BASED ON **CROSSROADS: THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY**
THE REPORT OF THE APA PRESIDENTIAL TASK FORCE ON IMMIGRATION

WORKING WITH IMMIGRANT-ORIGIN CLIENTS

AN UPDATE FOR MENTAL HEALTH PROFESSIONALS

AMERICAN PSYCHOLOGICAL ASSOCIATION

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THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY

APA Presidential Task Force on Immigration Members

Carola Suárez-Orozco, PhD (Chair)
Dina Birman, PhD
J. Manuel Casas, PhD
Nadine Nakamura, PhD
Pratyusha Tummala-Narra, PhD
Michael Zárate, PhD

APA Public Interest Directorate Staff

Lauren Fasig, PhD, JD (Director, Children, Youth and Families Office)
Amani Chatman (Program Coordinator, Children, Youth, and Families Office)
Efua Andoh (Communications Staff, PI Executive Office)

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BASED ON **CROSSROADS: THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY** THE REPORT OF THE APA PRESIDENTIAL TASK FORCE ON IMMIGRATION:

Every year since 1990, approximately one million new immigrants have entered the United States. According to the **U.S. Census Bureau** (2011b), over 40 million U.S. residents are foreign-born—13% of the total population. Of these, approximately 18.1 million are naturalized citizens, 11 million are authorized noncitizens, and another 11 million are undocumented.

As the foreign-born population has grown, so has the population of their children. Immigrant-origin children have become the fastest growing segment of the national child population. Thirty percent of young adults between the ages of 18 and 34 are first- or second-generation immigrants, and by 2020, one in three children below the age of 18 will be the child of an immigrant.

One in five persons residing in the United States is a first- or second-generation immigrant; thus, immigrants and their children have become a significant part of our national tapestry. Because psychologists are, and increasingly will be, serving immigrant adults and their children in a variety of settings, including schools, community centers, clinics, and hospitals, they need to be aware of this complex transformation in demographics and consider its implications.

FACTORS FUELING U.S. IMMIGRATION

Searching for work, reuniting with family members, and seeking humanitarian refuge are all reasons for immigration. The lack of documentation regulation has also contributed to the growth of undocumented immigration over the last 2 decades. Reasons for seeking humanitarian protection include wars, violence, risk of persecution, and environmental disasters.

Separated families often desire reunification, which may take years, especially when complicated by financial hurdles and immigration regulations. The longer the separation, the more complicated the family reunification and the greater the likelihood that children will report psychological symptoms.

DEMOGRAPHIC PROFILE OF THE U.S. IMMIGRANT POPULATION

Immigrants who have arrived in the United States over the last 4 decades represent a wide range of cultures, ethnicities, and races. This diversity of cultural values, beliefs, and practices provides a challenge to the science and practice of psychology. In addition, clinicians carry their own sets of cultural attitudes that influence their perceptions as they encounter those who are culturally different.

Racial and Ethnic Diversity

During the previous great wave of migration in the early 1900s, most new arrivals originated from Europe. It was only in the mid-1960s that immigrants began to contribute to the great diversification of the United States. Since 1965, more than three quarters of new immigrants arriving in the United States are "of color," with origins in Asia, Latin America, the Caribbean, and Africa. One third of the foreign-born population in the United States comes from Mexico, and Asians account for 28.2% of the foreign-born (**U.S. Census Bureau**, 2010). But by far the largest group of immigrants (nearly 55%) originate from Latin America, a racially and ethnically complex region consisting of indigenous origin, White European origin, African origin, and mestizo (or mixed origin) populations. Although Africans constitute only 3.9% of today's immigrants, the African-born population in the United States has increased dramatically since 1960, from 35,555 to 1.4 million, with most of that growth occurring in the last decade.

Many of these immigrants arrive in the United States at the stage in their lives when they are most likely to start a family, which further adds to ethnic and racial diversification of the U.S. population. According to the **U.S. Census Bureau** (2011a), four states with large numbers of immigrants have already become "majority/minority" states (less than 50% White)—California, Hawaii, New Mexico, and Texas—with Maryland, Mississippi, Georgia, New York, and Arizona projected to reach this designation next.

Diverse Destinations

Some geographical areas, such as California, Texas, New York, Florida, and Illinois, continue to be popular destinations for immigrants. However, other areas are also expe-

riencing an increase in immigrant populations. In the past 2 decades, a growing number of states with no previous immigrant populations have seen very high rates of new migration. Southern states have experienced the most dramatic change in immigrant populations compared with other states.

Educational Diversity

Immigrants arrive with varied levels of education, but they tend to be overrepresented at both the highest and lowest ends of the educational and skills continuum. For example, 25% of all physicians, 24% of science and engineering workers with bachelor's degrees, and 47% of scientists with doctorates in the United States are immigrants (Portes & Rumbaut, 2006). These highly educated immigrant adults are participating in and driving innovation, research, and development and contributing substantively to technological progress. But at the same time, many highly educated immigrants, particularly ethnic and racial minorities, experience unemployment, underemployment, and downward mobility.

At the other end of the spectrum, some immigrant adults have education levels far below those of the average U.S. citizen. Certain sectors of the U.S. economy rely heavily on "low-skilled" immigrants, including the agriculture, service, and construction industries. Approximately 75% of all hired farm workers and nearly all those involved in the production of fresh fruits and vegetables are immigrants (**Kandel**, 2008).

Language Diversity

An estimated 460 languages are currently spoken in homes in the United States. Acquiring the language of the new country is a critical aspect of the academic transition for first-generation immigrant students. According to the **U.S. Department of Education** (2010), 20% of children speak a second language at home. English language fluency levels vary among non-native English speakers. While there are concerns about the immigrant population's inability or unwillingness to learn English, research finds a consistent pattern of English language assimilation within a generation.

Religious Diversity

Immigrants also contribute to religious diversity. Religion is a fundamental part of life for most people throughout the world. Newly arrived immigrant adults and children who are feeling disoriented in their new land are particularly likely to turn to their religious communities for support.

CHARACTERISTICS THAT MAKE IMMIGRANT POPULATIONS RESILIENT

Immigrants demonstrate a remarkable pattern of strengths. Research suggests that immigrants today are highly motivated to learn English and do so more quickly than did previous generations. They have very high levels of engagement in the labor market, and the children of immigrants go on to outperform their parents. Although recently arrived immigrants often face many risks, including poverty, discrimination, taxing occupations, fewer years of schooling, and social isolation, they do better than expected on a wide range of psychological and behavioral outcomes compared with their counterparts remaining in the country of origin and second-generation immigrants born in the United States. New immigrants' optimism, greater family cohesion, and availability of community supports contribute to their resiliency.

MAJOR MENTAL HEALTH CHALLENGES FACED BY IMMIGRANTS

The Immigration Process

The immigration process involves separation from country of origin, family members, and familiar customs; exposure to a new physical environment; and navigation of unfamiliar cultural contexts. Stresses involved in the immigration experience can cause or exacerbate mental health difficulties, including anxiety, depression, posttraumatic stress disorder (PTSD), substance abuse, suicidal ideation, and severe mental illness.

Acculturation

Acculturation, a multidimensional process, involves changes in many aspects of immigrants' lives, including language, cultural and ethnic identity, attitudes and values, social customs and relations, gender roles, types of food and music preferred, and media use. Immigrants may feel pressure to assimilate to the U.S. mainstream culture.

Acculturation may occur in stages, with immigrants learning the new language first, followed by behavioral participation in the culture. While some settings, such as workplaces or schools, are predominantly culturally American, others, such as an immigrant's ethnic neighborhood and home environment, may be predominantly of the heritage culture. From this perspective, acculturation to both cultures provides access to different kinds of resources

that are useful in different settings and is linked, it is hoped, to positive mental health outcomes.

Psychological acculturation refers to the dynamic process that begins when immigrants enter the new country and begin to adapt to its culture.

Behavioral acculturation refers to the extent of immigrants' participation in their culture of origin and/or new culture. While adopting American ways, immigrant adults may continue to participate in their heritage culture and have friendships with others from the same country with whom they can share interests and values, consume ethnic foods, and read and view native-language print and electronic media.

Intergenerational conflicts are common in immigrant households, reflective of an acculturation gap between parents and children. Immigrant children behaviorally adapt to the U.S. culture quickly. Adolescents in particular are exposed to American culture through movies, music, television, and many other electronic outlets. As immigrant parents and children increasingly live in different cultural worlds, conflicts result, including verbal arguments between parents and children regarding friendships, dating, marriage, gender roles, and career choices.

Because immigrant parents are immersed primarily in one cultural context and their children in another, they often know little of their children's lives outside the home. For immigrant children, it can be difficult to live with the expectations and demands of one culture in the home and another at school. Children may not turn to their parents with problems and concerns, believing their parents do not know the culture and its institutions well enough to provide them with good advice or assistance.

In some cases, second-generation children and adolescents may experience role reversal when they are in a position to translate for their parents from their native language to English or to help their parents and/or grandparents navigate mainstream culture. Older adult immigrants are often the most vulnerable to mental health problems, with the exception of victims of warfare and torture.

Acculturative conflicts are often at the root of what brings immigrant families into treatment. Even immigrants who have lived in the United States for a long time and appear to have adopted the American lifestyle may continue to maintain strong identification with, and hold the values of, their culture of origin. Psychological services, which should include settings and programs designed to assist immigrants with adapting to their new country, must value the need to learn the ways of the new culture and the need to maintain a connection with the old.

Acculturation-based presenting problems include:

- Changes in gender roles
- Intergenerational conflicts
- Family conflict and loss of communication
- Role reversal
- Negotiation of identity and loyalty to culture of origin and new culture
- Loneliness and isolation

The process of integrating the social and cultural values, ideas, beliefs, and behavioral patterns of the culture of origin with those of the new culture can lead to acculturative stress if they conflict.

Employment Problems

Employment problems may impact immigrants' mental health as well. Loss of occupational status can lead to feelings of frustration, uselessness, and anger. Employment difficulties have been associated with depression and anxiety and are among the risk factors for perpetrating intimate partner violence. Meaningful employment can help the immigrant adjustment process by decreasing feelings of isolation; contributing to the building of new social networks; and providing opportunities for new friendships, cultural learning, and development of English-language skills.

Traumatic Experiences

Traumatic experiences place immigrants at risk for mental health problems, including depression and anxiety disorders, and particularly PTSD. Such experiences can occur at various stages in the immigration process and may include substandard living conditions, unemployment, low self-esteem, poor physical health, community violence, and lack of social support. Any of these traumatic events can affect the ways in which immigrants adjust to their new cultural context.

Undocumented immigrant children and youth are frequently subject to particularly traumatic experiences, including racial profiling, ongoing discrimination, exposure to gangs, immigration raids, the arbitrary checking of family members' documentation status, forcible removal or separation from their families, placement in detention camps or in child welfare, and deportation.

Trauma-based presenting problems include:

- Migratory trauma, including pre-migration, migration, postmigration, and deportation
- Interpersonal violence
- Depression, anxiety, PTSD
- Compromised identification with country of origin and adopted country
- Interpersonal difficulties
- Feelings of persecution and distrust of authorities and institutions

Discrimination and Racism

Discrimination and racism, both overt and subtle, have important implications for immigrants' sense of well-being and belonging. Immigrants, especially those of color, are often the targets of discrimination or at least the victims of aggression. Whether overt or subtle, the negative impact of discrimination on the psychological well-being of an individual is the same. Specifically, experiences of racial/ethnic discrimination have been associated with mental health problems, including stress, depression, anxiety, substance abuse, and thoughts of suicide. Distrust in the system affects immigrants' ability to seek care for mental health challenges.

The negative consequences of living with prejudice should be an issue of grave concern for psychologists.

Immigrants who are racially distinct from the majority are at greater risk for experiencing discrimination than those who are not. Many immigrants from Asia, Latin America, the Caribbean, and Africa encounter racial discrimination for the first time in the United States. Profiling contributes to a social atmosphere that produces fear and anxiety for those immigrants, especially those of color, who might possibly live in fear of being spotted and deported. Stereotypes mask the unique psychological experiences and concerns of different immigrant communities. The negative consequences of living with prejudice should be an issue of grave concern for psychologists.

Discrimination-based presenting problems include:

- Discrimination (overt and aversive)
- Overt and subtle or aversive forms of racism with detrimental effects
- Effects of profiling
- A sence of fear, anxiety, and a compromised sense of safety
- Racial identity issues
- Feelings of being a "second class" person
- Lack of a sense of belonging (e.g., perpetual foreigner stereotype)
- Decreased use of mental health services

BARRIERS TO MENTAL HEALTH SERVICES

While an increasing number of immigrants are seeking mental health services, most immigrants underutilize these services. These barriers can be broadly grouped into the following categories: social-cultural, contextual-structural, and clinical-procedural.

Social-Cultural Barriers

Social-cultural barriers include differences in symptom expression and attributions and conflicting views about the causes of, and ways of coping with, mental health problems. Some immigrants may view self-help as the best means of dealing with mental health problems or may not understand how psychological problems can be treated from a Western perspective. Others may prefer alternate sources of help rooted in their cultural origin (e.g., priests or imams).

Another social-cultural barrier is the stigma some cultures associate with mental health problems. Some cultures that maintain strong family ties see individuals with mental health problems as bringing shame to the family, destroying the family reputation, exposing a family weakness, or as retribution for family wrongs.

Contextual-Structural Barriers

Contextual-structural barriers include lack of access to appropriate and culturally sensitive mental health services in immigrant languages, lack of access to interpreters, shortage of racial/ethnic minority mental health workers and/or persons trained to work with racial/ethnic minority persons and culturally diverse elders, and lack of knowledge of

available and existing mental health services and resources (e.g., transportation and child care) for accessing services.

The racial and political contexts of the adopted country affect immigrant adults' and children's (both authorized and unauthorized) sense of safety and belonging and their ability to trust that systems of care will help them when they are facing mental health challenges.

Unauthorized immigrants face additional challenges related to documentation status (e.g., ineligibility for services provided by the county or state, fear of identification as undocumented, and deportation). Those who live a migrant existence typically do not seek help, either due to fears related to unauthorized status or to frequent moves in search of work. Immigrants in rural areas may face additional barriers, including lack of access to culturally competent services and service providers.

Clinical-Procedural Barriers

Clinical-procedural barriers include lack of culturally sensitive and relevant services, clinician bias, and communication problems related to language differences and cultural nuances. For example, a clinician might downplay the role of religion and spirituality in the client's life and overemphasize autonomy and independence as therapeutic goals, failing to take into account the client's cultural values. The clinician may misdiagnose presenting problems and fail to assess the appropriateness of tests and assessment strategies.

A solution to this impasse may involve combining both perspectives and articulating ideologies in which immigrants may preserve their cultural distinctiveness while simultaneously developing a shared American identity with those born in the United States.

Prevalence of Barriers

While contextual-structural and clinical-procedural barriers can be found across varied regions of the United States, they are becoming ever more prevalent and/or more noticeable in small towns and rural communities of the South and Midwest, where a growing number of immigrants from Mexico, Central America, and South America are settling in search of low-skilled labor opportunities.

TREATMENT CONSIDERATIONS FOR MENTAL HEALTH PROVIDERS

Assessment and Diagnosis

The role of **sociocultural context** must be recognized in order to provide ethical and appropriate standards of care, diagnosis, and treatment. Those in favor of cultural assimilation believe that the best approach is for immigrants (and other minority groups) to blend rapidly into the dominant culture. They contend that adopting the norms and rules of the dominant culture will eliminate ethnic differences and thus drastically reduced prejudice.

Conversely, those holding a multicultural ideology believe that all cultural groups should have the opportunity to retain their basic cultural norms, values, traditions, and language within a greater cultural framework. Those who advocate for multiculturalism believe that prejudice is reduced and self-esteem enhanced through an appreciation of group differences. According to this perspective, the country benefits from the presence of diverse groups that bring a broad array of skills. For example, diverse language skills are necessary for many jobs in the business and service sectors.

Findings from research on common group identity and group distinctiveness imply that assimilation and multiculturalism may mean different things to different groups, depending on their structural position in society. Within an assimilated world, the majority group is preserved and the status quo remains intact. At the same time, when minority groups espouse multiculturalism, the underlying message is that they do not want to change but rather preserve their cultural traditions. A solution to this impasse may involve combining both perspectives and articulating ideologies in which immigrants may preserve their cultural distinctiveness while simultaneously developing a shared American identity with those born in the United States.

For culturally competent treatment, clinicians must understand immigrants' experiences as encompassing an effort to fit between cultural frameworks. Immigrants bring with them cultural values, beliefs, and attitudes that may fit well or may clash with those in the United States. Clinicians must consider the interaction of person and environment

and related intersections of social identities (e.g., gender, race, ethnicity, age, sexual orientation, social class, disability/ability, and immigration status) in addressing mental health needs in immigrant communities.

Cultural context shapes the ways in which clients conceptualize and express psychological distress and resilience, cope with distress, and seek help. The significance of culture is relevant not only to the client but also to the mental health professionals who provide help and the care system in which it is provided. In the end, the solution may involve preserving cultural distinctiveness while also developing a shared identity with those born in the United States.

One difficulty in the assessment of immigrants is the lack of valid and culturally appropriate diagnostic tools that recognize cultural differences in the expression of and coping with psychological distress. This presents a significant challenge to clinicians who rely on established testing and assessment strategies and instruments. Clinicians must critically examine resources developed in a Western middle-class context before applying them to non-Western, non-middle-class participants.

Appropriate multicultural assessment requires that clinicians arrive at an accurate, sound, and comprehensive description of the client's psychological presentation by gathering data on historical, familial, economic, social, and community issues. This knowledge is critical in choosing appropriate tests and in interpreting the results.

Clinician bias, the tendency to universally apply Eurocentric models of illness without taking a patient's culture into consideration, can contribute to overdiagnosis and a lack of attention to resilience. Clinicians can benefit by using multiple sources of evidence when assessing immigrant clients and identifying culture-specific expressions of well-being and distress.

It is important that clinicians examine their own biases and expectations that may affect the testing process. They should also consult with colleagues and supervisors who may be more familiar with the client's sociocultural context, the specific diagnostic tests being considered, and culture-bound syndromes and who may be able to provide support throughout the assessment process. Bicultural and bilingual researchers are perhaps best able to establish a rapport and trust within immigrant communities and gain entry into populations that might otherwise be difficult to access.

Clinicians' self-assessment should include the extent to which their socialization informs their evaluation of the racial and cultural data of the client. Clinicians are encouraged to recognize that they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.

Clinicians should understand the implications of psychological testing and diagnosis. They should not only consider the fairness and utility of diagnostic tests in the context of language, educational background, and cultural norms but also recognize that many immigrant clients are concerned about diagnostic labels due to cultural stigma and/or immigration status.

Bicultural and bilingual researchers are perhaps best able to establish a rapport and trust within immigrant communities and gain entry into populations that might otherwise be difficult to access.

While assessments usually occur in the context of educational and clinical settings, practitioners may also assess clients in judicial/legal settings, including family courts, immigration courts, and criminal courts. Clinicians may be called on to make critical decisions that significantly affect the lives of immigrants and their families—deportation or asylum, family unification or separation, incarceration or freedom.

Issues in assessment include:

- Lack of standardized translations of instruments
- Lack of appropriate normative standards, norm referenced groups, and studies on reliability of test scores with different immigrant groups
- Problems with timed tests in educational, clinical, and forensic settings
- Research suggesting that poor, immigrant, and racial/ethnic minority children are disproportionately placed in low-ability groups early in their education (**Blanchett, Brantlinger, & Shealey**, 2005)
- Failure to take culture into consideration can lead to misdiagnosis (e.g., overpathologizing)

Issues in diagnosis include:

- The present diagnostic system (*Diagnostic and Statistical Manual of Mental Disorders*) favors Western, Eurocentric conceptualizations of mental illness
- Diagnosis does not typically include clients' cultural explanation of illness and health
- Complications with diagnosis occur when assessment is not conducted in native or first language or with the use of translators
- Failure of clinician to assess resilience
- Issues do not reflect the experiences of cultural adjustment and acculturative stress

BEST PRACTICES IN ASSESSMENT AND DIAGNOSIS

To cultivate best practices in assessing and diagnosing immigrant clients, clinicians should:

- Examine the extent of cultural and linguistic differences between the clients and the dominant culture (e.g., WISC-III Spanish and the WISC-IV Spanish; Ortiz, 2008).
- Consider using revised culturally sensitive versions of classic measures (e.g., Tell Me a Story [TEMAS]; Constantino, Malgady, & Rogler, 1988), which is a revision of the Thematic Apperception Test.
- Recognize the dynamic nature of culture and incorporate cultural variables as central to all phases of the assessment process (Yeh & Kwan, 2010).
- Use more comprehensive assessment approaches—for example: the Multicultural Assessment Procedure (**Ridley, Li, & Hill**, 1998) and the Multicultural Assessment-Intervention Process (Dana, 2005).
- Incorporate culturally sensitive assessment interviews, collecting information on acculturation, language, religious practices, racism and prejudice, and cultural values as part of the assessment process.
- Use a contextual approach that attends to clients' explanatory models and to clinicians' assumptions and biases.
- Recognize the conditions and circumstances under which assessment and diagnosis take place and the implications of testing and diagnosis on client's present and future.
- Assess the possibility of culture-bound syndromes.
- Recognize that disorders can lie on a continuum.
- Work in collaboration with translators and interpreters.
- Work in collaboration with families and community members when appropriate.
- Consult with colleagues.

PRINCIPLES CLINICIANS SHOULD APPLY IN PROVIDING EFFECTIVE MENTAL HEALTH SERVICES TO IMMIGRANTS

To increase the accessibility and efficacy of services, clinicians and practitioners should adhere to the following guiding principles:

- Use an ecological perspective.
- Integrate evidence-based practice with practice-based evidence.
- Provide culturally competent treatment.
- Partner with community-based organizations.
- Incorporate social justice principles in providing service.

Ecological Framework

An ecological framework proposes that the human experience is a result of reciprocal interactions between individuals and their environments, varying as a function of the individual, his or her contexts and culture, and time. Ecological approaches acknowledge that behavior does not occur in a vacuum but is affected by the larger culture and society, as well as the local community and its institutions. Thus, the social climate and receiving environment into which immigrants arrive help shape their experience in and adaptation to America.

Each immigrant has his or her own set of characteristics that, in interaction with the environment, may place him or her in varying positions of resilience or vulnerability. This information should be gathered and used to inform interventions, including effects of migration (before, during, and after), legal/documentation status, acculturation, risk and resilience, cultural and religious beliefs, age of mi-

gration/developmental stage, race, ethnicity, gender, social class, sexual orientation, disability/ability, experiences of racism and discrimination, language and educational barriers, and access to services and resources. This information is often critical to developing a complex understanding of the individual's experiences of distress.

Evidence-Based Practice and Practice-Based Evidence

To maximize effectiveness, clinicians should select interventions that are rooted in evidence-based practice (EBP) and practice-based evidence (PBE). The EBP approach stresses learning from research about intervention programs and components that have been found to be effective with other samples and applying this knowledge to the needs of the particular clients being served. Evidence-based practice approaches psychological treatment with the assumption that individual characteristics and sociocultural context both play important roles in assessment and intervention.

The PBE approach seeks to understand "practice as usual" and gather evidence on its effectiveness. It is particularly important to understand what is meant by practice as usual because when EBTs are implemented, they are integrated into existing practice settings. Practice-based evidence involves learning from the wisdom of clinicians who have provided direct clinical services to immigrant communities, in particular noting how they have modified traditional approaches to treatment in their work with immigrant clients and its effectiveness.

Culturally Competent Treatment

Cultural competency should be an inherent principle that underscores all work performed by psychologists. As defined here, culturally competent mental health care provides services in ways that are "acceptable, engaging, and effective with multicultural populations" (**Birman et al.**, 2005, p. 12). Clinicians should assess the capacity of programs to provide services in ways that are acceptable and effective with multicultural populations. Cultural competence involves three broad dimensions: therapists' cultural knowledge, therapists' attitudes and beliefs toward culturally different clients and self-understanding, and therapists' skills and use of culturally appropriate interventions. Cultural competence in practice includes attending to actual treatment practices and promoting access to services, such as interpreters and legal assistance. In addition, in recent years scholars from different theoretical orientations (e.g., cognitive–behavioral, psychodynamic, family systems, humanistic, and integrative) have increasingly addressed issues of diversity and cultural competence.

APA's Multicultural Guidelines (**APA**, 2002) provide six major principles of culturally competent psychological practice, research, education and training, and organizational change:

Guideline 1: Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically, racially, culturally or nationally different from themselves.

Guideline 2: Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically, racially, culturally, or nationally different individuals.

Guideline 3: As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education.

Guideline 4: Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds.

Guideline 5: Psychologists strive to apply culturally appropriate skills in clinical and other applied psychological practices.

Guideline 6: Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practice.

Cultural competence involves the use of appropriate cultural knowledge, positive attitudes toward culturally different clients, self-understanding, and the use of culturally appropriate interventions. Theorists of different orientations (e.g., psychodynamic, cognitive–behavioral, humanistic) in recent years have called for the integration of issues of sociocultural context into conceptualization and intervention.

Research on culturally adapted interventions indicates that interventions in clients' native languages are more effective than those conducted in English, culturally adapted interventions are more effective than those not targeted to specific cultural groups, and ethnic matching in the therapeutic dyad is likely to improve client retention and therapeutic outcomes. As such, it is particularly important to understand "practice as usual" because when EBTs are implemented, they are integrated into existing practice settings. With increasing pressure to implement EBTs, providers who have been serving immigrant communities for

many years are faced with integrating their existing practices with intervention approaches developed for populations different from the ones they serve.

When immigrants do require clinical treatment, a resilience and coping perspective is important to incorporate into the treatment process. Some immigrants may draw strength from family structures that U.S. therapists may judge negatively or misunderstand. It is important to note that what may be considered a strength in one cultural context may be considered deviant or undesirable in another. Culturally competent treatment requires an understanding of the complex interplay of pathology and resilience for immigrant clients.

Culturally competent psychological practice with immigrant-origin clients takes into account:

- Pre-migration factors
- Migration experience
- Reception in the new environment and trauma
- Language/communication
- Symptom expression, which can be culturally mediated
- Changes in gender roles and intergenerational issues
- Economic stress and marginalization
- Resilience
- Intersectionality/multiplicity of identity

Comprehensive Community-Based Services

The establishment of comprehensive community-based services that provide mental health, social, legal, and educational assistance and are located in settings where the target immigrant population is likely to be found (e.g., schools, churches, and community centers) is critical. There is evidence that when these varied services are provided together, there is an increase in the use of mental health services. An alternative to clinic-based services, community-based mental health services address the larger context of immigrants' lives.

Educational settings, including public and parochial schools and community colleges, have been identified as particularly effective sites from which to provide diverse mental health services to immigrant children and their families. Stigma surrounding mental health services can be reduced when such services are provided as an educationally connected intervention in a safe, familiar setting, and schools have natural access to families who may be reluctant to seek mental health services for their children in more traditional settings.

Social Justice Perspective

The social justice perspective in psychological treatment is rooted in the belief that all people have a right to equitable treatment, a fair allocation of societal resources, and a share in decision making. All relevant personnel within the legal system should be trained to work with immigrants in general and those with mental disabilities in particular.

Clinicians can work toward making society a better place for all by challenging systematic inequalities. To successfully follow a social justice approach, clinicians must make use of the ecological framework to interpret all of the contributing factors associated with immigrants' mental health status. Therapeutic interventions should then be designed to help individuals take steps to change themselves and to change the conditions contributing to the problems they face.

CONCLUSION

Psychologists are, and increasingly will be, serving immigrant adults and their children in a variety of settings, including schools, community centers, clinics, and hospitals. They should thus be aware of this complex demographic transformation and consider its implications as citizens, practitioners, researchers, and faculty.

Clinicians have a unique and important contribution to make to the immigration discussion in several domains. Specifically, the field must advance scientific research to understand, ensure, and maintain positive outcomes for immigrant-origin adults, children, and adolescents; promote the delivery of culturally and linguistically appropriate services among psychologists, educators, and community service providers; and educate and train psychologists and others who work with immigrants in understanding the broad range of migration, acculturative, and family stressors that can affect the mental and behavioral health of immigrant families.

By 2010, nearly 23% of U.S. children (16 million under the age of 18) had immigrant parents. Well over three quarters of these children are U.S. citizens, and these predominantly Latino and Asian families are driving the diversification of the United States. The successful incorporation of children of immigrants into the educational system is one of the most important and fundamental challenges today. In a knowledge-intensive economy, how they fare education-

ally will play a critical role in their future and—given their high numbers—in the kind of society we will become. Meeting the needs of immigrant-origin students, however, has not been a national priority. This population is largely overlooked and underserved, and more attention must be focused on their educational needs by supporting activities that underscore the importance of providing fair access to educational opportunities for immigrant-origin children and adolescents.

As the immigrant population continues to grow, more psychological research is needed to understand the complexities of the immigrant experience across the life span and immigrants' reciprocal interactions with their environments. At the very least, appropriate assessment instruments and qualified psychologists should be used in settings where there is a high density of a particular language and culture represented (e.g., Spanish-speaking clinicians in areas where many students or clients speak Spanish as a first language). When this is not possible and an assessment is done through an interpreter, extreme caution must be taken in making diagnoses. Psychologists should be mindful of making high-stakes decisions about individuals' lives based on what might be considered speculative assessment strategies with immigrant populations. More clinical training is needed to enable psychologists to provide culturally competent services to these populations and to better understand how to support and promote resilience.

Clinicians and researchers must consider the critical role of social, cultural, economic, and political contexts in the experience of immigration, acculturation, and psychological well-being. Clinicians would benefit from using knowledge from multiple sources of evidence in their approaches to assessment and treatment with immigrant clients. Evidence from empirical studies and from practice that is adapted to suit the mental health needs of specific groups should be used to guide the development of innovative clinical practices in clinics and community settings. ■

RELEVANT APA RESOLUTIONS AND REPORTS

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750 First Street, NE
Washington, DC 20002–4242
202-336-6056
www.apa.org/pi

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