

International Medical Graduates in Child and Adolescent Psychiatry: Adaptation, Training, and Contributions

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- International medical graduate • Acculturation

International medical graduates (IMGs) are a heterogeneous group who have immigrated to the United States from more than 140 countries and have diverse cultural, linguistic, and educational backgrounds. According to the American Psychiatric Association (APA) census of residents, currently, one-third of residency positions are filled by IMGs whereas according to the American Medical Association (AMA), nearly 30% of practicing psychiatrists in the United States are IMGs.¹ There is a growing literature on various aspects of IMGs, but it is mostly silent about IMGs as trainees in child psychiatry.

Child psychiatry is a shortage specialty, and considerable efforts are being made by its leaders to improve recruitment into the field. Historically, IMGs have played a critical role in filling positions in child psychiatry, but, of late, the IMGs selected for training in child psychiatry decreased from 250 in 2006 to 226 in 2009.

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This article describes IMGs' history, demographics, training issues, and professional challenges as well as their strengths and weaknesses. The overarching theme is cultural for this discussion. Culture influences various aspects of the clinical endeavor, and IMG psychiatrists from various cultures bring their parental cultural expectations, judgments, and attitudes, albeit unconsciously, to their clinical work. An appreciation of such background facilitates the development of more focused training strategies that benefit IMGs and the patients that they serve. A review of history of IMGs in the United States is offered as a backdrop for the article.

HISTORY AND BACKGROUND

It is well known that physicians have always traveled to far-off lands in furtherance of their skills and knowledge. In the early twentieth century, it took the form of US physicians traveling to Europe for medical education, and in the middle to late twentieth century, the reverse was seen (ie, physicians from the world over sought training in the United States). The first among them arrived in the aftermath of World War II, seeking protection from persecution in Europe. Although the early migrants were welcomed with open arms, subsequent ones encountered increasing doubt about their competence and skills from the medical establishment in the United States. Consequently, rigorous testing of their readiness to practice medicine was introduced through the creation of the Educational Commission for Foreign Medical Graduates. In the past 10 years, the process has been considerably tightened. At the present time, IMGs are required to be certified in the same examinations that US medical graduates take. Alongside of this evolution in the testing rigor, there have been multiple changes in immigration laws according to the needs and priorities of society, and each one of them restricted the ease with which IMGs could enter graduate medical education in the United States. Due to the complexity of the US economy and the fast expansion of the US health care system, however, IMGs continued to be needed, and, consequently, in spite of these ups and downs, the presence of IMGs has continued unabated.^{2,3}

The early generation of child psychiatrists was very much influenced by European child psychoanalysts. Consonant with the changes in immigration laws enacted in the 1960s that gave preference to technical skills over family ties, Asian nations, such as India, Pakistan, and the Philippines, became major sources of physicians and supplanted Europe and South America. Culturally, they came from non-Western European traditions that had significant differences in child rearing practices and relational paradigms, such as collectivism, versus individualism of the West. In addition, they lacked organized exposure to psychiatry in their home medical schools. Their commitment to psychiatry was suspect in the eyes of their teachers as were their clinical skills. Recently enacted health care reform and the expansion of American medical schools, without concomitant expansion of graduate medical education positions, have created an untenable situation for the IMGs—the former will result in increased demands for physicians whereas the latter can practically eliminate their presence of IMGs. In addition, recent difficulties in obtaining J1 and H1 visas have the potential to further reduce the number of candidates for child psychiatry. All in all, in 2010, the future does not look all that encouraging to IMGs in the United States.

What is the situation with child psychiatry's workforce? According to Thomas and Holzer,⁴ the number and the distribution of child psychiatrists are in dire straits in the United States. The estimates of their supply vary from 10% to 45% of the number needed to meet the mental health needs of American youth, among whom it is estimated that 1 in 5 develop a mental disorder. According to the Department of Health and Human Services⁴ the demand for child and adolescent psychiatric (CAP) services

will double between 1995 and 2020, and there will be a need for 12,624 child psychiatrists by 2020, whereas only 8312 will be available based on today's statistics. The number of IMGs who are child psychiatry residents has continued to diminish since 2004. The reasons for this decrease are not known, although the national security concerns that resulted in visa restrictions and the difficulties associated with IMGs taking the clinical skills assessment examination had much impact. Unless the Medicare cap is lifted and there is a broad expansion of residencies to accommodate the higher output of American medical schools and the IMG influx, the shortage of child psychiatrists may not improve.

COMPETENCE AND QUALITY OF IMGs

IMGs in CAP (IMG-CAP) face the same issues as their counterparts in general psychiatry. Weintraub⁵ has written about the preponderance of myths about IMGs. These include that they are more passive, prefer organic and directive therapies, and have difficulty learning dynamic therapies and forming relationships with their patients than do American graduates.

It has been repeatedly reported in the literature that some IMGs have difficulty with the culture, the language, and the attitudes that are emphasized in the United States. Similarly, many investigators have identified the specific needs IMGs have in their education. Searight and Gaffert⁶ looked at the behavioral science education of IMGs, and they observed that the IMG residents they interviewed reported limited education in psychiatry and behavioral science before starting residency. The specific deficits included medical interviewing, perceptions of family life in the United States, the doctor-patient relationship, and the mental health and psychosocial content of medicine. In a recent study, Dorgan and others⁷ found two broad themes as barriers to effective communication between IMGs and their patients: educational and interpersonal. Each of these categories had secondary themes: in education-related barriers, there were science immersion and lack of communication training, whereas in interpersonal barriers, there were unfamiliar dialects, new power dynamics, and different rapport building expectations.

In summary, IMGs, the US medical education system, and the US hospital industry have an ambivalent and symbiotic relationship. Although this state of affairs served them well all these years, the significant changes in both medical education and health care industry require fresh thinking. Child psychiatry has to acknowledge its need for IMGs and offer creative models for using them to address its workforce issue and maldistribution challenges, including developing effective ways of selecting the best among them as trainees and providing them culturally sensitive training.

DEVELOPMENTAL CONSIDERATIONS

The transition from living in a native country to life as CAPs in the melting pot of the world is generally not without its vicissitudes. This section reviews the relevant issues of immigration and the problems related to training and socialization of IMGs into the field of CAP.

Migration, Immigration, and Acculturation

The process of leaving a homeland, settling into a new place and culture, and developing a comfort with this new arrangement is a process that few outsiders can truly comprehend. The majority of IMGs voluntarily emigrate for financial and professional reasons, so can return at will. Nothing in their backgrounds has readied them for this new life, however. The process of migration is a series of cumulative traumas,

involving more than just leaving or arriving in a new country.⁸ The term, *culture shock*, most aptly embraces the IMG experience of entering this country. Garza-Guerrero⁹ has defined culture shock as “a reactive process stemming from the impact of a new culture upon those who attempt to merge with it as a newcomer”.^(p410) He views it as a violent encounter that confronts and threatens an immigrant’s intrapsychic status quo. An immigrant initially faces an anxiety-provoking situation that “challenges the stability of his psychic organization”.^{9(p412)} When the crisis has been managed successfully, growth occurs. This evolution co-occurs with a process of mourning precipitated by the individual’s “gigantic loss of a variety of love objects”.^{9(p410)} The coincidence of these two factors threatens an immigrant’s identity.¹⁰

Grinberg and Grinberg⁸ have delineated traced four stages in the psychobiologic adaptation to a new culture. Initially arising are feelings of intense sadness for all that is left or lost. A manic stage may follow in which the newcomer immigrant either minimizes the “transcendental significance of change in life or, on the contrary, magnifies and idealizes the change”.^{8(p37)} Later, nostalgia ensues and a sorrow for a paradise lost is experienced. At this point, immigrants have the opportunity to appreciate and work through previously unacknowledged emotions as they gradually assimilate the new culture. If this process is successful, aspects of the host culture are metabolized without rejecting previously embraced cultural values, “and as a result, the ego is enriched and the identity is consolidated”.^{10(p131)} Ticho¹¹ wrote that “Culture shock is the result of a sudden change from the average expectable environment to a strange and unpredictable one, and the experience of culture shock and the mastery of its disturbing effects seem to be preconditions for the integration of the new culture”.^(p325) Akhtar¹² refers this process of intrapsychic transformation as “the third individuation,” which is akin to the second individuation precipitated by adolescence in the separation individuation process.¹² Learning psychiatry occurs against this tumultuous backdrop of immigration. In the initial phases, cultural adaptation takes priority over mastering psychiatry.¹⁰ Rao writes, “the wounded self-esteem, stemming from slow and inadequate progress, or even the failure to learn psychiatry, will further add to an already overburdened self struggling with issues of loss and separation. This may manifest as a lack of enthusiasm for the field.”^{10(p132)}

If the IMG is not cognizant of the repercussions of culture shock, language, and communicational difficulties they blame themselves and the field of psychiatry rather than focusing on these other issues. Serious unresolved issues of culture shock may manifest as personality problems, academic underachievement, marital difficulties, clinical psychiatric problems, transfer to another specialty, and, finally, return to a native country in despair. Conversely, it may be displayed as excessive zeal for psychiatry, pseudo-Americanization, and rejecting behavior toward their native culture. Response from the host residency group may range from one extreme of unconditionally embracing IMGs and not requiring them to hold the same rigorous standards as their US compeers to scapegoating them for every system failure. Char¹³ notes that IMG residents are “accepted into a training program as ambivalently valued objects. The foreign resident is valued because he is needed to fill the critical shortage of residents, and to satisfy our ‘missionary’ need to train foreigners, but he is rejected because of his handicaps.”^(p237)

Training Challenges for IMG-CAP

An in-depth examination of the choice of child psychiatry, difficulties with language and communication, and not growing up in America help explicate some of the training difficulties that IMG-CAP trainees experience.

The choice of child psychiatry

Many international graduates have little exposure to the field of psychiatry in their native country. For example, according to Das and colleagues¹⁴ there are only 300 psychiatry training positions in India, which means that less than 0.6% of the graduating Indian medical students enter psychiatry training. Yet in the United States, 25% of IMGs become psychiatrists, with a disproportionate number of international graduates receiving further specialty training, including CAP. This suggests that IMGs make the choice of psychiatry, even if it is not the first choice. Thus, entrance into psychiatry is often akin to an arranged marriage (a culturally familiar process), a choice out of necessity and practicality, not initially out of passion or love. Most, at some point, however, fall in love with their profession and caring for patients and their families. How that process transpires is a question worthy of further study. It is known from social psychology research literature that mere exposure is likely to result in increased liking.^{15,16} The phenomenon of cognitive dissonance (not wanting to view ourselves doing things that we do not agree with or believe in) may also play a role in increased interest in one's work.¹⁷⁻¹⁹ It is likely also that interest and passion for patient care transcends the particular specialty. Regardless of how it happens, awareness of this dynamic is important to aid IMGs.

Little information is available as to why IMGs choose child psychiatry over general psychiatry or other specialties. Of all the specialties within psychiatry, the child and adolescent specialty remains a psychosocial field whose goals are consistent with protecting the next generation; it values the family, a goal consistent with Eastern cultural values. It is a field that encourages more introspection. The authors' informal survey of child psychiatry graduates reported that as child trainees, they thought they were more supported by their faculty than they were as adult trainees. On the one hand, they thought that they were given more autonomy and respect for their knowledge base. On the other hand, "regression in the service of training and learning" is more tolerated in CAP training programs. That is, child psychiatry residents are permitted to be professional yet still allowed to not know it all. Third, child and adolescent mental health programs and departments are filled with many caring, loving female staff, social workers, nurses, and teachers, who not only nurture patients and families but also nurture CAP trainees. This nurturing, in turn, can increase self-esteem and positive social mirroring. Lastly, the mere fact of providing care to adorable, undefended, and innocent children generally brings out the protective side in all of us, making us more humane and humble. All these factors can contribute to the psychological growth and development of IMG-CAP.

Difficulties with language and communication

For most IMGs, English is not their first language. Even though medical education is conducted in English in many parts of the world, the comprehension and expression of oral language may not be a well-learned skill. Communication is further made difficult by the use of idioms unique to the United States and dialects within subgroups.²⁰ Hein²¹ articulated specific difficulties that IMGs have in communicating with their patients and other professionals, which included self-consciousness in new speaking situations or when speaking before groups; variations in the pronunciations, rhythm, and voice inflection; difficulty pronouncing certain English sounds; occasional feeling of being forced to use shorter answers to questions when longer responses are desirable; occasional embarrassment at being asked to repeat themselves; and continued concern for their accents. The authors frequently encourage residents to talk in the

colloquial language familiar to children and their families. The residents, however, usually have only medical knowledge and formal English in their communication repertoire.

Greenson²² suggested that the importance of the mother's speech represents both the means of maintaining and holding relations with the mother and also for withdrawing from her. If so, IMGs may be enacting some unconscious conflicts about separation by choosing the psychiatry specialty where language facility is crucial.¹⁰ The guilt about leaving home may replay conflicts about using a new language. Connection to a mother tongue becomes heightened when beginning to live in a country with a different language.⁸ There are two aspects to learning acquisition: learning the word and form (grammar and syntax), which is a cognitive task, and learning the accent and the intonation, which is an emotional task having to do with identification. Training programs must address the emotional aspects of learning a language, rather than treating this learning of a language as a purely cognitive issue. Process groups commonly used in residencies may help in this endeavor.

Not growing up in America

IMG-CAP do not have the same childhood experiences as their patients who have grown up in this country. They often do not have similar familial experiences of living between two households of divorced parents or attending day care or knowledge of the social scene and rules for dating and hooking up, beginning in middle school and intensifying during high school. They did not grow up with television as an auxiliary babysitter, with programs, such as *Barney*, *Sesame Street*, cartoons, doctor and cop shows, or the barrage of reality shows that the American child has exposure to from a young age. In short, they have not been exposed to the environment with which American children are making sense of their world. They do not have the familiarity with unstated norms and behavior that children incorporate into their psyche by mere exposure. Relating to adolescent patients is even more difficult because this lack of experience with American life—their dress norms and behavior, their music, and ways of relating through e-mail and Facebook—compounds the cultural divide. Even the educational system, a central aspect of work with children either directly or indirectly, is often different from an IMG-CAP resident's own experience. This makes it difficult to help parents with their behaviorally difficult children.

MAJOR CHALLENGES FACED BY IMG-CAP IN PRACTICE

Immigrant child psychiatrists face special issues arising from their sociocultural experiences. Understanding their impact on IMG-CAP is important in providing culturally sensitive treatments to children, adolescents, and their families. This article reviews issues most central to IMG-CAP. These include cultural differences; dealing with prejudice and discrimination; self-esteem and social mirroring; child rearing; and unique aspects of the treatment for IMG-CAP.

Appreciating Cultural Differences

Culture plays a significant role in the determination of perceptions and attitudes about the world. Appreciating the cultural differences between culture of origin and a host culture is important in understanding children and their families. The major areas that the authors view as essential and particularly applicable to IMG-CAP are differences in conceptualization of the self, relationships to others, social attitudes, health care and training systems, and boundaries.

Development of the self

Child psychiatrists and their patients (and families) bring to the treatment setting an unspoken perspective on how one defines the self. Roland²³ described the developmental differences between the Eastern, extended family as “we or familial self” and the Western individualistic “I self.” In Western cultures, there are firm boundaries between the “you and I,” a sharp differentiation between what is inside the self and what is part of others. Individualism supports having rights and obligations equal to each other. Decision making and responsibility are the individual’s and not the group’s.^{24,25} All psychoanalytic theories of development reflect a “narrative of individualism”.^{23(p10)} In contrast, the Eastern “we self” incorporates more inner images of the extended family and community than the individualistic, more self-contained Western “I self.”²³ Roland²³ describes the concept of a highly developed private self, which is the core of individuality. It is this private self that maintains an equilibrium between that and the semimerger experiences in ongoing extended family and community relationships in Eastern cultures, such as Pakistan, Japan, and India. A highly developed intuitive sensing of the group “other” is relied on. In contrast, verbal expression is used as part of proper social etiquette.

IMGs, often from an Eastern culture, come to a therapeutic relationship with a familial self-perspective. Without an appreciation for the difference in perspective, there may possibly be a misunderstanding of the nature of the psychopathology. That is, these differences in Eastern and Western philosophic, sociologic, and anthropological thought can influence the manner in which a child psychiatrist conceptualizes and then provides treatment for Western patients and their families, which can have a negative adverse influence treatment. Take, for example, a sophomore male college student from the mountains of New England who has ongoing daily contact with family to assure their agreement with his choices at school. Although it is possible that this behavior is well within the emerging helicopter parents phenomenon, New Englanders pride themselves on their view of individual responsibility and hardy self-reliance and, to some extent, represent the prototype of American individualism and self-directedness. Thus, an adolescent psychiatrist whose background is congruent with an Eastern perspective may underestimate the extent of maladaptive behavior that this student exhibits. CAPs who are able to recognize and hold their own perspective as potentially different from the adolescent being treated, are likely to be able to use that to their advantage in understanding a case, such as this one, within its cultural context.

Differences in relationship to others

In some cultures, relationships are more lineal, authoritarian, and hierarchical. The father or the eldest male in an extended family is seen as the absolute ruler.²⁴ This world view affects how the problem is seen, the advice given, and the therapeutic relationship. If a child psychiatrist brings this perspective to treatment with children and families who view relationships as more egalitarian, the treatment may be problematic on at least two levels. First, the CAP who carries a world view of being better than others’ may view family dysfunction as due to lack of respect for this authoritarian hierarchical structure. Second, IMG-CAP may expect that families and children will follow their instructions or advice to the same degree and with the same reverence that a family from the native country might have. Not doing so, an IMG-CAP is likely to feel disrespected, disappointed, and angry with the family. The family, in turn, may view the psychiatrist as dictatorial and not understanding them. An IMG-CAP who comes to the treatment relationship with an understanding of differences in how

different cultures might view relationships is more likely to take this difference into account when viewing and treating problems.

Differences in social attitudes

Many IMGs come from traditional extended families. They may have difficulty accepting evolving American cultural/social mores, such as living together without a marriage, youth sexuality, single parenthood, gay and lesbian relationships, and entitlement systems. Thus, IMG-CAP may find it challenging to develop a position of therapeutic neutrality vis-à-vis their patients and families and may miss or project aspects of psychopathology. Self-recognition of internalized prejudices, discriminations, and sensitivity training to accept these can be helpful for IMG-CAP. For example, a mother of 9 children presents to the clinic with her youngest child, the only one not placed in foster care. She requests that social security papers be completed for her 5-year-old boy, for whom she reports symptoms consistent with an attention-deficit/hyperactivity disorder diagnosis. In the session, the boy does not exhibit hyperactive behavior. Both American and IMG child residents may find it difficult to look beyond the manipulative elements in the mother's presentation and feel some disgust at this misrepresentation. IMGs may attribute this to a dysfunctional American system, whereas American graduates may attribute it to liberal mores. Such affects and blame may obscure other behavioral disorders that may be present in the child, the recognition of a need for educational parenting skills, and the mother's underlying motivations for such a request (eg, her own psychopathology, narcissism, or dependency that may be interfering with good parenting).

In another example, an upper middle class white family presented for treatment after the 16-year-old daughter ran away for 4 days. This running away was precipitated by the parents refusing to allow their daughter to attend the prom with an African American. Both attended the same private school. The parents stated that they would disown their only child, an adopted Asian girl, if she dated someone of color. As the mother stated, "I would sooner see these one hundred thousand dollar diamonds that I am wearing today go to Goodwill than give to a daughter who dated a Black boy." In this second example, race, gender, rules of dating, and issues of who has authority are significant aspects that are culturally determined. IMGs from a culture that respects authoritarian rule may be prone to side with parents' right to determine their own rules for their daughter. Yet it is culturally within the norm to permit adolescents to attend a prom with culturally diverse classmates. Educated parents from the dominant culture who do not adapt to these norms risk their child being ostracized. Not recognizing the importance of this aspect could lead therapists to underestimate the parents' need to control and the effect that their racial bias can have on encouraging their daughter's self-hatred of her color and culture of origin.

Discrepancies in systems of care and training

Pumariaga and colleagues²⁶ outlined the importance of the congruence between the cultural competence of individual clinicians and that of the system of care they practice in. Some IMGs may experience culture shock between the health care and training systems of their native countries and the US model, particularly around understanding and accepting the complexity and multiplicity of the American systems. Most IMGs originally trained in a strictly medical model where doctors prescribe and those surrounding them are working to carry out the doctors' orders. But in the US system, there are complicated, overlapping, multiple systems with different lines of authority, such that it is difficult or impossible for IMG-CAP to be the solo authority. They may become frustrated easily, which accentuates feelings of immigrants' helplessness

and can lead to giving up. Also, the multiple systems may have trouble accepting the legitimate and generally accepted leadership role of IMG-CAP because of their immigrant status. Members of a care team may also attribute culturally based stereotyped traits to an IMG-CAP and subtly put up multiple cultural roadblocks. IMG-CAP have to understand and perhaps empathize with the cultural variations of the system. Those who perceive these systemic issues as personally intended end up feeling defeated, angry, and unable to work with school, welfare, primary care health, and governmental systems.

Boundary issues

On the APA Web site, a primer for residents discusses how gift taking, after-hours appointments, self-disclosure, and dual relationships are boundary crossings and leave residents vulnerable to being accused of boundary violations.²⁷ Although these may be somewhat intuitive for those reared in America, they are not so for IMGs. Myers²⁸ posits that differences in the collectivist (Eastern) versus the West European/American cultures contribute to differences in perspectives of appropriate relational boundaries (ie, group vs individualistic). Likewise, such differences in perspective also influence how privacy, confidentiality, and self-disclosure are conceptualized.

For instance it is common for IMG-CAP to have distant relatives and their friends calling or e-mailing them to discuss problems with their children. Such friends and relatives become confused and/or insulted if a child psychiatrist requested either to have the child come to the office or referred the child to a colleague. IMGs feel a loyalty conflict between what is appropriate back home and what is now appropriate with regard to good care and malpractice in America. If IMGs are burned enough times with this kind of interaction, they are likely to discontinue such practices easily enough. It is, however, the more subtle boundary crossings that are the cultural scotoma of immigrants.²⁸

These guidelines apply not only to physician-patient relationships but also to physician-nurse, physician-therapist, and other professional relationships. In particular, male IMG-CAP should be aware of these cultural norm variations and individuation/self-concepts. In that respect, IMG-CAP may benefit from additional training in recognizing, preventing, and handling these delicate issues.

Facing Discrimination and Prejudice

Xenophobia can contribute to the marginalization of immigrant populations and can have adverse effects on ethnic identity formation.²⁹ IMGs face possible discrimination and prejudice from professionals and patients.

There is a perception among IMGs that there is some prejudice and discrimination against them by the medical establishment. In surveys of training programs, 80% of psychiatry and family practice and 70% of the surgery programs were perceived to show discrimination against international graduates.³⁰ Indeed, 80% of IMGs surveyed self-report considerable bias and prejudice,³¹ although generalizations about group discriminations can be flawed particularly when applied to individuals.³² An informal e-mail survey of recent IMG-CAP (Nyapati Rao, MD, MS and Rao Gogineni, MD. IMG-CAP: on training and cultural issues, unpublished data, 2010) found that graduates did not feel overt discrimination from their colleagues but thought they had to work harder to overcome xenophobic stereotypes and build their reputations. Many IMG-CAP that the authors have spoken to do not perceive much discrimination for entry-level jobs but perceive a made-in-America glass ceiling for higher-level positions. Surveys of practice reveal that IMGs occupy less-attractive positions and care for the most indigent, difficult, and chronic children and adolescents in the

country.^{33,34} They are more likely to work in the public sector, administering direct care, and less likely to occupy administrative and medical school positions.³⁴ These differences remain significant even after age, gender, race, and board certification are controlled for.

IMG-CAP report that they need to work harder not only to work through the cultural and psychological barriers of systems but also with patients and their families. Surveys of patients in a general medical population showed discrimination against diverse groups of physicians based on emotional reasons rather than medical concerns.³⁵ A few examples illustrate the different problems.

Over the course of professional lives, racial and ethnic slurs have been mounted against IMG-CAP, who have been called various derogatory names, most often by oppositional, uninhibited, and conduct-disordered youth. It is important to ascertain the meaning of name calling within the therapeutic context because it could be a clinical issue. To do so requires a certain ability to stand apart from the perceived or intended narcissistic insult. If a CAP is reactive, then a clinical opportunity is lost. In cases where such an act seems primarily related to resistance, careful processing with patients can address it and help develop a stronger working alliance. For example, such name calling by a child with an oppositional defiant disorder and an excessive need for autonomy could be seen as an effort to push away the psychiatrist, consistent with behavior in the rest of this child's life. In other cases, where it seems primarily to push the boundaries of acceptable etiquette, some limit setting must be considered.

What is more common among children and adolescents is a less overt and dramatic display of prejudice. For example, an 8-year-old boy with a history of oppositionality underlying narcissistically vulnerability and impulsive aggression presented for treatment. Input from other residential staff revealed that the parents were racist. In the therapy sessions, the boy was withdrawn and had no eye contact and it was a struggle to develop a connection with him. It was suspected that some of the parents' prejudice was internalized by the boy and he felt reluctant to trust the child psychiatrist. The psychiatrist continued working with the boy but worked with the parents through intermediaries (teachers and support staff) to see the doctor as a caring expert professional who could help their child. This case required careful working through of these projected negative feelings with the parents and child. The parents never gave up their racist attitudes but began to contain their racism and develop trust in the psychiatrist to treat their son. This case was particularly difficult because the negative projections toward minorities always remained in the periphery of treatment and were a constant reminder to the psychiatrist of his foreign and unacceptable status. The psychiatrist was watchful of the potential for induced countertransference rage and helplessness that could invade their work together.

Another common demonstration of prejudice and discrimination is the preference for certain families to see a white pediatrician and/or a white master's-level clinician rather than a board certified IMG-CAP who has experience in providing both medication and therapy. At times they might reluctantly tolerate an IMG-CAP to prescribe medications but not therapy. Unfortunately, some agencies covertly or overtly promote this kind of prejudicial and discriminatory practice. The question becomes, What should an IMG-CAP do? This is a political issue that requires attention at the national level. At the local level, consultation and discussion with a trusted colleague or mentor often are helpful.

Self-esteem and Social Mirroring in IMG-CAP

Two common problems immigrants struggle with are immigration-induced or precipitated low esteem and problems with social mirroring. Superficially, both may seem to

look like low self-esteem. They can be and should be distinguished from each other, however, for the understanding and remediating of each. Self-esteem is an intrapsychic notion based on self-respect and self-worth.^{36,37} Although self-esteem is considered an enduring personality trait, immigrant guilt (leaving families behind, betrayal of culture, and loyalty conflicts), grief reactions to losses, and anxiety and depressive reactions contribute to lowering self-esteem.

Social mirroring originated with Winnicott's notion of mirroring wherein a child's sense of self is profoundly shaped by the reflections mirrored back to him or her by significant others.³⁸ This mirroring is essential for healthy development.³⁹ This concept was broadened and applied to minority and immigrant experiences.⁴⁰⁻⁴² IMGs do not necessarily think they are less but think that others do not value or undervalue them. An IMG looks into the eyes of the dominant culture and sees back a reflection of the dominant culture's view on him or her; that is, the IMG does not see the sparkle of approval from teachers and others but rather disapproval and disappointment. Often what IMGs experience in this social mirroring is that they are now minority physicians with inferior status, no longer considered trained and respected professionals but foreigners who must again prove their skills.

With immigration-induced low self-esteem and/or negative social mirroring, IMGs may feel vulnerable and less worthy. Feeling less wanted, they may compensate by working more than their peers or they may withdraw, which potentiates further projections onto IMGs. They may also become defensive and angry and these emotions may adversely affect treatment.

A story from a colleague illustrates issues with social mirroring. While attending his third meeting in a professional group whose membership is by invitation only, this colleague thought, "Nobody is talking to me, everyone is ignoring me. They don't like me. I am not at their level. They are real American professors and I am just an immigrant." When he noticed that he was feeling this way he decided to challenge his negative cognitions. He then realized that there was little reality to his thinking. It was the leaders who were not fraternizing with him and they were only talking among themselves and not to the newer members. It seemed, however, that it had not affected his overall self-esteem. It was more of a social mirroring problem rather than a self-esteem issue because he saw himself as accomplished but thought that the larger group did not recognize his contributions. With his understanding of the difference between self-esteem and social mirroring, the feelings dissolved quickly.

Recognition of immigration-induced self-esteem problems and the impact of social mirroring can help trainees put in perspective issues of worth and helps preceptors to mentor them. This same awareness is also helpful for immigrant and minority patients and families.

For example, a 13-year-old Latino boy presented with symptoms of depression and irritability, saying that nobody liked him or wanted to be his friend. Neither he nor the family could provide information on any major new stresses. Further examination revealed that he always felt inferior to whites and never felt he was equal in the school or on the playground. With the onset of adolescence and increase in cognitive capacities, he now "realized" more about his "lesser" status. Further explorations clarified this cognition as more of a projection of immigrant minority status and thus a social mirroring problem. When the therapist gave the social mirroring explanation to the family, the boy was visibly relieved and reported feeling much better in ensuing weeks.

Child Rearing Practices

Many investigators, such as Canino and Spurlock,⁴³ have described the influence of culture on child rearing practices. Healthy parenting practices differ across cultural

groups.⁴⁴ Child rearing practices and parent-child relationships play a significant role in socialization, personality, and symptom expression of illness. Some of the areas of cultural difference are in the promotion of the self, promotion of individuation, promotion of social skills, sleeping arrangements, sex roles and expectations, discipline, adaptive social behaviors, family values, role of extended family, and handling of habits and fears. For example, with sleeping arrangements in Western culture, infants are moved to their own crib and room early in life. This is in contrast to cultures where sleeping with parents until school age is not uncommon. Likewise, cultures manage promotion of individuation differently. In Western cultures, there is a tendency to positively reinforce being separate and pursuing one's own interests early whereas the Eastern family discourages by fear or shame early individuation and separateness of the child.

Ethnic identity and ethnic pride often are embedded in child rearing practices. We credit our children's accomplishments to our "correct" upbringing and in turn blame others' child rearing practices for their children's failures. In the mental health field, until recently there has been a great deal of blame placed on parents for their children's difficulties. Proud IMG-CAP unwittingly blame Western child rearing for substance abusing, oppositional, impulsive, conduct disordered, and promiscuous American teen patients. This can result in negative therapeutic reactions. Conversely, they sometimes perceive that Western child rearing practices are attributed to the advancement of the West, further contributing to low self-worth on the part of IMG-CAP. The latter is likely to result in an under treatment of Western patients.

UNIQUE TREATMENT ASPECTS

For IMG-CAP (and child psychiatrists of immigrant origins in general), there are several unique aspects of treatment worthy of discussion. This article discusses therapeutic alliance, resistance, transference, and countertransference. Assessment, understanding, and making necessary interventions to address these four areas are vital for good outcomes. In the treatment of children and adolescents by IMG-CAP, there are at least three different elements. First, the children we treat experience their own treatment alliance and manifest resistances and transferences. Second, parents and caregivers are actively involved experiencing and manifesting these same phenomena, which may be different from their children's. The child psychiatrist's countertransference is often entirely different to children than to their parents. Third, cross-cultural/immigrant status of the physician further complicates these elements.

Treatment Alliance

The establishment of a trusting, confiding, and collaborative therapeutic relationship⁴⁵ has been empirically shown to affect treatment outcomes.⁴⁶ It accounts up to for 30% of the variance in outcomes even when pharmacotherapy is the primary intervention.⁴⁷ In treating children, the clinician needs to establish a treatment alliance with the patients and with parents/care-givers and other systems involved in a child's life (eg, school or probation officer). Having originated from another culture can have an impact on the early connection with the child and family. Although speaking the same language, other than English, can enhance the therapeutic alliance, a recognizable accent or differences in communication style can interfere with it. Often the upfront acknowledgment of this difference and its possible impact help bridge the connection because families are appreciative of an IMG-CAP's ability to recognize their perspective and reluctance. For example, a psychotic inpatient boy insisted he had met his new doctor before. "I know, I've seen you before." The new doctor,

recognizing the youth's lack of discernment, said, "No you haven't, but we Indians all look alike." This addressed the unspoken anxiety and allowed the youth to move on. Maintaining cultural neutrality and judicious accommodation to the cultural differences are also crucial for establishing a workable therapeutic alliance.⁴⁸ The authors find the concept of multidirectional partiality as advocated by Boszormenyi-Nagy and Krasner⁴⁹ particularly useful. This is the ability of a therapist to give all family members, both those who are present in the session and those who are absent, a sense of being understood, accepted, and important.

Resistance

Resistance, the compromise between the striving for recovery and maintaining the status quo, manifests in many ways.^{47,50} Many resistances by children are even normative and culturally based, such as the striving of Western youth for autonomy and the distractions from many culturally sanctioned activities, such as socialization via cell phones and text messaging. Understanding and managing the resistance of patients and families are crucial to adherence to continued treatment. Instead of understanding and realizing the ubiquitous nature of these resistances as part of treatment, an IMG-CAP may take them personally, blame the patient for character flaws, or attribute these resistances to a decadent and unhealthy aspect of Western society. In doing so, IMG-CAP allow their patients and families to do the same, instead of helping them understand the integral part of understanding resistance in successful treatment. Such attributions can result in premature termination, premature dismissal, low self-esteem on the part of the therapist, or intense feelings of narcissistic injury, anger, guilt, and/or shame on the part of the patient as well as the clinician.

Transference

Comas-Diaz and Jacobsen,⁵¹ in writing about ethnocultural transferences in the therapeutic dyad, suggested that there are intraethnic and interethnic transferences. Interethnic transferences can be manifested in overcompliance and friendliness, denial of ethnicity and culture, mistrust, suspicion, ambivalence, and hostility. In intraethnic transference, the omniscient-omnipotent therapist, the traitor, the autoracist, and ambivalent reactions emerge. In short, the reactions emerge from "like me" and "not like me" projections.

Interethnic transferences can be negative or positive. Being asked by an adolescent boy if you are related to Osama bin Laden is not likely to be missed. The seemingly more positive transferences, however, are often not examined. In resident clinics where children and adolescents are transferred every 6 months to a year, many parents request their children be transferred to someone ethnically similar to their previous doctor. This sometimes carries with it an assumption that the painful aspects of the loss will be minimized. Or, projecting their values onto the treating psychiatrist, they hope that this next doctor will have the same understanding as the previous one because he or she is Hispanic or Indian.

The following is an example of a positive interethnic transference that proved difficult to work through with the adolescent and her family. A male Filipino CAP was seeing a 16-year-old Korean girl in therapy for oppositionality and defiance with intense battles with her parents over autonomy and individuation. The therapist thought that they had developed a good relationship. The adolescent seemed to make progress working on her contributions in her interaction with her parents. The therapist also reported that she expressed curiosity about his interests. After approximately 6 months of therapy, she reported that she had begun dating a Filipino boy. She gleefully reported that her parents would "kill her" if they found out that she

was dating anyone but especially a non-Korean. How much of her acting out was due to the projection of the idealized positive transference toward the therapist or to her need to be separated from her ethnocentric Korean parents? How much of it was her internalization of American multiculturalism? After careful working through, it became clear it was projection of the idealized transference and she was able to move on to the presenting issues.

Intraethnic transferences are less common. Many professionals assume that immigrant patients prefer to see someone from their native country. This is not always the case for many reasons. An example illustrates this problem. A white therapist was referred a Nigerian family. On the telephone, the therapist had some difficulty understanding the father's English and suggested the name of an excellent Nigerian child psychiatrist. It was evident that the father was reluctant to take the referral, so the therapist agreed to see the family. Later he learned how insulted the father had been. The father, a successful businessman, had wanted to see "the best." Referring to another Nigerian implied to him that he was being sent to someone who had an inferior status as he had, betraying a certain degree of ethnic self-hate often seen in minorities and immigrant groups. What the therapist also later learned was that this family was from a different part of Nigeria from the child psychiatrist and they would have had to communicate in English because they did not have the same mother tongues.

Patients or families may choose an immigrant therapist for unconscious reasons. Such a choice may lead to idealization or devaluation of an IMG psychiatrist. In the example previous example, the father devalued the psychiatrist's sameness. Patients can also project jealousy and racism onto the treating psychiatrist. In some instances, patients might be initially positive about seeing an IMG only later to express anger and dissatisfaction as they project their own self-hatred onto the psychiatrist.

IMG status of the clinician also can lead to triangulations. A 9-year-old boy was struggling with difficult-to-treat Asperger syndrome and mood disorders. His father, an immigrant Muslim, chose a Pakistani Muslim CAP outside of his health network with the hope that the psychiatrist would collude with his denial, prejudice against mental illness, and his harsh disciplinary tactics toward the boy. The Pakistani psychiatrist worked delicately with the child and the family to help them accept the illness and provide appropriate parenting. The family eventually accepted a transfer to a psychiatrist in their health network.

Language may play a significant role in treatment and the transference.^{52,53} If therapist and patient speak the same language, affective communication is made easier and may contribute to the idealization of the therapist by parents and child. Parentification of a child patient can often be minimized as the parents communicate directly with the psychiatrist without using their child as a translator. (This happens because the child is often more fluent in English than the parents). Conversely, a language barrier can contribute to fear of being misunderstood and can cause initial mistrust, particularly when the psychiatrist's accent is significant.⁵²

Countertransference

Although traditionally taught in the context of psychotherapy supervision, the importance of countertransference extends beyond the psychotherapeutic relationship. The recognition and the ability to manage countertransference is a skill that is considered second only to the ability to perform a comprehensive diagnostic interview.⁵⁴⁻⁵⁶

Comas-Diaz and Jacobsen⁵¹ divide the topic into interethnic and intraethnic countertransferences. They discuss how interethnic countertransference can result in denial of ethnocultural differences, the clinical anthropologist syndrome (excessive curiosity about the cultural background of the patient/family), guilt, pity, aggression,

and ambivalence.⁵¹ Intraethnic countertransference can contribute to an IMG distancing, cultural myopia, anger, survivor guilt, hope, and despair. These countertransference reactions can lead to emergence of conflicts underlying therapeutic issues as trust, ambivalence, and anger.

With patients of the same cultural background, there is often an assumption that they are “like us.” For example, a 21-year-old upper-caste intelligent Indian student was referred for anxiety, depression, and panic to an Indian psychiatrist. The CAP felt honored to get this referral of a smart and cultured girl. He started treating her as if she were an anxious, depressed young woman. Within a few weeks she developed an extremely ambivalent, demanding/blaming relationship with the therapist concomitant with agitation, pan anxiety, and deep depression. The psychiatrist quickly recognized that his cultural myopia and immigrant guilt had blinded him from examining her history of chronicity, past brief psychotic-like episodes, and severe past trauma that resulted in an underestimation of the intensity of transference reactions by patients with borderline characteristics. This newfound recognition enabled the clinician to change the treatment approach and address more a serious nature of illness. There might have been some degree of stereotypic idealized countertransference reaction by the psychiatrist—“people from my ethnic groups never get messy personality disorders.”

Interethnic countertransference can surface with significant world events. After 9/11, many South Asians and Arabs, even if they were not from the same country or same religion, suffered from guilt and shame because their patients made direct or indirect accusations about their relationship to the perpetrators. It is easy to become defensive and angry because patients inaccurately assume that there is some connection to the 9/11 aggressions. A sense of humor, understanding of transference, the role of negative cognitions, and the ability to carefully monitor countertransferences is important. IMG-CAP, in turn, can also have their own prejudices, elevating their own cultural heritage and undervaluing Western mores. The next example illustrates the interplay of interethnic transference and countertransference. A 42-year-old mother sought help parenting her two excessively attention-demanding children. The mother was a high school graduate, living in a blue-collar small town. The mother seemed depressed and was a survivor of sexual abuse. As they worked on parenting issues, transferences of ambivalence and projection of the aggressor role onto the therapist were apparent. She viewed the CAP as a dominant Muslim man who controlled women and demanded submissiveness. The psychiatrist saw her as a blue-collar, uncivilized, needy, dependent woman, these feelings partly induced by the patient. The therapist's recognition of the transference and of his countertransference prejudices helped the mother to become more assertive and parent more effectively her overanxious children.

Immigrant guilt at having achieved success can also have an impact on CAPs' ability to provide the best treatment. When overidentifying with a sufferer, whether or not an immigrant or an impoverished minority, they often experience guilt and shame. This can at times manifest itself as rescue fantasies, overidentification, and even boundary crossings as they want to “give” more than is therapeutic. It can set up re-enactments, poor outcomes, narcissistic injury, and anger.

Although cultural similarities in a therapeutic dyad can enhance treatment by facilitating understanding regarding cultural traditions and language, a therapist can unconsciously identify with something that has been stirred up in a patient and a parallel process for therapist and patient can occur.⁵⁷ For example, a parallel process between CAPs' acculturation, that of their children and family, and the acculturation/identity formation of minority children they treat can potentially contribute to

positive and negative outcomes both personally and in their therapeutic work (Andres Pumariega, MD, personal communication, July 2010). When IMG-CAP listen to a parent's helplessness and anger, their reaction may be reflective of their own struggles with children who have rebelled against the traditional and embraced a new culture.

Immigrant clinicians, because of their own experiences, share a special empathy for those who have had similar experiences. In a parallel process, IMG-CAP have an unconscious identification process that occurs between themselves and patients. IMG-CAP could examine these parallels and their impact in the context of supervision or within another psychological safe setting.⁵⁸ For example, an intelligent African American male was admitted to a magnet high school. Within 2 months he was withdrawn, depressed, and anxious, requesting to return to the local high school. The boy spoke to the CAP of having difficulties learning the formal and informal rules. The psychiatrist remembered his first months in the United States—his loneliness and difficulties transitioning from being a respected attending to a lowly postgraduate year 1 resident in the new hierarchical structure. In discussing this case with the guidance team, a group he trusted and respected, the CAP was irritated with what he thought was a rigid protocol for the boy's return to his former school and suggested special consideration for the boy. Reflecting back on his unusual demanding behavior, he recognized a parallel process between his interaction with staff and what the boy was experiencing but not directly expressing. As he thought about the boy and his complaints, he realized that in his empathic stance, he had not paid sufficient attention to the difficulty the boy was having in no longer being "a star." The boy expected that he be given special treatment and felt narcissistically injured when he was not. The CAP had not been aware of it because he too had difficulties dealing with his own anger when he too went from being a respected professional in his own country to being a resident in his new country. With his newfound understanding, he was able to help the boy with his disappointment and anger that he was not at the top of his class and that he had to accept his ordinary treatment and status in this school of exceptional children.

RECOMMENDATIONS FOR TRAINING AND SUPPORT

With a large portion of CAPs coming from other parts of the world, it behooves training programs and national organizations to consider the special needs of this group for training and ongoing support. Their experience with immigration and as a member of a minority group gives them a special empathy toward children and adolescents of diverse backgrounds. This section focuses on specific areas to augment their education and training, enhance their treatment skills, further their personal growth, and provide advocacy for minorities and the disadvantaged.

Some of the strategies recommended by various investigators to improve education and training include evaluating language skills and offering remediation opportunities, accenting reduction strategies, providing cultural education the first year of training, and the use of senior faculty to teach courses.⁵⁹ Faculty involved with IMG training should be conversant with the core cross cultural differences present in their residents.¹⁰ On university campuses, English and speech therapy departments can be enlisted to aid in language and accent improvement.

One such program that has attempted to address these issues is one sponsored by the APA under the directorship of Rao and Hales.⁶⁰ In this day-long course, lectures and small groups are used help IMG trainees identify areas of need and adapt to the fundamentals of psychiatric practice. There have been efforts to train the teachers

of IMGs on issues most relevant to this group.⁶¹ In this 6-module training curriculum, Steinart and Walsh⁶¹ elaborate on the possible differences in previous education based on hierarchical structures and propose various didactic and evaluative skill-training strategies. Clinical skills verification, if administered as residents enter a CAP residency program, can then be used to tackle problem areas not previously addressed in the adult training program. This same process could be used to focus on insufficiencies in psychosocial interventions, psychological theory, and psychotherapy theory and practice. Structured supervision can reinforce the biopsychosocial model over the linear medical model. Mentoring should be used to enhance treatment skills, not just case management and psychopharmacologic interventions. Learning how relationships affect physicians, therapists, patients, families, schools, and other social service agencies is particularly important for CAPs. This is often an unspoken dynamic that American graduates learn by growing up in the culture. IMGs often recognize their own lack of familiarity, but no one has helped articulate how these dynamics are in play in the treatment setting. Related to this is the application of cultural specific psychotherapeutic interventions.

It is also recommended that IMG-CAP develop greater familiarity with American culture—such as child rearing practices, history, literature, and religious and secular holidays. In addition to reading textbooks, familiarization can be aided by reading newspapers, watching TV, attending ethnic movies, watching cartoons, traveling within the new country, attending American cultural functions, and attending variety of religious activities. Help can be sought from training directors to find appropriate events. Teaching cross-cultural seminars using IMG and American graduates teaching each other can help address stereotypes, xenophobia, and the reality of diverse cultures. With this dyad, not only do IMGs learn about US culture but also US graduates learn about cultural diversity through the cultures and values from which IMGs originate (Andres Pumariega, MD, personal communication, July 18, 2010). Both IMG and American medical graduates need to recognize the lack of cultural uniformity and also learn that different subgroups and geographic regions may have variations in language and culture.

Often IMGs do not come from a culture that nurtures academic and research interests. The AMA has been a major advocate of using additional resources and training to enhance academic and research skills of IMGs. CME activities can be helpful in this regard. Participation in professional organizations and advocacy groups for children, adolescents, and their families are also professional and societal obligations. In particular, advocacy by IMG-CAP on behalf of minorities and other patients from disadvantaged and discriminated groups can be a special area of focus. IMG-CAP, in collaboration with many of these groups, can promote culturally sensitive, educational programs, lectures, and workshops in various communities. Some organizations covertly or overtly promote anti-IMG practices (discussed in the discrimination and prejudice section of the article). These should be addressed organizationally as well as politically.

An often-neglected area is personal growth and personal care. For IMG-CAP, the stress of acculturation, excessive guilt, and loyalty conflicts can hinder promoting themselves, promoting their own growth, and placement of the “I self” before “we self.” Personal psychotherapy and the development of a family genogram can be invaluable processes through which IMG-CAP can explore and address such conflicts. As many self-help gurus and resiliency enhancing strategists advocate, it is necessary to focus on personal growth to master a profession. The art of thinking positively, expressing oneself more openly, and the importance of making reasonable compromises also aid in adjustment to a new culture and improve personal and

professional functioning. As IMG-CAP are completing training, the focus often needs to be on assistance in securing a position, career planning, settling down, and even estate planning.

FUTURE CONSIDERATIONS AND SUMMARY

With globalization of medicine, the AMA and various national and international organizations are advocating a global focus on the learning and practice of medicine. As Mezzrich⁶² has suggested, the IMGs add a cultural richness to their environment. Due to their dualistic cultural identity and an array of professionally relevant, comparative experiences, they have the unique potential to contribute to the advancement of psychiatric concepts and deliver sensitive and effective patient care. They also provide an important liaison between the United States and the rest of the world, functioning as cultural ambassadors between American psychiatry and international psychiatry.

The United States has been welcoming of immigrants for the past 400 years. It also has opened doors to CAPs born and trained abroad to enhance mental health care for its children, adolescents, and their families. It behooves us to ensure their success in accomplishing this mission. Addressing the important adaptational issues, reviewed in this article, through the needed enhancements in training and supports, IMG-CAP can provide effective and culturally sensitive treatments for the most underserved population of children and enhance their own professional lives.

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