and family training programs and supervision.

SPECIFIC ISSUES FOR FAMILY THERAPISTS IN ISRAEL

For the most part, Israeli families face life challenges similar to those faced by families in other industrialized countries: normative, developmental transitions, such as transition to parenthood, raising children, and retirement, in addition to non-normative life events, such as illness, disability, and death. Families struggle with an array of daily hassles and with conflicting demands of the workplace and the family, as well as with chronic stressors, such as caring for a disabled or chronically ill family member, raising a child with a developmental disability or mental illness, or caring for an elderly parent. Families must also cope with stresses and strains that stem from inside the family itself—parenting stress and parent—child conflicts, marital crises, divorce, and violence. A review of literature on family treatment studies in Israel (Rabinowitz, 1996) confirms that Israeli family therapists deal with universal sources of family stress, such as life cycle transitions and other life events, as well as marital violence, child abuse, extramarital affairs, sexual dysfunctions, and a host of illness- and child-related problems.

There are, however, several unique characteristics of Israeli society that can compound the stress with which individuals, families, and communities are faced and that have specific relevance for the work of family therapists. Most notable are stresses and strains inflicted by the Israeli—Arab conflict—repeated wars, terrorist acts, and other security-related sources of stress. In addition, particular stresses exist in certain families and not in others—such as those of immigrants and Holocaust survivors—but in Israel these are so prevalent that they should be viewed as characteristic Israeli stresses. In this regard, we must consider the multicultural nature of Israeli society and its implications for family therapists.

WARS, TERRORISM, AND SECURITY-RELATED STRESS

The armed conflict between Jews and Arabs has had multiple effects on families in Israel: The effect of war on combat soldiers and their families (Solomon, 1993; Solomon, Mikulincer, Fried, & Wosner, 1987; Waisman, Mikulincer, Solomon, & Weisenberg, 1993); the impact of a soldier's death on his or her family (Rubin, Malkinson, & Wittzum, 1999); and the consequences of wartime hostility on civilians, such as the shelling of border settlements and the perpetration of random terrorist acts (Ay lion, 1993). Combat stress reaction (CSR) and posttraumatic stress disorder (PTSD) have long-lasting effects on the social aspects of the army veteran's life (Solomon, 1993). CSR casualties report more problems in social, family, sexual, and work functioning. A number of PTSD symptoms, such as numbing of responsiveness; reduced involvement with the external world; diminished interest in previously enjoyed activities; feelings of detachment, alienation, constricted affect, and increased hostility, have adverse effects on family relations and intimate marital relationships (Solomon et al., 1987). In addition, secondary posttraumatic symptoms leading to severe marital distress have been found among wives of CSR veterans (Waysman et al., 1993).

War-related loss and bereavement have a major impact on families in Israel. In its 50 years of existence, more than 19,000 soldiers have lost their lives. Needless to say, the loss of a spouse, parent, sibling, or child has a major effect on the life course of all family members, especially on parents. Research on bereaved parents has shown that a heightened level of bereavement responses is demonstrated beyond the number of years normally expected following such a loss (Rubin, 1993, 1996). In fact, Rubin and his colleagues (1999) suggest that such terms as coping, adaptation, and resolution are inadequate for describing the experience of the majority of bereaved parents. War and security-related stress can also have a direct effect on civilians through acts of terrorism, shelling targeted against border communities, and threats of chemical and biological warfare against the Israeli general population.

Terrorist acts throughout Israel are not a new phenomenon. These threats to the civilian population, resulting in trauma and loss of life, have come to define the reality of Israeli families who have long experienced violent attacks on passenger cars and school buses. More recently, violent attacks on civilians have been occurring in a variety of urban settings, such as discothèques, restaurants, and open-air markets. Especially for families in the West Bank, this constant sense of threat has been coupled with feelings of being "imprisoned in their own homes" and of being isolated from friends and members of the extended family because of travel limitations (Lavee, Ben-David, & Azaiza, 1997). Families in the West Bank as well as in the Gaza Strip and the Golan Heights continue to live under conditions of prolonged uncertainty even in the face of the "peace process" among Israel, the Palestinians, and neighboring countries (Ben-David & Lavee, 1996; Lev, 1998; Lev-Wiesel & Shamai, 1998; Shamai & Lev, 1999).

Shelling targeted against border communities, particularly in northern Israel, has been an ongoing source of stress for families over the past 30
years. In addition to the threat to life and limb involved in these incidents, families must be confined to the small space of a shelter during such attacks. Likewise, during the 1991 Gulf War, when the civilian population throughout the country was exposed to missile attacks with potential chemical weapons, families were repeatedly confined to hermetically sealed rooms. The forced closeness under stressful conditions sometimes created or intensified interpersonal tension in families (Ben-David & Lavee, 1994a; Lavee & Ben-David, 1993), with an increased need for help with marital distress (Rabin, 1995).

Family Therapy and War-Related Family Needs

Operating in an environment where war and security-related stress are an integral part of daily life, family therapists, like their counterparts in other mental health professions, are often faced with the need to provide help for bereaved families, families with a member in military service, families traumatized by a terrorist attack, or families with a member suffering from PTSD. Family therapists are called upon to provide help for families both in acute stressful situations and under conditions of prolonged distress and uncertainty. Many communities are now organized to provide support and intervention to victims and their families—such as the victims and those affected in the entire affected community (Ayalon, 1993). In addition, there is known to be an upsurge of volunteer activity by professionals in times of crisis.

Family therapists have responded to the unique needs of families under war-related stress by developing specific intervention programs. For example, Ayalon (1993) suggests a strategic method of short-term family therapy for survivors of terrorist attacks involving kidnapping and face-to-face killing. Dreman and Cohen (1982, 1990) report on a family intervention program for children of victims of terrorist activities that is concentrated on promoting family strengths and coping while deemphasizing individual pathology. Margalit and his colleagues (Margalit, Ezron, Rabinowitz, & Guri, 1993) present an integrative, multifaceted treatment model for surviving POWs and their families, and Levy and Neumann (1987) illustrate how families should be involved in the treatment of acute combat reaction casualties. In accordance with their report that family involvement enhances the speed and completeness of the victim's recovery, the emphasis in this program is on the victim's reaffirmation within the family. Shamai (1994) describes a unique mode of family crisis intervention by phone that was intended to help families deal with the impact of tension and insecurity during the Gulf War. Because of the special conditions of war, family therapy agencies must adjust to the needs of families that are unable to attend sessions.

An important element in the work of therapists with families affected by war and security-related crises is that therapists themselves are likely to be influenced by the same sources of stress. In all likelihood, the therapists themselves have been touched by war or terrorism through the loss of a family member, close relative, or close friend, or they are living under the same threat as their clients. Family professionals in the West Bank, for example, may be both part of a therapeutic system and members of the same community living in political uncertainty (Shamai, 1998, 1999).

Holocaust Survivors and Their Families

Although the Holocaust happened more than five decades ago, it is still a central theme in the existential reality of Israeli society (Charny, 1990). Its legacy persists not only in the survivors who continue to be haunted by their experiences but also in their children and grandchildren, who often need help because of the multigenerational transmission of unresolved issues of anger, guilt, grief, loss, abandonment, and a host of other powerful emotions (Good & Ben-David, 1995; Harel, Kahana, & Kahana, 1993). The traumatic wounds of the survivors are made more difficult as they grow older. The losses and disabilities associated with aging interact with the unsealed psychic wounds, and chronic health problems create a situation that places strain on family members (Harel et al., 1993). The entire family system may be dynamically affected by a reciprocal effect in which the children of these survivors enact a pattern of transference and experience many of their parents' problems in a personal way (Mazor & Mendelsohn, 1998; Mazor & Tal, 1996; Steinitz, 1982). Furthermore, the offspring of Holocaust survivors are often committed to a heritage that they cannot fully understand, which they absorbed either by overexposure or through the protective cover of silence (Mor, 1990).

For the most part, the literature on the long-range effects of the Holocaust on survivors and their children points to their conspicuous adaptive and reintegrative capacities. Similarly, although there is evidence indicating that children of survivors presented specific psychological problems, there is also considerable evidence to indicate that large numbers of survivors' children enjoy healthy family relationships (Klein-Parker, 1988). Nevertheless, the legacy of the Holocaust may be manifested when families deal with major traumatic life events. For example, the threatened use of gas warheads in the Gulf War brought to the surface Holocaust survivors' collective memory of gas extermination. A loss in general, and loss of a child in military service in particular, also has a unique meaning for survivors (Gay, 1982). Furthermore, research has shown that children of Holocaust survivors suf-
fer higher rates of PTSD than other soldiers (Solomon, Kotler, & Mikulincer, 1988–1989). In working with Holocaust survivors as well as with the second (and now third) generation of Holocaust survivors, family therapists need to take into consideration the many facets of this traumatic experience and the ways in which it may affect marital and family relationships.

**IMMIGRATION AND IMMIGRANT FAMILIES**

As was noted earlier in this chapter, Israel has been shaped by massive waves of immigration from all corners of the globe. More than 700,000 immigrants arrived from the former Soviet Union in the last decade alone, and about 56,000 immigrants came from Ethiopia in the mid-1980s and early 1990s. Although immigration is not unique to Israel, its proportions require family therapists to attend to the wide range of difficulties faced by immigrant families. It also requires family therapists to consider the suitability of models of therapy to different populations.

Immigration poses major stress for the families involved in a number of ways: movement from one geographical location to another, often requiring changes in climate and lifestyle; disengagement from a familiar network of social relations, with the disruption of longstanding ties and the accompanying sense of loneliness, isolation, and lack of support; and the need to abandon old norms and values and adopt new ones (Levenbach & Lewak, 1995; Shuval, 1993). Differences between family members in their willingness to immigrate and differences in their rate of absorption sometimes intensify interpersonal conflicts. New work conditions and living arrangements create shifts in patterns of closeness—distance regulation and changes in patterns of conflict resolution (Ben-David & Lavee, 1994b). Additionally, migration often results in changes in family structure and a shift in the balance of power, both between spouses and generations (Sharlin & Elshanskaya, 1997). For example, a father who traditionally wielded the power in the family may find himself stripped of his accustomed role, and role reversal may occur, as children become “socializing agents” and mediators in their parents’ relations with authorities.

For family therapists, the challenge posed by immigration is twofold. First, they are often called upon to treat families whose norms and values are different from their own. Second, they need to adapt models of family therapy, which were developed primarily in the United States and Western Europe, to a population that may not respond well to such therapeutic methods. These challenges are addressed in the following section.

**FAMILY THERAPY IN A MULTICULTURAL SOCIETY**

There are two characteristics of Israeli society that make it unique with respect to multiculturalism. First, there is a sizable minority group (about 20%) of Arab citizens, whose family lifestyle and values may be different from the dominant culture. Second, as a country of immigrants, Israel is host to a large proportion of newcomers relative to veteran Israelis.

In recent years, the awareness of cultural sensitivity in Israeli society has been growing. A number of Arab family professionals have examined cultural values of contemporary Arab society in Israel (Haj-Yahia, 1993), unique family forms among certain Arab groups (Al-Krenawi, 1998; Al-Krenawi, Graham, & Al-Krenawi, 1997), the gap in the understanding of cultural terminology (Al-Krenawi, 1999), and the relevance of these aspects to intervention. Abu-Baker (1999a) describes how the assimilation and integration within the dominant culture may lead to disharmony and disintegration within the home culture and suggests that therapists be aware of the complexity of acculturation and its interfamilial, intrafamilial, and social levels.

Culturally related issues of treating Arab families have also been raised by other family professionals. Savaya (1995) found that Arab women express readiness to seek professional help for problems with their children, but much less so for problems with their spouses. According to Lavee (1991), difficulties in treating sexual dysfunction in Arab couples may be encountered when commonly used techniques are employed, and he offers some guidelines for providing sex therapy to non-Western clients. In describing “an intervention that almost failed,” Rubin and Nassar (1993) discuss a case in which a Moslem Arab family was treated by a Christian Arab woman therapist, who was supervised by a Jewish man of American origin. They concluded that knowledge of the client’s cultural reference to the problem may help the therapist in diagnosing difficulties and directing intervention by understanding when intervention runs counter to tradition or in line with it.

Awareness of cultural norms and their relevance for treating immigrant families has also been raised in regard to Ethiopian families (Ben-David, 1993; Ben-David & Good, 1998) and families from the former Soviet Union (Bardin & Porten, 1996). There seems to be a growing recognition among Israeli family therapists that they have an obligation to meet the unique needs of ethnic minorities by offering systemic intervention services that are culturally sensitive (Abu-Baker, 1999b; Ben-David & Good, 1998; Slonim-Neko, Sharaga, & Mirsky, 1999). In a comprehensive book of competent family therapy, Ariel (1999) integrates family therapy theories and cultur-
ally oriented therapy and presents techniques that are modified to fit the character of families from different cultures.

CONCLUSION

The development of family therapy in Israel has been strongly influenced by models, approaches, and techniques developed in North America and Europe. In many respects, these models are well suited to the training and scientific orientation of clinical and school psychologists, social workers, and psychiatrists in this country. Although Western approaches to treating families are still quite influential (in part, because of ongoing contact with family professionals in Europe and North America), indigenous sociocultural and geopolitical characteristics of Israeli society are evident in both research and clinical work. In terms of family research, Israeli scholars have been among the leaders in studying war-related stress and trauma, the impact of immigration on family relationships, and intergenerational issues for Holocaust survivors. They also add original conceptualizations to established theoretical formulations of family systems (Halpern, 2001). At the same time, family practitioners have developed culturally congruent modes for intervention that better suit the multicultural nature of Israeli society and its unique circumstances.

REFERENCES


CHAPTER 14

Family Therapy in Brazil
Memoir and Development

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Not much has been written about the history of family therapy in Brazil. In 1989, we sought to systematize what there was in the field of family therapy in Brazil (Bucher, 1989). A few years later, a survey was taken of what was happening in the area (Macedo, 1993). After that, few efforts were made to trace the evolution of what had happened in the area. Recently, Kaslow (2001) published an article entitled “History of Family Therapy: Evolution Outside of the U.S.,” which was made available on the home page of the International Family Therapy Association (IFTA). However, the article carries information on family therapy in just one of the states of Brazil.

An attempt to relate the history of a movement is never easy. Generally, historical reconstructions are limited to identifying the personalities who initiated or transformed the movement. In this chapter, we intend to describe these aspects, which constitute the living memory of the family therapy movement in Brazil, considering that such a record will help identify the theoretical and conceptual issues that underlie the structural and dynamic transformations in families today and in therapeutic practice. Therefore, the recording of attainments provides an important opportunity to gather recollections of what has been done and accomplished with regard to family therapy in Brazil.

For three decades, as we shall see, family therapy in Brazil followed in the theoretical tracks of the North American and European continents. It may be stated that we are facing two fundamental questions, which must be better investigated: (a) how do family therapists, in practice, construct subjective and collective meanings regarding Brazilian families; and (b) what is the reality of Brazilian families, considering the continental dimensions of Brazil and its diverse regional, social, and cultural manifestations?