

Leaving No Children or Families Outside: The Challenges of Immigration

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This study addresses potentially stressful events that accompany the process of immigration for children and their families. Acculturation stress, combined with service disparities, may contribute to a higher risk for psychopathology among immigrant children and youth, as compared to their parents. Culturally informed, evidence-based treatment and preventive interventions that meet the mental health and cultural needs of immigrant children and families have the potential to minimize this higher risk of adverse mental health consequences.

The New Immigration to the United States: Realities and Controversy

The United States accepts the highest percentage of immigrants and refugees of any nation on earth. The total number of immigrants in the United States is estimated at 40 million, with 1.1 million immigrants and refugees legally entering each year. They have settled in all different regions of the nation; from 2000 to 2006, about 33% moved to the West, 32% to the South, 21% to the Northeast, and 13% to the Midwest (Camarota, 2007).

Although the United States has been a nation of immigrants (with only American Indians being native and African Americans descending from enslaved people), until the 1960s the overwhelming origin of immigrants to the United States had been European in origin. What is significantly different since the passage of the Immigration and Naturalization Act of 1965 is that immigrants to the United States have instead come overwhelmingly from what have been considered Third World nations. For immigrants living in the United States, the continents of origin are: Africa (2.8%), Asia (23.1%), Latin America (54.6%), Europe (12.5%), and North America (1.9%), with 3.3 million under 18 years of age. Additionally, many immigrants are indigenous people with distinct dialects and cultures.

Immigration law in the United States, as in most Western nations, has moved toward the use of labor shortage criteria for admission. The result has been a “brain drain” from developing

nations, but this trend has reversed with economic downturn in the United States and new development in Asia. However, most immigrants entering the United States (refugees, immigrants admitted to reunite with family members, and especially immigrants entering without proper documents) are poorly educated unskilled workers (Camarota, 2007).

Approximately 800,000–1.2 million undocumented immigrants enter the United States annually, with a net increase of 400,000–700,000 once those exiting to return to their home nations do so. An estimated total of 8–12 million undocumented immigrants currently live in the United States. Most of them are originally from Latin America, but some are from Asia or Europe. Undocumented immigrant workers are a major source of entry-level labor in the United States (farm labor, service, construction, etc.). Such workers perform work that U.S. residents and citizens generally are not willing to do (Camarota, 2007).

There has been much recent controversy about the entry of undocumented immigrants and any efforts to legalize their status. This debate has contributed to increasing anti-immigrant sentiment in a nation that paradoxically has been built by immigrants. Although nativist movements have been common in the history of immigration in the United States, the largely non-European composition of the current immigrant population fuels these sentiments more strongly.

Some of the arguments are cultural, including concerns that the new immigrants are not learning English and are not assimilating as did earlier European immigrants. Other arguments focus on the economic drain that undocumented immigrants may pose for states and communities, through both competition for jobs and expenditures for health and human services.

However, research does not support this claim. A recent study by the Texas state comptroller evaluated the revenues (gross domestic product and tax contributions) versus costs (health, welfare, education, juvenile justice, criminal justice, etc.) from undocumented immigrants in that state. The net balance was positive at \$25 billion annually (Strayhorn, 2006). Former Labor Secretary Robert Reich (2010) also recently indicated

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that the United States needs continued open immigration in order to grow out of the current recession and to fulfill the massive unfunded entitlements for the baby boomer generation.

Immigrant children and children of immigrants comprise an increasing proportion of America's younger population. Immigrants comprise over 12% of the U.S. population, but their children are over 20% of the population under the age of 18. About 2.2 million children in the United States are recent immigrants; they currently comprise 22% of school-age children in the United States. Eighty percent of children of immigrants were born in the United States and thus U.S. citizens. The majority of children of immigrants—61% in 2003—live in families where one or more children are citizens but one or more parents are noncitizens. First- and second-generation immigrant children are the most rapidly growing segment of the U.S. child population (over 30% of the U.S. school population; Capps, Fix, Ost, Anderson, & Passel, 2004).

Immigration and Cultural Adaptation

Risks and Benefits

The decision to emigrate from one's home nation, culture, and community, and venture into a largely unknown environment is not one that is taken lightly by any immigrant. It is a painful decision, even though it entails the hope or actuality of improving one's own circumstances and those of one's family. Immigrants inevitably involve many costs to immigrants and their families: loss of extended family support, loss of familiar values and language, psychological distress, new economic challenges, and potential exposure to multiple traumas. The host nation also incurs costs (e.g., strains on educational and social services, economic dislocation of citizen populations, cultural conflict).

Of course, immigration typically occurs because it is expected to have benefits for immigrants and their families (economic and educational advancement; political, religious, and social freedom; in general, greater opportunity). Immigration often also contributes to the host nation's economy, demography, history, and culture.

A similar risk–benefit equation exists for immigrant children and children of immigrants. They are able to attain overall better physical health than cohorts in nations of origin, higher numbers of immigrant youth advancing into higher education, increasing the participation in U.S. economy. However, they face multiple challenges, including indicators of higher stresses and conflict in their U.S. families; disparities in economics, education, health, and mental health compared to other American youth; and increasing risks for mental health problems (compared to youth in nations of origin).

The process of immigration can involve many steps that are potentially stressful and even traumatic. These challenges are not faced as frequently by skilled, educated, and nonpolitical immigrants, but they are frequently faced by poorer immigrants or those leaving their nations under adverse circumstances. Some of these stressors even start during their lives in their home nations (war, political strife, natural disasters, poverty, and famine) and are often the very stressors that propel emigration. The migration journey itself can be fraught with many dangers (desert and ocean crossings, complicated legal processes, surrep-

titious departures, victimization by smugglers or other travelers)—amid, of course, the immediate loss of extended family supports, unless other relatives and friends have already immigrated and are available to provide immediate support.

When immigrants arrive in the host nation, they then undergo many new stressful experiences, such as multiple moves and geographic dislocations (in search of economic opportunity or better living environments), new economic pressures (from the prevailing consumer economy), and lengthy and complex legal proceedings (typical even for documented immigrants), all while learning a new language, new customs, and new legal and educational systems. Additionally, the reality of a long-term separation from family and friends (and at times even from parents) sets in while living in a strange environment. For undocumented families, there is the added risk and heightened stress from traumatic experiences at the hands of immigration authorities, including workplace, school, and home raids that may end in arrests and potential deportation.

The long-term stressors faced by immigrants (discrimination, threat of social and economic marginalization, community and domestic violence, and long-term economic stressors) are those already faced by other minority populations. Of course, these stressors and traumas can have significant adverse psychological impact, on first-generation immigrants, who may deny them (as a psychological defense). More subtly, effects may stretch across generations, with continuing effects on adaptation and acculturation.

The main long-term stressors for immigrant children and families are those resulting from xenophobia in the host culture and society. *Xenophobia* (negative prejudice directed against a national or ethnic group) usually expresses itself through subtle to overt discrimination and social and economic marginalization. Racism can also be a component of xenophobia, given the racial differences seen in the newer immigrant groups. Xenophobic attitudes can be associated with strongly held views around the need for assimilation by immigrants. In particular, critics may expect immigrants to speak English and to refrain from the use of any translation or interpreter services in the course of receiving public services. Fears of terrorism in today's environment are another common form of expression.

The more extreme forms of xenophobia are associated with the anti-immigrant movement (related to the controversy around undocumented immigration) and the formation of anti-immigrant militia groups to patrol the borders with Mexico. The U.S. federal government itself has recently implemented military-style immigration enforcement raids in workplaces, homes, and schools. Thousands of undocumented immigrants have been apprehended, detained, and deported. Their children and other dependent family members may be left isolated and hiding in fear in their homes and communities with little means of support. These raids have had particularly adverse effects among the children of affected immigrants, often resulting in acute stress reactions and posttraumatic stress disorder (PTSD) symptoms. Poor and inconsistent social services responses by local agencies and communities have added to the distress experienced by children and families (Capps, Castaneda, Chaudry, & Santos, 2007; Chaudry et al., 2010).

Anti-immigrant violence has been reported in rural U.S. towns, resulting in serious injuries and even deaths. Many of these have

been triggered by immigrant Latino immigrant men engaging in relationships with local Caucasian women, some of them from Eastern European immigrant backgrounds (Hamill, 2008).

Another result of xenophobia has been school bullying against immigrant children by mainstream or more assimilated youth. One recent case involved an Irish immigrant adolescent engaged in a brief relationship with a popular male student in her high school. This relationship stirred resentment by other girls, who taunted her with anti-Irish ethnic slurs (face-to-face and in electronic social media) until she finally committed suicide by hanging. The striking aspect of this incident was that it involved a European Caucasian (Irish) immigrant living in a community predominately populated by the people of the same ethnicity (Eckholm & Zezima, 2010). Such incidents, along with the militancy of many descendants of immigrants in the anti-immigrant cause, raise the possibility of projected ethnic self-hate underlying such incidents and behaviors.

Refugee Children and Their Families

Because of the circumstances surrounding their emigration, refugee families and children face even greater stressors. They face many of the stressors described earlier, at times even more acutely. If their dislocation from their home nation was abrupt or if it involves acute traumatic events (such as war, political persecution, or disasters), they may have faced extended periods in refugee camps, with adverse conditions and high rates of victimization (including criminality, physical and sexual violence, and bullying or intimidation). Refugees (particularly refugee children) exposed to war experience very high rates of acute stress disorder, PTSD, depression, and anxiety, either post-migration (Arroyo & Eth, 1985) or in camps (Rothe et al., 2002). Refugees also suffer from more sudden and unpredictable separations from family and other supports, more extended disconnection from these critical supports, and uncertainty about the permanency of their residency in the host nation (relocation vs. return to their homeland, facing many risks if they return).

There is a growing subpopulation of the “new immigrants” who are primarily political exiles and whose exit was less abrupt and traumatic (such as Eastern Europeans, the early Cuban émigrés, Venezuelans, and West Africans). Along with refugees, they also face unique longer term stressors, such as uncertain legal status, expectancies (at times unrealistic) to return to their homeland pending political changes, and the development of an “exile mentality” that makes rootedness and adaptation difficult (Rothe & Pumariega, 2008).

Acculturation and Adaptation

Culture is the shared collective knowledge, beliefs, skills, and traditions that allow a group of people and families to adapt successfully to their ecological contexts over multiple generations and often millennia. The process of learning about and adapting to a new culture is termed acculturation (Berry, 1980). What is commonly believed to be the ideal outcome of this adaptation for immigrants is that of *integration or biculturality*, where the immigrant maintains their identity rooted in their culture of origin and learns to navigate the host cultural environment by combin-

ing aspects of the host culture along with aspects of the culture of origin in their cognitive and behavioral repertoire.

Instead, some social critics and traditionalists emphasize *assimilation* as the ideal adaptation, where the native cultural orientation is replaced by that of the host culture. This was the preferred form of adaptation promoted by the United States for many decades for its multiple waves of European immigrants, with at times sudden rejections of traditional identifiers (such as names, language, customs, traditions, etc.) in order to fit into the American “melting pot.” However, potential knowledge and skills are lost in adaptation, as are connections of the individual to their heritage, extended family supports, and many other adaptive resources offered by the culture of origin. Some authors (e.g., Spiegel, 1971) have described psychological problems arising at normal developmental life stages in individuals (including European-origin ones) who have assimilated into mainstream American culture, but whose ambivalence becomes manifest in later life stages.

Bicultural adaptation is a challenge for immigrants who arrive as adults to the host nation with a fairly established personal, ethnic, and cultural identity, or who are less educated and have greater limitations in learning new concepts and knowledge (including language). It is additionally challenging if the cultural differences are greater, such as individuals from non-Western cultures.

The traditional ethnic enclave (such as Chinatowns in various cities and Little Habana in Miami/South Florida) has adaptive value in that it offers an initial base of community support for immigrants and their families from which they can move into the mainstream society once they obtain new knowledge and skills. Many older immigrants adopt a pattern of cultural *separation or enculturation*, where they remain in the ethnic enclave and maintain and prefer the values, beliefs/practices, and language of their native culture and nation while rejecting those of the host culture (Berry, 1997).

Increasingly, however, immigrants settle in newer immigrant destinations in relatively homogenous regions where such same culture community support is limited, with consequences for higher levels of isolation and stress. Some younger first- and second-generation immigrants may become alienated from both cultures as a result of living in isolated in homogeneous communities, losing adaptational skills and language from their culture of origin, or both. They may become *marginalized*, and thus lose economic and social opportunities afforded by wider sociocultural contacts and activity (Berry, 1997).

Acculturation plays a significant role in the development of the immigrant children and children of immigrants. Culture is central to the understanding and interpretation of human psychological and psychosocial development. Culture influences such concepts and constructs as gender and relational roles, behavioral norms, and normative approaches to childrearing and discipline. Cultural values determine the cognitive skills (instrumental, analytical, social, etc.) and adaptive psychological skills that are reinforced as children develop (influenced by cultural values). Various protective beliefs, including taboos against certain risky behaviors, are also reinforced by different cultures. Cultural values are transmitted by the family to the child, and later reinforced by societal institutions such as schools, churches, and other community institutions.

Acculturation and Psychosocial Development

Immigrant and minority children face added challenges around their process of acculturation. There is often inherent conflict over the values and beliefs that are reinforced by the family in contrast with the community and societal institutions. They also face the challenges of discrimination and bias, which are seen from the earliest stages of development even among toddlers as they discover “others.” In fact, categorization bias (the propensity to categorize “others” of the same species by external characteristics) is even seen among other species (mammalian and avian), most acutely in primates (Rajecki, Ivins, & Kidd, 1977; Sackett, Holm, & Ruppenthal, 1976). Such categorization bias can be reified into social constructs, such as racism and xenophobia, within families and in societal institutions. In multicultural environments, some “pecking order” can be established, but it is not as reified. In minority/majority environments, racism and discrimination have been shown to contribute to ethnic self-hate by youth (Phinney, 1989).

The process of identity formation is another one that is critical in acculturation. Erikson (1968) defined *identity* as the unique sense of self that is derived from the influences of both the family and the extrafamilial world, with a past, present, and future. He argued that identity is a reciprocal concept that needs to be internally owned as well as externally validated by others. *Ethnic identity* is an important aspect of psychological identity. The development of ethnic identity is the process of ethnic exploration and resolution of the meaning of one’s culture and ethnicity to individual identity, usually completed in adolescence or young adulthood (Erikson, 1968; Phinney, 1989; Umana-Taylor, Yazedjian, & Bamaca-Gomez, 2004). This is a process described eloquently by Obama (1995/2004) in his autobiographical account of his youth as he addressed his bicultural and biracial identity, a reality that is increasingly common in the United States. In this process, peer and family interactions are the “mirrors” against which psychological identity develops. The child and adolescent lives in and has to adapt to two worlds: the traditional one in their home and family, and the mainstream world of peers, school, and community. The child faces significant pressures from peers and the media to assimilate. The alternative may be social and economic marginalization.

Acculturation stress is the adverse effect of psychological conflict resulting from the process of acculturation, apart from the physical health and lifestyle effects of acculturation (Berry, 1997). This results from internal conflicts over cultural values (e.g., between achievement vs. family relations and family loyalty), pressure to assimilate to avoid discrimination and marginalization, the loss of natural protective beliefs and values, the loss of extended family and kinship social support (especially moving from an individualistic orientation from a family and collective orientation), and strains over changing roles (gender, relational, etc.).

A common source of acculturation stress is intergenerational cultural conflict, more recently termed acculturative family distancing (AFD). These conflicts are set up by the immigrant youth’s greater cognitive flexibility, resulting in rapid assimilation into the host culture, especially their ready adoption of the new language, cultural norms, and particularly new expectations

around family roles and limits. In these contexts, immigrant parents have slower adaptation to the new cultural milieu, particularly as a result of greater enculturation and social isolation, difficulty in mastering the new language, and fears of new parenting role expectations and of their children’s loss of their identification with the traditional culture (and consequently with their family). The conflicts between home and external community environments around cultural norms and values become acted out and these differences lead to intergenerational psychological conflicts. AFD has been reported among both Latino and Asian immigrant youth and families, and has been associated with an increased risk for youth substance abuse and conduct problems (Portes & Rumbaut, 1996; Szapocnik, Kurtines, & Fernandez, 1980), and more recently related to depression and anxiety (Hwang, 2006).

Acculturation and the Mental Health of Immigrant Youth and Families

Epidemiological studies on the mental health of immigrants have been consistent in demonstrating that first-generation adult immigrants have lower levels of identified psychopathology than the mainstream population and than their children (Escobar & Vega, 2000; Oquendo et al., 2001). In analyses of data from the Epidemiological Catchment Area study, less acculturated individuals were found to have a better mental health profile, individuals with moderate acculturation had medium levels of mental health, and more assimilated individuals had the worst mental health outcomes. Suicide was also less prevalent in the less acculturated group.

The following hypotheses have been developed around these findings:

1. First-generation immigrants are naturally selected to be a more resilient group given their decision to emigrate against many odds, with the second-generation being “softer” and less resilient.
2. First-generation immigrants suppress their mental health needs in order to subsume them below their more basic and immediate needs for personal and material/economic security. Once the second-generation immigrants are more comfortably established, they can then pay attention to pent-up mental health needs.
3. The second-generation immigrants may identify more readily with the devalued and denigrated concepts of their ethnic identity, adopted from the xenophobic attitudes of the host culture, which may lead to “ethnic self-hate” and higher risk for psychopathology (Escobar & Vega, 2000).
4. Family support may be strained for immigrant youth because of AFD. This relationship may be responsible in part for the higher risk of psychopathology among immigrant youth and children of immigrants.

Family and Community Factors

In the second-generation and generation 1.5 youth (born in the country of origin and raised in the host country and its culture), risk for mental health problems increases. Much of

their adaptation or lack thereof is highly dependent on family and community factors and circumstances. For example, Sullivan et al. (2007) found that integrated Latino immigrant adolescents who maintain heritage culture practices and adopt receiving culture practices reported higher parental involvement, positive parenting, and family support, but assimilated adolescents reported the greatest levels of aggressive behavior. Mena, Mitrani, Muir, and Santiestaban (2008) found that extended parental separations in Latino immigrant youth are linked to problem behaviors, and separations from mothers are particularly linked to depressive symptoms, especially for females.

Similarly, family relationships mediated the impact of Russian immigrant youth's acculturation stress, in both directions (Birman & Taylor-Ritzler, 2007). Youth and families in language-brokering contexts have shown higher levels of family stress, lower parenting effectiveness, poorer academic and emotional adjustment, and substance use in Latino immigrant youth (Martinez, McClure, & Eddy, 2009). Greater youth culture brokering is linked to less parental acculturation and more family conflict in Vietnamese immigrants (Trickett & Jones, 2007). These findings support concerns about the adverse psychological burdens of placing youth in the positions of being linguistic interpreters and cultural brokers for their less-aculturated immigrant parents.

Substantial research confirms the role of AFD in the mental health of immigrant youth and families. Immigrant families who perceived higher levels of AFD experienced more parenting difficulties (Buki, Ma, Strom, & Strom, 2003), whereas those perceiving lower levels of AFD reported less family conflict (Farver, Narang, & Bhadha, 2002). Asian immigrant youth who reported higher AFD experienced higher individual and family distress and risk for depression, with the quality of the parenting relationship between fathers and adolescents serving as a mediator (Hwang & Wood, 2009; Kim, Chen, Li, Huang, & Moon, 2009). Korean Canadian youth identifying with their traditional culture perceived their families as more supportive and less rejecting (Kim & Choi, 1994). Liu, Lau, Chen, Dinh, and Kim (2009) found that increased acculturation among immigrant mothers related to higher maternal monitoring and lower conduct disturbance in their children.

Individual Factors

A number of early studies have found associations between higher acculturation/assimilation and risk for psychopathology among the children of immigrants. These studies not only support the findings of higher level of mental health problems in second-generation immigrants but also clarify the processes through which these generational disparities arise:

1. Greater degree of acculturation to U.S. cultural norms was associated with higher abnormal eating behaviors among Latina adolescents (Pumariiega, 1986).
2. Substance abuse is higher among Mexican-origin youth living on the U.S. side of the border than among Mexican youth, with second-generation status, depression, male gender, and cultural factors (lack of family cohesion, unsupervised time with friends, no religious ties, media exposure) and school problems being predictors of higher risk

(Pumariiega, Swanson, Holzer, Linskey, & Quintero-Salinas, 1992; Swanson, Linskey, Quintero-Salinas, Pumariiega, & Holzer, 1992).

3. Suicidal ideation and attempts are more frequent in U.S. Mexican origin youth than Mexican youth, with cultural factors (lack of family cohesion, media exposure, nonsupervised time with friends, no religious ties) associated with higher suicidal ideation but not actual attempts (Pumariiega et al., in press; Swanson et al., 1992). The findings around suicidality in many ways predicted the higher levels of suicidality found among Latino youth in the CDC Risk Behavior Survey (Eaton et al., 2008).
4. Latino children suffer from higher levels of anxiety than European origin or African American children, with significantly higher anxiety symptoms in second-generation versus first-generation Latino youth (Glover, Pumariiega, Holzer, & Rodriguez, 1999).
5. Problem (externalizing) behaviors in Latino youth increase with increased acculturation, with that relationship mediated by parental involvement (Dihn, Roosa, Tein, & Lopez, 2002).
6. In a study of 285 Asian American youth, acculturation interacted with parent-child conflict to predict suicidality, with less acculturated Asian youths being at greater risk for suicidality in the context of high parent-child conflict (Lau, Jernewall, Zane, & Myers, 2002).
7. In a study of Japanese, Chinese, and Korean immigrant youth, age, acculturation, and cultural adjustment difficulties significantly predicted mental health symptoms (Yeh, 2003).

Recent studies have further reinforced the relationship between acculturation stress and psychopathology among immigrant youth. Fenta, Hyman, and Noh (2004) found that Ethiopian immigrant youth have rates of depression slightly higher than U.S. Whites (9.8% vs. 7.4%), but 3 times higher than their cohorts in Ethiopia (3.2%). Romero, Carvajal, Valle, and Orduña (2007) found that bicultural stress was higher for Latino and Asian origin youth and that it was significantly associated with depressive symptoms after accounting for ethnicity, socioeconomic status, gender, and age. In another study, Latina teens reported greater differences in traditional gender role beliefs between selves and their parents than Latino males, and higher levels of depression mediated by increases in family dysfunction (Cespedes & Huey, 2008). Lower levels of ethnic identity have been correlated to substance abuse risk, acculturative stress, and self-esteem in Latino youth (Zamboanga, Schwartz, Jarvis, & Van Tyne, 2009). Parental acculturation has been associated with antisocial behavior in Puerto Rican youth in both Puerto Rico and the Bronx, although youth acculturation was not correlated to psychiatric symptoms (Duarte et al., 2008). Latino youth with higher English language fluency reported greater violence exposure and PTSD symptoms than those with lower fluency, but no differences by English fluency (Kataoka et al., 2009). Acculturative stress in Latino youth has been correlated with physiological, concentration, and worry symptoms of anxiety, with perceived discrimination accounting for a large proportion of the variance (Suarez-Morales & Lopez, 2009).

Disparities in Services

In addition to acculturation stress, disparities in services may also contribute to the increasing risk for psychopathology being identified among immigrant children and youth. For example, Pumariega, Glover, Holzer, and Nguyen (1998) found that Latino youth used half as many counseling services as used by Whites and African Americans, and that first-generation Latino immigrants used even fewer services. For example, Latino youth use fewer mean visits in school-based health centers (Juszczak, Melinkovich, & Kaplan, 2003). A number of studies have similarly shown lower levels of utilization of mental health services by Russian, Bosnian, and Southeast Asian immigrants (Chow, Jaffee, & Choi, 1999; Hsu, Davies, & Hansen, 2004; Weine et al., 2000).

Yeh, McCabe, Hough, Dupuis, and Hazen (2003) found that Latinos and Asian youth showed higher levels of unmet mental health needs than Whites, but parents endorsed fewer barriers to care, with cultural factors influencing parental perceptions of barriers. A result of such disparities may be a high risk of referral of Latino youth to juvenile authorities for behavioral difficulties, with similar high rates for Southeast Asian immigrant youth (Vander Stoep, Evens, & Taub, 1997).

Ethnic disparities appear to play a role in the diagnosis and treatment of mental health problems among diverse immigrant populations of children and youth. Stevens, Harman, and Kelleher (2004) found an underdiagnosis of ADHD among Latino children, whereas Pina and Silverman (2004) found a differential expression of anxiety symptoms in Latino youth. Disalver (2001) found that Hispanic children with manic symptoms were diagnosed as "socially deviant." Rates of prescribing psychotropic medication are lower for Latino and Asian youth than for Caucasians (Leslie et al., 2003; Martinez et al., 2009; Snowden, Evans-Cuellar, & Libby, 2003). Various studies have found significant disparities in the delivery of psychotherapy services in immigrant groups. For example, Pumariega et al. (1998) found half as much utilization of school-based counseling services among Latino youth versus Caucasian and African-American youth in Texas, while first-generation immigrant Latino youth utilized even fewer such services. Bui and Takeuchi (1992) and Lahey et al. (1996) found similar lower utilization of mental health services by Latino youth in Los Angeles and in New York respectively. Juszczak et al. (2003) found that Latino youth used fewer mean visits in school health centers than did African Americans.

Culturally Competent Mental Health Services for Immigrant Children and Families

Cultural Competence Model for Mental Health Services

The concept of *culturally competent services* is critical in effectively serving immigrant children and youth and their families. Cross, Bazron, Dennis, and Isaacs (1989) defined cultural competence as the ability to serve people across cultural differences. They identified important provider characteristics in that regard (e.g., awareness and acceptance of differences; awareness of own cultural values; understanding of the dynam-

ics of difference; development of cultural knowledge; ability to adapt practice to the cultural context of the patient). Cross et al. also identified important system characteristics in cultural competence (e.g., valuing diversity, cultural self-assessment, management of the dynamics of difference, institutionalization of cultural knowledge, and adaptation of policies, values, structure, and services to better address diverse cultural needs). Both types of characteristics are needed in order to deliver culturally competent services effectively.

For mental health services, as for other human services, culturally competent services can be operationalized in relation to phases of service delivery:

- *Assessment* includes attention to the cultural context of symptoms/problems, symptomatic expression, youth and family acculturation, immigration history, related stressors or trauma, the context of adaptation, and cultural strengths.
- *Linguistic support* is critical for effective service delivery, whether through trained and certified interpreters or (preferably) clinicians who are fluent in the family's native language and familiar with their culture. The use of family members, especially children, as interpreters should be avoided at all costs. There should even be caution about using interpreters from the same community as the family, doing so may result in a breach of confidentiality.
- *Family involvement* is critical. Family therapy needs to focus on intergenerational conflicts, bridging the generational acculturation gap, mobilizing family supports, promoting respect for the traditional family structure, promoting some cultural flexibility on the part of parents and elders with their children, facilitating the negotiation of gender roles, and negotiating confidentiality, so that youth can have privacy but remain engaged with their families.
- *Psychotherapy* needs to be practical and problem solving. It should address immigration traumas, acculturation, and ethnic identity conflicts (internal or generational). The use of culturally specific modalities, themes, or stories may be helpful in addressing these issues.
- To build *contextual (systemic) supports*, clinicians should promote and utilize family strengths and community natural supports. As much as possible, they should avoid institutionalizing youth or removing them from their families and communities. If available, ethnically specific programs may be particularly effective. Additionally, case managers from the population of origin are needed, so that they can mobilize such community supports and serve as intermediaries between the immigrant family and the mainstream community agencies (schools, courts, child welfare, juvenile justice, and mental health).
- *Pharmacotherapy*, if utilized, should reflect genetic and dietary factors that impact on the metabolism of different medications. Clinicians should demystify the use of medications, provide effective education to youth and family members, and address cultural myths or beliefs that may intersect with the use of medications. At the same time, clinicians should respect the autonomy of and decision by parents and elders on using pharmacotherapy.

Culturally Informed Evidence-Based Practices

A number of culturally informed evidence-based interventions have been developed to address the special mental health needs of immigrant populations. For example, Brief Strategic Family Therapy (Santisteban et al., 1997), a family-based intervention focusing on AFD, has demonstrated significant improvements in addressing youth substance abuse and conduct disturbance, and has been adopted as a National Institute for Drug Abuse (NIDA) endorsed evidence-based practice. Culturally Informed and Flexible Family-Based Treatment for Adolescents (Santisteban & Mena, 2009) is a newer combined family and individual cognitive behavioral treatment (CBT) and psychoeducational intervention that runs 16 sessions twice weekly and combines interpersonal and crisis management skills borrowed from Linehan integrated and culturally relevant materials and themes relevant to Latinos. Cognitive Behavioral Therapy for Traumatic Stress (Kataoka et al., 2003) is a school-based, multilevel CBT intervention (group, individual, and psychoeducational) that is delivered by educators and mental health professionals in school settings and addresses acculturation stress and cultural trauma. Evaluation has demonstrated significant reductions in PTSD and depressive symptoms.

Culturally based interventions based on themes and practices from cultures of origin are also utilized to meet the unique mental health and cultural needs of immigrant populations. A number of these have been developed for Latino populations. For example, Cuento Therapy (Constantino, Malgady, & Rogler, 1994) is a culturally sensitive storytelling form of cognitive behavioral therapy using culturally based myths and stories. It has been shown to improve academic performance and self-esteem and reduced anxiety symptoms (Ramirez, Jain, Flores-Torres, Perez, & Carlson, 2009). Magical realism is a similar cultural intervention for traumatized Latino children (De Rios, 1997). Parenting interventions include Latino-specific parenting groups for parents with limited literacy (McGrogan, 1998) and group action planning for Latino families with youth with developmental disabilities (Blue-Banning, Turnbull, & Pereira, 2000). Rotheram-Borus et al. (1999) adapted the Hispanic media genre of *telenovelas* as part of an emergency room intervention with suicidal Latinas in Los Angeles; the result was a significant reduction in ER recidivism and subsequent suicide behaviors. The Club Amigas Latina youth mentoring program pairs Latina college and middle-school students, with mentee self-esteem having been shown to correlate with participants' commitment to the program (Kaplan, Turner, Piotrkowski, & Silber, 2009). Adaptation of traditional cultural approaches to services, such as the *promotoras de salud* model of neighborhood health care workers (Grames, 2006) and mental health collaboration with cultural healers (*curanderos* and *santeros*; Ruiz & Langrod, 1976), have also been used effectively.

Treatment of Refugee Children and Youth

A phased approach is recommended in providing mental health interventions to treat refugee children exposed to war or other traumas. The phases include: (a) establishing safety and trust; (b) trauma-focused treatment, with a focus on those who have had the greatest exposure; and (c) reintegration (rebuilding

relationships and supports, assistance to the family and child in settlement and resumption of normal life activities, developing future goals and plans).

Brief grief resolution therapy and traditional healers and rituals can be used to address traumatic grief. Special attention must be given to the needs of unaccompanied refugee youth, who may be facing added trauma because of separation from their parents and family. Group psychosocial interventions and mutual support networks have also been used for that purpose. Promising evidence-based approaches that can also be considered for refugee children and youth include CBT, testimonial psychotherapy, narrative exposure therapy, eye-movement desensitization and reprocessing, and expressive techniques for younger children.

The establishment of psychosocial supports is essential for recovery from refugee-associated trauma. For children under 8, the primary aim of psychosocial intervention is to promote their development and well-being through parental support and psychoeducation, with a special emphasis on strengthening the mother-child interaction (Ehnholt & Yule, 2006; Pumariega & Rothe, 2003). Rothe (2008) has developed a psychotherapy model for treating child and adolescent refugees living inside refugee camps, in order to minimize psychological trauma and to prevent dissociative memories that result from these experiences. Birman et al. (2008) studied services provided by the International Family, Adult, and Child Enhancement Services (FACES), a service component of the Heartland Alliance for Human Needs & Human Rights. These services addressed the needs of children who experienced an average of 4.5 traumatic events before fleeing to the United States, coming from 32 different countries and speaking 26 different languages. They were served by immigrant and refugee-origin therapists who spoke 15 languages, language-matched as much as possible to meet the child's and family's needs. The study found that multimodal community-based flexible mental health services were most effective, with an average of over 100 hr of service per child.

Immigration: Community and Societal Responses

Preventive Approaches in Communities

There are beginning models for preventive services for immigrant and refugee children and their families in local communities that show promise in addressing the generational mental health risks for this population. Rousseau and Guzder (2008) described a number of promising school-based prevention programs for refugee children. Morse (2005) reviewed a number of promising preventive models and practices (mostly based in schools) to facilitate the adaptation of immigrant and refugee children and their families in the United States. These programs promote the development of adaptive family support, and community support for immigrant and refugee children and youth.

Among the innovations are 6- to 18-month *newcomer programs* to bridge gaps in students' academic backgrounds and integrate them quickly into the regular school program. In addition to English language training, literacy programs, and academic instruction, most programs offer cross-cultural

orientation to help students become familiar with the school system and community. Most also provide broader human services, such as health care, mental health care, career counseling, and tutoring. They may also provide parents with school liaison services, adult English as a second language (ESL), community orientation, and help in accessing social services, health care, housing, and employment.

Programs for immigrant and limited-English-proficiency parents combine ESL instruction with social support. Among the topics covered are American norms for dating, the dangers of gang involvement, and opportunities for postsecondary education. In general, such programs strive to help parents overcome language barriers, cultural conceptions of the role of teachers, and lack of familiarity with the public school system. In contrast, however, to programs for preschool children, few programs target immigrant families with adolescent children.

After-school programs are important in helping immigrant youth to improve academic achievement, stay in school, and avoid risky behaviors such as pregnancy and substance abuse. These programs also provide academic assistance, language tutoring, recreational opportunities, behavioral counseling, life skills training, and cultural enhancement opportunities. They also provide parents with the training on school governance and educational programs. All of these models have demonstrated considerable success with a diverse range of populations, including Latino, Bosnian, Hmong, and African immigrant and refugee communities.

Societal Response: Policy and Community Supports

The United States should make an investment in the health, education, and social welfare of immigrants. Although assimilation into the melting pot has been both discredited and rejected by many scholars and even by our newer immigrant populations, there is still a tendency to promote this model of adaptation indirectly. Our nation should develop and implement acculturation policies and practices (in human services and education) that facilitate immigrants both to learn their new host culture and to retain the strength-based, adaptive aspects of their cultures of origin.

Since passage of the Refugee Act of 1980, which incorporated the United Nations definition of refugee and standardized resettlement services for all refugees admitted to the United States, the Office of Refugee Resettlement has worked with 10 voluntary resettlement organizations to help newly arrived refugees settle into local communities. These organizations include Church World Service, Ethiopian Community Development Council, Episcopal Migration Ministries, Hebrew Immigrant Aid Society, International Rescue Committee, Kurdish Human Rights Watch, Lutheran Immigration and Refugee Service, U.S. Committee for Refugees and Immigrants, U.S. Conference of Catholic Bishops/Migration and Refugee Services, and World Relief. This collaboration has resulted in some important success stories, most notably in relation to Cuban émigrés and Vietnamese refugees. At the same time, however, policy makers have been hesitant to develop a broader and more systematic program for the facilitation of immigrant and refugee accultura-

tion and adaptation based on these experiences. The community-based preventive models cited in the previous section can also serve as potential models for such broader efforts.

Mental health and support services are most effective in the context of a rational immigration policy that is based on rational national interests rather than on emotional (and often xenophobic) responses. These should include legalization pathways for undocumented immigrants, with the option for family reunification. Guest worker programs for unskilled immigrant workers with a “buy-in” option for residency might rationalize and regulate what is otherwise a chaotic and stressful process. Although the United States is a nation of immigrants, it is one that faces a demographic and cultural transition of historic proportions.

National policy to meet the challenges posed by this transition should include active preparation of Americans for 2050, which is the year that there will only be minority groups in the United States. Such efforts should include the education and preparation of homogeneous areas and populations of the United States for rapidly changing population make-up, promoting increased national diversity as a major national strength in the new global economic competition and in addressing internal financial and social challenges. The media and all institutions in civil society (schools, churches, volunteer organizations, etc.) should be recruited toward this important endeavor. Such public education efforts can support enhanced efforts toward preventive cultural adaptation programs and community supports for immigrant children and their families.

Further research is needed on the biological, sociocultural, psychological, and psychopathological factors underlying xenophobia and ethnic self-hate. These often appear to be two sides of the same coin and have the same intergenerational repetition among succeeding generations of immigrants, as does child abuse in families. They require significant societal attention in order to address them at their root causes. One recent example of recognition of the importance of this task is the adoption by the American Psychiatric Association Committee on Hispanic Psychiatrists (2010) of an official position statement on xenophobia, immigration, and mental health, which was drafted during the current national debate around immigration.

Conclusion

Immigration has been a traditional characteristic of the United States and its national identity. However, its future success is more dependent on this unique characteristic than ever in its history. Immigrants, particularly immigrant children and the children of immigrants, are future citizens. Meeting their developmental, educational health, and mental health needs reduces marginalization, improves the overall social and community climate, and makes immigrants stakeholders in future of the nation. Meeting the adaptive needs of immigrant children and families minimizes future health, mental health, and social welfare expenditures. Furthermore, immigrants comprise a major portion of the future U.S. workforce, and meeting their health and educational needs maximizes the nation's potential for productivity and success.

Keywords: immigrants; refugees; children; families; mental health; cultural competencies; prevention; acculturation; assimilation;

ethnic disparities; ethnically specific services; xenophobia; immigration policy; racism; acculturative family distancing; school-based programs

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