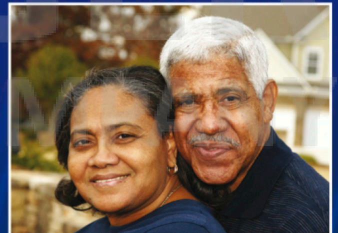
MULTICULTURAL PERSPECTIVES IN SOCIAL WORK PRACTICE WITH FAMILIES

THIRD EDITION

Elaine P. Congress • Manny J. González
EDITORS



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Multicultural Perspectives in Social Work Practice With Families

Elaine P. Congress, MSW, DSW, is Associate Dean and Professor at Fordham University Graduate School of Social Service in New York City. Dr. Congress has written extensively in the areas of cultural diversity, social work ethics, and social work education. She has published six books including *Social Work with Immigrants and Refugees: Legal Issues, Clinical Skills, and Advocacy* and over forty journal articles and book chapters. She has presented on cultural diversity and social work ethics at national and international conferences in the United States, Europe, and Australia. She developed the *culturagram*, a tool for assessing and working with culturally diverse families. Dr. Congress serves on the United Nations (UN) team for the International Federation of Social Workers (IFSW) and is a past president of the New York City chapter of the National Association of Social Workers (NASW). Before entering academia, she was a practitioner, supervisor, and administrator in a community mental health program.

Manny J. González, DSW, is an Associate Professor at the Silberman School of Social Work at Hunter College, City University of New York and Chairperson of the Clinical Practice Concentration. He is co-editor of *Mental Health Care for New Hispanic Immigrants: Innovative Approaches in Contemporary Clinical Practice* (2005). He has practiced in primary health care centers, teaching hospitals, school-based mental health clinics, child welfare agencies, and community mental health centers, providing clinical services to patients of various immigrant and ethnic/racial minority backgrounds. Dr. González has published articles and chapters on mental health practice with Hispanic immigrants and refugees, Hispanic community health outreach, urban children, and evidence-based practice. He has a private practice in Brooklyn Heights, New York.

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Elaine P. Congress, MSW, DSW

Manny J. González, DSW

Editors

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EPC

In memory of Dr. Gladys González-Ramos—friend, colleague and "sister." Her clinical and research contribution in the areas of mental health, delivery of care to Hispanic children and families, and mothers' cultural child-rearing values was outstanding—and her examination of the clinical social worker's role in health care, interdisciplinary team training, and the delivery of care to persons with Parkinson's disease and their caregivers was absolutely ground-breaking. While the essence of Dr. González-Ramos's work will continue to thrive, she will always be missed.

MJG

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Contributors

Wahiba Abu-Ras, PhD Adelphi University, School of Social Work, Garden City, NY

Gregory Acevedo, PhD Fordham University, Graduate School of Social Service, New York, NY

Dana Alonzo, PhD Columbia University, School of Social Work, New York, NY

Samuel R. Aymer, PhD Silberman School of Social Work, Hunter College/ City University of New York, New York, NY

Patricia Brownell, PhD Fordham University, Graduate School of Social Service, New York, NY

Mary Bunn, LCSW Heartland Alliance Marjorie Kovler Center, Chicago, IL

Fernando Chang-Muy, JD University of Pennsylvania, Law School, Philadelphia, PA

Irene W. Chung, PhD Silberman School of Social Work, Hunter College/ City University of New York, New York, NY

Elaine P. Congress, MSW, DSW Fordham University, Graduate School of Social Service, New York, NY

Carole B. Cox, PhD Fordham University, Graduate School of Social Service, New York, NY

David Engstrom, PhD San Diego State University, School of Social Work, San Diego, CA

Robin Gearing, PhD Columbia University, School of Social Work, New York, NY

Lauri Goldkind, PhD Fordham University, Graduate School of Social Service, New York, NY

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Manny J. González, DSW Silberman School of Social Work, Hunter College/City University of New York, New York, NY

Irene A. Gutheil, PhD Fordham University, Graduate School of Social Service, New York, NY

Meredith Hanson, DSW Fordham University, Graduate School of Social Service, New York, NY

Janna C. Heyman, PhD Fordham University, Graduate School of Social Service, New York, NY

Marianne Joyce, LCSW Heartland Alliance Marjorie Kovler Center, Chicago, IL

Eun Jeong Ko, PhD San Diego State University, San Diego, CA

Winnie W. Kung, PhD Fordham University, Graduate School of Social Service, New York, NY

Edith A. Lewis, PhD University of Michigan, School of Social Work, Ann Arbor, MI

Maxine Lynn, PhD NYF Senior Citizens Guardian Services, New York, NY

Gerald P. Mallon, DSW Silberman School of Social Work, Hunter College/City University of New York, New York, NY

Claudia Lucia Moreno, PhD Columbia University, New York, NY

Carmen Ortiz Hendricks, MSW, DSW Wurzweiler School of Social Work, Yeshiva University, New York, NY

Manoj Pardasani, PhD Fordham University, Graduate School of Social Work, New York, NY

Rafael Perez, Jr., Esq. Private Practice, New York, NY

Jessica Rosenberg, PhD Long Island University, Brooklyn, NY

Samuel Rosenberg, PhD Ramapo College, Ramapo, NJ

Yvette M. Sealy, PhD Fordham University, Graduate School of Social Service, New York, NY

Zulema E. Suárez, PhD Capella University, Minneapolis, MN

Hilary N. Weaver, DSW University at Buffalo, State University of New York, Buffalo, NY

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Foreword

The rate of change around the world that affects life in the United States is occurring at such a rapid pace that it has become extremely difficult to stay current with social work practice innovations and research. Over the past decade, drastic changes are attributable to international events such as wars overseas, violent overthrows of governments, and global economic shifts while others are clearly attributable to national circumstances. Resulting from some of those changes has been the arrival of new immigrant and refugee groups who frequently cluster in decaying cities that historically have accommodated persons arriving from other shores. Members of a number of these newly arrived groups have also moved into rural areas that, heretofore, were unaffected by mass migrations of persons born in other countries, many of who do not speak English and are people of color. During the past 50 years technology has redirected the way that we think, learn, and relate to one another and traditional relationships and family forms have given way to nontraditional family forms and alternative lifestyles across the country. Many social work professionals fail to understand the cultures of people for whom they are called on to provide service. They frequently have little knowledge of these different family forms and want to intervene appropriately, but they lack both the practice skill and wisdom to work effectively with these families. There are also ever-changing institutional arrangements that have come about as accommodations and in some instances nonaccommodations to the changing economic, political, racial, and ethnic character of our nation, which unfortunately often leave us feeling as if we are living in a nation divided. A major challenge for us as a nation, and particularly for us as service providers, is to value the social and cultural differences that each of the groups who live here adds to the great American mosaic and to understand the economic, political, and social forces of our society that either inhibit or enhance the opportunity structure of all those who inhabit this nation. A careful read of this book will help the practitioner meet this challenge.

The book is arranged in a manner so that each section builds on the preceding section. This edition expands the scope of practice that is examined to include practice with multicultural families where health and disabilities are central to their concerns, and practice with lesbian, gay, bisexual, and transgender (LGBT) individuals and their families. Throughout the book, practice examples are used that help the reader appreciate the complexity of working within and across fields of practice with specific problem behaviors

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and conditions. The book begins with approaches to practice and ends with a full consideration of ethical issues and future directions that should be taken by professional social workers as they engage clients from varied backgrounds in achieving better life chances, and it features direct practice as well as indirect practice strategies and modalities. Illustrative of approaches to practice is the chapter on assessment by Congress and Kung, "Using the *Culturagram* to Assess and Empower Culturally Diverse Families," Ortiz Hendricks's chapter on "The Multicultural Triangle of the Child, the Family, and the School: Culturally Competent Approaches," the Abu-Ras chapter on "Working With Arab Americans," and the chapter by Pardasani and Goldkind, "Managing Agencies for Multicultural Services," which will enlighten the reader about using administrative practices to create a welcoming environment for a diverse clientele.

This text addresses a range of social problems of diverse cultural and ethnic groups across the life course. The problems of substance abuse, domestic violence, and families living with HIV are addressed respectively by Hanson and Sealy in "Evidence-Informed Marriage and Family Treatment With Problem Drinkers: A Multicultural Perspective"; Brownell and Ko's chapter, "Multicultural Social Work Practice With Immigrant Victims of Domestic Violence," and the chapter by Moreno titled "Latino Families Affected by HIV/AIDS: Some Practical Practice Considerations." Also, the reader is introduced to the negative impact of trauma on the family lives of immigrants and refugees in Joyce, Bunn, and Engstrom's chapter, "Clinical Work With Survivors of Torture" and legal issues that are presented by Chang-Muy in the chapter, "Legal Issues in Practice With Immigrants and Refugees: Clinical Social Service Practice With Vulnerable Newcomer Communities—Women, Youth, and Refugees."

This book represents a good jump start for professional social workers and other human service providers who wish to practice in a more culturally sensitive and appropriate manner. Appreciation of culturally sensitive and culturally appropriate practice allows the practitioner to respect the diversity of clients, and in addition this appreciation helps the professional celebrate the richness that cultural, racial, and ethnic diversity brings to this society, which is so well portrayed by Suárez and Lewis in "Spirituality and Culturally Diverse Families: The Intersection of Culture, Religion, and Spirituality." It also provides a platform from which practitioners cannot only begin to understand the differences that are a part of the relationship between the social worker and the client from different backgrounds, but it provides ways of developing a mutually respectful helping relationship. Hopefully as a jump start the book will provide the impetus for professional practitioners to explore each problem area and each group highlighted in the succeeding chapters in more depth than can be achieved in any single book chapter. As a text for master's students it will assure that at completion of their graduate studies they will begin their journey in multicultural practice paces ahead of those of us who did not benefit from such readings in our own graduate study.

Peter B. Vaughan, PhD
Dean, Fordham University
Graduate School of Social Service

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Preface

Multicultural Perspectives in Social Work Practice With Families (third edition) includes "something old, and something new." The old has been significantly revised to include current knowledge and research to help practitioners work more effectively with culturally diverse families. For the most part, the case vignettes and illustrations are new. A third of the chapters are completely new, such as Chapter 3 that focuses on evidence-based models of care with multicultural families; Chapter 6 that looks at issues with multicultural adolescents; Chapter 7 that focuses on day laborers; Chapters 11, 12, and 13 that look at practice with Hispanic American, Asian, and Native American/indigenous families; and Chapter 17 with a focus on legal issues that affect practice with culturally diverse families.

As in the second edition of *Multicultural Perspectives*, culture is used as an umbrella term that includes ethnicity, race, national origin, and religion (Lum, 2004). Although religion and race are subsumed under culture, class is not. The practitioner must consider the socioeconomic class of the family in order to avoid inaccurate generalizations. Often families that have recently immigrated to the United States or have been the victims of generations of racism and discrimination are poor. Many of the families described in this book are poor, but certainly not all families from diverse cultural backgrounds are. Clinicians must be cognizant of the following factors when assessing families of diverse cultural backgrounds: degree of acculturation, poverty, history of oppression, language and the arts, racism and prejudice, sociopolitical factors, child-rearing practices, religious practices, family structure, values and attitudes specific to life, and help-seeking behaviors (Lum, 2004). Clinicians must also be aware of what financial resources are available to the family, as this may affect their functioning.

The third edition of *Multicultural Perspectives* addresses cutting-edge issues in the assessment and treatment of families from diverse cultural backgrounds. These chapters are not all-inclusive, but rather focus on some of the most important, emerging issues in multicultural practice with families. This edition captures the three emerging elements in cross-cultural practice that must be incorporated into the effective psychosocial treatment of ethnic cultural groups: the client's worldview, language, and religion (González, 2002).

Both micro and macro perspectives are important in working with culturally diverse families. Assessment of families begins simultaneously with the beginning of treatment. A good assessment should include an understanding

of family boundaries, rules, roles, and structure. The Olson self-report assessment tool (Olson, Russell, & Sprenkle, 1989) looked at a family's reactions to situational stress in terms of flexibility and cohesion. The Beavers model (Beavers & Hampson, 1993) and the McMaster model (Epstein, Bishop, Ryan, Miller, & Keitner, 1993) have been used in assessing family functioning. The ecomap (Hartman & Laird, 1983) looked at the relationship of the family to external resources, while the genogram (McGoldrick, Gerson, & Schallenberg, 1999) helps the practitioner learn more about family relationships, both current and past.

One issue that none of the existing family assessment instruments focused on—understanding the cultural background of the family—led to the development of the *culturagram* (Congress, 1994) and its revision (Congress, 2002; Congress, 2008). The first chapter in the book looks at the *culturagram* as an assessment and treatment planning modality. The authors, Congress and Kung, use clinical examples from their extensive teaching and practice experience to illustrate different parts of the *culturagram* and how it can be used in assessment.

How do we make decisions about whether to see clients for group or family therapy? Chapter 2 focuses on similarities and differences between group and family work. Drs. Congress and Lynn discuss these issues by using a case vignette of a West African family with adult children to illustrate important principles in family and group work.

What treatment methods are the most effective in working with culturally diverse families? Evidence to support the use of different treatment modalities is viewed as paramount in the delivery of social services (Gambrill, 2010). In Chapter 3, Dr. González looks at evidence-based practice that supports the use of specific interventions with multicultural families. Culturally adapted cognitive–behavioral therapy is highlighted as an exemplar of evidence-based treatment for ethnically and racially diverse patient populations.

Most people seek help because of family problems and are seen in family service or mental health agencies. No matter how skilled the clinician is, if agency context is not considered, then family engagement, assessment, and intervention may not be successful. Green (1999), for example, has noted that multicultural skills and knowledge are not just for individual providers of psychosocial care. Human service organizations—the social systems in which most providers of care are employed—must also promote the delivery of culturally competent clinical services. In Chapter 4, Drs. Pardasani and Goldkind outline how practitioners and administrators can "manage for diversity competence" within the workplace. They suggest that agency leaders must continually assess their cultural competence at all levels—board of directors, administrators, staff, policies, and programs. They raise concerns about microagressions that occur in the workplace and how they can be addressed.

The second section of the book focuses on work with families from diverse backgrounds across the life cycle. School is the primary place where children from very different cultures interact and learn. In Chapter 5, Dr. Ortiz Hendricks looks at the multicultural triangle of child, family, and

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school. She stresses the need to understand these differing cultures in order to work effectively with children and their families within the school system. She discusses the need for social workers to understand their own cultural backgrounds and to apply culturally competent standards in their work with culturally diverse children and their families.

Adolescence is often a challenging time for immigrant families, especially when adolescents are anxious to be Americanized and parents are more committed to the mores and customs of their homelands. In the sixth chapter, Dr. Aymer writes about the special challenges of work with multicultural adolescents.

An important new addition to this edition of *Multicultural Perspectives* is the seventh chapter by Drs. Acevedo and Perez that focuses on policy and practice issues with day laborers. This population is extremely vulnerable and often exploited, but has rarely been discussed previously in social work literature. Legal as well as social work intervention may be needed in work with this population.

Older people are increasing in numbers globally and in the United States. Older people come from many different cultural backgrounds. In Chapter 8, Drs. Gutheil and Heyman point out important issues in social work with older people from diverse cultural backgrounds. This chapter looks at health disparities between diverse older populations, important assessment issues, service utilization, and treatment approaches with older people and their families. The need for social workers to understand and work within the cultural background of older clients and their families is illustrated through a case vignette.

Grandparents raising grandchildren is an increasing phenomenon especially among communities of color. In Chapter 9, Dr. Cox aptly describes the very successful use of an empowerment-training program to provide support and foster strength among grandparents from culturally diverse backgrounds.

"An Afrocentric Approach to Working With African American Families," Chapter 10 written by Dr. Aymer, addresses the historical background of African Americans in the United States and the racism they encounter. The importance of adopting an Afrocentric framework, the use of language, spirituality, family relationships, and conceptions of mental health are all addressed in this chapter.

Dr. González, the co-editor of *Multicultural Perspectives*, and Dr. Acevedo look at clinical issues in working with Latino families in Chapter 11. Since Hispanics/Latinos are the minority diverse populations showing the largest increase in numbers in the United States, this new chapter is particularly timely. The authors look at the diversity of national backgrounds of Hispanics, as well as important cultural characteristics of Hispanics such as *simpatía*, *personalismo*, *familismo*, *confianza respecto*, and the gender roles of *marianismo* and *machismo*. The importance of religion and spirituality for many Hispanics/Latinos is stressed. This new chapter concludes with strategies to use in clinical work with this expanding population.

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The number of Asian American families is rapidly increasing and in Chapter 12 Dr. Chung looks at clinical assessment and treatment issues that have an impact on work with Asian families. Dr. Chung addresses timely issues such as intergenerational conflict, challenges in working with Asian American families, and culturally responsive interventions.

In planning for *Multicultural Perspectives in Social Work Practice With Families*, the editors of this book became aware that they had not included the first Americans, that is, native and indigenous peoples. As many of the Native Americans have been decimated over the centuries because of disease and war and are now often invisible in cities, the number of American Indians in the United States constitute only about 1% of the total population. In Chapter 13 Dr. Weaver, a social work educator from the Lakota tribe, examines how trauma and oppression have negatively impacted the economic, social, and psychological well-being of American Indians. Understanding the importance of the medicine wheel—mind, body, spirit, and heart—to Native American families increases clinicians' ability to provide culturally sensitive services to these families.

An exciting addition to the third edition of *Multicultural Perspectives* is Chapter 14 by Dr. Abu-Ras that focuses on Arab American families. This growing U.S. immigrant group is frequently misunderstood, especially post-9/11. Practitioners will learn more about the differences among Arab countries and the religious backgrounds of Arabs, their psychosocial needs, attitudes toward mental health, family relationships, and treatment issues.

In Chapter 15, Dr. Mallon addresses issues that gay and lesbian people face within their families. The psychosocial needs and risks of gay and lesbian people, clinical issues in working with gay and lesbian people, and recommendations for working with this population are addressed.

Drs. Suárez and Lewis describe the role of spirituality in culturally diverse families in Chapter 16. Major religious trends in the United States, as well as the differences between religion and spirituality, are outlined. This chapter focuses on the interrelationship between cultural and religious views and the effects they have on psychological and interpersonal behavior. Implications for practice with culturally diverse families who recognize their religious beliefs and spirituality conclude the chapter.

Many culturally diverse families have members with differing status ranging from citizen to "green card holder" and "undocumented." Chapter 17 by Fernando Chang-Muy, a law professor, serves to demystify the confusing complex legal status of clients that we serve. This chapter presents relevant immigration policies and laws with a specific focus on three newcomer populations—women, children, and refugees. Ways in which social workers can work with lawyers in advocating for rights of immigrant clients and families are discussed.

Recent immigrants to the United States including legal immigrants, refugees, and undocumented immigrants are the focus of Chapter 18 written by Drs. González, Rosenberg, and Rosenberg. The chapter also explores their mental health needs, access to services, and implications for social work practice. Although immigrants and refugees may be at increased risk for a host of psychological problems such as depression and traumatic stress, they

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are less likely to access treatment, because of financial inability, the lack of availability of culturally competent services, their own cultural prohibitions against participating in mental health care, and a general mistrust of government agencies. The importance of accurate assessment and culturally sensitive intervention is illustrated through case vignettes.

Chapter 19 is a new chapter that focuses on clinical work with survivors of torture. This topic is particularly important as an increasing number of refugees emigrate to the United States after having experienced torture in their country of origin and in transit. Others apply for asylum status after immigrating to the United States. Marianne Joyce, Mary Bunn, and Dr. David Engstrom have used a comprehensive approach to address clinical assessment and treatment issues in survivors of torture.

Although HIV/AIDS is more treatable now than a decade ago, the effects of HIV/AIDS for both affected individuals and their families are devastating. In Chapter 20, Dr. Moreno looks at the stigma and treatment issues for Latinos, especially women and LGBT (lesbian, gay, bisexual, and transgender) individuals. The chapter concludes with a discussion of interventions that have been especially helpful in working with Latinos and their families who have been affected by HIV/AIDS.

Evidence-based treatment is a major focus of current treatment interventions. In Chapter 21, Drs. Hanson and Sealy look at the latest studies on effective marriage and family treatment with problem drinkers. Adopting an evidence-based practice (EBP) perspective, the authors present the case of a Puerto Rican family with an alcoholic member and how this approach can be used to engage and facilitate treatment.

Domestic violence presents special problems in families from culturally diverse backgrounds. Chapter 22 by Drs. Brownell and Ko discusses the unique needs and challenges that many culturally diverse women who have been abused encounter in acknowledging the need for help, as well as in seeking and securing services. Special difficulties for non-documented women, as well as issues specific to Latino battered women, Asian battered women, and Southeast Asian women are discussed. Different types of treatment interventions as well as policies that affect the identification and treatment of battered women from culturally diverse backgrounds conclude this chapter.

Latinos are the fastest growing ethnic group in the United States and by mid-century 25% of adolescents will be of Hispanic background. A growing concern is the increasing number of suicide attempts by adolescent Latinas. Chapter 23 by Drs. Alonzo and Gearing describes strategies for prevention and intervention in Latina adolescents and their families. Treatment interventions are illustrated through a case vignette.

The final chapter of the book by Dr. Congress looks at ethical issues and trends in family therapy. For many reasons, family therapy often presents the most ethical challenges. Issues of countertransference, confidentiality, self-determination, and value differences in culturally diverse families are discussed. Evidence-based practice is seen as an important current trend affecting the course of family therapy. The increasing diversity of clients and their therapists will affect the future course of clinical work with families.

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ONE

Using the *Culturagram* to Assess and Empower Culturally Diverse Families

Elaine P. Congress and Winnie W. Kung

The United States is becoming increasingly culturally diverse. It is estimated that by the year 2050 less than half (46%) of the population will be non-Hispanic Caucasian (U.S. Census Bureau, 2008). While the number of foreign-born people is 13% at the national level, in large metropolitan areas such as New York City as much as 37% of its residents are foreign-born (U.S. Census Bureau, 2010). Additionally, approximately 21% of the U.S. population, aged five and older, speaks a language other than English at home, out of which 13% speak Spanish (U.S. Census Bureau, 2010).

From the beginning of the social work profession social workers have stressed the importance of respect for clients from diverse backgrounds (Addams, 1911). In the most recent Code of Ethics, social workers are advised to understand cultural differences among clients and to demonstrate competence in working with people from different cultures (National Association of Social Workers [NASW], 2008). In addition, the recent Code of Ethics advises social workers to work against discrimination based on immigration status. The *culturagram*, a family assessment instrument discussed in this chapter as well as previous editions of *Multicultural Perspectives in Working With Families*, grew out of the recognition that families are becoming increasingly culturally diverse and that social workers must be able to understand cultural differences among families and their implications for their work.

When attempting to understand diverse families, it is important to assess the family within its cultural context. Considering a family only in terms of a generic cultural identity, however, may lead to overgeneralization and stereotyping (Congress, 2008b). A Puerto Rican family that has lived in the United States for 40 years is very different from a Mexican family that emigrated last month, although both families are Hispanic. A Chinese family that emigrated to the United States in the early 20th century is very different from a Tibetan refugee family that has recently been relocated. Even two families from the same country and region are very different.

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THE *CULTURAGRAM*

While the ecomap (Hartman & Laird, 1983) and genogram (McGoldrick, Gerson, & Schallenberg, 2007) are useful tools in assessing the family, they do not address the important role of culture in understanding the family. The *culturagram* was first developed (Congress, 1994, 1997) and revised (Congress, 2002, 2008b) to help in understanding the role of culture in families. This tool has been used to promote culturally competent practice (Lum, 2010) and in work with battered women (Brownell & Congress, 1998), children (Webb, 1996), older people (Brownell, 1997, Brownell and Fenly, 2008), immigrant families (Congress, 2004, 2010), and families with health problems (Congress, 2004).

The *culturagram*, a family assessment tool, serves to individualize culturally diverse families (Congress, 1994, 2002, 2008b). Completing a *culturagram* on a family can help a clinician develop a better understanding of the sociocultural context of the family, which can shed light on appropriate interventions with the family. Revised in 2008 the *culturagram* examines the following 10 areas (see Figure 1.1):

1. Reasons for relocation
2. Legal status
3. Time in the community
4. Language spoken at home and in the community
5. Health beliefs and access
6. Impact of trauma and crisis events
7. Contact with cultural and religious institutions, holidays and special events, food and clothing
8. Oppression and discrimination, bias and racism
9. Values about education and work
10. Values about family structure—power, hierarchy, rules, subsystems, and boundaries

Reasons for Relocation

Reasons for relocating to the United States vary among families. Many families come because of economic opportunities in the United States, whereas others relocate because of political and religious discrimination in their countries of origin. For some, it is possible to return home again. They often travel back and forth for holidays and special occasions and ultimately may move back to their country of origin. Being able to maintain continuous close social ties with families of origin and other acquaintances in the native land reduces the sense of uprootedness of the family. Such close contacts also facilitate the family, especially the younger generation, to maintain their cultural heritage and identity. The cultural gap between the generations in these immigrant families may be diminished as a result. For those who know they can never go home again, the sense of isolation and the need for greater social network in this new land becomes more poignant. The social worker can encourage them to actively reach out to their ethnic communities. Modern means of communication such as email and Skype have made

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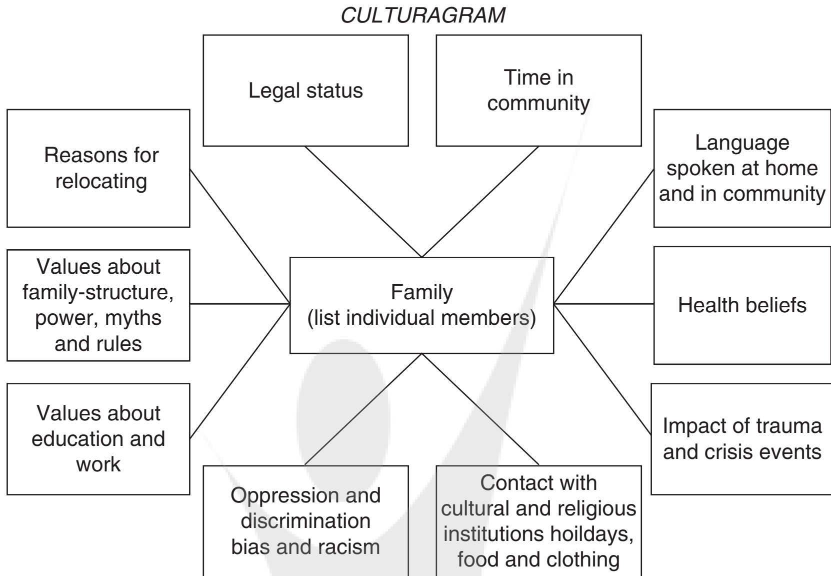

FIGURE 1.1 ***Culturagram.***
Note: The previous version of this *culturagram* appeared in Congress (2008a).

it possible for immigrants to maintain contact with relatives who still live in their countries of origin.

In contrast to earlier immigration patterns, current immigrants come as families or parts of families (Lum, 2010). Some exceptions include undocumented immigrants from Fuzhou in southern China (Kwong, 1997), and second generation South Asians from India and Pakistan, who frequently come as single persons. Many want to marry within their ethnic group and "mail-ordered brides" are a growing phenomenon (Loiselle-Leonard, 2001). Because immigrant brides have to adjust to new roles within their families and adapt to a different culture and geographic location, their stresses are enormous (Liao, 2006).

In cases where the marriage does not work out, these women may feel trapped in this foreign land with no social support. Some may even have to endure domestic violence since the prospect of making it outside of the home in America is so dim, and the shame of going back to their home countries so unbearable (Loiselle-Leonard, 2001). Some feel trapped because their immigrant procedures have not been completed, and they fear deportation if they leave their husbands. Fortunately, recent changes in immigration laws allow some battered women without legal status to stay on (Violence Against Women's Act, 1998). This has brought relief and hope to many oppressed immigrant women.

Other families move within the United States, often from a rural to a more urban area, often due to dwindling economic opportunities. This

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requires establishment of a new social network and adjustment in the new location as well.

Legal Status

The legal status of a family may have an effect on both individuals and the family as a whole. In the same family there may be members who are citizens, those who are "green card holders," with the legal right to remain in the United States and proceed toward citizenship, and those who are undocumented. Chang-Muy's chapter on "Legal Issues in Practice With Immigrants and Refugees" in this book explains in greater detail different immigrant statuses. If family members are undocumented and fear deportation, the family may become secretive and socially isolated. Latency-age children and adolescents will be discouraged from developing peer relationships because of the fears of others learning about their status. Using the family systems lens, the external boundaries of these families may become more rigid and within families a corresponding trend toward more diffuse internal boundaries leading to greater enmeshment. The family may resist seeking necessary social and health services lest they be deported. There is even more anxiety about this post 9/11.

Some undocumented immigrants come to this country on their own, leaving behind their families and support system. An example is the recent influx of immigrants from Fuzhou, southern China (Kwong, 1997). These single immigrants have experienced enormous hardship, handicapped by language deficiency and the enormous economic burden of having to repay the smuggling debts to come to this country (Kwong, 2002). Moreover, the lack of medical benefits makes life even harder when they have health or mental health problems (Kwong, 2002). A social worker working with this population in Chinatown in New York City revealed that perhaps due to social isolation and enormous stress, many individuals suffering from schizophrenia, indicated a revolving-door phenomena, going in and out of hospitals after brief psychiatric treatments. The relapse rate is as frequent as four times a year.

Length of Time in the Community

The length of time living in the community may differ for individual family members. Usually family members who have arrived earlier are more assimilated than other members. A current phenomenon involves mothers from Guatemala or South America first immigrating to the United States and then sending for their children. These circumstances can certainly impact on individual and family development. Not only does the disruption of the primary caregiver at a critical period affect the child's development, the subsequent reunion at an older age in this country could also cause some adjustment problem for the family. Sciarra (1999) suggested that the issues these families face include resentment of the child over the parents' earlier "abandonment," the conflict between loyalty toward the reunited parents and the interim caregiver from whom the child is now forced to separate, inadequate parental authority and leadership, and the different level of acculturation between

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the parent and the child. Sciarra found that techniques such as reframing the intergenerational conflicts as intercultural issues and stating the treatment goal as working toward biculturalism helpful.

The problems faced by other immigrant families are the exact opposite of these reunited families. These have been called the "astronaut families" (Irving, Benjamin, & Tsang, 1999). Because of the political instability in Taiwan or Hong Kong in the past decade, many Chinese families migrated to the United States and Canada. However, such moves often mean an economic loss to these families since the breadwinner, usually the father, experiences some diminished income in his career as his professional qualifications and experiences overseas are often not recognized here. Many families opt to have the children and the mother migrate first, while the father "shuttles" back and forth to join the family periodically. Not only does it pose challenges to the marital relationship, sometimes resulting in affairs and marital breakdown, but it also jeopardizes the father–children relationship. These are high prices to pay for migration.

The current worldwide economic recession has only exacerbated immigration challenges for families and has increased the need for family separation and dislocation.

Language

Language is the vital medium through which families communicate. Often families may use their own native language at home, but begin to use English in contacts with the outside community. Sometimes children may prefer English as they see knowledge of this language as most helpful for survival in their newly adopted country. This may lead to conflict within the family. A very real communication problem may develop when parents speak no English and children speak only minimally their native tongue. Another key factor affecting family communication is that members relocate at different ages. Because of attending American schools and developing peer relationships, children often pick up the new language and culture more quickly than their parents. This may lead to shifts in the power structure of the family as the parents' limited English competency can erode their authority (Hong, 1989; Hendricks, 2005). In some situations, the children may assume the role of interpreter and cultural broker for the family, and sometimes even the leadership role since they have better knowledge about community resources. This may be especially difficult for cultures in which the generational hierarchy within the family is important (Tamura & Lau, 1992).

One of the challenges in the work of bilingual social workers with a bilingual family is that they have to decide which language to adopt and when. Caution should be taken to ensure that the worker does not appear to be "siding" with either the English or the native speaker. For families in which the children can understand but not speak the native language, it is important for the bilingual worker to speak mostly in the native tongue even when talking to the children to indicate that the language is respectable and to show respect to the parents (Hong, 1989). When an interpreter is needed, care must be taken if the worker decides to use a family member as

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interpreter to ensure that he or she does not avoid or distort sensitive messages. For example, social workers must ensure that the interpreting family member does not avoid explorations of suicidal ideations when he or she does not feel comfortable asking the questions and believes that it would not happen (Hong, 1989). Discussion with an external interpreter before meeting with the family is also helpful to ensure they understand the major thrust of the session (Caple, Salcido, & di Cecco, 1995; Lee, 1982).

Health Beliefs and Access

Families from different cultures have varying beliefs about health, disease, and treatment (Congress & Lyons, 1992; Congress, 2004). Many medical anthropologists have contended that individuals' cultural beliefs influence the way they perceive the etiology of an illness, interpret the symptoms, and act on the symptoms (Cheng, 2001; Kleinman, 1980; Tseng, 2001). Individuals' and families' health beliefs, which include their perception of their susceptibility, the seriousness of the consequence of an illness and the benefit of medical intervention, affects their readiness to use preventive health services and to seek actual help when a family member faces an ailment (Hsu & Gallinagh, 2001; Rosenstock, 1990). Families' reaction to an illness can affect the course, outcome, and level of incapacitation of an illness and the families' adjustment to it (Rolland, 1994). For example, a delay in seeking treatment for HIV/AIDS because of the stigma could lead to more devastating and lasting impact on the family through transmission of the illness to other family members.

There are differences between immigrant and refugee groups in how they understand mental illness (Bemak & Chung, 2000). Among many Asians, mental illness is seen as the result of malingering bad thoughts, a lack of willpower, and personality weakness (Narikiyo & Kameoka, 1992; Suan & Tyler, 1990; Sue & Morishima, 1982). Hence, self-control and solving one's own problems are culturally valued, and seeking help from mental health professionals is often delayed (Boey, 1999; Loo, Tong, & True, 1989; Zhang, Snowden, & Sue, 1998). Given Asian Americans' tendency to somatize emotional distress, emphasize the physical expression of one's distressed state (Kleinman, 1980; Sue & Morishima, 1982; Tseng, 2001; Zhang et al., 1998), or subscribe to the holistic mind–body–spirit conceptualization, they are likely to turn to physicians, herbalists, acupuncturists, fortune tellers, or ministers for help instead of mental health professionals (Kung, 2001; Kung & Lu, 2008; Sue, Nakamura, Chung, & Yee-Bradbury, 1994; Uba, 1994). Some Hispanics may rely on botanicas or spiritualists as the first and sometimes the only approach to dealing with health or mental health problems (Congress, 2004). The intense stigma attached to mental illness in some cultures also poses barriers to seeking mental health service (Kung, 2004; Kung & Lu, 2008). Some of these impediments to help seeking among Asians include the attribution of psychiatric problems to hereditary causes, interpreted as "genetic taints" and "bad seeds" (Pearson, 1993; Sue & Morishima, 1982). Because of the sociocentric nature of the Asian culture (Triandis, 1989), families are concerned about the loss of face and avoid reaching out for help beyond the immediate family, thus overburdening the

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family (Kung, 2001; Sue & Sue, 1999; Sue & Morishima, 1982). Hispanics may seek to avoid the label of “loco” because of the stigma connected with this designation (Congress & Lyons, 1992).

In the face of physical illness, many immigrants prefer to use health care methods other than traditional Western/European medical care involving diagnosis, pharmacology, X-rays, and surgery (Congress, 2004). The social worker who wishes to understand families must study their unique health care beliefs.

Immigrants, especially those who are undocumented, may have limited access to ongoing health care (Goldman, Smith, & Sood, 2006; Derose, Escarce, & Lurie, 2007). Denied access to regular health care and prevention, many immigrants are forced to rely only on emergency care. The Health Care Reform Act (NILC, April 2010) did not greatly expand health care coverage to immigrants as it denied health care to undocumented immigrants and limited health care even for those immigrants who had legal status to remain in the United States. Some states, however, have chosen to provide Medicaid and Children’s Health Insurance Program (CHIP) benefits to children and pregnant women. Even for those who are entitled to receive health care could be denied access to needed care due to the lack of bilingual service providers serving the monolingual citizens who are not English speaking (Kung, 2004).

Crisis Events

Many immigrants have experienced multiple traumas in their homelands, in transit, and in their current situation. Often these traumas can detrimentally affect the mental health of immigrants and refugees (Pumariega, Rothe, & Pumariega, 2005).

Families can encounter developmental crises as well as “bolts from the blue” crises (Congress, 1996). Developmental crises may occur when a family moves from one life stage to another. Stages in the lifecycle for culturally diverse families may be quite different from those for traditional Caucasian middle-class families. For example, for many culturally diverse families the “launching children” stage may not occur at all, as single and even married children may continue to live in close proximity to the parents (Uba, 1994). If separation is forced, this developmental task might become traumatic.

Families also deal with “bolts from the blue” crises in different ways. During the 9/11 attack on the World Trade Center people from more than 80 countries of origin died (Lum, 2004). There has also been concern that many victims, especially those who were undocumented, were never acknowledged and their families often were not able to secure the assistance that others received. A family’s reaction to crisis events is often related to its cultural values. The death or injury of the male head of household may be a major crisis for an immigrant family that highly values the role of the father as a provider. While rape is certainly a major crisis for any family, the rape of a teenage girl may be especially traumatic for a family that highly values virginity before marriage.

Because of cultural differences, families may have varied perceptions of child-rearing practices and child abuse. This may cause some immigrant families

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to be accused of child abuse and become involved with child protective agencies and the legal system. A referral to child protective services is perceived as a crisis to many families and especially so for those who interpret court-ordered counseling upon disciplining a child as an outrageous punishment—a crisis that evokes tremendous anger and shame (Waldman, 1999).

Different beliefs about the treatment of physical ailments may result in different approaches to remedy these problems. Some approaches may result in parents being accused of abuse and neglect. For example, methods such as coining or cupping administered by parents to help relieve the child's bodily pain may leave scars that may be misinterpreted as child abuse (Uba, 1994). Some parents may refuse to have their children take medication because of possible side effects or because of their health beliefs, and as a result, they are accused of child neglect (Fadiman, 1997). Such accusations, when experienced as uncalled for and deeply shameful, can cause a major crisis to families.

Holidays and Special Events, Contact With Cultural and Religious Institutions, Food, and Dress

Each family has particular holidays and special events. Some events mark transitions from one developmental stage to another, for example, a christening, a *bar mitzvah*, a wedding, or a funeral. It is important for the social worker to learn the cultural significance of these events, as they are indicative of what families see as major transition points in their lives. Some ethnic families have their own high holidays, such as the Lunar New Year, which is often considered as important to many Asian families as Thanksgiving to many native-born Americans, if not more so. It is worth encouraging immigrant families to celebrate their own important holidays to help them uphold their tradition and to strengthen their cultural identity. Special foods may be associated with the celebration of these holidays.

Contact with cultural institutions often provides support to an immigrant family. Family members may use cultural institutions differently. For example, a father may belong to a social club, the mother may attend a church where her native language is spoken, while the adolescent children may refuse to participate in either because they identify more with the American culture. Religious faith may provide much support to culturally diverse families and the clinician will want to explore their contact with formal religious institutions. Some clansmen's associations are common among Asian Americans, often providing important support to immigrant families. For example, they provide significant financial support for new Chinese immigrants from Fuzhou in New York City (Kwong, 1997). The support among business owners is also found to be an important factor accounting for the successes among many Korean American businesses (Park, 1997). The social worker should be aware of these resources so as to help families tap into them. Most Asian clansmen's groups, however, do not provide assistance or support on psychosocial issues due to the lack of knowledge about mental health issues by these immigrant groups.

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Oppression and Discrimination, Bias, and Racism

Many immigrants have experienced oppression in their native countries, which has led to their departure from their homelands and immigration to the United States. Some of them enter the United States as refugees because of the extent of social, political, physical, and emotional discrimination they experienced in their countries of origin, while others apply for asylum status after their arrival here because they fear a return to their homelands.

Other immigrants, however, may have been the majority population in their home country and thus never experienced prejudice until their arrival in the United States. In the United States, they may be the victims of discrimination and racism based on language, cultural, and racial differences. The current U.S. policies on undocumented immigrants further serve to separate and discriminate this newcomer population from other Americans.

After review of previous versions of the *culturagram* and feedback about the instrument, this area was added in 2008 as an important aspect in understanding the immigrant family experience.

Values About Education and Work

All families have differing values about work and education, and culture is an important influence on such values. Social workers must explore what these values are in order to understand the family. Economic and social differences between the country of origin and the United States can affect immigrant families. For example, employment in a low-status position may be very denigrating to the male breadwinner in some culture. It may be especially traumatic for the immigrant family when the father cannot find work or is engaged in work of a menial nature. This is often a result of the individuals' professional qualifications and experiences in their native land not being recognized in this country. Such a downward move in the socioeconomic hierarchy often induces additional stress and challenges for many immigrant families.

Sometimes a conflict in values arises due to competing desires of family members. This occurred when an adolescent son was accepted with a full scholarship to a prestigious university miles away from home. While the family had always believed in the importance of education, the parents believed that the family needed to stay together and that they did not want to have their only child leave home, even to pursue education.

Another example occurs when American latency-age children often attend large schools far from their communities and begin to develop peer relationships apart from their families. For immigrant families that come from backgrounds in which education has been minimal and localized, and where young children were expected to work and care for younger siblings, the American school system with its focus on individual academic achievement and peer relationships may seem alien. Furthermore, immigrant children who have experienced a history of individual or family oppression may feel very isolated and lonely in their new academic environments, which is made worse when actual bullying by peers and discrimination by insensitive school personnel take place.

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Some cultures value education differentially for different genders. For example, many Hispanic girls drop out of school because academic attainment for girls is not highly valued compared with boys (Zambrana & Zoppi, 2002). More importantly, these girls have major responsibilities in taking care of the household and younger siblings. They often find little or no time left to attend to their academic demands after school and thus have a hard time keeping up with academic work, and eventually drop out of school.

Values About Family Structure—Power, Hierarchy, Rules, Subsystems, and Boundaries

Each family has its unique structure, its beliefs about power relationships, rules, boundaries within and outside the family, and significance of certain familial relationships. The clinician needs to explore these family characteristics individually, but also to understand them in the context of the family's cultural background. Some families may have differing beliefs about male–female relationships, especially within marriage. Families that promote a male-dominant hierarchical family structure may encounter conflict in American society with its stated preference for more egalitarian gender relationships. This may result in an increase in domestic violence among minority families (Erez & Globokar, 2009). Traditionally gendered roles within the family also exert significant impact on the family, especially when circumstances change after migration. For example, in some cultures women are expected to take care of internal familial affairs, including household chores and child care, while men are expected to work outside and be income earners. However, changes in socioeconomic status of the family after migration may necessitate both spouses to work outside of the home. If the role of domestic caretaker continues to be rigidly assigned only to women, they may become overburdened. In situations in which the woman is able to find a job while the man is unemployed, if the family lacks flexibility in their role adaptation, conflict, blame, and burden within the family may become so enormous that it may threaten the survival of the family unit.

Not only is gender hierarchy much affected by cultural norms, so is generational hierarchy. More traditional cultures tend to ascribe much higher authority and respect to the older generation, and in some the parental authority can at times be rather absolute (Tamura & Lau, 1992). Clinicians should recognize such inherent cultural differences, and sometimes mediate between the generations. They have to navigate cautiously: They should show respect to the family's culture on the one hand, but tactfully facilitate communication across the generations on the other hand, in order to ease tension and conflict. Through careful mediation, it is hoped that views from both sides can be heard and considered in final decision making. However, sometimes the worker may have to accept that some cultures do dictate that senior members have the ultimate power in decision making after the views of the younger generation are articulated.

Finally, families from different cultures may place varying emphasis on family subsystems. In Western culture, the spousal subsystem is considered the bedrock of the family (Minuchin, 1974). In some cultures, though, the primary unit is the parental subsystem, emphasizing the co-parenting role

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between the spouses (Uba, 1994). Moreover, the parental subsystem could be much more inclusive—for example, not only are grandparents, aunts, and uncles important partners in the parental subsystem, but the godparents' role could also be very significant in Hispanic families (Garcia-Preto, 1996). Clinicians should be conscious of cultural values and practices so as not to leave out important system players who could be valuable resources to the family. In some cultures, like that of traditional Chinese, the parent–child subsystem (both the father–son and mother–son dyads) and even the relationship among brothers are considered more important than the spousal relationship (Tamura & Lau, 1992).

Whether the boundary within a family or within a subsystem is considered appropriate or overly diffuse is also very cultural (Olson & Gorall, 2003). For example, in some Asian cultures, since the future care of the aging mother is dependent on the son, and the mother–son bond is usually close, a mother is often seen as being intrusive in the son's marital relationship and is sometimes domineering toward the daughter-in-law (Berg & Jaya, 1993). In some Asian families, for the child to sleep with the parents till the age of 8 or 10 is considered a very normal practice, and it does not necessarily indicate marital dysfunction or enmeshment between parent and child (Berg & Jaya, 1993). Social workers have to avoid judgmental attitudes toward families who have different cultural values from their own.

The following case vignette (Congress, 2008b) illustrates how the *culturagram* can be used to better understand a family with its unique cultural background and to provide treatment intervention:

CASE VIGNETTE

Mrs. Maria Sanchez, 32 years old, contacted a family service agency in her community because she was having increasing conflicts with her 12-year-old son, José, who had begun to cut school and stay out late at night. She also reported that she had a 9-year-old daughter, Maritza, who was "an angel." Maritza was very quiet, never wanted to socialize with other children, and instead preferred to stay at home with her mother helping her with household chores. Maria indicated the source of much conflict was that José believed he did not have to respect Manuel, Maria's current partner, as the latter was not his real father. José complained that his mother and stepfather were "dumb" because they did not speak English. José felt it was very important to learn English as soon as possible as at school several students had made fun of his accent. He felt that his parents did not understand how difficult his school experience was as he believed that teachers favored lighter-skinned Latinos. José had much darker skin than his mother, his stepfather, or his half-sister Maria. The past holidays had been especially difficult as José had disappeared for New Year's weekend.

At 20, Maria had moved to the United States from Puerto Rico with her first husband José Sr. The two were very poor in Puerto Rico and had heard there were better job opportunities

here. When José Jr. was an infant, José Sr. had made a visit back to Puerto Rico and never returned. Shortly afterwards, Maria met Manuel, who had come to New York from Guatemala. After she became pregnant with Maritza, they began to live together. Manuel indicated that he was very fearful of returning to Guatemala, as several people in his village had been killed in political conflicts. Because Manuel was undocumented, he had been able to find only occasional day work. He was embarrassed that Maria had been forced to apply for food stamps. Maria received minimum wages as a home care worker. She was very close to her mother, Gladys, who had come to live with the family 9 years ago. Gladys had urged Maria to seek help from a spiritualist to help her with her family problems before she went to the neighborhood agency to ask for help. Manuel has no relatives in New York, but he has several friends at the social club in his neighborhood.

Not only does the *culturagram* help the social worker assess families from different cultural backgrounds, but also to begin to move toward appropriate interventions. After completing the *culturagram* (see Figure 1.2), the social worker was better able to understand the Sanchez family, assess their needs, and begin to plan for treatment. She noted that Manuel's undocumented status was a source of continual stress in this family. She referred Manuel to a free legal service that provided help for undocumented people in securing legal status. She also explored their religious affiliation and found that although the family subscribed to the Catholic faith, they had not attended church since they came to this country, because they could not find a church with Spanish-speaking priests. The worker helped the family find a Catholic church in the neighborhood that has a weekly mass in Spanish and a large proportion of Hispanic parishioners. The church later became a support network for the family as Maria and Maritza became involved with women's and children's groups at the church.

The social worker recognized some kind of communication problem across the generations. While José and Maritza are bilingual, they often speak English at home, which for the most part Maria and Manuel do not understand. The adults communicated with each other and the children in Spanish. Maria and Manuel sometimes wanted to practice their English with the children, but the latter, especially José, were rather impatient with their parents' broken English. In any case, communication was limited to basic information exchange and rule setting. The worker encouraged the couple to study English in a free adult education program in their neighborhood. The bilingual worker, however, was careful to speak in Spanish when seeing the couple and especially during family sessions so as to subtly convey her respect for the language to the children. When she had individual sessions with the children she used English since they were better able to express themselves.

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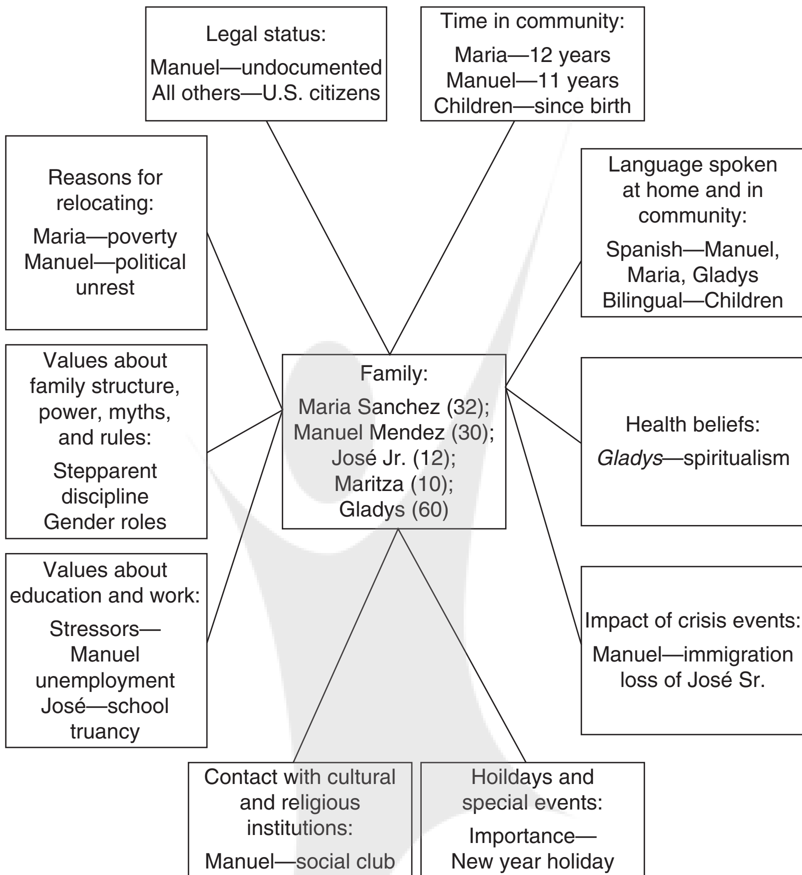

FIGURE 1.2 ***Culturagram* applied to the case example.**
Note: The previous version of this *culturagram* appeared in Congress (2008a).

Due to language barriers, José occasionally had to act as interpreter on behalf of the family, for instance when the family had to deal with the Social Security Department or with his grandmother's medical doctors during a serious illness that involved hospitalization. José was sometimes resentful toward these familial obligations as it took away time from being with his peers. He also felt that all his mother and stepfather wanted was to ask him to help out in the family and to impose rules on him, without ever caring about his needs. The worker reframed his responsibility for the family as having an honorable task as cultural broker, but recognized his need for appropriate autonomy. While the worker worked toward the therapeutic goal of empowering the parents, especially the mother, to assert control over José, she also acted as a mediator to help the parents understand José's need to gain more age-appropriate independence.

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Within the school, José reports that he has often been the subject of bias and discrimination. Chapter 5 by Carmen Hendricks outlines some of the challenges faced by immigrant children within the American school system. The clinician working with this family might want to contact the school to learn more about their policies and programs in helping students from different cultural backgrounds.

Maritza's social withdrawal was also explored. It was found that Maritza wanted to stay home to do the household chores as this was expected of her as a girl. She noted that her family did not think it appropriate that men in the family (her father Manuel and her brother José) help out with household chores. She wished to spare her mother from additional chores after a hard day's work outside, and lighten her grandmother's load because of her frail health. As a result, she sacrificed her playtime with peers and stayed home to take care of the house. The worker tactfully invited Manuel to be more involved in domestic duties on days that he did not have to work and reframed it as his way of showing his love for the family through such sacrifice. Maritza was also encouraged to attend activities at the church and after-school programs so as to socialize more with her peers.

The following is another case vignette about an immigrant family.

Ping is a 44-year-old Chinese woman who was referred for counseling at a family service center in Chinatown by the psychiatrist who was treating her husband for his mental illness. At intake she stated that she suffered from nervousness, frequent palpitations of the heart, difficulty breathing, and insomnia as she was faced with her husband's temper tantrums. She often felt "caught in the middle" in her relationships with her in-laws over the care of her husband and her two children aged 18 and 16.

Ping came from a poor rural area in southern China. She immigrated to the United States 20 years ago as part of an arranged marriage to a man whose family had successfully immigrated to this country. The marriage was an explicit arrangement in which the groom's family found a wife for a son with mental health issues, and the bride's family could gain American citizenship. The client's motive for marrying was a filial willingness to better her family's prospects.

The client worked in restaurants in Chinatown when she first came to the United States but eventually became fully preoccupied with the care of her husband and the two children. The husband has been diagnosed with schizophrenia, and three years ago contracted HIV through prostitutes. The couple has not been sleeping together for over 10 years and the client did not react strongly to the news. It was when the husband began a regimen of anti-viral drug treatment for his HIV that his mental health

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seriously deteriorated. The erratic and paranoid behavior that followed impacted the son who became prone to violent outbursts. Neither the husband nor the son admitted to any mental health or emotional problems, and the extended family was opposed to the client's efforts to seek help outside of the traditional and familial channels. She persisted, however, and eventually was able to gain access to a range of services including psychiatric care for her husband, and counseling help for herself.

By the time the client arrived at the agency, there had been an amelioration of her husband's symptoms, though caring for him still left her drained. The young daughter lives separately with her paternal grandparents and is doing reasonably well. The client's major concern from the outset was the fear that her son would "get into trouble with the police." With developmental disability the son is receiving vocational training with other individuals with mental or physical disabilities, whom he found threatening. Ping fears that he would succumb to bad influences if she cannot find him a suitable employment. He also does some "volunteer work" in a small grocery store owned by one of the client's friends and is active in a martial arts group. Over the course of several sessions, it gradually became clear to the social worker that the client threatens to withhold affection from her son, leaves the apartment, and stays with her in-laws and her daughter. This is her way of attaining compliance and good behavior from the son. The son, in response, however, becomes more insistent and even violent in an effort to secure his mother's attention.

Another major issue is that Ping is so preoccupied with her care-giving roles that she rarely thinks about her own needs and self care. It is, however, also a reality that she plays a very vital role in her family, which is sustained by the social and cultural presuppositions of her marriage. One of the few areas where the client finds time for herself is in her life of faith. She is a Buddhist and spends several hours in the temple each Sunday, where some kind of small group sharing and support is often available. Client's cultural understanding of "help-seeking" seems to have caused her to look up to the helping professionals as the expert, thereby relinquishing her own initiation and input in the counseling process. Due to the fragmentation of services, the need to respond to so many agencies on behalf of her family is itself a significant stressor for the client, especially with her limited English proficiency.

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Using the *culturagram*, the worker was able to gain a more comprehensive understanding of Ping and her family's situation. First, through exploration of the reason for relocation, it is clear that at the outset the client agreed to enter into a very difficult situation with an arranged marriage with a person with mental illness. Her obligation to stay in the marriage to facilitate her family of origin to migrate to the United States could be a pressure in

addition to the usual migration stress experienced by new immigrants. The worker came to an appreciation of the importance of the cultural value of filial piety to the client and her obligation to her family of origin as well as her family of procreation. He understands and respects the centrality of family in Chinese culture. However, he is able to help the client to strike a balance in taking care of herself and her family by highlighting the fact that if she is not in a state of well-being, she is in no shape to perform her familial roles adequately. In this reframing the worker is starting where the client is, fully accepting her cultural obligation to her family.

Although Ping had migrated to the United States two decades ago, due to her language barrier, her contact and support in the community is very limited. The worker takes note of the client's Buddhist faith and the support she obtained from it spiritually and through social support at the temple. The client was encouraged to maintain regular visits there. Due to the limited social support the client has, the worker also referred her to a support group at the agency for relatives of patients with a mental illness. He also encouraged her to enroll in English as a second language (ESL) classes to increase her mobility in the city beyond the Chinese community. It should be noted that many entitlement agencies, health, mental health, and social services are in extreme shortage of bilingual staff to provide services to minorities with limited or no English proficiency. This is indeed discrimination. Various agencies and organizations are involved with the family, including SSI, medical care, and mental health care for her husband, vocational training and counseling for her son, individual and group counseling for the client, and an Asian community center with adult education programs for the client. The worker had to do a lot of advocacy and case management functions on behalf of the client and her family in order to attain the needed services in place.

In the helping process, the worker also realized the deferential stance that Ping often takes in relating to him. From an empowerment and strengths-based approach he emphasizes the fact that the client knows herself and her family best and thus elicits her input in the counseling process. Conscientious effort was made by the worker to formulate the treatment goals together with Ping throughout. She gradually responded and became more active in the helping process. The client is indeed a very strong and resilient person; her strengths are often reflected back to her by the worker.

As Ping indicated, her family had a lot of resistance in seeking external help for her husband's mental health and health problems. Delayed help-seeking especially for mental health issues is a rather common phenomenon among Asian Americans since problems are expected to be resolved within the family. The reluctance was partly due to the strong stigma attached to mental illness in many Asian cultures. It was fortunate that the client persisted in her effort to seek external help and eventually was hooked up with various services through the help of the worker. The worker compliments the client's willingness to seek help, and assures her that sharing difficulties with the worker ("an outsider") about her family is an active and positive way to help herself and her family instead of a betrayal to her family. Further family psychoeducation about the nature of mental illness and its course would be necessary to help the family to stay in treatment and ameliorate the shame and stigma attached to mental illness.

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It is important to note that within the Chinese culture, the parenting role is given greater importance compared to the spousal role. Thus when Ping chooses to focus her concern on her children instead of her husband, it is important that the worker goes along with it. Also, the extended family is of great importance in the Chinese culture, and given the circumstance, the client does not want to alienate this source of support. The worker suggested to the client some strategic ways to interact with the son so as to reduce the negative vicious cycle of mutual escalation. He also helped the client to ameliorate the frequent conflicts with her in-laws.

In the Chinese culture, work is given very high value. Thus to be able to find some kind of job for Ping's son is important to her and her family. The worker also noted the informal resources the client was able to rally for the son to engage him in productive activities. The volunteer opportunity at the local grocery store and the martial arts group are important resources available in the Chinese community that the son can benefit from.

The proceeding discussion helps to clarify how the *culturagram* can be used not only to assess the family, but also to help plan appropriate interventions. The *culturagram* has been seen as an essential tool in helping social workers work more effectively with families from many different cultures. Use of the *culturagram* enables the practitioner to have a longitudinal understanding of immigrant families. As Drachman (1992) stresses in working with immigrants, it is important to understand not only the current situation of immigrants but also what they experienced in their homelands and in transit. Applying the *culturagram* helps to understand the multiple physical and emotional traumas immigrants may have encountered in their countries of origin, their transit to the United States, and in their current environment and thus plan appropriate interventions.

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TWO

Family and Group Approaches With Culturally Diverse Families: A Dialogue to Increase Collaboration

Elaine P. Congress and Maxine Lynn

Although clinicians usually study family and group work separately, it is helpful to examine how both these methods can be combined in work with culturally diverse families. This chapter focuses on comparing and contrasting assessment and intervention skills in family and group work. Each method can be used effectively with diverse families, especially if the clinician takes into account how the family's culture affects the use of family and group work.

Although there are numerous models for group work, as well as family therapy, there are few articles that integrate group work and family therapy. A review of recent literature indicated that group work has been used with family members of AIDS patients (with divorcing families) (King, 1998), and with the families of children with mood disorders (Fristad, Goldberg, & Gavazzi, 2003). Getz (2002) demonstrates how family therapy techniques can be integrated into group work. There has also been multiple family group work with families of schizophrenia (Mullen, Murray, & Happell, 2002). It is noted that by developing a support network multiple family groups reduce social isolation and overcome the stigma related to mental illness (Gopalan & Franco, 2009). Earlier literature sources took a more theoretical look at how these two models differed and were similar (Garvin, 1986; Hines, 1988; Ritter, West, & Trotzer, 1987).

In the first edition of this book, we raised the question: How close and how disparate are family therapy and group work? A focus on the similarities emphasizes the generic nature of practice, increases understanding of differences, and helps family and group workers learn new skills to enhance their work with clients. For both family and group work, clinicians must be tuned into their own biases and prejudices and be sensitive to cultural differences between themselves and clients. In addition, clinicians must be aware of the immediate social system and environment, as well as the larger community in which the family belongs (Norton, 1978). This chapter will include a case example to illustrate how a group worker and a family therapist approach assessment and treatment for a culturally diverse family. Current

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literature states that there is an increasing immigrant and refugee population (U.S. Census, 2012). Many of these families are traumatized when settling in this country. The process of coping and adaptation is affected by numerous triggers and result in clients having serious emotional challenges. A multicultural perspective needs to integrate a range of helping roles. One needs to include the family and the extended family, as well as a meaningful number of community members. One will use both family and group models to intervene (Chung, Bemak, Ortiz, & Sandoval-Perez, 2008).

Important topics in the beginning stages of family and group work are composition, engagement, and assessment. Discussion about contracting, building norms, and roles lead into the middle phases of treatment, where different interventions of both family and group work are compared. Contrasting termination issues for families and groups in the final stage of treatment are discussed. Conclusion and recommendations based on this dialogue between a group worker and family therapist conclude this chapter.

CASE VIGNETTE

This family was referred for services to a community guardian program because of impending eviction and the single mother was diagnosed with a bipolar disorder. The family includes Gaby, a 45-year-old widow of West African Christian background from Ghana and her five adult children: Mewa, daughter, 24; Nana, daughter, 23; Koby, son, 21; Kio, son, 19; and Osa, daughter, 18. The mother has two siblings living close by. Her parents still live in Ghana.

She came to the United States 16 years ago and the children came six years ago. She completed high school in Ghana and was married for 12 years when her husband died in a car accident. She worked as a home attendant in the United States for 15 years. She has a history of hospitalizations for bipolar disorder.

At the time of the referral she had no income and serious rental arrears, and displayed major psychiatric symptoms since she was not compliant with taking medication. Four of her adult children were at home and three were working but did not contribute to the household. The youngest daughter attends a state college and the youngest son stays at home. The youngest son has a developmental disability and has never completed school or attended any programs for mentally retarded and developmentally disabled children (MRDD).

The children were shocked that they would have to contribute part of the rent or lose the apartment. The oldest daughter, Mewa, has taken some household responsibility but also treats her mother as a child. Gaby was upset that she cannot provide for her children. There are many cultural issues that are challenging to deal with. Although in many African cultures the children feel it is their duty to take care of the parents, Gaby believes that she is responsible for taking care of her adult children. She does admit that the U.S. culture has played a part in the children not being independent and having attitudes of entitlement.

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Besides seeing the family, the social worker has met with members of the church congregation and attended hospital staff and treatment planning meetings while Gaby was hospitalized.

SYSTEMS THEORY

Although the unit of attention is different for family and group work, the most obvious similarity between these two models is that they both rely heavily on systems theory. This suggests that a change in one member's status affects every other member as well as the system as a whole. A family therapist interprets symptoms in one member as meaning the family is experiencing stress and is having difficulty maintaining its previous equilibrium. Each family member is seen as both affecting and being affected by external stress. Behavior is seen as circular, rather than lineal. In terms of the previous case example, a family therapist believes that not only Gaby but every member of the family has been affected by the mother's psychiatric illness, which resulted in not being able to provide for her family.

Both group and family therapists believe that context is important, both historical and in the here and now. A critical difference, however, is that from the very beginning the family therapist can draw on a vast family history, whereas the group worker must create a history in the group. Everyone has had an initial group experience in the family, and Yalom and Leszcz (2005) speak of problems in the initial group experience as the prime motivator for clients to seek group therapy. Both group and family therapists see their respective treatment unit as providing the context for change, and both would examine and use process in the therapeutic sessions to help effect change of individual members. Cultural issues form the fabric of the context and need to be examined within the chosen intervention.

INCLUSION

A beginning issue for both family and group workers is inclusion. With families there is little choice. As a familiar proverb states, "One can choose one's friends, but not one's family." An early family therapist believed that all family members living in the same household should participate in family therapy (Ackerman, 1966). There are difficulties of having all family members participate. In the case example, the children did not want to meet with the social worker and were suspicious of her. They saw their mother as being ill and in need of therapy and the government should be responsible through disability to pay the rent. Some family therapists include extended family living elsewhere (Boszormenyi-Nagy & Spark, 1973). With this approach, a family therapist might want to include Gaby's brothers who lived nearby. Often trauma such as a major illness and loss of income can reawaken old conflicts and lead to divisions. The children may feel the previous abandonment when she left them in Ghana or the previous hospitalizations or that she did not help them adapt to a new culture.

The family may experience further isolation and stigma because they are members of a minority group. Prejudice may aggravate the feelings of trauma and loss they have experienced.

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A most important issue for members of a group is inclusion (Northern & Kurland, 2001). New members are cautious about being hurt (Northern & Kurland 2001). Although there are many African families and community services in the neighborhood where they live, this family remains isolated and Gaby was active in a church congregation a great distance from where she lives.

Gaby has had offers to join groups to help her cope with her mental illness. She was generally reluctant since she does not accept her condition or fully understand the nature of her challenges. Gaby may not be ready for a group and may be cautious of it because of the nonreponsiveness of her family. Yet the group experience can help Gaby with needed advice on negotiating the numerous systems that she has to deal with, confirmation of her feelings, and opportunities to explore issues that she cannot discuss with her family.

Mewa has been taking over the maternal functions in the family. A group could allow her to deal with her frustrations, develop her life away from the family, and not always have to feel so responsible. The other family members could also benefit from social experiences from groups to gain some independence from the family. Only the youngest daughter has been able to break away by attending college upstate. This family faces the stigma of being immigrants and also the stigma of having a member with mental illness and a member with a developmental disability. Groups provide healing through the process of universalization, increasing interpersonal learning (Yalom & Leszcz, 2005).

The power in this family has shifted substantially. Gaby managed the family financially and emotionally. Gaby, overwhelmed by her illness and lack of income, could not assume this role. The children were unable to take on this role and looked for a powerful person to protect them. Group work is a modality that often deals with power and influence and increases a person's individual power.

ENGAGEMENT

Heterogeneity and homogeneity of group composition are often problematic in initial group development. Group therapists know that some heterogeneity encourages growth, but too much leads to scapegoating and early termination (Yalom & Leszcz, 2005). The "Noah's Ark" principle of group composition provides a means of introducing heterogeneity without encouraging scapegoats (Yalom & Leszcz, 2005). Yet in family therapy, there is by definition heterogeneity in terms of age, role, and power. Certainly in families there is often one parent, one child, or one male member. The family appears to be enmeshed in ways that are not always functional and has prevented the members from developing their individuality.

Group experience for the adult children might help them increase social skills and provide opportunities for interaction with role models. In groups, the children can connect with others in a different way than in their family, as there are no demands on them to assume a specific familial role.

In group work, new members have no shared history, and an initial task for the group leader is to facilitate the development of a group culture

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(Shulman, 2009). Groups are based on the democratic value that each member has equal power, and the therapist continually works toward ensuring that each member has an equal opportunity to participate (Brown, 1991). In contrast with groups, families have preexisting power differences, and the therapist may choose either to reinforce these differences or to create other power differentials within the family. In this family discussed previously, Mewa may have been asked to assume responsibilities previous to our involvement. Many youth who have a parent with mental illness have increased responsibilities beyond their chronological age and feel frustrated that they did not have a nurturing family life. They are still looking to be taken care of. Therefore, it might be important for the children to be in a more heterogeneous group. One might question how culturally sensitive it would be to attempt to change the structure of this family, and be concerned that this might have unfavorable consequences.

Engagement of clients is essential in both group work and family therapy. Often it is difficult to engage families if there is an identified patient, as families often believe that therapists should only treat and cure the member who is showing symptoms. This belief may be especially strong among culturally diverse families unfamiliar with the systems perspective in family therapy or the efficacy of therapy in general. Gaby may be denying that she and the whole family are in need of family treatment.

Another reason this family might be difficult to engage is that Gaby may deny problems in her family. Often families rationalize or deny symptoms in children to avoid acknowledgment of problems that could bring shame on the family. This may be an especially important issue for an immigrant family that is trying to survive and fit into a new unfamiliar country. The family may be sensitive to the issue that if a family member has a problem, that person may not be accepted.

There is one son 19 years of age who has a developmental disability and stays in the house. He did not complete high school and is often found in bed. A group could provide a corrective emotional experience (Yalom & Leszcz, 2005).

ASSESSMENT

As part of the assessment process, a family therapist studies the structure of the family, the hierarchical arrangement, the type and degree of connection between people, communication patterns, decision making, and prevailing values and myths. It was very difficult for this family to pursue help since many West African families are reluctant to seek professional help. In fact, we can speculate that if the family were not going to be evicted and separated they never would have agreed to attend treatment. Even now there may be a focus on "fixing" individual family member's problems, such as Gaby's mental illness or the rental arrears, rather than focusing on family systemic issues. No member mentions their father and his death or being left in Ghana for eight years.

Families often have different reactions to loss. The family therapist might also ask what the prior relationships with the extended families were. There

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was the death of their father. They lost their primary caretaker of eight years and relatives in Ghana. Their mother due to her mental illness cannot always be available to them. Groups often provide a recapitulation of the primary family and provide the nurturance that may have been lacking due to the challenges that this family faces.

CONTRACTING

Contracting takes place both in family treatment and group work. Contracting with this family for family treatment may be difficult since they do not see the need for family work or because they feel only one member has a problem.

The contract for group work has to be very clear so that members do not have false expectations. Shared history has sometimes created a reluctance to participate in a group. The members also do not want to be singled out as different.

Building Norms

From the beginning into the middle stage of group treatment, the group worker must struggle to create group norms. To facilitate achieving this, members must develop appropriate norms that include listening to each other, respecting differences, and helping others participate. This can be a challenging prospect when members may be extremely wounded and needy. Group members can benefit a great deal from receiving the support of other group members who have experienced loss and trauma. Group members may develop new norms to help them cope within the group and in their outside lives and learn the elements of mutual aid. Through the group experience a member of this family could transfer skills to help in coping with their current day challenges.

Families, on the other hand, already have very strong norms. In fact, the existent norms of families may make it difficult for the family therapist, as an outsider, to initially connect with the family. With Gaby's family, the family must explore existing norms, especially in terms of relating to strangers, as well as communicating past and present feelings. The family's norms and values in terms of education, work, and raising children must be explored as well. The son who has a disability is kept hidden and taken care of by the family but not given outside opportunities to learn skills. The family expects their mother to provide and take care of all the members and they do not recognize her vulnerabilities. The family therapist may have to build appropriate norms for becoming involved in therapy. The practitioner can teach clients that family therapy can help them with their problems. Families can also be encouraged to develop the norm that makes it appropriate to communicate their feelings openly and honestly in therapy.

CLINICAL ISSUES IN FAMILY THERAPY AND GROUP WORK

The worker's role, especially in terms of transference and countertransference, is particularly significant in family therapy. Often original family constellations are recreated as the therapist is drawn into the family system. Gaby and her adult daughter have a great deal of power in the family, and it is unclear whether this reflects their culture. There are many hopes being

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placed on the youngest daughter who is attending college full time and wants to become a lawyer.

Strong countertransference feelings are often evoked in the family therapist, as all therapists have had their own unique familial experiences and there is the risk of vicarious traumatization for the family therapist. This concept has been defined as the negative effect on the therapist after prolonged work with traumatized clients (Cunningham, 2003). The therapist may have a negative countertransference that Gaby should pull herself together as this is her responsibility. Another countertransference issue is the therapist reaction that the adult children should be taking responsibility for themselves. This response to vicarious traumatization can occur both to family and group therapists (Cunningham, 2003).

In group treatment, the irrational aspects of relationships between the members, and between the members and the leader, influence the group a great deal. Transference underlies distortions and angry feelings that may emerge in group.

TREATMENT MODELS AND TECHNIQUES

While family and group therapists use similar techniques, including support, reframing, confrontation, and interpretation to bring about changes, clinicians should always be aware of a significant difference. Group members often do not see each other between sessions. In fact, social contact in between sessions is usually discouraged in therapy groups (Yalom & Leszcz, 2005). Families who participate in family therapy, however, continue to live with each other. Because of this continued close proximity the family therapist must be careful, especially in the use of confrontation and interpretation, or encouraging family members to use these techniques, with the risk of possible negative consequences between sessions.

Different models have been identified for family therapy and group work. Family intervention models include the psychodynamic, structural, humanistic, communication, strategic, and narrative. The structural and communication models have been noted for their usefulness in work with immigrant families (Ho, 1987). Reframing and symptom reduction are effective treatment techniques frequently used with immigrant groups. A psychodynamic family therapist would focus on making more conscious repressed feelings about severe losses, the therapist might explore with family members ambivalent feelings they might have. There would also be an attempt to connect this loss with previous losses the family had experienced, such as loss of grandparents and leaving their homeland to travel to the United States. A therapist who follows the structural model of family therapy would try to reorganize the family by making it clear that the mother is in charge and the children should listen to her. A therapist would be concerned that since the recent episode of Gaby's mental illness occurred, Gaby has abrogated her role as an authority figure in the family. A family therapist from the humanist school, such as Satir, would work on building up the self-esteem of each family member. A communications family therapist would encourage family members to speak more openly especially in terms of their feelings. He or she might identify certain family members who get stuck in certain roles and whose behavior has become rigid

and solidified. A strategic family therapist might interpret Gaby's illness as an attempt to continually remind the family of the loss they have suffered. He or she might circumscribe the symptom within certain limits or reframe the issue. Using a paradoxical intervention, the family therapist might tell Gaby that she should continue to be depressed as this holds the family together. A narrative family therapist would not come to the family with any set ideas, but rather would allow each family member to tell his or her own story and thus create their own reality. No matter which family treatment model the therapist uses, one must remember that this family is from a culture that may be very different from that of the therapist and this may have a major influence on the course of treatment.

Social group work models presume health. This model becomes useful for this family since they did not feel they had a need for mental health services. The behaviors of this family can be viewed not as symptoms, but rather as ineffective or nonhelpful adaptation to the traumatizing experiences. Joining a group can help individuals change how they see their identity and provide a sense of community (Dass-Brailsford, 2007). This is especially important for immigrant families as they struggle want to appear as normal and fit in. Group membership is effective for vulnerable people who do not feel accepted (i.e., immigrants) by mainstream society (Dass-Brailsford, 2007). Groups can also fill in the losses that this family experienced. The family has experienced the loss of a peer network from their country of origin. The group provides opportunities to share traumatic issues in a safe arena. The social group work model helps members develop new peer networks.

The group modality using a crisis would be helpful to the family because it would help the adult children begin to build independent lives. Children are more vulnerable to stressful events. The children lost their mother for eight years; their father died, they left their grandparents who were raising them in Ghana; their mother is not able at present to be there for them. Groups cushion stressful events, recognize and build on members' strengths, and strengthen coping skills (Shulman, 2009).

Group work includes a remedial model that reflects a treatment orientation and therapeutic aspects. In the model, individual change would be expected and activities would be directed to fostering change. With group treatment, the range of interventions can be psychodynamic, supportive, or psychoeducational.

Gaby would benefit from a group treatment approach for her mental illness and to deal with life changing issues. She could more effectively deal with her symptoms and have her basic needs addressed. The adult children could benefit from group treatment to increase their coping skills in adjusting to changes in the family and in developing independence. They could also benefit from a group of children who have a mother with mental illness in dealing with their frustrations and understanding how to adapt to their mother's behavior.

TERMINATION

This family has had many losses including their father, their support system, and family members left in Ghana, as well as the current lack of nurturance from their mother and family members.

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Termination in group work is very different than termination in family therapy. When a group terminates, members often never see each other again. Group workers, however, must not minimize the group experience and must carefully work through individual and group feelings about termination.

In contrast, when a family terminates treatment, the individual family members will continue to have ongoing contact with each other. Terminating with a family, however, can awaken previous feelings of loss that the family therapist must be prepared to address in the final sessions. Feelings of loss may be especially acute for families from diverse backgrounds who have experienced other recent losses.

CONCLUSIONS AND RECOMMENDATIONS

This chapter describes the similarities and differences of group and family work in the context of practice with an immigrant family who is experiencing the trauma of one family member diagnosed with mental illness, loss of financial stability, and possible eviction from their home. The knowledge of both group and family therapy theory and techniques should enhance the practice skills of group and family workers. A growing dialogue between the two models should help professionals make a decision about whether family therapy, group treatment, or a combination of both would be more effective in working with specific culturally diverse families.

Being attentive to cultural diversity cuts across all modalities. The workers must be aware of their own cultural background and assess how this impacts treatment. The worker must also be sensitive to cultural nuances and be aware of biases and assumptions about the client's culture. Whatever model is selected, the social worker should be able to maintain a family approach within group therapy, as well as a group perspective in working with families. To achieve this goal, the following guidelines have been developed:

- Students in helping professions should be prepared for more integrated practice by the study of group and family models in work with culturally diverse clients and their families.
- Practitioners should explore the possibility of their clients being helped by both family and group work.
- In working with a group, a practitioner should always be cognizant of family dynamics that affect group functioning.
- In working with a family, a family therapist must be mindful that the family is a group and that group processes affect family functioning.
- The dialogue between family therapy and group work should continue.
- Research on the interrelationship and effectiveness of a dual perspective can be conducted.
- Understanding the culture of the client affects the intervention arena and allows for a more integrated approach to helping. Practitioners using both or ether modality should address cultural differences in an open and direct method with their clients.

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- Both family therapists and group members can benefit from an increased range of interactions by using an integrated model in work with culturally diverse clients.
- One needs to take into account the challenges of the current political environment which has increased the discrimination and prejudice toward immigrants and added stressors to the mental health of this population.

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THREE

Evidence-Based Practice With Ethnically Diverse Clients

Manny J. González

Treatment outcome studies in the discipline of social work, psychology, and psychiatry have demonstrated the efficacy and effectiveness of differential psychotherapy approaches in addressing the psychological needs of individuals across the life span (Beutler & Crago, 1991; Hibbs & Jensen, 1996). Throughout the last four decades, scholar-practitioners have engaged in a professional quest to find evidence to support the efficacy of psychotherapy in ameliorating an array of clinical symptoms and levels of distress in identified patient or client populations. La Roche and Christopher (2009) contend that this quest began largely as a response to Eysenck's (1952) review of the treatment outcome literature, from which he concluded that the success rate of psychotherapeutic models of treatment was not greater than spontaneous remission. Eysenck's (1952) review set the stage for systematic therapy outcome studies aimed at demonstrating the efficacy and effectiveness of clinical interventions and selected psychotherapy approaches. Evidence-based practice and the current state of empirically supported psychosocial therapies are a by-product of this quest.

While it is evident that treatment outcome studies and the development of evidence-based psychosocial therapies have contributed to significant improvement in the delivery of clinical and mental health services (see Whaley & Davis, 2007), clinical researchers (e.g., Bernal, Jimenez-Chafey, & Domenech Rodriguez, 2009; Hwang, 2009; Rossello & Bernal, 1999) have raised concerns about the applicability of evidence-based practices to the psychosocial treatment of culturally diverse patient populations. At the root of the concern is the issue of whether evidence-based treatments developed within a particular cultural and linguistic context are appropriate for ethno-cultural patient populations that do not share the same cultural values, mores, and language of the patient or client cohort for whom the treatment was developed. Because culture and specific socioethnographic variables influence the effective delivery of clinical services and the diagnostic and treatment process (see González & González-Ramos, 2005), the noted concern must always be in the forefront of competent psychosocial practice. In addition to this concern, some mental health scholars (Atkinson, Bui, & Mori, 2001; Miranda, Bernal, Lau, Kohn, Hwang, & LaFromboise, 2005) have

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documented the absence of ethnic and racial minority sample groups in studies of evidence-based treatments. The recruitment and retention of ethnically, racially, and linguistically diverse sample populations in psychotherapy research studies is of vital importance for the cultural adaptation of evidence-based practices.

This chapter will present an overview of evidence-based practice with ethnically diverse clients. Predicated on an integrative understanding of evidence-based practice and cultural competency in mental health and clinical care settings, selected conceptual frameworks for the cultural adaptation of evidence-based treatments will be presented. Culturally adapted cognitive-behavioral therapy will also be highlighted as an exemplar of evidence-based treatment for ethnic and racially diverse patient populations.

EVIDENCE-BASED PRACTICE AND CULTURAL COMPETENCE IN MENTAL HEALTH CARE

Evidence-based practice—to a significant extent—is guided by Paul's (1967) seminal practice-informed research questions: "*What* treatment, by *whom,* is most effective for *this* individual, with *that* specific problem, and under *which* set of circumstances?" (p. 111). Consistent with the evidence-based movement in medicine (see Sackett, Strauss, Richardson, Rosenberg, & Haynes, 2000), evidence-based practice in the professional disciplines of social work and psychology has as its major aim the improvement of patient outcomes—across specific psychological and social domains—through the integration of clinical practice with relevant research and patient values. Directed by this aim, the American Psychological Association has defined evidence-based practice in psychology as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 273). This definition—with its emphasis on the clinical expertise of the practitioner in the context of client characteristics, culture, and preferences—resonates well with the value base of the helping professions, including social work. The purpose of evidence-based practice, according to the Task Force, "is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship and intervention" (p. 284). If this purpose is to be implemented by clinical practitioners and systems of care, the individual and cultural characteristics, preferences, and values of ethnically and racially diverse populations must converge with the overall intent of evidence-based practice: improved patient outcomes and effective delivery of psychosocial treatment. The convergence will be facilitated by understanding the need for cultural competence in the provision of mental health and clinical services.

The need for cultural competence in the provision of psychosocial services is justified by two important factors: (a) the increasing cultural diversity and multicultural population within the United States and (b) the well documented ethnic, racial, and linguistic disparities in the utilization of mental health services (Bernal & Scharron-del-Rio, 2001). From a clinical

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and organizational perspective, Sue and Torino (2005) define cultural competence in the following manner:

> Cultural competence is the ability to engage in action or create conditions that maximize the optimal development of the client and client systems. Multicultural counseling competence is achieved by the counselor's acquisitions of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds) and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all people. (p. 8)

Culture, the major variable in culturally competent practice, is a complex and multidimensional construct that directly influences the process of psychotherapy and the understanding of the human condition. It has not always received, however, adequate attention as a construct that is of paramount importance in the development of culturally sensitive psychotherapy and culturally competent mental health services (Guarnaccia & Rodriguez, 1996; La Roche & Christopher, 2009). Evidence-based practice with ethnic minorities or ethnically and racially diverse clients must be guided by the recognition that culture is a phenomenon that impacts the bio-psycho-social functioning of the human organism across time and space. In acknowledgment of the role that culture plays in the development and implementation of evidence-informed psychosocial interventions, the American Psychological Association Presidential Task Force on Evidence-Based Practice (2006) has articulated the following definition of this construct:

> Culture . . . is understood to encompass a broad array of phenomena (e.g., shared values, history, knowledge, rituals, and customs) that often results in a shared sense of identity. Racial and ethnic groups may have shared a culture, but those personal characteristics are not the only characteristics that define cultural groups (e.g., deaf culture, inner-city culture). Culture is a multifaceted construct, and cultural factors cannot be understood in isolation from social class, and personal characteristics that make each patient unique. (p. 278)

The integration of evidence-based practice and cultural competence can lead to the implementation of culturally sensitive psychotherapy in clinical settings. Drawing on the work of Hall (2001) on psychotherapy research with ethnic minorities, La Roche and Christopher (2009) note that: "Cultural sensitive psychotherapy is the tailoring of psychotherapy to specific cultural groups, so that persons from one group may benefit more from a specific type of intervention than from interventions designed for another cultural group" (p. 398). Culturally sensitive psychotherapy is composed of three interrelated domains. The first domain is composed of carefully defined ethnic, racial, and

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cultural factors that are unique to a specific patient population. The second domain encompasses the constellations of characteristics that are unique or more prominent in certain cultural groups relative to others. The last domain includes culturally sensitive clinical interventions that are targeted to address the needs of an identified culturally diverse patient group. Evidence-based practices that are adapted or created to meet the mental health or psychosocial needs of ethnically diverse should include these noted domains.

CONCEPTUAL FRAMEWORKS FOR THE CULTURAL ADAPTATION OF EVIDENCE-BASED TREATMENTS

Integrating cultural competent practice with evidence-informed psychosocial therapies is a complex task. The integration, however, is not impossible—and it may serve to provide a systematic approach to treatment that takes into account the sociocultural and socioeconomic context of ethnically diverse patients. Bernal et al. (2009) argue that the integration can be achieved through the use of cultural adaptation procedures. They define cultural adaptation as "the systematic modification of an evidence-based treatment . . . or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (p. 362). Cultural adaptation serves as a unifying bridge between scientist-practitioners who state that the psychosocial problems of ethnically diverse patients should primarily be treated with new treatment approaches (see Comas-Díaz, 2006) and those scholars (see Elliot & Mihalic, 2004) who believe that existing psychosocial treatments should be tested, unchanged, with culturally diverse populations before embarking on any type of adaptation task.

A number of conceptual frameworks (e.g., Bernal, Bonilla, & Bellido, 1995; Hwang, 2006, 2009) have been developed with the intent of facilitating the integration of cultural competence and evidence-based treatments, thereby making psychotherapy or psychosocial treatment culturally malleable for patient populations of diverse ethnic, racial, and linguistic backgrounds. Rogler, Malgady, & Rodriguez's (1989) framework for culturally competent mental health research provides the seminal domains on which current cultural adaptation psychotherapy frameworks rest. Rogler et al. (1989) recommended improving cultural understanding in mental health research, practice, and treatment innovation along five domains: (a) cultural factors in the emergence of a clinical/mental health presenting problem, (b) help seeking and service utilization, (c) factors that may affect an accurate diagnosis, (d) therapeutic and treatment issues, and (e) posttreatment adjustment of the patient. Hwang (2006) notes that this seminal framework is important—in providing effective treatment to ethnic minorities—because "it underscores the temporal sequence of problem development in relation to service delivery and highlights areas where culture is likely to play a role" (p. 703).

Ecological Validity and Culturally Sensitive Framework

Developed by Bernal, Bonilla, and Bellido (1995), the Ecological Validity and Cultural Sensitivity framework is predicated on the proposition that in the

provision of culturally competent and evidence-based treatment, it is necessary to increase the congruence between the experience of the client's ethnocultural world and the properties of a particular psychotherapy as assumed by the therapist. The framework focuses on eight culturally sensitive elements: language (whether it is appropriate and culturally syntonic), person (role of ethnic similarities and differences between client and therapist in shaping therapy relationships), metaphors (symbols and concepts), content (cultural knowledge of the therapist), concepts (treatment concepts consistent with culture and context), goals (support of positive and adaptive cultural values), methods (cultural enhancement of treatment methods), and context (consideration of economic and social context that might increase the risk of acculturative stress problems, disconnection for social support systems and reduction of social mobility for specific ethnocultural diverse client populations). Rosselló and Bernal (1999) were able to successfully use this framework to culturally adapt cognitive-behavioral and interpersonal treatments for depressed Puerto Rican adolescents, and these adapted treatments have been shown to be efficacious in clinical trials. Similarly, the framework has been used to culturally adapt cognitive-behavioral group treatment for Haitian American adolescents (see Nicolas, Arntz, Hirsch, & Schmiedigen, 2009).

Psychotherapy Adaptation and Modification Framework

Hwang (2006) created the Psychotherapy Adaptation and Modification Framework (PAMF) to help guide therapeutic adaptations of empirically supported treatments. A major conceptual underpinning of Psychotherapy Adaptation and Modification Framework (PAMF) is that culture affects different mental health domains including: (a) the prevalence of mental illness, (b) etiology of disease, (c) phenomenology of distress, (d) diagnostic and assessment issues, (e) coping styles and help-seeking pathways, and (f) treatment and intervention. The framework incorporates six therapeutic domains and 25 therapeutic principles (see Hwang [2006] for a complete review of the therapeutic principles). The six therapeutic domains of the framework are: (a) dynamic issues and cultural complexities, (b) orientating clients to psychotherapy and increasing mental health awareness, (c) understanding cultural beliefs about mental illness, its causes, and what constitutes appropriate treatment, (d) improving the client–therapist relationship, (e) understanding cultural differences in the expression and communication of distress, and (f) addressing cultural issues specific to the patient population. Examples of the 25 therapeutic principles include: orienting clients to a bio-psycho-social or holistic model of disease development, focusing on psychoeducational aspects of treatment, finding ways to integrate extant cultural strengths and healing practices into the client's treatment, and aligning with traditional and indigenous forms of healing. While PAMF was created to meet the mental health needs of recently arrived Asian American immigrants, it may be used to adapt evidence-based practices for many diverse ethnocultural groups. In fact, in one treatment outcome study, PAMF has been use to adapt cognitive-behavioral therapy for Mexican American students who suffer from anxiety disorders (Wood, Chiu, Hwang, Jacobs, & Ifekwunigwe,

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2008). The framework may also be used to improve the clinical training of practitioners across the helping professional disciplines.

Formative Method for Adapting Psychotherapy

As a by-product of the Psychotherapy Adaptation and Modification Framework, Hwang (2009) also developed the Formative Method for Adapting Psychotherapy Framework (FMAP). FMAP is a community-based bottom-up approach for culturally adapting psychotherapy. According to Hwang (2009), FMAP "was developed to be used in conjunction with the top-down PAMF . . . to generate ideas for therapy adaptation, provide additional support for theoretically identified modifications, and help flesh out and provide more specific and refined recommendations for increasing therapeutic responsiveness" (p. 370). Consistent with the principles of practice-based evidence (see Fox, 2003), the FMAP approach consists of five phases: (a) generating knowledge and collaborating with stakeholders, (b) integrating generated information with theory and empirical and clinical knowledge, (c) reviewing the initial culturally adapted clinical intervention, (d) testing the culturally adapted intervention, and (e) finalizing the culturally adapted intervention. This framework has been used to create a manualized treatment for depressed Chinese Americans.

CULTURALLY ADAPTED COGNITIVE-BEHAVIORAL THERAPY

Cognitive-behavioral therapy (CBT) is based on the premise that thoughts, actions, and feelings are closely related (see Beck, Rush, Shaw, & Emery, 1979). CBT is an evidence-based, short-term therapy approach for the treatment of depression, anxiety, and other related mental health and psychosocial disorders. To treat depressive feelings, this treatment approach attempts to identify those thoughts and actions that influence these feelings. In the treatment of depression, the primary aims of CBT are: to diminish depressive feelings, shorten the time the identified client feels depressed, teach alternative ways of preventing depression, and increase the person's sense of self-control over his or her life. Treatment is directed at assisting the identified client to understand how thoughts influence mood, how daily activities influence mood, and how interactions with other people influence mood as well.

Recent reviews of the literature (see Miranda et al., 2005; Voss Horrell, 2008) on the impact of evidence-based mental health care on ethnic minorities provide support for the effectiveness of CBT for African American, Hispanic, and Asian American patients suffering from anxiety and depressive disorders. Culturally adapted CBT approaches are also effective in reducing symptoms of distress among ethnocultural patient populations. Wood et al. (2008), for example, documented via a detailed case study how cultural modification of CBT can lead to positive outcomes for Mexican American students who suffer from anxiety disorders. In their study, Wood et al. (2008), integrated the following cultural competence principles in their adaptation of CBT: (a) spend time learning about the client's cultural practices, acculturative status, migration history, language proficiencies and preferences, and

other relevant background history; (b) respect the clients' and their family's conceptualization of mental illness and its treatment to increase acceptance of CBT techniques; (c) establish CBT goals that are valued by the client and family to improve the working relationship; (d) actively collaborate with school staff to alleviate parental apprehension; (e) provide an orienting session early on to increase family understanding and participation; (f) learn about the cultural context of parenting to facilitate engagement in CBT; (g) engage the extended family in the child's CBT treatment; (h) align CBT techniques with family cultural beliefs and traditions to enhance commitment to treatment; (i) consider whether culturally based conversational norms are masking poor adherence to treatment; and (j) remain attuned to the role of acculturation gaps in children's adjustment problems, but consult with cultural experts before addressing this topic with families. The integration of these principles with an evidence-based model of treatment increased the probability of a positive treatment outcome for an ethnically diverse client group that underutilizes mental health services and is more likely to drop out of treatment prematurely.

In a pilot study of a 12-session culturally adapted cognitive-behavior therapy for Hispanics with major depression, Interian, Allen, Gara, and Escobar (2008) reported a 57% mean reduction of depressive symptoms, at posttreatment, among patients who completed the intervention. Cultural adaptation that were made the treatment protocol included: (a) the use of an ethnocultural assessment, which involved inquiring about the patients' number of years in the United States, their adaptation to the migration, whereabouts of family members and changes in social support; (b) providing the treatment in Spanish including the phraseology commonly used by Hispanics to describe therapeutic phenomena; and (c) allowance for the centrality of the family in treatment. Based on the findings of the study, Interian et al. (2008) note that cultural adaptations to existing treatments may be clinically beneficial, and they recommend that clinicians complement CBT with an ethnocultural assessment.

Similar to the study by Interian and colleagues (2008), Kohn, Oden, Munoz, Robinson, and Leavitt (2002) adapted a manualized, 16-week cognitive-behavioral group therapy intervention for depressed, low-income, African American women. Adaptation of the CBT group intervention took place along two domains: structural and didactic. Adaptations at the structural level included: (a) limiting the group to African American women, (b) keeping the group closed to facilitate cohesion, (c) adding experiential meditative exercises during treatment and a termination ritual at the end of the 16-week intervention, and (d) changes in some of the language used to describe CBT techniques. For instance, rather than using the term homework the group participants preferred the term "therapeutic exercises." At the didactic level four culturally specific sections of content were added to the therapy modules: (a) creating health relationships, (b) spirituality, (c) African American family issues, and (d) African American female identity. At termination of the intervention, women in the group exhibited a significant decrease in their depressive symptoms as measured by the Beck Depression Inventory (BDI).

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The cited studies provide a level of evidence for the effectiveness of culturally adapted cognitive-behavioral therapy in reducing symptoms of depression and anxiety in some ethnocultural patient populations. While the noted studies are primarily applicable to Hispanic and African American patients, some published case studies would seem to suggest that culturally adapted CBT may be the treatment of choice for other ethnically diverse populations such as Japanese clients (see Toyokawa & Nedate, 1996) and Orthodox Jews (see Paradis, Friedman, Hatch & Ackerman, 1996). As a treatment model, culturally adapted CBT is illustrative of a treatment approach that is informed by both research evidence and cultural competence. The model also demonstrates the type of integrative and complementary relationship that can exist between empirically supported therapies and the reality of culture.

CONCLUSION

The integration of science with the phenomenon of culture and social context are equally important in the development, testing, and implementation of evidence-based practices. If this integration is overlooked in clinical research and in the delivery of clinical services, clients from diverse ethnic, racial, and linguistic backgrounds may be placed at risk for receiving psychosocial care that is not adequate or appropriate. Cultural adaptation frameworks must be employed to evaluate the appropriateness of evidence-based models of psychosocial treatment. The psychotherapy adaptation frameworks highlighted in this chapter serve to bridge the gap between evidence-based therapies and cultural competence. As demonstrated by the cited studies on the effectiveness of culturally adapted cognitive-behavioral therapy, the literature on evidence-based treatment with ethnocultural patients is increasing and points to positive treatment outcomes. The positive treatment outcomes with culturally adapted evidence-based therapies are welcome in an era where there is growing recognition that mental health services must mirror the diverse and changing demographic profile of the nation. Cultural competence and evidence-based practice are two critical issues that will continue to shape clinical services in the near future. This chapter has addressed both issues and the need for their integration.

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FOUR

Managing Agencies for Multicultural Services

Manoj Pardasani and Lauri Goldkind

THE CHANGING DEMOGRAPHICS OF THE NATION AND THE SOCIAL WORK PRACTICE FIELD

The nation's human services agencies mirror the cultural diversity of the U.S. population today. Multicultural workforces and clients are no longer atypical. Demographics indicate that by the mid-21st century, about 50% of Americans will be racial and ethnic minorities. Latinos are the largest minority ethnic group, while Asians have the highest rate of growth among racial/ethnic groups (U.S. Census, 2011). Between 2000 and 2010, the Hispanic population grew by 43%, rising from 35.3 million in 2000, when this group made up 13% of the total population. If current demographic trends continue, the people of Hispanic or Latino origin's population is projected to steadily increase as a percentage of the total U.S. population through 2050, increasing from 12.6% in 2000 (or about one in seven persons) to 30.2% in 2050 (approaching one in every three persons) (Shrestha & Heisler, 2011). The Asian population increased by 43% between 2000 and 2010 to 4.8 million while the African American population increased only slightly and now comprise 12.6% of the total U.S. population (U.S. Census, 2010). Immigrants and refugees are also changing the demographic composition of America as individuals and families from a wide variety of cultures, ethnicities, and nationalities relocate throughout the states in search of better opportunities and conditions. Currently, the U.S. Census Bureau estimates that there are nearly 39 million documented immigrants living in the United States and projects that another 70 million foreign-born individuals will immigrate to the country by 2050 (American Community Survey, 2010). What was once regarded as an urban phenomenon can now be seen across the country in towns and rural communities. Moreover, the trend toward a more diverse population and workforce is expected to continue.

Social service agencies continue to face two challenges in this multicultural environment: (a) managing workplaces in which workforces have become increasingly heterogeneous in terms of gender, race, age, religion, sexual orientation, ethnicity, and national origin; and (b) meeting the service needs of client populations who may represent a wide range of very different cultures, languages, values, religions, and preimmigration or refugee experiences.

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While there is wide agreement with regard to changing U.S. demographics, less is understood about how to successfully create organizational cultures that embrace diversity and serve multicultural populations well.

THE CHANGING U.S. WORKFORCE

The U.S. workforce (aged 25 to 64 years) is in the midst of a sweeping demographic transformation. From 1980 to 2020, the Caucasian working-age population is projected to decline from 82% to 63%. During the same period, the minority portion of the workforce is projected to double from 18% to 37%, and the Latino portion is projected to almost triple from 6% to 17% (National Center for Public Policy and Higher Education, 2005). The U.S. Department of Labor reports that nearly one-third of all individuals working in social work, social service, or community practice are non-Caucasian (2011). In contrast, a national survey of licensed social workers conducted by the National Association of Social Workers (NASW) found that the profession was disproportionately female (81%) and Caucasian (86%). They reported that Asian, Latino, and African American social workers comprised only 14% of the professional workforce, however, they predicted that this cohort would increase significantly in the next few decades (NASW Center for Workforce Studies, 2006). There is inadequate information on the proportion of lesbian, gay, bisexual, and transgender (LGBT) individuals and religious backgrounds within social work at this time. Nonetheless, it is easy to see why diversity and multiculturalism in the workplace is a critical issue.

WHO ARE THE LEADERS IN HUMAN SERVICES?

While all indicators overwhelmingly point to growing multicultural and multiracial population trends, human services organizational leadership at the senior executive and board levels remain overwhelmingly Caucasian and male. Many nonprofit boards are cut off from the public they serve by an ethnically homogenous membership and a failure to engage in externally oriented activities. Eighteen percent of nonprofits whose clientele is more than 50% percent black have no African American/Black trustees, while 32% of their Latino counterparts have no Latino board members. On average 86% of board members are Caucasian, 7% are African American, 3.5% are Latino, and the balance are from other ethnic groups (Ostrowerer, 2007).

Little is known about the demographic characteristics of social work agency leadership best practice in multicultural management suggests that leadership mirror the racial/ethnic distribution of social work staff, and that staff represent some reflection of a similar demographic as clients. Yet, the leadership of social work and social service agencies continues to be overwhelmingly Caucasian. Male leaders of such agencies are in higher proportion than their overall proportion of the professional social work workforce. A survey of nearly 200 social service agencies in the tri-state area (New York, New Jersey, and Southern Connecticut) conducted by the authors found that nearly 78% of the leaders identified as Caucasian, while only 2.4% identified

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as Latino and 7.1% as African American, which is not reflective of the racial/ethnic compositions of these communities. One-third of the leaders surveyed (34%) identified as male (Goldkind and Pardasani, 2010).

But social work agencies are not limited to just social work professionals. Most human service organizations now function in an interdisciplinary format, whereby individuals from different professional backgrounds are required to work in teams. Thus, organizations and agencies are even more challenged today to accommodate a varied workforce while simultaneously tending to the needs of a diverse clientele.

DEFINING CULTURAL COMPETENCE AND MULTICULTURALISM

Multiculturalism is defined as "a general rejection of the straight-line assimilation norm, the promotion of equality for racial and ethnic groups, respect for, tolerance of, and celebration of cultural diversity, the facilitation of cultural difference, and an assertion of rights and protections for particular racial and ethnic groups" (Bass, 2008). But the social work profession does not just celebrate diversity and difference. The profession strives to engage cultural norms and beliefs into the conceptualization of human suffering and utilize them to inform individual and societal transformation. In fact, the NASW Code of Ethics directs social workers to obtain education and seek to understand the nature of social diversity as well as uphold social justice standards and actively fight against oppressive forces.

Culture is an essential component in the helping process because it is embedded in how problems are defined and manifested, how individuals seeking help, and how help providers conceive of and offer treatment options (Pinderhughes, 1989). Cultural competence is ethical and legal social work practice. Cultural competence is a set of behaviors, attitudes, and policies that enable social work agencies and professionals to effectively serve individuals by incorporating the values and belief systems of those being served. Cultural competence is a process whereby individuals are challenged to recognize their internal biases and how they distort their own worldview. Cultural competence may also be built into our agencies organizational cultures to create welcoming climates and work environments for employees as well as clients.

Individuals and organizations may be at various levels of awareness, knowledge, and skills along the cultural competence continuum and this may impact their effectiveness (Cross, Bazron, Dennis, & Isaacs, 1989). A culturally competent practitioner or agency develops a deep respect for other cultures, is willing to learn about other cultures, is ready to engage people's different world views, is willing to use appropriate engagement skills, and tailor and adapt interventions for culturally diverse individuals and groups (Cross et al., 1989).

MULTICULTURAL CHALLENGES IN THE WORKPLACE

There are two main challenges faced by leaders and managers in social work agencies discussed here.

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Culturally Competent Service Delivery

The need for culturally competent service delivery has been recognized by several researchers and service providers (Furman, Negi, Iwamoto, Rowan, Shukraft, & Gragg, 2009; Ramos-Sanchez, 2009; Switzer, Scholle, Johnson, & Kelleher, 1998; Taylor, Garcia, & Kingson, 2001). Studies have found that African American and Latino consumers are most likely to not have access to, and limited knowledge of, available resources (Martin & Bonder, 2003; Ramos-Sanchez, 2009; Furman et al., 2009). The most common barriers reported by minority consumers to receiving services are provider insensitivity, minority consumer distrust of providers who may be from different socioeconomic and ethnic backgrounds, reluctance of providers to incorporate a consumer's spiritual and religious beliefs into care, lack of outreach by providers, and communication barriers (Hodge & Bushfield, 2006; Martin & Bonder, 2003; William, 2006; Yan & Wong, 2005). Bandyopdhyay and Pardasani (2011) found that consumers of interdisciplinary community health centers highlighted cultural sensitivity on part of staff, an understanding of the unique needs of different genders, recognition of the importance of religion and spirituality in treatment plans, and culturally appropriate communication (translators, bilingual reading materials, etc.) were critical tools to serving diverse consumers effectively.

In addition to issues of race/ethnicity, greater attention is being paid to sexual identity and sexual orientation in social work practice. Davies (1996) highlighted culturally competent practice as one that "affirms a lesbian, gay, or bisexual identity as an equally positive human experience and expression to heterosexual identity" (p. 25). Affirmative practitioners celebrate, advocate, and validate the identities of LGBT individuals (Crisp and McCave, 2007; Tozer & McClanahan, 1999). Frequently though, the issues of gender identity are lost in the maze of discussion about gay and lesbian clients. Markman (2011) and Vanderburgh (2008) have highlighted the critical need to prepare social workers to conduct outreach, comprehensively assess needs, and develop interventions specifically tailored for transgendered clients.

There is a growing emphasis on assessing and incorporating the spirituality or religious beliefs into practice with consumers. Hodge (2006) coined the term "spiritual interventions," which called for the incorporation of a religious/spiritual component as a central dimension of treatment if it was important to the clients. Gilligan and Furness (2005) posit that social workers need to respond appropriately to the needs of service users for whom religious and spiritual beliefs are crucial. They argue that culturally competent practice depends on an understanding of the impact of faith and belief on an individual's decisions in life (Gilligan & Furness, 2005).

Finally, in a country historically built on immigration, the needs and concerns of immigrants and refugees within the purview of social service are also of paramount concern. Understanding the complex process of migration is necessary as it has been shown to impact individual experiences and challenges (Foster, 2001; Furman et al., 2009; Shier, Engstron, & Graham, 2011). The nature of migration with respect to choice (voluntary vs. involuntary), past trauma, separation from family, pressure of assimilation, and adaptation

to an alien culture, legal status of residency, and exploitation influence help-seeking decisions made by refugee and immigrant consumers.

Culturally Competent Leadership and Human Resources Management

As mentioned earlier, social work managers are increasingly challenged with creating an inclusive organizational culture by welcoming and promoting diversity in their organizations (Findler, Wind, & Mor Barak, 2005; Cox, 2001; Miller & Katz, 2002). Social work agencies are increasingly multidisciplinary and leaders need to manage a diverse workforce with respect to gender, race/ethnicity, age, national origin, sexual orientation and sexual identity, religious affiliation, and social class, as well as educational backgrounds.

Reviews of existing diversity research suggest that demographic differences can have both positive and negative effects on how organizational members interact and perform (O'Leary & Weathington, 2006). A diverse workforce (in terms of race/ethnicity, education, and work experience) has been found to be positively associated with creative problem solving (McLeod & Lobel, 1992; Watson, Kumar, & Michaelsen, 1993), innovative practice techniques (Bantel & Jackson, 1989), cooperation between staff (Cox, Lobel, & McLeod, 1991), and a readiness to consider diverse perspectives and values (O'Reilly, Williams, & Barsade, 1997). Acquavita, Pitman, Gibbons, and Castellanos-Brown (2009) conducted a national survey of social workers and found that organizational diversity actually increased social workers' job satisfaction.

However, simply having a diverse workforce in itself does not guarantee greater productivity or job satisfaction. In fact, diverse workplaces have also been linked to greater interpersonal conflict, lack of team cohesion, poor communication, and lowered job satisfaction (O'Leary & Weathington, 2006). In order to utilize the diversity inherent in the workforce to create a healthy environment and effectively serve clients, social work managers and leaders need to pay attention to their own role in cultivating a culturally competent workplace. In other words, organizational culture needs to embrace and commit to promoting cultural competence. Findler, Wind, and Mor Barak (2007) reported "organizational-culture variables such as fairness, inclusion, and social support to employee outcomes of well-being, job satisfaction, and organizational commitment" (p. 64). Mamman (1996) also identified factors such as situational factors (attitudes toward others from different backgrounds, exposure to diverse groups, organizational culture, and management attitudes toward diversity), and interaction strategies employed by staff in dealing with differences (avoidance vs. action) as mediating the experiences of an individual working in a diverse workplace. Mamman (1996) posited that while an individual's cultural background cannot be changed, factors identified as mediating variables could be addressed by the management of an organization to enhance worker motivation and teamwork while serving diverse consumers more competently. Acquavita et al. (2009) also reported that supervisory support of employees and perception of inclusion/exclusion in the workplace played a significant role in workers' satisfaction on the job and their motivation to do good work.

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Strategies for Developing Cultural Competence

Edewor and Aluko (2007) identified several steps to creating a multicultural workplace—managing by example, explicit policies regarding diversity, training programs, awareness, and acknowledgment of differences, actively seeking input from minority groups, rewarding culturally competent behavior, increasing opportunities for socialization among staff, flexible work environment, and consistent monitoring of staff interactions and performance. In this section, we will identify strategies to develop and/or enhance cultural competence within organizations on two levels:

1. Service delivery
2. Leadership within organizations and human resources management

In order to create a culturally competent and inclusive organization, leaders (board members and managers) need to engage in some soul-searching with regard to their motives for transforming the workplace. This introspection is important as it will determine the plan of action undertaken by the leadership. Ely and Thomas (2001) identified three perspectives that inform the actions of organizational leaders: discrimination-and-fairness, integration-and-learning, and access-and-legitimacy. "The discrimination-and-fairness perspective suggests that cultural diversity is essentially a moral imperative that should be implemented because of its inherent virtue, and not be tied to financial outcomes. The integration-and-learning perspective proposes that the diversity of ideas arising from diverse backgrounds and experiences can benefit the organization in a variety of ways. Finally, the access-and-legitimacy perspective espouses the benefits of matching the organization's cultural diversity to that of its surrounding area or customer base" (as cited in O'Leary & Weathington, 2006, p. 6). The authors of this chapter believe all three perspectives need to be incorporated into any process of change, as they underscore the basic professional values and mission of social work.

Once the organizational motives have been clearly espoused, leaders need to conduct a comprehensive assessment of services, personnel, board of directors, and their consumer base. This involves several steps: (a) collecting demographic information about managers, board members, staff, and clients; (b) developing a profile of the community in which the organization is located; (c) assessing whether the current service model meets the needs of diverse consumers and other members of the community; (d) evaluating staff morale and cohesiveness; (e) assessing the level of awareness, knowledge, and skills of staff with respect to working with diverse groups; (f) reviewing organizational mission and policies regarding diversity in the workplace; and (g) collecting a historical perspective on how the organization has dealt with diversity. Once this assessment has been completed and reviewed by the management, board of directors, and staff members, the organization can begin the process of transformation and growth.

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(i) Ensuring culturally competent service delivery

In order to ensure that the services and programs offered by an organization are meeting the needs of diverse consumers, the following steps are critical:

a. *Hiring staff that reflects the demographic profile of consumers and/or community*. The staff profile needs to reflect the diversity of their consumer base to the greatest extent possible. Consumers from minority groups, especially those who belong to disenfranchised, oppressed, or discriminated groups, may be wary of staff members who have difficulty in "connecting" with them. Trust is an essential component of building worker–client therapeutic rapport and this can be enhanced by recruiting personnel from the clients' respective groups. We are not advocating for matching every client with staff that has the same demographic characteristics. We believe that the presence of competent staff from diverse backgrounds could enhance outreach and relationships between the agency and consumers. It is also important to ensure that staff members speak the languages most prevalent in the community in which the agency operates. If bilingual staff is not available, efforts should be made to offer translation services through interns, community peers, or volunteers. Agency forms could also be translated into a format that encourages accurate and comprehensive information sharing. Informational materials such as flyers and brochures need to linguistically appropriate, but more importantly, the picture needs to reflect the consumers who are being served.
b. *Training for staff and managers*. Becoming a culturally competent professional requires developing self-awareness and enhancing one's practice knowledge and skills. In this regard, training for staff is critical. Training would challenge staff and managers to confront their own biases, prejudices, long-held stereotypes, and values. Being able to verbalize and understand one's own beliefs about others is necessary in order to unlearn what is not helpful and integrate new information and ideas. The second goal of training would be to enhance one's awareness and knowledge of diverse client populations and develop critical skills for effective practice. This requires dialogue between staff members themselves, dialogue between staff and current consumers, and dialogue with community leaders and representatives of the groups being served. Agencies can invite community leaders, professional trainers, and experts who can inform and educate the staff. One issue to keep in mind is that training needs to be consistent. Very often, agencies will offer training in response to a crisis or serious complaint, and then there is no follow-up. Since developing cultural competence is a long-term process, trainings need to be offered strategically and consistently. In other words, these trainings must become part of the organizational culture and be a crucial component of the job responsibilities of staff, managers, and even board members.

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c. *Including evidence-based interventions.* There is an increasing awareness and incorporation of evidence-based interventions in social work agencies. There is also a significant body of research on effective interventions with diverse groups. It would behoove agencies to investigate these documented practices and service models, and adapt them to suit the specific needs of their consumer base. These models can provide ideas for effective recruitment, engagement, assessment, and practice with members of historically underserved, oppressed, or stigmatized populations.
d. *Setting up a consumer advisory group.* Client empowerment is a critical goal of social work, and allowing consumers to collaborate in their treatment is an important strategy to realize that mission. A consumer advisory group that is reflective of client diversity would be an effective tool to building trust between management, staff, and consumers. An advisory group could also serve as a vehicle to test out new program ideas, assess current perceptions of staff competence, identify unmet needs, and evaluate consumer satisfaction with services. The group could provide ideas and guidance to the agency to enhance their services and provide maximum benefit to the community. Management would have to be cognizant of the fact that group members may feel vulnerable to backlash or be treated in a patronizing manner. All efforts must be made to protect the advisory group members from staff persecution, and any ideas generated by the group must be given full and serious consideration. Otherwise, the advisory group will be viewed as "spokespersons" for management and will lack the support of their fellow consumers.
e. *Cultivating community leaders and peer mentors.* Developing partnerships and linkages within a community is important if an agency wishes to thrive. Partnerships with other community organizations need to be strategic and coordinated in order to increase access to new clients, enhance services for current clients (through referrals to partners), and building goodwill in the community. Similarly, cultivating leaders of minority groups or peers from underserved groups would assist the agency in reaching out to a wider cross-section of consumers. These members of the community can act as gatekeepers for referrals, help reduce community suspicions and/or opposition, and provide valuable guidance for effective service.
f. *Recruitment and outreach of underserved and vulnerable groups.* As discussed earlier, some members of a community may be resistant to seeking help from agencies due to a lack of trust or knowledge of an agency's services. Additionally, societal stigmatization of their identity, status, or problems may lead to avoidance of assistance. Developing specialized outreach efforts that speak to members of underserved groups would be essential. The agency can use their staff, community partners, and peer mentors to build inroads into the community. Incorporation of evidence-based engagement techniques with diverse populations could be helpful and effective. Recruitment materials (posters, advertisements, presentations at various sites, etc.) should be designed to keep the linguistic abilities, demographic characteristics (race/ethnicity, sexual orientation, sexual identity, religious affiliation, health status, etc.), and needs of the people being reached.

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(ii) Ensuring culturally competent leadership and human resources management

In order to develop and maintain a workforce that is culturally competent, the following steps are critical:

a. *Recruitment of a diverse board of directors*. The board of a nonprofit organization like a social work agency should be comprised of volunteers from diverse backgrounds. However, board members do not always reflect the diversity of the consumers served. This directly impacts the motivation and ability of an organization to engage in the exhaustive process of developing cultural competence. Board members from diverse backgrounds could provide guidance on, and raise awareness of, cultural differences. They could assist the management in making inroads into underserved communities and help build agency credibility.
b. *Ensuring concise and specific written policies*. All organizations have a policy and procedures manual. Usually, organizations have clearly spelled out policies regarding promotion of diversity in human resources and prevention of discrimination in the workforce. These written policies are strongly influenced by the various human resource laws that exist and which social work agencies need to be in compliance with. Clearly written policies can be effective in preventing racial, ethnic, and sexual harassment from taking root and creating hostile work environments. The reputation and public image of agencies can easily be tarnished, while worker morale is damaged, because of racially motivated remarks, ethnic slurs, and subtle forms of intimidation that fall within the definition of sexual harassment. Agencies need to develop policies (and monitor compliance) that acknowledge the dignity of each worker and right to work in an environment free of undue personal harassment, stress, and interpersonal friction. These policies should specifically forbid all forms of harassment and discriminatory behavior, and spell out the penalties, including dismissal or personal legal and financial liability. A policy manual should also provide guidance to employees to report incidents of abuse or harassment and assure them of protection for doing so.
c. *Providing training for staff, managers, and board members*. This type of training is different from the one proposed earlier to enhance the cultural competence of service delivery. This training would specifically center around providing information on what constitutes a culturally competent organization, existing laws, and agency policies regarding discrimination and harassment and options available to employees for reporting such incidents. The trainings would also engage managers and staff in confronting their own biases and stereotypes about each other in a safe environment while learning effective means of legal and ethical communication. It would also be helpful if staff and managers can learn techniques of conflict resolution and team building in order to increase group cohesion.
d. *Providing mentoring for staff members*. Frequently staff members belonging to minority groups feel estranged from their colleagues or excluded from strategic alliances. It is very difficult for a new staff member from

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any background to break into or join an existing group. However, it is exceptionally hard for members of minority groups to be accepted. This may be due to disinterest, wariness, or the reluctance of other staff members to engage a person they deem "different." The reluctance could stem from existing biases about the group the new staff member belongs to or a fear of offending the person by saying the wrong thing. At other times, the new staff member may be peppered with questions about their beliefs and customs, making them feel like they need to be spokespersons for their community. Dialogue and exchange of information is a positive means of building a cohesive team and enhancing cultural competence, but this process needs to be supervised. Managers could offer mentoring to all staff members to facilitate the process of inclusion. Care must be taken to not just mentor staff members from minority groups as this may lead to conflict or envy. But a general mentoring process would allow all staff members to feel valued and respected.

e. *Creating opportunities for socialization*. Opportunities for socialization outside of daily work responsibilities makes staff feel valued for their contributions and allows staff to get to know each other personally. A typical workday can be quite hectic or frenzied, allowing little time for staff members to engage with one another in a meaningful manner. Socializing away from the workplace, staff members are more relaxed and are able to communicate freely. This allows for a free and open exchange of ideas, increases awareness and empathy, and helps develop rapport. If staff members are left to socialize on their own, they may only invite individuals they like or are comfortable with. But events organized by management would ensure that all employees are invited and have the opportunity to engage with one another. Such events would increase staff morale and help build team spirit.

f. *Consistently monitoring policy compliance and organizational morale*. It is the ethical and moral responsibility of the board and management to ensure that an agency is constantly working on enhancing its cultural competence. Provisions need to be made to consistently and systematically monitor compliance with agency policies regarding staff recruitment, development and training, prevention of harassment or discrimination, and optimum service delivery. Furthermore, the leadership needs to engage in a process of routinely assessing morale of both staff and consumers, evaluating complaints and grievances, and ensuring the promotion of participatory decision making at all levels.

Building a Multicultural Perspective Into the Organizational Culture

As we have discussed, creating an agency culture that optimizes heterogeneity is considered to be one of the major challenges facing human service administrators and leaders today (Brody, 1993; Hasenfeld, 1996; Menefee, 1997). Hyde (2004) uses the phrase "diversity climate" to begin to explain the diversity and multicultural dimensions of an organizations culture and as a framing conceptualization to explore the organizational characteristics that contribute or detract from building a functional and flourishing climate

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of diversity. They define diversity climate as a construct designed to capture the breadth and depth of organizational diversity measured by both the literal degree of staff diversity and also the efforts to promote and further an environment that maximizes the benefits of such diversity.

> An organization's diversity climate reflects the degree to which a primary goal of most diversity intention models is achieved: the creation of a culturally pluralistic setting in which all workers perform at their optimal levels. (Hyde & Hopkins, 2008, p. 27)

Organizations with more robust diversity climates engage in efforts that reflect a long-term orientation and commitment to infusing the organization's culture with a multicultural perspective. This includes reflecting diversity in outreach efforts (both staff and clients), staff accountability, resource allocation, and planning (Cox, 2001; Hyde, 2003, 2004; Iglehart, 2000; Norton & Fox, 1997). While long-range orientations toward building a diversity climate tend to yield the most robust and lasting results, more frequently organizations engage in trainings (including occasional trainings on cultural sensitivity and communication), and developing nondiscriminatory policies tend to result in only weak to moderate changes in organizational culture. Similar to other organizational change or development strategies, diversity initiatives seem to be most sensitive to sabotage by a lack of leadership, high workload demands, staff resistance, and a failure to engage the community (Hyde, 2003, 2004; Hayles & Russell, 1997; Iglehart, 2000).

Barriers to Cultural Competency

We have outlined several strategies for increasing cultural competency both internally by creating climates respectful of difference and externally in terms of thinking about how we are employing culturally competent treatment modalities. However, we must also have a realistic understanding of the barriers to creating organizational climates and cultures that respect difference and where a diverse range of staff can succeed as human services professionals. Two well-documented barriers or challenges to effective multicultural climates are microaggressions and aversive racism. These two forms of subtle racism and oppression may be perpetrated on the staff to staff level as well as on the staff to client level. As human services managers we must be aware of how these unconscious oppressive mechanisms operate and begin to develop strategies for creating respectful and welcoming climates for all staff and clients.

Racial microaggressions are brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color. Perpetrators of microaggressions are often unaware that they engage in such communications when they interact with racial/ethnic minorities (Sue et al., 2007). Microaggressions are unconsciously delivered as subtle snubs, dismissive looks, gestures, and tones. These exchanges are so pervasive and automatic in daily conversations and interactions that

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they are often dismissed and glossed over as being innocent and innocuous. Yet, as indicated previously, microaggressions are detrimental because they impair performance in a multitude of settings by sapping the psychic and spiritual energy of recipients and by creating inequities (Franklin, 2004; Sue, 2004).

Sue and his colleagues identify three main types of microaggressions: microassault, microinsult, and microinvalidation. A microassault is an explicit racially motivated attack, characterized primarily by a verbal or nonverbal assault meant to hurt the intended victim through name-calling, avoidant behavior, or purposeful discriminatory actions. Microassaults are most similar to what has been called "old fashioned" racism conducted on a micro or individual level. They are most often conscious and deliberate, although they are generally expressed in limited "private" situations (micro) that allow the perpetrator some degree of anonymity. A microinsult is characterized by communications that convey rudeness and insensitivity and demean a person's racial heritage or identity. Microinsults represent subtle snubs, frequently unknown to the perpetrator, but clearly convey a hidden insulting message to the recipient of color. Microinvalidations are characterized by communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of color (Sue et al., 2008).

It is clear that any plan for creating holistically developing a culturally competent management practice must help managers to overcome their fears and their resistance to talking about race by fostering safe and productive learning environments (Sanchez-Hucles & Jones, 2005). It is important that any training or development program be structured and facilitated in a manner that promotes inquiry and allows managers to experience discomfort and vulnerability (Young & Davis-Russell, 2002). The prerequisite for cultural competence has always been racial self-awareness. This is equally true for understanding microaggressions. This level of self-awareness brings to the surface possible prejudices and biases that inform racial microaggressions. Education and training must aid managers in achieving the following: (a) increase their ability to identify racial microaggressions in general and in themselves in particular; (b) understand how racial microaggressions, including their own, detrimentally impact clients of color; and (c) accept responsibility for taking corrective actions to overcome racial biases (Sue et al., 2008).

Future Directions for Culturally Competent Management

Social work agencies are charged with creating and sustaining culturally competent, multicultural organizations. "An organization which simply contains many different cultural groups is just a plural organization, but it is considered multicultural only if the organization values this diversity" (Edewor & Aluko, 2007, p. 190). A culturally competent organization is one that integrates diverse staff at all levels within an organization, promotes the human rights of staff and consumers, prevents discrimination and harassment, builds bridges with the community in which they exist, offers programs and services that meet the needs of their constituents, and

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advocates for a just and equitable society. It is important that agencies not just accommodate diversity but also value and incorporate that diversity.

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FIVE

The Multicultural Triangle of the Child, the Family, and the School: Culturally Competent Approaches

Carmen Ortiz Hendricks

In 2006, school social work celebrated 100 years of being a part of the social work profession. "School social workers started as and remain an integral link between school, home, and community" (Allen-Meares, 2008, p. 3).

Social work in urban public schools is one arena of multicultural social work practice in which knowledge of a client group's culture and status in society is central to service delivery. With rapidly increasing racial and ethnic diversity in cities throughout the United States, there is an urgent need to increase the numbers of bilingual, bicultural, and culturally competent school social workers and to decrease the cultural dissonance often found between mainstream school systems and the communities they serve. This chapter looks at the complex interplay of cultures present when families and children from diverse cultural backgrounds interact with public school professionals—each representing different values, beliefs, and historical experiences—a factor frequently overlooked in the process of assessing and helping children with their learning needs. Freire (1998) considers teachers to be "cultural workers" and exhorts them to think "about the learners' cultural identity and about the respect that we owe it in our educational practices" (p. 71). The same can be said of school social workers who are required to be culturally competent practitioners and "cultural mediators" (de Anda, 1984), since they are the primary school professionals who work with children while simultaneously mediating the environmental dynamics of the family and the school (Bronstein & Abramson, 2003). Culturally competent school social workers know their personal and professional identities and values, and are in the best position to function as interpreter of the language, experiences, and beliefs of diverse families, children, and the schools they attend (Constable & Montgomery, 1985; Staudt, 1991; Franklin, 2000; Garrett, 2006).

The school setting has a major impact on the lives of children and families. Public schools have traditionally been held responsible for transmitting the dominant, mainstream U.S. cultural values and beliefs, and promoting acculturation and assimilation to that culture. Schools have the power to strongly influence children, especially when the child's cultural background

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is different from the mainstream culture of the society or the school. These differences may be the result of recent immigration to the United States or bicultural/bilingual life experiences. Schools also exert enormous power over families that have limited understanding of the school system as a whole, or families that have to deal with underfunded, overcrowded inner-city schools. These families may already feel powerless and alienated within their communities. Take, for example, an immigrant family whose children are removed and placed into foster care because of a myriad of family issues and concerns (Jackson & McParlin, 2006; Johnson-Reid et al., 2007; Trout, Hagaman, Casey, Reid, & Epstein, 2008). Given the current anti-immigrant mood of the country, how are these families and their children's needs attended to by the school system and school social worker? Freire's renowned *Pedagogy of the Oppressed* (1993) urges educators and schools to be a liberating and enlightening force in the lives of children, families, and communities rather than perpetuating the oppressive broader environmental conditions.

THE MULTICULTURAL TRIANGLE

A multicultural triangle (see Figure 5.1) invariably forms when the child, the family, and the school conflict over measures of a child's ability, intelligence, or educability (Compher, 1982; Constable & Walberg, 1988; Douglas, 2011). Each feels the tensions of differing cultural values and objectives, and each encompasses a culture that needs to be understood and negotiated in order to promote positive learning experiences for children (Aponte, 1976; Woolley, Kol, & Bowen, 2009). To begin with, there may exist radically different cultural assumptions and expectations by the family and the school regarding the following questions:

- How does a particular cultural group view children?
- What is it like to be a child of a particular cultural group?
- How does it feel to not belong to the "dominant" mainstream cultural group?
- What is it like to grow up feeling different or "less than"?
- What is the particular culture of the school?
- What value is placed on the parents' role in educating children?

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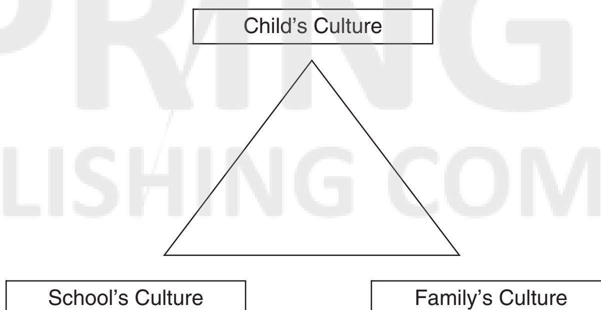

FIGURE 5.1 The child/family/school triangle.

- How do different cultural groups measure intelligence?
- What value do different cultural groups place on education?
- How do professionals define “normalcy” or a normal range of development?
- How are different behavioral norms understood and applied?
- In what context are learning needs and problems defined?
- How culture-bound are the labels and definitions of educability?

These questions also point to the inter-relationship between a child’s school performance, the family’s identity, and the school’s policies and practices (Figure 5.2). Many immigrant families value education for their children. The children’s educational performance is considered to be a family matter and it is given prominence and recognition in their community (Ryan & Smith, 1989; Appleby, Colon, & Hamilton, 2001).

From a systemic point of view, what affects one part of the system has a reverberating impact on other parts of the system. Therefore, assessment of a child’s school performance cannot be separated from assessment of a family’s self-identity or evaluation of a school’s educational policies and practices (Dowling & Osborne, 1985; Douglas, 2011). The problems or positions of one by necessity affect the other. This triangle, like most triangles in family systems theory, provides many convenient issues to focus upon while avoiding the fundamental cross-cultural conflicts at hand. For example, school programs like Head Start and other early childhood intervention programs frequently expect or mandate parental participation in a child’s educational plan, but these expectations are not enough to ensure parental participation. School professionals tend to focus attention on a child’s educational needs while ignoring the important aspects of the parent/school relationship (Correa, 1989; Hill & Torres, 2010). Parent/professional interactions are sometimes so structured as to render parents effectively powerless as partners in their children’s educational careers. Culturally competent approaches can build shared understanding and shared responsibilities between parents and school professionals. When parents are genuinely invited and their participation is properly utilized, they are an invaluable resource and highly effective collaborators in the educational process (Aponte, 1976; Chavkin & Garza-Lubeck, 1990; Correa, 1989). Parents are in the best position to assist

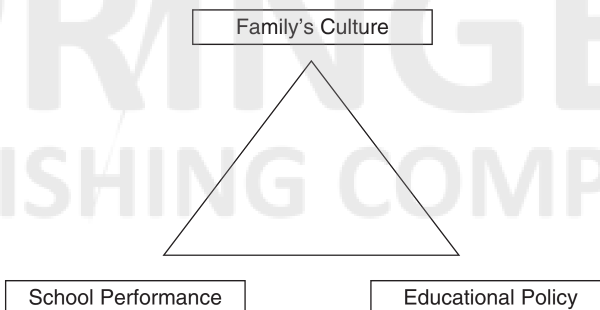

FIGURE 5.2 The identity, performance, and policy triangle.

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educators and social workers in decision making while protecting and advocating for their children.

Overburdened parents may be limited in the time available to attend school conferences, or their lack of understanding may be misinterpreted as resistance or lack of interest (Delgado & Rivera, 1997; Delgado-Gaitan, 1987). Limited English proficiency combined with the lack of bilingual, bicultural, and culturally competent school personnel also limits parental participation. Language usage and professional jargon further alienate parents from participating in their child's educational plans. There are many different interpretations for such terms as *bilingual education*, *special education*, *learning disability*, *speech or developmental delays*, *attention deficit disorder*, *hyperactivity*, and *special needs children*. These technical terms have been socially constructed in the United States and have different meanings and interpretations. They also do not always translate accurately for parents (Bennett, 1988). School professionals freely use these diagnostic categories or labels that are based on mainstream, middle-class, Western standards of measurement for evaluating intelligence. In the United States, these terms are used uniformly across a range of cultural and social class groups with little appreciation for the different life experiences that contribute to or could assist with educational difficulties.

A perfect example is the use of the term *disability*, which inevitably suggests a deficit in the individual. "The moral and medical models define disability as a pathological individual characteristic. In contrast, the social model defines disability as a diverse attribute in society" (Mackelprang, 2008, p. 39). Social workers deal with neurocognitive, physical, and psychiatric disabilities. Most parents will resist such categorizations of their child, and will seek to protect the child's identity from labels that appear to stigmatize the child completely rather than describe a particular difficulty in some aspect of the child's learning capacity. In *The Learning Differences Sourcebook* (1998), Boyles and Contadino list a range of learning difficulties including speech and language disorders, attention deficit/hyperactivity disorders, obsessive compulsive disorders, Tourette syndrome, oppositional defiant or conduct disorders, autism, mental retardation and developmental delays, visual or hearing impairments, and environmentally induced impairments such as those resulting from lead poisoning or fetal alcohol syndrome. When a parent denies a diagnosis or categorization, it should not be automatically assumed that the educational assessment is correct and the parent is misguided or resistant to recognizing that the child is suffering from a mild to serious learning problem (Dowling & Osborne, 1985; Golden & Cupuzzi, 1986; Hill & Torres, 2010). Rather, parents should be asked to provide their own explanation for their child's learning difficulties. School personnel may learn some valuable information to assist them and the parents in addressing the child's needs (Bennett, 1988; Harry, 1992b; Kalyanpur & Rao, 1991). The parent's point of view may be a more accurate representation of the child's needs as well as the parent's experience of the world. For example, parents of color can see with their own eyes the disproportionate placement of children of color in special education classes. This supports the parental perception of the arbitrary nature of such designations as learning disabled

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and promotes the view that special education programs are discriminatory or oppressive (Dao, 1991; Delgado-Gaitan, 1987; Kalyanpur & Rao, 1991; Gandara & Contreras, 2009).

Culturally competent school social workers are aware that placement in special education programs may be a more accurate reflection of the school's culture or social values than objective reality, especially when it relates to the underachievement of children of color from inner-city neighborhoods (Kurtz & Barth, 1989; Woolley, Kol, & Bowen, 2009). Problems in school performance have a range of meanings to parents, children, and teachers alike. A few example case vignettes can help underscore these issues:

CASE VIGNETTES

Eight-year-old Maria came home sobbing that her teacher did not like her anymore and was sending her to another classroom. The mother, with her 15-year-old son as interpreter went to the school to explain to the teacher that Maria was a good girl, she worked hard at her homework, and she could read and speak both English and Spanish quite well. The teacher tried to explain the learning disability that had been diagnosed in Maria, but to this Dominican mother a disability was some kind of severe incapacity like being blind or paralyzed. Her daughter was not incapacitated like that, so she continued to resist the change to a special classroom.

Elementary school teachers were frustrated with an Asian mother whose child was severely delayed in speech and language development, but she steadfastly refused all efforts to move her child to a remedial educational placement outside the immediate neighborhood. The school social worker learned that this mother had lost four children in a devastating flood that destroyed her village in Bangladesh a few years earlier. Losing a child, even to a nearby school, was too stressful for this mother, and other arrangements had to be made to meet the child's needs.

A mother, raised and educated in Jamaica, was finally able to bring her 8-year-old son to live with her in the United States. Before leaving Jamaica, she consulted the village wise man who told her that her son would experience many difficulties during his first year in the United States. She was convinced that when the year ended, her son's health problems and learning difficulties would cease as well.

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These examples demonstrate the kinds of multicultural misunderstandings that can arise when there are different definitions of the problem at hand (Lynch & Stein, 1987). Parents may be interpreting or naming the child's difficulties in their own way, and are trying to help their child by reframing the issues in words that are more compatible with their cultural values and

beliefs and less harmful to the child's self-image (McAdoo & McAdoo, 1985; Harry, 1992a; Greene, Jensen, & Jones, 1996). These redefinitions and clarifications need to be respected no matter how strange they may seem to school officials. Parents use any number of phrases or personal narratives to explain to school professionals how they view a child's learning difficulties:

- "He's just the way my brother was at this age."
- "She'll grow out of it, the way I did."
- "His father was just like him."
- "She is much smarter than she lets on to the teachers."
- "My child knows to not boast about his abilities."
- "She just needs time to catch on."

These perceptions should be utilized in the child's individual educational assessment and plan and included when discussing such things as genetic predisposition, developmental or maturational factors, different historical evolutions, medical and psychological progress, and individual or family strengths. The focus is on the strengths of parents' perceptions rather than on the pathology or deficits perspectives of school professionals (Tower, 2000; Hill & Torres, 2010).

Bicultural and bilingual children who hear conflicting comments about their cognitive–behavioral abilities from their parents and teachers are frequently torn between the demands of two cultures—the culture of home and the culture of school (Freeman & Pennekamp, 1988). As bicultural/bilingual children, they struggle daily to live up to teacher expectations, to learn new ways of solving problems and relating to others (Bennett, 1988; Lynch & Stein, 1987), to deal with peer demands for mainstream behavioral responses, and to remain true to family admonitions to put their culture of origin first regardless of what they experience around them. These children need "culture brokers" (Ortiz Hendricks, Haffey, & Asamoah, 1988)—persons who can teach them how to negotiate conflicts and facilitate resolution of multicultural dilemmas and opportunities. When the child is biracial, they are forced to deal with the additional task of choosing one racial identity over another, an enormously stressful and difficult experience for children and youth faced with multiple developmental tasks.

When school professionals and parents use different culturally based and culturally biased criteria for describing a child's behavior, it is the child who gets caught between their respective interpretations (Ryan & Smith, 1989). "For the most part, school curricula are designed to have each student achieve certain academic milestones along a predetermined timetable . . . The problem? Not every child is on this developmental schedule" (Boyles & Contadino, 1998, p. 1). The same authors describe a number of biases in instruments that are used to assess intelligence such as "value bias," which involves designing tests so that answers reflect the responses acceptable to the dominant culture, and "linguistic bias," which means assessment of a child's knowledge of a particular language like English rather than assessment of their general language development. Before resorting to biased criteria to evaluate a child's difficulties in school, school professionals would do well to

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pay careful attention to the parents' criteria for normalcy and intellectual ability, which holds special meaning for the families they serve. There are different cultural meanings to what school professionals may believe are uniform and universally accepted definitions of intelligence, competence, and disability (Dao, 1991; Kalyanpur & Rao, 1991). Many parents are incredulous when they are first told that their child is learning disabled or suffers from a more severe neurological impairment (Bennett, 1988). They see a healthy body, a child who can use common sense, a child who has achieved elementary academic skills in two languages, and a child who has already exceeded a parent's educational attainments (Ryan & Smith, 1989). These accomplishments clearly deny a diagnosis that is designed for someone whose competence is impaired or who is mentally deficient. Parents cannot view their child as anything but intellectually superior when a seven-year-old's homework is harder than anything the parents have experienced in their own education (Spener, 1988). From a strengths perspective, by working with the definitions offered by parents, school professionals can reinforce the fact that the child is not severely incapacitated. This positions the school to motivate children and parents to address learning needs in a more empowering manner.

When examining a child's difficulties in school, educational experts point to several important themes that emerge as children and parents struggle to understand why a child is having trouble. Family identity, school performance, and educational policies are culturally bound and culturally interwoven aspects of school social work services (Harry, 1992a, 1992b). Together, these factors contribute to narrow definitions of a child's difficulties and rigid triangulations of communication among all parties concerned.

FAMILY IDENTITY

Family identity is very important when interpreting a child's developmental patterns or learning needs. The Coleman Report of 1966, a national study, reported that family background influenced an individual's school achievement more than any other factor (Andersen & Collins, 1998). Wherever there is a strong cultural value placed on the family as a whole, there is an equally strong value placed on the family's identity as a group rather than as a collection of individuals. Problems are viewed as family problems rather than as issues solely of the individual. The family feels a collective shame when school professionals inadvertently or intentionally give the impression that the child's learning difficulties result from some deficit in the home or other family problem. Parents may associate the child's difficulties as tied to some family trait or characteristic or even to some past wrongdoing by a relative. On the other hand, a strong family identity diffuses the stigma on a child who is having school problems. While a strong family identity engenders vulnerability in the whole family, it also serves to protect the child's identity. The child is not different because he or she is just like everyone else in the family. Lynch and Stein (1987) found that Latino and African American children were described in terms of family traits and were often not considered to be outside the family's normal range of behavior. Culturally competent practitioners recognize that family group identity

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has to be taken into consideration when addressing a child's learning needs. For example, a child who is withdrawn or hyperactive may be demonstrating behavior that is viewed as culturally syntonic to the family. The family may see the quiet or overactive child as exhibiting some inherited aspect of family behavior, or a part of the family's preferred mode of behavior. In other words, the child has always been this way, and it is an inherited characteristic from her grandfather or aunt. The family has always accommodated the child, and will continue to help the child deal with this behavior. They do not view the behavior as a problem or symptomatic of any other condition. Culturally competent practitioners need to build on the strength of family identity while securing remedial services for the child (Douglas, 2011).

SCHOOL PERFORMANCE

When looking at the school performance of diverse children, especially immigrant and refugee children, an appreciation of the advantages and disadvantages of second language acquisition in a child's education are essential. Children can experience problems simply from the confusion associated with changing from one language at home to another language in school (Cummins, 1984; Spener, 1988; Douglas, 2010). It is the school that generally assesses whether a child enters into regular English-speaking classes with a bilingual aide or whether they need English as a second language (ESL) classes, or a comprehensive bilingual education program. The point of immigration in the child's life cycle has a great deal to do with how a child adjusts to English and American schools. Parents may feel that their children were doing well academically in schools in their country of orgin, and see their children's problems now as emerging from the high demands or tough expectations of teachers. They may even feel like their children are being singled out because of their limited English proficiency (LEP) and not other learning difficulties. Some parents are so proud of their children's ability to speak and read English that they see American teachers as overly critical of accents or mispronunciations, or expecting their children to speak English perfectly (Correa, 1989).

Parents are further confused by such terms as ESL, LEP, and IEP (individualized educational plan), and special programs like bilingual education, special education, and resource rooms, and they have many misconceptions about these terms or programs. The battles fought over bilingual education had parents believing that these programs held children back rather than helping them learn better. In truth, bilingual education is ill-defined in practice and inconsistently implemented. "Critics complain that it [bilingual education] produces low-scoring students with poor English language skills. Supporters counter that . . . ultimately language minority children who learn to read and write in their native tongue will be more cognitively developed than language minority children who learn to read and write in English" (Ravitch & Viteritti, 2000, p. 187). There is limited research to support either point of view. Historically, bilingual education has focused on Hispanic children whereas Asian students have been allowed to learn primarily in English. These distinctions need to be thoroughly researched in a culturally sensitive way in order to determine what is in the best interest

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of bilingual/bicultural students. Many immigrant parents are adamant that their children learn English even if the parents themselves are resistant to learning the new language (Dao, 1991; Spener, 1988). These same parents are concerned that their children maintain their language of origin and not forget it. To lose the ability to speak the language of origin or native tongue frequently means losing the ability to speak to relatives and friends back home. These factors put enormous pressure on children to be bilingual at all costs. At the same time, the broader social environment in the United States today, with growing support for English-only laws and anti-immigrant sentiment, communicates a less than welcome environment for immigrants, migrants, and refugees. Young children often have to struggle alone with the demands of their parents and families, the school, and the broader society. Cultural sensitivity is necessary to help children succeed in their school performance and to navigate their bilingual and bicultural identities.

EDUCATIONAL POLICIES AND PRACTICES

The school's culture extends to things like how curricula are delivered, how reading and math are taught, and how children are evaluated. Parents frequently complain about how unstimulating curricula can be, how inflexible teaching methods can be, and how frequently a child's classrooms, programs, teachers, and even schools are changed due to some new evaluation of a child's learning needs (Sarason, 1982; Gandara & Contreras, 2009). Mainstream as well as immigrant parents are not always able to assert their parental authority, and they are reluctant to refuse to go along with educational practices recommended by school professionals. Parents and children get confused and frustrated when educational changes occur without their approval or understanding or without any credence given to their position or interpretation. Some parents fight back, but they are not always successful. A perfect example of this was discussed in a *New York Times* article entitled, "City Retools Special Education, But Pupils Are Slipping Through Cracks":

> Under special education law, when children do not get services, parents can request a hearing . . . Siow Wei Chu and her husband, Harry Sze, Chinese immigrants, asked that their daughter Jane be given a bilingual aide in her second-grade class at P.S. 203 in Queens, along with daily academic support. The City agreed that Jane should have a bilingual aide, but wanted to move her to another school: one that used a teaching model with a mix of 25 special ed and general ed students, and two teachers . . . At one point, the parents' lawyer asked a teacher if the family's request to keep Jane in P.S. 203, where she had been since kindergarten, was a better plan than the city proposal to move her. "Of course," said the teacher . . . Immediately before the [second] hearing, the city agreed to give the parents exactly what they had requested. Their victory was bittersweet. Instead of getting the bilingual aide at the I.E.P. meeting on October 7, 2003, Jane would get one in September—one school year later. (Winerip, 2004, p. 26)

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This example demonstrates that even when parents are able to advocate for their children, inefficient and ineffective school policies and overburdened and underfunded schools are barriers to achieving educational goals. Some parents who have struggled with public schooling in the United States are determined that the only way to secure adequate education for their children is to avoid school policies that hinder and obstruct this objective. They try to outsmart the educational system by falsifying or losing their child's records from the country of origin in their eagerness to have their child seen as possessing normal intelligence and placed in regular, age-appropriate grades. When parents and schools are caught up in family identity issues and school policies, the child's school performance suffers.

CULTURALLY COMPETENT SCHOOL SOCIAL WORKERS

Achieving cultural competence is an ongoing, lifelong process for all social workers, as no one is born culturally competent. "Cultural competence does not come naturally to any social worker and requires a high level of professionalism and sophistication, yet how culturally competent practitioners are trained is not clear in professional education or practice" (Ortiz Hendricks, 2003, p. 75). More bilingual, bicultural, and culturally competent professionals are needed to meet the needs of fast-growing, diverse client populations, and to help ensure unbiased and culturally sensitive assessments for educational, familial, and social services. Cultural competence is a fundamental necessity for school social workers, who must mediate between the client's culture and the agency's culture while increasing their sensitivity and knowledge of the values, practices, customs, and beliefs of each culture and simultaneously appreciating their own personal and professional values and beliefs (Figure 5.3).

Culturally competent school social workers need to be culturally aware, culturally sensitive, and culturally knowledgeable practitioners who are open to new ways of defining and evaluating children and their learning needs. They do this over time and in several ways. First, they can begin by recognizing that there are many important ways in which the meanings of terms such as *learning* and *learning disabled* differ among cultural groups, and they need to examine these meanings and their significance to the parents and the communities they serve. Second, they should examine the parameters of what is *normal*

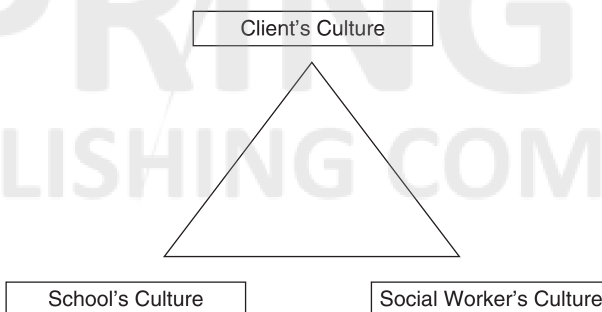

FIGURE 5.3 The cultural triangle of client/school/worker.

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in child development and integrate much broader explanations of normalcy than those utilized by educational institutions. Third, they can best help parents by listening carefully to their theories about their children's difficulties, and from a constructivist approach work with parents to bridge the fine distinctions between learning difficulties and measurements of emotional and mental stability. Lastly, culturally competent school social workers have a role in advocating alternative school policies and practices that welcome parents' participation in the educational plans for their children, and that are culturally sensitive and friendly to diverse populations. Cummins (1984) supports this holistic approach that incorporates the cultural, linguistic, and community needs of populations served and calls for a collaborative versus an exclusionary approach to working with parents. "Children's seeming unpreparedness for mainstream schooling is only a measure of the rigidity and ignorance of our school system which creates handicap out of social and cultural difference" (p. 70).

A major contribution by school social workers involves sharing their assessment of the social and cultural needs of children and families with other school professionals. These assessments include comprehensive data and evaluation about

1. family structures and functions,
2. generations and length of stay in the United States,
3. trauma experienced in the country of origin and in the process of immigration itself,
4. socioeconomic conditions of the family in the country of origin and in the United States,
5. educational history of all family members,
6. racial identity, and
7. language proficiency among all family members.

In addition, social workers should pay attention to parents' attitudes toward education. Initially, they may be filled with great hope and faith in the educational system in the United States, but gradually they become disillusioned and develop a negative attitude toward education in general. Understanding these patterns can help school professionals intervene to prevent or explain the frustration parents encounter in meeting the educational needs of their children.

Lynch and Hanson (1992) propose a specific methodology for competent cross-cultural practice that includes appreciating the impact of cultural assumptions on the intervention process, enhancing cultural self-awareness, understanding the factors that contribute to cultural identification and acculturation, gathering information on other cultures, and establishing guidelines for using interpreters or translators. It is equally important to understand how a particular culture views the helping relationship, how cultural traditions affect problem solving, and "what specific intervention skills and ways of thinking work more effectively with particular groups than those based primarily on the Euro-American frame of reference" (Dungee-Anderson & Beckett, 1995, p. 460).

Furthermore, social workers need to engage in an ongoing self-evaluation of their own cultural backgrounds and values (Pinderhughes, 1989; Aponte, 1991; Lum, 1999; NASW, 2007). This ensures their ability to listen to and hear different cultural perspectives and not just the prerogatives of their own

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cultural heritage or of the social work profession that is in and of itself a cultural point of view. A broad definition of cultural self-awareness includes an appreciation of the following factors:

- Personal values, beliefs, attitudes, biases, prejudices, knowledge paradigms, and how these may differ from other worldviews or values orientations.
- Differences within broad categories of diversity and differences between these groups; for example, Hispanic/Latino encompasses 19 or more different nationalities, social classes, histories, immigration experiences, and geographic locations.
- Definitions of diversity that include race, skin color, ethnicity, gender, gender expression, sexual orientation, religious and spiritual beliefs, social class and status, age, abilities, language, national origin, political beliefs, and geographic and regional locations that interact and combine in complex and significant ways. The challenge for social workers is to be cognizant of individual features of diversity while understanding the multifaceted and intersecting nature of these factors.
- Power, privilege, and oppression and how these affect people, and define who they are, especially as members of oppressed or dominant groups.
- The impact of trauma, colonialism, dominance, and exploitation on human development and mental health.
- Identity development issues, including stages of racial identity formation, and stages of "coming out" and the formation of sexual orientation identity and gender expression.
- Multiple status integration and intersecting identity issues (e.g., a biracial adolescent struggling to solidify their identity).
- Cultural competence in all aspects of practice including work with individuals, families, groups, and communities; clinical work, research, administration, program development, policy analysis and advocacy, and community organizing.
- Culture as a part of personality development and mental health and not just an economic, social, or political variable.
- The impact of bias and discrimination, especially racism, ethnocentrism, sexism, ableism, and heterosexism, on the beneficiaries and survivors of these unequal power relationships.

The development of culturally competent knowledge, skills, and values is critical for social workers, particularly given certain social, political, economic, and professional realities operating today. Among these realities are changing population demographics and data on the continuing underutilization of mental health services by clients of color. The social work profession has also advanced cultural competence through its recent accreditation and ethical standards on diversity (National Association of Social Workers [NASW], 1999). NASW has developed *Standards for Cultural Competence in Social Work Practice* (2000) that was endorsed by the Council on Social Work Education in 2003. In 2007, NASW developed *Indicators for the Achievement of Cultural Competence in Social Work Practice*. The indicators now give social workers the ability to evaluate their individual strengths and weaknesses in the arena

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of cultural competence. There are also indicators for what constitutes a culturally competent organization.

Diversity is creating many new tensions in North American societies where it is often experienced as a threat rather than as an opportunity to open up dialogue on intergroup conflicts, and enhance intergroup relationships. Greene (1994) speaks of *cross-cultural* and *culturally diverse* as "umbrella terms for the diversity of human experience that is rooted in ethnic, national, or religious identity, race, gender, and social class membership" (p. xii). Along similar lines, this author proposes the following definition of culturally competent social work practice (CCSWP) for consideration:

> CCSWP encompasses a range of professional knowledge, skills, and values that address the complex cultures emerging in a society from the interplay of power, privilege, and oppression associated with race and ethnicity, gender and sexual orientation, religious and spiritual beliefs, social class and status, and age and abilities.

This definition recognizes that all people have a cultural group identity, and that many types and forms of group membership in society take on varying significance depending on the societal context. A societal context in which difference is not merely "different from" but is associated with "better or less than," is a society in which differences are not viewed as the norm for human behavior but rather differences are viewed as deviant or deficit. Power and privilege are then used to minimize these differences or oppress characteristics that are simply a part of human diversity. Whoever has power or is in a dominant position contributes to the oppression of those not considered within the mainstream of society (e.g., immigrant women), or those that are part of the mainstream society (e.g., White women), or those who are relegated to an inferior status (e.g., lesbian women).

CCSWP involves a dynamic, interactive assessment of a client's particular lifestyle, which moves from universal categories of cultures (Latino, African American, Asian, Jewish American, Irish-Catholic, etc.) to more specific, individualized, and complex categories of cultures within cultures (Fong & Furuto, 2001; Lum, 1999). Gould (1995) proposes that a multicultural framework refutes the basic assumption that cultural identity has to be unidimensional or that becoming more of something automatically means becoming less of the original. "A multicultural framework goes beyond encouraging intercultural learning and multicultural competency to building a multicultural identity for all groups" (Gould, 1995, pp. 202–203). A specific situation can help to clarify exactly what is entailed in such a multicultural framework:

> A Puerto Rican social worker is assigned to work with a family from the Dominican Republic. Each can be viewed from very broad class, racial, ethnic, or gender categorizations, but these distinctions do not do justice to the multifaceted cultures each uniquely encompasses. The social worker is a 42-year-old Latina social worker who was born in Puerto Rico and raised

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> in New York City. She considers herself a White, middle class, Hispanic American professional. The Velasquez family is composed of a 27-year-old woman who is a laboratory technician and a 28-year-old man who works in his cousin's food market. They are married and have two children aged 7 and 5. The family has recently re-migrated for the third time to New York City from the Dominican Republic for a variety of family reasons. A referral is made because of suspected incidents of family violence, excessive school absences, and a recently diagnosed learning disability for the 7-year-old child. The case is automatically referred to the only Latina social worker in the school because of ethnic and linguistic commonalities.

A multicultural framework can help this social worker appreciate the similarities and differences between her and the Velasquez family. As Hispanics, they share experiences of oppression both within and outside their countries of origin. Yet each has distinct experiences as Dominicans and Puerto Ricans in the United States, including different historical and social evolutions, English and Spanish language proficiencies, skin colors, immigration patterns, and citizenship status. The social worker can best help this Dominican family and others like them by recognizing the oppression experienced by immigrant Latinos who deal with the stress of immigration, resettlement, and family reorganization in addition to economic hardships and discrimination in the United States (Organista, 2009). Together, the social worker and clients will engage in a multicultural encounter in which understanding each other's unique experiences will be integral to the work they do in confronting an inner-city public school system (Falicov, 1995).

CONCLUSIONS

As cultural diversity increases in the United States, school social workers are on the front lines of empowering children and families to deal effectively with a public school system that has the power to influence the lives of children and families in positive and negative ways. The development of bilingual, bicultural, and culturally competent social workers is critical for a positive interaction and healthy relationship between the child, the family, and the school systems, especially when a child demonstrates some form of learning difficulty. Culturally competent social workers play a central role in appreciating and dealing with the power, powerlessness, and unequal power relationships that are inherent in these systems. All school professionals need to recognize that enhancing the parents' power to understand and attend to their children's educational needs is in the best interests of the children served. "True empowerment benefits both the client system and the practitioner in that client and worker experience a sense of each other's freedom and individuality which includes a real appreciation of each other's differences and similarities" (Pinderhughes, 1989, p. 240). Empowering diverse families will result in vast numbers of children experiencing more satisfying and productive relationships with the educational system, and will help them

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reconcile the various cultural challenges presented by the home, the community, and the school. "As we look into the future of school social work, concerns about the quality and cost of education, student learning outcomes, accountability, increased demand to serve more diverse student populations, and increased social problems among children and families, will challenge the profession to think creatively and differently about their services and how to organize them for greater effectiveness and efficiency" (Allen-Meares, 2008, p. 6). This is difficult but extremely rewarding work as school professionals, children, and families help each other to live in a multiculturally diverse society.

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Clinical Practice With Multicultural Adolescents

Samuel R. Aymer

Erikson's (1963) idea of *identity versus role confusion* provides a context for understanding that an adolescents' psychosocial growth is predicated on internal and external influences, which propels them to "try on" multiple social roles before the consolidation of a strong sense of ego development. Moreover, the importance of familiar and societal influences on the character development of Latino, Asian, and African American adolescents are discussed throughout the chapter, and the differences (e.g., social class, language, immigration, migration, race, skin color) that exist within and among these groups are emphasized. The psychological well-being of adolescents from these groups is often impeded by racial and ethnic animus, thus shaping their view of themselves. The chapter provides an overview of adolescent development in multicultural youths. It summarizes the physical and psychological changes typical of this developmental period.

Two models of identity development specific to race and ethnicity are discussed (Cross, 1991; Phinney, 1989), giving insights into the emotional processes of individuals of cultural and ethnic groups. Drawing from the author's clinical experiences, a case vignette of an interracial family serves as an example, accentuating how development (or the lack thereof) of self-identity in a mixed-race adolescent was inextricably linked to his psychological development. Framing this young man's lived experiences in the context of Phinney's (1991) and Cross's (1991) models of identity formation underscored that his ethnic and cultural identity was influenced by familial circumstances and the ridicule he experienced from peers.

OVERVIEW OF ADOLESCENT DEVELOPMENT

Adolescence denotes the onset of an array of physical and psychosocial changes and produces anxiety in children. Such changes take place during the following periods: "early adolescence (11–14 years of age), mid-adolescence (15–16), or late adolescence (17–20)" (McKenzie, 2008, p. 1). Each stage and its accompanying vicissitudes affect the overall functioning of adolescents (Blos, 1962; McKenzie, 2008). For example, Blos (1962) infers that, "adolescence is most prominently characterized by physical changes, which are reflected in all facets of behavior" (p. 5). Regardless of race, culture, ethnicity, or gender,

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this view, which is undergirded by biological and physiological factors, has merit (Blos, 1962; Mishne, 1986). Physical changes in a boy's body (e.g., the presence of facial hair and muscular development of the torso) signals the onset of puberty. Likewise, girls begin to menstruate and this developmental shift suggests they are able to become pregnant. The development of breasts and hips in girls becomes more pronounced and this also signals the beginning of puberty. Blos (1962) writes: "Pubescence is often marked by physical changes which make the afflicted adolescents acutely self-conscious of his changing body" (p. 8). Furthermore, sexual characteristics increase in both genders, accounting for the development of pubic hair and sexual organs (Blos, 1962). Depending on the temperament and personality of adolescents, these changes can have an enduring or temporary effect on their self-concept. Some girls may become self-conscious about their bodies based upon excessive attention (negative or positive) from others. Likewise, the presence of outward physical changes such as facial hair and the development of muscles can begin to establish a sense of masculinity in boys, signifying physical prowess. It is worth noting that some adolescents may undergo a delay in their development, triggering feelings of inadequacy. Mishne (1986) notes that, "typical ages for pubescent changes are subject to many expectations and irregularities, as children mature at a vastly different rate" (p. 14). In addition, the advent of physiological growth in adolescence produces hormonal changes, accounting for the array of affective responses common to this developmental process (Blos, 1962).

The psychological growth of adolescents is fortified by family attachment, which plays a pivotal role in facilitating identity-formation, and this contributes to ego development (Blos, 1962). Adolescents develop autonomy, judgment, and relational skills as a result of having relationships with caring and nurturing parents or parental figures (Aldwin, 1994). Bowlby (1988) underscores this point, indicating that a secure attachment provides the emotional infrastructure for children within which they can develop relational skills as they mature. Correspondingly, Winnicott (1965) and Fairbairn (1962) point out that positive psychological outcomes for children cannot be assessed unless we understand the significance of the parent–child matrix, a dynamic fostering security and emotional well-being. Psychological stability, supported by attachment, helps children internalize the values, attitudes, and morals of their families; this contributes to the formation of their identities. Furthermore, Bowlby's (1983) notion of *internal working models* is derived from children's attachment with their caretakers, which help adolescents to form internal representations, which, in turn allow them to acquire interpersonal skills.

Erikson's (1963) concept of *identity versus role confusion* is noteworthy because it speaks to young people's quest to examine who they are in connection to their family, their peer group, and their social environment. The values and teachings arising out of attachment to family often stand in sharp contrast to the evolving selves of adolescents, who tend to be more attuned to the philosophies of their friends. Thus, familial standards that were unchallenged during early childhood become prone to scrutiny, increasing adolescents' ability to develop their own voice. The ability to question values

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that are inherently associated with family and home life can be complex due to, first, the cultural context of a particular family and, second, the power differential that is fundamental to the parent–child relationship. As such, research suggests that identity development in adolescence is predicated on adopting a rebellious and oppositional stance, particularly with authority figures (Blos, 1962; Erickson, 1963; McKenzie, 2008). In a sense, however, teachings originating from the home may not be totally discarded by adolescents. Instead, their experiences with peers inculcate different views of life that, at times, may be at variance with their parents' beliefs. Furthermore, connections to the peer group can mediate the emotional "angst" adolescents feel when they are unable to exercise their sense of agency when relating to parental figures. Indeed, Phinney (2010) notes that, "All young people must navigate complex worlds of home, school friends, work, and leisure, in contexts that are continually changing" (p. 33). Central to this point is that adolescents are subjected to multiple challenges and, as a result, confusion and conflicts abound. The need to be understood by parents and friends, the desire to maintain a sense of individuality, and the need to be accepted are commonalities that are related to identity development. Erikson (1968) underscores this by stressing that,

> [a] state of identity confusion usually becomes manifest at a time when the young individual finds himself exposed to a combination of experiences which demand his simultaneous commitment to physical intimacy (not by any means always overtly sexual), to decisive occupational choice, to energetic completion, and to psychosocial self-definition. (p. 166)

Identity confusion by definition unearths anxiety in adolescents; it is difficult for them to feel emotionally anchored if parents are demanding that they fulfill expectations (e.g., completing high, attending college, or obtaining employment) that are perceived as challenges. Erikson (1968) amplifies this by indicating that, "it is the inability to settle on an occupational identity which most disturbs young people" (p. 132). Adolescents struggling with sexual orientation or gender identity worries may feel alienated from their family, and this can adversely affect how they perceive themselves. Identity confusion can lead to rebellion and turbulence. Yet, Erikson (1963) contends that the processes related to undergoing the various stages of adolescence help strengthen young people's self-development, thus bolstering identity.

SOCIOCULTURAL INFLUENCES AND IDENTITY DEVELOPMENT

In general, the aforementioned overview provides a framework for understanding the psychosocial growth of young people. In contrast to their White counterparts, however, identity formation among adolescents of color (e.g., African Americans, Latinos, and Asians) is punctuated by sociocultural variables (e.g., race, culture, ethnicity, language, immigration acculturation, and racial oppression). Young people of color from diverse backgrounds are perceived as minorities within our society and, as such, Phinney (1996) aptly

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states that, “minority status is the presence of negative stereotypes” (p. 924). The promulgation of negative stereotyping originates from multiple forms of oppression, including racism, and this is captured in West’s (1994) book, *Race Matters*, in which he points out that race is perceived as “the most explosive issue in American life precisely because it forces us to confront the tragic facts of poverty and paranoia, despair and distrust” (p. 155). The potency of race and racism in our society admittedly sets the foundation for other forms of oppression (e.g., xenophobia, colorism regarding skin tones, and gender bias) to take root. In addition, this point is echoed by Thomas and Schwarzbaum (2010), who state, “[i]ndeed racial bias has underpinned many oppressive acts, including slavery, the removal of the Native American from their lands to reservations, and the internment of Japanese Americans during World War II” (p. 1).

Racial oppression and/or ethnic bias can affect how multicultural adolescents attempt to understand their social location within U.S. society. Although African American, Latino, and Asian adolescents have different worldviews based on their familial, cultural, and ethnic backgrounds, identifiers such as skin color, physical features, immigrant status, and/or language limitations suggest how society marginalizes these individuals. Ascribing negative or positive connotations to any of these identifiers ostensibly places a group on the margins. Lopez’s research (2008) on Puerto Rican women and skin color, for example, speaks to this point: It illuminates the variations that exist in how lighter- and darker-skinned women are viewed by society, implying that the former group is not burdened by stereotypical reactions from society because of their skin color, unlike darker-skinned Latinos. A view that is in support of Lopez’s research is the work of Pinderhughes (1989), who indicates that, “[t]he status assignment based on skin color identity has evolved into complex social structures that promote a power differential between White and people-of-color” (p. 71).

Exposure to racial and ethnic discrimination is common among Latino adolescents, especially males, who are more apt to report discrimination (Umana-Taylor & Guimon, 2010). Umana-Taylor and Guimon note that the reason why males are more likely to report ethnic bias is that the freedoms that are afforded them within Latino families predispose them more to discriminatory circumstances than their female counterparts. Similarly, African American adolescents are subjected to racial discrimination, with males also reporting higher levels of bias reactions from society. Stevenson (2004) places this in context, suggesting that, “the struggle of African American identity or identities in the bodies, souls and minds of African American male adolescents is a complex one that involves levels of personal and social vulnerability unprecedented in American human social interaction despite advances of civilization” (p. 59). The potency of societal stereotypic representations of young men of color (e.g., images of young men as criminals or deviants) constructs a persona that marginalizes them. Highlighting the male’s positionality in society should not obscure the fact that adolescent girls from Latino and African American communities endure racial and gender oppression; rather, the point is to note how oppression may shape the development of young men and women in different ways.

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Like the aforementioned groups, Asians have a narrative replete with racial and ethnic discrimination (Sue, 1981). Canino and Spurlock (2000) emphasize Yamamoto and Igar (1983) assertion that Asians' civil rights were violated by stating that, "[t]he ostensible reasons for stripping this groups of citizens of all their rights and properties and relocating [them] into camps during World War II was fear that they might commit acts of disloyalty" (p. 18). Because this historical reality became a part of the Asian cultural experience, it would be important to understand how it has informed Asian adolescents' view of themselves. Thomas and Schwarzbaum (2011) stress that cultural identity includes a range of factors such as historical forms of oppression and their resulting consequences. This is certainly relevant to African American adolescents, whose families were descendants of slaves. The view that adolescents should be aware of how past atrocities affected the narratives of their racial or ethnic groups is debatable. Yet, knowing and understanding one's history can facilitate a strong affinity for one's racial and ethnic identity. Phinney (1989) believes this is important and claims that children of color who are estranged from their ethnic identity tend to experience uneasiness about their self-worth, thus feeling a "sense of alienation" (p. 39).

Feeling a sense of alienation increases when adolescents have no understanding of the cultural context of their particular reference group. Research on the experiences of second-generation Asian young people whose parents discourage exploration of historical issues and their immigrant struggles is an example that highlights a possible sense of cultural estrangement in this group (Park, 2008). In view of this finding, Asian young people from this type of client system may lack a cultural frame of reference concerning how their parents coped with oppressive treatment. Park also observed that because the young people in her study did not know about the hardships their parents endured as immigrants, they were more inclined to embrace the common dictum of being the model minority. Although this notion can convey positive qualities and strengths, it also buttresses a stereotypical construction of Asians in the U.S. society. And, regarding adolescent self-development, the idea of being a model minority ultimately reinforces a one-dimensional view of how they are perceived in society. The success of some Asians cannot be used as a gauge for the entire Asian population residing in the United States (see Sue, 1989; Park, 2008). In general, the migratory processes of Asians, along with the concomitant challenges of acculturation, language limitation, and physical differences (e.g., features that do not resemble the normative model of white skin, blue eyes, blond hair) parallel, to some degree, the difficulties that other non-White ethnic groups (e.g., Latino/as from non-U.S. ports) endure.

The quest for upward mobility and the ability to cope with the angst of being an immigrant in a distant environment can be viewed as common themes in the lives of Asians and other immigrants of color (Park, 2008). Yet, society's classification of Asians as model minorities places them in a seemingly privileged position, implying their psychological drive to succeed is superior to other non-White immigrants. Research (Sue, 1989; Park, 2008) indicates that the "model minority" is a myth advancing the marginalization

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of Asian American. Like Latinos and African Americans, who are also subjected to marginalized representations of themselves, Park (2008) believes that the reference to Asian Americans as a model minority can affect their functioning by stating that, "[t]he notion of the model minority does not imply full citizenship rights but, rather, a secondary one reserved for particular minorities who 'behave' appropriately and stay in their designated secondary place without complaint" (p. 135).

RACIAL AND ETHNIC IDENTITY DEVELOPMENT

Clinical work with multicultural teenagers should consider the importance of racial and ethnic identity. Race may be used by many African American adolescents to understand their social identity, whereas ethnicity may be a more suitable classification for Latinos and Asians. Race and ethnicity are complex constructs that are impossible to discuss comprehensibly given the length constraints of this chapter. Furthermore, a comprehensive review of the literature of racial and ethnic identity development is also beyond the scope of this chapter, which is why Phinney's (1989) research on ethnic identity development and Cross's (1991) work on Black racial identity development was used to ground this portion of the chapter.

On the one hand, Helms (1990) notes that racial identity development is defined as a person's level of consciousness that a person has about his or her racial heritage and affiliation to a specific racial group. On the other hand, Phinney (1996) states that ethnic identity development is an important hallmark of one's self-concept, and stresses that it involves a person's connection to and with a specific ethnic group when they share common values, customs, and cultural activities. Pinderhughes (1989) argues that, "[t]he significance of ethnicity is demonstrated in the strong emotional reaction that people display when they examine ethnic meaning and experience related to their own ethnic backgrounds" (p. 40). Within the domains of race and ethnicity, identity formation in adolescents is fluid and is informed by the media, globalization, urbanization, immigrant status, acculturation and/or assimilation experiences, and an individual's idiosyncratic processes. An adolescent of Caribbean extraction who considers themself African American because they were born in the United States may also feel connected to and claim Caribbean heritage because of their parents' and grandparents' West Indian background. Such a dual consciousness about one's cultural and ethnic roots reflects the need to feel planted in one's traditions and customs and the need to embrace one's country of origin.

Cross's Model of Black Identity Development

Cross (1991) postulates that in order for identity development to occur, Black individuals (a term used by Cross when the model was established) must go through a set of stages, specifically, pre-encounter, encounter, immersion-emersion, and internalization-commitment.

Minimizing race-related oppression and the ways in which it impinges on the lives of African Americans is one of the features of the *pre-encounter*

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phase. The individual lacks cultural awareness and is divorced from the cultural and historical traditions (e.g., the value of the extended family and spirituality) specific to the African American community, causing them to identify solely with Eurocentric ideals and values.

A sense of personal awareness emerges when the individual experiences the *encounter phase,* which brings them in contact with racist behaviors. As a result, this leads to turmoil, prompting an evaluation of the Eurocentric views they held during the *pre-encounter phase.* A self-assessment occurs that relates to the meaning of being African American.

The need to connect with and see one's self through the prism of being African American is one of the features of the *immersion-emersion phase.* The person becomes totally engaged with cultural and social esthetics that are primarily related to African American culture. In spite of this, the person may not have authentically internalized the values and ideologies of African American culture, thus reinforcing a superficial sense of what it means to be African American.

The *internalization phase* occurs as the person's perspectives about life mature. They acquire more substantive knowledge of what it means to be African American, and the need to form a social network with other African Americans becomes pronounced. Inherent in this phase is that an appreciation for African American culture does not mean a denigration of White culture.

The *internalization-commitment phase* marks the end of the process, suggesting that the person has incorporated cultural values synonymous with African American cultural lifestyles. This serves to fortify a sense of cultural identity, and the person feels attached to African American culture as well as to the larger society.

Phinney's Model of Ethnic Identity Development

Like Cross's (1991) model, Phinney's (1989) model focuses on facets of ethnic identity development encompassing the following states: diffuse, foreclosed, moratorium, and achieved. According to Phinney (1989), *diffuse* means that individuals lack knowledge of their ethnic heritage. *Foreclosed* is accompanied by having a limited understanding about ethnicity as a social construct, yet there is a seeming awareness of one's ethnicity, which may be placed in a binary context of desirable or undesirable, based upon one's upbringing. *Moratorium* represents the ability to examine one's ethnicity, despite confusion about one's identity. *Achieved* reflects a desire to look at oneself, which provides clarity about self-affirmation in the context of one's ethnic identity development.

Both models provide frameworks for understanding the development of identity relative to race and ethnicity. On the one hand, Cross's (1991) model deals specifically with how race and racism color the self-concept of African Americans, revealing that each stage evokes an array of behavioral and emotional reactions, leading to self-examination and introspection concerning one's identity. On the other hand, Phinney's (1989) model focuses on the stages of the self-identification process of ethnic minority adolescents, outlining their struggles to form identities that are consonant with their ethnic group status.

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CASE VIGNETTE

A medium-built youngster with freckles, green eyes, curly hair, Negroid features, and two tattoos on his shoulder, Charles is a 16-year-old biracial adolescent who came to an initial consultation appointment with his parents, Ralph and Maria. Charles's school reported excessive absenteeism and marijuana usage. This prompted his parents to contact their employee assistance counselor who referred the family to the author for an assessment. After conducting four interviews (there were individual sessions with Charles as well as joint sessions with him and his parents), the family was referred to a clinician for ongoing family treatment.

Charles's Presenting Difficulties

Sessions with Charles were interactive and relational—he talked about concerns regarding his parents, his use of marijuana, and being teased by peers. He asked me what it meant to listen to people's problems every day. I responded by saying that listening prepared me to be helpful and that I wanted to know if I could be helpful to him. That response facilitated a solid working alliance. Charles smoked marijuana to "calm his nerves when he got angry." He complained about being teased and attributed this to his mixed heritage. He has been called the following names by his classmates and people in his community: "Oreo, yellow rat, half and half, and Irish wannabe." Charles vacillated between anger and sadness when referring to these racial epithets, pointing out that he has had the propensity to use aggression to deal with his feelings. Charles's fear of confrontation may have averted his use of aggression.

Charles's social network consisted primarily of White adolescents even though his classes were diverse. He felt comfortable with White students—he considers himself White. He has more in common with them than students of color, emphasizing his father is Irish, and that he has been to Ireland several times, and likes Irish culture. Charles described his White friends as cool, whereas he characterized students of color as "loud and pushy."

Charles described his father as cool because he can "get away with things," noting that he has his green eyes and curly hair. He depicted his mother, who is Puerto Rican, as "fussy and serious," and he has to listen to her complaints "all day," elaborating that both parents are concerned about his academics and would like him do well in school. Attempting to talk to his parents about being taunted by classmates resulted in his father minimizing his feelings. Charles and his parents rarely discuss issues of race and/or ethnicity; he noted that he did not know if they knew he perceives himself as being White.

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Familial Issues

Ralph is a White Catholic Irish man who is 47 years of age. He has one sibling who resides in Ireland. Maria, 43 years of age, is a light-skinned Puerto Rican who was born to a dark-skinned Puerto Rican mother and a light-skinned Dominican father, both of whom are also Catholic. Ralph and Maria dated for two years before informing their parents about their relationship. The interracial nature of their union has been a source of contention for their families; they eloped after Maria discovered she was pregnant. Their parents have stopped speaking to them; Maria's siblings have reached out to her intermittently, but she does not feel close to them.

Ralph and Maria are college-educated, middle-class professionals who own a home. They appeared to have a stable relationship. Based on my interview with Charles, I explored whether Ralph and Maria understood their son's feelings about his mixed background. Ralph felt his son was fine and did not have any struggles with his identity. Conversely, Maria felt Charles grappled with being biracial for two reasons: his physical features and his view of himself as being White, as opposed to biracial, which contributed to his being teased. Ralph minimized his wife's view, indicating that teasing is "child's play," and that Charles can deal with it, a point that Maria seemed to abhor. It was apparent that Ralph and Maria held different perspectives of how issues of race and ethnicity may be affecting Charles. Nonetheless, Ralph and Maria agreed that it would be useful to help Charles with his feelings regarding his identity via treatment.

DISCUSSION OF THE ASSESSMENT PROCESS

Family Dynamics

Charles's mother and father did not seem to have a strong sense of themselves as an interracial couple raising a mixed-race child. This observation was strengthened when I engaged them on Charles's struggles with his identity. Clearly, differences pertaining to their perceptions of race, culture, and ethnicity were present, and this seemed to have influenced how they functioned as a family unit. Conversations regarding race and culture were omitted from the home. Research (Root, 1990) indicates that the strong emotionality induced by discussing racial and cultural issues in interracial families often impedes their ability to have such conversations. In light of my observation that Charles was wrestling psychologically with his identity, I felt it appropriate to explore how race, culture, and ethnicity were addressed (or not) within the family. Based upon their differing impressions of Charles' racial identity development, I inferred that anxiety may have surrounded his parents' ability to talk about their cultural differences as a couple, as well as Charles's biracial background, confirming Root's (1990) conjecture regarding the difficulties that biracial families endure when they attempt to engage in conversations about race and cultural issues.

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Multicultural families wrestle with the idea of how and when to talk to their children about racial and ethnic issues without inducing feelings of stigmatization. Yet, scholars such as Thomas, Davidson, and McAdoo (2008) believe that it is important for people of color to have a good grasp of how the stress related to racial oppression mars their functioning, arguing that this helps them employ adaptive coping skills. Although this assertion has relevance for Maria and Ralph—their difference based on gender, race, culture, and ethnicity—may have accounted for the stark contrast in their perceptions of how they perceived their son's view of himself as White. This strengthened the viewpoint that interracial families may employ differing perspectives when they process racial and cultural concerns (Crawford & Alaggia, 2010).

It is important for practitioners to be mindful of the ubiquitous nature of racial and ethnic bias, which is inherently connected to the American ethos and adversely affects these families, placing them at the margins of society (Canino & Spurlock, 2000; Boyd-Franklin, 2003; Park, 2008; Pinderhughes, 1989; Sue, 1981). Attempting to help Charles's parents, I pointed out that they needed to provide emotional support and validation to Charles to help him cope with the challenges associated with his identity development. The point was to sensitize his parents to Charles's pronounced sense of feeling different. According to Pinderhughes (1989), "[f]eelings of differentness evoke a sense of aloneness, isolation, and abandonment for they signify a sense of connection or relationship to another. They can threaten the sense of psychological wholeness and intactness that people need" (p. 30). Pinderhughes's argument about acquiring a sense of wholeness with respect to developing self-worth contradicted Charles' father's view of his son: He thought it was fine for Charles to perceive himself as being White, because after all one of his parents *is* White. Although I had empathy for his father's position and understood his need to accept his son, I wondered if it was possible for a father who is culturally and ethnically different from his son to truly understand how matters of race complicate his son's identity.

CHARLES'S INDIVIDUAL DYNAMICS

As noted previously, identity formation and physical maturation are intrinsic to the developing adolescent (Blos, 1962; Canino & Spurlock, 2000; 2006; Mishne, 1986; Taylor, 1989). Research (Boyd-Franklin, 2003; Phinney, 1989, 1996; West, 1994; Zayas, 2001) illuminates that racial, ethnic, and cultural differences in our society are still significant. Because of this, it is important for adolescents of color to cope with this reality. Zayas (2001) affirms that children of color are subjected to "[r]acism, discrimination, and marginalization" (p. 363). Charles's negative internalizations of himself may have stemmed from the belittling comments he endured from peers about his identity. Crawford and Alaggia (2010) declare that mixed-race children confront ridicule based upon who they are, and this culminates in self-loathing behaviors, thus precipitating conscious and unconscious reactions regarding themselves and their cultural and/or ethnic reference groups (Akbar, 1984; Cross, 1991; Mayo, 2004).

It was my clinical impression that Charles's ethnic identity development was quite *diffuse,* showing what Phinney (1989) refers to as "[l]ittle or no exploration of one's ethnicity identity and clear understanding of the issue" (p. 38). At this stage, the adolescent lacks any real meaningful connection to his or her own ethnicity. Charles's lack of ethnic identity development was shaped by his social and familial experiences. Being raised in a family where ethnicity, race, and culture were treated as invisible entities, and being exposed to negative societal projections about his mixed race may have accounted for his lack of affinity for his biracial background. Likewise, Charles's outlook can be understood through the lens of Cross's (1991) *pre-encounter phase.* His identification with being White may have originated from his father's support for this cultural leaning. And, the view of race, skin color, and having a White father may have played a role in Charles's strong identification with his father. The need to separate from his mother and identify with his father is indicative of a developmental predisposition consistent with adolescent males. Notwithstanding race and ethnicity, fathers' physical representations become a model with which boys begin to identify in order to nurture their sense of masculinity (Blos, 1962). This may have been reinforced by having a father whose social identity is imbued with power and privilege (Pinderhughes, 1989). Peers disparaged Charles racially and ethnically, therefore, it was helpful for his parents to cultivate an environment that celebrates all facets of his cultural and ethnic self-identification. Scholars posit that having systems (e.g., familial, friends, and other social networks) that validate one's cultural identity fosters a sense of belonging and connectedness to one's culture and ethnicity (Boyd-Franklin, 2003; Phinney, 1996; Pinderhughes, 1989). In contrast, Phinney (1989) makes the case that children who do not feel connected to their culture and ethnicity may feel psychologically isolated from themselves and others.

CONCLUSION

This chapter provides a lens through which we can understand multicultural adolescents, underlining the importance for this group to have a strong sense of self that includes awareness of their racial and ethnic identity. The formation of identity is very important for adolescents, because it gives them a sense of connection to peers and their communities. The relevance of this point when placed in the context of the lived reality of multicultural adolescents is even more compelling. It may be psychologically affirming for them to be able to relate to others who share a sense of kinship and who may be capable of mirroring their potentials—particularly in light of how oppression undercuts their functioning. What is important for practitioners to consider in working with adolescents of color is although they are not homogeneous and issues of social class and education can mediate how they define themselves and react to being marginalized, it is prudent to help them cope with and adjust to their struggles with any form of social injustice.

Finally, the case vignette of Charles and his family serves as an example that shows many of the ways in which ethnicity, race, and culture can impinge on family relationships. That Charles's behavior at school was induced by race-related teasing highlights that stress, emanating from feeling

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marginalized, should not be underestimated. Furthermore, the case vignette stresses the salience of culture, race, ethnicity, and family dynamics in helping adolescents from ethnic and racial minorities construct social identities consistent with life in a society where they are often victims of racial and ethnic bias.

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SEVEN

Contingent But Resilient: The Plight of Young, Male Day Laborers in the United States

Gregory Acevedo and Rafael Perez

YOUNG, MALE DAY LABORERS

Young male day laborers are among the most marginalized groups in the United States. According to the federal government,

> . . . individuals working as day laborers are some of this nation's most vulnerable workers . . . the characteristics that make day laborers most susceptible to workplace abuses also make it difficult for Labor and others, especially in light of limited resources, to find and protect them. It is also difficult to protect a group of workers that may not want to be found. These difficulties may lead to workers who are not receiving the protections they are entitled to under law, as well as larger problems associated with an underground economy, illegal immigration, and unreported income. (United States General Accounting Office, 2002, p. 25)

Day laborers are marginalized in a myriad number of ways, and are often "living in the shadows" of society.

Who are day laborers? Day labor is a type of contingent work. Contingent work is any form of part-time or temporary work. The United States General Accounting Office notes:

> "Day laborers" is a term that generally refers to individuals who work and get paid on a daily or short-term basis. To find work, day laborers often congregate on street corners and wait for employers to drive by and offer them work. The term also includes those who may be employed by temporary staffing agencies that assign them work on a daily basis with client employers. Day laborers have an informal relationship with the labor market, often working for different employers each day, being paid in cash, and lacking key benefits, such as health or unemployment insurance. (2002, p. 1)

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Day labor is a global phenomenon and has a long history in the United States that traces its roots as far back as the Early Republic, and has been part of the nation's dynamics of racializing labor markets (Valenzuela, 2003). The growth of day labor in the current era is an outcome of the intensification of global economic integration and its concomitant unprecedented increase in immigration (Sassen, 1991, 1995).

As is the case with counting the homeless, the poor, and other marginalized and stigmatized groups in the United States, achieving reliable and exact counts of the day labor population is difficult. To date, only the Bureau of Labor Statistics (BLS) has compiled nationally representative data on the day laborer population. In 2001, the BLS pegged the number of day laborers "who wait on street corners for employment" each day at about 260,000 (United States General Accounting Office Highlights, 2002, p. 1). The most substantial scholarly study on day laborers found that: "On any given day, approximately 117,600 workers are either looking for day-labor jobs or working as day laborers" (Valenzuela, Theodore, Meléndez & Gonzalez 2006, p. i).

Counts of day laborers may vary, but the profiles they yield converge: "While individual sources may be limited in scope, taken together, they provide a general picture of the day laborer population as young Hispanic men with limited educational skills and significant language barriers" (United States General Accounting Office, 2002, p. 10). Valenzuela et al. (2006) provided the most comprehensive portrait of day laborers thus far. Among the day laborers they studied, they found the following:

- Most were either married (36%) or living with a partner (7%), and almost two-thirds (63%) have children; 28% percent of those children were U.S. citizens;
- They were "active members of their communities" as 52% percent attended church regularly and 22% were involved in sports clubs;
- 59% were born in Mexico and 28% in Central America; the third-largest group was U.S.-born (7%);
- 75% were of undocumented status.

THE NATURE OF DAY LABOR

These demographics help "put a face" on the typical young male day laborer. We must also understand the nature of the type of work they do. Here again, Valenzuela et al. (2006) were instrumental in documenting the experience of day laborers in the United States, albeit in a "snapshot" point of time:

- 42% of day laborers were located in the West, followed by 23 % in the East, 18% in the Southwest, and 4% in the Midwest;
- 79% of the "hiring sites" for day laborers were informal; these included, standing in front of businesses, home improvement stores, gas stations, and busy streets primarily located near residential neighborhoods;
- Most day laborers were employed by homeowners/renters and construction contractors; they were employed as construction laborers, gardeners and landscapers, painters, roofers, and drywall installers;

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- 83% were relying on day-labor work as their sole source of income and that day labor paid "poorly";
- Earnings from day labor work were "unstable and insecure, resulting in volatile monthly earnings . . . [and] it is unlikely that their annual earnings will exceed $15,000, keeping them at or below the federal poverty threshold." (p. ii)

In addition to meager and irregular wages, day laborers are exposed to unregulated and unsafe work environments that commonly lead to injuries, many of which result in lost time from work (Valenzuela et al., 2006). Yet, day laborers are likely to be medically uninsured, and are unlikely to be formally compensated.

LEGAL ISSUES AND DAY LABOR

The socioeconomic vulnerability of day laborers hinges on many aspects of public policy, particularly labor law, civil rights, and immigration legislation. The rise of anti-immigrant sentiments over the last one to two decades, fueled by heightened national security concerns and a sharp economic downturn, have resulted in a wave of anti-immigrant polices that weigh hard on day laborers. As is traditional, some of this legislative activity has been federal in scope, but there has been a noticeable shift toward state and local policymaking.

The public and lawmakers argue that the current federal immigration laws are broken and the federal government is not assisting the states in curtaining off an influx of undocumented immigrants. As a result, lawmakers in many states are enacting anti-immigration legislation that require local police enforcement to become quasifederal agents and enforce local anti-immigration laws. Anti-immigration laws have been met with great resistance from the U.S. Department of Justice (DOJ) and from immigrant advocacy groups.

Undocumented immigrants, particularly day laborers, are feeling the brunt of this discrimination and as a result are being unfairly targeted. Their vulnerability and lack of available recourse leaves them in a constant state of fear and uncertainty. As a result, immigrant families are separated, exploited, and disenfranchised from society by current anti-immigration policies. Additionally, many recent immigrants are victims of fraudulent behavior because of their inability to effectively communicate in English and/or understand cultural differences.

Various pieces of legislation are of significant consequence to day laborers and relate to a variety of policy domains. The following overview delineates the array of policies and programs that need to be accounted for in work with young male day laborers.

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Federal Immigration Laws

The federal immigration law that directly affects day laborers is embodied in the Immigration and Nationality Act ("INA"), 8 U.S.C. §§ 1101–537, Title VIII of the Civil Rights Act of 1968, Department of Labor Wage and Hour Laws,

and the Fair Housing Act. Until recently, implementing and enforcing federally mandated immigration laws were exclusive within the federal government's jurisdiction. However, in response to an increase of immigrants within their borders, states have taken the initiative to pass legislation aimed at enforcing local immigration laws, resulting in inconsistency, confusion, and a disconnect between local authorities, immigrant communities, and federal agents.

Constitutional Challenges

The DOJ and interest and advocacy groups have challenged anti-immigration laws in federal court with a variety of constitutional challenges. The most common and most successful has been the Supremacy Clause, which is found in Article VI, Clause 2 of the U.S. Constitution, and establishes that the U.S. Constitution, U.S. treaties, and federal statutes are "the supreme law of the land." Other constitutional challenges include violations of the due process clause, equal protection under the 14th Amendment, and the prohibition of unreasonable search and seizure under the 4th Amendment.

Federal courts utilize the Supremacy Clause to ensure that states do not circumvent Congressional intent. Congress can expressly preempt the states from imposing criminal or civil penalties in a particular area of law and Congress can also implicitly preempt states from enacting legislation. For example, Congress may expressly forbid the states from passing legislation within a certain area of law or Congress may implicitly preempt states from passing legislation by occupying an entire field of law or if complying with federal law and state law would be impossible.

The Immigration and Nationality Act

The current state of federal immigration law is a reflection of a reactive response to a proactive problem. Currently, Congressional immigration legislation fails to address ongoing system failures that continue to leave millions of undocumented immigrants vulnerable and exposed to harassment, exploitation, and inhumane treatment.

In 1952 Congress revamped the immigration laws by enacting the Immigration and Nationality Act of 1952. Although Congress has repeatedly amended the INA, it remains the primary statute for federal immigration laws. In 1986, Congress passed perhaps one of the most debated amendments to the INA, the Immigration Reform and Control Act (IRCA). The IRCA prohibited undocumented aliens from legally working in the United States on a federal level. The IRCA established a comprehensive framework on immigration policymaking and enforcement efforts. Congress's goal was to ensure uniformity by exclusivity in the area of immigration law. The IRCA expressly preempted states from enacting, enforcing, or in any way circumventing the federally imposed immigration laws; however, it purposefully excluded "licensing and similar laws" from the prohibition.

Furthermore, 8 U.S.C. §1304 and 1306, require that aliens over the age of 14 and who have remained in the United States for more than 30 days register with the U.S. government and carry the registration documents with

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them at all times. States enacting anti-immigration laws are making it a local crime, normally a low class misdemeanor, for aliens to not possess their federally required registration documents, establishing the necessary probable cause to arrest. Once in police custody, the police further inquire about their immigration status in the United States and seek confirmation from the federal government before releasing the person.

In 1996, Congress passed the Illegal Immigration Reform and Immigrant Responsibility Act (IIRAIRA), Section 287(g). This authorized the Secretary of the U.S. Department of Homeland Security (DHS) to enter into an agreement with local enforcement agencies to authorize them to perform immigrant law enforcement functions under federal supervision. There are currently more than 1,075 local officers trained and certified through the program under the 67 active Memoranda of Agreements (MOA) in 24 states. Local law enforcements use the authority granted to them by the MOA's and enforce federal legislation with very little guidance, support, or oversight from the federal government.

Pursuant to the IRCA's "licensing and similar laws" exception, states have passed legislation that focuses on employers and landlords who employ, lease, or transport undocumented aliens. The laws make it a local crime to employ or lease real property to an undocumented alien. Pursuant to the "licensing and similar laws" exclusion, an employer found guilty of violating local laws would be in risk of having his license suspended and for repeat offenders, possibly revoked.

State-Level Anti-Immigration Policy

In 2010, Arizona passed what was at the time the harshest anti-immigration legislation (SB 1070). Some aspects of the law mirrored federal immigration law by converting federal crimes into local crimes and having local law enforcement enforce any violation of local ordinances. While some have argued that this was not anti-immigration, but "anti-illegal" legislation, the play on words is not convincing and is only contributing to creating an environment where racial profiling, exploitation, and sheer hatred for Latinos are allowed to flourish. As a result, immigrant families are being taken advantage of and misplaced. Kids are being bullied, adults are victims of hate crimes, and discrimination occurs on a daily basis.

In June 2012, the Supreme Court issued a monumental decision holding most of Arizona's anti-immigration law unconstitutional. The decision sent a clear and unequivocal signal to other jurisdictions, which have either passed or were considering passing similar legislation, that immigration law is mainly within the federal government's purview. The court held three major provisions unconstitutional as preempted by federal law and left another controversial provision intact, but suggested that it may be vulnerable to future constitutional challenges.

A summary of the Arizona law is as follows:

1. SB 1070 made it a state misdemeanor for an alien not to be in possession of his federal registration papers. The Supreme Court held this section unconstitutional because it is preempted by federal law.

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2. Permission for warrantless arrests, if there is probable cause the offense would make the person removable from the United States. The Supreme Court held this section unconstitutional because it is preempted by federal law.
3. Anti–day laborer/solicitation provision. This provision made it a crime to impede traffic and/or solicit work on a street corner. The Supreme Court held this section unconstitutional because it is preempted by federal law.
4. Pursuant to IRCA's "licensing and similar laws" exclusion, Arizona threatened revocation or suspension of a company's business license if they knowingly or intentionally sheltered, hired, and transported an undocumented alien. The Supreme Court held that federal law did not preempt this section because the law fit squarely within IRCA's "licensing and similar law" exception.
5. SB 1070 also required local law enforcement to attempt to determine an individual's immigration status during a "lawful stop, detention or arrest" if the police officer has reasonable suspicion that the detainee is an illegal immigrant. If arrested, the detainee cannot be released without confirmation of his lawful status from the federal government. The Supreme Court upheld this section but left the door open that it could be susceptible to future constitutional challenges after the law is implemented. This "wait and see" approach is a vital threat to immigrant communities because it opens the door to racial profiling, harassment, and bias treatment.

Learning from Arizona's experience in federal court, Alabama tailored its anti-immigration law to avoid the fate suffered by Arizona's and created new provisions that attacked every aspect of immigrant life. It attacked how they earn a living, how they attend school, and where they congregate. In addition to the provisions in the Arizona law, Alabama included the following provisions:

1. Prohibits illegal immigrants from receiving any public benefit at either the state or local level.
2. Prohibits immigrants from attending publicly owned colleges or universities.
3. Revealing your legal status as a precondition prior to attending any high, middle, and elementary public school level. The Supreme Court has held that every child, regardless of citizenship, is entitled to a public school education up through 12th grade. This provision does not prevent the student from attending; it just requires them to reveal their status.
4. Prohibits employers from knowingly hiring legal immigrants for any job within Alabama. A presumption of due diligence is implemented if the employer complied with the federal E Verify requirements.

Immigrant day laborers live in a constant state of fear that they may be arrested and deported, get injured on the job and not be able to support themselves and/or their families, or not get paid for work performed. A "wait and see" approach only drives a bigger wedge between immigrant communities and the police officers in charge of policing their community. The "show me your papers" provision not only invites racial profiling, it gives police

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officers sole discretion on whom to approach and when. Coincidentally, undocumented immigrants wear the same clothes, eat the same food, go to the same schools, shop at the same grocery stores, and play at the same park as documented immigrants. Therefore, the only way to distinguish undocumented from documented is by racially profiling a certain sector of society. This leaves all immigrants, regardless of status, susceptible to racial profiling and police harassment.

In addition, requiring students in public schools to provide their immigration status creates tension and fear in the immigrant community because it promotes segregation and prejudice treatment and promotes and creates a second tier of students that are incapable of achieving in today's economy. Parents might refuse to send their children to school and children will be in a constant state of fear while in the classroom. In *Plyler v Doe*, the Supreme Court held that all children, regardless of immigration status, are entitled to a public school education up to high school. That decision should also be interpreted as meaning that every child, regardless of immigration status, has a right to not fear going to school because of segregation and prejudicial treatment by the local authority.

Federal Fair Housing Act

Under the federal Fair Housing Act (the FHA), undocumented immigrants have the same claims and rights as a U.S. citizen. The FHA creates a private right of action against discrimination on the basis of race, color, religion, sex, familial status, or national origin. While the federal act does not discriminate against citizenship, it does protect against national origin. However, discrimination against citizenship can become discrimination against national origin if the landlord is refusing to meet with candidates from a particular national origin.

Some states, such as New York, have enacted legislation that further protects undocumented citizens. The City Human Rights Law protects residents of most types of housing discrimination in New York. It is unlawful for landlords, superintendents, building managers, condominium owners, cooperative owners, and boards to discriminate in the sale, rental, or lease of a housing accommodation or in the provision of services and facilities because of a person's actual or perceived race, color, national origin, gender, disability, sexual orientation, creed, marital status, partnership status, alienage or citizenship status, any lawful source of income, age, lawful occupation, or because children are or may be residing with the person.

While the FHA protects against discrimination based on race, color, religion, sex, familial status, or national origin, however, it does not protect against discrimination of citizenship. Thus, under the FHA the landlord may discriminate against undocumented immigrants as a long application process for all potential candidates is equally applied and they do not discriminate based on national origin. For example, a landlord is required to see every Latino's passport, but doesn't ask non-Latinos for theirs. Anti-immigration legislation has sought to penalize landlords by imposing civil and criminal penalties for renting to undocumented immigrants. Federal courts have

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reacted unanimously, and voided such legislation as being unconstitutional and preempted by Congress.

Fair Labor Standard Act

Pursuant to the Fair Labor Standard Act (FLSA) all workers, documented or undocumented, are entitled to earn at least the federal minimum wage, establishment of a 40-hour workweek, overtime after 40 hours, and a 30-minute lunch break. It also requires employers to keep adequate time and payroll records. The FLSA applies to "employees who are engaged in interstate commerce or in the production of goods for commerce, or who are employed by an enterprise engaged in commerce or in the production of goods for commerce," unless the employer can claim an exception.

Many employers avoid the penalties of the FLSA by classifying day laborers as independent contractors. The misclassification permits the employer to avoid the FLSA and any local equivalent. Employers do not have to pay local or federal taxes, workers compensation, or pay overtime. Day laborers are exploited under this misclassification. Because employers are fully aware of their vulnerability, they are able to underpay day laborers for physically demanding work, avoid liability if the day laborer suffers an injury, and either refuse to pay or pay less than previously agreed to because the normal day laborer is not aware of his legal rights.

For those states that passed anti-immigration laws, the effect of those laws sent a chilling message to the immigrant community. The message was clear and unambiguous—hatred, bias, and discrimination are the intended goal and private right of action, and the use of local law enforcement is the means to accomplish them. As a result of recent anti-immigration legislation, stories are beginning to emerge of families being torn apart, injured and/or pregnant immigrants afraid to go to the local hospital, crime victims afraid to contact local law enforcement, and parents afraid to send their children to school. Furthermore, "The entire City suffers when a substantial part of its population lacks adequate housing, insurance coverage, heath care or education." We need comprehensive immigration reform to come from the federal government, not from individual states that are not trained to handle immigration enforcement and only results in further dividing a community that already has a problem fitting in.

The Public Battle Over Informal Day Labor

In terms of legal rights and statuses informal day laborers "on the street corner" may be "living in the shadows," but due to the nature of their search for employment, they are often in full view. In an era that has seen a rise in anti-immigrant attitudes, rhetoric, and punitive policies, day laborers have become an easy public target of suspicion, derision, and injustice. The study by Valenzuela et al. (2006) found that

> Almost one-fifth (19 percent) of all day laborers have been subjected to insults by merchants, and 15 percent have been refused services by local businesses. Day laborers also report being

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> insulted (16 percent), arrested (9 percent) and cited (11 percent) by police while they search for employment. (p. ii)

A *New York Times* editorial from September 21, 2011 applauded the United States Court of Appeals for the Ninth Circuit ruling that threw out an antisolicitation ordinance in Redondo Beach, California. The editorial's comments are forceful:

> While officials couch their concerns in terms of safety, the anti-immigrant hostility is usually clear. A contemptible dissent in the Ninth Circuit decision, by Chief Judge Alex Kozinski, summed up a pernicious stereotype. He called day laborers "a bunch of scraggly men smoking and spitting while waiting for jobs," and wrote that he saw no reason why Redondo Beach should not be allowed to drive them away in the name of "safety, beauty, tranquility and orderliness." No reason except the Constitution, of course. (*New York Times*, 2011)

The battleground that has taken hold at the community level is exemplified by two countervailing policy trends, the secured communities program and the sanctuary cities movement.

Secured Communities

Secured communities (SC) is a federal deportation (also known as "removal") program administered by the Department of Homeland Security. The program creates a bilateral partnership between federal, state, cities, and municipalities. According to the DHS, the goals of the program are to

1. IDENTIFY criminal *aliens* through modernized information sharing;
2. PRIORITIZE enforcement actions to ensure apprehension and removal of dangerous criminal aliens; and
3. TRANSFORM criminal alien enforcement processes and systems to achieve lasting results." According to the DHS, the program was intended to deport "the worse of the worst" and only "the most dangerous and violent offenders."

In fact, the majority of the people deported have been convicted of nonviolent crimes, minor offenses, or no crime at all.

Under SC, the fingerprints of any person arrested in a participating state, city, or municipality are scanned through a Department of Homeland Security's immigration database. Normally, those fingerprints would only be sent to an FBI criminal database to determine if the arrestee is wanted in any other jurisdiction. However, under SC, the arrestee's fingerprints are also scanned through the DHS's immigration database. The DHS database keeps biometric records of immigration applicants, violent criminals, and those with terrorist connections.

If there is a match, Immigration and Customs Enforcement (ICE) is immediately notified and is given the option whether or not to issue a detainer.

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A detainer is a request from the ICE to the arresting law enforcement agency to notify the ICE before releasing the immigrant detainee or to detain them for an additional 48 hours while the ICE decides how to proceed.

Under the Obama administration, the DHS has aggressively increased their deportation and detainer efforts. For example, in 2009, there were 828,119 submissions, 95,664 hits and 14,360 deportations. In 2010, there were 3,376,753 submissions, 248,166 hits, and 49,484 deportations. In 2011, there were 6,919,917 submissions, 348,958 hits, and 78,246 deportations. In total, over 11,000,000 fingerprints have been scanned through ICE's biometric fingerprint database and it has resulted in over 692,788 hits, resulting in over 142,000 deportations. Currently there are over 1,590 jurisdictions in 44 states and territories participating in SC. The numbers are only increasing and the DHS seeks to have the program implemented in all 3,141 jurisdictions by the year 2013.

In addition to targeting nonviolent immigrants, SC also infringes on state sovereignty. Typically states are able to create laws and regulations that protect the general welfare of anyone living within their borders. SC infringes on that right and prohibits the state from protecting the general welfare of its residences. Generally, individual states balance the need to protect residents living within its borders with the need to efficiently enforce law and order. SC prohibits states from making that balance by creating an environment of conflicting ideologies. In addition, the ICE has only exemplified the problem by issuing contradictory statements as to whether localities can "opt out" of the program.

Furthermore, there is the financial strain placed on the states by enforcing SC. States do not receive federal funding for SC enforcement. As a result, states and municipalities carry the financial burden for housing the arrestee until turned over to federal custody, paying overtime to police and administrative personnel while implementing SC, and expose themselves to legal liability if they unlawfully detain the wrong person because of an ICE detainer. Finally, SC exposes some serious concerns about the role of local law enforcement acting as federal agents. Local law enforcement officers are not trained to govern federal immigration laws and as a result execution of SC will vary from state to state thus creating inconsistencies among neighboring states.

Ultimately, SC creates a profound wedge between immigrant communities and local law enforcement and opens the door to racism, community harassments, and bias against the Latino communities. SC further destroys communal trust between local law enforcement and the communities they are supposed to serve and protect. Immigrant families and immigrant communities live in a constant state of fear. The simplest task can result in being detained and possibly deported. Immigrants are afraid to report crimes, come forward as witnesses, or sit on a jury because they fear any contact with local law enforcement. Native-born Latinos are often targeted by means of racial profiling by local law enforcement and can turn a simple encounter with local law enforcement into a detention and possible deportation case. SC amplifies these fears by creating an atmosphere filled with tension and uncertainty.

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Sanctuary Cities

Sanctuary cities is a term used for cities or municipalities that do not distinguish between legal resident immigrants and undocumented immigrants. They are called sanctuary cities because employees in the public sector, police, fire department, emergency units, teachers, and so on, are instructed not to inquire about a person's immigration status during the course of their employment and if their immigration status becomes known to the public employee, they are prohibited from sharing such information with the DHS, thus making the municipality a sanctuary for immigrants.

In 1996, Congress passed the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA). The IIRIRA created an affirmative duty on a public employee to report a person's immigration status to the DHS, thus banning a city from prohibiting its public employees from contacting federal officials if they come in contact with an undocumented immigrant. As a result, most sanctuary cities refused to become agents for the federal government and instead shifted toward implemented a "don't ask, don't tell," immigration policy. This approach doesn't prohibit sharing immigration status information with federal agents; instead, it prohibits a public sector employee from ever asking about a person's immigration status unless it is directly relevant to the situation. As of recently, politicians running on anti-immigration platforms are introducing legislation that bans the implementation of sanctuary cities within its respective states.

WORKING WITH DAY LABORERS

In 2010, one of the authors of this chapter worked on a report analyzing the legal issues confronting day laborers ("workers") in Newark, New Jersey (Norcia, Perez Jr., Malhorta, & Lonegan 2010). The report exposed Newark's underground labor market and documented a market plagued with wage and hour and safety violations. The report was the first of its kind and has since been used as an advocacy tool to support employee rights, the adoption of communal work centers, and harsher penalties for employers who violate local and federal wage and hour laws.

In the winter months of 2010, I made multiple observational visits to the "shape up site" located on Stockton Street in Newark, New Jersey. There were approximately 50 workers looking for work on any given morning. They were broken up into groups of 3 to 10 and stretched nearly a quarter mile down Stockton Street.

My first obstacle was gaining the workers' trust. Initially, I introduced myself as a student attorney working on a report that will be used to advocate for better protection of workers' rights. The workers either refused to talk to me or would move down Stockton Street if they saw me approaching. The workers were very skeptical of my presence and distrusted my intentions. I spoke to the workers in Spanish and the workers either remained silent or simply responded with sayings like, "not interested" or "we just want to work, get paid, and go home."

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Then, I collaborated with a local community organization group that was working with the Newark workers to organize and better protect their labor rights. The organization organized weekly meetings at a church and discussed current issues confronting the workers. During the next two months, I attended weekly church meetings, continued to visit the shape-up site, participated in neighborhood human rights meetings, met with local politicians, and assisted the workers to recoup past wages from previous employers. The workers slowly began to trust and confide in me and open up to me about their personal experiences.

The workers preferred waiting on Stockton Street because it had a high level of commercial traffic due to a giant lumber/hardware store located at the end of the road and its accessibility to two major highways. Employers can shop for needed supplies and workers simultaneously. While the workers preferred waiting on Stockton Street, they paid a heavy price for the convenience. They were often harassed and targeted because of their occupation and/or nationality.

The workers were constantly harassed on a daily basis by local business owners, people driving by, and the police. Previously, the owner/manager of the lumber/hardware store chased the workers off his property for months by screaming and yelling profanities at the workers congregating in front of his store. The gas station, the check cashing store, and the restaurant called the police every morning to report that the workers were trespassing on their property. The Newark Police Department, while professional during every interaction, instructed the workers every day around noon that they were trespassing and had to disburse. The officers threatened to issue summons if the crowd did not disburse quickly enough. The workers always complied with the officers' requests knowing that by moving they were also forfeiting any opportunity for gainful employment.

Then, I asked to hear stories of wage and hour abuses to better understand what questions I should ask during my survey. The stories I heard were so inhumane I had a hard time believing they occurred on U.S. soil. For example, two workers were hired to rebuild a roof on a two-family home. The workers were promised $100 a day until the job was completed. As is traditional, the owner agreed to pay the workers on Friday at the end of each week. As agreed upon, after their first week, the workers sought to get paid. The owner said that he did not have the money, but he promised to pay them the following week. After completing their second week, the workers requested to get paid and the owner again refused to pay and insisted that they would get paid the following week. After completing the job by the end of the third week, the workers again requested to be paid. The owner became irate and began yelling that he was not going to pay the workers and that if they threatened to go to the police he would call his cousin, an ICE agent, and make sure that the workers' whole families would be deported. The workers nonetheless demanded to be paid and the owner threatened them with physical violence and deportation. Ultimately, due to fear of authorities' involvement, the workers abandoned any attempt to collect from the owner. As a result, the workers forfeited $1,500 apiece because of intimidation, fear, and unavailable recourse.

Another worker sustained serious bodily injury when he fell off a roof while working on a commercial building. The employer drove him to the hospital, gave him $100 cash, told him to change his name and deny ever working for the employer. The worker sustained serious back injury, underwent back surgery, and was unable to work as a worker for nearly one year afterward. The employer subsequently changed his cell phone number and when confronted on Stockton Street, denied ever employing the worker. A third worker was hired to shellac a newly constructed house. The owner agreed to pay the worker $125 a day until the job was completed. The worker completed the job in two weeks. When the worker asked to be paid, the employer exploded into a rage, said that the work was "horrible," that he "had to hire someone else to re-shellac the walls," and accused the worker of "stealing tools." When the worker asked why he had not complained earlier, the employer picked up his cell phone and began to call 911. The worker abandoned the work site, not because he had stolen anything, but because he feared the police and felt that the officers would immediately take the employer's side and arrest him.

Finally, I learned enough that I was ready to conduct my survey. I surveyed the workers and asked questions pertaining to their living conditions, family situations, and employer–employee relationships. Their stories differed, but there were some themes that were common: nearly all of them lived with other workers or with their immediate families or both, had experienced various levels of wage and hour abuse in the past year, and supported the creation of a worker's center.

Ninety-six percent of the workers surveyed had experienced at least one occurrence of wage and hour violation in the past two years. Seventy-seven percent reported being paid less than previously agreed to, 62% reported not being paid at all, and 88% reported not being paid overtime for working over 40 hours in one work week.

What emerged was an image of an underground labor market that operated in the shadows and contained no checks and balances. Employers have all the leverage and the workers have little recourse. As a result, the workers are left vulnerable, exposed, and exploited by business owners, general contractors, subcontractors, or private homeowners.

Workers' Centers

Historically, immigrant co-ethnic aid societies and organizations have provided social services, resettlement programs, and advocacy (Cordero-Guzmán, 2001). A new form of community organization has emerged that plays a similar role: Worker's Centers (Fine, 2005a; 2006, 2007; Sullivan, 2005). Fine's (2006) description of Worker's Centers harkens back to the origins of the Settlement House tradition:

> [Worker's Center's] have emerged as central components of the immigrant community infrastructure and are playing an indispensable role in helping immigrants navigate the world of work

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> in the United States. They are gateway organizations that provide information and training in workers' rights, employment, labor and immigration law, legal services, the English language, and many other programs. They represent a new generation of mediating institutions that are integrating low-wage workers into American civic life and facilitating collective deliberation, education, and action. (p. 452)

One-quarter (26%) of the day laborers in the Valenzuela et al.'s (2006) study had participated in community worker's centers.

Worker's centers "vary in terms of their organizational models, how they think about their mission, and how they carry out their work" (Fine, 2007, p. 54). However they do share core characteristics: (a) a social movement orientation; (b) organizing around both economic issues and immigrant rights; and (c) favoring alliances "with religious institutions and government agencies" as well as seeking "to work closely with other activist groups in a variety of formal and informal coalitions" (Fine, 2007, p. 54).

In their coalition-building efforts, Worker's Centers have navigated a number of cross-current interests between: unionized and nonunionized workers; immigrant and native-born workers; and racial and ethnic groups. Fine (2005) notes that, for strategic reasons, traditional labor unions targeting low-wage workers have not often focused on immigrant workers in this sector; thus, while Worker's Centers do not oppose traditional unions relatively few partnerships have developed with them. Worker's Centers have also attempted to foster solidarity between immigrant and nonimmigrant workers and to encourage mutual recognition of their common concerns. One example of this is "the joint lobbying of worker centers in Chicago and the Illinois AFL-CIO in support of a new law that would criminalize the failure of employers to comply with state wage and hour law" (AFL-CIO, 2006). Worker's Centers have also focused on addressing racial and ethnic differences. For example, "Worker centers in the South are working with Latino and African American communities . . . to bridge cultural differences that are causing tensions in these communities and dividing workers in the workplace" and as part of this effort they have "been providing training to union organizers on the rights of immigrant workers, as well as cross-cultural issues, and have provided bilingual steward training jointly with the union" (AFL-CIO, 2006).

Despite the variation among Worker's Centers nationally, it is clear that "they provide low-wage workers a range of opportunities for expressing their 'collective voice' as well as for taking collective action" (Fine, 2005, p. 2). In this sense then, Worker's Centers appear to be strategically positioned as important channels for "bottom-up" activism and have much potential for aiding the immigrant rights movement, labor organizing, and social movements in general.

Social Work With Young, Male Day Laborers

The social work literature on day laborers is sparse (one notable piece is by Cleaveland & Kelly, 2008). In considering the roles for social work in

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addressing the needs of young male day labors, obviously policy practice and advocacy loom large. The constellation of risks and stressors that comprise the daily life of young male day laborers and their psychosocial implications are staggering.

For example, recently, studies have begun to investigate the nature of occupational stress that day laborers experience. Duke and Bourdeau (2010) tested the validity and reliability of the Migrant Stress Inventory (MSI), a scale originally designed for migrant farmworkers, a contingent form of labor that has received some scholarly attention. They assumed that day laborers are likely to suffer from high rates of work-related stress. Based on survey data collected from day laborers in Northern California, the study found that 57.8% of day laborers experienced high rates of stress along four key stressor domains: instability, relationships, communication, and alcohol and other drug use.

The plight of young male day laborers is a tangled web of micro-, mezzo-, and macro-level processes that call on the social profession's full scope of social work practices. Much work needs to be done in such areas as trauma, health damaging, promoting behaviors, and family intervention. Also, this type of work requires close collaboration at the community level and in concert with legal professionals. The main ingredients in the mix of course are the young male day laborers themselves. The resilience that they exhibit in the face of such highly risk-laden and oppressive conditions is a solid foundation to work upon.

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EIGHT

Working With Culturally Diverse Older Adults

Irene A. Gutheil and Janna C. Heyman

Understanding and respecting cultural diversity is a critical component of social work practice. The term cultural diversity is broad, and includes a range of perspectives. While recognizing that there are many ways to approach a discussion of cultural diversity, this chapter is limited to examining ethnic diversity among older adults and the implications for social work practice.

The growth of the older population of the United States has received increasing attention over recent years, with consideration of social and policy implications at the forefront of discussions. Less attention has been directed to the growing ethnic diversity of the older adults of today and tomorrow. Yeo's (2003) reference to the "ethnic imperative" of the growing numbers of older adults and diversity within ethnic groups is as compelling today as it was almost a decade ago.

According to the 2010 census, persons aged 65 numbered over 40 million, 13% of the total population (U.S. Census Bureau, 2011). This represented an increase of 5.3 million persons since 2000. By the year 2030, the older population is expected to increase to over 72 million (U.S. Department of Health and Human Services, 2010). This represents an increase of approximately 80%. By 2030, persons aged 65 and older are expected to represent almost 20% of the total U.S. population (U.S. Department of Health and Human Services, 2010).

This older population continues to grow increasingly diverse. While Whites continue to represent the majority of older adults (86.7% in 2009), the U.S. Census reports that other groups are gaining a larger proportion. Blacks/African Americans represent 8.6% (up from 8.2% in 2000); Asians 3.4% (up from 2.3%), and Native Americans 0.6% (U.S. Census Bureau, 2010). The U.S. Census considers Hispanic origin an ethnicity, so Hispanic individuals are not distinguished by race. Approximately 7% of the older population identified themselves as of Hispanic origin (up from just under 5%). An indication of the aging of the Hispanic population in the United States is seen in the growth of the proportion aged 65 and older. While the overall Hispanic population increased by 37% between 2000 and 2009, the 65 and older group increased by 59% over that same period (U.S. Census Bureau, 2010).

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Older adults identifying themselves as of two or more races increased by almost 48% between 2000 and 2009. In 2000, 186,100 indicated this designation. The number increased to 274,700 in 2009 (U.S. Census Bureau, 2010).

The U.S. Department of Health and Human Services (2010) projects that by 2020 ethnic minority populations will represent almost 24% of the older population. The growing diversity is strikingly illustrated by additional projections. While the White population aged 65 and older population is expected to grow by 59% between 2010 and 2030, the projection for other groups are much greater: Hispanics, 202%; African Americans, 114%, American Indians, Eskimos and Aleuts, 145%; and Asians and Pacific Islanders, 145% (U.S. Department of Health and Human Services, 2010).

The challenges in addressing the needs and concerns of a diverse older population are complex. In addition, differences within ethnic groups must be acknowledged and understood. For example, while Hispanic elders may share a common language, they come from many countries of origin, including Mexico (52.8%), Puerto Rico (11.5%), and Cuba (10.9%). Smaller percentages of Hispanic elders represent a host of other countries of origin (Pew Hispanic Center, 2009). Asian Americans do not all share a common language and come from over 30 different nations (Yeo, 2003). Scholars underscore the importance of considering the differences among groups of Asian American older adults (Mui, Nguyen, Kang, & Domanski, 2006). The diversity among non-Hispanic White older adults must be considered as well. Immigrants from around the world bring rich and vastly different cultural heritages.

Older adults from diverse backgrounds may have lived their entire lives in the United States or may have immigrated at some point in their lives. The older immigrant population, currently 11% of the U.S. foreign born and 8% of all older Americans, is projected to quadruple by 2050 (Leach, 2008–2009). Older immigrants today are less likely to come from Europe than in the past. For example, "Mexicans and Chinese account for one quarter of recent older immigrants" (Leach, 2008–2009, pp. 36–37).

HEALTH CONCERNS

Health concerns, one of the most common issues linked to aging, may vary by different ethnic groups. Asking older adults to rate their own health has been identified as a good measure of health (Ocampo, 2010). Racial difference in self-rated health has been documented in large, national samples. Non-Hispanic White adults were "more likely to have excellent or very good health and were less likely to have fair or poor health than either non-Hispanic black or Hispanic adults" (U.S. Department of Health and Human Services, 2009, p. 10). Data also showed that health for the age 65 cohort varied by individuals with Medicare or Medicaid coverage. Over half (53%) who had Medicaid and Medicare had fair or poor health compared with 29% of those with only Medicare coverage and 18% with private pay (U.S. Department of Health and Human Services, 2009).

The leading causes of death for older adults differ by gender and race. For woman aged 65 years or older, the five leading causes of death are heart disease, cancer, stroke, chronic respiratory diseases, and Alzheimer's disease.

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For men, the leading causes are heart disease cancer, chronic respiratory disease, stroke, and diabetes. Although the leading three causes of death were similar for women who were described as minority, diabetes emerged as a higher ranking for this group (Federal Interagency Forum on Aging-Related Statistics, 2010).

There are indications that health disparities is a complicated concept. According to the National Institute on Aging's report (2010), "In general, African American, American Indian, and Hispanic ethnic and racial groups are disadvantaged relative to whites on most health indices, whereas Asian Americans appear to be as healthy, if not healthier, than whites on most indicators" (p. 5).

Older adults often have chronic diseases that impair their health, as well as impact the activities of daily living and instrumental activities of daily living (Caskie, Sutton, & Margrett, 2010). Chronic diseases may differ by race. For example, more than two-thirds of older Blacks have had hypertension compared with one-half of the White and Hispanic participants. According to a national study conducted by the Centers for Disease Control and Prevention, "In 2007–2008, among people age 65 and over, non-Hispanic blacks report higher levels of hypertension and diabetes than non-Hispanic whites (71 percent compared with 54 percent for hypertension and 30 percent compared with 16 percent for diabetes)" (Federal Interagency Forum on Aging-Related Statistics, 2010, p. 27).

Hearing impairment is a commonly reported chronic illness, affecting 16% of adults in the United States (Pleis & Coles, 2003). A recent study by Pratt and colleagues (2009) found that self-reported hearing loss differed by race, gender, and age. Being White and being male were related to higher loss. In general, hearing loss increases as older adults reach their eighth decade (Pratt et al., 2009).

Physical health may be related to mental health (U.S. Surgeon General, 2009). Research on depression among older adults suggests that it is difficult to get an accurate picture of the extent of the problem, as a wide range is reported. Individuals with depressive symptoms have greater disability and are often high users of health care resources (Federal Interagency Forum on Aging-Related Statistics, 2010) and experience other difficulties such as loneliness (Adams & Moon, 2009). Research on the link between race and depression among older adults is mixed. Some researchers have found African American older adults to have more depressive symptoms than Whites (Cochran, Brown, & MacGregor, 1999) and others have found few racial differences in depression among older adults (Blazer, Landerman, Hays, Simonski, & Saunders, 1998; Cummings, Neff, & Husaini, 2003; Sach-Ericsson, Planty, & Blazer, 2005). The role of socioeconomic factors in the link between depression and racial differences has been highlighted in the recent literature (Sachs-Ericsson et al., 2005).

ECONOMICS

Economic concerns have been center stage in recent years. Due to the volatile change in our nation's economy, many older adults are not traditional retirees,

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choosing phased retirement or returning to work (Giandrea, Cahill, & Quinn, 2009; Raymo, Warren, Sweeney, Hauser, & Ho, 2010).

Approximately 10% of older adults live in poverty (U.S. Census, 2010). The majority of older adults have income from Social Security, some savings, and limited retirements. Many older adults are struggling for survival to maintain their housing, food, and medical care (Pulley Radwan & Morgan, 2010).

The challenge of economic need may vary for the different ethnic groups. In a recent study in California, 45% of older persons aged 65 or older fall into an economic insecurity gap (Dumez & Derbrew, 2011). This gap varies by race/ethnic groups, with 76% of Latinos, 69% of African Americans, and 67% of Asian Americas disadvantaged economically (Dumez & Derbrew, 2011). According to Dumez and Derbrew (2011), many of these older persons do not have enough money to meet basic needs, but may not qualify for many public programs because of eligibility criteria.

For older adults, one of the primary barriers to accessing health care is financial. Although Medicare is the primary source of coverage for older persons, a significant amount of health care is not covered under Medicare. Older adults often pay out of pocket for these costs. According to Stanton (2006), persons older than 65 consume about 36% of total U.S. personal health care expenses. The burden on out-of-pocket health care expense is higher for older adults (Desmond, Rice, Cubanski, & Newman, 2007). "The existence of minority group disadvantages in health indicators have led many to speculate about how poverty might create and perpetuate health disparities" (Angel & Angel, 2006, p. 1153).

ASSESSMENT

Assessment of the older adult combines an understanding of biological, psychological, and social factors. Special attention must be paid to environmental factors because, in the face of changing or declining abilities, older persons are often profoundly impacted by their physical environments. The key components in assessment of any older adult are physical health, psychological functioning, emotional well-being, sexual functioning, social functioning, spirituality, functioning regarding activities of daily living, financial well-being, and environmental issues (McInnis-Dittrich, 2009). Cultural issues, too, are a critical, but often overlooked, component of the assessment. Clarke and Smith (2011) underscore the importance of cultural context in fostering psychological resources, a key factor in well-being.

To arrive at an accurate assessment, older adults must be understood in the context of their families. In addition, when doing as assessment, family members may be able to provide important information, particularly when the older adult has a poor memory (Baden & Wong, 2008). For older adults who have no family, understanding their family history can be helpful. A growing awareness of the importance of families in the lives of older adults developed with the increasing appreciation of the role of family caregivers as a bulwark of this country's long-term care system. Whereas it was once common to discuss older adults in popular and even professional literature

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as individuals with little attention to connections with families, there is now greater appreciation of the depth of the relationships between older persons and their families and the critical importance of these relationships. Moreover, the reciprocity of these relationships is recognized and celebrated. For the most part, it is impossible to understand older adults outside of the family context. This may be particularly true with ethnic older persons, where there is a strong family orientation and family is seen as the primary source of care (Gelfand, 2003; Trang, 2008–2009).

There may be differences within ethnic groupings regarding who is expected to provide this care. For example, not all Asian Americans have the same expectations. In Vietnamese families, all children are expected to care for their parents, often on a rotating basis (Tran, Ngo, & Sung, 2001). For Korean families, this responsibility is likely to fall to the eldest son (Kim & Kim, 2001).

While there is limited information on Arab American older persons, one of the largest studies of Arab Americans (Fakhouri, 2001) found them at the center of the extended family. The majority lived with their spouse or children. Over two-thirds of those not living with their children saw them at least twice a week, indicating the importance of close contact among family members. Interestingly, almost two-thirds of the 230 Arab Americans in Fakhouri's study were born outside the United States. Mireshghi's (2008–2009) discussion of an Iranian senior's group noted that, despite differing circumstances, all said they were in the United States to be closer to their children.

The family's immigration history may be a critical factor in assessment. Because of their ineligibility for many programs, undocumented immigrants may be particularly vulnerable (Gelfand, 2003). Reasons for immigration and whether immigration was a result of traumatic events in the country of origin need to be considered. It is also critical to understand the degree of the older person's beliefs and ethnic identity (Kolb, 2007). As Damon-Rodriguez (1998) writes, "Many ethnic elders have a life style created both from their country of origin . . . and their country of residence" (p. 61). It is important to assess the degree of acculturation and identification of other family members as well. Disparities between older persons and others in their families can lead to misunderstandings, disappointments, and, at times, conflicts.

Language is another key component of the assessment. It is not possible to assume that an older adult who has lived in the United States for many years is proficient in English. Some settle in neighborhoods or communities with others who speak their language, and may have little need to learn English.

It is critical that the social worker understand that many ethnic older adults "seek intervention only as a last resort" (Beckett & Dungee-Anderson, 2000, p. 284). Accurate assessment must take into account the client's cultural values. For example, older persons from traditional Asian cultures may not be comfortable with professional intervention because of a wish to protect family honor (Harris, 1998). Cultural values may also determine how health concerns are understood and how symptoms are interpreted. Berkman, Maramaldi, Breon, & Howe (2002) note that culturally sensitive assessment protocols are needed to adequately assess factors such as health care beliefs and patterns of family relationships.

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Baden and Wong (2008) underscore an additional challenge to assessment. In their discussion of culturally biased assessment, they contend that ". . . one of the major difficulties in assessing ethnically diverse elderly in the United States is that the psychological measures used to assess them have generally been developed both by and for white elderly individuals" (p. 596). The authors note concerns regarding commonly used depression screening scales with non-Western older adults. Baden and Wong (2008) end their chapter with a call for clinicians to understand the limitations of many translated measures.

Understanding caregiving patterns is an important part of assessing an older adult's situation. While families are understood to be the primary source of care to older adults, it is important to recognize that caregiving and support are not one directional. Often, it is the older adult who is providing for younger family members. The most striking example of this phenomenon is grandparents raising grandchildren. While this caregiving crosses ethnic groups, African American and Hispanic grandparents are more likely to assume this role than are White grandparents (Hooyman & Kiyak, 2011).

Caregiving by adult children is influenced by cultural beliefs and may differ across racial groups (Cravey & Mitra, 2011). Becker, Beyene, Newsom, & Mayen (2003) examined intergenerational reciprocity among African Americans, Hispanics, Filipino Americans, and Cambodian Americans. They found mutual assistance to be an integral part of family life for all four groups. The pattern of mutual assistance did differ between the groups, reflecting broader cultural values. "These portraits of mutual assistance illustrate how family continuity is perpetuated in culturally specific ways" (p. S157).

Assessment of older adults and their family caregivers must always include an understanding of the strengths that can be drawn upon. Older adults, dealing with the numerous challenges and losses of later life, are continuing life-long patterns of coping and adaptation. Family strengths, such as the strong family orientation of many ethnic groups (Gelfand, 2003), should also be identified. At the same time, it is important not to assume that strong family orientation means that service providers do not have to plan for or reach out to ethnic older persons. When needs increase, older persons may have to turn to formal services, even when they prefer assistance from family members (Gelfand, 2003). Family caregivers, too, may need help from the formal service system. Even in cultures with a strong commitment to the importance of family over the individual, caregivers may be burdened, isolated, and in need of support.

SERVICE UTILIZATION

Access to services is a primary issue for ethnic older persons (Min, 2005). Higher service needs do not translate into greater service use. Although there are mixed findings regarding utilization of services by older persons of color, there is general concern that the service needs of these individuals are not being adequately met. In addition, there is evidence that family caregivers of ethnic older adults make less use of formal services than do their White counterparts (Dilworth-Anderson, Williams, & Gibson, 2002).

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Even when they access services, older persons of color may not receive the full range of care they need. For example, one study found that African Americans are four times more likely than whites to be in nursing homes with fewer resources (Mor, Zinn, Angelelli, Teno, & Miller, 2004).

Hooyman and Kiyak (2011) enumerate a range of barriers to service utilization. They divide these barriers into (a) cultural and economic barriers and (b) structural barriers in the service system. Among the cultural barriers are language differences, perceived stigma associated with service use, fear or lack of trust in care providers, and lack of knowledge. Structural barriers include changes in eligibility for some services for legal immigrants as a result of the 1996 welfare reform legislation, lack of services oriented to and provided by specific ethnic groups, lack of transportation to services, which may be some distance from the ethnic neighborhood, and staff who are not conversant in the language or culture of ethnic older persons (p. 641).

Other system considerations may also play a role in service utilization. For example, if older persons are given information about diabetes when they are hospitalized for their illness, there is no assurance they will fully understand what diabetes is or how it can be managed. The institution may have distributed the information in a manner the older person is unfamiliar or uncomfortable with. The recommendations, such as dietary changes, may feel too foreign. In addition, the older person may feel he or she can get better help from the informal support system. If the institution has not reached out to family members, the opportunity to form a partnership in providing care may be lost. Finally, some older persons may have more confidence in traditional healers than in Western medicine.

Ortiz and Cole (2008) present a model of service provision for older Hispanic immigrants. They underscore the importance of taking into account the experiences older immigrants had in their country of origin and the influence of these premigration experiences on current service use. Belief in family obligations to meet the needs of elders and stigma if care is not provided can have a powerful impact on use of formal services. In addition, "Latino older adults bring with them the expectations built by the service delivery structures they experienced in the country of origin and often have difficulty adjusting to the service delivery system in the country of migration" (Ortiz & Cole, 2008, pp. 307–308).

One of the most widely recognized barriers to service is lack of proficiency in English and limited services provided in other languages. For example, among New York City's Asian American older adults, speaking English well was associated with use of formal services (Asian American Federation, 2003). When older persons do not speak English and service providers do not have people available to translate, family members may be asked to serve in this capacity. While it may be comforting for an older person to have a family member present during an interview, using family to translate may create serious obstacles. The older adult may be uncomfortable talking openly about certain health conditions or situations with the family member present. This may be particularly problematic when the family member is young or not the same gender, or when the situation involves abuse by a family member. The family member serving as translator may

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alter the communication during translation. There may be various reasons for this, including wanting to make the statements by the service provider more culturally appropriate, and protecting family privacy when speaking for the older adult. At times, the service provider has no way of knowing that the meaning of the communication has been altered.

It makes good sense to offer services in ways that are consonant with the cultures of diverse older adults in the languages they are most comfortable with. One study of senior centers in New York found greater participation of minority older adults in those centers targeting specific ethnic or racial groups. In addition, minority participation was greater when programming was offered in more than one language and there was a greater proportion of minority staff (Pardasani, 2004).

CROSS-CULTURAL PRACTICE

Cross-cultural competency underscores the importance of working with diverse populations and addressing the concerns specific to their individual needs and concerns. Hinton, Franz, Yeo, & Levkoff (2005) refer to cross-cultural care as the "cornerstone" of practice in addressing assessment, implementation, and outcomes. Social workers need to be informed about their clients' culture and be sensitive to the needs of the client and their family and environment.

Equally important, social workers must examine their own values, cultural backgrounds, and life experiences, and assess the impact of these factors on their own view. Social workers should consider their own experiences with persons from other cultures and be aware of how this impacts their work.

The social worker who anticipates working with a different ethnic group can prepare by learning as much as possible about the history, values, and beliefs of this group. Using the necessary caution to avoid making assumptions that all persons from an ethnic group experience the world in the same way or hold the same values, social workers nonetheless enter into the relationship with information that may help them better understand the older person.

However, it is unlikely that social workers can be prepared for every ethnic group they may encounter or that being prepared necessarily will help them accurately understand that unique individual. Consequently, the cultural literacy model, while helpful, is not sufficient. Dyche and Zayas (1995) advocate a process-oriented approach.

> We have consistently observed that when an immigrant or minority client first meets a medical or mental health care provider, the strongest impressions are left not by the professional's skill or knowledge of the client's culture, but by an attitude that reassures the client that he or she will be treated respectfully. (p. 394)

Respect is a critical component of a therapeutic relationship. In many cultures, older persons are shown more respect and deference than in this

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country (Yeo, 2003). Consequently, the way a social worker greets and treats an ethnic older adult may strongly influence the development of the relationship with both the older person and the family.

When working with any older person, it is important to demonstrate respect by slowing the process to accommodate to his or her pace if necessary, or adapting to individual sensory or cognitive limitations. However, with ethnic older adults, other factors may need to be taken into consideration. It may be necessary to anticipate how to greet the individual. Maintaining eye contact or shaking hands may not be considered respectful. Yeo (2003) underscores the importance of gestures, and advises that some gestures, such as showing the bottom of one's shoe to a traditional Middle Eastern older person, may be considered offensive by different cultures.

CASE VIGNETTE AND TREATMENT APPROACHES

The choice of treatment approach is based on the needs, capacity, and values of the older person and his or her family. Understanding of and respect for the experiences and wishes of the older adult is paramount. In addition, the broader cultural context of the family must be considered. The social worker may need to be creative and tenacious in order to provide the service and care most appropriate to the older person's cultural and ethnic background.

> Miss W is an 85-year-old single Japanese woman referred by her legal guardian for services to identify supportive senior housing. Miss W was born in Japan, and moved to California right before the start of WWII. She and her family were detained in a Japanese American Internment Camp. Upon their release, Miss W's family returned to Japan. She relocated to a large U.S. city, and began work for a Japanese company, where she remained throughout her working career.
>
> Miss W came to the attention of adult protective services (APS), when her neighbors complained that she was yelling out her windows, and that there was a stench emanating from her apartment. Her rent had not been paid in months, and she had no phone or electricity, as these services had been shut off. APS found her incoherent and malnourished, though her dog seemed well fed. Her apartment was dirty and in need of repair.
>
> Upon evaluation by the mobile crisis team, Miss W was sent to a medical emergency room, and then admitted as a psychiatric in-patient. Neighbors looked out after her dog. The hospital then petitioned for guardianship. The court evaluator was able to track down two brothers in Japan. However, they were embarrassed by Miss W's behavior and did not want to have any contact with her, stating she disgraced their family. A guardian was appointed, and the geriatric care management referral was made. Miss W was diagnosed with Alzheimer's disease.
>
> The team at the hospital felt Miss W required live-in assistance. The court evaluator reported that there were significant

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withdrawals from her bank accounts that she seemed incapable of making independently. Through APS and a police investigation, it was discovered that an employee at Miss W's local bank branch was embezzling her funds Her guardian, in reviewing the situation, determined that Miss W's apartment should be sold, and the money used to cover services in a supportive residential setting.

The geriatric care manager (GCM), a social worker, first met Miss W in the psychiatric hospital. Miss W was sociable and gracious, and able to converse in English quite clearly. She was extremely worried about her dog, and could not discuss anything beyond her love for him. The GCM visited her neighbor and took pictures of the dog to show Miss W Within the first week of that meeting, Miss W fell and broke her hip, warranting surgery and then a period of rehabilitation in a nursing home.

In the nursing home, Miss W appeared wary and frightened of people around her. She particularly reacted to the staff wearing uniforms. Anytime she wheeled too close to the elevator, loud alarms would startle her. The GCM met with her care team at the nursing home and discussed the possibility of post-traumatic stress related to the internment experience and current nursing home placement.

The GCM researched senior residential programs with Japanese populations through outreach to key local programs including, among others, the area agency on aging, Alzheimer's Association, The Japan Society, and the Japan-American United Church. None of these agencies or organizations had any information on residential programs focusing in on the cultural needs of older persons of Japanese ethnicity.

Finally, while researching options on the Internet, the GCM found an article about special residences for seniors. A local independent senior building was noted to have a growing "discreet/naturally occurring" population of Japanese residents, based solely on word of mouth. This residence had begun to cater to their Japanese residents through adaptation of the dining services to include rice and miso soup at every meal and Japanese condiments on each table. A library of Japanese books and movies/music was established, and the recreation staff hired a Japanese musician to run the chorus and a former Japanese ballerina to offer movement to music and dance programs. Japanese holidays were also acknowledged and celebrated.

The GCM contacted the residence and arranged for a tour with Miss W. Miss W spoke animatedly in Japanese with some of the Japanese residents. She approved of the view from an available apartment, and was relieved to hear that her dog could join her.

Miss W moved in to this residence, and quickly adjusted to her new environment. Her GCM arranged for her to have health aides to assist her with her activities of daily living and to advise

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> her to take her medications. During her first few weeks at the residence, numerous Japanese residents visited her, bringing small gifts of flowers or food to welcome her. Miss W joined every possible activity, and was soon walking with a walker, getting stronger and progressing to independent ambulation. Today, Miss W is surrounded by familiar belongings in her apartment, and has her dog with her.

Miss W was well served by the social work geriatric care manager. The social worker understood that Miss W's dog was her strongest connection and responded by reassuring her about the dog's care and gaining Miss W's trust. In addition, she recognized the importance of finding a setting where Miss W would be with others who shared her culture and worked tirelessly to find the best possible setting. The social worker's tenacity and creativity led to a solution that enabled Miss W to reach her fullest potential.

This case involved physical, social, and mental health issues. When working with older adults, social workers should bear in mind that today's generation of older adults is not, in general, accustomed to seeking mental health services. For some ethnic older persons, seeking mental health services would stigmatize the family. There may be issues involved in accepting other kinds of services as well. In the case of Miss W, there was no family locally, and family members in Japan were unwilling to become involved because they felt disgraced by Miss W's behavior.

Social workers must take the entire picture into account when making treatment and service recommendations. While the social worker may quickly be able to identify the "best" treatment and service package for an older client, the older person and his or her family may have very different ideas of what they are able to accept. Consequently, social workers need to be flexible in their approach to serving ethnic older adults and their families. They must listen to direct and indirect communications about what is viewed as acceptable by the individuals involved.

CONCLUSION

Social work will be challenged in the coming years to serve an increasingly diverse older population. To effectively serve ethnic older adults, social workers need to bear in mind that older persons are generally, but not always, integral parts of their families. Social workers must recognize that the ways older adults and their families understand, experience, and cope with age-related changes may be strongly influenced by their cultural background. This may influence the ways help is defined, whether help is sought outside the family, and how offers of help will be received. In addition, depending on the generation and degree of acculturation, family members may view age-related concerns in different ways or may have very different views about the best ways to manage them.

In a diverse society, practice with older adults and their families is built on knowledge and skills from generalist social work practice, gerontological social work practice, and cross-cultural practice. Social workers need to be

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able to draw on all these areas to practice effectively. They also need to be clear about the influence of their own values and culture on their work so they do not impose their own views on others.

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NINE

Grandparents Raising Grandchildren From a Multicultural Perspective

Carole B. Cox

Grandparents have always played major roles in the lives of their grandchildren, but in recent years this role has magnified in intensity, as more and more grandparents have become the primary caregivers of these grandchildren. According to data from the U.S. Census Bureau, nearly 5 million children under the age of 18 live in grandparent-headed households and nearly one-quarter of these households have no parent present (U.S. Census, 2010).

Moreover, although the increase in these families is occurring throughout the population, it has been most noticeable among ethnic minority groups. The proportion of these grandparent-headed families varies with race and ethnicity. Fifty-one percent of these grandparents are White and not Hispanic, 24.2% are Black/African American, 18.7% are Hispanic/Latino, and 2.9% are Asian (U.S. Census, 2010).

Many reasons have been given for the rapid growth and consistent increase in the number of these people. Among these are substance abuse by parents (HIV/AIDS, Joslin & Brouard, 1998; incarceration, Dressel & Barnhill, 1994); homicide (Kelly & Danato, 1995); mental illness; and abandonment. Child welfare policy also contributes to grandparent-headed families as it mandates that relatives be given priority in placement when a child is removed from a biological parent: In the majority of cases this is the grandparent. However, research also notes that kinship caregivers receive little or no preparation prior to the children's placement, receive limited formal training, lack resources, and have a lack of understanding of the child welfare system (Christenson & McMurtry, 2007).

At the same time, it is important to note that most grandparents provide care outside of the formal child welfare system through private and informal family arrangements. It is estimated that for every child being raised by a relative in the formal system, 20 are being raised informally (U.S. Census, 2010). Grandparents are often reluctant to become involved with agencies as bureaucratic processes could threaten their roles as primary caregiver to the child while a formal relationship could also aggravate conflict with the biological parents. They may also be reticent about submitting their homes and families to investigations and agreeing to agency demands. However,

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this reticence also means that they are less likely to receive financial assistance and benefits increasing the challenge of raising the grandchildren (Cox, 2010).

CHARACTERISTICS OF GRANDPARENT CAREGIVERS

The majority of grandparent caregivers are between 55 and 64 years with the majority (67%), under the age of 60 (AARP, 2010). Poverty is pervasive among these families with 20% living below the poverty line. Custodial grandparents have also been found to have high rates of depression, poor self-rated health, multiple chronic health problems, and limitations in functioning that can affect their daily activities (Emick & Hayslip, 1999). Moreover, caring for grandchildren with severe behavioral problems has been found to be a critical factor impacting the psychological health of custodial grandparents (Kelley, Whitley, & Campos, 2011).

Social isolation is a major problem confronting grandparents, as many have had to give up their activities as they began caring for their grandchildren. Such feelings of isolation and alienation have been found to be very prevalent among African American and Hispanic grandparents who are providing care due to AIDS or the substance abuse of the parents (Joslin & Harrison, 1998).

Given the many needs of custodial grandparents and the growth of grandparent-headed families among ethnic groups, it is important to consider the ways in which ethnicity and culture influence the experiences of these families. This chapter discusses the ways in which culture impacts on grandparent roles and behaviors and the ways in which ethnicity may affect the appropriateness of interventions. The chapter also describes the use of a model of empowerment training that has been effective in working with culturally diverse custodial grandparents.

ETHNICITY AND CULTURE

Ethnic groups are bound by a shared culture that dictates values, beliefs, traditions, and norms for behavior. Culture acts as a set of shared symbols, beliefs, and customs that shape individual or group behavior (Ogbu, 1993). It influences the ways in which people interact and interpret actions and thus can be a major determinant of the way in which grandparents experience their roles.

Ethnicity, as distinct from culture, refers to a group's shared sense of peoplehood based on a distinctive social and cultural heritage passed on from generation to generation (Gordon, 1964). In the United States, this sense of peoplehood is primarily associated with race, religion, or national origin as people identify themselves as belonging to a specific ethnic group based on one of those characteristics.

It is important to also note that although others may recognize persons as being members of a distinct ethnic group, individuals differ on the extent to which they themselves actually maintain this identification. In addition, ethnicity is not a constant as its importance in a person's life varies with

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the length of time since immigration as well as with the ease with which groups can assimilate into the greater society. Consequently, any assumptions regarding the ease with which grandparents have accepted the parenting role must be made with caution.

The grandparent role itself is influenced by culture and traditions. Whether grandparents play active pivotal roles in the family, providing direct care for the grandchildren, or more distant ones is often culturally determined. In some societies, grandparents are relied upon to care for the children while the parents work while in others, grandparents are not expected to be involved in the daily lives of the grandchildren. Accordingly, their roles may be more that of storyteller, family historian, and occasional baby sitter. But whatever the traditional role, most grandparents raising their grandchildren had never anticipated being the primary and sole caregiver and are doing so out of necessity rather than choice.

Assimilation can be a particular source of stress as those most assimilated may resent having to forgo other roles and activities that had been sources of enjoyment in order to parent their grandchildren. Conversely, those who are less assimilated may find themselves in constant struggles with grandchildren who do not adhere to the traditional culture or its expected behaviors. In particular, adolescents may resent limitations on their autonomy or other cultural expectations regarding behavior. Such conflicts as they cause further dissention in the relationship further undermine the well-being of the grandparents.

Variations in assimilation underscore the importance of understanding the role that culture can play in grandparent-headed households. Stereotyping, which overlooks and ignores the individual and uses assumptions that may not be valid ignores the reality of the individual grandparent's situation. Without this reality, it is difficult to design or offer interventions that can effectively assist the family.

Culture and Interventions

The issues encountered by these families often require individual and family counseling. Feelings of loss and grief over the absence of the child's parents frequently permeate the relationship and make parenting even more difficult. These problems are magnified by the fact that many of the children come to the grandparents after years of neglect or abuse and are thus prone to behavioral problems and difficulties in school. However, even with high rates of need, grandparent caregivers are unlikely to access services, particularly if they are not in a formal relationship with the grandchild (Ehrle & Green, 2002).

Many factors may underlie this reluctance to use the formal system. For many, raising the grandchild is shameful and connotes failure on the part of the family. The associated stigma can be a barrier to seeking help. For those who are less assimilated and adhere more closely to cultural traditions, accepting the role of custodial grandparent may be perceived as a normative duty, and using assistance, regardless of needs, may be viewed as conflicting with traditional expectations and norms.

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Systems designed to assist families and protect children can also be offensive to grandparents. Workers may reflect attitudes that blame grandparents for the failures of their children and thus question their ability to parent their grandchildren. Inexperienced child welfare workers can cause grandparents to feel that they are dealing with an adversarial bureaucracy rather than a supportive program (Pinson-Milburn, Fabian, Schlossberg, & Pyle, 1996).

A multicultural perspective on interventions recognizes that the oppression and discrimination that many ethnic minority grandparents have suffered from the formal service system can act as barriers to service use. Histories of inadequate services, long waits, and insensitive staff can be powerful deterrents to using needed programs. In addition, those who have come from countries where officials, including social workers and social agencies, cannot be trusted may identify them with historical hurt and injustice and thus have difficulty perceiving them as potential helpers (Cox & Ephross, 1998). In offering interventions to grandparents, these many potential barriers must be considered so that the lack of utilization is not perceived as a lack of real need.

Understanding the ways in which culture and ethnicity may affect the perception of help seeking and assistance is a prerequisite for service utilization. It is important to know not only why help is being sought but also what help-seeking means to the grandparent. This implies the worker's understanding of varying ethnocultural perspectives of needs for assistance, stigmas that might be associated with receiving help, who else in the family should be involved in the process, and a person's receptivity to receive assistance from another ethnic group.

For many groups, interventions that emphasize growth, enhancement, and learning may be more attractive than those that focus on counseling and problem solving. Programs that emphasize services for the children, recreational, educational, or counseling may also be more appealing than those focusing on the needs of grandparents.

Trust is a prerequisite for the development of relationships with ethnically diverse grandparent caregivers. Grandparents need to feel that the worker understands and empathizes without being judgmental and without stereotyping. Consequently, it is important that practitioners are aware of their own beliefs and values and the ways in which they influence their responses and actions. This necessitates recognizing their own attitudes regarding the grandparents' situations and their assumptions regarding the grandparents' ability to raise the grandchildren after their own children have failed.

As in all social work relationships, the goals that are developed should be realistic and meaningful to the individual grandparent. This means being in accordance with their own sense of ethnic identity and its adherence to traditional values and norms. In some instances, goals may be more radical than would be dictated by tradition such as those focusing on self-advocacy and leadership. Consequently, in setting goals it is important to know about cultural traditions but not to be limited by them since any individual grandparent may not share equal adherence to them. Thus, assuming that a grandmother seeks to maintain a traditional role of remaining in the home can negate her interest in expanding and developing her abilities to assume a leadership role in her community.

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Support Groups

Support groups can play important roles in combating the isolation that is frequently experienced by grandparent caregivers. Support groups for grandparents have developed across the country and have become important sources of assistance as they combat a sense of isolation, offer a means of socialization, and can also help in educating and teaching.

However, the importance of support groups in serving ethnic and minority grandparents remains uncertain. A national survey conducted by AARP (AARP, 2004) found that only a minority of participants in support groups was either African American (34%) or Hispanic (8%). Given that these two groups are the most likely to be raising their grandchildren, their low rate of participation is an issue of concern. The findings suggest that outreach is either ineffective in reaching these populations or that the support groups are not addressing the needs of these populations.

Ethnicity and culture are important factors to consider in the design of support groups (Cox, 2011). Indeed, for some persons the idea of sharing with others in a group setting may be completely contradictory with established norms of behavior. One does not share problems or family difficulties outside of the immediate kinship circle; to do so may be to risk contempt, shame, or exclusion. Thus, many may be resistant to participating in a group publicized as a setting in which persons can discuss their problems and issues. Increasing participation may depend on redefining the group as one focusing on parenting skills or education.

Concomitantly, as discussed above, it is imperative not to assume that because a person belongs to a specific group that they strongly adhere to particular cultural values and behaviors. Any one individual may be quite willing to join a support group and openly discuss problems and concerns. In addition, ethnic differences fade in importance as compared to the common problems shared by the grandparents. Moreover, if a group is developed in accordance with traditional beliefs with the worker sensitive to and knowledgeable about ethnic values and norms, even those strongly adhering to cultural norms and values may find participation rewarding.

AFRICAN AMERICAN CULTURE AND GRANDPARENTS

A history filled with discrimination and oppression has had a major impact on the roles of the African American grandparent in this country. In fact, it is impossible to ignore the role of slavery as an influential factor in the position of women in African American culture. As slaves forced to work in the fields and in the households, women found themselves assuming roles that conflicted with the primary traditional ones associated with child rearing. At the same time, they were often the pivotal figures in the slave household holding the family together. With emancipation, many families moved north where women frequently had an easier time than men finding work. Consequently, many were thrust into the role as primary provider for the family.

During this period, grandmothers were frequently called upon to raise the grandchildren as the children searched for work (Jackson, 1986) or migrated to urban areas in the North and West (Burton & Dilworth-Anderson,

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1991). From the early 19th century until the mid-1960s, it was common for the black grandmother to accept and raise both her own grandchildren as well as more extended kin and orphans.

The legacy of slavery, coupled with years of discrimination and oppression, has encouraged self-sufficiency as a common trait among Black women (Tate, 1983). Black women have tended to internalize the Black community's perceptions of them as strong, independent, and resourceful (Watson, 1974). In fact, when such feelings of competency are threatened, African American women acting as caregivers are particularly vulnerable to stress and depression (Cox, 1995).

However, given this tradition of caring for grandchildren, it is important to recognize that most African American grandparents today did not anticipate raising their grandchildren. They do so out of a sense of family responsibility and obligation to keep their children out of the child welfare system. At the same time, research indicates that as custodial grandparents they struggle financially, feel stressed over the responsibility, and worry over their ability to continue to raise the child (Brown & Mars, 2000).

Hispanic Culture and Grandparents

The value, familism, which places the needs of the family above those of the individual with a sense of duty to offer emotional and material support to family members, is often used to characterize Hispanic culture (Sabogal, Marin, & Otero-Sabogal, 1987). The value places strong emphasis on the importance of children and the elderly and the strong obligation to help each as needed. Moreover, to the extent that adult children are perceived as not meeting these obligations and roles are not being adequately enacted, there is an increased likelihood of intergenerational dissatisfaction (Cox & Gelfand, 1997).

Gender roles tend to remain strong among the first generation Hispanic immigrants, particularly among older persons. These norms expect that men will be controlling, authoritarian, possessive, and a good provider to the family, demonstrating characteristics associated with machismo. Women are expected to be protected, submissive in relation to the male, and protective of their children.

In her study of elderly Puerto Rican women, Sanchez-Ayendez (1994) found that child rearing was viewed as the primary responsibility and one that persists through adulthood. At the same time, although motherhood is a central role for women, other roles such as breadwinner and wife may also be enacted. Moreover, with suitable mentors and encouragement, younger Hispanic women have assumed effective leadership positions in the community (Lazzari, Ford, & Haughey, 1996).

It is a common practice for older Hispanics to assist their children with childcare. When Hispanic families immigrate to the United States, their role as childcare providers often becomes even more critical as it contributes to the family's ability to succeed. However, such involvement does not assure that conflicts will not ensue according to value differences between the generations (Gelfand, 1993). Grandparents assuming the parental role due to

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the absence or incapacity of their adult children may find themselves experiencing considerable role conflict and strain as they struggle to adjust their traditional role perceptions to the reality of the new society (Burnette, 1999).

EMPOWERMENT GROUPS WITH AFRICAN AMERICAN AND HISPANIC GRANDPARENTS

Empowerment training is a specific intervention, usually offered in groups that can assist grandparents in coping with their new roles. Empowerment entails developing feelings of self-reliance and self-esteem including innate strengths and abilities so that an individual feels in control of herself and her environment. Consequently, empowerment training is particularly appropriate for parenting grandparents struggling to cope with their grandchildren and their environments.

The author developed a program in empowerment training that has been effectively offered to African American and Hispanic grandparents (Cox, 2000). The program has been widely used and in 2009 received the Aging Achievement Award in Caregiving from the National Association of Area Agencies on Aging.

The training, which involves 14 classes, was developed in consultation with custodial grandparents, support group leaders, and others working with grandparents in the community. These discussions highlighted concerns that were the most stressful for grandparents and were the most appropriate for empowerment training. Among the topics offered are the importance of self-esteem, communication, dealing with behavioral issues, loss and grief, substance abuse, advocacy, navigating the service system, and legal issues.

Both African American and Hispanic grandparents share a common interest in each of the subjects with these interests overcoming any cultural separateness. In fact, upon completion of the course, African American grandparents, giving presentations to Hispanic groups through use of a translator, on grandparent issues were so successful that they were invited back several times. This provides further support of how common problems outweigh any cultural separateness.

However, differences do exist between the groups that can affect their roles as parenting grandparents. The African Americans are better educated having generally completed at least the 8th grade. In comparison, the majority of Hispanic grandparents completed only primary school with several having no formal schooling. None of the Hispanics were educated in the United States and the majority had only limited proficiency in English.

The grandparents also differed in their relationships to their grandchildren. The majority of Hispanic grandparents were in an informal relationship without any legal custody or guardianship. Often, the parents were involved with the grandparents providing care during the day and sometimes overnight while the parent worked. In contrast, the majority of African American grandparents did have legal custody of the grandchildren and there was little, if any, contact with the parents. Consequently, the African American group was responsible for making all decisions regarding the grandchildren while

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the Hispanics had only limited authority. Indeed, several Hispanic grandparents remarked that they had responsibility for their grandchildren but did not have the ability to assure their welfare.

The two groups also differed with regard to their involvement in the community and their use of services. The African Americans, in contrast to the Hispanics, were accustomed to assuming active community roles with many involved as volunteers in Head Start or in local political organizations. Although both groups were knowledgeable about services and programs, the Hispanics were much less assertive about demanding benefits or services for which they might be eligible. Limited English and a lack of translators further hindered their involvement and activism.

The two groups also differed in their approaches to the empowerment training. The African American grandparents were more comfortable in discussing, questioning, and challenging the material, each other, and the group leaders. They were also very open in sharing family issues and problems, including their disappointment with their own children.

In comparison, the Hispanic grandparents, even in a group led in Spanish by a facilitator from the same ethnic background, required more encouragement to share their concerns. They were eager to learn and absorb the material but reluctant to discuss any negative interactions with their family. In particular, they were reticent about discussing issues such as substance abuse and AIDS or difficulties with their own children.

Both groups were eager to learn how to communicate with their grandchildren, to understand them, and to deal with a perceived lack of respect. They all felt that adolescents presented more challenges than younger children. Both sets of grandparents were equally worried about protecting their grandchildren and assuring their safety in regards to both the environment and their peers. However, the African American grandparents were more anxious about the emotional health of their grandchildren, many of whom were in counseling. With the loss of the parent, they were also more interested in learning how to deal with grief and assisting their grandchildren to cope with loss.

At the conclusion of the training, both African American and Hispanic grandparents felt they benefited from the group experience. Both felt more comfortable in discussing problems with their families, making their own needs known, and in asserting themselves in the home and with agencies. Several of the Hispanic grandparents reported that they had begun reinforcing their roles within the family including making their own needs known and voicing their concerns about the grandchildren. They also began to assume stronger roles in the community with some accompanying a group to the state capital to lobby for more after school programs for children. Indicative of the impact of the empowerment was the logo that the Hispanic grandparents developed for their own support group—a tree with large branches and strong roots symbolizing the critical role of grandparents in the family.

SUMMARY

Given the large proportion of grandparents among ethnic minority populations, effective social work with these groups demands a multicultural perspective. These grandparents bring to their new roles values, traditions, and

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histories that can continue to influence their interactions with their grandchildren and the systems with which they are involved. At the same time, it is important to recognize that such interactions may also be influenced by the systems themselves. Histories of indifference and discrimination by the formal sector can deter many from the use of services.

Social workers are in key positions to ease the burdens and challenges faced by these families. But in order to be most effective they must be sensitive and knowledgeable about specific cultures and the ways in which culture may affect the roles of grandparents as well as their perception of needs. With this background and an awareness of their own values and possible biases and attitudes, relationships can be developed that can strengthen grandparents and their families.

The empowerment training model offers an intervention that helps to develop skills and coping abilities of grandparents. The model is proven to be applicable to two ethnically diverse populations with varying backgrounds and experiences but with shared concerns. The success of the model indicates that by recognizing and being sensitive to cultural influences, grandparents, regardless of ethnicity, can learn and grow through the program as they further develop their own self-efficacy.

Above all, it is imperative to recognize that culture and ethnicity are important facets of identity and social interactions but that they are permeable. Indeed, grandparents who are able to integrate their own rich cultural heritage with the norms and expectations of American society are in the strongest positions to be powerful influences on the lives of their grandchildren.

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TEN

An Afrocentric Approach to Working With African American Families

Samuel R. Aymer

The chapter discusses elements of Afrocentricity—pointing out that Afrocentric scholars deemphasize the marginalization of people of African ancestry and place them at the center of all discourses (Akbar, 2004; Asante, 1987). In promulgating matters of culture, spirituality, nature, and collectivity, its philosophical underpinnings are rooted in the precepts of both African American culture and traditional Africa (Akbar, 1985; Schiele, 1996). The chapter, stressing that Afrocentricity is a social science framework, also focuses on the need to contextualize a treatment framework that encompasses the confluence of a family's idiosyncratic processes and the *Nguza Saba*—the seven principles of Kwanzaa. (These principles will be discussed later in the chapter.) Developed by Karenga (1989), Kwanzaa is a cultural celebration and its self-affirming purpose can be used in clinical work to help African American families address facets of self-identity that have been affected by the effects of historical and present-day oppression.

In addition, this chapter also explores how an Afrocentric perspective can be used in family treatment with African Americans. It is understood that this group is not homogeneous. What is common among African Americans is that because their ancestors were enslaved, the stain of slavery has informed their narratives. Thus, the chapter begins with a brief overview of slavery, highlighting the multiple ways in which families have been affected. Slave trauma syndrome (STS) and posttraumatic slaves syndrome (PTSS) are two relatively new constructs that are receiving attention from social scientists who have argued that the horrendous acts of physical and psychological violence perpetrated under the institution of slavery have culminated in psychic trauma (Akbar, 2004; Latif & Latif, 1994; Leary, 2005; Poussaint & Alexander, 2000).

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HISTORICAL OVERVIEW

From an epistemological perspective, the Afrocentric paradigm includes the history, culture, values, mores, and spirituality of people of African ancestry (Akbar, 2004; Asante, 1987). Because of this, an Afrocentric view—in relation to family treatment with African Americans—must pay attention to the varied ways in which the legacy of slavery affected family dynamics. Having

knowledge of slavery adds context to the treatment process, and prevents clinicians from assuming a historical stance when working with this population. Boyd-Franklin (2003) notes that "slavery set the tone for people of African descent to be treated as inferior" (p. 9). An in-depth discussion concerning the pernicious effects of enslavement on family life is beyond the scope of this chapter; nevertheless, it is hoped that this brief overview will provide a backdrop for increasing awareness of how the intersecting issues of enslavement and contemporary facets of racism converge, thus influencing the functioning of African American families.

Enslavement meant "the repeated separation of mothers and children and the loss of language, culture and natural religion worked to depose the real African self" (Akbar, 2004, p. 102). The notion of the real African self, as posited by Akbar, meant that indigenous African people had a range of cultural expressions and religious beliefs, and strong familial bonds that fostered self-efficacy (Johnson, 1982; Kardiner & Ovesey, 1962; Staples, 1982). Slavery undermined the concept of the real African self in that women were abducted, raped, and expected to produce as workers for slaveholders. Women were forced to witness the emasculation of men: fathers, sons, and mates. Staples (1982) writes:

> Beginning with the fact slave men and women were equally subjugated to the capricious authority of the slaveholder, the African male saw his masculinity challenged by the rape of his woman, sale of his children, the rations issued in the name of the woman and children bearing her name—which his presence went unrecognized. (p. 2)

Men's physical and psychological welfare were dangerously unstable (Kardiner & Ovesey, 1962, p. 45). Lynching was an inescapable truth for Black men—this practice, in conjunction with being sold, impelled men to flee—and this ruptured family stability (Johnson, 1982). For that reason, "[t]he mother-child family with the father either unknown, absent, or, if present, incapable of wielding influence, was the only type of family that could survive in the new environment" (Kardiner & Ovesey, 1962, p. 45). This familial configuration was known as the *uterine family* (or *uterine society*) and was not consonant with traditional African culture (Kardiner & Ovesey, 1962). Kardiner and Ovesey posit that, "under the conditions of enslavement, the uterine family was not institutionalized, but incidental to a host of conditions that held priority of claim" (p. 46). As a result, slave women employed adaptive and maladaptive reactions to the circumstances relating to the institution of slavery (Billingsley, 1968; Kardiner & Ovesey, 1962).

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SLAVE TRAUMA SYNDROME

Slave trauma syndrome (STS), a term coined by Latif & Latif (1994), is an area of research that is beginning to offer insights into the traumatic effects of slavery on African Americans whose ancestors were slaves. Latif and Latif (1994) refer to STS as the "psychic trauma" of African Americans, proclaiming that

"the psychological trauma from slavery has never been addressed, and the resulting emotional scars have been passed down, generation to generation" (p. 20). They raised the following questions to explore the consequences of STS on African Africans whose bloodline is affected by slavery:

> What happens to those citizens who are smuggled away, locked in chains, and shipped off to a foreign land, where they are murdered, tortured, raped, beaten, and forced to labor in the fields under the lash of whip and the constant threat of death? What happens to them when they are forced to have sex with each other for the purposes of producing babies, who are then snatched away and sold, like puppies, to strangers? (p. 18)

Moreover, this question also helps frame the STS discourse. Latif and Latif (1994) believe that the essence of these questions draw attention to the psychological damages connected to slavery, and the dehumanizing activities that treated slaves as chattel and stripped them of their humanity. The traumatic conditions of slavery can be viewed through the prism of what Herman (1992) refers to as "the damaged self," which reflected how slavery impeded the mental lives of its victims by undermining their sense of agency, ego strengths, and the capacity to feel psychologically safe, whole, and secure. This viewpoint is supported by Poussaint and Alexander (2000) who assert that posttruamtic slavery syndrome has affected the "minds and bodies of black people" (p. 15).

In addition to Latif and Latif's (1994) research, Leary (2005) also calls attention to enslavement and its impact on African Americans, using the term "posttrauma slave syndrome" (PTSS) to define a condition that exists when a population has experienced multigenerational trauma resulting from centuries of slavery and continues to experience oppression and institutionalized oppression. Likewise, research by Fanon (1963) and others (Akbar, 2004; Altman, 1995; Kardiner & Ovesey, 1962; Karenga, 1982) shows that the consequences of slavery have influenced African Americans' perception of themselves in relation to White American standards, which, in turn, reinforces Leary's (2005) observation that deep-rooted feelings of inferiority pervade the psyche of victims of slavery. Framed as multigenerational trauma, Leary's view of PTSS is that the injurious effects of enslavement create maladaptive behaviors in its victims, and, in turn, such effects have been passed on to succeeding generations, a view also held by Latif and Latif (1994). Such a postulation implies that the nexus of multigenerational trauma and the ongoing reality of racial oppression inevitably hamper the stability of African American families. Thompson and Neville (1999) make the same argument:

> Racism has evolved over time as a changing yet enduring outgrowth of American political and social life. Therefore, it is inaccurate to conclude that racism was essentially nonexistent during certain historical periods (e.g., following the civil rights movement) and prevalent during other periods (e.g., slavery the segregated U.S. South). (p. 168)

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Indeed, it has been difficult for African Americans to work through the internalized feelings emanating from being the descendents of slaves and victims of contemporary oppression. The psychological and behavioral dynamics from enslavement and contemporary oppression that have been passed on to descendents of slaves (as delineated by Leary [2005]) are vacant esteem, ever-present anger, and racist socialization.

Vacant self-esteem speaks to the self-development of African American people, who must live in oppressive contexts that devalue their personhood. Leary (2005) believes that it is onerous to feel psychologically fortified in a society that promotes stereotypic images of African Americans. Implied in this idea is the notion that internalizations (negative or positive) of one's group are critical to fostering self-worth. And, when negative internalizations are combined with knowing that one's history is connected to enslavement, this can induce feelings of anxiety, shame, and self-loathing behaviors in African Americans.

Ever-present anger refers to African Americans' tendency to externalize angry feelings that may not be proportional to the situation that triggered the reaction. From a contemporary perspective, Leary (2005) contends that blocked resources and opportunities, linked to structural racism and oppression, deny African Americans access to rights and privileges. The degree to which African American individuals are able to mange this reality depends on how they have come to understand their social reality within a hostile environment. Ever-present anger can be traced back to slavery, and Leary states that "slavery was an inherently angry, violent process" (p. 137). The violence and inhumane treatment perpetrated against slaves induced a range of emotions, including anger and rage (Grier & Cobbs, 1968). Leary indicates that anger was modelled by slave owners, whose oppressive behaviors served as a catalyst for cultivating generalized anger in slaves. An important aspect of Leary's thesis is that anger observed in many African Americans should be contextualized from a historical and contemporary vantage point, and it should be acknowledged that it can be a coping mechanism to manage oppression.

Racist socialization has its beginnings in slavery—enslaved Africans endued egregious treatment that led to self-hatred (Leary, 2005). Slave owners, for instance, manufactured a system of discrimination based upon skin color, favoring lighter-skinned slaves (who were the product of rape) over darker-skinned ones. Leary (2005) argues that skin-color dynamics among African Americans persist and correlates it to the legacy of slavery and the devaluation of Negroid attributes, including skin color and hair texture. Other scholars have made similar claims and argue that such issues operate in African American families (Grier & Cobbs, 1968). Factors regarding skin color will be discussed in the latter part of this chapter.

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AFROCENTRICITY

The utility of Afrocentric concepts in social work and human behavior theories has received attention over the last 10 years (Schiele, 1996). In the academy, for instance, one of the aims of Afrocentric scholarship is to disrupt

traditional Eurocentric paradigms that promote a one-dimensional view (i.e., White middle class) of normative human growth and development. Afrocentrists believe that it is critical to raise questions about the primacy of Eurocentric constructs in terms of their relevance to the social and psychic reality of people of African ancestry (Akbar, 2004; Davis, Williams, & Akinyela, 2010). By doing so, people of African ancestry are located at the center of all discourses, thus, creating conditions for portraying their experiences in ways that obviate marginalization. Afrocentric theoreticians emphasize the centrality of Africa and its relationship to the collective consciousness of African Americans (Akbar, 2004). Asante (2008) argues a similar point by stating that, "Afrocentricity is about location precisely because African people have been operating from the fringes of the Eurocentric experience" (p. 32). Afrocentricity espouses that culture, spirituality, nature, and the collective (or tribe) is inextricably linked to the social and psychological circumstances of people of African ancestry (Asante, 2007). Black psychology, a domain of social science that interrogates Black psychosocial functioning through the lens of culture, race, oppression, spirituality, racial identity development, and the developing practice of Afrocentric social work, subscribes to Asante's view of Afrocentricity (Akbar 2004; Schiele, 1996). Correspondingly, Davis, Williams, and Akinyela (2010) concluded that, "[a] basic premise of an Afrocentric approach is that culture matters—in the past, in the present, and in the future" (p. 4).

In addition, Schiele (1996) indicates that, "[t]he Afrocentric paradigm is a social science paradigm that is embedded in the philosophical concepts of contemporary African America and traditional Africa" (p. 285). It underscores the salience of traditional African ethos, stressing that philosophical African assumptions about human existence are predicated on respect for spirituality and connectedness to people, nature, community, and the ancestors (Mazama, 2002; Mendes, 1982). In the purview of spirituality, for instance, Mazama maintains that it has been of paramount importance to African Americans throughout the diaspora, and has served to assuage the daunting effects of racial oppression and colonization. Further elaboration of Mazama's argument is as follows:

> Afrocentricity, as an emancipatory movement, then inscribes itself with a tradition of African resistance to European oppression. One commonly noted feature of African resistance is its reliance on spirituality. Indeed, spirituality has always historically played an important role in our many struggles for liberation, from Nanny in Jamaica to the Haitian revolutionary war and Nat Turner. Why, after all should Afrocentricity differ? (p. 219)

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RELATIONAL AND NARRATIVE LENSES IN FAMILY THERAPY

Aspects of relational and narrative family therapy tenets can be useful in treating African American families. Honesty, authenticity, and openness are relational attributes that can serve to establish a working alliance. Race and

class notwithstanding, it is important for the practitioner to reflect on how his or her subjective reality has been marred by similar forms of oppression (e.g., internalized oppression, exposure to daily microaggressions), a process that would occur due to a two-person psychological model (Altman, 1995). Likewise, Boyd-Franklin (2003, p. 179) advances the idea that "the person-to-person connection" can be effective in work with African American families because it engenders trust in the working alliance between the practitioner and the family. This idea is supported by Hadley (2008), who reminds us that in the sphere of relational work, mutuality and dynamic and interactional processes are salient to the interplay that occurs between the clinician and the client; it is necessary for the practitioners to be attuned to these variables so that she or he can gain insights into how transferential and countertransferential issues are affecting the work. Finally, Altman (1995) notes that, "[f]rom the perspective of relational psychoanalysis, patient and analyst inevitably bring their own predispositions to the encounter" (p. 132).

African American families are not homogeneous, and, therefore, they present a range of idiosyncrasies in treatment. It must be acknowledged, however, that this population is exposed to the deleterious effects of racial oppression, which creates a sense of shared vulnerability. Shared vulnerability means that many African Americans have some level of psychological consciousness about the potential physical and psychic danger of living in a society that has a history of racial animus toward them. In spite of this, there is variability in how African Americans attempt to cope with exposure to environmentally based toxins, for example, microaggressions (i.e., racial slights and discrimination). Shared vulnerability becomes a pivotal part of this group's narrative and it shapes aspects of their social identities. Cooper and Lesser's (2008) formulation of narrative therapy is apt in that they contend that, "[n]arrative therapy is about knowledge and how the client has 'storied' her life to make sense of it" (p. 162). Clinicians start from a point of not knowing, minimizing their inclination to be the expert on the clients' circumstances; employing this orientation with oppressed populations can lead to a clearer understanding of their subjective truths about experiencing social injustice. "Constructivism is rooted in post modern thinking—which assumes that there no universal truths and that there are many realties as there are perceivers of reality" (Cooper & Lesser, 2008, p. 177). Negative stereotypic messages from society and the family erode family members' self-worth (Leary, 2005). Utilizing a constructivist perspective in treatment can enable families to develop a positive view of themselves, thus providing them with an alternative construction of psychic reality.

What makes a relational and narrative approach to work with families useful is that research (Boyd-Franklin, 2003) reveals that African American individuals and families tend to be suspicious and distrustful of professionals, especially if they sense insensitivity to and lack of understanding of historical and here-and-now experiences with oppression. Boyd-Franklin (2003) uses the concept of *vibe,* articulating that families develop uneasiness with professionals who may not be sensitive to the social and cultural contexts of their experiences. The notion of *vibe* means that families are hypersensitive to whether they can connect with the therapist and whether the therapist

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can relate to them. This phenomenon is rooted in a basic "gut level" feeling, which can either support or hinder the development of a treatment relationship (Boyd-Franklin, 2003, p. 178).

THE *NGUZO SABA* AS FOUNDATION FOR TREATMENT

As noted above, an Afrocentric emphasis on treating African American families needs a framework that addresses internal (i.e., intrapersonal/idiosyncratic processes) and external (i.e., historical and current forms of oppression) variables. Majors and Mancini Billson (1992) state that Afrocentricity "is not anti-white, but it is an ideology that encourage[s] Black Americans to transcend their problems by reclaiming traditional African values" (p. 11). Majors and Mancini Billson's goal can be achieved by infusing the *Nguzo Saba* (the principles of Kwanzaa [Karenga, 1989]) in family treatment. Kwanzaa, an annual cultural holiday (celebrated in December and January), is associated with practices designed to inculcate in African Americans positive messages about Africa and African American experiences. The seven principles of Kwanzaa can counteract feelings of marginalization and self-hatred, which foster poor self-esteem (Aymer, 2010). The seven principles are the following:

Unoja (unity): To strive for and maintain unity in the family, community, nation, and race.

Kujuchagulia (self-determination): To define ourselves, name ourselves, create for ourselves, and speak for ourselves instead of being defined, named, created by others.

Ujima (collective work and responsibility): To build and maintain our community together and make our sister's and brother's problems our problems and to solve them together.

Ujamma (cooperative economics): To build and maintain our own stores, shops, and other businesses and profit from them together.

Nia (purpose): To make our collective vocation and building the development of our community in order to restore our people to their traditional greatness.

Kuumba (creativity): To do always as much as we can in the ways we can, in order to leave our community more beautiful and beneficial than we inherited it.

Imani (faith): To believe with all our hearts in God, our people, our parents, our teachers, our leaders, and the righteousness and victory of our struggle (Karenga, 1989, p. 45).

The value of infusing the principles of Kwanzaa in treatment affirms self-efficacy, an important ego function that may have been affected by historical and contemporary issues of oppression. Karenga (1989) indicates that *Nguzu Saba* is an Afrocentric value system akin to the following goals: (1) "organize and enrich our relations with each other on the persons and the community level; (2) establish standards, commitments and priorities that would tend to enhance our human possibilities as persons and a people; (3) aid in the recovery and reconstruction of lost historical memory and cultural legacy

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in the development of an Afrocentric paradigm of life and achievement; (4) serve as a contribution to a core system of communitarian ethical values for the moral guidance and instruction of the community, especially for children; (5) contribute to an ongoing and expanding set of Afrocentric communitarian values which would aid in bringing into being a new man, woman, and child who self-consciously participate in the ethical project of starting a new history of African people and humankind" (p. 44).

TREATMENT IMPLICATIONS

Treatment themes that African American families may present include—but are not limited to—the following: parent–child difficulties, grandparents as "other mothers," marital discord, immigration and migration, financial anxiety, internalized oppression relating to skin color and hair texture anxieties, and paternal issues. An important caveat is that these are examples of presenting difficulties that may surface in therapy and should not be viewed as definitive concerns unique to African Americans.

Combining *Nguzo Saba* with Hill's (1999) groundbreaking work on African American strengths (e.g., strong achievement orientation, strong work ethic, flexibility of family roles, strong kinship attachment, and strong religious values) enable clinicians to address coping and adaptive factors relative to family functioning. Hill's assertion is that these strengths are the foundation of African American family stability because social and political institutions work against their interests. The strong kinship attachment system must be assessed by examining who is living in and out of the household, as well as the types of familial bonds that exist among family members, excavating the viability of the family social network (e.g., godparents, close friends of the family, deacons of the church). *Umoja* (unity) can be used to understand the closeness and connections among and between family members. Akbar (2004) states that "[t]he often-described extended family among African people is relevant to this notion of oneness" (p. 125). Under the conditions of slavery, families maintained a strong sense of kinship, underlining why clinicians should have historical insights into the African American experience (Kardiner & Ovesey, 1962). In addition, Hill's use of strong religious values complements the principle of *Imani* (faith) because it will enable practitioners to assess how families use faith-based coping (e.g., praying, calling on the ancestors for guidance, engaging in religious practices) to alleviate psychosocial stress (Mazama, 2002). It should be noted that Mazama indicates that the use of spirituality is a protective factor that has served an emancipatory function for diasporic people.

Afrocentrists believe that African Americans' esteem is nurtured by their attachment to family and the African American community (Akbar, 1985, 2004; Karenga, 1989; Mbiti, 1969). Individuals obtain high regard from the group or tribe, supporting Hill's views about a strong achievement orientation, strong work ethic, and flexibility of family roles. Moreover, *Ujima* (collective work and responsibility) builds on this premise because it emphasizes collectivism over individualism—a functional factor in clients who may appear to be dependent on their families and community for

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support—as opposed to public systems of care. Underpinning a central precept of Afrocentricity is Mbiti's (1970) stance: "I am because we are; and because we are, therefore I am" (p. 108).

Internalized oppression, which can take the form of self-loathing reactions manifested in anxieties about skin color, hair texture, and facial features, has the potential to surface in psychotherapeutic work with African American families. As noted previously, skin color is a troublesome concern shaping identity and interpersonal and intrapersonal processes within families. Research (Akbar, 2004; Boyd-Franklin, 2003; Leary, 2005; Russell, Wilson, & Hall, 1992) reveal that lighter skin tones (and hair texture) within the families are imbued with a sense of privilege and beauty, causing turbulence among siblings and other family members. Russell et al. (1992) delineated a myriad of ways in which skin color dynamics are played out in the African American communities and families:

> Identity is a multifaceted and in some ways nebulous concept. Being Black affects the way a person walks and talks, his or her values, culture, and history, how that person relates to others and how they relate to him or her. It is governed by one's early social experience; history and politics, conscious input and labeling, and the genetic accident that dictates appearance. Skin color appears to affect identify, but in complex and seemingly unpredictable ways. (p. 62)

Boyd-Franklin (2003) echoes a similar view: Lighter-skinned children are revered in families, whereas dark-skinned children are sometimes ostracized and devalued. This phenomenon often culminates in secret keeping and can produce unspoken turmoil, undercutting family members' self-esteem (Boyd-Franklin, 2003). Emblematic of Latif and Latif (1994) and Leary (2005) discourses, skin-color issues are significant outgrowths of STS that can be traced to the institution of slavery (specifically, the rape of slave women that produced mulatto children who were privileged and worked in the master's house as opposed to working in the field). Boyd-Franklin (2003) suggests that contemporary African American families continue to grapple with skin-color anxieties and may be reluctant to share their feelings with a professional due to shame. Utilizing the principles of *Nia* (purpose), *Kujichagulia* (self-determination), and *Kuumba* (creativity) in treatment enables individuals to consider self-acceptance, an important factor that can counteract internalized negative stereotypic societal projections. Akbar (1985) argues that:

> Self-acceptance is the beginning for all positive social activity. Knowing who you are acquaints you with the best of your human potential and leads to productive acceptance of self. Accepting self means that you like yourself and have a commitment to self. Accepting self means that you want to be yourself and not anyone else's self, the self-accepting person does whatever he can to express himself. From physical feature to cultural features the objective is to express self. The non-self-accepting person tries to change their features to look like another self. (p. 31)

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The point is that the infusion of the principles of Kwanzaa in treatment serves to raise psychological and cultural consciousness for many families—mitigating cognitive dissonance—stemming from daily encounters with environmental deficits.

CONCLUSION

Utilizing an Afrocentric approach in treating African American families is one important way for clinicians to help families cope with stressors related to their familial idiosyncratic dynamics and racial oppression. An Afrocentric viewpoint to practice contextualizes the social location of families and provides insights into how the intersection of race, oppression, and family life cohere in order to shape their psychological reality. The *Nguza Saba* can be used to instill cultural, spiritual, and social awareness in the treatment process. Furthermore, an Afrocentric approach to treatment can enable families to connect with thematic elements of the *Nguza Saba*: cultural pride, heritage, spirituality, faith, coping, and self-efficacy. The empowering effects of these themes in work with African American families affirm their resilience and determination to survive and thrive despite the ubiquitous circumstances of institutionalized cultural and racial oppression.

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ELEVEN

Clinical Practice With Hispanic Individuals and Families: An Ecological Perspective

Manny J. González and Gregory Acevedo

The term Hispanic was created by the U.S. Census Bureau in 1970. Latino[1] is a self-ascribed term that emerged from the everyday interpretative and linguistic practices of Hispanics in the United States. The term Latino appeared on the U.S. census form for the first time in 2000. However it may be categorized or defined, the Hispanic rubric remains "under construction" (Torres-Saillant, 2002). The pan-ethnic, Hispanic population in the United States varies in terms of such important characteristics as immigration status (foreign-born Hispanics comprise a substantial proportion of both the Latino and the total foreign-born population in the United States), national origin, racial and ethnic identification, language use and proficiency, place of residence, and socioeconomic status. Common elements of the Hispanic rubric and Latino identity include: the preponderance of Spanish-language use; similarity in sociohistorical and geopolitical influences; the psychosocial influence of family origins, socialization, and personal feelings; and the geospatial context of barrio life.

In 2010, the Hispanic population in the United States (excluding the island of Puerto Rico) numbered 50.5 million (50,477,594). Between 2000 and 2010, the Hispanic population increased by 15.2 million and grew by 43% (at a rate four times that of the nation's overall growth rate of 9.7%). Latinos accounted for more than half of the total 27.3 million increase in the U.S. population (Ennis, Rios-Vargas, & Albert, 2011a). In 2010, Mexicans comprised 63% of the total U.S. Hispanic population. Between 2000 and 2010, this Mexican group increased by 54% (from 20.6 million in 2000 to 31.8 million in 2010); they grew more than any other U.S. Hispanic group and accounted for about three-fourths of the total increase in the total Hispanic population between 2000 and 2010 (Ennis, Rios-Vargas, & Albert, 2011b).

The traditional "Big 3"—Mexicans, Puerto Ricans, and Cubans—continue to comprise the lion's share of the overall Hispanic population (about three-quarters in the 2010 census). That said, the population of other national-origin groups has increased substantially as well. (See Table 11.1 for a detailed disaggregation of the Hispanic population in the United States.) Between 2000 and 2010, the Guatemalan population grew by 180%, the Salvadoran by 152%, the Colombian by 93%, and the Dominican by 85% (Lopez & Dockterman, 2011). The Cuban and the stateside Puerto Rican

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TABLE 11.1 Hispanics by Origin and Type

	2000		2010		CHANGE 2000–2010	
	NUMBER	% OF TOTAL	NUMBER	% OF TOTAL	NUMBER	%
Total Hispanic	35,305,818	100.0	50,477,594	100.0	15,171,776	43.0
Origin and Type						
Mexican	20,640,711	58.5	31,798,258	63.0	11,157,547	54.1
Puerto Rican	3,406,178	9.6	4,623,716	9.2	1,217,538	35.7
Cuban	1,241,685	3.5	1,785,547	3.5	543,862	43.8
Other Hispanic or Latino	10,017,244	28.4	12,270,073	24.3	2,252,829	22.5
Dominican	764,945	2.2	1,414,703	2.8	649,758	84.9
Central American	1,686,937	4.9	3,998,280	7.9	2,311,343	137.0
Costa Rican	68,588	0.2	126,418	0.3	57,830	84.3
Guatemalan	372,487	1.1	1,044,209	2.1	671,722	180.3
Honduran	217,569	0.6	633,401	1.3	415,832	191.1
Nicaraguan	177,684	0.5	348,202	0.7	170,518	96.0
Panamanian	91,723	0.3	165,456	0.3	73,733	80.4
Salvadorian	655,165	1.9	1,648,968	3.3	993,803	151.7
Other Central American	103,721	0.3	31,626	0.1	–72,095	–69.5
South American	1,353,562	3.8	2,769,434	5.5	1,415,872	104.6
Argentinian	100,864	0.3	224,952	0.4	124,088	123.0
Bolivian	42,068	0.1	99,210	0.2	57,142	135.8
Chilean	68,849	0.2	126,810	0.3	57,961	84.2
Colombian	470,684	1.3	908,734	1.8	438,050	93.1
Ecuadorian	260,559	0.7	564,631	1.1	304,072	116.7
Paraguayan	8,769		20,023		11,254	128.3
Peruvian	233,926	0.7	531,358	1.1	297,432	127.1
Uruguayan	18,804	0.1	56,884	0.1	38,080	202.5
Venezuelan	91,507	–0.3	215,023	0.4	123,516	135.0
Other South American	57,532	0.2	21,809		–35,723	–62.1
Spaniard	100,135	0.3	635,253	1.3	535,118	534.4
All other Hispanic or Latino	6,111,665	17.3	3,452,403	6.8	–2,659,262	–43.5

Source: Ennis et al. (2011a).

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TABLE 11.2 Largest Hispanic Subgroups in the United States

COUNTRY OF ORIGIN	POPULATION
Mexican	31,798,000
Puerto Rican	46,240,000
Cuban	1,786,000
Salvadoran	1,649,000
Dominican	1,415,000
Guatemalan	1,044,000
Colombian	909,000
Honduran	633,000
Ecuadoran	565,000
Peruvian	531,000

Source: Lopez and Dockterman (2011).

population grew more slowly, at 44% and 36%, respectively. (See Table 11.2 for a detailed disaggregation of the largest Hispanic subgroups in the United States.) The particular Latino subgroups are the most dominant in number, and vary by state, region, and metropolitan area (Lopez & Dockterman, 2011).

An essential thread in the history of the Latino experience in the United States is social marginalization, poverty, and political disenfranchisement. Due to the stigmas associated with "illegal" or undocumented immigration (although over half of the Hispanic population in the United States is native-born) the focus of public perceptions, debates, and policies have centered on Latino immigrants, and has cast a shadow over all Latinos, whatever their legal status or origin. A recent report by the Southern Poverty Law Center (2009) noted: "The assumption is that every Latino possibly is undocumented. So [discrimination] has spread over into the legal population" (p. 5). Hispanic immigrants in the United States and, by default, their native-born Latino counterparts are currently embroiled in a number of policy related debates. The issues that are the subject of these debates are quintessential illustrations of the practice of policy deployed to regulate the lives of people of color, including immigration and border control, and also policies related to citizenship, bilingual education, welfare reform, and labor rights (Acevedo, 2010).

Hispanics are an essential part of the sociocultural, political, and economic life of the United States and are altering the demographic landscape of the United States. Latinos are the fastest growing "minority" group in the United States (Ennis et al., 2011a). Hispanics comprise a substantial part of the nation's labor force (almost 15% and projected to increase to 18% by 2018 (National Institute for Latino Policy, 2011)). Yet, Hispanic socioeconomic well-being is, at best, tenuous. Wide range of income and wealth disparities, high rates of poverty and unemployment, and low rates of educational attainment characterize the current state of Latino socioeconomic well-being. In a recent op-ed piece in the *New York Times*, Professor Douglas S. Massey, the renowned scholar and sociologist wrote: "Over the past two decades Hispanics have

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moved from the middle of the socioeconomic hierarchy, between blacks and whites, to a position below both. On virtually every indicator of socioeconomic welfare, Hispanics fell relative to blacks" (Massey, 2011).

In light of the overall profile of Hispanics in the United States, the sociocultural, political, and economic dynamics that determine the Latino experience, and the differences between and within the various Hispanic national-origin groups, including linguistic diversity and immigration status, the task of mastering competent social work practice with this population takes on increased significance. The psychosocial issues associated with the emigration experience and complex personal and social environment transactions are reason enough to justify the relevance and need for culturally competent treatment models or approaches to clinical practice that are attuned to Hispanic individuals and families. Compounding the acute stressors of emigration—that many Hispanics must face on a continual basis—is the silhouette of an enduring shortfall in the economic, educational, and social arenas, creating the oppressive context of daily life that, if unaddressed, erodes the psychosocial well-being and coping strengths of this large and growing population. Informed by the tenets of the ecological perspective and the life model of social work practice (Gitterman & Germain, 2008), this chapter presents an overview of clinical practice with Hispanic families. The ecological perspective helps to promote clinicians' understanding of the psychosocial problems experienced by culturally diverse client populations as well as the socioenvironmental variables (e.g., racism, discrimination, poverty) that impede optimal physical, psychological, and social well-being. Because the process of individual or family treatment cannot separate personality structures and issues from the cultural factors that influence the emotional health of the individual, this chapter will also underscore the key cultural characteristics of Hispanic individuals and families and their relevance for culturally competent clinical practice. Treatment recommendations and strategies for effective psychosocial intervention with Hispanic families will be emphasized throughout the chapter.

CULTURAL CHARACTERISTICS OF HISPANIC INDIVIDUALS AND FAMILIES

The clinical care for Hispanic clients must be predicated on an understanding of the way specific cultural values or characteristics directly affect how practitioners can provide effective psychotherapeutic and culturally congruent treatment. Sandoval and De la Roza (1986), as well as other Hispanic scholars (Gil, 1980; González & González-Ramos, 2005; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002), have identified and described the salient cultural values or characteristics that may inform the treatment strategies employed in the amelioration of psychological distress and social functioning among Hispanics. The values or characteristics are those of *simpatía*, *personalismo*, *familismo*, *respeto*, and *confianza*. There are also two gender-specific roles (Gil, 1980) that are part of the traditional Hispanic experience that may influence therapeutic approaches and outcomes: *marianismo* (female self-sacrifice) and *machismo* (male self-respect and responsibility). *Marianismo* and *machismo* may be terms that have acquired such common and pejorative

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usage that their actual centrality in the Hispanic maintenance of intrapersonal and interpersonal coherence is obscured.

Religion or a sense of spirituality also informs the traditional Hispanic experience and may serve to enhance, or at times challenge, the curative process of clinical social work practice. Clinical practitioners must be mindful of the fact that, irrespective of differences within or among Latino ethnic groups (e.g., Cubans, Mexicans, Puerto Ricans), Hispanics do share similarities based on these traditional characteristics. Hispanics' level of acculturation, socioeconomic class, and family and gender roles, however, will affect both their adherence to traditional cultural values or characteristics and their utilization of clinical services and the broader applications of psychosocial care. Examples of traditional Hispanic cultural values/characteristics and how they may impact the provision of clinical and mental health care are described below:

- ***Simpatía.*** *Simpatía* relates to what many call *buenagente* (the plural form of a nice person). Hispanics are drawn to individuals who are easygoing, friendly, and fun to be with. *Simpatía* is a value placed on politeness and pleasantness. Avoidance of hostile confrontation is a vital component of this specific ethno-cultural value.
- ***Personalismo.*** *Personalismo* as a cultural trait or value is reflected in the tendency of Hispanic patients to relate to their service providers personally rather than in an institutional or impersonal manner. Hispanic clients expect to develop a warm personal relationship with their clinician characterized by interactions that are authentic.
- ***Familismo.*** *Familismo* is a collective loyalty to the nuclear and extended family that outranks the individual. The extended family within the Hispanic culture includes members who are biologically related to each other, as well as members who join the family system via *compadrazco* (godparentage). Biological parents select *compadres* (godparents) before the baptism or christening ceremony of a child. Historically, this practice is directly linked to Catholicism. Godparents assume a vital resource role in the Hispanic family particularly during times of crisis when instrumental and emotional support may be needed. It is important to note that this cultural value (*familismo)* remains strong even among highly acculturated families (Santiago-Rivera et al., 2002).
- ***Respeto.*** *Respeto* (respect) dictates appropriate deferential behavior toward others based on age, gender, social position, economic status, and authority. Within the Hispanic community, older adults expect respect from youngsters, women from men, men from women, adults from children, teachers from students, employers from employees, and so on. Clinicians must keep in mind, however, that respect within the Hispanic culture implies a mutual and reciprocal deference. The clinician receiving respect as a professional is equally obligated to observe deferential courtesies to the client based on age, gender, and other sociocultural characteristics.
- ***Confianza***. *Confianza* (trust) refers to the intimacy and familiarity in a relationship. The term in Spanish implies informality and ease of interpersonal comfort. Clinicians who are able to develop a bond of trust (*confianza*)

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with Hispanic clients may eventually notice a level of improvement in the patient's psychological status, and a willingness of the client to comply with mental health or psychosocial care recommendations.

It is important to note, especially regarding *confianza* as a kind of culminating relational state based on the other named cultural values and expectations, that engagement and maintenance of a clinical working alliance could be similarly defined. The culturally sensitive practitioner is assisted in their development and maintenance of a productive clinical process by bearing in mind that these Hispanic-specific concepts offer practical guidance in work with all populations. Their conscious centrality to clinician and client in work with Hispanic clients may call for a more overt demonstration of cultural protocols, particularly where there is divergence from the clinician's cultural orientation. However, the essential features of sympathy/empathy, respect, individuality, and trust apply across most, if not, all interpersonal lines.

The essence of the most common traditional Hispanic values or characteristics may be summarized in the following points: (a) unity and interdependence among members of the nuclear and extended family; (b) expectation that the family (nuclear and extended) will care for the young and the elderly; (c) flexible sense of time—many Hispanic clients adhere to a present-time orientation; (d) physical closeness and touching in an appropriate context can be expected during conversation or an interpersonal exchange; and (e) respect for tradition and traditional family and social roles (Taylor, 1989).

Gender-Specific Roles

Gender role expectations and values constitute an area where transference and countertransference may create the strongest potential for cultural misalignment and misunderstanding within the client–clinician treatment relationship. Demarcated gender roles are an important component of the Hispanic relational matrix. Traditional gender roles within the Hispanic family structure have intrinsically been linked to the concepts of *marianismo* and *machismo*. *Marianismo*, the term associated with Hispanic female socialization, implies that girls must grow up to be women and mothers who are pure, long-suffering, nurturing, pious, virtuous, and humble, yet spiritually stronger than men (Gil, 1980). The concept of *marianismo* is religiously associated with the Virgin Mary and, therefore, it is directly tied to the Roman Catholic faith. Although *marianismo* has contributed to a view of Hispanic women as docile, self-sacrificing, and submissive, it is clear that from a family systems' viewpoint women (particularly mothers) are the silent power in the family structure.

Clinicians need to be alert to the temptation to view the submissiveness of female Hispanic clients as a deficiency in self-esteem or self-assertiveness. Much clinical potential can be lost if the clinician, to whom it is also apt to demonstrate deference, focuses on gender roles per se rather than deconstructing the ways in which the client's posture toward others is or is not inherent to the problem brought to clinical attention. In his seminal paper,

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"Masochism, Submission, and Surrender—Masochism as a Perversion of Surrender", Ghent (1990) clearly distinguishes deference from powerlessness or self-devaluation. The culturally sensitive and clinically skilled practitioner, seeking empathic understanding of the client's meanings and methods without superficial evaluation of manifest behavior, is well advised to understand that surrender of dominance is a legitimate relational–interpersonal dynamic, especially if matched by protective factors and relational reciprocity as Hispanic values dictate. Surrender to the cultural and individual attributions of meaning and worth of the client is a cornerstone of the constructivist, non-positivist, practice required particularly with clients of differing worldviews (Jordan, 2010).

The gender role socialization of Hispanic males has centered on the construct of *machismo*. *Machismo* has been defined in the general social science literature as the cult of virility, arrogance, and sexual aggressiveness in male-to-female relationships (Santiago-Rivera et al., 2002). From a Hispanic perspective, however, Sandoval and De la Roza (1986) state that *machismo* refers to a man's responsibility to provide for, protect, and defend his family. Loyalty and a sense of responsibility to family, friends, and the community make a Hispanic male a good man. Hispanic males are expected to be honorable and responsible men. Within the Hispanic family structure, men (especially fathers and husbands) command and expect respect from others. If clinical treatment initiatives are to succeed, practitioners must be skilled at proffering this expected respect to Hispanic adult male clients. This applies to male and female clinicians alike. It is important to note that the process of acculturation may determine the degree to which both Hispanic males and females adhere to the concepts and cultural definitions of *machismo* and *marianismo*. Thus, adherence to these traditional roles may be more visible among recent Hispanic immigrants than among third and fourth generation Hispanics. Sandoval and De la Roza (1986, p. 174) have noted the impact that *machismo* may have on the delivery of mental health services:

> Machismo is one of the Hispanic cultural traits which greatly affect therapeutic intervention, especially family therapy. Machismo might be the reason why the Hispanic male seeks help at a more advanced stage of deterioration than is typically the case with females. Apparently the Hispanic male needs to be in greater pain in order to seek mental health assistance. Machismo [may] negatively influence the therapeutic process. There is resistance by the male to get involved in couples or family therapy, since males [may] generally perceive this involvement as having a deteriorating effect on their integrity and authority.

Religion and Spirituality

The literature on cross-cultural mental health and psychotherapeutic care (Flores & Carey, 2000; González & González-Ramos, 2005; Santiago-Rivera et al., 2002; Sue & Sue, 1999) has identified Hispanics as an ethnic-minority group whose adherence to an array of religious or spiritual beliefs impact

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the clinical social work process. From a mental health perspective, religion and spirituality may shape how individuals view and relate to their psychological world and social environment. Comas-Diaz (1989), for example, has observed that for Hispanics religion not only affects their conception of mental illness and treatment, but it also influences their health-seeking behaviors. In some instances, when a religious (denominational) value is placed on suffering and martyrdom (self-denial), certain Hispanics may opt not to seek mental health treatment (Acosta, Yamamoto, & Evans, 1982). As noted above regarding *marianismo* and *machismo*, culturally sensitive practice principles (Harper & Lanz, 1996) prescribe open and co-constructed exploration of how a psychosocial problem can be approached in ways that are congruent with the client's cultural outlook.

Historically, Hispanics have Self-identified themselves as Roman Catholics. However, conversion to Protestant sects/denominations is not an uncommon phenomenon within the Latino community. Currently, many Hispanics identify themselves as Pentecostal, Seventh-Day Adventists, or Evangelical. In addition to adhering to institutionally organized religious belief systems, some Hispanic may profess faith in ancestral spiritual practices such as *santería* (combined Yoruban–Catholic religious practice), *espíritismo* (spiritism), or *curanderismo* (rural folk medicine). The interpenetration of religious beliefs and self-definition or problem accessibility is the clinician's obligation to discern.

Hispanics have used religion and spirituality as survival mechanisms within the context of an often hostile social environment. For example, for many immigrants, religion has served as a buffer against the toxic emotional effects of entrance into the United States as unwelcome interlopers. Urrabazo (2000) has noted the curative potential of faith and religion in therapeutically assisting undocumented Hispanic immigrants who have been robbed, raped, and beaten while crossing the border into the United States. Religion appears to emotionally sustain Hispanics who are subjected to the realities of racism, discrimination, and social injustice on a continuous basis. During times of psychological crisis or environmental distress, the religious belief systems of Hispanics may be used as a complementary adjunct to conventional clinical social work practice. Clinicians must be cognizant of the fact that for many Hispanics the church provides an opportunity for mutual aid and social support. Urrabazo (2000), for example, has observed that the growth of storefront churches in urban Hispanic communities provides evidence for understanding the desire of many Hispanics to belong to a "healing community" where self-validation, connection to others, guidance, and social support may be found.

Because of the importance of religion and spirituality among individuals of Latin American and Caribbean descent, it is important to note that Hispanics do not dichotomize physical and emotional health or illness. Thus, the Hispanic culture tends to view health and psychological well-being from a more integrated or synergistic point of view. This view is expressed within a continuum that includes the body, mind, and *espíritu* (spirit). Therefore, many Hispanic folk concepts of disease etiology appear to be related to the ill effects of experiencing intensely negative emotional states, such as fright,

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anger, or envy (The National Alliance for Hispanic Health, 2001). Treatments for these cultural maladies, therefore, are based on a variety of sociospiritual rituals including purification, social integration, and—at times—penance (Kaiser Permanente Foundation, 2000). Hispanics may often consult *curanderos* (Mexican folk healers), *espíritistas* (spiritualists who are primarily Puerto Rican folk healers), or *santeros* (Cuban and/or Puerto Rican folk healers) in an attempt to seek symptom relief for physical and/or emotional complaints.

Nervios: An Example of a Culturally-Bound Physical and Emotional Syndrome

Nervios (nerves) refers to restlessness, insomnia, loss of appetite, headache, and non-specific aches and pains (Kaiser Permanente Foundation, 2000; The National Alliance for Hispanic Health, 2001). *Nervios* is often linked to experiencing chronic, negative life circumstances particularly in the domain of interpersonal relationships. Thus, this culturally bound syndrome may be often noticed in individuals who are experiencing maladaptive patterns of interpersonal relationships and communication as well as high levels of social stress. Closely linked to *nervios* is *ataque de nervios* (nerve attacks), which is a seizurelike conversion syndrome characterized by mutism, hyperventilation, hyperkinesis, and uncommunicativeness (Guarnaccia, De la Cancela, & Carillo, 1989; Lewis-Fernandez & Kleinman, 1994). *Ataque de nervios* may resemble a panic attack, but providers of mental health care should not confuse one with the other.

Folk healers (e.g., *curanderos*, *santeros*, or *espíritistas*) who are sought after for the treatment of the above-described culturally bound condition will often perform special religious/spiritual rituals using a variety of methods such as massage with special ointments, prayers, candles, herbal teas, baths, and invocations to specific Catholic saints or spirits. Adherence to the practice of folk healing is predicated on the cultural understanding that many Hispanics accept the possibility that illness and disease are linked to the supernatural world; therefore, spirits and witchcraft may cause or significantly contribute to psychological and physical distress. Illness and disease may also be linked to external environmental or internal (individual) factors such as bad air, excess cold and heat, germs, dust, fear, envy, and shame. Clinical efforts that are aimed at improving the psychological status of Hispanics in the United States must be based on an understanding that many Hispanics will probably conform to both a medical–biological model of help-seeking behavior and a spiritual model of symptom relief.

ECOLOGICALLY INFORMED TREATMENT: STRATEGIES AND RECOMMENDATIONS

The ecological perspective with its emphasis on niche, adaptation, transactions, reciprocity and mutuality, and the goodness of fit between people and their environments is well suited for analyzing the lived experience of Hispanics. The life model (Germain & Gitterman, 1995; Gitterman & Germain, 2008), with its keen attention to social ecology, life-cycle development, and vertical and horizontal stressors, offers a practice approach that is able to account for the clinical challenges experienced by Hispanic clients

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in its assessment and intervention strategies. This is clearly demonstrated when the ecological perspective and the life model are deployed to understand the mental health and psychosocial needs of Hispanic individuals and families.

Informed by the science of ecology and ego psychology, the life model of social work practice views the human being as constantly adapting in an interchange with differential aspects of the social environment. Both the human being and the social environment react to each other and change within a transactional matrix (Gitterman & Germain, 2008). The person and the environment can be understood only in terms of their relationship, in which each continually influences the other within a particular context.

Gitterman (2009) has noted that throughout the life course people attempt to maintain a harmonious fit with their surrounding environments. This harmonious fit is usually achieved through a sense of self-efficacy—or when the individual feels positive and hopeful about his or her capacity to survive and thrive within multiple social contexts—and the environment's responsiveness to human need via provision of life-sustaining resources. Conversely, this noted harmonious fit may be seriously compromised when the individual lacks adaptive coping capacities or when such capacities have been placed at risk by psychosocial stress and toxic environmental conditions. Within the life model (Germain & Gitterman, 1980), stress is conceptualized as a psychosocial state spawned by inconsistencies between the human being's needs and capacities and environmental qualities. As a psychosocial condition, stress is the by-product of complex personal and environmental transactions.

A central tenet of life-modeled practice is that individuals will encounter stress or experience life stressors over the life course. From an ecological perspective, life stressors breed by complex and precarious life issues that human beings perceive as being greater than their coping capacities and environmental resources (Germain & Gitterman, 1995). According to the life model, stress or life stressors will arise or be manifested in the following three interrelated areas of living: life transitions and traumatic life events, environmental pressures, and dysfunctional interpersonal processes. Gitterman (1996) has underscored the fact that while these three life stressors are interrelated, each takes on its own "force" and "magnitude" and provides direction for multi-method (e.g., individual, family, group, and community practice) and integrative interventions with diverse client systems.

Intervention or treatment within the life model is informed by the historic purpose of the social work profession: to enhance the problem-solving and coping capacities of people, and to promote the effective and humane operation of systems that provide people with needed resources and services (Germain & Gitterman, 1980). While not prescriptive in nature, life-modeled practice recognizes that clinical practitioners require a broad repertoire of skills and techniques in addressing the needs of individuals and families who are overwhelmed by significant life stressors. These skills and techniques must be aimed at increasing a client's self-esteem and problem-solving and coping capacities; facilitating group functioning; and engaging and influencing organizational structures, social networks, and social environmental

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forces (Gitterman & Germain, 2008). Payne (2005) has noted the type of therapeutic and socioenvironmental skills or techniques that practitioners may employ when implementing a life model approach with identified clients. Some of these skills and techniques include: strengthening the client's motivation toward change, validation, support, management of emotionally laden content, modeling behavior, mobilization of environmental supports, case advocacy, mediation, and teaching problem-solving skills.

Ego-Supportive Intervention

Consistent with the treatment principles of the ecological perspective and the life model, Comas-Diaz (1989) has stressed that regardless of the treatment approach/modality used with Hispanic clients, clinicians need to address the complex set of treatment expectations Hispanics have, which involve a multiplicity of psychological, physical, and environmental dimensions. Within the set of treatment expectations, clinical practitioners must effectively incorporate a client's individual worldview and the ethno-cultural variables of language and religion (González, 2002). Le Vine and Padilla (cited in Padilla & Salgado De Snyder, 1985), for instance, have proposed a pluralistic counseling approach for the psychosocial treatment of Hispanics that encompasses these important variables. In describing the treatment approach they note:

> Pluralistic counseling is defined as a therapeutic intervention that recognizes and understands a client's culturally based beliefs, values, and behaviors. This approach encompasses the client's personal and family history as well as social characteristics and cultural orientation in order to evaluate all the ways in which culture affects the individual. The goal of pluralistic counseling is to help clients clarify their personal and cultural standards and to orient their behavior according to these standards. (p. 160)

Within this counseling approach, culture (which includes an individual's worldview, use of language, and belief systems) and environmental conditions prevail as the principal source for comprehending the client's psychosocial problems.

Because the psychosocial problems and needs of Hispanic clients are often exacerbated by socioeconomic stressors, racism, and political oppression, an ego-supportive therapeutic approach may also be effective in meeting the psychosocial needs of this population. According to Goldstein (1995, p. 168):

> Ego-supportive intervention focuses on the client's current behavior and on his conscious thought processes and feelings, although some selected exploration of the past may occur. . . . A here-and-now and reality-oriented focus identifies current stresses on the client; restores, maintains, and enhances the client's conflict-free areas of functioning, adaptive defenses, coping strategies, and problem-solving capacities; and mobilizes environmental support and resources.

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Ego-supportive treatment stresses the empowerment of clients, and intervention within the social environment is promoted. In addition, the following practice principles, relevant to the lived experience of Hispanics in the United States, are endorsed: appreciating the impact of the sociopolitical context on the functioning of clients; balancing a focus on ethnic/cultural group membership and individualization of the client; enhancing client strengths; building self-confidence, self-esteem, and personal power; educating clients about options to problem resolution and maximizing choice; linking clients to needed resources; connecting clients to mutual aid groups and peer supports; and encouraging collective and political action (Goldstein, 1995). Ego-supportive treatment is carried out through the use of selected psychological and ecological techniques or strategies. These techniques or strategies include: support, ventilation, instillation of hope, use of structure, exploration, clarification, confrontation, education and advice, and environmental modification (Woods & Hollis, 2000).

Social/Environmental Change Agent Role Model

Given that many Hispanic clients (especially new immigrants) often lack instrumental support from their U.S.-based extended families, many attempt to negotiate complex environmental conditions (e.g., employment, housing, medical care, learning English as a second language) with minimal appropriate guidance. Predicated on this notion, Atkinson, Thompson, and Grant (1993) developed a three-dimensional psychosocial intervention approach (social/environmental change agent role model) for the mental health treatment of ethnic–racial minority clients that recognizes the impact of the social environment in promoting or handicapping psychological growth and development. Within this treatment model, clinicians who treat Hispanic clients can function as agents of change or as consultants or advisors with the therapeutic aim of strengthening the identified client's support systems. Because the successful psychosocial treatment of Hispanics may also require case advocacy and home visits, both environmental manipulation and home-based treatment services are quite consistent with the tenets of this therapeutic approach.

Atkinson et al. (1993) recommend that the following three factors should be diagnostically assessed when treating an ethnic minority patient: (a) the client's level of acculturation, (b) the perceived cause and development of the presenting problem (internally caused versus externally environmentally caused), and (c) the specific goals to be attained in the treatment process. In implementing this treatment approach with Hispanic clients, clinicians should be prepared to extend their professional role of psychotherapist to that of advocate, mediator, and broker or resource consultant. As an advocate, the clinician targets his or her intervention at problems-in-living that are exacerbated by the dynamics of oppression, discrimination, and unequal access to community resources. In the role of a mediator, the clinician attempts to reduce the tension and conflict that may emerge between a client and a human service institution when psychosocial services are sought, but the delivery or nature of the services are inadequate or ineffective in meeting

the needs of the client (Woods & Hollis, 2000). When treatment entails referring clients to community resources, the clinician assumes the role of a broker or resource consultant. In implementing this role, and consistent with the cultural value base of Hispanics, clinicians, at times, may need to refer clients to both indigenous support systems and indigenous systems of healing.

Ecological–Structural Family Treatment

Hispanic families often experience psychosocial distress because of intergenerational and acculturation conflict. Because the locus of the family dysfunction is not only internal but also external in nature, ecological–structural family treatment is well suited for the amelioration of maladaptive family patterns that are often observed in Hispanic families that are attempting to cope with complex psychological and social issues. Predicated on the theoretical and clinical work of Aponte (1976) and Minuchin (1974), this family treatment approach highlights the stress of acculturation and its disruptive impact on the adaptive functioning of the Hispanic family. The approach draws attention to how normal family processes may interact with acculturation processes to create intergenerational differences that may exacerbate intrafamilial conflict.

Altarriba and Bauer (1997) note that when applying ecological–structural family treatment to Hispanic families an assessment of the interaction between the identified client or patient and their environment should be conducted early in the initial phase of treatment. The diagnostic assessment process should include an appraisal of the boundaries between and among family members, the strength of the relationships between and among family members, an understanding of the hierarchical and authority structure of the family, and an examination of any inherent contradictions in the request for service. Szapocznik et al. (1997) have empirically studied the value of ecological–structural family treatment in assisting Cuban families to address their interactional problems from both a content and a process level. At the content level, the cultural and intergenerational conflicts can be the focus of clinical attention. At the process level, the treatment approach aims to modify the breakdown in communication processes resulting from intensified cultural and intergenerational conflicts. The content and process distinction is crucial in treating Hispanic families who are attempting to cope with life transitional issues, maladaptive interpersonal interactions, environmental problems and needs, and adaptation to a host culture.

CONCLUSION

To achieve and maintain an optimal degree of emotional equilibrium and social well-being, basic human needs, including a sense of usefulness, a sense of control over one's life, and healthy connections to others must be satisfied. In order to achieve this goal, culturally informed clinical practice must address the psychological needs of the individual while understanding how the social and cultural milieu informs the development and unfolding of the self. Because Hispanics represent one of the largest ethnically diverse

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groups in the United States, clinicians should be familiar with selected culturally sensitive treatment approaches that are appropriate in ameliorating psychosocial distress within this population. Culturally competent or culturally sensitive psychosocial treatment requires clinical skill, empathy, and an awareness of how cultural values, gender roles, and religion or spirituality impact the effective delivery of psychosocial services. This chapter has presented an overview of clinical practice with Hispanic individuals and families. Informed by the conceptual underpinnings of the ecological perspective and the life model of social work practice, the chapter has highlighted selected treatment approaches and strategies that may be used to address the transactions of individuals and families of Hispanic origin within the context of the social environment. The locus of problem etiology, the client's level of acculturation, and the goal of clinical intervention should always guide the culturally sensitive or culturally competent psychological and social treatment of Hispanic clients.

NOTE

1. The terms "Latino" and "Latina" are the masculine and the feminine forms of the term Latino in the Spanish language.

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TWELVE

Practice With Asian Immigrant Families and Intergenerational Issues

Irene W. Chung

DIVERSITY OF ASIAN IMMIGRANT POPULATION IN THE UNITED STATES

For the past five decades, Asian Americans have proportionately been the fastest-growing racial group in the United States (Barnes & Bennett, 2002). Since 1965, liberal immigration policies have opened up opportunities for Asians to immigrate to the United States under circumstances of family reunion, refugee asylum, labor shortage, and business investments. According to the 2010 U.S. Census (Census Briefs and Reports 2010), the Asian population grew by 43.3%, a rate faster than any other race group in the country between 2000 and 2010. Individuals who identify themselves as "Asian alone" now comprise 4.8% of the total population in the United States. It is projected that the number of U.S. residents in 2050 who will identify themselves as Asian or Asian in combination with one or more other races will be 9% of the total population. Presently, the majority of Asian Americans are foreign-born or first-generation who identify with traditional Asian cultural values and norms in varying degrees. The majority of Asian American children live in families where one or both parents are immigrants (Zhou & Gatewood, 2000). However, Asian immigrants are by no means a homogenous group. Increasingly they are diverse in terms of ethnicity, country of origin, religion, language, culture, and history. The predominant Asian ethnic groups in the United States are from East Asia (China, Korea, and Japan), Southeast Asia (the Philippines, Vietnam, and Cambodia), and South Asia (India, Pakistan, and Bangladesh) (U.S. Census Briefs and Reports, 2010). Varied socioeconomic background, reasons for migration and immigration status, support for their resettlement, and levels of acculturation also added diversity to the profile of the Asian population in the United States.

COMMON CULTURAL VALUES AND PSYCHOSOCIAL EXPERIENCES AMONG ASIAN IMMIGRANTS

There are common values and experiences among Asian immigrants that shape their adjustment challenges and psychosocial issues. As a group that prescribes to a collectivistic worldview that favors the well-being of the family

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and community over individual interests, deference to authority figures, and the reciprocal fulfillment of obligations and responsibilities within the family and kinship network, the Asian sense of self and family is uniquely different from that of the Euro-American worldview (Lam, 1997; Marcus & Kitayama, 1994). In addition, the drastic differences between Asians and other racial and ethnic groups in values and norms, languages, physical features, and the lack of job skills and resources for Asian immigrants with low socioeconomic background have often made Asian immigrants a collective target of discrimination and a marginalized population that struggles with harsh working and living conditions, social isolation, and lack of access to services and benefits. In the following section, we will examine how these cultural differences and environmental stressors create tremendous adjustment issues that jeopardize the integrity of the immigrant family, and the implications for family intervention approaches.

INTERGENERATIONAL CONFLICTS IN ASIAN IMMIGRANT FAMILIES

Intergenerational conflicts in the Asian immigrant families have been a noted concern in the Asian community, as the lack of parental support is often a key underlying issue of poor academic performance, delinquent behavior, depression, suicides, and other mental health issues among Asian adolescents and children (Choi, Meininger, & Roberts, 2006; Nguyen, 2008; Qin, 2008). In Asian immigrant families, issues of independence versus interdependence, and autonomy versus conformity are the common conflicts identified between immigrant parents and their adolescents and young adults who are at the developmental crossroads of yearning for peer acceptance and exploring identities and lifestyles. The conflicts range from issues of meeting parental expectations of daily routines of chores, homework, and leisure time, to socialization activities with friends, dating, college, and career choices. While these conflicts could be perceived as developmental issues that are common in all families, they are often amplified by the perceptions and responses of both parents and children in the family who are influenced by different sets of cultural values and norms and immigrant-specific circumstances (Chung, 2006; Qin, 2008).

From the perspective of the children who have been schooled and socialized in a Western cultural milieu, the traditional Asian parenting style could be perceived as authoritarian and restrictive, which demands the child's adherence to absolute standards of behavior with little explanation, negotiation, and emotional support (Chao, 1994; Nguyen & Cheung, 2009). Asian parents also tend to adhere to the traditional style of communication, which minimizes expression of emotional intimacy and direct compliments, and emphasizes problem-solving and dispensing of advice over processing of experience and feelings (Lee, 1996; Sue & Sue, 2003). Their lifestyles, shaped by difficulties with acculturation and the economic hardships that they endured prior and/or after immigration, tend to revolve around work and socialization within their kinship network and ethnic enclave. Children are often expected to take on more responsibilities at home when parents have to work long hours and/or rely on their language fluency to negotiate

with an English-speaking society (Fong, 2002; Qin, 2008). All these could be cumulative risk factors that exacerbate emotional distance among members in the Asian immigrant families. In this author's work, with Asian immigrant families, children often made remarks that reflect both the cultural dissonance between the two generations, and more importantly, the underlying issue of uncertainty that their parents' different style of parenting and relating were communication of dissatisfaction with and rejection of them:

> When I said "I love you" to my mom the other day, she said "thank you". . . . When I told her I got an A in my math, she also said "thank you" and then "keep it up," and that was it. (7 year-old girl who was comparing her Caucasian friends' interaction with their parents)

> My parents invited all the relatives over to celebrate my birthday the other day. When I was younger I didn't care, but now that I am 16, I was hoping it would be different. . . . I just ate the food and stayed in my room most of the time. (16-year-old girl who complained that her parents were always thinking of relatives and friends, and she couldn't understand why she had to "share" her birthday celebration with others)

> My mom likes to clean my room even though I told her I did not want her to do that. I hate it when she goes through all my stuff without asking me. . . . My dad talked about his meeting with my teacher and her concerns about me at the dinner table the other night. When I told him I did not want him to share the information with all the family relatives there, he said that it didn't make any difference. Family is family. . . . (15-year-old boy who talked about how he often got into arguments with his parents about his need for privacy)

On the other hand, some parents have also acknowledged that they felt hurt and humiliated by the rude outbursts of their children in the American adolescent lexicon, that is, "shut up," "leave me alone," "I don't care," and so on. They perceived such response as disrespectful and totally unacceptable in their own history of growing up in traditional Asian families.

From a family system perspective, the Asian immigrant family with intergenerational conflicts is an overstressed system coping with structural changes that undermine the integrity of the family as a source of support for and validation of the family members' self-worth. Parents, in finding their culturally prescribed roles as authoritative figures and caretakers being challenged as their children become older and more immersed in the American culture, often feel inadequate when their children's behavior fail to measure up to the cultural benchmarks of obedience and academic success (Chung, 2006; Lee, 1996). It is not uncommon to hear parents berate themselves for "failing" to be competent parents. On the other hand, parents also tend to react angrily toward their childrens' shortcoming and step up on their efforts to pressure them to comply with their expectations. In response,

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children either escalate their antagonistic behavior by isolating themselves from the family or yield to the parental demands with great resentment and acting out behavior. While varied personality issues and coping mechanisms among parents and children are important considerations in improving the emotional distance between the family members, the traditional norms of parenting, and communication within the family in a changed sociocultural environment needs to be the first line of assessment and intervention.

CHALLENGES IN WORKING WITH ASIAN FAMILIES

Literature has often characterized Asian Americans as difficult to engage in counseling services because of their drastic differences in communication style and help-seeking behavior. While the Eurocentric model of psychotherapy emphasizes articulation and processing of feelings as a therapeutic tool and objective, Asian Americans are described as less inclined to disclose personal thoughts and feelings in the counseling session, and are primarily interested in seeking advice and concrete solution to their problems. Those who adhere to traditional values tend to believe that distraction of one's negative thoughts via work and activities is the best antidote to emotional distress (Sue & Sue, 2003; Chung, 2008). Studies have shown that Asian Americans underutilize mental health services because of a different belief system in regard to the causes of mental health symptoms, and the cultural stigma associated with mental illness and seeking mental health treatment (Sue, 1994). For example, depressive symptoms of lethargy, the inability to concentrate, and suicidal ideations are traditionally perceived as personal weaknesses that could be overcome by self-discipline and motivation. Thus children and young adults who are not able to perform well in school and/or exhibit behavioral problems at home are generally deemed as having personality flaws and require further inculcation of moral values and development of character integrity. Such linear cause-and-effect view of aberrant behavior in the family reinforces the focus on the identified patient and the presenting problem, and present challenges in engaging the family in examining broader issues of family interactions. This author's experience has been that Asian families are more inclined to seek counseling in regard to intergenerational conflicts because of the cultural emphasis on family cohesion and academic success of the children. However, the expectation is often for the clinician to help the identified child and adolescent to make desirable behavioral changes, that is, improve absenteeism and tardiness at school, follow through with responsibilities at home and at school, and so on. Such perception invariably exerts tremendous pressure on the clinician to assume a similar parental and authoritarian role with the children without addressing the family dynamics as underlying issues. In families where the children are reactive and emotive, and parents are angry and unwilling to compromise, it can be extremely challenging for the clinician to engage the family in a therapeutic dialogue. For clinicians who are trained to apply a Eurocentric theoretical lens in assessing issues of differentiation, boundaries, and hierarchical structure in the family system, it may also be difficult to relate to and empathize with the subjective experience of the parents who seem to hold a different worldview in regard to the cause and solution to the conflicts.

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CULTURALLY RESPONSIVE INTERVENTIONS

Cultural competence practice emphasizes the importance of contextualizing issues of clients of diverse cultural backgrounds through appreciation of the history and experiences that contribute to their belief systems and behavior, and facilitating adaptive changes by building on their strengths and garnering resources that are relevant to their sociocultural environments (Greene, 2008; Sue & Sue, 2003). From the perspective of family system interventions, structural and behavioral changes within the family have to be initiated in ways that are culturally relevant, empowering, and in resonance with the subjective reality of the family.

An Empathic View of Asian Parenting Style and Values

In working with Asian immigrant parents, it is important for the clinician to appreciate the values associated with the traditional parenting style from a historical, cultural, and psychological perspective so that they could effectively engage the family and assess its strengths and vulnerabilities (Chao, 1994; Stewart, Bond, Kennard, Ho, & Zaman, 2002). Historically, the genesis of a collectivist and interdependent culture in Asian countries could be traced to Confucianism, a secular social theory that promoted harmonious interpersonal relationships based on a hierarchical political and social order when China was an agrarian society intermittently plagued by wars, famines, and social unrest (Bond, 1991; Lam, 1997). Within this hierarchical order of life, every individual has their place and rank, and social and economic stability is maintained with each adhering to a specific set of responsibilities and obligations in the family and society. Parents and elders are responsible for providing proper care and inculcation of moral and social values to the younger generation, embodied in a concept known as *guan* (in the Chinese language) that can be translated as "to govern," or "vigorous teaching and inculcation" by the parents. However, *guan* has a broader connotation than an authoritarian style of parenting. While parents are expected to emphasize the cultural values of self-discipline, obedience, hard work, and academic success among their children in the parenting process, they also need to become highly involved by providing supervision, care, and structure to the daily routines of their children. The parents' hard work, thoughtfulness, and self-sacrifices in anticipating their children's needs is generally considered to be the highest form of expression of their love for the children, as befitting the cultural emphasis on doing for others over verbal affective communication (Chao, 1994). Ideally, the children feel the dedication of their parents to provide for them and the closeness of their relationship, and are motivated to reciprocate by fulfilling their obligations and meeting their parents' expectations (Wu & Yi, 2008). Indeed, many children in Asian immigrant families acknowledge that they do feel their parents' love and sacrifices through their care-taking behavior, and it is a key inspiration for them to succeed in school and work (Wu & Chao, 2011). Unfortunately, these positive bonds are often not sufficient to withstand internal and external stressors impacting the immigrant family.

As discussed earlier, immigrant-specific circumstances—long working hours of both parents, language fluency, and acculturation differences between parents and children—are logistical obstacles for Asian parents to provide guidance, involvement, and role modeling as part of the *guan* practice. Their communication of parental warmth and love is often compromised by the authoritarian aspect of *guan* that focuses on the children's compliant behavior (Qin, 2008). From a psychological perspective, these are unfortunate but common occurrences of cultural values and norms being rigidly observed by parents at the service of gaining an illusory sense of control over their life's stressors, resulting in a vicious cycle of antagonistic relationships in the family.

Last but not least, it is important for the clinician to appreciate the premium value placed on academic success of children in the Asian culture without assuming that parents are exerting undue pressure on their children. It began in China when competitive civil examinations were historically used as the gateway for upward social and economic mobility for the mass peasantry class, and parents were known to invest all their resources to support their children's success in these examinations. With subsequent migration of Chinese families to other Asian countries and the prevalence of economic hardships in those regions, it has become a common cultural practice for parents to focus on their children's scholastic achievements as a means to bring honor to the family and give testimony of their capability as parents. Similar dynamics could be said of Asian immigrants in the United States, many of whom sacrificed their accomplished identity, social status, and lifestyle in the home country for better opportunities for their young generation. Thus their anger and anxiety toward their children's academic problems is very much tied to their own losses and the threat to their only source of self-esteem within their kinship network.

From a psychodynamic perspective, these interdependent, family-centered values, and self-discipline, self-sacrificial norms denote the need to defend against the feelings of chaos, loss, and vulnerability experienced historically in China and other Asian countries. The cultural belief in the efficacy of hard work as an investment for the future generation offers a sense of control over one's life and binds the feelings of helplessness and anxiety, especially in times of economic hardship. By the same token, aggressive feelings such as hostility and anger toward parental figures are culturally forbidden under the ethics of filial piety in traditional Asian society (Chung, 2006). Instead, aggressive drives are channeled and internalized to acceptable norms such as conformity to authority, self-criticism, hard work, and self-sacrifice for the family. Such ethnic defenses provide prescribed coping behavior and cohesive meanings in times of stress. Thus deviant behavior among the young generation is often experienced as more threatening and disconcerting by the parents.

The enriched understanding of the psyche and behavior of Asian parents as influenced by sociocultural factors should enhance the clinician's empathy toward the parents, as well as contextualize intervention approaches in working with the families.

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Strategic Approaches in Brokering Positive Emotions and Behavior in a Culturally Relevant Context

Underlying the culture-specific way of thinking, feeling, and relating among the Asian parents are essentially some universal attachment needs to seek love, care, and validation from others (Bowlby, 1969). And the same unmet needs could be identified underlying the children's responses and perhaps challenging behavior. Somehow, cultural meanings, environmental stressors, and personality issues have created barriers for meeting these needs in the family. As a result, anger, anxiety, and fear stemming from perceived rejection prevail in the family and preempt any form of positive communication and modification of behavior between the parents and the children. Herein lies the interplay of culture, emotions, and behavior that could perpetuate cyclical and negative patterns of thoughts, feelings, and reactions (Chung, 2006).

Given the indirect communication style of most Asian families, it would be important as an engagement and intervention strategy for the clinician to play an active role in amplifying positive emotions in the family to repair estranged relationships and reinforce motivations for behavioral change. This could be done via direct validation of the parents' subjective experiences of their disappointment and frustration with their children in the context of the hardships they endured and sacrifices they made as caretakers of the family. Such validation addresses the anger and anxiety in regard to their perceived rejection by their children and their sense of failure as capable parents by traditional cultural standards. At the same time, validation of the children's resentment in being told to attend the family session is equally important to alleviate their antipathy. This will also set the tone for a safe space that tolerates conflicting feelings and divergent views of the family members. While direct validation of strengths and feelings may not be a norm in the family, this would be a corrective experience that models new ways of processing negative and strong emotions among family members. Sue & Sue (2003) discuss the importance of the clinician transcending cultural-bound rules to help family members expand their roles and behavior to cope with stressors. By articulating feelings that would normally not be acknowledged, the clinician projects a cultural transference of a parental figure who is attuned to the emotional needs of the family, and takes responsibility for changing the family norms without pressuring the other members to respond. This approach would be more congruent with the Asian indirect communication style than the traditional Western modality of probing thoughts and feelings of the parents and children to facilitate communication.

Another related strategy in providing validation could involve asking for specifics from the parents and the children some fond memories of each other reciprocating care-taking behavior. By focusing on a culturally significant bonding issue of the family and eliciting responses that are descriptive and not exploratory of inner thoughts and feelings, the responses are generally forthcoming and heart-warming, that is, "he used to bring me a cup of tea when I came home from work"; "she would be the only one who stayed

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behind to help with dishes"; "my mom used to get up early to make me a hot breakfast before school"; "my father is a good cook," and so on. Such exchanges should help to rekindle a sense of validation of each other's role in the family and promote more shifting of emotions among the family members. Sometimes, the sharing of narratives of positive interactions among the estranged members could also initiate the structural process of realignment of dyads among parents and siblings.

Strategic Approaches in Brokering Positive Meanings and Behavior in a Culturally Relevant Context

Reframing, a common strategy in family therapy whereby the clinician highlights a more positive connotation of an occurrence of a family member's behavior (Nichols & Schwartz, 2001), can be used to alleviate negative emotions and create an incentive for behavioral change in the family. In working with Asian immigrant families, it is important for the clinician to use constructs that resonate with their sociocultural realities, such as allegiance to the family, interdependence of family members embedded in the reciprocity of obligations and responsibilities, and hard work and self-sacrifices in the pursuit of the American dream. For example, it is often helpful to reframe children's challenging behavior in the context of the parents having succeeded to provide a comfortable life for them in the United States that is different from the impoverished and disciplined childhood of the parents. So the children's behavior, albeit antagonistic, is a testimony of the parents' hard work in attaining the American dream, whereby their children have become acculturated and acquired individualistic ideology and behavior. Parents could also be reminded that another payoff for the success of immigration is their struggle in fulfilling the full *guan* practice, that is, the immersion and involvement in their children's academic and social life, despite their long working hours and unfamiliarity with the American school curriculum and popular culture. In addition, education of adolescent developmental issues and behavior—moodiness, rebellion toward authority figures, acceptance by peers, changes in sleep patterns, and so on—could be presented in the context of physiological changes influenced by American popular culture and lifestyle. Such reframing and validation often alleviate the blame that both parents and children have directed at each other, and help them develop more empathy for each other's behavior.

As parents are engaged, more reframing can be made to encourage them to modify their parenting style. For example, the rationale for parents to focus less on the daily supervision of their children's chores and responsibilities and their social activities could be reframed as the need for them to provide opportunities for their children to acquire self-care and social skills in the competitive college and work settings that they will soon encounter. Also, inculcating the virtue of owning one's responsibility is consistent with the Asian cultural ethos and the *guan* practice, and that would be a valuable character trait that the parents could reinforce in their children by allowing them to learn from their mistakes with their support. As the parents feel valued again in their roles and more motivated to invest in being more effective

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parents by reconsidering some of the rules in the family, the children will likely feel a positive shift of their feelings and desires as well. In this author's practice experience, many children will acknowledge that they do appreciate the familiar albeit restrictive structure of the family and the involvement of their parents in their lives, as long as they are no longer the target of their parents' wrath and they have been reassured that their parents still value and love them. Thus the children are also more likely to commit themselves to make some measurable behavioral change to appease the parents, that is, going to school or completing homework on time, adhering to curfew time, and so on. Such mutual behavioral compromises generally initiate the process of healing in the family.

The Clinician's Use of Self

As in all family practice, the clinician's use of self in the interactions with the family is an important intervention. Like all families, Asian immigrant families can be wrought with personality issues, marital discord, and maladaptive behavior that accentuate intergenerational conflicts. It is important that the clinician be able to immerse in the family dynamics, identify, and contain the aggressive emotions and behavior embedded in culture-specific interactions, and take a risk in restoring boundaries and structure of the family. These interventions support a cultural parental transference of the clinician that denotes fairness, strength, and care, and would enhance engagement of the family.

CASE VIGNETTE

The following case vignette is an illustration of the clinician's differential use of self and adaptation of family system approaches from the perspectives of psychodynamic, structural, and strategic theory in a culture and immigrant relevant context.

> Mary is an 18-year-old girl who was referred by her family doctor at the request of her mother, Mrs. Lee. At the intake session, Mrs. Lee voiced her concerns that Mary was failing in her schoolwork, isolating herself at home, having anger outbursts at her and Emily, her twin sister, and neglecting her household chores.
>
> Mrs. Lee described herself as a single parent who immigrated to the United States about 20 years ago. She worked as a clerk in a garment factory with mostly Chinese immigrants. She and her husband legally separated a couple of years ago, but they still share the same living quarters due to financial constraints. Mrs. Lee felt that Mary had always been close to her father and regrettably the estranged marital relationship had split the family. Mrs. Lee claimed that her husband did not believe in counseling, and he would not participate in any family sessions. Mrs. Lee herself also thought that it would be best if Mary saw the therapist individually to resolve her own issues and apparent depressive symptoms.

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Mary was cooperative in the two individual sessions she had with the clinician. She seemed to appreciate the support she received in regard to all the changes and demands of the family, but would not divulge any negative feelings she might have toward her parents. She also denied any other stressors in terms of romantic relationships or issues with teachers and peers at school, and she did not feel she was excessively worried about her father being on his own.

Then Mrs. Lee called to say she needed to come in to show the clinician a "suicidal" letter that she found in Mary's computer. It was actually a journal entry where Mary expressed her sadness and loneliness: "I wish there was someone I could confide in and turn to . . . life is tougher than I thought . . ." In the session, Mary denied having any suicidal ideations. Mrs. Lee, however, continued to look upset and quiet, and her only comment was, "Mary still has not improved a bit, and that's not acceptable." The clinician acknowledged that she had not been helpful enough, and sensing Mrs. Lee's anxiety and anger, decided that it was important to address the underlying emotions. But instead of asking Mrs. Lee directly to share her feelings, the therapist reflected on her comment, and said respectfully, "Mrs. Lee, you have high standards for your children. You must have had high expectations for yourself growing up." Mrs. Lee looked surprised, but nodded emphatically. She finally made a comment that was revealing." My worst fear now is for Mary to become seriously depressed and suicidal. My husband's extended family is always comparing their children's well-being and accomplishment with mine, and now that I am divorced, they would really look down on me if Mary is not doing well." Then she volunteered some information about how she had never gotten any support from her own mother growing up, and she had learned that she had to be self-sufficient and tough. The clinician commented that Mary and Emily were fortunate to have a supportive mother. Mrs. Lee demurred and said she had not done a good job raising them to be more disciplined. The clinician pointed out that children who felt secure and close to their parents would invariably become more negligent with their responsibilities because they knew they could always count on their parents being there for them. Mrs. Lee smiled a little but did not directly accept the compliment. Then the clinician seized the opportunity and said that she could tell Mary really needed her mother's support to get through this difficult time. Mrs. Lee looked surprised and said, "She has her father." The clinician asked Mary for her thoughts. Mary spoke up and said she agreed, but that she could never really talk to her father. Mrs. Lee was quiet but looked pleased. The clinician then reframed Mary's distance from her mother and sister as her having similar personality traits like Mrs. Lee, that is, she put up a tough front

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and did not want to ask for affections. Mrs. Lee nodded, and said that Mary was always different from Emily who was outspoken about her needs and very affectionate with people. The clinician then suggested that Mrs. Lee try to give Mary some compliments when she did something right, even though the traditional belief was not to spoil the child with too much praise. The session continued with the therapist exploring similar personality traits between Mrs. Lee and Mary, and stories of Mary growing up under Mrs. Lee's care.

A couple of weeks later, Mrs. Lee decided to bring Emily in for a family session. Emily indeed was more open about her thoughts and feelings. When the therapist asked her what she might be worried about in regard to her mother and sister, Emily replied that she wished Mary would just do what her mother expected her to do instead of silently protesting, because her mother had a hot temper, and it just made everyone in the family miserable when she was upset. Mrs. Lee was not pleased with Emily's disclosure in front of the clinician, and started challenging Emily. The two quickly got into an argument, and Emily started crying. At that point, Mary moved over to Emily and the two sisters hugged each other. The clinician made a point of saying that Mrs. Lee was upset and she would like the girls to wait outside of the office so she and their mother could talk privately.

The clinician listened to Mrs. Lee and validated her feelings of rage and shame that her own daughter was making a judgment of her behavior in front of people outside of the family. As Mrs. Lee calmed down, the clinician walked her out, and told the two daughters that their mother felt better and turning to Mrs. Lee with a smile, "I think we will all be fine by the time we get home!"

Mrs. Lee sent Mary for a couple of more individual sessions over a span of several weeks, and then came in for a final family session. Mary seemed to be feeling better and had made good progress in taking more responsibilities at home and at school. Interestingly, Mary got a part-time job working at Mrs. Lee's factory through Mrs. Lee's intervention, and her job skills and performance won the praise of Mrs. Lee's boss and co-workers. Mrs. Lee was very proud and pleased, and the final session was spent on highlighting everyone's strengths and how the family had pulled through a difficult transition.

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From a family therapy perspective, the goal of helping the family adapt to the loss of a significant member and the subsequent changes in the family dynamics seemed to be successful at the termination of the work with the family. In engaging the family, the clinician addressed the underlying emotional needs of Mrs. Lee and Mary as parent and child, and facilitated the exchange of positive emotions via reframing and interpreting behavior in

the context of cultural and familial constructs, and posing historical questions to rekindle attachment bonds. The clinician adopted a psychodynamic approach in joining Mrs. Lee's behavior and containing her anger and anxiety, and took risks to step into the family dynamics by protecting the sisters from being targets of their mother's displaced emotions, thus restoring a sense of boundary and structure in the family. While other clinicians might intervene on the issue of Mrs. Lee being invasive and controlling with her daughters as transgression of family boundaries, this clinician opted not to challenge Mrs. Lee's traditional but somewhat maladaptive parenting style, and instead focus on improving the emotional distance of the family members by supporting Mrs. Lee. The clinician also did not pressure the family to disclose their feelings, and respected the family's norm of communicating intimacy and approval through sharing of narratives of interactions. As a parallel process, the clinician herself did not receive any verbal validation for her interpretation, comments, and support, and had to accept that Mrs. Lee's initiative to bring in her other daughter to attend the session and voluntary disclosure of her childhood experience were communication of trust in her skills. Mrs. Lee's anger outburst in the session and her continued participation was the ultimate culturally relevant acknowledgment that the clinician had earned her trust to be privy to the internal dynamics of the family.

CONCLUSION

This chapter provided a preview of the use of culturally responsive approaches in working with intergenerational issues in Asian immigrant families. Culture-specific and immigrant-specific knowledge from a historical and psychosocial perspective was elucidated to provide a more empathic and authentic context for assessment and intervention. Most importantly, the chapter emphasized the therapeutic value of looking beyond cultural values and norms to address the emotional needs within the family. Sue and Zane (2009) postulate that the clinician's credibility and ability to offer "gifts," that is, benefits from treatment and symptom improvement, and so on, are congruent with the quality and rituals in Asian interpersonal relationships, and are effective approaches with Asian clients who are unfamiliar with counseling services. This author believes that the clinician's efforts to establish an empathic connection and culturally meaningful relationship with Asian clients is the ultimate "gift" that creates trust and a sense of hope for the family to stay in treatment. The crafting of this connection and relationship is informed by both theoretical and cultural knowledge, and the clinician's attunement to the emotional needs of the family. This indeed would be the essence of cultural competent practice that integrates the universality of human nature and specific cultural values and norms, as well as unique proclivities of individuals and families.

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THIRTEEN

Assisting Native American Families: Striving for Well-Being in the Seventh Generation

Hilary N. Weaver

Native Americans are the descendents of the original inhabitants of North America. Over 560 distinct Native American nations are recognized today by the federal government as existing within the boundaries of the United States (Ogunwole, 2006). Some of these Native nations straddle the borders with Canada and Mexico. Other Native nations such as the Shinnecock and Unkechaug of Long Island are recognized by the states that surround them but are not acknowledged by the federal government. Native nations (known as tribes) are diverse in terms of languages, cultures, social systems, forms of government, and spiritual belief systems.

While these diverse groups are often referred to by general labels such as Native American or American Indian, many indigenous people prefer to be referred to as a member of a specific tribal nation such as Comanche or Arapaho. Some indigenous people find the use of labels that include the term American (i.e., Native American, American Indian) to be offensive since indigenous people predate the founding of the United States and the labeling of this continent. The terms indigenous and First Nations are preferred by some Native people. While there is no consensus on one acceptable term, usage of some terms is more common in certain geographical areas. Additionally, individuals often have strong preferences about terminology. The terms Native, Native American, and indigenous are used interchangeably throughout this chapter.

DEMOGRAPHIC PROFILE

Native Americans are a young and growing population. The U.S. Census Bureau estimated the indigenous population to be 5 million as of July 1, 2009. This constitutes 1.6% of the U.S. population. The Native American population is growing faster than the U.S. population as a whole and is projected to reach 8.6 million, or 2% of the population, by July 1, 2050 (U.S. Census Bureau, 2011). The average age of Native Americans was 29.7 in 2009, compared to 36.8 for the population as a whole. Approximately 30% of the indigenous population is under age 18 and 8% is older than 65 (U.S. Census Bureau, 2011).

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While indigenous populations exist throughout the United States, California has the largest Native population (739,964) followed by Oklahoma (415,371) and Arizona (366,954) (U.S. Census Bureau, 2011). Although more than 300 reservations serve as indigenous homelands and seats of tribal governments, more than two-thirds of Native Americans currently live in urban areas (Ogunwole, 2006). Urbanization of indigenous populations is a trend, yet, many Native families have lived in cities for generations as a result of a federal relocation program that began recruiting Native Americans to cities after World War II (Venables, 2004). The indigenous population that remains on reservations tends to be younger, poorer, and less educated than their urban counterparts.

Native Americans are disproportionately affected by poverty with 23.6% living below the poverty line in 2009 (U.S. Census Bureau, 2011). It should be noted, however, that poverty varies significantly among Native groups with the reservation communities in South Dakota typically having the highest rates of unemployment and poverty. Likewise, Native Americans lag behind others in the United States in terms of educational attainment with 80% earning a high school degree by age 25 (compared to 85% of the overall population) and 16% earning a college degree compared to 28% of the overall population (U.S. Census Bureau, 2011).

Sovereignty Versus Colonization: The Legal and Policy Context for Native Americans

As indigenous peoples, Native Americans have a status distinct from other groups in the United States. While in 1924 the U.S. Congress passed a law declaring that Native Americans were U.S. citizens (Steinman, 2011), not all Native Americans embrace U.S. citizenship. Many indigenous people consider themselves primarily or solely citizens of their own Native nations. While the United States recognizes Indian tribes as domestic dependent nations (Venables, 2004), some of these nations continue to hold a broader vision of their sovereign status. Native nations are governed by their own tribal governments and have the power to set and enforce laws, much as states can, while still being subject to the authority of the federal government. Some indigenous governments, such as the Haudenosaunee Confederacy, offer passports and reserve rights such as the ability to declare war, although such assertions of sovereignty are not necessarily recognized by the United States or other countries. Nonetheless, the United States recognizes that partial sovereignty is retained by Native nations; thus, the federal government continues to operate distinct entities such as the Indian Health Service, the Office of Indian Education, and the Bureau of Indian Affairs that have no parallel for other ethnic populations in the United States.

The understanding that Native Americans are members of distinct political bodies rather than an ethnic or racial group is affirmed by historical and contemporary jurisprudence and policies (Steinman, 2011). The United States, however, has ambivalent and conflicting perspectives on indigenous sovereignty. Tribal nationhood has been both affirmed and undermined by Supreme

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Court rulings and Acts of Congress. Tribal members have been included in U.S. citizenship yet retain citizenship in tribal nations. The political and legal status of Native Americans within the United States evokes strong feelings in many, with some Native people vehemently asserting sovereignty claims while others fully embrace being American. These different perspectives reflect the ambiguous and uneven incorporation of Native Americans into the United States (Steinman, 2011).

Sovereignty, or the ability to self-govern, is reflected in the fact that all Native nations have their own governments with the ability to pass and enforce laws including the ability to define criteria for citizenship within each Native nation. Many Native nations offer social and health services to their citizens. Sovereignty, however, has been significantly eroded by colonization. While most reservation territories maintain legal authority over their citizens while they are within reservation boundaries, they have little or no authority over non-Natives within their borders and are still subject to federal authority. Additionally, most Native governments are heavily dependent on federal funding to operate their social and health services and in many cases the governments themselves. Indeed, the legal and policy context for Native Americans is a murky mix of sovereignty and colonization, the balance of which is subject to constant reinterpretation by the U.S. Congress and Supreme Court.

ACCESS TO SYSTEMS OF CARE

Because of their unique status as indigenous peoples, Native Americans have access to some social and health services not available to others. Native Americans may have access to services through their specific nations and/or may have access to federal programs such as the Indian Health Service (IHS). In spite of what would appear to be greater availability of services, Native Americans experience a lack of adequate healthcare (Blankenau, Comer, Nitzke, & Stabler, 2010).

The IHS is a federal program that provides health and some human services for Native Americans. Native dependence on the U.S. government for health care is an outgrowth of colonization (Blankenau et al., 2010). As the United States made treaties with indigenous nations they established ongoing trust obligations. Federal provision of health care was often used as a bargaining chip for land successions. The devastating diseases introduced by Europeans rendered provision of health care highly important to Native nations (Blankenau et al., 2010).

The obligation to provide health care to Native people has never been fulfilled in a responsible manner. Federal studies have found Native people have less access and inferior health care than others in the United States (Blankenau et al., 2010). A significant part of the problem is that the IHS is chronically underfunded. The IHS spends approximately $1,900 per patient per year compared with an average of $3,800 spent on federal prisoners. In a related problem, only 50% of Native people have access to employer-based health care as compared to 78% of Whites. This lack of insurance is compounded by the

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poverty of many tribes, which limits their ability to provide adequate services under their own auspices (Blankenau et al., 2010). In 2009, 24.1% of Native Americans lacked any type of health insurance (U.S. Census Bureau, 2011).

Native people may receive services under different auspices than those used by others. For example, Native youth are more likely to receive mental health treatment through juvenile justice systems and inpatient settings than non-Native youth (Bigfoot & Schmidt, 2010). Under such circumstances, services are less likely to be voluntary and may not be welcomed or productive.

When examining access to systems of care, it is important to differentiate between urban and reservation-based populations. Urban populations are less likely than their reservation-based peers to have access to Native-specific services. Moving to cities has sometimes resulted in increased employment and educational opportunities, yet it has also meant decreased access to health care (Castor, Smyser, Taualii, Park, Lawson, & Forquera, 2006). Federal funding streams typically target tribal governments with only 1% of IHS funds supporting urban health care, even though the majority of Native people do not live on reservations (Castor et al., 2006; Duran, 2005).

Reservation-based populations also face challenges in accessing social and health services. Most reservations are rural. Often IHS and tribal social services are the only options and services may be very limited. For example, the IHS human service delivery system on reservations is limited to acute, crisis-oriented outpatient services that do not meet the needs of people struggling with persistent mental illness (Yurkovich & Lattergrass, 2008). Lack of transportation may also be a barrier to accessing services as populations may be spread over great distances on larger reservations. It is also important to note that access to services varies significantly between reservations and there may be very different experiences, even for tribes located near each other (Blankenau et al., 2010).

STRUGGLES AND RESILIENCE: THE PSYCHOSOCIAL RISKS AND NEEDS OF NATIVE AMERICANS

Native families experience significant stressors. Struggles in the lives of many contemporary Native Americans include trauma, health, mental health, substance abuse, and an environment mired in poverty and violence. While it is important for helping professionals to be aware of the prevalence of these concerns, it is also important to understand the strengths and resilience indigenous people have displayed and continue to display in the face of these assaults.

Trauma

Trauma is a significant factor in the lives of many Native Americans. The genocide conducted against indigenous populations as this continent was colonized left a painful legacy with traumatic memories passed to succeeding generations. This trauma is often the result of specific historical events and federal policies (Bigfoot & Schmidt, 2010). Attacks on indigenous cultures and ways

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of life can result in cultural trauma. Likewise, the contemporary circumstances of many Native people are mired in poverty and violence, which compounds preexisting trauma. The nature of trauma for indigenous populations is historical, intergenerational, cultural, and contemporary (Bigfoot & Braden, 2009).

Colonization, genocide, acculturative stress, cultural bereavement, and racism have resulted in historical trauma that is cumulative, unresolved, and ongoing as well as historical (Brave Heart, 2004). The rate of posttraumatic stress disorder (PTSD) is 22% for Native Americans, compared to 8% in the general population. The traumatic events that Native people experienced in the past have an impact on contemporary health issues, thus supporting health disparities (Brave Heart, 2004; Beauchamp, 2004).

The genocide against Native Americans deliberately destroyed indigenous cultures as well as directly killing Native people. Specific and deliberate efforts were made to undermine the roles of women and elders as part of the colonization process (Byers, 2010; Smyer & Clark, 2011). Colonization attacked the fabric of indigenous societies, which affected the essence of the community and its members. Culturally based attacks included prohibiting the speaking of Native languages, banning spiritual practices, and relocating individuals or whole communities.

The significant presence of trauma in the lives of Native people has implications for contemporary service use. "The history and experiences of Native American elders cannot be ignored in the development of trust with the conventional health care system. This cohort of elderly has experienced the forced boarding school experience, laws banning spiritual practices, and the societal belief that Indian culture was unacceptable. The prohibition on speaking the Native American language, lack of parental role modeling due to the boarding school experience, and the resultant diminution of generational transmission of cultural and spiritual knowledge have resulted in intergenerational anger and grief and have profoundly influenced the development of this cohort of elders" (Smyer & Clark, 2011, p. 203).

Health, Mental Health, and Substance Abuse

Health is defined as being in balance or maintaining equilibrium. Being healthy means having a sense of harmony, and not being out of control in the spiritual, cognitive, emotional, and physical domains (Yurkovich & Lattergrass, 2008). This definition of health is more akin to wellness and differs from a more Western perspective of health as being the absence of illness. Health statistics reveal that indigenous populations are significantly out of balance.

Native Americans have some of the poorest health and social indicators of all people within the boundaries of the United States (Bird, 2002; Droste, 2005; Swan et al., 2006; Wiletto, 2007). Changes in traditional lifestyles of Native Americans have led to changes in eating habits and activity levels that impact health (Coble & Rhodes, 2006). Native Americans suffer from obesity more than any other population in the United States and often struggle with related health issues such as diabetes (Story, Evans, Fabsitz, Clay, Holy Rock & Broussard, 1999). Diabetes has increased rapidly in recent decades and is a risk factor for cardiovascular disease, currently the number one killer

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of Native Americans (Berry, Samos, Storti, & Grey, 2009). Smoking rates for Native American youth and adults are the highest in the nation (Hodge & Struthers, 2006; Swan et al., 2006).

Native American adolescents have high rates of mental health problems (La Fromboise, Albright, & Harris, 2010; Tsethlikai, Peyton, & O'Brien, 2007). The percentage of Native people experiencing mental illness is greater than 10% and could be as high as 30% (Yurkovich & Lattergrass, 2008). Native youth are more likely to suffer from depression accompanied by the use of alcohol and drugs (Nalls, Mullis, & Mullis, 2009).

Urbanization has placed Native people at increasing risk for a host of biopsychosocial problems (Evans-Campbell, Lindhorst, Huang, & Walters, 2006). Among Native American women in New York City, 64.5% reported experiencing a period of depression, 50.9% reported a history of dysphoria, and 86.9% reported engaging in unsafe sex (Evans-Campbell et al., 2006).

Significant trauma histories and subsequent social and health problems provide a context in which high rates of substance abuse fester. Native Americans have the highest rates of alcohol, marijuana, cocaine, and hallucinogen use in the United States and the second highest rates of methamphetamine abuse behind Native Hawaiians (Dickerson et al., 2011). High rates of substance abuse coexist with high rates of trauma and suicide. Native American substance abusers also experience higher rates of psychiatric problems, higher rates of sexual and physical abuse, and more chronic medical problems than non-Natives.

Alcohol and drug use begins earlier for Native youth than for their non-Native peers (Heavyrunner-Rioux & Hollist, 2010; Nalls et al. 2009). In part, this may be attributed to self-medication for high rates of depression (Nalls et al. 2009). Reservation-based youth report the most high-risk behavior (Heavyrunner-Rioux & Hollist, 2010). Being surrounded by delinquent peers is associated with substance use.

Violence, Poverty, and Environmental Issues

Poverty and socioeconomic disadvantage are significant factors for many Native people (Johnson et al., 2007). Many Native people experience financial hardship, which increases stress and compounds the risk of exposure to crime and violence (Bigfoot & Braden, 2009).

Native grandparent caregivers raise children within a context of lower socioeconomic status and a multitude of social and health disparities. This group also has much lower service use (Byers, 2010). Among the Cherokee Nation of Oklahoma, 64.3% of all grandparents are caregivers; for the Muskogee Creek Nation the percentage is 58.9%. Part of the necessity for caregiving is the absence of mothers, as Oklahoma is the state with the highest percentage of incarcerated females (10.6% of the state's female population). Cyclical detention and incarceration were also noted as issues in the Baltimore Native community (Johnson et al., 2007).

Violence is almost 2.5 times the national rate. Native people have the highest rates of homicide and domestic violence. Native youth suffer child

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abuse and neglect more than other children (Bigfoot & Schmidt, 2010). A study of Native American women in New York City found 65.5% have experienced interpersonal violence and most experienced sexual assault (Evans-Campbell et al., 2006). In spite of the traditional respect accorded to elders, abuse is a growing problem for older Native people, with financial abuse being the most common followed by neglect and psychological abuse (Smyer & Clark, 2011). Straying from traditional cultural values is a factor leading to the abuse of elders.

The social environment of Native youth often exposes them to poverty, violence, drugs, alcohol, and prejudice. Lack of neighborhood safety, particularly crime and drug sales, is a strong predictor of depression and use of alcohol and drugs. Negative school and neighborhood environments have a detrimental impact on Native youth (Nalls et al., 2009). The current climate of racism and oppression experienced by Native people contributes to health disparities (Northridge, Stover, Rosenthal, & Sherard, 2003; Yurkovich & Lattergrass, 2008).

In addition to destructive factors in their neighborhoods, traditional Native youth constantly face prejudice and oppression from peers and schools. As one father described in a letter to his son, "You worked to undermine the biased educational system to assert your cultural identity, and you suffered social, cultural, and psychological isolation for it" (Robbins, 2010, p. 21).

A study of Native reservation youth resilience found the biggest issue facing students was being judged by the majority white culture. In contemporary society, discrimination, prejudice, and exposure to oppression are inevitable (Feinstein, Driving-Hawk, & Baartman, 2009). Contemporary poverty and racism compound the effects of historical trauma (Bigfoot & Schmidt, 2010).

In spite of significant challenges, Native people are working to improve their environments. Indigenous resilience is evident in positive trends in business ownership, homeownership, and educational attainment. Native people have made significant strides in working toward economic viability while maintaining cultural integrity (Grandbois & Sanders, 2009).

ASSESSMENT

When working with Native families, it is important to begin with the basic question, what constitutes a family? Traditionally, the nuclear family is not the norm in indigenous societies. Households are often multigenerational and families may maintain connections to ancestors as well as generations yet unborn. It is not uncommon for Native families to contain people who are not related by blood, but nevertheless are considered family members (Smyer & Clark, 2011).

Many Native American cultures have a sense of existing within the context of seven generations. This may be defined as seven generations preceding and seven generations following the present generation, or three generations before, three after, with the current generation nestled in the middle. Either way, there is a sense that the current generation is interdependent within a

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larger indigenous context. Earlier generations had a responsibility to think ahead and plan for the present day. Because of their foresight, indigenous people have retained some of their land, culture, languages, and sovereignty. The current generation, in turn, bears a responsibility to plan for the future to insure it will be possible for subsequent generations to exist as distinct, indigenous populations. The strong cultural value placed on the seven generations is often incorporated in prevention messages that resonate with Native people. For example, it is crucial that Native women not drink or use drugs during pregnancy because this can harm generations to come.

In the indigenous cultural context noted above, the family may be defined broadly. Some traditional teachings of the Haudensaunee emphasize that spirits of children exist prior to conception. In a way these are "pre-birth" family members. These spirit beings come from the Creator and can choose a family. Prospective parents have a responsibility to prepare their lives socially and economically for two years before a pregnancy. This traditional way of thinking provides an optimum environment for a baby. Likewise, strength and resources can be drawn from those who have passed on. A strong legacy of survival passed down from the ancestors encourages resilience in contemporary Native people (Grandbois & Sanders, 2009).

Extended family networks and clan systems are still viable parts of the lives of many Native Americans. Clans are groups of related individuals and may be named for an animal or feature of the natural world (i.e., Beaver clan). Clan leaders typically have responsibility for the well-being of clan members and may serve as counselors, mediators, or spokespersons when needed.

Traditionally, a high value is placed on group connections as part of an interdependent, sociocentric worldview (Grandbois & Sanders, 2009). "Resilience is embedded not only in their culture and close inter- and intrapersonal relationships, such as tiospaye and clanship, but also in the Oneness and sense of connection they feel with all of life" (Grandbois & Sanders, 2009, p. 575). This group orientation and extended family networks can be protective factors when the nuclear family is dysfunctional. In other words, members of the extended family and clan are poised to take on responsibilities such as caring for children or elders when other household members are not able to do so. As an example of this, Native women raise their grandchildren at a higher rate than any other ethnic group (Byers, 2010).

The strong sense of connection to others is often a positive source of support. For example, elders' resilience can be nurtured through families, relatives, and tribal communities. Likewise, youth resiliency is affected by support from family or peers but strain in these systems can also have an impact (Feinstein et al., 2009). If family or peer networks are dysfunctional, this can have a strong negative influence.

Group cohesiveness is supported by an emphasis on the values of respect and responsibility. Members of indigenous societies typically have particular role expectations that contribute to the well-being of the community. Likewise, the emphasis placed on respect for all beings (human and otherwise) contributes to the well-being of the family, community, and environment. Differential stature in Native communities may be based on factors

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such as age and community roles. For example, older women in Native cultures have a special stature based on their age and role as caregivers (Byers, 2010).

While many Native Americans, including some in urban areas, firmly espouse traditional values and cultures, this is not true for all Native people. Some Native people know little of indigenous values or choose to live their lives more aligned with the dominant society standards or those of other cultural groups. Helping professionals must determine the level of connection that an indigenous person maintains to his or her culture as part of the assessment process and determine whether culturally grounded interventions are appropriate. While some assessment tools attempt to measure cultural attachment, it is not necessary to use such instruments and in fact, many such tools are based on outdated theories of cultural identity. Rather, helping professionals can simply include a line of questioning about connection to culture as part of the larger assessment process.

The concept of balance is helpful for anchoring an assessment for indigenous clients grounded in their culture. Balance is a defining aspect of indigenous health and wellness (Rybak & Decker-Fitts, 2009). Many Native cultures place great importance on the medicine wheel or a comparable circle. The medicine wheel is a circle divided into four quadrants. While there are tribal variations in the details, typically the quadrants of the medicine wheel are associated with four colors, directions, life stages, and races of people, among other things.

From a health and wellness perspective, the medicine wheel quadrants represent mind, body, spirit, and heart. If there is an imbalance in any aspect of the circle, it affects all others. For example, diabetes may originate as a medical disorder (body) but it also affects other areas of life (mind, spirit, and heart). Recognizing these connections across areas of a client's life is important. Using the concept of balance and the medicine wheel as part of the assessment will help identify how the client sees the problem and determine how to target an intervention in a culturally meaningful way. It is important to note, however, that the medicine wheel framework, while important to many, does not resonate with all Native people. Some come from traditions where other circular concepts are meaningful. Others may not connect to indigenous concepts.

While maintenance of cultural traditions can be sustaining for many Native people, environmental contaminants make continuance of some traditional practices problematic. Native people may find themselves in a bind when practices that support traditional cultures and ways of life now pose health risks. For example, traditional seafoods nurture cultural identity for the Swinomish and are associated with community cohesion, knowledge transmission, ceremonial use, and food security. Unfortunately, in contemporary times, pollution has tainted the seafood they depend on. In this case, although seafood is contaminated, it may be more harmful to the Swinomish to avoid its consumption based on their holistic conceptualization of health (Donatuto, Satterfield, & Gregory, 2011).

While there are abundant risk factors associated with being Native American, resilience is evident in those confronted with daily traumas associated with

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poverty and a chronic lack of resources. Survival, tenacity, and resilience are embedded characteristics of Native cultures (Grandbois & Sanders, 2009). In the traditional way of thinking, the current generation has a pact with the ancestors and must survive for the sake of the future. As part of the assessment process, helping professionals can look at effective coping mechanisms, resilience, and strengths.

There are several things to keep in mind when conducting an assessment with Native clients:

- Cultural identity must be assessed, as there is substantial variation in how Native people do or do not connect with indigenous cultures.
- Historical trauma is an intergenerational phenomenon that plays a role in the contemporary well-being of some Native people.
- Contemporary racism, oppression, and violence are common experiences for many Native people and can compound historical trauma.
- Poverty and limited access to resources is a common experience and an additional situational stress that can compound trauma.
- Many strengths can be found in indigenous traditions including cultural values, clans/extended networks, and spirituality.

TREATMENT APPROACHES

While there are a variety of intervention approaches available for social and health problems, few have been developed or adapted for Native Americans. Today's push for evidence-based practice poses a particular bind for helping professionals working with Native people. Because of their small population numbers and the diversity among Native groups, few interventions have been tested and documented for effectiveness with Native Americans. In fact, the mandate that many Native-serving agencies have from their funding sources to use evidence-based models has forced them to use treatment approaches that have been proven effective for others but are of unproven merit for Native people. These models typically do not take into account indigenous values and may be ineffective or harmful with Native clients, particularly clients from traditional cultural orientations. In such cases, the true spirit of evidence-based practice is lost and cultural incompetence triumphs.

As an alternative, some Native scholars, most notably Terry Cross, executive director of the National Indian Child Welfare Association, do call for practice-based evidence. In this way of promoting quality services, researchers are encouraged to examine the interventions that appear effective with Native clients, thereby gathering evidence from practice and identifying effective models that may be replicated in other Native settings. This is a viable alternative to the more heavy-handed imposition of models developed for others on Native people.

As a general principle, interventions grounded in social learning and cognitive behavioral theories are often compatible with Native cultural values. Cognitive behavioral therapy principles are complementary to many traditional teachings and healing methods (Bigfoot & Schmidt, 2010).

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There are a number of Native-specific models developed and implemented at the grassroots level in Native communities. The Don't Forget Us program is an example of substance abuse, hepatitis, and HIV prevention services tailored for urban Native Americans delivered in four-weekly sessions (Wiechelt, Gryczynski, & Johnson, 2009). While many Native-specific programs have yet to receive empirical evaluation, several have been described in the scholarly literature. For example, "Honoring Children: Mending the Circle" is a trauma-focused, cognitive behavioral therapy designed to facilitate children's healing from trauma. This intervention is compatible with indigenous values and concepts of well-being. This framework is built on a circle, a conceptual scheme that resonates in many Native traditions and is appropriate for people with a strong Native cultural affiliation. "Honoring the Children: Mending the Circle" is one of a series of interventions that are adaptations of evidence-based treatments developed by the Indian Country Child Trauma Center at the University of Oklahoma Health Sciences Center including Honoring Children: Making Relatives (parenting techniques), Honoring Children: Respectful Ways (promoting children's self respect and respect for others), and Honoring Children: Honoring the Future (suicide prevention) (Bigfoot & Braden, 2009).

Like the medicine wheel discussed in the "Assessment" section, the interventions described above are based on a circular design. Other groups have also found this type of foundation to be helpful in interventions. For example, the circle of wellness model is an effective intervention for Native people with persistent mental illness (Yurkovich & Lattergrass, 2008).

Many Native people participate in traditional indigenous healing practices instead of or in addition to Western ways of helping. This has been documented in urban populations as well as with reservation dwellers. In a study of Native American women in New York City, 60.7% have utilized mental health counseling and 67.9% have utilized traditional healing (Evans-Campbell et al., 2006). Sometimes Western-based interventions can be combined with traditional indigenous ways of helping. A combination of Western and traditional healing may be appropriate for Native veterans struggling with posttraumatic stress disorder (PTSD) (Shore, Orton, & Manson, 2009).

When possible, culturally grounded interventions should be based on the culture of the participants rather than a generic, pan-Indian model. The Healthy Living in Two Worlds project is a wellness intervention developed for urban Haudensaunee (also called Iroquois) youth. This prevention initiative educates youth and promotes healthy lifestyles with a particular focus on mitigating the health risk factors of recreational tobacco use, unhealthy dietary practices, and lack of physical activities (Weaver, 2010; Weaver & Jackson, 2010).

A qualitative study of practitioners experienced in serving Native people found that practitioners can enhance their work by: "1) unlearning stereotypes and paternalistic patterns of relating with American Indian clients and putting that new learning into practice, 2) obtaining a deep understanding of how contemporary racism and cultural genocide form the lens through which non-Indian practitioners, especially white practitioners, may be viewed by American Indian clients, and 3) truly hearing and honoring the life stories

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of Native clients and recognizing that these stories reflect inherent personal and cultural strengths" (Nicotera et al., 2010, p. 213).

There are several treatment recommendations that can enhance the effectiveness of interventions with Native American clients:

- Strengthen healthy social networks and positive role models
- Interventions that incorporate circular ways of understanding life are likely to resonate with culturally grounded Native clients
- Interventions must recognize that life stresses such as racism and poverty often exacerbate other conditions such as mental illness and substance abuse
- Seek out interventions proven effective with Native populations rather than assuming evidence-based practice modeled on other populations will be effective
- Given the extensive trauma experienced by many Native people, interventions that acknowledge grief and loss and promote healing may be appropriate
- Helping professionals should be aware that clients may also participate in traditional healing processes and these can be productive
- Given that colonization and racism are intimately associated with the health and social issues affecting Native people, it is appropriate for helping professionals to incorporate social justice concepts as integral components in their work.

CONCLUSION

Native Americans are a young and growing population. Poverty, racism, and trauma are common factors in the lives of many Native people, which provide a context for significant social and health disparities. It is also important to recognize the resilience and tenacity that have allowed Native people to survive as distinct cultural and political groups in spite of centuries of colonization. Helping professionals can play an important role in assisting Native clients to access needed services and nurture their resilience. Professionals can also bring a strong grounding in social justice to combat many of the struggles that affect indigenous peoples. In these ways, helping professionals have an important role to play in assisting Native people to improve their lives and the lives of generations to come.

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FOURTEEN

Working With Arab Americans

Wahiba Abu-Ras

Historically, culture, cultural diversity, and cultural differences have had major influences on the development of nations, communities, ethnic groups, families, individual identities, and on how we perceive and treat each other. Barnett (1988) argues that we should judge the human rights aspect of a cultural practice relatively, in terms of the context in which the practice is embedded and respect cultural diversity, for it is the basis of human survival. In the field of social work, researchers tend to place much emphasis on how cultures affect people's attitudes, belief systems, interactions with others, and access to social and health services. Furthermore, these cultural differences determine and shape our understanding and knowledge of ways to best approach and assist people of different cultures.

As one of the fastest growing populations in the United States, the Arab American community consists of many other subcultures grounded by different religions and religious practices, sectarian affiliations between and within each group, ethnicities, socioeconomic classes, sociodemographic backgrounds, political histories and identities, immigration experiences, acculturation processes, belief systems, values, and individual differences. In order for social workers to effectively assist and work with individuals and families from this diverse culture, we must recognize these traits, as well as risk factors related to them, such as histories of political and social oppression, discrimination, stereotypes, prejudice, language barriers, cultural attitudes toward help-seeking, and utilization of services. It is also important that we identify and emphasize their protective factors such as religious beliefs, family support, educational values, role of community leaders, resiliency, and collective identity, and build on their unique strengths and resources. This chapter will highlight these risk and protective factors and needs, and also suggest common practice approaches with Arab families and individuals.

ARAB AMERICANS: A SOCIODEMOGRAPHIC PROFILE

The culturo-linguistic term *Arab* refers to those who consider Arabic their native language or who identify as being of Arab descent (Abraham & Abraham, 1983; The Arab Population: Census 2000; Brief, 2003). *Arab American* refers to Arabs who have immigrated to the United States from the Arab world (Abraham & Abraham, 1983) stretching from North Africa to the Arabian Gulf (Suleiman, 1999).

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Arab American emigration occurred in three waves. The first and largest wave (1880–1931) consisted of 212, 825 immigrants from the Ottoman Empire, approximately 50% of whom were illiterate, single, and unskilled men (Abraham & Abraham, 1983; Indiana Historical Society, 2010; Naff, 1983; Suleiman, 1987, 1994). But instead of identifying with the broader Arab community, they associated themselves with symbols of their homeland and had little interest in domestic or foreign affairs (Abu-Laban, & Suleiman, 1989). Their relative ethnic invisibility, due to their small numbers and successful assimilation, made them part of the "hidden minority" (Abraham & Abraham, 1983). During the late 1940s and early 1950s, however, and due to political changes back home and American foreign policy, many of them became politically and socially isolated and alienated from mainstream society.

The second wave (early 1950s to mid-1960s) consisted of those escaping political instability (e.g., Palestinians displaced by the 1948 Arab-Israeli war), Sunni Muslims, highly educated professionals, and college students (Suleiman 1999, p. 9). They tended to settle where jobs were available: the largely unskilled in the industrial towns of the East and the Midwest, and the highly skilled and professionals in the new suburbs and rural towns around major industrial cities (Abraham & Abraham, 1983). The third wave (1970s to 1980s) consisted of refugees who resisted assimilation by establishing schools, mosques, charities, and Arabic language classes that, among other things, stimulated ethnopolitical consciousness (David, 2007; Abraham & Abraham, 1983).

While most Arab immigrants share a common language, culture, and ancestral homeland, the Arab American community is very diverse, depending on immigrants' location, village, religion, nationality, family, and period of arrival (David, 2007). They also differ in terms of assimilation and feelings of "foreignness." According to the most recent census, many male Arab Americans feel that they do not belong here or are not made to feel part of the country (U.S. Census Bureau, 2010).

This community contains an estimated 1.6 million (U.S. Census Bureau, 2010) and 3.5 million people (Arab American Institute [AAI], 2007; Zogby, 2001). Exact numbers may be difficult to determine, for many are reluctant to identify themselves because they distrust Washington and fear that such information might be used against them (U.S. Census Bureau, 2010, p. 66). About 31% were born here; 55% of those born abroad are naturalized citizens (Arab American Institute Foundation [AAIF], 2009). Around 34% arrived after 2000 and 28% between 1990 and 2000; 38% arrived before 1990 (AAIF, 2009). Their average length of residency is between 18 and 32 years (men) and 6–27 years (women) (El-Badry, 1994; U.S. ACS, 2010); others have lived here for over 45 years (Abu-Ras, 2008, 2009). According to the 2000 U.S. Census, 27% live in the Northeast, 26% in the South, 24% in the Midwest, and 22% in the West. Although they live in every state, 48% are concentrated in California, Florida, New Jersey, and New York, with the highest number in Michigan (Brittingham & De La Cruz, 2005; U.S. Census Bureau, 2000).

The vast majority (77%) are Christian (Zogby, 2001). About 89% are high-school graduates. Over 46% and 19% have bachelor's degrees and

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postgraduate degrees, respectively, compared to 28% and 10% of the total American population (AAI, 2007). About 70% aged five and older are bilingual (AAI, 2007). Approximately 79% work in the private sector; 12% are government employees. Their median household income is $59,012, compared to a median income of $52,029 for the entire American population (AAI, 2007). Finally, married-couple households are more common among Arabs than among the total population (Brittingham & De La Cruz, 2005).

PSYCHOSOCIAL RISKS AND NEEDS

The importance of psychosocial risk factors in assessing immigrants' needs should not be understated. Many Arab Americans have experienced the hardships of migration. This usually difficult and stress-inducing experience (Aroian & Norris, 2003) can lead to social and mental health issues (Blair, 2000; Hinton, Tiet, Tran, & Chesney, 1997; Kuo & Tsai, 1986) ranging from social isolation and adjustment limitations (Carlson & Rosser-Hogan, 1991) to depression and anxiety (Abu-Ras & Abu-Bader, 2008; Blair, 2000; Hinton et al., 1997). Migrants from politically unstable or culturally different countries are more likely to exhibit mental health problems than those from more politically stable and culturally similar countries (Aroian & Norris, 2003; Khawaja, 2007; Knox & Britt, 2002). Many immigrant Arabs, therefore, feel alienated from their host country's authorities and fear and mistrust what is beyond their own culture (Abu-Ras & Abu-Bader, 2009). In addition, many Arab Americans are political refugees who have endured torture, abuse, displacement, and war (Pew Research Center, 2007), which makes them more susceptible to anxiety, mistrust, and the development of mental health issues.

As anti-Arab sentiment increased in the 1990s, fueled by racial discrimination after 9/11, Arab Americans were made to feel unwelcome and to suffer from negative feelings about their status as inferior citizens (Gavrilos, 2002). Post-9/11 governmental policies targeting the community, such as detention and deportation based on national origin and ethnicity, contributed to a pervasive sense of insecurity and vulnerability (Abu-Ras & Abu-Bader, 2008, 2009; ADC, 2002). The post-9/11 backlash left many Arab Americans with a "sense of the indelibility" of the event, that their lives had reached a turning point (Abu-Ras, Senzai, & Laird, in press, 2013). Many reported "feeling less safe" due to discrimination and hate crimes (Abu-Ras & Suárez, 2009). Studies addressing the prevalence and incidence of post-9/11 mental health issues in this community (Abu-Ras & Abu-Bader, 2008, 2009; Amer & Hovey, 2007; Amer & Hovey, 2011) show that the most common mental health issues, namely, anxiety, posttraumatic stress disorder (PTSD), and depression, may be passed down from parents to children (Sack, Clark, & Seely, 1996).

Although immigrants are at risk for substance abuse, Arab Americans are represented in publicly funded treatment centers at a much lower rate proportionate to their population size (Arfken, Kubiak, & Farrag, 2008). This may be because their homelands have strongly stigmatized alcohol and drug use (Michalak & Trocki, 2006), restricted their availability, and have less

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tolerance for their consumption than does the United States (United Nations Office of Drugs and Crime, 2008). Yet this stigma can be a cultural barrier to seeking treatment (Link, Yang, Phelan, & Collins, 2004).

Due to their preimmigration lives, many Arab immigrants may be vulnerable to PTSD, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), depression, or substance abuse (Weine & Laub, 1995; Nasser-MacMillian & Hakim-Larson, 2003, p. 156). The 9/11 attacks also uniquely traumatized this group, for Arab American individuals and community organizations were quickly subjected to increased suspicion and hostility (American Civil Liberties Union [ACLU], 2002; American-Arab Anti-Discrimination Committee [ADC], 2002; Singh, 2002), and investigations by the Federal Bureau of Investigation (FBI, 2002), as well as hate crimes, which increased by 1,700% in the year after 9/11 (Singh, 2002). As a result, they felt anxiety and concern for their own safety (Abu-Ras & Abu-Bader, 2008, 2009; Abu-Ras & Suárez, 2009).

Additionally, 9/11 revived their earlier traumatic memories and experiences, thereby intensifying experiences of discrimination and exacerbating preexisting political, economic, social, spiritual, psychological, and medical problems. According to the Arab American Association of New York and others (Abu-Ras, 2003, 2007; Ali, Milstein, & Marzuk, 2005), increasing numbers have sought psychological counseling from religious leaders, mosques, and churches for mental health concerns, marital problems, partner abuse, divorce, emotional and personality growth, and the promotion of inner consciousness (Abu-Ras, Gheith, & Courns, 2008; Al-Radi, 1999).

BARRIERS TO ACCESSING MENTAL HEALTH SERVICES

Existing services, which are geared toward the host country's dominant ethnic and religious population, are not set up to deal with minority groups' cultural influences, service delivery systems and policies, personal resources, patriarchal ideology, and cultural beliefs toward seeking outside help (Abu-Ras, 2003). Arab Americans face additional complications: the cultural stigma associated with Western mental health services (Gorkin & Othman, 1994) and most non-Muslim social workers' lack of familiarity with the Arabic language and/or Islamic culture and values (Abu-Ras & Abu-Bader, 2008). More appropriate additional services may not be established due to a lack of resources, a fear of negative societal reactions, a personal or professional backlash, and/or discrimination (Abu-Ras & Abu-Bader, 2008). After 9/11, community members' immigration status, political and social concerns, as well as fear of discrimination, detention, and deportation, increased their reluctance to access services. Instead, they largely turned to their religious leaders. A study (Abu-Ras et al., 2008) examining the role of imams in mental health settings for Muslims in New York City showed that the former played a major role in providing culturally competent mental health services after 9/11. Due to the limited services available to Arab Americans, however, many of them are at an even higher risk for mental health problems (Abu-Ras & Abu-Bader, 2008, 2009; Abu-Ras & Suárez, 2009; Abu-Ras et al., 2008).

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Environmental Risks and Needs

Immigrants have always faced discrimination and frequent anti-immigrant attitudes and policies. In the case of the Arab Americans, such views are based on historical representations of Arab and Muslim societies as deficient or deviant versions of a modern, rational Europe (Said, 1978). After 9/11, however, discrimination against them became endemic, for mainstream America based its reaction on a patriotic sentiment that reflected its communal and cultural solidarity and demonized those who shared any physical, linguistic, or cultural affiliations or similarities with the perpetrators. Many Americans shared the biases underlying the violence against "Muslim-looking people" and manifested this in the form of racial discrimination and harassment (Abu-Ras & Suárez, 2009).

This discrimination varies according to one's "foreign" look, dark skin, or gender, all of which intersect with other forms of institutional discrimination (Abu-Ras et al., in press). One report (Council on American-Islamic Relations (CAIR) (2001)) analyzing discrimination suits filed by Arab and Muslim Americans reveals the following: denial of religious accommodations (37%), job termination (13%), verbal abuse (8%), unequal treatment (8%), denial of employment (7%), and denial of access to public facilities (5%). Half of these incidents occurred in the workplace; 15% occurred in schools. The victim's perceived ethnic origin was associated with 25% of the cases; 18% stemmed from Muslims praying. Certain anti-Muslim activists have called for interning Muslim Americans who do not demonstrate "sufficient" loyalty to the United States (Ali, Liu, & Humedian, 2004; Nasser-McMillan & Hakim-Larson 2003).

Arab and Muslim Americans also suffer more profoundly from a relative lack of social support. Coming from cultures that place a high value on social support systems, their ability to reach out to Americans may be impeded by linguistic/cultural barriers. As a minority population, their ability to form strong social support systems may also be hindered by mistrust of Americans and feelings of "otherness." This might, conversely, actually help them form strong-knit communities. The lack of social support can harm their mental health (Abu-Ras & Suárez, 2009).

The Impact of Policy and Legislation

Several post-9/11 immigration policies that specifically target this community have set Muslim and Arab Americans apart from other minority and immigrant groups. These policies have resulted in the detention of over 1,200 Muslims of Arab and South Asian heritage (Singh, 2002); the investigation of over 8,000 individuals; the monitoring of international students; and the deportation of 16% of the 130,000 individuals who registered under the Immigration and Naturalization Service alien registration process based on national origin and ethnicity (American Arab Anti-Discrimination Committee 2002; Eggen, 2003). These policies and occurrences have led many Arab Americans to express a constant sense of insecurity and vulnerability (ADC, 2002).

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Prejudice and Stereotypes

In general, the West still perceives Arab Americans as a dangerous, emotionally volatile, and backward racial "other" (Said, 1978). Since 9/11, they have typically been labeled terrorists, hijackers, and extremists (Abu-Ras & Abu-Bader, 2008; Gavrilos, 2002). Discrimination against Arabs and Muslims in particular is also thought to be linked to a general Western perception of these people as enemies of Christianity (Abu-Laban, 1988; Haddad, 1997; Suleiman, 1996). The aforementioned problems regarding racial identification and citizenship have traumatized the Arab American population (Suleiman, 1987), and the ensuing hostility have negatively affected the quality of life of Arabs and Muslims in this country (Haddad, 1997).

Numerous studies support the prevalence of such sentiments. Lipset and Schneider (1977) found a pattern of "negative, close to racist" attitudes toward Muslims. Slade (1981) discovered that "Arabs remain one of the few ethnic groups who can still be slandered with impunity in America" (p. 148). Jarrar's (1983) study of 43 high-school social studies textbooks showed that Arabs were characterized as "primitive, backward, desert-dwelling, nomadic, war-loving, terrorist and full of hatred" (pp. 387–388). Bushman and Bonacci (2004) stated that Arab Americans encountered more prejudice than African Americans, Asian Americans, and Hispanic Americans. Thus, it can be argued that vandalism, threats, attacks, discrimination, and hate crimes against Arab and Muslim individuals and institutions derive from pre-9/11 and ongoing pervasive anti-Muslim and anti-Arab sentiments (Abu-Ras & Abu-Bader, 2008, 2009; Abu-Ras & Suárez, 2009; Akram, 2002; Abu-Ras, 2011a; Abu-Ras 2011b; Cainkar, 2004, 2006, 2009).

Such sentiments not only present serious challenges to the development of a positive ethnic self-identity (Jackson, 1997; Suleiman, 1988), but can also lead to biases and mistaken assumptions among social workers. This can significantly compromise the effectiveness of such services for Arab Americans. And yet this issue has received little attention in the counseling or mental health literature (Erickson & Al-Tamimi, 2001).

At different level, prior to 9/11 mental health and social services in the Arab American community were nearly nonexistent. There was also a prevalent lack of awareness of what was available. Many services were created to address the wider community trauma of 9/11; however, the Arab American and Muslim communities largely turned to their religious leaders, although the latter were not really trained and equipped to address such issues (Abu-Ras et al., 2008 Abu-Ras (2011a and 2011b)).

COMMUNITY-SPECIFIC CLINICAL ASSESSMENT FACTORS

Several community-specific psychological, sociocultural, spiritual, and political aspects need to be considered by social workers and service providers. For example, all Arab immigrants, regardless of their national, religious, or ethnic backgrounds, share a common experience, language, many cultural norms, and belief system. Some of the sociopolitical pressures were mentioned above.

One cultural challenge is their reluctance to access social and mental health services for personal or family-based problems (Aswad & Gray, 1996;

Kulwicki, 1996; Abu-Ras, 2007; Abudabbeh, 1996). One study of battered Arab American immigrant women revealed that mental health and social services related to partner abuse were the least frequently used. Participants were far more likely to turn to family, legal, and/or medical services, as they were seen as less intrusive into a woman's private life. In addition, Arab clients with mental health problems commonly expressed them in terms of physical complaints in order to create "legitimate" excuses for discussing them (Budman, Lipson, & Meleis, 1992; Gorkin, Massalha, & Yatziv, 1985). Such somatic behavior may be explained as one result of cultural stress, a heightened awareness of the mind–body connection, or the lack of concepts or terminology in Arabic to describe mental states as distinct from physical symptoms (Meleis, 1982). Such resistance may be due to the individual's association of mental health intervention with insanity or fear of being labeled crazy, which can carry considerable stigma (Gorkin et al., 1985; Kulwicki, 1996). From my experience as a social worker in the Arab American community, most of my 30 male and female clients worried that other community members would see them at the site and specifically asked me not to tell anyone that they had sought out counseling (Abu-Ras, 2007).

Arabs in general are more concerned about people and their feelings. Unlike Westerners, who are taught to attempt objectivity and control their emotions, Arabs are more subjective in their approach to certain situations and express their emotions freely, talking openly about their pain and sorrow, and weeping, if death is involved (Nobles & Sciarra, 2000). But when it comes to counseling, Arabs tend to be less "psychologically minded" than Westerners (Jackson, 1997) and usually lack experience with or exposure to Western counseling approaches. This may be because they traditionally seek the advice of a family member, parent, or elder (Abudabbeh, 1996; Jackson, 1997). Arab Americans tend not to discuss family or personal problems with non-family members, including social workers (Jackson, 1997), for doing so may be seen as a threat to group honor or as disloyalty toward the family (Abudabbeh & Nydell, 1993). For example, studies (Abu-Ras, 2003, 2007) show that many immigrant Arab women remain in abusive marriages rather than face the consequences of socially unacceptable dishonor, such as violating family privacy by seeking help, which may actually precipitate violence.

Regarding gender roles, many Arab Americans still link family shame and honor with their women's reputations and sexual behavior. Premarital sex, flirting, asking for divorce, challenging men's authority, criticizing one's husband, and dressing "provocatively" can all be seen as shaming the family, given traditional understandings of women's sexual purity and subordination to men (Glazer & Abu-Ras, 1994). Despite women's larger role in the labor force, greater access to education, and higher levels of financial independence, this linkage is still considered the most sensitive value that Arabs in general hold. In addition, social workers and mental health providers need to pay attention to differences within genders and between groups. Arab women in general may experience more psychological stressors, as they have different responsibilities within the household and society. Some become more socially isolated in their foreign county, due to their missing the social circle and family support system they used to have. Others may

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face difficulties integrating or interacting due to language barriers. Both of these limit their support system, affect their help seeking behavior, accelerate their social isolation, and decrease their interaction with others in the new culture.

Another challenge is the reluctance to seek professional help because of potential deportation, cultural and language barriers, ignorance of such services, and poor understanding of their rights in the community. If they are here illegally, the challenges are multiplied. New Arab immigrants often fear and mistrust the non-Arab world, a trend reinforced by post-9/11 realities (Abu-Ras & Abu-Bader, 2008). Their perception that Washington's policies and actions are unjust only fuel such attitudes. In fact, the post-9/11 political climate has further deterred battered Arab immigrant women from contacting police, as they fear even more political harassment and a backlash against them and their family (Abu-Ras, 2007; Abu-Ras & Abu-Bader, 2008).

Once in counseling, many Arab Americans might expect the mental health provider to offer detailed advice or give explicit directions and thus may come to view them as an "expert" (Gorkin et al., 1985). This might be due to the cultural practice of seeking advice from elders, cultural adherence to a hierarchical social structure, or early socialization experiences that foster respect for authority by displaying careful listening (Abudabbeh, 1996). Consequently, many Arab Americans turn over authority to someone more knowledgeable for important decisions. They may even view this act as a measure of how much the authority figure cares for them (Meleis, 1982). Therefore, social workers need to clearly explain their professional role and the social worker–client relationship, as well as address their clients' expectations.

Another cultural aspect that may affect this relationship is a less structured time orientation. Arab Americans may be more interested in and focused on present, as opposed to future, events or circumstances. Meleis (1982) described them as being less concerned with whatever else was scheduled for the day, because it can be dealt with later. Thus, expecting clients to be comfortable with considering the hypothetical consequences of future decisions may be unrealistic.

Strengths and Resources

Family support and strong family values are among the Arab immigrant's most important sources of strength (Ajrouch, 2000). As Abudabbeh (1997) stated: "There are today many signs of strain on the Arab family system due to factors such as industrialization, urbanization, war and conflict, and Westernization. Despite these pressures, the family remains the individual's main system of emotional and concrete support throughout the Arab world and for Arabs living elsewhere" (p. 118). Many Arab societies tend to be collectivistic and therefore discourage individualism and individuation (Almeida, 1996; Abudabbeh, 1996); consider enhancing family (instead of individual) honor and status an important goal for each family member (Nydell, 1987); and view the family as crucial to their social organization and individual and collective identity (Abudabbeh & Nydell, 1993; Naff, 1983; Soliman, 1986).

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Therefore, many Arab Americans are more concerned for their family's well-being than their own. Considering one's personal needs may cause confusion or even guilt at having betrayed their family (Gorkin et al., 1985).

Religion, another key strength in personal well-being (Ellison & Levin, 1998), seeks to provide a framework for dealing with emotional hardship. In an urban environment, where many religions and cultures converge, it is often paradoxically difficult to find the support one might require in times of crisis. During a difficult time, faith and religion can be the first or only available source of support.

Since 9/11, many religious leaders were called on to help counsel Arab Americans (Flannelly, Robert, & Weaver, 2005). Although the majority of Arab Americans are Christian, both Muslim and Christian Arab Americans often uphold Muslim traditions and values because a large percentage of Arabs practices Islam (Loza, 2001). Faragallah, Schumm, and Webb (1997), on the other hand, found that Arab American Muslims felt isolated from American society and were less likely to have a sense of belonging than their Christian counterparts. They are also more likely to retain traditional family roles and cultural traditions (which are highly intertwined with religious values), experience greater discrimination, and feel less satisfaction with life in this country.

But religion may also serve as a source of prevention and coping for both communities. Religious social networks often emerge from immigrants' attempt to recreate a familiar world (Hattar-Pollara & Meleis, 1995; Maloof, 1981). Abudabbeh and Hamid (2001) suggest that religious or social networks at places of worship can help acculturate Arab Americans by substituting for one's extended family. Although serious emotional issues require professional assistance, an "otherized" immigrant community will find it difficult, if not impossible, to locate appropriate services.

In general, Arab cultures dictate behaviors that reflect well on others at all times (Nydell, 1987), such as magnanimity, generosity, and hospitality. Additionally, prosperity can increase a family's ability to display them (Naff, 1983). As the pursuit of family honor encourages hard work, thrift, and conservatism, educational attainment and economic advancement are highly sought after. Conversely, individuals are strongly encouraged to avoid criminal or indigent behavior (Naff, 1983).

TREATMENT APPROACHES

Given the multiple psychosocial, cultural, spiritual, and political factors that may impede or encourage Arab Americans' access to systems of clinical care, several treatment strategies would best engage members of this population group in a therapeutic helping process. While there is little knowledge available on appropriate culturally specific mental health care for Arab Americans, a few suggestions can be made.

Before using any intervention approach, social workers are strongly encouraged to assess the resources available to their Arab clients, as well as their social environments, and the impacts of these factors on their clients' well-being, as discussed in the previous section. The second step is to assess the person's strengths and the level of their connectedness to family and the

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strictness of the family in dealing with each other. The third step is to assess their religious beliefs and how their beliefs influence their attitudes toward help-seeking and mental health issues. The fourth step is to assess the impact of 9/11 on their well-being including mental health, fear, anxiety level, and fear and identity issues. In assessing the personality traits, non-Arab social workers should pay extra attention to certain behavior such as anger, frustration, feeling of inferiority, shame, guilt, and acceptance toward Western people in general. These are common feelings that many Arab Americans have toward American people, who in their view represent the Western attitudes toward Arabs in general and toward Arab Americans in particular. The transference may be expressed by using certain words such as "you" (Americans) verses "we" (Arabs). For this particular situation, social workers may wish to help their client to differentiate between American "general public," and therapist/social worker, as individual persons, while showing empathy, tolerance, and understanding. This would be one of cement in building trust between the therapist and clients. Based on these assessments, the therapist may choose to apply Western therapy approaches or a culturally sensitive approach designed specifically to address the needs of Arab clients.

Building Trust

Some Arab clients may initially hesitate to disclose their issues to a nonfamily member, especially if they are less acculturated to Western culture and unaccustomed to drawing attention to themselves in therapy (Abu-Ras, 2007; Amer & Hovey, 2005). Thus, they may ask about the social worker's intentions and motivations and appreciate an opportunity to discuss their cultural mistrust of psychologists (Ali et al., 2004). A general distrust of the social worker's ability to maintain client confidentiality is also an issue (Nasser-McMillan & Hakim-Larson, 2003). This can be especially detrimental for female Arab Americans, given the social stigma associated with exposing family matters to strangers (Abu-Ras, 2003, 2007). In addition, clients need to be reassured about their mental stability and social worker–client confidentiality to make them feel more comfortable. Given the Arabs' predominantly patriarchal and hierarchical societies (Al-Issa, Al Zubaidi, Bakal, & Fung, 2000), they expect the social worker to take an active approach to the treatment process. As insight-oriented or client-directed psychotherapy may be resisted (Al-Abdul-Jabbar & Al-Issa, 2000; Nasser-McMillan & Hakim-Larson, 2003), it could be useful for the social worker to assume a more directive or advisory role. Social worker disclosure of emotions and client consolation are also believed to strengthen the client–social worker relationship (Al-Abdul-Jabbar & Al-Issa, 2000; Nobles & Sciarra, 2000). These approaches allow Arab clients to learn from the social worker while fostering a safe environment for change.

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Psycho-Education Intervention

Because the stigma many Arab Americans show toward mental illness and their negative attitudes toward utilization of mental health services, psychoeducational approach would be the first and maybe the most appropriate

approach to use. This approach helps Arab clients, as well as other clients from diverse ethnic backgrounds, "to identify and surmount barriers to learning about emotional response and other psychological processes associated with ongoing and cumulative stress and stigma" (Lukens et al., 2004, p. 109). To be more effective in using the psychoeducation intervention model, social workers and therapist need to bear in mind that psychoeducation is not only intended to educate their clients about mental health issues and raise their awareness, but also to use it as a tool to learn about their clients; perceptions, views of the world around them, their attitudes, belief systems, cultural values and strengths, resources they have and use, and areas that should be developed and addressed. Mental health providers must also be trained in Arab- or Muslim-specific issues. Sue et al. (1992) outlined three domains in which their attitudes, knowledge, and skills are crucial to providing competent services: (a) awareness of their own client-related assumptions, values, and biases and awareness of negative stereotypes about Arabs and Muslims; (b) their understanding of clients' worldviews by providing a safe environment for them to discuss discrimination, hate crimes, and stereotypes as well as to address their attitudes toward seeking therapy; and (c) the use of culturally appropriate interventions and techniques, while avoiding group counseling, as feelings of fear, guilt, and shame may limit its effectiveness (Nasser-MacMillian & Hakim-Larson, 2003; Ali, Liu, & Humedian, 2004).

A psychoeducational approach can be also used with the entire community, especially when traumas "threaten the community's existence, purpose, focus, or goal" and may involve the death of community members (Williams, Zinner, & Ellis, 1999). Using the psychoducational model, social workers could build on many factors, including past exposure, cultural and spiritual factors, immigration status, and available formal and informal avenues (Lukens et al., 2004). Immediately after the 9/11 attack, a strength-based psychoeducational approach was developed by HOPE-NY (see more Lukens et al., 2004, p. 111). The model seemed appropriate and adaptable for members of diverse New York City communities faced with the overwhelming and incomprehensible trauma of the 9/11 tragedy. The model includes four major principles: (a) building a collaborative community of care across and within systems (individual, family, community, and provider), (b) attending to culturally relevant processes, context, and content, (c) disseminating information as a step toward personal and community empowerment, and (d) fostering resilience in the context of ongoing community trauma.

A psychoeducational intervention is necessary and should be integrated into nonstigmatizing physical settings, such as community centers, to minimize the stigma associated with mental health services and their facilities (Abu-Ras, 2007). Disseminating language-appropriate information and promoting psychosocial knowledge and education, which are essential to identifying severe stress reactions, will also enhance individual and community recovery and healing, especially post 9/11 attacks. Such an intervention could allow social workers to brief clients on mental health and illness, help them develop a fundamental understanding of therapy, and further convince them to commit to long-term treatment. Such approaches should enable clients to understand and accept the illness and cope with it successfully.

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In addition, social workers could integrate Islam's spiritual and religious teachings and introduce a psychotherapy faith-based intervention.

Empowerment Approach

Describing a client's problem or deficit in the context of their relative strengths and assets, in addition to providing reassurance that they are not being denigrated or devalued, is an effective therapeutic approach. McWhirter (1998) outlined a potentially useful model: collaboration, context, critical consciousness, competence, and community. In sum, the social worker must identify the problem, understand how/why it arose or was exacerbated, and help the client realize how their unique strengths and personal/communal resources can be used for personal empowerment (Ali et al., 2004). Such a model could help the clients realize their strengths and the mental health provider's attempts to provide culturally competent care.

When applying this empowerment model to Arab clients, social workers may initially engage them by exploring their identity (e.g., age, race, religion, sexual orientation, and other aspects) in order to ease their anxiety levels and help both parties better understand the client's issues and concerns. It will also help the clients present their identity as they perceive it, completely separate from the common Arab American stereotypes. The mental health provider could then build on the positive and ethical values considered central to the client's cultural and religious teachings and belief systems in order to help foster such values as resources of strength (Abraham, 1995; Abudabbeh, 1996; Erickson & Al-Tamimi, 2001; Jackson, 1997).

In addition, due to some conflicts existing between the American culture, for Arab second generation, and the Arab culture, for first Arab generation, Arab clients must be encouraged to explore and identify their perception and definition of ethnic identity, acculturation strategy, acculturation stress, and religiosity level. Mental health providers should urge them to explore, discuss, and address their sense of belonging to their own community and the American mainstream, as well as emphasize that healthy psychological acculturation strategies may differ for different subgroups of an ethnic population. For example, Amer and Hovey (2007) found that second-generation/early immigrant Christian Arab Americans retained their own cultural values and practices while participating in mainstream culture which was the optimum acculturation strategy. In this case, mental health providers might have encouraged their clients to further explore and negotiate the challenges and benefits of both cultures that might positively shape and practice a healthy bicultural identity (Amer & Hovey, 2007).

Using Religion and Religious Coping

Muslims believe in the Jewish and Christian scriptures, Jesus's ethical teachings, the Ten Commandments, and a monotheistic God (Jackson, 1997). The word *Allah* is merely the Arabic word for God and refers to the same God revered by Christians and Jews. Religion is integral to many Arab Americans and may be a central component of their identity (Abudabbeh, 1996; Abudabbeh & Nydell, 1993). In fact, it may be the factor that "differentiates"

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people (Naff, 1983), as opposed to nationality, occupation, or marital status. When working with Arab Americans, more specifically those who are Muslim, non-Arab social workers need to familiarize themselves with Islam and its practice to treat clients using culturally specific techniques. Although religion and spirituality have been incorporated into a cognitive therapy model to treat mental health disorders among Christians and Jewish populations, limited attention has been paid to Arab Muslim clients (Hamdan, 2008).

Social workers might suggest that Arab Muslim clients use Islamic tenets to cope with trauma, such as praying or reciting/reading specific Qur'anic passages (Abu-Ras et al., 2008). However, this approach should be used with caution, particularly when trauma seems to be linked with clients' struggles with their religious identity (Hedayat-Diba, 2000). The assessment of one issue in particular, suicidal ideation, may be difficult for devout Muslim clients, especially if they are less acculturated to Western culture. As Islam forbids suicide, many Muslims see it as a criminal act. Therefore, a social worker could ask about it in a passive manner: "Do you wish that God would let you die?" (Hedayat-Diba, 2000).

Social workers may also wish to undertake a religious psychotherapy intervention. According to Islamic thought, one's mental and spiritual development is in a constant state of evolution that starts from a purely self-gratifying stage and progresses toward a stage of inner peace and self-assuredness (Mohit, 2001). During this process, a person may experience self-doubt, self-accusation, and self-acceptance before reaching the "pure self" and, finally, the ultimate "peaceful self." Imams have used this Islamic therapeutic process, which combines elements of cognitive, behavioral, and psychodynamic therapy to treat Muslim clients (Abu-Ras et al., 2008). Traditional Islamic teachings explain mental illness as a defective relationship with God, a divine punishment, or the imponderable result of God's will (Al-Krenawi, 1996; Al-Krenawi & Graham, 1999). Many Arab Muslims perceive mental illness as part of human suffering, often regarded as a way of atoning for sins, and believe that the reward may be doubled if the suffering is endured with patience and prayer. In the face of such tests, and to promote personal healing, strength, and growth, redoubling ritual acts of devotion (e.g., prayer, fasting, repentance, and reciting the Qur'an) is made part of the healing process. While treading on this moral battleground, Arab Muslims seek to understand the nature of the particular mental illness that could be preventing them from overcoming their inherent weaknesses. It is important to note, however, that the Qur'an is meant to be followed as a religious guide and not as a substitute for prevailing medical (both mental and physical) knowledge.

Family Support and Family Therapy

As previously mentioned, family is the central component for most Arab Americans. Paying attention to the family dynamic is crucial in the planning and the implementation of the treatment approach. Learning about the status of the client within the family will determine the level of their independency, individualistic views of the worlds around them, and the level of support the

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client may need to cope/deal with the problem. More attention focused on the intrafamilial conflicts is very important. Family functioning and social support are coping resources that could ease anxiety and depression. As Arab culture is built around the extended family system, a social worker would be strongly advised to advocate a multisystem intervention approach using the strong bond of blood relatives, community actors, and groups (e.g., religious leaders), and medical and social services. Family therapy may be an effective intervention regardless of the context (Amer & Hovey, 2005). The value of family within the context of a collectivist worldview dictates the inclusion of most, if not all, family members in the effective delivery of services. Family therapy could also help its members support each other and provide them with more security, especially for those who feel isolated (Abdudabbeh, 1996). Social workers working with a predominantly Arab American population have reported that including family members can alleviate client concerns and facilitate the development of trust in the social worker (Nasser-McMillan & Hakim-Larson, 2003).

However, as this inclusion process can cause some difficulty in regard to the traditional norms of Western psychotherapy, it should be discussed with the client. Including the family is especially pertinent when dealing with Arab American women. Child care may be difficult to arrange, which may hinder individual counseling (Nasser-McMillan & Hakim-Larson, 2003). Moreover, as the woman is not usually in charge of the family's finances, her husband may consider it an unnecessary expense (Nobles & Sciarra, 2000). Engaging him in the therapeutic process may reduce his own concerns, thereby making it easier for her to attend the sessions. It may also be part of a natural course in the collectivist culture, for issues confronting Arab American women also affect the family (e.g., her depression affects the marital relationship and her ability to complete her assigned duties) (Abu-Baker, 2006). However, this may not be useful for treatment purposes if her problems are based on dissatisfaction with her husband or domestic abuse (Abu-Baker, 2006). In sum, social workers need to assess whether including a particular family member(s) will help their client's psychological well-being.

PRACTICE IMPLICATION AND RECOMMENDATIONS

It is evident that culture and cultural diversity are vital aspects in understanding and serving families from minority ethnic groups. The Arab American community is a minority group that is among those most misunderstood, misrepresented, and negatively perceived by mainstream American society and the mass media. Such views do not only affect the ability of Arab immigrants to cope with their mental health issues, family crises, and sociocultural and political challenges, but can also lead to prejudices, biases, and faulty assumptions on the part of social workers and others who serve them.

This chapter has highlighted important similarities, differences, and false assumptions associated with the Arab dominant culture. It is essential to understand the culture of Arab American immigrants, their special needs and strengths, their cultural attitudes toward mental health services, and the

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post-9/11 anti-Arab political climate before choosing an intervention plan or approach. These individuals have special needs and concerns that are affected by both cultural, traditional, religious, and patriarchal beliefs and values, and external patterns including discrimination, stereotypes, prejudices, hate crimes, and political and social policies.

Based on these cultural and structural issues, social workers need to be aware of, and take into consideration, the diverse cultural attitudes, values, and beliefs maintained by the Arab American community while educating, planning, and practicing mainstream mental health delivery systems. Additionally, providers must educate themselves, at least to the point of familiarity, on Arab cultural and Islamic values, especially when dealing with Muslim Arabs. Finally, it is also imperative that social, health, and mental health providers explore other appropriate techniques and approaches when dealing with Arab individuals, families, and communities that reflect on their unique experiences.

To reduce the mental health stressors as a result of the anti-Arab political climate and instances of hate crimes, and discrimination against Arab immigrants, it is important to consider not only the social roots of these mental health stressors, but also the way in which cultural and faith institutions might assist in propagating information. Religion and spirituality play an important role in the way Arab and Muslim individuals, families, and communities cope with their mental health issues. Therefore, using spiritual/religious counseling and religious teachings might be effective with Arab clients, especially with Muslim clients, as the Qur'an and the Hadith are generally considered a way of life among most Muslims, including those who are nonpracticing.

The overall implication of this chapter, for both research and social work practice, is the importance of studying the differences between Arab subcultures and subethnic groups, their faith and sectarian affiliations, men's and women's reactions to and coping with stressors, and the community's cumulative and historical impact of trauma as a result of political instability and war in their home countries, as well as racial harassment, discrimination and hate crimes in their host country. Ten years after 9/11-related stressors and public harassment, the Arab American community is primed to begin recovering. Social workers must immediately take advantage of this timing by effectively addressing their particular mental health needs.

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FIFTEEN

Practice With Families Where Gender or Sexual Orientation Is an Issue: Lesbian, Gay, Bisexual, and Trans Individuals and Their Families

Gerald P. Mallon

"Are you out to your family?"
"How did your family deal with your being a lesbian?"
"Do your children know that you are gay?"

All of the above are questions that almost inevitably arise in the process of getting to know a lesbian, gay, bisexual, or transgender (LGBT) person. Families supply physical and emotional sustenance, connect us with our past, and provide a context within which we learn about the world, including attitudes and mores of our society (Mallon, 2008a, 2008e). A LGBT person's family is very important. Although some radical right ideologues erroneously promote the belief that a LGBT identity is a threat to the family, as if it were intrinsically antithetic to the idea of family life, nothing could be further from the truth. LGBT persons need to be part of their families as much as any other individual. Given the possibly stigmatizing status that LGBT identity continues to hold for many in Western society, the family is one place where a LGBT person most needs to feel accepted. Most LGBT people hope that their family will continue to love and care for them, after they disclose their LGBT identity to them. For many, this is the case, sadly, for others acceptance by one's family is not forthcoming (Ryan, Huebner, Diaz, & Sanchez, 2009).

Utilizing an ecological perspective of social work practice to work with LGBT young people and families offers a broad conceptual lens for viewing family functioning and needs. The late Carel Germain (1985), who led the development of this perspective in social work, noted that "practice is directed toward improving the transactions between people and their environments in order to enhance adaptive capacities and improve environments for all who function within them" (Germain, 1985, p. 31). As such, practitioners need to seek to influence the direction of change in both the person and the environment. With respect to a LGBT young person within a family context, changing the environment means educating families and assisting them in dealing with homophobic attitudes.

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Consider the following case vignette:

CASE VIGNETTE

> Damond is a 16-year-old, Trinidadian youngster who has been sent to the United States to live with an aunt after his mother has been psychiatrically hospitalized. His aunt, a single mother, has lupus, works full-time, and has three other children to support in her home. Damond is depressed because of his mother's illness. He is feeling isolated by his separation from his mother and the difficult acclimation to a new country and culture. In addition, Damond is dealing, in silence, with his own emerging gay identity.
>
> While cleaning Damond's room one afternoon, his aunt finds a letter that he wrote to a boy in school. Enraged, confused, and armed only with religious and culturally pejorative notions about LGBT persons, even worrying that Damond's gay identity might be contagious and put her own children at risk, she tells him that he is sick and needs help.

From this brief sketch, one can begin to see how and why this family is in crisis. There are numerous stresses in this environment (Kelleher, 2009; Ryan et al., 2009). The economy requires that the aunt work to support her family despite her chronic illness; the young man is grieving over his mother's illness, his own relocation to a new environment, and dealing in silence with his own emerging gay identity. Add to this the cultural factors that promote a particularly negative view of individuals (even family members) who are homosexually oriented, and that the young man was "found out" and did not choose to disclose his orientation, and it is easy to see how this young person may become the target of his family's anger. As this example suggests, many personal, family, and environmental factors converge and interact with each other to influence the family. In other words, as Germain (1985, p. 43) so eloquently said it almost three decades ago, "human behavior is not solely a function of the person or the environment, but of the complex interaction between them."

All too often, despite the increasing emphasis on family-centered social work practice (Hartman & Laird, 1983) there is a tendency for social work practitioners to see LGBT persons primarily, if not solely as individuals who are "gay," "lesbian," "bi," or "transgender" rather than as members of a family of origin and as possible creators of their own family systems, families of choice (Weston, 1996), or biological families (Mallon, 2008e). By not acknowledging that "human beings can be understood and helped only in the context of the intimate and powerful human systems of which they are a part," of which the family is one of the most important (Hartman & Laird, 1983, p. 4), practitioners miss out on many important opportunities for fostering more positive relationships between LGBT persons and their families.

This chapter, based on the author's analysis of the existing literature, qualitative data analysis from interviews conducted with LGBT adolescents and their families, and 36 years of clinical practice with individuals and their families,

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examines the experience of LGBT persons and their families through an ecological lens. Such a perspective creates a framework where individuals and environments are understood as a unit, in the context of their relationship to one another (Germain, 1985, p. 33). As such, this chapter examines the primary reciprocal exchanges and transactions that LGBT persons and their families face as they confront the unique person:environmental tasks involved in a society that assumes all of its members are heterosexual. The focus of this chapter is limited to an analysis of the LGBT persons within the context of their family system. As such the author explores the following areas: demographic issues; psychosocial risks and psychosocial needs of LGBT persons; the clinical assessment issues of working with an individual where gender or sexual orientation is the presenting issue; and recommendations for intervening with this population. Recommendations for social work practice with LGBT persons and their families are presented in the conclusion of the chapter.

DEMOGRAPHIC PROFILE

Although there are many stereotypes of LGBT persons, one-dimensional images that the popular media perpetuates about LGBT persons, the reality is that LGBT persons are part of every race, culture, ethnic group, religious, socioeconomic affiliation, and family in the United States, and most likely all other countries as well.

Since LGBT persons are mostly socialized to hide their gender or sexual orientation, most are a part of an invisible population. In addition, in many areas of the United States (mostly outside of urban areas), it is still unsafe for most LGBT people to live openly and acknowledge their gender or sexual orientation. There are not U.S. Census Bureau data that support or deny the existence of this population. Individuals who are socialized to hide or who have real or perceived reasons to fear for their safety do not usually come forward to be counted. In fact, although there is an increasing awareness about LGBT persons, mainly from media representations of the population and increasingly because celebrities and others are more frequently self-disclosing, it is safe to assume that many LGBT persons in the United States remain closeted and do not live as “out” or “openly” LGBT persons.

PSYCHOSOCIAL RISKS/PSYCHOSOCIAL NEEDS OF LGBT PERSONS

LGBT persons experience environmental and psychological stresses that are more elevated than most of their heterosexual counterparts not necessarily because of their LGBT gender or sexual orientation, but due in large part to the negative societal response to their LGBT gender or sexual orientation (Cochran, Stewart, Ginzler, & Cauce, 2002; Kelleher, 2009). Such conditions are unique to their membership in what remains in American society as a stigmatized population.

As such, many LGBT persons experience difficulties in the following areas.

Accessing systems of care (health, mental health, social services) (Appleby, 1998; Bockting & Avery, 2005; De Vries, Cohen-Kettenis, & Delemarre-Van, 2006; Hunter & Mallon, 1998; Hunter, Cohall, Mallon, Moyer, & Riddel, 2006;

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Israel & Tarver, 1997; Lev, 2004; Page, 2004; Mental Health America, n.d.; White Holman & Goldberg, 2006) that are affirming of and sensitive to the needs of LGBT clients.

Mental health illnesses that may be correlated to the need to hide—especially anxiety-related disorders and mood disorders (Jones & Hill, 2003; Bartlett, Vasey, & Bukowski,2000). LGBT youth, according to some studies (Garofalo, Wolf, Wissow, Woods, & Goodman, 1999; Remafedi, 1999; Silenzio, Pena, Duberstein, Cerel, & Knox, 2007; Suicide Prevention Resource Center, 2008; Zhao, Montoro, Igartua, & Thombs, 2010) are up to three times more likely to attempt suicide than their heterosexual counterparts.

Substance abuse is generally thought to be elevated in the LGBT community, since much of the initial coming out process may center on the "gay bar" scene (Baer, Ginzler, & Peterson, 2003; McMorris, Tyler, Whitbeck, & Hoyt, 2002).

The effect of trauma, psychological, political, and vicarious are often reported by LGBT persons as issues of concern since living within the context of a "false sense of self" or "inauthentic self" and hiding or monitoring one's behaviors, mannerisms, speech, and life can be very debilitating and lead to maladaptive responses. Politically, LGBT persons are frequently the subjects of "moral" debates by politicians—the issue of LGBT marriage is one recent politicalized issue, which causes trauma for many LGBT persons who are tired of politicians who attempt to make their lives illegal or immoral (Cooperman, 2004). The issue of coming out in and of itself—since this is a process and not a one-time event but a lifelong process—is an exhausting life event that can lead to trauma. LGBT persons who are parents and have children may experience vicarious traumatization in watching their children struggle with homoignorant comments or reactions from peers or their community (Johnston & Jenkins, 2004).

Environmental Risks/Needs: Although it is a common myth that all LGBT persons are economically advantaged, many LGBT persons experience economic poverty, inadequate housing, or threat of losing one's housing and unemployment (see www.aclu.org). The literature is replete with evidence that LGBT persons experience high levels of oppression and exploitation (Pharr, 1988) and incidence of community violence and discrimination on multiple levels (Whittle, Turner, & Al-Alami, 2007). Racism is also an issue for LGBT persons to contend with, both from inside the LGBT communities and outside it (Walters & Old Person, 2008). In bisexual (Bradford, 2004, 2006; Fox, 1995, 2004a, 2004b; Israel & Mohr, 2004; Ochs, 1996; Weber & Heffern, 2008). and trans populations, such issues may even be further exacerbated (Davis, 2009; Mallon, 2009; Bill & Pepper, 2008; White Holman & Goldberg, 2006; Whittle et al., 2007).

CLINICAL ASSESSMENT FOR FAMILIES WHERE GENDER OR SEXUAL ORIENTATION IS AN ISSUE

Although not all LGBT persons need counseling because someone in the family has identified them as lesbian, gay, bisexual, or trans, some families come to the attention of a social services agency for a variety of reasons

and services, which might not at initial assessment seem to be pertaining to issues of gender or sexual orientation.

The following actual case vignettes illustrate the relevance of these concerns.

CASE VIGNETTES

A young couple, Betsy and Clark, sought help from a family service agency. Initially they identified concerns with the behavior of their 9-year-old son Todd who was attending an after-school program. The after-school center staff reported that he was hitting other children, unable to relax during quiet time, and had frequent temper tantrums. Betsy and Clark were concerned that the center might refuse continued service, affecting their ability to maintain their employment. The social worker engaged with Betsy and Clark to assess Todd's behaviors, the tensions with the marital relationship, and both parents' satisfaction with their lives. Clark was struggling with a worsening depression that he attributed to a growing remoteness between himself and Betsy, a detachment he couldn't explain. Several times Betsy mentioned being unable to be herself in the relationship and alluded to a secret that she couldn't share. Through a skillful series of individual and joint discussions, the social worker was able to help Betsy acknowledge the reality of her lesbian gender or sexual orientation and share this with Clark. With the secret out, the social worker, Betsy, and Clark began to identify and work together on the many decisions that each faced individually and as parents to Todd. In reflecting upon their initial call to this particular family service agency, Betsy noted having seen a brochure in Todd's pediatrician's office describing the agency's service, including a group on parenting issues for LGBT parents. Once connected to the agency, Betsy had experienced the social worker as open in her ongoing assessment of the range of possible sources of Betsy's expressed ability to "be herself" in her relationship with Clark.

The following case vignette explores issues of gender or sexual orientation from a different family-centered perspective.

Shamir and his family: Shamir, a 15-year-old Pakistani male is sitting in his bedroom in the apartment, which he shares with his mother, father, and three younger brothers, reading a very personal letter that a boy in school wrote to him. He has already read this letter several times, but like many adolescents venturing into the world of relationships, he is re-reading it because it is a special letter to him. When his mother yells at him from the kitchen that he has a phone call, he puts the letter down on his bed and leaves his room to get the phone. During the time that he is on the phone his 9-year-old brother enters his room and begins

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> to read the letter that Shamir has left on the bed. The younger sibling, realizing that its contents are questionable, shows the letter to his mother.
>
> When Shamir returns from his phone call, finding his letter missing, he begins to panic. Shamir knows that it will be obvious to anyone who reads the letter that he is gay. Up to this point, Shamir has been successful at keeping his identity a secret. But now his secret is out in the open. He is angry that he didn't have an opportunity to come out on his own terms. He has been found out—and there is a big difference! When he sees his mother's face, he knows that she has read the letter, but she says nothing to him. When he approaches her, she backs away and says, "We'll talk about this when your father gets home and when all of your brothers are asleep."
>
> The next few hours are filled with dread and isolation for Shamir. What's going to happen? What is his father going to do? He's not prepared for this, and terrified of the repercussions. What Shamir doesn't know is that his mother and father feel the same way. This is not the way things are supposed to be and they are not prepared for this. No one ever told them about the prospect of having a son who was gay. Should they send him for therapy? Should they send him away to protect the other boys? Should they even tell anybody about this?

For the social worker experienced in working with family systems, the situation in the above vignette presents the ideal opportunity for an intervention. A crisis has occurred, the family is in turmoil, and everyone is poised for something to happen. Family members are confused, frightened, shame-filled, unprepared, and angry. They can act in a reckless manner, lashing out at the individual who has disclosed or they might fall into a conspiracy of silence and become completely paralyzed and numbed by the circumstances. Professionals who have spent years with families, or even those who have recently entered the field, know that what happens next is not always predictable. When the situation involves an issue of gender or sexual orientation in the family, one can almost guarantee that there will be a great deal of ambivalence in this process. Coming out in the context of a family system can yield unpredictable outcomes.

THE COMING OUT PROCESS WITHIN A FAMILY

Coming out, a distinctively LGBT phenomenon (see Coleman, 1981, 1987; Cass, 1979, 1983/1984, 1984; Troiden 1979, 1988, 1989), is defined as a developmental process through which LGBT people recognize their gender or sexual orientation and integrate this knowledge into their personal and social lives (De Monteflores & Schultz 1979, p. 59). Although several theorists have written about coming out from a uniquely adolescent experience (Hetrick & Martin, 1987; Mallon, 1998b; Malyon, 1981), developmentally, the coming out process can eventuate at any stage of an individual's

life (Johnston & Jenkins, 2004). Therefore, it is important to consider the consequences of a person coming out in the context of his or her family, as a child, as an adolescent, as an unmarried young adult, as a married adult, as a parent, or as a grandparent.

The events that mark coming out and the pace of this process vary from person to person. Consequently, some people move through the process smoothly, accepting their sexuality, making social contacts, and finding a good fit within their environments. Others are unnerved by their sexuality, vacillating in their conviction, hiding in their uneasiness, and struggling to find the right fit.

Although the experience of an adolescent coming out is qualitatively different from that of a parent or an adult who comes out, there are several conditions, broadly conceived, which all family members share. Earlier literature (Silverstein, 1977) focused primarily on the negative consequences of disclosure, and indeed there can be many, but a range of responses to a family member's disclosure is perhaps a more appropriate characterization (Ryan et al., 2009). The following description by Rothberg and Weinstein (1996, 81), I believe captures many of the salient aspects of this experience:

> When a family member comes out there are a multitude of responses. At one end of the spectrum is acceptance, . . . but rarely, if ever, is this announcement celebrated. Take for example, the announcement a heterosexual person makes to his or her family of origin of an engagement to marry. This is usually met with a joyous response, a ritual party, and many gifts. The LGBT man does not receive this response. Instead, the coming out announcement is often met with negative responses which can range from mild disapproval to complete non-acceptance and disassociation. These responses, though usually accepted, cause considerable stress and pain for the LGBT person seeking approval.

Religious Factors

Some families, particularly families with strong religious convictions, may openly condemn an LGBT identity, unaware that one of their own family members is LGBT (Helminiak, 1997; Herman, 1997; Henrickson, 2007).

Blumenfeld and Raymond (1988) note that families with strong religious convictions often support their views of their religion even against a family member. Personal biases, particularly cultural or religious biases that view a LGBT identity negatively, can make "coming out" to one's family a painful experience. This distress is manifest by this young person's narrative:

> Everybody in the family knew that I was trans. The only person who could deal with me being trans was my mother. Everyone else that I thought was going to have a hard time didn't. My mother is a devout Jehovah Witness and she has a very hard time with my being transgender. She has said that she hated me and to this very day she

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> tells me that it is against God's will and it's against His proposition and when the day comes for Him to take over the world again I'm going to suffer. She always says that she doesn't want me to suffer because I am her son, but she doesn't realize that she is making me suffer because of the ways that she acts toward me.

Social workers must be aware of the strong anti-LGBT sentiment held by many religious groups and the impact that this has on family members for whom gender or sexual orientation is an issue. The Bible has historically been erroneously used as a weapon against LGBT persons causing a great deal of distress in many families of faith. Several excellent resources (Cooper, 1994; Henrickson, 2007; Metropolitan Community Church, 1990; Parents & Friends of Lesbians and Gays, 1997) exist, which provide practitioners with an alternative LGBT affirming perspective.

Cultural Factors

Race and cultural ethnicity can also play important roles in the disclosure process. Persons of color, many of whom have experienced significant stress related to oppression and racism based on skin color or ethnicity, may experience even greater difficulty coming out within the family context as some may view a LGBT gender or sexual orientation as one more oppressed status to add to one's plate (Battle, Cohen, Warren, Fergerson, & Audam, 2002; Bridges, 2007; Greene, 1994; Grov & Bimbi, 2006; Savin-Williams & Rodriguez, 1993; Walters & Old Person, 2008).

People of color who are LGBT confront a tricultural experience. They experience membership in their ethnic or racial community and in the larger society (Battle et al., 2002; Bridges, 2007; Grov & Bimbi, 2006; Walters & Old Person, 2008). In addition, they are not born into the LGBT community. Many become aware of their difference in adolescence and not only must deal with the stigma within their own cultural/racial community but must also find a supportive lesbian/gay community to which they can relate. The lesbian/gay community is often a microcosm of the larger society, and many may confront racism there, as in the larger society. To sustain oneself in three distinct communities requires an enormous effort and can also produce stress for the adolescent (Chan, 1989; Hunter & Schaecher, 1995; Kelleher, 2009; Morales, 1989). The reality is that LGBT persons are part of every race, culture, ethnic grouping, class, and probably family.

Emotional Factors

If the individual identified as LGBT chooses to come out voluntarily, then they have time to prepare for the event. Some individuals may have role played their coming out process with a supportive friend or therapist, while others may have written a letter or planned the event after experiencing positive disclosure events with several other trusted confidants. The truth, however is that in most cases, even if the individual has had time to prepare for this event, the actual moment of disclosure catches most families off guard.

Families have frequently not had this period of time to prepare and are often shocked by the disclosure.

Jean Baker (1998), psychologist and mother of two gay sons, expresses these feelings perfectly when she writes:

> I still recall the night so vividly. Gary was helping me with dinner, which he occasionally did. He had just gotten a new haircut and immediately I hated it. I still don't know why, because it had never occurred to me that Gary might be gay, but for some reason I said to him, "With that haircut people will think you're gay." He hesitated for a moment and then, looking directly at me he said, "I think maybe I am."
>
> I stared at my son, totally speechless, stunned, momentarily unable to react. Then I started crying and found myself talking incoherently about the tragedy of being gay. . . . I rambled on senselessly about homosexuality as an adolescent phase, something people can grow out of, something that may be just a rebellion. . . . Knowing what I know about homosexuality and having examined my own feelings and attitudes, I think my reactions that night were deplorable. My son deserved to hear immediately that I respected him for his honesty and his courage. What he heard instead was that his mother thought being homosexual was a tragedy.
>
> As I think about my reactions that first night and during subsequent days and nights, I am still ashamed of what I learned about myself as a mother dealing with a son's homosexuality. Instead of thinking first about how I could help my son cope with what he might have to face in a society so condemning of homosexuals, I focused on how I felt. Though I didn't want to admit it, I was concerned about the prejudice and stigma I myself might have to face.
>
> Baker 1998, 41–43

Feelings surrounding the initial disclosure can range from shame, to guilt, to embarrassment, or even complete disassociation.

Acceptance is also a possible reaction, but one that is seldom experienced by most LGBT persons.

Managing Disclosure to Others

Deciding how to manage the disclosure of a LGBT gender or sexual orientation to the family is an important consideration at this point. The family that reacts extremely negatively to the disclosure, that is, a child who is thrown out of the home by parents or a spouse who is told to leave their home by their partner, may require outside intervention to assist them in dealing with the disclosure, which should be viewed as a crisis situation (Duffy, 2006). Who to tell and who not to tell, and how to address the disclosure within the context of the family, are other issues that families must eventually discuss.

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Getting through the initial crisis of disclosure however should be the primary focus of the intervention (McDougall, 2007).

Being "found out," as illustrated in Shamir's case presented earlier in this chapter, precipitates a somewhat different type of crisis, which may also require immediate intervention. In the sections that follow, we will explore the possibilities of a child's or adolescent's coming out in their family system.

When a Child Comes Out Within the Family System

Although disclosure can occur at any point in the developmental process, for the purposes of this section, I will specifically address the issues as they pertain to a child or adolescent who comes out or is found out by their family.

Although one of the primary tasks of adolescents is to move away from one's family toward independence, families are still extremely important economic and emotional systems for them. Lack of accurate information about LGBT identity and fears about individuals who identify as LGBT lead many families to panic about how to manage the disclosure of a family member.

The following two case vignettes illustrate several points with respect to the coming out process for adolescents.

CASE VIGNETTES

Yuan Is Found Out

Yuan Fong is a Chinese American 18-year-old senior in a public high school in a large West Coast city. He resides with his parents who are Chinese-born in an apartment with an older brother, aged 20, and two younger siblings aged 12 and 10. Yuan is the captain of the football team, well-liked by his peers and by teachers. He is a very handsome young man. Yuan has dated a few girls, but is so into his football career that it leaves little time for anything else. Yuan has been aware of his feelings for guys for some time and has been trying to repress these feelings. Recently, however he met a guy named Tommy whom he really likes and Yuan's feelings have become more difficult to repress. Tommy and Yuan begin to see each other, first as friends, and then their friendship blossoms into a romance.

One evening, while talking to Tommy on the phone, Mrs. Fong overhears their conversation. It seems to her that Yuan is speaking to Tommy like she would expect him to speak to a girl that he was dating. When Yuan hangs up the phone his mother confronts him about what she heard. Yuan blows it off and laughs, blaming her interpretation on her imperfect English, but he knows that this is not the case. He is in a state of panic because he knows that his mother will not let this go.

Mrs. Fong becomes hypervigilant about Yuan and begins to search his room while he is at school for clues. She finds letters that Tommy has written to Yuan and then when she finds a small card from a LGBT youth group she takes it as confirmation that

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her son Yuan is gay. Mrs. Fong shares this information with her husband who chastises her for snooping in their son's room. But they are both upset and unprepared for how they should deal with this new information which changes their notion of their family.

When Yuan arrives home from football practice, both Mr. and Mrs. Fong ask to speak with him. They tell him what they have found and ask him if he is gay. Yuan, fearful and caught off guard, is unsure of how to respond, but it seems like there is no way out. Even though he is pretty sure that he is gay, Yuan tells them, "I think I am bisexual," rationalizing that being half-gay is easier than being totally gay. Mr. and Mrs. Fong ask if he has ever been sexually abused by someone, or he is just going through a phase, and insist that he is going to see their family doctor. Although they do not say it out loud, Mr. and Mrs. Fong are also concerned about how this will affect their two younger children. Yuan has on occasion babysat when they went out, and they wonder if Yuan might molest the younger children. This family is obviously in a crisis state.

Robin Comes Out

Robin is a 17-year-old Caucasian who lives with her mother, father, and two younger sisters on a small family-run farm in the Midwest. Robin is an average student, in the eleventh grade in a public high school. Robin has a very close friend named Patsy who is a year older and attends the same school. After an initial period of confusion, Robin and Patsy realize that they have strong feelings for one another and that their feelings for each other are "more than just a phase." Although neither of them identifies as lesbian at first, in time they come to label their identity as gay, and then later are comfortable calling themselves lesbian.

Robin has always been close to her family and has always been helpful around the farm. Not wanting to lie to her parents, Robin decides that she should tell her parents how she feels about Patsy. She plans the event, making sure that it is an evening when her sisters are already in bed and asks her parents to sit with her in her bedroom. She starts by telling her family that what she needs to tell them is not an easy thing to tell, but that she loves them and wants them to know her for who she really is. They seem puzzled thinking that they already know their daughter quite well. She explains that since she was little, about six or seven, she has always liked other girls, not boys. She tells them that at first she thought the feelings would go away, but they didn't. At this point, her mother and father are completely aghast about what she is trying to tell them. Robin makes it clear and says, "Mom, Dad, I still like girls and I have come to understand lately that I am a lesbian."

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Robin's parents are without words. They are completely unprepared for having a lesbian daughter. They suggest therapy, ask if she is sure, and suggest that it still might be a phase, and also ask if it is her way of rebelling against them. She answers no to all of their queries. Robin's parents are in shock, confused, embarrassed, and unsure of what to do. Robin's disclosure has embroiled this family into an imbroglio, which all are unprepared to deal with.

Like many families, these families had little accurate information about LGBT persons and as a consequence relied mostly on myths as their primary source of information. At first both families believed that their family member's "differentness" might be an adolescent phase. Both families suggested that their young person should attempt to change their gender or sexual orientation via therapy. Additionally, although it was almost too frightening to mention, the families expressed fears about the possible molestation of younger siblings by their LGBT child. These families, like most families who have had to deal with an unexpected disclosure, are clearly in a state of shock. Consequently, they are unprepared as their teens are growing up LGBT in a heterosexual world. Most parents never allow themselves to think that they might have a child who is LGBT. Parents are also aware of the shame and secrecy surrounding homosexuality and as such are unsure of what their child's disclosure will mean for them and for the other family members.

In some cases, though not in Yuan's or Robin's case, the disclosure of a LGBT identity can lead to an array of abusive responses from family members. In other instances, a LGBT disclosure can lead to a youth's expulsion from his home, leading to out-of-home placement. In many families the crisis of disclosure is resolved after the initial reaction of shock and the family moves forward (Savin-Williams, 2001). When a parent comes out in a family context, however, the issues are quite different.

When a Parent Comes Out Within the Family System

When a parent or a spouse comes out or is found out by family members there are unique and distinctive repercussions. As observed in the above case vignettes, lack of accurate information about LGBT identity and fears about individuals who identify as LGBT lead many families to panic about how to manage the disclosure of a family member. The issues of shame and stigma serve to further complicate these issues. The following two case vignettes illustrate several points with respect to the coming out process for family members. A dad discloses his gay identity to his son in the first case vignette, and a husband is unexpectedly "found out" by his wife in the second scenario.

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CASE VIGNETTES

A Gay Dad's Disclosure

Wade, an African American, fifth grade child, attending Catholic elementary school, resides in a large urban environment in a

mid-income housing apartment with his Dad, Brandon, aged 35, and Joe his "uncle." Wade was ten when his Dad decided to tell him that Uncle Joe, who had lived with the family for eight of Wade's ten years, was really his life partner.

Brandon decided to disclose his gay orientation to Wade because he felt that he was getting older and he wanted him to know the truth about his dad. He didn't want anyone to make fun of Wade or for him to find out that he was gay before he had the opportunity to tell him. Brandon planned the disclosure and sat with Wade privately in their kitchen to tell him. Joe, although not initially involved in the disclosure, joined them after Brandon had told Wade.

At first Wade was shocked and denied that his dad or Uncle Joe with whom he had an excellent relationship were gay. Wade said he didn't want to talk about it. Although he didn't say it at the time, he was embarrassed that his friends and teachers in school would find out about his dad and that he would be treated differently. After the initial disclosure Wade began to distance himself from his Dad and Uncle Joe. When Brandon checked in to see how things were going with him, Wade simply replied that things were "fine."

But things were not fine. Wade began to have problems in school (prior to the disclosure Wade was an A student) and on two occasions, Wade's dad received notices from school notifying him that Wade had gotten into trouble in the classroom.

Noting this marked change in behavior, the social worker at the school phoned Wade's dad and asked him to come into school for a conference.

Marcellino and Marta

Marcellino, a 35-year-old Latino, has been married to Marta, a 31-year-old Latina, for eight years. They have two children, Pedro, aged 6 and Isabel aged 4. They live in a small house in a suburb of a large southern city, which is comprised primarily of working-class Latinos like themselves. Although they have been married for eight years, Marcellino has always known since he was a teenager that he is "different." When he married, he thought that his feelings for men would change, but they did not. He never discussed these feelings with Marta, but some part of him always thought that she knew. Although Marcellino never engaged in dating relationships with men, he frequented gay bars and sometimes a local bathhouse in the urban area near his home.

One evening, while Marcellino was exiting a well-known gay bar in the city near where they lived, he ran into Marta's sister, Sonia. Sonia immediately confronted him about being in the gay bar and he denied being gay, saying that he just met a friend from work who was gay. His sense of panic however was evident. Sonia went to her sister's home, asked to speak with her privately, and told her about seeing Marcellino coming out of the gay bar.

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> Marta was devastated by this information and asked Sonia if she could watch her children so that she could talk to Marcellino privately.
>
> When Marcellino arrived home, Marta met him at the door and asked for an explanation. Marcellino initially denied that he had been in the bar, but after a few minutes acknowledged that he had indeed been there and further noted that it was not his first time. Marta told Marcellino that he had to leave their home immediately. She screamed that he had exposed her and her children to all kinds of things and that he had lied to all of them. Marcellino did not know where to turn. His family lived in Peru and he did not have a close family support system except for Marta and his children. Marcellino pleaded with Marta to go with him to see someone—a marriage or family therapist. Marta refused and told him to leave their home immediately.
>
> Marcellino was confused, now estranged from his partner and his children, and feeling completely dejected. Marcellino went to the home of a co-worker to ask if he could stay overnight. In the morning he went to visit his parish priest to ask for counseling. The priest referred him to a family center in the community. Marta was devastated, ashamed, and talked to no one about her separation from Marcellino, except her sister.

Although the issues of disclosure for a parent coming out to their child are far different than for a spouse who finds out that her partner is LGBT, both case examples reflect the level of denial, shock, and confusion that some family members experience in this process. In the first case, Brandon has clearly thought out his disclosure and it seems that he will work with his son to process this new information. In the second case, Marta and Marcellino have definitely not planned the disclosure and the consequences of his being found out seem to be, at this juncture, quite weighty for him and his family. Most families bring themselves out of a crisis without professional help, others will need support during the disclosure of a LGBT identity of a family member so that the family may remain intact and its members may grow through the experience (Fraser, Pecora, & Haapala 1991; Kaplan, 1986; Tracy, Haapala, Kinney, & Pecora 1991). Others will need assistance. The benefits of a family support and family counseling have particular relevance in each of these four cases (Ryan et al., 2009).

Treatment Considerations With Families Where Gender or Sexual Orientation Is the Issue

Family-centered services often call for crisis intervention services at least in the initial phases of the disclosure process. Families experiencing high stress, such as the disclosure of a LGBT gender or sexual orientation, may find that their regular coping mechanisms have broken down, leaving them open to change in either a positive or negative direction. The family member's increased vulnerability under these conditions can serve as a catalyst

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to seeking help to resolve their immediate issues (Tracy, 1991; Weissbourd & Kagan, 1989). If professionals trained in family preservation techniques can be available and gently encouraging, the pressure families feel can motivate them to change and to share their concerns. The immediate goal of this intervention is clearly to move the family out of crisis and to restore the family to at least the level of functioning that existed before the crisis (Kinney, Haapala, & Booth, 1991, 16). Many family preservation professionals go well beyond that goal, increasing families' skill levels and resources so that they function better after the crisis than they had before.

Utilizing a family-centered approach (Brown & Weil, 1992; Hartman & Laird, 1983) for working with families, the following section suggests some intervention guidelines for practitioners.

INTERVENTION

Addressing issues of gender or sexual orientation disclosure requires professionals to first explore their own personal, cultural, and religious biases about persons who are LGBT-oriented. Although many professionals might believe that they are nonbiased in their approach to LGBT persons, all professionals must first examine their own bias and be comfortable dealing with issues, which are seen by most in Western society as "sensitive." Although most professionals receive little, if any, formal training on dealing with issues of gender or sexual orientation in child welfare, there are several recent books (Mallon, 2009, 2010), which can be helpful for professional development.

Initial Preparations

Keeping people safe is one of the primary goals of this intervention. Workers should be aware that issues of gender or sexual orientation can frequently lead to violence within the family system. Being able to predict the potential for violence is an essential skill for workers to possess.

Preparing for the initial meeting by gathering information: for example, talking to the referring worker (if the case has been referred) or by gathering information directly from the family members by calling them to schedule an interview, can assist in forming a positive relationship that might make things easier when the worker arrives at the home. In some situations, as in Marcellino and Marta's case, it might be a good idea to schedule the initial meeting outside the family's home in a public, structured environment such as a restaurant or a community center. When situations are potentially volatile, meeting in a public place can make it easier for family members to retain control.

The Initial Meeting

Whenever possible, the initial meeting should take place in the home of the family. In three of the four cases presented above, this would be advisable. Meeting clients on their own turf, in their home, is an integral part of the philosophy of family preservation. Professionals should be conscious of being

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considerate and careful with all family members. In cases when a disclosure of gender or sexual orientation is involved, family members might view the person who has come out or been found out as the only person who needs to be spoken with.

In some cases family members should be met with one at a time. This is particularly true for the family members who are most upset, pessimistic, or uncooperative. In most cases, they should also be talked with first. This individual needs to feel important and understood. Deescalating this family member and gaining his or her confidence can be helpful in supporting the process and encouraging other family members to participate. Engaging in active listening techniques—using "I" statements (Kinney et al., 1991, Chapter 4); permitting the professional to share their own feelings about the situation; notifying family members of the consequences of their actions; calling for a time out; seeking the assistance of a supervisor, if necessary; reconvening at a neutral location or actually leaving the home if the situation escalates to a point where police intervention is necessary—are all options that professionals may need to consider and act upon during their initial visit.

Subsequent Contacts

The first session is usually the most fragile one. The family who has had a member disclose their gender or sexual orientation is, as noted, in a crisis mode. Family members in crisis feel vulnerable and anxious. Some may be angry, and others mistrustful. Many families feel secretive about disclosing family business to a stranger especially when it pertains to a sensitive issue like one's gender or sexual orientation. The goal in the first session is usually to calm everyone down. Establishing trust and forming a partnership between family members and the professional are the next steps.

Assessing Strengths and Problems and Formulating Goals

In subsequent sessions, the professional will need to assist the family in organizing information about their crisis. Workers should work with family members to minimize blame and labeling and instead focus on generating options for change. This may be facilitated by working with the family to reach consensus about the fact that their family member is in one way not as they thought he or she was, but at the same time, still the same person that they have always been. Assisting family members with shaping less negative interpretations about a LGBT identity is an important place to begin. Helping families to define problems in terms of their own skill deficits by settings goals, taking small steps, prioritizing issues of concern for the family, and being realistic with family members can lead families back toward homeostasis. In the context of an emerging managed care environment, and as a means toward addressing issues of accountability, utilizing standardized outcome measures to test the veracity of clinical interventions with clients has increasingly become a significant aspect of practice (Bloom, Fischer, & Orme 1995; Blythe, Tripodi, & Briar 1994).

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Helping Families Learn

One of the most dominant elements that is apparent in each of the earlier case vignettes is the lack of accurate and relevant information about LGBT individuals. The myths and misconceptions that guide families are graphically present in their initial concerns about molestation, about the need for therapy, and about the possibility of changing one's gender or sexual orientation. Changing family's notions about LGBT family members is not always a smooth or easy process. A great deal of the worry that families have about LGBT persons is based on irrational fear and shame. The disclosure of a LGBT gender or sexual orientation within a family context spreads the societal stigmatization of homosexuality to all family members. Goffman called this phenomenon "courtesy stigma" (Goffman, 1963).

Although they caution about developing realistic expectations for all families, Kinney et al. (1991, 95) posit that there are several ways to facilitate learning with clients: (1) direct instruction; (2) modeling; and (3) learning from one another. These strategies can be useful in helping families affected by issues of gender or sexual orientation as highlighted below.

Direct Instruction

The social work professional who engages a family with issues of gender or sexual orientation must be prepared to present and provide a great deal of direct instruction with family members. Providing families with accurate and relevant information about their child or their family member's orientation is an essential part of this process. Bibliotherapy, that is, providing families with reading material, is an integral component of this strategy. Although finding this information is not the problem that it once was as there is a plethora of information available, workers may have to access this information by visiting a local LGBT bookstore or via the Internet as they are frequently not carried in mainstream bookstores. Increasing the family's knowledge about gender or sexual orientation (Baker, 1998; Dew, 1994; Fairchild & Haywood, 1989; Griffin, Wirth, & Wirth, 1986; Strommen, 1989; Switzer, 1996; Tuerk, 1995) and knowing about resources that support families, like Parents and Friends of Lesbians and Gays (Parents and Friends of Lesbians and Gays 1990, 1997; www.pflag.org; www.glpci.org) are important ways to strengthen and support the families of LGBT persons. Furnishing young people with literature, especially work written by LGBT young people for LGBT young people, is one of the most beneficial techniques that can be employed (see Alyson, 1991; Heron, 1994; Kay, Estepa, & Desetta, 1996; Miranda, 1996; Monette, 1992; Reid, 1973; Savin-Williams, 1998; Valenzuela, 1996; Wadley, 1996a, 1996b). Videos and guest speakers can and should also be utilized in this process. Such information is useful in assisting the LGBT-oriented youngster in abolishing myths and stereotypes and correcting misconceptions about their identity. This information can also help educate nongay teens about their LGBT peers (Greene, 1996; Mallon, 2010).

The Internet and The World Wide Web have liberated LGBT persons from their extreme isolation, supplying them limitless opportunities to communicate

with other gays and lesbians in chat-rooms and bulletin boards. Most LGBT adolescents have little access to information about their emerging identity and few adult role models from whom to learn. However, in recent years the Internet has grown exponentially and its growth has permitted access to thousands of LGBT persons who might not be able to go to openly visit libraries or bookstores, or who might live in geographically isolated areas.

Although there is a very limited body of literature, which focuses on the impact of disclosure on the nongay spouses of LGBT persons (Buxton, 1994; Gochros 1989, 1992), there is an excellent web site, known as the Straight Spouses Network located at www. ssnetwk.org, that offers valuable support to the partners of LGBT spouses. Ali (1996), MacPike (1989), and Saffron (1996) have all addressed issues of parental disclosure to their children. An excellent web site which addresses the concerns of the children of LGBT parents (Children of LGBT Parents Everywhere [COLAGE]) is located at www. colage.org

Published sources can be purchased at LGBT bookstores in metropolitan areas; these sources and many others not mentioned here can also be ordered via the Internet through Amazon and Barnes & Nobles web sites.

Modeling

Modeling the behaviors ourselves to show clients how to do them is a very useful strategy for working with families who are dealing with issues of gender or sexual orientation. The LGBT adolescent who comes out or the family who is affected by a disclosure by family members might benefit from attending a support group with other individuals or family members who share their experience. Individuals and family members, anxious about attending a support group for the first time, might very much benefit from a professional who agrees to accompany the client to the session. Accompanying the client to purchase books about LGBT topics at the bookstore or attending a LGBT run function with clients can be other ways for workers to model acceptance for the client. Linking clients to religious leaders in their communities and of their faith, who have an affirming stance about LGBT individuals, can also be a useful modeling experience for family members.

Learning From Others

Families can also learn from one another by connecting with other families where gender or sexual orientation is an issue. If connections with other families cannot be made in person because of geographic distance, the Internet can be a useful substitute. There are many sites that include opportunities for LGBT individuals and families affected by issues of gender or sexual orientation to communicate with one another. It is the responsibility of the professional working with the family to identify and access resources for support within the community where families live. Workers need to be aware of these resources and visit them prior to making such referrals to clients.

Social workers must also be prepared to assist families in overcoming barriers that will inevitably occur while assisting them in the learning process.

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Acknowledging, validating, and rewarding small signs that family members are considering new options and beginning to try them is also an important task for workers.

Solving Problems

Social work practitioners trained in problem resolution strategies must incorporate issues of gender or sexual orientation into such designs. Professionals must focus on listening to and helping families to clarify what is causing them the most discomfort. Intervening with clients to assist them in intrapersonal problems can occur via direct interventions, cognitive strategies, values, clarifications, and behavioral strategies, all methods suggested by Kinney et al. (1991, pp. 121–124).

Most families dealing with issues of gender or sexual orientation need help controlling and clarifying their own emotions. Assisting families to develop effective communication skills and problem-solving strategies is a major focus of a family preservation model, which can be effective with LGBT children, youth, and families.

CONCLUSION

All family-centered services, notwithstanding issues of gender or sexual orientation, from family support to family preservation, maintain the position that children and adolescents are best reared by their own families. Viewed ecologically, both assessment and intervention with families must focus primarily on the goodness of fit (Germain & Gitterman, 1996) between the LGBT individual and those other systems with which he or she is in transaction, the most central of which in this case, is the family. Many of the issues that surface when a family member discloses or is dealing with aspects of gender or sexual orientation can be best dealt with by a competent social worker trained in family systems. Such issues must be viewed as deficits within the environment, dysfunctional transactions among environmental systems, or as a lack of individual or family coping skills or strategies. Providing education and intensive training effort for family-centered practitioners (Faria, 1994; Laird, 1996) that would help them feel competent about broadly addressing issues of gender or sexual orientation could provide support for families in crisis and prevent unnecessary family disruption. Family-centered practitioners must also be prepared to serve as advocates for their clients, including a LGBT child or adolescent; a parent who identifies as LGBT; or for a couple where one of the partners identifies as other than heterosexually oriented.

Family-centered social practitioners with their primary goal of keeping families together can deliver these services within the context of the client's natural environment—their community. Programs like the Homebuilders model (Kinney et al., 1991) have opportunities to help families grappling with issues of gender or sexual orientation. Community-based family and children's services centers also provide many opportunities for addressing issues of gender or sexual orientation within the family system. These approaches also have relevance for other situations where spouses or parents

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come out as LGBT. Working with family systems in their communities makes social workers in family-centered programs ideally situated to see what is really going on in a family's natural environment. By being located in the home or in the community, the worker is able to make an accurate assessment and design an intervention that would support and preserve the family system. With a greater awareness of issues of gender or sexual orientation, family-centered practitioners can educate parents, ease the distress experienced by couples where one partner is LGBT and the other is heterosexual, and model and shape new behaviors that can transform lives for young LGBT persons.

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SIXTEEN

Spirituality and Culturally Diverse Families: The Intersection of Culture, Religion, and Spirituality

Zulema E. Suárez and Edith A. Lewis

Given the vast diversity within and between families, the existence of 22 major world religious groups, and an estimated 34,000 separate Christian groups in the world (Barrett, Kurian, & Johnson, 2001), writing about religion and spirituality in culturally diverse families is daunting. The United States is the most religiously diverse and changing nations in the world (Fuller, 2001; Lugo, Stencel, Green, Smith, Cox, & Pond, 2008). Moreover, there has been a religious resurgence worldwide (Derezotes, 2009), and many of the immigrants coming to this country have diverse religious traditions and practices (Jasso, Massey, Rosenzweig, & Smith, 2003; Lugo et al., 2008).However, the increasing complexity of our society (Pargament, 1997; Pargament, Maton, & Hess, 1992) and emerging issues like religiously inspired terrorism and globalization require that social workers have some understanding of the cultural, spiritual, and religious dimensions of people's lives (Canda & Furman, 2009; Derezotes, 2009; Hodge, 2003). While it is unrealistic to write about such vast practices, cultural and religious world-views, and religious and spiritual trends in the United States can inform and guide social work with families.

We begin by providing an overview of contemporary religious trends in the United States to show its increasing diversity and the shifts that are taking place in people's religious and spiritual identification. Following this demographic context, we examine the interrelation between ethnicity and religious identification. To better understand some recent changes in the spiritual lives of Americans in the United States, we review the distinction between religion and spirituality; once used interchangeably, these terms have different meanings in today's world. From there, we explore religious and cultural worldviews, their interrelationship, and how these influence our feelings, and behaviors. Finally, we discuss implications for practice with ethnically diverse families and communities.

Before proceeding, bear in mind an important caveat while reading this chapter: We are only providing a macro level overview of religions in the United States since we are lumping several denominations under the

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umbrella terms; yet, religions often encompass different movements that result in vast differences within and between denominations. For example, Christianity consists of four groups: Evangelical, Catholic, Mainline Protestant, and Orthodox (Lugo et al., 2008). Judaism consists of four (Orthodox, Conservative, Secular Humanist, and Reformed), and Islam consists of Sunni, Shia, and other groups.

RELIGIOUS TRENDS IN THE UNITED STATES

Although the majority of U.S. Americans identify with a specific religion, contemporary religious and spiritual trends reveal a changing and increasingly diverse and complex society (Lugo et al., 2008). According to the 2008 American Religious Identification Survey (ARIS), the majority of U.S.citizens (80%) identify with a specific religion, with the overwhelming number of these, approximately 78%, identifying as Christian. Slightly over half of Christian adults identify as Protestant with about a quarter identifying as Catholic; and, if current trends persist, the United States is on its way to becoming “a minority Protestant country” (Lugo et al., 2008). The largest growth within the Christian population, however, has not been in the mainline religious denominations, which have been declining sharply, but in the Evangelical movement, which has been climbing since 2001.

At the same time, the United States is undergoing significant changes in religious identification, and the overall number of Christians living in this country is declining—from 86% in 1990 to 76% in 2008 (Kosmin et al., 2008). While the number of adults (15%) who may identify as spiritual but do not have a religion affiliation, also known as “spiritual but not religious,” or as unaffiliated (Fuller, 2008; Lugo et al., 2008), has more than doubled since 1990, the percentage of people who belong to non-Christian religions is also rising (Kosmin et al., 2008). For example, although the percentage of people who practice Judaism has dropped to approximately 1.2%, as of 2008 from 1.8% in 1990, the number of other groups classifying themselves as non-Christians (Eastern religions, Buddhists, Muslims, and others) has increased from about 1.6% in 1990 to 3.2% in 2008. Note that this percentage excludes those in the population that identify as atheists (1.6%) and agnostics (2.4%).

Another phenomenon taking place in the United States is the increase of mixed religion marriages (Lugo et al., 2008). Almost 37% of people who are married were in mixed religion households. This percentage includes Protestants who are married to a Protestant from a different denomination, such as a Lutheran marrying a Methodist. Mormons and Hindus are more likely to be married (71% and 78%, respectively) and least likely to intermarry (83% and 90%, respectively). In this section, we saw that although the United States is an overwhelmingly Christian country, this is quickly changing due to an increase in the number of people with no religious identification and an increase in non-Christian groups. However, while traditional, or mainline, Christian churches are losing membership, the Evangelical movement is growing (Lugo et al., 2008; Hodge, 2003). Given these changes, it may not be surprising that more than a third of married people in the United States are living in mixed religion households.

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Next, we look at the relationship between race, ethnicity, and religious identification.

RACE, ETHNICITY, AND RELIGIOUS IDENTIFICATION

Although the role of race has been key in the establishment of religions and/or denominations in this country (e.g., the Puritans, the African Methodist Episcopal (AME) church, Mormons, the Amish), social scientists still often confuse the external status of race with the internal or self-ascribed status of ethnicity. We wish to make this distinction clear at the outset, as the literature on this topic must be understood within the context of the definitions of race and ethnicity used by researchers.

There is a strong interconnection between race, ethnicity, and religious affiliation (Canda & Furman, 2009). For example, there are close associations between ethnicity and religious beliefs in groups like the Amish, Mormons, Jews, American Hindus, and Buddhists. Because of the close link between culture and religion, these groups may intentionally or unconsciously maintain a boundary between themselves and outsiders. Indeed, there is still considerable segregation according to religion with Sunday morning service being consistently reported over decades as the most segregated hour in the United States, according to social scientists and many theologians (Kosmin et al., 2008).

Given the interrelationship between race and religion, it is not surprising that several traditionally embraced denominations in the United States are predominantly White, according to a recent PEW Religious Landscape Survey (Lugo et al., 2008). For example, 91% of Mainline Protestant churches are White with 2% Black, 3% Hispanic, and 1% Asian, and the rest are mixed race (3%). Similarly, 95% of Jews are White. Catholics in the United States, 65% of whom are White, are more diverse than other Christian denominations due to a 29% Latino/Hispanic membership (Lugo et al. 2008). Although proportionally, 46% of African Americans are Baptists, they are still primarily White. Further, 92% of Black Baptists attend historically Black churches and it is not unusual to find Korean Presbyterian congregations as well as Eritrean Protestant congregations in major cities in the country. Muslims, on the other hand, tend to be more racially diverse. Although still predominantly White, only 37% of Muslims are White, 24% are Black, 20% are Asian, 15% of mixed race, and 4% Latino/Hispanic) (Lugo et al., 2008).

At the same time, the relationship between ethnicity and religion is weakening among some groups; this is especially evident among Latino/Hispanic groups. Only 53% of adults classifiable as Jewish identify with Judaism as a religion. The remaining 47% indicated that they had Jewish parentage, were raised Jewish, or considered themselves Jewish. Although Hispanic/Latino groups have been predominantly Roman Catholic, 24% reported being Pentecostal, and 5% belong to a Mainline Protestant denominations, 3% are Jewish, and 11% are unaffiliated (Lugo et al., 2008).

In this section, we saw that the relationship between race, ethnicity, and religion is so strong that, despite advances made in the Civil Rights Movement, churches in the United States are still primarily segregated. This relationship, however, is beginning to weaken.

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SPIRITUALITY VERSUS RELIGION

Although before the 20th century, the terms religious and spiritual were often interchangeable, they have assumed distinct meanings in a contemporary society where modern intellectual and cultural forces have accentuated the difference between "private" and "public life" (Fuller, 2001). Moreover, the advent of scientific and biblical scholarship, and cultural relativism has challenged educated U.S. residents' blind loyalty to the traditions of established religious institutions, causing them to question existing orthodoxies (Fuller, 2001; Borg, 2004).

Since spirituality is difficult to define (Canda & Furman, 2009; Richards & Bergin, 1997), a composite of different definitions provides a working understanding of the concept. According to Canda and Furman (2009), "Spirituality refers to the fundamental aspects of what it is to be human—to search for a sense of meaning, purpose, and moral frameworks for relating with self, others, and the ultimate reality" (p. 37). Richards and Bergin (1997, p. 13) define spirituality as "those experiences, beliefs, and phenomena that pertain to the transcendent and existential aspects of life (i.e., God or a Higher Power, the purpose and meaning of life, suffering, good and evil, death, etc.)." Although spirituality may be expressed through religion or independently, today, many associate spirituality with "private" or personal belief systems and religion with the public realm of institutional membership, participation in formal rituals, and adherence to official denomination doctrine. On the other hand, in recent years, the proliferation of global meditation events for world harmony challenges the assumption that spirituality is strictly a personal affair (Williams, 2004).

Richard and Bergin (1997) view religion as a subset of spirituality, suggesting:

> Religious expressions tend to be denominational, external, cognitive, behavioral, ritualistic, and public. Spiritual experiences tend to be universal, ecumenical, internal, affective, spontaneous, and private. It is possible to be religious without being spiritual and spiritual without being religious. (p. 13)

Although religion has to do with theistic beliefs, practices, and feelings often expressed institutionally, denominationally, and personally, this is not always the case. Research shows that many people attempt to integrate elements of religion and spirituality; people who identify as religious have higher interest in church participation and commitment to orthodox beliefs (Fuller, 2001). Hence, although the terms spiritual and religious are interrelated, they are different. Indeed, research shows that whether a person gravitates toward "subjective spirituality" as opposed to "tradition-oriented religiousness" is related to different personality dispositions. (Saucier & Skrzypińska, 2006).

SPIRITUAL, BUT NOT RELIGIOUS

Although the United States is argued to be the most religious nation in the world (Fuller, 2001), an increasing number of U.S. Americans, perhaps

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the fastest growing group, consider themselves spiritual, but not religious. According to Fuller (2001), almost 40% of U.S. Americans have no connection to organized religion. But just as religions are diverse, so is this group; according to Fuller (2001), there are three types of nonreligious U.S. residents. Some are not religious at all (e.g., atheists or agnostics), reporting, instead, to being drawn to reason, science, and common sense. A second group has "an ambiguous" relationship to organized religion (Fuller, 2001, p. 3). This group consists of people who hold official membership in a church but attend sporadically and those who do not belong to a church but attend on special occasions and holidays. Finally, the third group is concerned with spiritual issues but choose not to practice within the context of organized religion. For example, a person may pray and read the Bible, living life according to their understanding of scripture, but not to belong to a religious institution. When viewed in total, this group is the fastest growing in this country (Lugo et al., 2008).

While the majority of research disaggregates religious affiliation, there may be a fourth relationship between religiosity and spirituality. For more than 50 years there have been groups of individuals who have formed institutions in which aspects of multiple faith traditions are practiced simultaneously. These "interfaith" groups have developed a body of thought linking religious and spiritual ideals. Over the last two decades they have developed formal scholarly training leading to recognized certifications, for example, as ordained Interfaith Ministers. Along with this formal training, these groups have developed and been successful in disseminating magazines and books for audiences in several countries, including the United States.

Traditional Native American religious practices might also be included in these numbers. Although they differ in terms of practices, beliefs, and practitioners, these religious practices have been instrumental in the development of other religious theories such as creation or feminist theologies.

Worldview and Values

Whether one chooses to express one's spirituality intrinsically or extrinsically, through organized religion, the cultural life of all societies is shaped and directed by worldviews—beliefs about the universe and the nature of reality that provide answers about the meaning of life and about the most daunting questions about the human condition (Wager, 1977, as cited in Richards & Bergin, 1997, p. 51). Whether or not we are aware of our worldviews, they influence our behavior, our conceptions of nature, of our place in the world, and our interpersonal relationships. Worldviews also include affective-cognitive elements that are inextricably bound and vary on a continuum from explicit to implicit (Papajohn & Spiegel, 1975). Indeed, in many societies, members do not always draw a clear line between their culture and way of life and Western researchers' concept of religion. For example, although some Koreans may be Christian, culturally, their family lives are often influenced by Confucianism (Kim, 1997). Hence, to understand families culturally and spiritually, awareness of the existence of diverse worldviews is essential. Although cultural and spiritual-religious worldviews are interrelated, anthropologists and social scientists have approached these separately (see Richards & Bergin, 1997).

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RELIGIOUS WORLDVIEWS

According to Dilthey (as cited in Richards & Bergin, 1997), although there are a variety of religious belief systems in the world, these can be subsumed into fewer than three major types in their existential and metaphysical questions. Following, we briefly summarize naturalism, idealism of freedom, and objective idealism.

Naturalism posits reality as a physical system accessible only through the five senses. The "good life" is the pursuit of happiness and power, and the idea of mechanistic determinism tends to override freedom of will. Rationalism, positivism, existentialism, Marxism, and secular humanism are provided as examples of this worldview. The United States, as a secular industrialized country that has placed its faith in science and technology, adheres to a naturalist view. However, given the overwhelming number of Christians in this country, and the influence of religious worldviews in our public debates, it becomes questionable whether we are a Christian rather than a secular society. Despite the separation of church and state in the United States, the motto "In God We Trust" is printed on all its currency. Positivism (i.e., if it cannot be seen or measured, it does not exist) may explain the reverence in our society and universities for science and empirical research that validate our physical reality. Others argue that every experience in the world cannot be accessed through the five senses and that there is an "inner life" for all matter (Zukav, 1999; Guadalupe & Lum, 2005). Each of these experiences evinces the diversity in this worldview.

The Kantian notion of idealism of freedom takes a subjective view of reality in which human beings have free will, and is grounded in a transcendental spiritual realm (Allison, 1996). The "good life" is defined as obedience to conscience or divine will and upholds moral freedom. As Mahatma Gandhi and Rev. Dr. Martin Luther King Jr. demonstrated with their practice of *satyagraha* (nonviolence), people facing injustice can either respond in kind, or exercise their moral freedom by choosing to love their enemies to bring about the change they sought (McGreal, 1995). Western, or monotheistic, world religions like Judaism, Christianity, Islam, Zoroastrianism, and Sikkism exemplify this worldview.

Finally, objective idealism avoids the dualism in idealism of freedom by proclaiming the unity and divinity of all that is and uniting determinism and indeterminism (Almeder, 1980). In this worldview, dichotomies in thinking (Black or White, we are either dead or alive) are absent. Things are not seen as opposites of each other but as part of a whole that encompasses reality. For example, in this belief system, we cannot understand White without understanding Black and how they interact with each other, nor can we know life without knowing death, as exemplified by the popular Yin and Yang symbol. Eastern religions, such as Buddhism, Hinduism, Jainism, Shintoism, Confucianism, and Taoism, are examples of this worldview.

The ability of religions and people to recognize the similarities they have with one another is only possible when the "other's" divinity can be recognized (Derezotes, 2009). Although according to Dilthey (cited in Richards & Bergin, 1997), naturalism, idealism of freedom, and objective idealism have

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traditionally rivaled each other in providing alternative answers to the major questions of life, many people combine elements of these three types to form their own unique worldview that draws upon and transcends the prevailing view of the major religions.

CULTURAL WORLDVIEWS

As spirituality is concerned with finding the meaning and purpose of life, the suffering that befalls us, and moral and interpersonal frameworks for relating to others, cultural value systems also include moral standards and mores for living, as well as motivation and patterns of interpersonal behavior (Papajohn & Spiegel, 1975; Guadalupe & Lum, 2005). Cultural anthropologists and social psychologists have synthesized the variations in existential judgments and systems of belief, such as those found in various religious orientations, philosophies, and science with other cultural patterns to give us a better understanding of unique and universal cultural patterns (Mattis et al., 2001; Chatters et al., 2008) Although the generalizations based on observations of one culture cannot be universally applied, some scholars argue that there is a fundamental universality to human problems, and societies have found similar answers for some of these existential challenges (Kluchon & Strobeck, 1961; Papajohn & Spiegel, 1975; Guadalupe & Lum, 200). Building on the work of Kluckhohn and Strodbeck (1961), Papajohn and Spiegel (1975) present a classification for understanding people's worldviews across cultures. This model of value orientations has three underlying assumptions. First, the number of existential problems to which all peoples must find solutions is finite since we all must die, and live in families and communities, no matter what our ethnic and racial background. Second, although there is variability in people's responses to these problems, there is a limited, nonrandom range of possible solutions. For example, since death is universal, we all must grieve. How that happens may be different within and between ethnic groups. This was evident when one of the authors ran an immediate loss group for Dominican women. Whereas people from rural areas included the community in their mourning rituals, the urban women in the group were more private and resented opening their homes for community members to mourn with them. Third, although there will be a dominant profile of value orientations composed of the most highly valued orientations, there will also be variant orientations that are universal. Hence, although as noted earlier, the naturalist worldview is dominant in Western countries like the United States, numerous values may also permeate our personal and public lives. Guadalupe and Lum (200) suggest that social workers must be aware of these constructions of spirituality and religiosity, both for themselves as well as those with whom they are engaged in services.

According to Papajohn and Spiegel's model, four major problems have challenged people across places and times. What is the modality of activity (activity orientation)? What is the relationship of humans to nature (human nature orientation)? What is the modality of human relationships (relational orientation)? What is the relationship of humans to nature (human nature orientation)? The responses to these questions are complex and reflect all

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the value orientations simultaneously. Hence, the authors caution the reader from literally interpreting these tendencies. For the sake of definition, however, we examine these orientations separately.

The activity orientation question refers to humans' mode of self-expression in activity and includes at least three possibilities: being, being-in-becoming, and doing. Cultures with a being orientation prefer spontaneous expression of impulses and desires. This does not mean, however, that people are not censored from acting on aggressive or negative impulses since all societies have a moral code, although these may vary. People with this orientation tend to live in the present instead of planning or anticipating the future. Being present requires attention to the overt and covert experiences of the current moment or situation. The focus of activity is not development, but the "is-ness" of the personality and the spontaneous expression of the "is-ness." For example, a person with this orientation may be late to a class if they bump into a friend they have not seen in a while along the way, since the chance encounter may override the planned event. This is not to say that the person does not value the planned activity; however, she is just being spontaneous. Some non-Western societies such as India or Latin American countries are considered to have a dominant "being" orientation. Thich Nhat Hanh's body of work on mindfulness is an example of a "being" orientation.

Although the being-in-becoming, like the being orientation, is concerned with what the human being is instead of what they can accomplish, the idea of development is paramount. Hence, within the being-in-becoming orientation, activity strives to develop a more integrated and whole personality. People who identify as "spiritual but not religious" view spirituality as a journey of spiritual growth and development (Fuller, 2002). Hence, they will read extensively and will attend workshops and retreats that will enhance their growth. While secular in its orientation and not affiliated with a religious or spiritual tradition, Byron Katies's work of "Loving What Is" contains strategies consistent with a being-in-becoming orientation.

The doing preference characterizes American society, according to Papajohn and Spiegel (1975). This orientation stresses activity that is goal-oriented and leads to measurable accomplishments. The more we do, the more we will achieve. This is important because an individual's worth in this society is determined primarily on their past and future accomplishments more so than by their virtues. Consistent with the naturalist value for measuring, degrees and stock portfolios gain significance over kindness and compassion, the abstract concepts that cannot easily be quantified. Hence, for the most part, the pursuit of money and status is revered above personal and spiritual development. This value is in contrast to Confucianism (objective idealism worldview) that holds that inner virtue and proper conduct is the path to personal and social harmony (Richards & Bergin, 1997).

The second human problem, according to this conceptual framework, addresses interpersonal relationships (Papajohn & Spiegel, 1975). This orientation also has three subdivisions: lineal, collateral, and individualistic. Although all societies pay attention to all three principles in relationships, it is a matter of emphasis. In Shintoism, as an example of a lineal and objective

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idealism worldview, "Loyalty and fulfilling one's duty to family, ancestors, and traditions are important" (Richards & Bergin, 1997, p. 70).

Collateral relationship patterns consist of a network of horizontal extended relationships consisting of large family systems that include blood and fictive kin since humans do not stand alone, but are part of a web (Papajohn & Spiegel, 1975). Therefore, children are trained to depend on the family network and to be obedient. Family loyalty is exchanged for care-taking throughout the person's life. Latin American families tend to nurture collateral relationships.

Individualism is a dominant U.S. middle-class value (Papajohn & Spiegel, 1975). From early on, children are raised to be independent and to exercise self-control. They are also trained to experience separation from the family as normal by, for example, going to day care and summer camp (Papajohn & Spiegel, 1975). Under this value orientation, adults make decisions based on their individual self-interest as opposed to considering the needs of the extended family network. This value is consistent with a naturalist world-view.

Of interest in the present economic period, however, is the extent to which this individualistic worldview can survive. With the number of economic blows facing formerly middle income families, adult children moving back to their parents' homes, and the rise of a young adult population, sociologists refer to as "emerging adulthood" (Arnett, 2004), and the numbers of health disparities leaving grandparents raising their grandchildren, rugged individualism may be waning. The number of religious organizations now engaged in providing food and shelter, the use of small and large groups to identify methods of support to the unemployed workers with families, and the incorporation of worldwide "days of prayer" or "global meditations" may represent a shift in the persistent idealism of individuality in the country.

Three preferences characterize human beings' place in time, the third existential problem. All societies deal with a past, present, and future, but they vary greatly according to which dimension they make dominant. Earlier, we said that cultures with a being orientation value spontaneity and living in the present. Since values and religious worldviews are interrelated, this time orientation is also evident in religious thought. For example, most North American Christians, according to Marcus Borg (2003), a Lutheran theologian, "see[s] the Christian life as centered in believing now for the sake of salvation later—believing in God, the Bible, and Jesus as a way to heaven" (p. xiii); "[a]n emerging paradigm with God that transforms life in the present" (p. 15). Hence, rewards come from being in relationship with God in the present, not from the afterlife (the future). As a relatively young country, the United States emphasizes a future orientation that will bring bigger and better things.

The fourth human problem is human being's relationship with nature. The three-point range in this orientation is subjugation-to-nature, harmony-with-nature, and mastery-over-nature. Eurocentric scholars with a doing orientation often misinterpret the subjugation-to-nature orientation to mean that people who adhere to this orientation are fatalistic about climate changes, illness, and death—implying passivity before the forces of nature and giving

up without a fight. Our interpretation is different. We see subjugation-to-nature orientation as knowing when to surrender to forces greater than we are when things are beyond our control. In Taoism, this is known as we-wei—principle of passive action meaning that one should not resist, confront, or defy (Richards & Bergin, 1997). Ironically, in the U.S. culture we try to outwit nature via medical technology and meteorology and we have allowed the medical community to medicalize natural changes in our bodies, such as menopause, aging, and dying. The Hospice movement is a response to this medicalization, as are strategies of healing that integrate holistic methods with Western medicine.

The harmony-with-nature orientation does not separate humans from nature as they both are seen as being part of the same whole (objective idealism). This orientation is more characteristic of Eastern, many African, South or Central American countries, and of Native American people who see humans as being one with the natural environment. For example, Native American shamans see the earth as a living organism, a belief common among many tribes, and encourage their clients' connections to natural forces (Krippner & Welch, 1992). The Asian religion, Shintoism, views spirituality "as feelings of appreciation and closeness to nature and enjoyment of life" (Richards & Bergin, 1997, p. 70). To Native Americans and women who practice women's spirituality, the Earth Mother is sacred and should not be exploited or pillaged (Spretnak, 1982; Starhawk, 1990). Jains follow the principle of *ahimsa* (non-violence) and apply this to all humans, animals, and plants. This knowledge may help us to better understand why Julia Butterfly Hill lived in a giant redwood tree named Luna for two years to protect it from the ax and to raise consciousness about saving these magnificent trees (Fitzgerald, 2002).

Mastery-over-nature, a third way of conceptualizing this relationship, is consistent with a naturalist worldview. According to this view, human beings can overcome and exploit natural forces, confident that the resources used can be replenished, or that alternatives for them can be discovered and utilized. This orientation is dominant in industrialized countries like the United States and is evinced by our destruction and exploitation of the natural environment for material and scientific gains. Since as a country, we do not share a harmony-with-nature view, we will cut down forests to build housing developments and shopping malls, and ignore climate changes due to pollutants, as well as defiling grounds that are sacred to people who have a harmony-with-nature orientation.

The fifth common human problem deals with innate human nature. Are human beings evil (neutral or a mixture of both)? Whether these are changeable or unchangeable increases this threshold classification to six possibilities. Human beings can be considered evil and unalterable or evil but redeemable. According to Richards and Bergin (1997), many Christians see humans as being evil because of the fall of Adam and Eve, but as alterable through God's grace. Hindus see humans as being divine, while Shintoism sees them as inherently good and unalterable. This may explain why Hindusim does not provide a binding moral code for its followers. Other societies see humans as being good and corruptible since they have free will (some Christians, some Muslims, Sikhs, and followers of Zoroastrianism, to name a few). Others

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view humans as an unalterable mixture of good and evil. Since religions, for the most part, provide a way out of our state of suffering and imperfection, this may be a secular value. Finally, some hold that humans are a mixture of both good and evil but this is subject to influence. In other words, we are a mixture of light (good) and darkness (innocent misunderstanding, or evil). According to Pema Chödrön (see Chödrön, 2010), a Western Buddhist monk, the Buddha taught that:

> There is a kind of innocent misunderstanding that we all share, something that can be turned around, corrected, and seen through, as if we were in a dark room and someone showed us where the light switch was. It isn't sin that we are in a dark room. (1991, p. 13)

In the preceding section, we examine the importance of religious and cultural worldviews in human behavior. Although people do not generally distinguish between their way of life and their worldviews, awareness and knowledge of these can help us understand the feelings and behaviors of people who are different from us.

SUMMARY AND IMPLICATIONS

In this chapter, we highlight some of the issues to consider when working with families when acknowledging the role of spiritual or religious traditions in their lives. Using Papajohn and Spiegel's (1975) conceptual framework and the ARIS survey (2001), we have identified the following "lessons" of importance for this work.

There are as many intrareligious differences as there are interreligious differences. Given the large number of Christian denominations, Jewish, and Muslim, not to mention other less well-known traditions in the United States, we cannot make assumptions about the religious beliefs or practices of clients. Instead we must think of combinations and permutation of religiosity and spirituality (Canda & Furman, 2009). For example, among Christians, Lutherans may belong to the Missouri Synod, Wisconsin Synod, or Evangelical Lutheran Church in American (ELCA). The differences between these groups are so great that the Wisconsin and Missouri Synods do not welcome ELCA Lutherans to the communion table, while the Synod and the Eipiscopal Church of the United States have formed an alliance to recognize and share the sacraments with one another. Therefore, we need to learn from the clients about their Christian affiliation and/or any other traditions; we must be especially careful not to impose our understanding of the requirements of that traditions on our clients, even with those who are nominally in the same religion as we are. One way to accomplish this is to directly engage others at the time of intake or initial discussions with an exploration of their belief systems and how these influence their lives and decision-making processes.

The diversity between and within religious groups in the United States has grown to the extent that despite, admonitions to the contrary being sent through Internet sources with increasing frequency in recent years, it is no

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longer enough to view the country as a Christian nation. At the same time, the United States is still numerically Christian from primarily Protestant and Catholic denominations. The number of non-Christians is, however, rapidly increasing. Given current anti-Muslim sentiment, and that most Evangelicals are disproportionately drawn from minority groups, like women and the poor, and others who have been denied power, we must attend to issues of religious freedom and social justice (Canda & Furman, 2009; Hodge, 2003).

We need to be clear about the ways in which these traditions are being ignored in our public social lives, and how as social workers we may be contributing to the oppression of these groups. Of utmost importance is to understand the ways in which our own subjective and objective orientations about spirituality and religiosity influence our lives.

We must also bring forth into the public limelight the needs of these religious minorities, highlighting the strengths of their different traditions. For example, in many parts of the country it is not uncommon to see Muslim workers bring their prayer mats to the workplace, find a quiet place in the building, and do their daily prayers. Even two decades ago, that would have been unheard of. In cities like Detroit, Michigan, the presence of large numbers of Muslims have influenced change so that their religious needs are being recognized and positively addressed. It is now not uncommon to find spaces devoted to spiritual or religious practice within larger corporations or hospitals. The Peace Alliance Foundation (formerly the World Renaissance Alliance), an umbrella organization made up of several spiritual traditions, has organized prayer circles throughout the country for citizens to gather with their neighbors and to identify ways to individually and collectively work toward peace nationally and in the world. The alliance, built around a 12-step model, is another current example of the way religious and spiritual traditions are beginning to blend for the purposes of social justice.

Because the number of people without a religious identification is also markedly rising, we need to bear in mind that just because a client does not indicate a religious preference on an intake form, it does not mean the individual is not spiritual, perhaps having an orientation like the "spiritual but not religious," or adhering to at least one major religious category such as Christian, combined with other traditions such as Buddhism or Jainism (Canda & Furman, 2009). Since multiple orientations would not be represented in a standard agency intake form, social workers should ask the people they work with about their spiritual tradition or choice to refrain from engagement with spiritual or religious practices.

Because people differ in their ways of understanding themselves and others, partly because of their socialized ways of viewing human behavior, it is useful to stop and determine the differences and similarities between the client and the worker when attempting to address religion and spirituality in practice. Using the Papajohn and Spiegel (1975) and the Dilthey typologies, the social worker can generate useful dialogue, leading participants to using mutually understandable terminology in their communication. In cases where this knowledge may be essential, such as counseling services provided by a particular religious or spiritual body, making a grid of these typologies and asking consumers to use checkmarks to identify

their worldviews about these positions may be helpful. Social workers can also use these grids to communicate clearly with those seeking service about the services their agencies can or cannot provide.

Finally, given the rise in mixed religion marriages, families and couples can benefit from acknowledging the differences in their spiritual and religious traditions so that conflicts can be managed effectively. McGoldrick, Giordano, and Garcia-Preto (2005), in their work across ethnic backgrounds, identify the conflicts that may arise for mixed ethnicity families over when to celebrate a holiday, childrearing practices, and how to mourn their dead. By helping mixed religion (and sometimes mixed ethnicity) couples harmoniously acknowledge and determine methods to live out their different traditions, social workers can help them gain insight about these conflicts without judgment. From that exploration, new ways of integrating both sides of a couple's tradition can be established and shared with other members of the extended family.

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SEVENTEEN

Legal Issues in Practice With Immigrants and Refugees: Clinical Social Service Practice With Vulnerable Newcomer Communities—Women, Youth, and Refugees

Fernando Chang-Muy

Given the evolving demographics with the movement of people across borders, nonprofit organizations and their social service staff must adapt and ensure that programs and services respond to meet the needs of clients. As a best practice, effective organizations from boards of directors, to management, to line staff should continuously evaluate their programs, human resources, and operations, to ensure that they integrate newcomer strengths and challenges and are meeting the needs of the populations they serve.

In order to be effective, providers should have a working knowledge of immigration issues that their clients face regardless of the providers' areas of expertise, be it health, mental health, employment, education, or housing, and regardless of populations served—women, youth, elderly, and homeless. Providers' lack of knowledge of clients' legal immigration challenges may result as a barrier to care, adding to mental and physical health stressors in the client, and impeding resolution of other core issues, which the social service provider is trying to resolve.

This chapter hopes to raise service providers' knowledge by providing a framework of immigration policies, with a focus on three particular newcomer populations—women, youth, and refugees. Understanding newcomer clients' strengths as well as challenges, including legal immigration challenges, will allow providers to develop in partnership with the client, a comprehensive action plan to move forward. To do so, this chapter first provides a brief overview of key legal classifications in U.S. immigration such as undocumented, immigrant, and citizen. Then the chapter focuses on women, youth, and refugees and their particular legal challenges as newcomers. As refugees are a particularly vulnerable group, the chapter details the process for applying for refugee status and how service providers can support asylum seekers. The chapter concludes with overall suggestions on cultural competency in serving newcomer communities.

The ultimate desired outcome is a newcomer who is an engaged participant in their own life and that of the community. The hope is that given

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the tools to understand relevant knowledge of immigration law, social service providers, in collaboration with legal service and other human services providers, can support newcomers so that they in turn can build on their strengths and resilience, and contribute to their own well-being, their families, and their new host communities.

U.S. IMMIGRATION LEGAL CLASSIFICATIONS: NONIMMIGRANT AND UNDOCUMENTED

U.S. immigration law[1] sets out a variety of methods in which newcomers can enter the country legally. This section will deal with *short-* and *long-term* methods of entry. Typically, foreigners, (to be called "newcomers" in this chapter) can enter the United States for a short term or long term. Short-term reasons include entering for (a) humanitarian reasons, (b) tourism, (c) education, or (d) short-term employment. This section will focus only on humanitarian-type short-term visas.

In order to enter the United States legally, that is, with documents, newcomers must have a passport and a visa. Just as in order to enter a room, one needs a door and a key—a passport (issued by the country of origin) is analogous to a door, and a visa (issued by the U.S. embassy or consulate in the country of origin) is the "key" permitting newcomers to enter the room (in this context, the United States). All newcomers must have a passport and some may need to have a visa. The Visa Waiver Program (VWP),[2] however, allows citizens of specific countries to travel to the United States for tourism or business for up to 90 days *without* having to obtain a visa. In turn, and as a reciprocal agreement, U.S. citizens similarly do *not* have to apply for a visa to enter those countries. All countries participating in the Visa Waiver Program are regarded as developed countries (e.g., most European countries).

Persons can also be classified as illegal, or undocumented, if they enter without a passport or visa. Alternatively, persons could enter *with* the proper documents (passport and visa), but could then become *undocumented*[3] if the visa expires and the person does not return to their country of origin as per the visa type described below. It is estimated that there may be 10 million undocumented individuals in the United States.[4]

In this decade, the predominant country of origin for undocumented newcomers is Mexico, where estimates indicate that Mexicans make up over half of undocumented immigrants—57% of the total, or about 5.3 million. Another 2.2 million (23%) are from other Latin American countries. About 10% are from Asia, 5% from Europe and Canada, and 5% from the rest of the world. Almost two-thirds of the undocumented population lives in just six states: California (26%), Texas (12%), Florida (10%), New York (8%), Illinois (4%), and New Jersey (4%). Estimates indicated that the undocumented populations of Arizona, Georgia, and North Carolina have grown so rapidly that they may already have surpassed New Jersey's undocumented population.[5]

As to entering with documents, a visa allows newcomers to travel to the United States as far as the port of entry (airport or land border-crossing).

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Immigration matters are the responsibility of the U.S. Department of Homeland Security (DHS). The U.S. immigration officials working for the DHS, Immigration and Customs Enforcement (ICE) branch, have the authority to permit newcomers to enter the United States. Officers from ICE decide how long newcomers can stay for any particular visit (www.unitedstatesvisas.gov/whatis/index.html).

When meeting with newcomer clients, social service providers workers may want to ascertain first *how* the person first entered and what immigration status the person is in now, as a way to later determine possible legal remedies. By gathering the relevant legal information, and with the client's consent sharing the information with a nonprofit legal services immigration agency, the collaboration between the client, social service, and legal service provider can be made smoother as all work toward resolution and stabilization of the immigration status.

Of special interest to social services providers are the nonimmigrant or short-term visas given to persons who may have entered legally and their visa expired or who entered without visas. They are now undocumented or "illegal," but for the reasons described below, the government gives them permission to remain.

Humanitarian Short-Term Visas: Victims of Trafficking

Some women may be in the United States because they are or have been a victim of a severe form of trafficking. If such a person is physically present in the United States, American Samoa, or the Commonwealth of the Northern Mariana Islands, or at a port of entry, on account of such trafficking, and has complied with any reasonable request for assistance in the federal, state, or local investigation or prosecution of these acts, the person is allowed to remain. When the government designates a person a victim of trafficking, she may be given a document, or in their passport (if they have one) may be stamped with the letter "*T*," which is a designation that they have been classified as a victim of trafficking and allowed to remain in the United States legally.[6]

Humanitarian Short-Term Visas: Victims of Crimes

There may also be newcomers in the United States who, like victims of trafficking, have also suffered, not because of trafficking, but because they have suffered substantial physical or mental abuse as a result of having been a victim of *criminal* activity. Examples of such activity include:

> Rape; torture; trafficking; incest; domestic violence; sexual assault; abusive sexual contact; prostitution; sexual exploitation; female genital mutilation; being held hostage; peonage; involuntary servitude; slave trade; kidnapping; abduction; unlawful criminal restraint; false imprisonment; blackmail; extortion; manslaughter; murder; felonious assault; witness tampering; obstruction of justice; perjury; or attempt, conspiracy, or solicitation to commit any of the above mentioned crimes.

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If the newcomer has been or is being helpful, to a federal, state, or local law enforcement official investigating or prosecuting a criminal, the person may be allowed to remain in the United States. When the government designates a person a victim of trafficking, the individual may be given a document, or in their passport (if they have one) may be stamped the letter "*U*," which is a designation that they have been classified as a victim of crimes and allowed to remain in the United States legally.[7] As will be described below, individuals who obtain short-term visas due to being victims of trafficking or crimes can later apply to stay in the United States permanently.

For both T and U visas, a provider's role can be to provide psychological and other case management support, and as described in the following section, to help the client gather the necessary documents to apply for lawful permanent residence later on.

U.S. IMMIGRATION LEGAL CLASSIFICATIONS: IMMIGRANTS AND CITIZENS

In addition to entering the United States as a nonimmigrant for a short term in the various categories briefly described above (e.g., trafficked, victim of crime), individuals may enter the United States as immigrants and be able to live permanently in the United States. If they choose, they never have to return to their country of origin. Just like nonimmigrant visas are for individuals who want to enter temporarily, immigrant visas on the other hand, are for people who intend to live permanently in the United States. Terms like obtaining a "green card" or a "lawful permanent residence" are all synonymous.

Although there are a number of methods, newcomers can enter or remain in the United States legally and permanently. This section will cover the main avenues for lawful permanent residence that are relevant to social work practice, that is, obtaining residence by:

a. Family sponsorship
b. Surviving domestic violence
c. Being adjudicated a dependant minor
d. Applying for refuge/asylum

Family Sponsorship as a Path to Lawful Permanent Residency

Newcomers who wish to become a lawful permanent resident may do so if they have a close relative who can sponsor them. As part of a comprehensive intake with newcomers, social services providers may want to assess if a client has an immediate family member, both for immigration reasons as well as for family support reasons (though the family member may be a factor in causing trauma and not a source of social support or immigration support).

U.S. immigration law only recognizes certain types or relationships for purposes of obtaining lawful permanent residence. In other words, only a U.S. citizen or permanent resident mother/father, brother/sister, husband/wife, or child over 21 can sponsor a foreigner.[8] Procedurally, the U.S. citizen or permanent resident needs to file the appropriate documentation and

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depending on the nature of the relationship (e.g., husband sponsoring wife vs. parent sponsoring child), there may be a longer waiting period for the family to be reunited.

The United States or lawful permanent resident relative in the United States will need to sponsor the newcomer, and prove that the petitioner has enough income or assets to support the person who wishes to immigrate. By ascertaining whether the client has immediate relatives as described previously, the social worker can make a more efficient referral to an immigration nonprofit provider or private attorney, as a way to help the client remain in the United States. The relative sponsor and the intending immigrant must successfully complete certain steps in the immigration process in order to come to the United States. Some of the key steps that service providers can help with include:

- Completing the Immigration Form I-130 Petition for Alien Relative.[9]
- Gathering information to prove relationship between the sponsor and the newcomer (e.g., marriage certificates, birth certificates).
- Assistance with demonstrating adequate income or assets to support the intending immigrant, by completing and signing a document called an Affidavit of Support Immigration Form I-134.[10] For low-income families, this may prove an obstacle in helping newcomers obtain permanent residence through family sponsorship.

Even if income status is not an obstacle in obtaining permanent residence, there may still be a backlog in obtaining an immigrant visa (or green card). The U.S. government sets annual minimum family-sponsored visas in the following categories:

Immediate Relatives of U.S. Citizens (IR): The spouse, widow(er), and unmarried children under 21 of a U.S. citizen, and the parent of a U.S. citizen who is 21 or older.
First preference: Unmarried sons and daughters of citizens.
Second preference: Spouses and children, and unmarried sons and daughters of permanent.
Third preference: Married sons and daughters of citizens.
Fourth preference: Brothers and sisters of adult citizens.

The U.S. Department of State publishes a visa bulletin, which lays out categories and backlogs describing waiting periods for family members to be reunited.[11] The service provider can share this resource with the petitioner and intending immigrant so that they can assess the waiting period, if any, for obtaining lawful permanent residence.

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Violence Against Women Act (VAWA) as a Path to Lawful Permanent Residency

Service providers are also important in supporting newcomer women who are survivors of violence. Before Congress amended the Immigration Act,

U.S. and permanent resident husbands could hold newcomer women in virtual slavery, dangling the application for a lawful residence as a carrot, forcing the woman to endure physical, mental, and sexual abuse. Through the provisions of the Violence Against Women Act,[12] the government amended the Immigration Act. As a result, newcomer women, married to lawful permanent residents or U.S. citizens, can *self*-petition without the need of the abusive sponsor/husband to petition for them. The immigrant woman can safely flee domestic violence and even prosecute their abusers.

In addition, the law now also extends immigration relief to immigrant victims of sexual assault, human trafficking, and other violent crimes who agree to cooperate in criminal investigations or prosecutions. A key goal of VAWA's immigration protections is to cut off the ability of abusers, traffickers, and perpetrators of sexual assault to blackmail their victims with threats of deportation, and thereby avoid prosecution. VAWA allows immigrant victims to obtain immigration relief without their abusers' cooperation or knowledge.

Social service providers can assist individuals who have been victims to prove abuse by helping the client put together the evidence required to prove a case of abuse, which will ultimately result in lawful permanent residence. The abused woman can now self-petition if married to a U.S. citizen or lawful permanent resident. Unmarried children under the age of 21, who have not filed their own self-petition, may be included in petitions as *derivative beneficiaries*. Social service providers can assist the applicant to prove abuse, through affidavits and other documents by

- submitting affidavits that the marriage was ended within the past two years for reasons connected to domestic violence;
- getting copies of the Protection from Abuse Order;
- obtaining hospital records, if any, of medical treatment because of the abuse;
- obtaining police records to show that the police had been called;
- submitting affidavits that the social worker is providing counseling as a result of the trauma suffered through abuse.

Special Juvenile Immigrant Status (SJIS) Act as a Path to Lawful Permanent Residency

Newcomer children who are dependent on the state, because they are victims of abuse, neglect, or abandonment are among the most vulnerable people in the United States. But in many cases, the children or their advocates can obtain a critical legal immigration benefit that will help the children gain control of their lives and successfully transition to adulthood.

Newcomer children who have experienced abuse suffer the same emotional and physical problems as abused U.S. citizen children—and often more. Added to the other insecurities facing them, youth without documentation will not be able to work legally or qualify for in-state tuition at college, and face the constant threat of deportation. In addition, the counties caring

for the children will not qualify for federal foster care matching funds if the children remain undocumented.

To address these challenges, federal immigration law now provides that dependent immigrant children in permanent placement can apply for lawful permanent residency as "special immigrant juveniles."[13]

Social service providers' role, especially those working with children and youth, is crucial in raising awareness of this benefit both to clients, as well as to government agencies and other nonprofit providers who work with children. If the children have counsel or county caseworkers, they too can help to complete and submit the necessary paperwork to help the child obtain lawful permanent residence.

As mentioned above, abused immigrant children who are *not* county dependents may still be eligible for immigration benefits. An immigrant who was battered or abused by a U.S. citizen or permanent resident parent or spouse may be able to apply for permanent residence under the VAWA (Violence Against Women Act) immigration provisions. In this case the child (or spouse) does not have to have been taken in by the county or made a court dependent. However, the abuser must have been a permanent resident or U.S. citizen.

The service provider's role can be to assist in completing the application for this immigration status resulting in lawful permanent residence. Social services providers can assist in proving abuse through affidavits and other documents by ensuring that the child

- obtains an order from a dependency court confirming that the child is eligible for long-term foster care due to abuse, neglect, or abandonment;
- completes USCIS forms[14] (although there is a fee for the application process, a fee waiver is available);
- obtains a special medical exam; and
- provides fingerprints, a photograph, and proof of age.

The federal government will grant the applicant employment authorization (if relevant to the youth) as soon as the application is filed, and schedule a date for the SIJS interview. Generally, the government will decide the case at the time of the SIJS interview. While the child is a juvenile court dependent it is important to apply for SIJS because the process may take from 6 to 18 months after submitting the application to get an SIJS interview. If the child is released and is no longer an adjudicated dependent *before* the immigration interview takes place, the current government policy is to deny the case.

Refugee Protection as a Path to Lawful Permanent Residency

The service provider's role in providing support to newcomers is perhaps most relevant in applications for asylum. More than 130 nations have signed a United Nations international treaty: the 1951 Convention and 1967 Protocol relating to the Status of Refugees.[15] By signing this Refugee Convention, the signatory countries agree to provide refuge to persons who meet the definition

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of refugee. The United States signed the treaty in 1967 and incorporated the principles of the treaty into domestic law through Congress's enactment of the 1980 U.S. Refugee Act.[16] The international and U.S. definition of a "refugee" is a person with

- well-founded fear of persection on the grounds of
  - race, religion
  - nationality
  - political opinion
  - membership in a particular social group

Applicants for asylum can file for protection either before an Asylum Officer or an Immigration Judge. For newcomers who are applying for asylum in the United States, the social worker's role can be crucial in helping the client to obtain legal assistance in filing the case, and later, in helping both the client and attorney in supporting the application by submitting affidavits[17] to support the claim. No matter the venue, whether in front of an Asylum Officer or an Immigration Judge, the service provider can help the applicant in drafting an affidavit to submit to the government.[18] The service provider's role can be crucial in helping the client prove the first prong of the refugee test: that the applicant is indeed afraid and that the provider is providing therapy to alleviate the fear of past (and future) persecution if deported to the country of origin. In addition, the service provider may also be helpful in assisting to conduct research on information on human rights abuses to support the second prong of the definition: persecution as substantiated through reported human rights violations.[19]

Under the U.S. Refugee Act, in alignment with the internationally accepted definition, a refugee is a person who has fled his or her country of origin because of past persecution or a well-founded fear of persecution based upon race, religion, nationality, political opinion, or a membership in a particular social group. If the person is not in the United States, he or she may apply overseas to *enter already recognized* as a refugee. If the person is *already within* the United States, for example, having entered as a visitor, or a student, or even entered without documents (passport and/or visa), he or she may apply for asylum.[20]

In order to obtain refugee status (outside the United States so as to be resettled to the United States) or obtain protection as an asylee (inside the United States so as to be allowed to remain inside the United States), applicants must prove each of the prongs of the international and U.S. definition of "refugee" as described earlier.

For newcomers entering the United States who are already recognized as refugees, the service provider's role is relevant perhaps above all, in ensuring that the applicant has access to mental health (and if necessary physical health) counseling. Many refugees have suffered triple trauma: in the country of origin suffering violations of human rights on themselves or their families; in flight (crossing mountains, sea, borders), and now in the host country due to factors such as language, customs, and alienation, resulting in depression.

Hence ensuring access to culturally competent mental health services can be a key provider role. Refugees have many strengths—business acumen, language, and education. The service provider can play a role in helping to restore the refugee and build on their strengths.

Social services providers can also support newcomers in their goal of obtaining protection so as to be able to remain in the United States. An individual who enters the United States as a nonimmigrant (e.g., student, visitor, or even without documents) may apply for asylum through the “affirmative” asylum process as described below.

Step One: Arrive in the United States

The service provider can assist newcomers wishing to apply for asylum by first ensuring that the application is filed within one year of the client’s last arrival in the United States. Although the law states that applicants must apply within one year of arriving, an exception to the rule is if the applicant can prove “changed circumstances” materially affecting the applicant’s eligibility for asylum or “extraordinary circumstances” related to the delay in filing.[21] If one year has passed and the applicant wishes to apply for protection, the social service provider can support the applicant by helping to gather information relating to changed or extraordinary circumstances explaining why the applicant is applying **after** the one year deadline.

Step Two: Complete the Application for Asylum

The applicant must complete Form I-589, “Application for Asylum and for Withholding of Removal.” This form requires the applicant to explain the fear of returning, the persecution suffered or to be suffered, and on what grounds. The social service provider can help the applicant relive the trauma, with care, so as to be able to draft an Affidavit in support of the Application for Asylum. In collaboration with legal counsel, the service provider can use this first draft as the foundation for a final Affidavit to be submitted as part of the application.

In addition to assisting the applicant in drafting his or her own affidavit with the narrative of what happened, the service provider can also write an affidavit attesting to the provider’s own clinical support being offered to the applicant. The affidavit can go into detail as to the assessment and diagnoses of physical scars or mental health trauma that the provider has observed. The provider’s affidavit will be used by the government as one more bit of evidence to assist in the U.S. government’s final determination: grant or denial of asylum.

Step Three: Asylum Interview

The government notifies applicants for an interview with an Asylum Officer typically at one of the eight Asylum Offices or at a USCIS field office,[22] depending on where the applicant lives and where the application is filed. Service providers can support applicants by accompanying the applicant and providing psychological support, serving as interpreters, and/or serving

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as a bridge between the applicant and the attorney. An asylum interview may last about an hour, although the time may vary depending on the case. Applicants may also bring witnesses to testify on the applicant's behalf. Service providers can testify as to the applicant's fear of being persecuted based on clinical, social, and psychological services rendered.

At the interview, the asylum officer will determine whether the applicant meets the definition of a refugee as listed previously, and also assesses whether the applicant is barred from being granted asylum for reasons such as the applicant can return to another safe third country or is filing one year after the date of the alien's arrival in the United States. (If however, the applicant demonstrates the existence of changed circumstances or extraordinary circumstances relating to the delay in filing the application, the applicant may still be able to file for asylum.[23]) If for example the applicant did not file before the one year deadline due to post traumatic stress disorder, a provider's affidavit can be useful in proving "extraordinary circumstances," which caused the filing delay.

Step Four: Applicant Receives Decision

In most cases, the government advises the applicant within one or two months of the interview and the applicant returns to the asylum office to pick up the decision. The decision may also be to deny or to refer to the Immigration Judge.[24]

In addition to applying for asylum before an Asylum Officer in an "affirmative" setting, depending on the situation, individuals may have to apply for asylum in a "defensive" setting before an Immigration Judge. The provider's role is similar as described above in helping the applicant draft an Affidavit, as well as the provider drafting his or her own affidavit in support of the application.[25]

U.S. Citizenship

The final portions of the Immigration Law of relevance to social services providers deals with how immigrants can become citizens. The United States, unlike other countries, grants citizenship under three circumstances:

1. Citizenship by parentage
2. Citizenship by birth on U.S. soil
3. Citizenship by application

Many countries provide for passing on citizenship by parentage or blood, for example, if the parents are German, then the child is German at birth. Similarly, U.S. immigration laws follow the principle of *jus sanguine* and citizenship is conferred even if the child is born *outside* of the United States (e.g., in China to U.S. missionaries, the child is considered a U.S. citizen).

Other countries provide for citizenship if the individual is born on their soil. Similarly, U.S. immigration laws, pursuant to the U.S. Constitution, follow

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the principle of *jus solis*.[26] Thus a child born in the United States, regardless of whether the parent is with or without documents, is considered a U.S. citizen. Given the perception of the rise in undocumented newcomers, a segment of the population has been calling for an end to "birthright citizenship" and advocate for an amendment to the Fourteenth Amendment of the U.S. Constitution.

Finally, unlike other countries, U.S. immigration laws provide a third path toward citizenship and also allows citizenship by *application*, even if the applicant had neither U.S. parents (*jus solis*), was not born on U.S. soil (*jus sanguine*), and even if the applicant was born abroad. In this case, for example, a newcomer arrives in the United States as a student or refugee. The person then becomes a lawful permanent resident based on a sponsorship by a family member or employer or gaining asylum as described above. In these cases, after a 3- to 5-year period of being a lawful permanent resident, the individual can *apply* for naturalization—hence citizenship by *application*.

Social service providers can assist applicants who wish to become citizens by helping to gather information required by law. The provider can assist to prove that the applicant

a. is at least 18 years old
b. is a permanent resident of the United States
c. has lawful permanent residency for 3 to 5 years
d. during the last 5 years has been inside the United States for 30 months or more
e. has the ability to read, write, and speak basic English
f. has the ability to pass the civics test
g. is a person of good moral character

For clients who are English-language learners, passing the test of reading, writing, and speaking basic English may be a problem. This is especially true for elderly newcomers, who may have been residents for a long period of time, but for a number of reasons, are not able to speak English. However, for elderly persons who are already residents and are older than 65 years and have resided in the United States as permanent residents for at least 20 years, they have different requirements for history and government knowledge: They may also be tested in the language of their choice because they are exempt from the English literacy requirements.

Social service providers may want to urge their lawful permanent clients to seriously consider applying for U.S. citizenship since benefits include

- the right to vote
- faster family sponsorship
- public benefits/entitlements
- educational grants and scholarships
- U.S. travel document passport
- nondeportation if convicted of a crime

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RECOMMENDATIONS ABOUT THE ROLE OF SOCIAL SERVICE PROVIDERS IN ASSISTING REFUGEES

As described earlier, service providers can play specific roles to support newcomers, depending on the legal remedy available as to whether the applicant is an abused woman, an unaccompanied minor, or an asylum seeker. Regardless of the specific group, some general principles that will assist the provider in becoming more culturally competent include the following:

Micro advocacy competencies to advocate for *the client*

1. Listening skills so as to develop trusting relationships with the woman, child, or asylum seeker.[27]
2. Ability to refer clients to legal services providers to navigate the legal systems.
3. Crisis intervention skills and finding culturally appropriate partners to assist in areas such as housing, health, mental health, education, immigration, and legal services.
4. Ability to seek and access emotional and stress support for oneself.

Mezzo advocacy competencies to advocate *in-house* within the organization

5. Securing organizational commitment to ensuring newcomer access and participation (newcomer board members; bilingual bicultural staff; bilingual external communications tools [web; brochures; signage]).
6. Staff and board understanding of different cultures and belief systems.
7. Staff and board knowledge of the difference between integration versus assimilation.
8. Multiagency partnerships built around the needs of refugees and asylum seekers, at both strategic and operational levels, which will facilitate access to and development of appropriate social care provision.

Macro advocacy competencies to advocate for *change in systems*

9. Political understanding of the larger picture including the triple trauma of: country of origin events the client faced in the country of origin which resulted in the client leaving; the trauma encountered in flight; and the trauma in the host country.[28]

In the end, providers can listen to and partner with newcomers, to ensure their engaged participation in leading their own lives in the host community. When providers raise their awareness of immigration laws, then in collaboration with legal service providers and other service providers, with newcomers leading the way, newcomers will be able to play to their strengths, and contribute to their own well-being, their families, and their host communities.

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NOTES

1. 8 U.S.C.
2. 8 U.S.C. §1103,1187), and 8 CFR 235.1, 264, and 1235.1.
3. 8 U.S.C. § 1325 Improper entry by alien.
4. For estimates of numbers of undocumented, see http://pewhispanic.org/files/reports/46.pdf; www.uscis.gov
5. http://www.urban.org/publications/1000587.html
6. In October 2000, Congress created the "T" nonimmigrant status by passing the Victims of Trafficking and Violence Protection Act (VTVPA). The legislation strengthens the ability of law enforcement agencies to investigate and prosecute human trafficking, and also offers protection to victims.
7. 8 U.S.C. § 101(a) (15) (U).
8. 8 U.S.C. § 201(b).
9. See www.uscis.gov to obtain copy of the form.
10. Ibid.
11. See http://travel.state.gov/visa/frvi/bulletin/bulletin_1360.html for monthly updates as to waiting periods/backlogs from time of filing to date government issues visa to relatives.
12. 42 U.S.C. § 13981.
13. 8 U.S.C. § 203(b)(4).
14. See www.uscis.gov to obtain copy of the form.
15. UN General Assembly, *Convention Relating to the Status of Refugees*, 28 July 1951, United Nations, Treaty Series, vol. 189, p. 137.
16. Refugee Act of 1980 (Public Law 96-212).
17. 8 C.F.R. 208.1 et seq.
18. See www.uscis.gov/portal/site/uscis for forms, specifically Form I-589 Application for Asylum and Withholding of Removal
19. For sample supporting affidavits, see www.immigrationequality.org/issues/law-library/lgbth-asylum-manual/sample-cover-letter/ for sample applications, and Corroborating Client-Specific Documents; see www.theadvocatesforhumanrights.org/uploads/app_e_sample_annoted_table_of_contents_for_asylum_filing.pdf
20. www.dhs.gov/xlibrary/assets/statistics/publications/ois_rfa_fr_2010.pdf
21. 8 U.S.C. § 208(a)(2)(D); 8 C.F.R. § 208.4(a).
22. For list of locations for asylum office see: https://egov.uscis.gov/crisgwi/go?action=offices.type&OfficeLocator.office_type=ZSY
23. INA Section 208(b)(2).
24. For more information on the "affirmative" asylum process see: www.uscis.gov/portal/site/uscis/menuitem.5af9bb95919f35e66f614176543f6d1a/?vgnextoid=888e18a1f8b73210VgnVCM100000082ca60aRCRD&vgnextchannel=f39d3e4d77d73210VgnVCM100000082ca60aRCRD
25. For more information on the "Defensive" asylum process see http://trac.syr.edu/immigration/reports/159/

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26. U.S. Constitution, Fourteenth Amendment: All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside . . .
27. Social worker role in "listening" www.blackwellpublishing.com/journal.asp?ref=1356-7500&site=1
28. www.communitycare.co.uk/Articles/02/07/2010/114825/social-care-for-refugees-and-asylum-seekers.htm

EIGHTEEN

Utilizing an Ethnographic Lens in Clinical Social Work Practice With Immigrants and Refugees

Jessica Rosenberg, Manny J. González, and Samuel Rosenberg

"Keep, ancient lands, your storied pomp!" cries she with silent lips.
"Give me your tired, your poor, your huddled masses yearning
to breathe free, the wretched refuse of your teeming shore. Send
these, the homeless, tempest-tossed, to me; I lift my lamp beside the
golden door."

EMMA LAZARUS

This chapter examines contemporary immigration to the United States, highlighting the major psychosocial conditions shaping the immigrant experience. The focus is on recent immigrants, referred to as "first generation." The chapter further explores the mental health needs, access to services, and implications for clinical practice applicable to this population. Research shows that although immigrants and refugees are at increased risk for a host of psychological problems such as depression and traumatic stress, they are less likely to access treatment, due to lack of availability of culturally competent services, their own cultural prohibitions against participating in mental health care, limited insurance, and a general mistrust of government agencies (Padilla, 1997).

Competent multicultural social work practice with immigrants and refugees requires that, in order to practice effectively, social workers must inform themselves about the relevant cultural, social, historical, and political factors that shape the immigrant experience. Accordingly, this discussion of clinical practice with immigrants and refugees begins by locating itself within a sociopolitical analysis, which suggests that the current immigrant experience in the United States occurs during a time of heightened xenophobia, a period in which there is suspicion of that which appears foreign.

The experience of immigrants and refugees relocating to the United States is, more often than not, one of economic uncertainty and social marginalization. In particular, periods of social turmoil, such as wartime, are associated with increases in anti-immigrant sentiment. For example, during World War II, in response to the Japanese attack on Pearl Harbor, approximately 110,000 Japanese Americans were forcibly imprisoned in internment camps

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(Wu, 2002). Similarly, we see that the present-day immigrant experience is impacted by a decade-long period of political and economic upheaval in the United States that stem from two major events: (a) the New York Twin Towers and Pentagon attacks on September 11, 2001 (9/11) and the subsequent war on terror and (b) the economic downturn, which began in 2008 and has developed into a persistent recession.

First, the 9/11 attacks stimulated strong concerns of terrorism on domestic soil, fueling fears, which were quickly embodied in the public imagination as perpetrated by persons of Middle Eastern descent. As a result, hate crimes against Arabs and members of the Muslim faith rose immediately after 9/11 (Akram & Johnson, 2004). Soon after 9/11, anti-immigrant policies were codified into law by new federal legislation. In October, 2001, President George W. Bush signed the USA Patriot Act, a law that contains sweeping provisions that curtail civil liberties and allows for the indefinite detention of any immigrant, without judicial due process, who is suspected by the United States government of terrorist actions (USA Patriot Act, 2001).

The second major social factor shaping contemporary immigration is the economy, which began with a free-fall in 2008 as a result of a meltdown in the housing industry, and which continues to be fragile and volatile, marked by persistently high levels of unemployment and poverty, particularly in immigrant communities. The unstable economy is the backdrop for a series of harsh new anti-immigration laws that have been passed across the country. State legislation designed to target undocumented immigrants (primarily affecting persons of Hispanic descent) have been passed in Alabama (HB-56), Arizona (SB-1070), Georgia (HB-87), and Mississippi (SB-2179). These laws give law enforcement officers and employers the right to verify a person's immigration status. In Alabama, public schools are required to check the immigration status of students, a fact which immediately lead to thousands of parents keeping school-age children home. Hispanics are fleeing these states, a consequence that legislators acknowledge was intended in order to make jobs available for Americans (http://immigrationpolicy.org).

The laws, which have been passed in the context of growing economic insecurity, create a climate of fear and tension for immigrants in the United States. Social workers practicing with this population should be cognizant that their clients may be experiencing increased stress as a result of heightened anti-immigrant sentiment.

Newcomers to the United States can be divided into three categories: legal immigrants, refugees, and undocumented immigrants. This population has similarities and some important differences. All contend with the stressors of being strangers in a strange land and with the difficulties associated with adjustment to a new culture. However, the majority of legal immigrants come to the United States by choice, having engaged in planning and often joining family and friends in their new country. They may, in varying degrees, feel prepared, financially and emotionally, for the transition. Refugees, in contrast, are typically fleeing from their country of origin, and have no other option but to leave. They are desperate, afraid, and often alone, and most likely have been victims of or witness to traumatic violence. It is likely that they will

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never return to their country of origin. In sum, the circumstances surrounding refugee migration are likely to be of pronounced distress. Section 601 of the Illegal Immigration Reform and Individual Responsibility Act of 1996, enacted on September 30, 1996, stipulates that "a person qualifies as a refugee prosecuted for political reasons if forced to undergo, has a well founded fear of being compelled to undergo, or resists a coercive population-control procedure. Also the Act set a combined annual ceiling of 1,000 persons who may be granted refugee or asylee status under this provision" (U.S. Department of Justice, 1999, p. 109). Finally, there are an unspecified number of persons who enter the United States annually without documentation. These individuals are generally trying to escape poverty and squalor in their countries of origin. Many undocumented immigrants suffer greatly in their travels to the United States. Rape, other acts of violence, and physical hardship are not uncommon. Furthermore, undocumented immigrants are often in a state of constant worry that they will be discovered by the U.S. authorities and deported. They are suspicious of any government or official institution and are wary of seeking legal or health services. Undocumented immigrants are barred from many endeavors U.S. citizens take for granted, such as the legal right to work, to hold a driver's license, and to collect Social Security, despite their contribution to the tax base. The millions of undocumented immigrants in the United States, many of whom work under harsh conditions and for substandard wages, constitute an invisible, shadow subculture, which has become essential to the functioning of the U.S. economy.

Life transitions, environmental problems and needs, the effects of acculturation stress, and interpersonal conflict may often compel immigrants and refugees to seek out mental health services. Mental health practitioners (e.g., clinical social workers, psychologists, psychiatric nurses) then provide services to those recognized as conventional immigrants, refugees from a variety of cultural and regional origins, and an unspecified number of undocumented immigrants with a host of legal, economic, and public health concerns. The varying needs of this diverse group constitute a challenge to the social work profession and its historical commitment to ease the process of adjustment to a new society. The scope of this chapter, restricted by length, is directed toward a discussion of the needs of the more vulnerable among this population, as the more vulnerable are most likely to be recipients of social services.

POPULATION

In the year 2010, 1,042,625 immigrants obtained legal residence in the United States. Of this population, more than two-thirds originated from North America (427,031) and Asia (410,209), numbers which support the demographic trend of significant growth among the Hispanic and Asian populations in the United States. Immigration from the rest of the world is comparatively smaller: Europe (95,379), Africa (98,246), South America (85,789), and Oceania account for the smallest group (5,946).

The number of refugees granted entrance to the United States has declined over the past 40 years. In 2010, a total of 73,2930 refugees were

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admitted to the United States, compared to 1980 (the first year for which data is reported), when 207,116 refugees were granted admission.

The largest group of refugees is from Asia (52,695), followed by Africa (13,325), North America (4856), Europe (1238), and South America (126) (U.S. Department of Homeland Security, 2011).

A large-scale comprehensive report issued by the Center for Immigration Studies provides an analysis of the U.S. immigrant population along several variables. Extrapolating from data from Census 2007, findings reveal that a large number of immigrants are in the country illegally (nearly one-third are undocumented); lack formal education (31% of immigrants have not completed high school); are likely to receive social welfare entitlements (33% of immigrant-headed households use at least one major welfare program); are not covered by health care (34% percent of immigrants lack health insurance); are vulnerable to poverty, and have a poverty rate of 17% (which is nearly 50% higher than the rate for American-born citizens). The report identifies their low education status as the primary reason for the high poverty rate, lack of health insurance, and reliance on social welfare programs (Camarota, 2007).

In sum, immigrants and refugees constitute a diverse ethnic, cultural, and socioeconomic group that is at high risk for psychosocial problems, with different styles of help-seeking behavior. It is well-known that culture strongly influences the way people experience the world. In the multicultural ethnographic framework proposed in this chapter, clients' unique personal narratives are elicited. This perspective suggests that services to clients and client systems must be based on a comprehensive understanding of their lives in their country of origin, their journey to the United States, and their experience of immigration in the United States.

PSYCHOSOCIAL RISKS/NEEDS

Immigrants and refugees may often feel confused and marginalized in this country where they do not fully speak or understand the dominant language. In describing his experience as a high-school student in California, a recent immigrant from Argentina said, "I felt the other students didn't like me because I spoke strangely and often didn't understand those who spoke to me. I didn't know how to maneuver in the culture—how to get around and get things done" (Rosenberg, 2000). Consequently, he became withdrawn, his educational performance lowered, and he eventually engaged in antisocial behavior.

In addition to causing social marginalization, language limitations are a critical factor contributing to unemployment and low-wage occupations. Immigrants who do not speak English and have a low level of educational attainment have difficulty finding gainful employment and are generally trapped in low-paying, unskilled jobs. The U.S. Department of Labor, Bureau of Labor Statistics (2004) reports that for the period of 1996 to 2002, only approximately 7% of 25- to 34-year-old workers born in the United States had not completed high school, whereas about 26% of recent immigrants in this age group had not obtained a high-school diploma.

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Access to Systems of Care

Difficulties in accessing services among the immigrant and refugee population stem from three primary areas: First, for those from countries of origin in which mental health problems and mental health care are perceived very negatively, seeking treatment is not culturally acceptable, and accordingly, some immigrants and refugees will choose not to seek services. Second, because many of these individuals lack adequate health insurance and have limited funds, many lack the means to access mental health care. Third, services themselves are not often designed with a multicultural awareness, including employing staff with appropriate linguistic skills. As such, existing services may not appeal to or seem relevant to many immigrants and refugees.

The Undocumented Immigrant

Because they typically do not have health insurance, many undocumented immigrants will not seek services on a consistent basis. Current systems of care are rarely designed to meet the needs of undocumented immigrants. For example, in the wake of 9/11, a large number of undocumented persons were adversely affected because they were either present during the attack and/or because they and their families depended on the downtown financial district area for their livelihood. It is well-known that a large number of undocumented immigrants, primarily of Latino origin, provided a source of available and inexpensive labor to businesses in and around the disaster area (e.g., janitorial workers and restaurant workers). Nonetheless, despite their representation among the victims of 9/11, undocumented immigrants, due to their illegal status, may not be eligible for some services. Given the convergence of the social, economic, and legal obstacles experienced by this population, they are at high risk for falling through the cracks and being exposed to the more pernicious consequences of mental illness.

The Post-9/11 Climate: Heightened Tensions and Obstacles

The post-9/11 world ushered in a climate characterized by stricter policies for immigrants, as well as increased fear and suspicion among the public toward foreigners. The backlash against immigrants of Middle Eastern descent is well documented (Bernstein, 2004), with numerous accounts of being targets of hostile actions, including unlawful detainment and deportation. In addition, many immigrants, regardless of their country of origin, are subject to longer waits for immigration applications and work permits, and experience more frequent denials of driver's licenses. The net effect of this chilled climate is a tendency among many immigrants to be apprehensive of seeking help from social institutions including the legal system, health care services, and social service organizations.

Cultural Norms

Mental illness, perhaps more than any other psychosocial condition, elicits powerful cultural responses. Mental illness has been understood to acquire

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religious significance, endowing the ill person with special gifts or devilish powers. In many cultures, mental illness is a taboo subject, a cause for shame among families with a mentally ill member.

For example, Vietnamese culture considers a mentally ill person to be born under an unlucky star and ill-fated. Mental illness brings shame upon the family, affecting the fortunes and future of the whole family. As such, families are likely to try to care for the ill member within the confines of the family rather than seek outside help (Ganesan, Fine, & Lin, 1989).

Attitudes toward mental illness can vary considerably even among groups with many shared cultural traditions. In particular, class, level of education, and whether one comes from a rural or urban background, mediates perceptions toward mental health. For example, attitudes of urban, well-educated Mexicans from the capital city will differ considerably from those residing in rural Guatemala, and their attitudes in turn will be different from those of Colombians.

In working with immigrants and refugees, it is essential to understand how their culture views mental illness. Working within cultural frameworks can greatly enhance services. For example, one mental health center partnered with the local *curanderos* or *santeros* who, operating within a belief system that spirits inhabit the material world, utilize their healing arts with the Latin American immigrant community. The mental health center invited these local healers to help their clients. They found that the participation of the santeros was symbolically important as an acknowledgment of their cultural place within the community, and as a result, they gained increased participation and credibility among the Latin American immigrant community (Rosenberg, 2000).

Linguistic Barriers

Among the greatest challenges facing the provision of clinical services is the shortage of bicultural, bilingual mental health practitioners. Demographic trends indicate that the number of non-English-speaking clients is expected to continue to rise, but there are few bilingual social service providers. The demand for bilingual/bicultural social workers far exceeds the supply, and as the non-English-speaking population continues to grow at a rapid pace, it is expected that their need for social services will grow as well (Ortiz-Hendricks, 2004).

Communication problems prevent many immigrants and refugees from accessing services, and reports of staff insensitivity to clients who are not proficient in English are not uncommon. Many service programs routinely rely on clients to provide translators, typically family or friends. This practice is strongly discouraged due to the proximity of the person translating to the client; the information gathered will be censored and generally incomplete. In addition, it is often the younger members of families who acquire language skills at a faster pace. As such, it may be culturally distonic for an adult family member to disclose personal information to a son, daughter, niece, or nephew. As has been stated already in this book, it is important to advocate for the development of professional translators who can enhance comfort levels, particularly during the initial stages of counseling.

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For many immigrants and refugees, language represents the primary means for retaining a sense of heritage, safeguarding cultural identity and expressing emotionality. Because language has such a central place in the treatment of immigrants, mental health practitioners who wish to communicate effectively with monolingual or bilingual clients must first find out what language the client communicates best in, and then must demonstrate sensitivity to the fact that people who are in a state of crisis or who are experiencing significant psychological distress may struggle to communicate in a second language, and may also regress to the use of their native language as the primary means of expression. Researchers (see González, 2002) have suggested a relationship between linguistic inaccessibility and underutilization of clinical services by immigrants. Human service organizations engaged in community outreach initiatives to immigrant and refugee populations, therefore, must ensure that immigrants have access to competent bilingual and/or bicultural clinicians.

CLINICAL FACTORS

Psychosocial Assessment

Conducting a careful psychosocial assessment is a crucial element in developing an appropriate diagnostic plan for treating immigrants and refugees. In his work with Indochinese refugee clients, Kinzie (1981) identifies five central areas of inquiry that form the assessment stage of treatment: (a) life in the country of origin, (b) the escape process, (c) refugee camp problems, (d) attitudes and concerns about life in the United States, and (e) future outlook.

The following case vignette illustrates the importance of sound diagnostic psychosocial assessment.

CASE VIGNETTE

> L, a young Latino woman of about 34 or 35 years of age, was hospitalized on a psychiatric unit for about 3 years. The police, who had found her in the street, homeless, very poorly groomed, and very depressed, had brought her in. She presented as catatonic, with flat affect, no eye contact, and was verbally nonresponsive. A male psychiatrist who didn't speak Spanish initially interviewed her. The woman just sat with her head down, didn't make eye contact, and didn't answer any questions, probably because she didn't understand. But even if the interview had been in Spanish, she might not have answered. The psychiatrist noted her poor eye contact, flat affect, and nonresponsive state, and diagnosed her as schizophrenic and she was put on antipsychotic medication. In the case of this woman, the medication sedated her more. She became more isolated, more depressed, and for 2 years she sat, doing absolutely nothing.
>
> At this point, a Puerto Rican nurse took an interest in the woman and started to talk to her, as much as possible, with the goal of establishing a personal relationship with L. Finally L began to respond, very little, but she was talking.

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> The treatment team working with L had failed to conduct a sound psychosocial assessment. Her chart noted "Place of origin: El Salvador" but the implications of this were never explored. The nurse learned that the woman was in El Salvador in the 1980s and that she had seen her whole family—her husband and children—killed by the Salvadorian military in front of her. She was the only survivor. Somehow she was smuggled out of the country, brought to New York, was with somebody for just 3 months, and then got lost. L was extremely depressed and suffering from posttraumatic stress disorder, yet she was misdiagnosed as schizophrenic and placed on the wrong medication.
>
> In a sound diagnostic psychosocial assessment, the significance of L's country of origin, that is, the fact that El Salvador was torn by civil war in the 1980s, would have been explored and perhaps L might not have languished for years in the back wards of a psychiatric inpatient unit (Rosenberg, 2000).

Consequently, it is clinically indicated when providing services to immigrants to pay particular attention to the following areas:

1. Client's country of origin has experienced violence due to war, civil war, invasion, paramilitary violence. Has client experienced directly any aspects of organized violence? Has client's family been affected by violence? Has client witnessed violent acts?
2. Determine whether client's life experience is primarily rural or urban. Despite globalization, most rural areas in the underdeveloped world lack basic services generally taken for granted by practitioners: running water, electricity, telephones, medical care, and, most importantly, mental health care. Lack of exposure to these amenities affects the receptiveness and willingness of immigrants to engage in a therapeutic process.
3. Assess the relative power assigned to gender and try to evaluate the character of gender relations in the client's culture of origin. It is particularly important when working with families to respect the power protocols established by the client's background at the initial stages of engagement. This in no way constitutes an acceptance of unequal power relations in the family. It is however, a culturally competent approach to gather information and engage the client system in the therapeutic process.
4. Evaluate the levels of loss experienced by the client and get an approximation of its impact given the client's life experience. Adults and adolescents will experience family separation or loss of friends in emotionally distinct ways. Try to elicit from the client a picture (genogram of sorts) of all the different parts of the family and their current location.

The high rate of violent life events as well as high stress associated with the immigration experience can place immigrants and refugees at increased risk for a number of the following clinical conditions, as detailed in the

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Diagnostic and Statistical Manual of Mental Disorders—Text Revised ([*DSM IV-TR*]; American Psychiatric Association, 2000): Posttraumatic stress disorder, acute stress disorder, adjustment disorders, and major mood disorders.

Traumatic Stress Disorders

Posttraumatic stress disorder (PTSD) is a disabling psychiatric disorder that develops subsequent to experience of a life-threatening or traumatic event such as war combat, terrorism, and violent attacks such as rape and assault (Herman, 1992). PTSD can severely interfere with daily functioning. Symptoms include flashbacks, sleep problems and nightmares, feelings of isolation, guilt, paranoia, and panic attacks. Persons suffering from PTSD typically repeatedly relive the traumatic event through painful memories and are prone to intense feelings of fear, helplessness, and horror. Often such feelings are accompanied by anxiety or panic attacks.

Studies of psychotherapy with South East Asian refugees provide numerous accounts of severe hardship, including torture and other war-related horrific experiences (Ganesan et al., 1989). It is estimated that the vast majority of the Indochinese refugees that entered the United States following the 1975 collapse of the South Vietnam government were exposed to severe brutality and cruelty and debilitating living conditions in their home country. Such clients may struggle with depressed and irritable moods, pervasive feelings of being unsafe, and feelings of intense guilt, especially if they survived when others did not.

It is important to note that immigrant and refugee children are also vulnerable to traumatic stress disorders. When immigrant parents dream of bringing their children to the United States, they usually do so with the belief that their quality of life will improve. They flee political persecution, extreme economic desperation, and look to the “land of opportunity,” with the expectation that living in a democratic society will result in educational and employment opportunities. On arrival to the United States, however, the reality of sheer survival often becomes paramount. Finding housing and some type of employment become primary goals. Igoa (1995) has observed that, “In low-income immigrant families, it may be difficult for parents to nurture their children because the uprooting experience itself saps the parents’ energy” (p. 40). Children in the family are often left to cope on their own, with the hope that they both (parent and child) learn English and acculturate as quickly as possible. The multiple losses the children and their families have gone through, the fears, confusion, sadness, and alienation they may feel are often left unattended. Urrabazo (2000), for example, has noted the multiple traumas that undocumented Hispanic families have been exposed to in their attempt to cross the border into the United States: robbery, sexual assault, and physical and psychological torture. Yet it is these losses and “unspoken” traumas that immigrant children carry with them into their new schools and that teachers, educational administrators, and school mental health personnel (e.g., guidance counselors, school social workers, school psychologists) are confronted with.

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Adjustment Disorders and Depression

Immigrants and refugees are frequently diagnosed with adjustment disorders and depression (Yu, 1997). While such disorders are typically less severe in intensity and duration than traumatic stress disorders, they can be disabling and cause significant distress. According to the *DSM IV-TR* (American Psychiatric Association, 2000), the central feature of adjustment disorder is distress that markedly exceeds what is normally expected by a stressor and impairment in job, academic, or social functioning.

Major depression or dysthymic disorders are characterized by two or more of the following symptoms: appetite decrease or increase, sleep decrease or increase, fatigue or low energy, poor self-image, reduced concentration or indecisiveness, and feelings of hopelessness. These symptoms cause clinically important distress or impair work, social, or personal functioning. These psychological disturbances are viewed as prevalent among immigrants and refugees because of the combination of past harrowing experiences in their country of origin and ongoing psychosocial stressors in the United States. In a study of 147 adult Vietnamese Americans, depression was correlated to acculturation problems (Tran, 1993).

For instance, in looking specifically at what is known about the incidence of mental health among Hispanic immigrant children and adolescents, studies consistently show that Hispanic youth seem to be particularly vulnerable. Psychiatric epidemiological studies of children and adolescents appear to suggest that Hispanic youth experience a significant number of mental health problems, and in most cases, more problems than Caucasian youth (U.S. Department of Health and Human Services [USDHHS], 2001). Glover, Pumariega, Holzer, Wise, & Rodriguez (1999), for example, found that Hispanic youth of Mexican descent in the Southwest reported more anxiety-related problem behaviors than White students. Lequerica and Hermosa (1995) also found that 13% of Hispanic children screened for emotional-behavioral problems in pediatric outpatient settings scored in the clinical range on the Childhood Behavior Checklist (CBCL). Similarly, other studies (e.g., Achenbach, Bird, Canino, & Phares, 1990; Chavez, Oetting, & Swaim, 1994; Vazsonyi & Flannery, 1997) appear to indicate a greater frequency of delinquency behaviors among Hispanic youth in middle schools as compared with Caucasian youth.

In addition to anxiety and behavioral problems, depression is a serious mental health predicament affecting the psychosocial functioning and adjustment of Hispanic youth. Studies of depressive symptoms and disorders have revealed more psychosocial distress among Hispanic youth than Caucasian adolescents (USDHHS, 2001). This finding may be related to the fact that about 40% of African American and Hispanic youth live in poverty, often in chaotic urban settings that disrupt family life and add considerable stress to their already fragile psychological condition (Allen-Mears & Fraser, 2004). Nationally, for example, Roberts Chen, and Solovitz (1995) and Roberts and Sobhan (1992) have empirically noted that Hispanic children and adolescents of immigrant descent report more depressive symptomatology than do Caucasian youth. In a later study that relied on a self-report measure of

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major depression, Roberts, R. E., Roberts, C. R., and Chen (1997) found that Hispanic youth of Mexican descent attending middle school were found to have a significantly higher rate of depression than Caucasian youth, at 12% versus 6%, respectively. These findings held constant even when the level of psychosocial impairment and sociodemographic variables were taken into account.

Family Disruption

The impact of war and migration on children and families is profound. Family violence, marital problems, and acting out among children and adolescents are some of the manifestations of family disruption. Intergenerational tensions between parents who adhere to cultural traditions and their children who often acculturate at a faster pace are common. A significant number of refugee applications since 1997 have been granted for family reunification, typically when a spouse and children join a refugee already in the United States. Many of the recent refugees who arrived from Eastern Europe, Afghanistan, and Ethiopia did so for family reunification. The stressors impacting these families are severe, with such families likely to struggle with family dysfunction (González, Lopez, & Ko, 2005).

Individual, Family, and Group Treatment Considerations

While group and family treatment can be quite beneficial, it is a treatment decision that is best made with client consensus. Group and family modalities may not necessarily be culturally indicated, particularly with clients for whom sharing personal information is culturally distonic. Some cultural groups have a prohibition against sharing personal material with outsiders or even among family members. With such clients, a referral to group or family treatment can be disruptive to the healing process. For example, in one instance of a social worker working with a Muslim woman, the social worker assumed that the client would feel a sense of a community from participating in a support group for Muslim women and referred her. The client, citing her discomfort at discussing taboo topics such as marital satisfaction with members of her own cultural group, quickly dropped out of treatment.

In the treatment of some of Hispanic immigrants and refugees—like Cuban Marielitos and balseros—individual, family, and environmental interventions, however, may be quite appropriate (see González et al., 2005). The "Mariel boatlifts" of the "Marielitos" represents the third migration wave of Cuban immigrants. This third migration wave ushered into the United States more than 125,000 Cubans. The exodus of this group has at times been depicted as chaotic because of the many overcrowded boats that in a brief span of time arrived in the state of Florida (Miami), bringing thousands of individuals and families in need of political asylum and freedom. Cuba's persistent economic crisis and its political deterioration set the stage for the fourth wave of migration: Cuban "balseros." Balsero is the Spanish term that describes an individual who has left Cuba on a raft or small boat. From 1989 to 1994, over 37,000 Cuban balseros have successfully reached Miami,

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Florida, by dangerously traveling on small boats and rafts. González (2002), for example, has noted that from an ecological systems perspective, the mental health problems of Hispanic immigrant patients will be significantly reduced if they are assisted in mediating complex social systems, in obtaining community resources, in attaining vocational/job skills, and in learning English as a second language. Likewise, the family reunification issues of Cuban Marielitos and balseros must be addressed via an ecologically based family treatment approach. Therefore, ecological structural family therapy, bicultural effectiveness training, and the social/environmental change agent role model are recommended as viable treatment approaches that may ameliorate the family reunification dynamics and conflicts presented by Cuban immigrant/refugee patients.

Research evidence (Szapocznik Scopetta, & King, 1978; Szapocznik, Herns, & Rio, 1991; Szapocznik, Kurtines, & Santisteban, 1997) appears to suggest that ecological structural family therapy is an effective treatment approach in addressing intergenerational conflict and acculturation differences in Hispanic families primarily of Cuban descent. Because the locus of the patient's dysfunction is not only internal but also external in nature, ecological structural family therapy stresses the interaction between the organism and its environment. Based on the theoretical and clinical work of Aponte (1974) and Minuchin (1974), this family treatment approach highlights the stress of acculturation and its disruptive impact within the structure of the Hispanic family. This treatment model pays careful attention to how normal family processes may interact with acculturation processes to create intergenerational differences and exacerbate intrafamilial conflict.

Altarriba and Bauer (1998) suggest that when applying ecological structural family therapy to Cuban immigrants, an assessment of the interaction between the individual patient and their environment should be conducted early on, during the initial phase of treatment. The diagnostic assessment process should include an appraisal of the boundaries between and among family members, the strength of the relationships between and among family members, an understanding of the hierarchal and authority structure of the family, and an examination of any inherent contradictions in the request for service.

Szapocznik and associates (1997) have empirically studied the value of ecological structural family therapy in assisting Hispanic Cuban families address their interactional problems from both a content and process level. At the content level, the cultural and intergenerational conflicts can be the focus of clinical attention, making this model of family therapy particularly specific to the Cuban family. At the process level, this treatment model aims to modify the breakdown in communication processes resulting from intensified cultural and intergenerational conflicts. The content and process distinction is crucial in treating maladaptive family reunification issues often found in Cuban patients who have entered the United States via the Marielitos or balsero migration wave.

Bicultural effectiveness training (BET), developed at the Spanish Family Guidance Center at the University of Miami by Szapocznik (1984) and Szapocznik, Rio, and Perez-Vidal (1986), is predicated on structural family theory and is delivered as a 12-session psychoeducational treatment

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approach. Empirically tested with Cuban American families experiencing conflict with their adolescent children, bicultural effectiveness training is specifically designed to decrease acculturation-related stresses of two-generation immigrant families. For Cuban balsero patients who may be integrating into U.S.-based, established family systems, this intervention model may be useful in treating family reunification dynamics.

Given the fact that many recently arrived Cuban refugees often lack instrumental support from their U.S.-based extended families, many attempt to negotiate complex environmental conditions (e.g., employment, housing, health care, learning English as a second language) with minimal appropriate guidance. Atkinson, Thompson, and Grant (1993b) developed a dimensional intervention approach (social/environmental change agent role model) for the mental health treatment of ethnic/racial minority patients that recognizes the impact of the social environment in promoting or handicapping psychological growth and development. Within this treatment model, the mental health clinician treating Cuban patients can function as an agent for change, or as a consultant or advisor to an identified individual patient acting to strengthen the patient's support systems.

Atkinson, Morten, and Sue (1993a) recommend that the following three factors be diagnostically assessed when treating an ethnic (immigrant or refugee) patient: (a) the patient's level of acculturation, (b) the perceived cause and development of the presenting problem (internally caused versus externally/environmentally caused), and (c) the specific goals to be attained in the treatment process. In implementing this treatment model with Cuban refugee patients, however, mental health care providers must be prepared to extend their professional role beyond that of psychotherapist to that of advocate, mediator, educator, and broker (González, 2002).

An essential feature of the engagement stage of the treatment process in the ethnographic multicultural approach entails learning about the client's cultural norms with respect to sharing personal material, the client's values and belief system, and their linguistic styles of communicating within family and group systems. The ethnographic multicultural approach is illustrated in the following case vignette:

CASE VIGNETTE

> A, a South American woman in her mid-thirties, entered therapy, presenting with depressed mood and eating binges. She is undocumented, and employed off the books as a full-time nanny, where she often binge eats. A recounts a horrific journey to the United States in which she and others from Latin America were smuggled into a filthy, hot, oil tanker. A relates that while she was not physically harmed, she witnessed her companion being raped.
>
> In the initial phase of treatment, A educated her American-born, Spanish-speaking therapist about the political and economic upheaval in her country of origin, her traumatic journey to the United States, and her fears about being deported. The process of therapy became a shared voyage. The social worker's

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posture was open and curious about learning about A's culture, and the patient, in turn, became increasingly enthusiastic about treatment via this "guided journey." This approach greatly helped A. to establish a trusting bond with her therapist, enabling her to fully express her range of feelings about premigration traumas. Her compulsive eating diminished and her mood improved.

AN ETHNOGRAPHIC MULTICULTURAL APPROACH

Mental health professionals need to develop a service approach that is culturally competent. Unfortunately, the concept of cultural competence is an idea that has suffered from the lack of fit between the theoretical conception of competence and the execution of competence as practiced by social workers, psychologists, psychiatrists, and sociologists (Leigh, 1998; Rosenberg, 2000; Vega & Murphy, 1990). Practitioners need to reframe the idea of competence into something that utilizes concepts from anthropology, adopting some of the methodologies and the approaches of the discipline, and searching with both a clinical lens and an ethnographic lens to begin to imagine what it must be like to be in the position of a person of another racial/ethnic category or cultural group.

Valle (1986) has described the elements necessary for the development of what he terms "cross-cultural competence." These include the following:

1. A working knowledge of the symbolic and linguistic "communicational" patterns of the target ethnic minority group(s);
2. Knowledge and skill in relating to the naturalistic/interactional processes of the target population; and
3. A grasp of the underlying attitudes, values, and belief systems of the target population.

An ethnographic multicultural approach to working with immigrants and refugees is based on a comprehensive understanding of their lives in their country of origin, their premigration stressors, their journey to the United States, and their initial experience of immigration in the United States. During this process, practitioners must adopt a clinical curiosity analogous to what a person experiences when traveling in unknown territories. Thus, the client becomes the cultural guide who leads the way into areas and experiences that heretofore were unknown to the practitioner (Green, 1998; Leigh, 1997). As this process evolves, the practitioner becomes an educated traveler by becoming acquainted through study and reflection with the cultural and social aspects of the client's premigration culture. In effect, a parallel process of mutual trust evolves, where the practitioner openly acknowledges a desire to learn from the client and at the same time, demonstrates to the client an interest in their experiences by becoming acquainted with the client's cultural background. An informed traveler has an a priori appreciation of unknown places and is capable of formulating incisive questions. Concomitantly, the client feels empowered by being able to teach the practitioner about the nuances of their culture and develops a feeling of acceptance of difference generally lacking in the immigrant experience.

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Clinically, this process results in the construction by the client of a narrative, containing genuine and intimate information. In this manner, the client does not feel intruded upon and establishes their own pace of disclosure. Again, it is important to reiterate that this is an interactive process where the client guides the journey, and the practitioner actively demonstrates interest and concern.

CONCLUSION

The psychosocial needs of immigrants and refugees vary considerably. The extent to which an individual is prepared for the transition to life in the United States, particularly with regard to educational and employment readiness, can impact on how well he or she adjusts. Clinical syndromes often seen in this population include traumatic stress and adjustment disorders and depression. Such symptoms may, in part, derive from experiences surrounding the individual's life in their country of origin and their presentation will be shaped by cultural norms. Clinical practice with the population must begin with a comprehensive assessment process that includes developing an understanding of the premigration experience. Psychotherapy with this population should be undertaken with an open and inquisitive attitude and a willingness to learn about the client's culture. Mental health practitioners, who become attuned to listening to their clients with a "cultural ear," can utilize an ethnographic multicultural approach, as described in this chapter, to help and empower clients and to promote trust and healing in the treatment encounter.

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NINETEEN

Clinical Work With Survivors of Torture

Marianne Joyce, Mary Bunn, and David Engstrom

The field of social work is uniquely equipped and historically shaped to intervene in areas where a social justice/human rights lens is required. Partnering with torture survivors for an effective, integrated healing process is a relatively new practice area and one in which social workers can be helpful where few helpers exist, while incorporating proven practices with a flexible, multicultural model. There are an estimated 500,000 torture survivors in the United States, most of whom present layered and multifaceted signs of somatic, psychological, and social problems affecting their health and well-being.

There is an inherent political dimension to torture treatment in which practitioners helping survivors cannot remain neutral (Silove, 2004). Just as we recognize a child should be protected and safe in her family, a citizen should be free from officially sanctioned torture in her country. Freedom from torture is widely accepted as a basic human right; nevertheless, it may be one of the weightiest human rights issues of this era. The deeply damaging consequences of torture affect individuals, families, and the wider social collective. Indeed, Diana Ortiz reminds us that we ignore the societal costs of widespread use of torture at great risk to the health of our democracies (Ortiz, 2002).

Helping survivors of politically motivated torture, among other severe abuse survivors, is therefore an important clinical area for social workers, rooting us to our core values and necessitating the incorporation of a human rights framework (Reichert, 2003; Engstrom & Okamura, 2004). Understanding torture and how to help survivors rebuild after this extreme experience may be enhanced by historical, sociological, anthropological, as well as bio-psycho-social perspectives.

It should be noted that reports of torture within prisons and police stations have been documented inside the United States and presents another compelling area for attention from the field for social work. However, this chapter addresses treatment principles for those who fled countries around the world and seek safe haven in the United States.

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DEMOGRAPHICS

The prevalence of torture is difficult to estimate. In part this is because there are many and varied definitions of torture; more importantly because it is a covert practice and its victims are often unable to report the crime. Governments actively deny practicing torture and suppress information about it. Amnesty International provides social workers with a sense of how pervasive torture is globally; its 2010 report documented the existence of torture in 111 countries (Amnesty International, 2010). Useful as these reports are, they do not provide information on the prevalence of torture.

Torture is common in countries and regions experiencing social and political conflicts. Globally the UNHCR estimates that there are 21 million refugees, asylum-seekers, and internally displace persons, some of whom reach the United States as refugees and asylum-seekers. While not all refugees and asylum seekers are torture survivors, many are. Quiroga and Jaranson (2005) report that among refugees and asylees in the United States and Europe the prevalence rate for torture is between 6% to 55%. For some subgroups, the rate may be even higher. In a study of Somali and Oromo (Ethiopian) refugees resettled in the United States, Jaranson and colleagues (2004) document that the torture rate varied by ethnicity and gender and went as high as 69%.

An unknown number of torture survivors are in the United States as legal and unauthorized immigrants. All told, the U.S. government estimates that the country is home to 500,000 torture survivors (U.S. House of Representatives, 2009).

UNDERSTANDING THE EXPERIENCE OF TORTURE SURVIVORS

Dynamics of Power and Control

Torture is perpetrated under conditions of impunity in a culture of fear, silence, and denial of the torture. Torture is designed to maximize psychological impact by enhancing unpredictability and uncontrollability of stressors (Basoglu, 1991; McCoy, 2006) The effects of torture vary according to each person's particular experience and unique bio-psycho-social status, yet inevitably result in a complex picture of psychological, health, social, and existential vulnerabilities. Regimes often combine isolation with extreme brutality for maximum long-term psychological impact. A central objective of perpetrators is convincing their captive, in conditions of extreme isolation and humiliation, that no one will believe their story even if they survived to tell it. Torture's most insidious aftermath: a legacy of internalized psychological vulnerabilities that persist throughout a survivor's lifetime after enduring and surviving the worst of it. The suffering does not end with the end of torture.

Powerful regimes institutionalize these dehumanizing practices by keeping the population in fear of speaking out, organizing, or challenging its power. The threat of violence is well known and paid informants are often listening. Survivors, their families, and communities are marked by this terror and forced by fear into silence. Communities and individuals may demonstrate resilience under this adversity, but a sense of caution and mistrust is an undeniable by-product. Regimes may also employ propaganda

machines to generate myths about or exaggerate threats to state security from dissidents—so threatening to the state that they are relegated to subhuman status (Gourevitch, 1998). Systems that utilize torture to stifle sociopolitical change are typically rigid hierarchies, such as militaries, where its members are compelled to follow orders (Conroy, 2000). However, even a powerful military needs some civilian backing, and there are often collaborating institutional structures, such as religious groups (Osiel, 2004), foreign government allies (Danner, 1994) and professionals, such as physicians and psychologists (Lifton, 2004), to lend credibility to violent methods of retaining complete state power and control.

Fundamentals of the Torture Experience

Treatment providers have learned people are tortured for a wide range of reasons, and not all survivors of political torture are risk-taking political actors. People may be tortured because they are affiliated (or are perceived affiliated) with political opposition to the regime in power. People may be tortured for attempts to improve social conditions (e.g., literacy in rural areas) or for documenting and reporting human rights violations and corruption. People may be tortured because they diverge from a strict cultural norm (e.g., lesbian, gay, bisexual, and transgender [LGBT] or female genital mutilation). People may be tortured for being in the wrong place at the wrong time (e.g., being in the area of a demonstration). And people may be tortured because of their religious affiliation, race and ethnicity, nationality, and social group.

Torture is the calculated and deliberate infliction of pain and suffering and the means to that end are unfortunately too numerous to exhaustively list. Nevertheless, the techniques of torture can be classified as being applied psychologically and physically (see Table 19.1). It is all too common for torture survivors to have multiple methods of torture used on them, often over an extended duration of time. While all means of torture produce injuries, it

TABLE 19.1 Commonly Practiced Methods of Torture

METHODS OF PSYCHOLOGICAL TORTURE	METHODS OF PHYSICAL TORTURE
Mock executions	Pharmacological
Forced to witness or participate in torture	Positional torture
Threat of violence or death toward victim or their loved ones	Exposure to extremes of sensation (light, sound, and temperature)
Isolation	Blunt trauma
Sensory deprivation / overstimulation	Burns
Sleep deprivation	Electric shock
Deprivation of basic needs	Water immersion (water boarding)
Use of phobias to enhance fear	Sexual / rape
Religious humiliation	Beatings
Cultural humiliation	Falanga (beating on the soles of the feet)
Sexualized humiliation	Amputation

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is widely accepted that psychological torture is the most difficult from which to recover (Gerrity, Keane, & Tuma, 2001).

Resettlement

Triple Trauma Paradigm

Having survived the unfathomable experience of torture, survivors' resettlement into a new country is unfortunately heavily laden with vulnerability to trauma, extreme stress, and hardship. For torture survivors in exile, there is no end to the ongoing destruction of their home, family, and community. Nor is there an end to the events they experience as life-threatening, such as the ongoing fear of deportation for an asylum seeker.

The *triple trauma paradigm* is a useful concept that social workers can use to increase understanding of the multilayered experiences of trauma for torture survivors. This paradigm describes three phases of traumatic stress that apply to survivors in the United States who may or may not enter the United States with refugee status (National Capacity Building Project at the Center for Victims of Torture, 2005).

Preflight: The preflight phase covers the events, sometimes occurring over a period of years, that lead to the eventual decision to flee their country of origin. This period often includes harassment, clandestine detentions, beatings, threats to family members, or loss of property. It also includes the broader sociopolitical conditions in the survivors' country of origin that creates a climate of constant threat and fear.

Flight: Though fleeing from their country of origin represents a critical break from the pressing threat of future persecution, survivors continue to be faced with ongoing exposure to retraumatizing circumstances during the "flight" phase. Flight includes the events and conditions associated with fleeing the survivor's country of origin and arriving in the country of refuge. This phase may, and often does, include a harrowing prison escape, border crossing by foot over mountains, deserts, or simply dangerous terrain, often in the hands of human smugglers. For refugees, this phase may include prolonged periods of living in a refugee camp where conditions are often extremely difficult and can include poor access to food and health resources as well as continuous threat from rebel or military groups in the country of origin. Flight is characterized by a loss of control while one's life is in a state of extreme uncertainty and persistent vulnerability to further abuse and betrayal.

Postflight: The postflight phase includes the period of resettlement. Though many torture survivors may associate this phase with an increased sense of safety and well-being, it also includes the profound difficulties and losses associated with adjusting to life in a new country.

The medical and psychological distress resulting from torture and forced exile often impedes survivors' ability to function or to perform activities of daily life (i.e., caring for self, family, school). The traumatic events and forced migration experienced by survivors disrupt the most basic roles in their lives and the meaning systems attached to those roles. While struggling to adapt to their new environment, survivors struggle with the profound isolation

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experienced in their new country. Disconnected from home, survivors grieve the loss of their role in their family, as provider, parent, and community member.

CLINICAL WORK WITH SURVIVORS

Given the complexity of experiences and needs, practitioners are naturally daunted by the task of working with torture survivors. The layers of loss, grief, trauma, and the pressing needs for basic survival challenge the best of conceptualizations and tools for interventions. And so, the question of how to best wrap our hearts and minds around the experience of torture, flight, and resettlement arises.

Basic Principles of Clinical Work

Like many specializations in the field of social work, competent and sensitive work with torture survivors at any stage of treatment relies on a number of core principles that guide engagement and treatment. These core principles are: (a) human rights framework; (b) empowerment and resilience; (c) safety; (d) developing trust; and (e) flexibility, working across cultures and concepts of trauma and meaning. (The Appendix at the end of the chapter provides resources to assist social workers helping survivors of torture.)

Human Rights Framework

Torture is a fundamental human rights violation according to the Universal Declaration of Human Rights and the UN Convention against Torture. That there are international human rights covenants and conventions against torture demonstrate a global consensus that torture is immoral, illegal, and should be condemned. Despite efforts to prohibit torture, regimes use it as a tool of political oppression. Torture occurs in a political context, and by extension, torture treatment also occurs in a political context. Over the years, many torture treatment professionals have underscored this fact. When torture treatment began in the United States, the first wave of clients were predominantly Latin American and Southeast Asian, and therefore, it was imperative to understand the sociopolitical history and current policies of U.S. involvement in those hemispheres. Presently, torture survivors are coming from the Middle East and Africa so social workers must acquaint themselves with the human rights issues in those regions (Engstrom & Okamura, 2004). A therapist may need to demonstrate to survivors that they have views independent of the U.S. government and are not antagonistic to the survivors' activities their governments found threatening. Torture in a political context requires healing in a political context. Survivors come from all corners of the world. Some will have had direct experience with the reach and harm caused by U.S. foreign policy and may have strong reactions to being here, forced to find safety and trust in a country they inherently cannot trust. Other survivors may feel safe, respected, and protected here. Some arrive with idealized notions of the benevolence of the United States but eventually encounter a disillusioning political asylum process.

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Promoting Empowerment by Sharing Power

Empowerment is both a goal and a way for practitioners to share power. Recognizing the systematic nature of the use of torture, many in the torture treatment community see the need to systematically apply empowerment principles over the course of treatment. Empowerment includes offering choices throughout treatment and access to a range of services that address the complex and varied consequences of torture (i.e., English language instruction, access to health care, and employment and education). Reduced symptoms of insomnia, depression, and anxiety, along with participation in activities beyond the therapeutic dyad signal an increasing sense of agency and change from the core dynamics of torture (Wolf, 1999; Fabri, Joyce, Black, & Gonzalez, 2009).

Safety

The primary task in torture treatment is restoring a sense of safety. Survivors face the exhausting challenge of trying to cope with significant psychological trauma while finding themselves in a new country often hostile to their interests. Survivors are forced to be dependent on others while compromised by trauma. They lose status, feel ashamed of their loss of dignity and functioning, and feel saddened by separation from their families and communities. In this new reality, safety is constructed by conveying understanding and respect for the survivors' challenges and responding with assistance in multiple domains. As stable housing and sources of food become more accessible and the most distressing physical and psychological symptoms are addressed, a sense of safety will grow and seeds of trust will be planted.

Developing Trust

Torture represents the ultimate violation of the social contract in which another human being manipulates power to intentionally harm another. Emerging from the experience of torture, survivors are often sensitive to power dynamics, especially in an unfamiliar place with considerable deprivation. Survivors may be particularly wary of those perceived to be in positions of power or authority. For example, the initial assessment and the inherent imbalance in the client–helper relationship can provoke unsettling dynamics of power and control and is often a loaded experience for torture survivors. It is also frequently the first time that survivors disclose details about the abuse that they experienced. Intake questions require survivors to recall memories and feelings that they are attempting to put behind them and survivors frequently become very symptomatic during sessions (e.g., sobbing, flashbacks) when asked about them.

Communicating safety and trust is fundamental for a meaningful interaction. Social workers do well by demonstrating appropriate respect for this interaction, acknowledging the difficulty of talking with someone new in an unfamiliar language or with an interpreter. Framing the survivor's apprehension and difficulty trusting in a practitioner and others as

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an understandable response can help to communicate a willingness to be patient with the process. Efforts such as these demonstrate flexibility and understanding and help promote a balance of power and sense of security in the new relationship.

Flexibility

Clinicians should remain open to the need to make adjustments to the therapeutic frame in order to make the interaction more comfortable and culturally relevant for the survivors. There may be a significant cultural gap between practitioner and survivor. It is the responsibility of the practitioner to make attempts to narrow that gap. One step is to become familiar with the political conditions in the clients' countries of origin and another is to engage your client as a teacher/guide of cultural practices that have helped her in the past. In dialogue with survivors, we will learn that some may need to meet in a home rather than an office, others will feel safer when more rooted to tradition and need to incorporate meaningful ritual, and still others will feel safer when the therapist invites her to collaborate on all decisions affecting therapy, awakening her sense of agency (Fabri, 2001).

Practitioners must also demonstrate genuine concern for their social conditions, often dire and demoralizing. At times it may be necessary to advocate or intervene with systems most affecting survivors. We may be actively partnering with our clients or carrying most of the responsibility in the process, reflecting the client's capacity at the moment. The practice of accompaniment challenges traditional ideas of clinical boundaries (Fabri, 2001). This may include, but is not limited to, a physician conducting a forensic medical examination in a nonmedical setting; a psychotherapist accompanying a survivor who was raped as part of her torture to a medical examination; and a case manager driving and staying with a client through her dental appointment. The guiding principle determining how and when to adjust conventional boundaries is answering the questions—Is this therapeutic for the survivor? Will it enhance engagement in treatment? Does it promote greater safety and trust? We have learned boundaries are internalized and professional roles can be maintained in any physical environment (Fabri, 2001; Fabri et al., 2009).

Other Issues

Asylum

The legal path to safety and stability for most torture survivors is applying for political asylum once they have reached the United States. This legal remedy also provides a way to reunify with spouse and biological children and eventually adjust status to permanent residency and finally citizenship. Unfortunately the asylum process is itself highly traumatizing. To begin with, it is common for survivors to arrive in the United States with no official identity documents and no supplemental evidence to support an asylum claim (Bohmer & Shuman, 2008). Most survivors are ignorant about the asylum process until after arrival. To compound the difficulty, tens of thousands of asylum-seekers over the years have been placed in immigration detention

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during some part or all of the asylum process. Immigration detention makes it much more difficult for asylum-seekers to prepare their cases and to have access to legal representation. Moreover, detention is associated with high rates of posttraumatic stress disorder (PTSD), depression, and anxiety.

The asylum process requires a thorough, detailed account of their torture, something most survivors are ill-equipped to produce within the first year of arrival. Unfortunately, survivors are often unable to comply with expectations of our asylum procedures—their narratives of torture are subject to PTSD-related difficulties (e.g., memory gaps, intentional or unintentional omission of significant details, etc.) and they are frequently overwhelmed by the retraumatizing effects of their narratives of torture and loss. Torture survivors bear the burden of proof in asylum, and authorities are empowered to make discretionary and highly subjective decisions about their credibility. Survivors are routinely alarmed and sometimes terrified by their complete reliance on a legal system that seems random and unpredictable. The arbitrary asylum experience of survivors is backed up by research. The Stanford Review Comparison Study showed that asylum decisions across the United States appeared to be made randomly by asylum officers and immigration judges, with little to no oversight or standards (Ramji-Nogales, Schoenholtz, & Schrag, 2008).

Recognizing the primary role of securing safe refuge in a survivor's overall well-being, treatment will include documentation, collaboration with the legal team, and solidarity with naming the persecution. A trauma-informed approach to preparing an asylum application might allow additional trust-building time with the attorney or paralegal and accommodate the survivor's own pace and comfort with discussing a trauma narrative. The survivor may also benefit from involving her therapist in the legal preparation as consultant and advocate for the client when she cannot or does not know the questions to ask her attorney. The therapist may also be assisting the survivor as she processes her asylum narrative with additional tools for managing an increase in traumatic symptoms. Ideally, through the prism of the asylum process, survivors can experience restoration of hope in humanity's potential for good, after living the worst possible experience.

Clinical Assessment of Survivors

Clinical assessment of torture survivors is a complex endeavor for reasons of trauma, culture, and complex needs. Successful assessment and understanding of torture survivors comes with combining an understanding of torture, trauma phenomena, and cross-cultural mental health practice brought to bear with a dose of flexibility, compassion, and humility. There are several concepts that social workers need to understand in order to facilitate a meaningful interaction and achieve a balanced assessment. Social workers need to use a systems framework to understand and assess the consequences of torture, be savvy to the impact of culture on paradigms of well-being, have a contextual understanding of trauma symptoms specific to torture experience and informed by neurobiology, know how to work with interpreters, and recognize how they can be personally affected by hearing disturbing trauma narratives.

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Need to Engage Multiple Systems and Multiple Disciplines

Grounded in an understanding of how torture undermines human relationships, we now look within and beyond the individual to consider the ways that torture infiltrates every aspect of the human experience. Survivors come to services with physical, emotional, and spiritual wounds. Distressing psychological symptoms of PTSD and depression are common among torture survivors as are feelings of guilt, grief, and loss. The experience of torture often leads survivors to question basic held beliefs and spiritual practices. Physical health needs can include complex wounds, musculoskeletal injury, nerve damage, injury to organs of sensation, and consequences of severe dental and genital trauma. Survivors may need care for chronic infections such as tuberculosis, HIV, and other sexually transmitted diseases, intestinal parasites, and tropical diseases. Their general health can be adversely affected by severe deprivation and they frequently suffer from chronic pain.

Though providers may only be able to assist with a limited number of problems, it is important to take a triage approach and coordinate with a multidisciplinary network of providers whenever possible. Facilitating access to other providers is a natural advocacy role for social workers when identified needs go beyond what is provided programmatically. It also resonates with the core goal of integration that is inherent to the healing process and one that stands in direct contrast to the experience of fragmentation inherent in torture.

Unfamiliarity With Systems of Mental Health

The assessment process with torture survivors requires social workers to be attuned to the various ways that the role of culture may manifest in the interaction. Most survivors come to treatment services with little to no understanding of mental health services. In many non-Western countries, people are accustomed to turning to a family member, trusted community member, spiritual leader, or traditional healer when facing personal problems (Fabri, 2001). The idea of talking with a stranger is often very unfamiliar. Mental health services, if there are any in the country of origin, are often reserved for people with severe and persistent emotional problems.

Many survivors, on the contrary, grow up in healthy, connected families and communities with no prior thought or wish to leave their countries and no history of psychological problems. With no safe option but fleeing their countries, survivors mobilize resources for the often long, arduous journey to the United States. Survivors draw on enormous internal (individual) and external (collective) resources surviving torture and getting to a safer country. Clinicians should operate from a strength-based approach that recognizes the likelihood of a survivor's deep reservoir of cultural and individual resilience and in order to normalize (depathologize) the toll torture aims (and is designed) to inflict on their lives. As important as it is to understand the torture experience, it is equally important to look beyond the trauma to see the whole person present. The torture story is one of horror, undoubtedly, but it is also one of strength, perseverance, and courage (Mollica, 2006).

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Depending on the country of origin, survivors will differ in the way that they describe psychological distress. For example, in many parts of the world people frequently express traumatic symptoms through their bodies, frequently describing chronic and severe headaches, stomach and digestive problems, and nonspecific pain. Ruling out a larger health issue, social workers should include these symptoms as part of the overall assessment picture. Languages also vary widely in the vocabulary available for describing inner emotional states (Okawa, 2008) and psychological concepts such as depression and posttraumatic stress. Consider the comment from a psychologist from Rwanda who reported that the word "trauma" did not exist before genocide. The extent to which survivors will understand the concepts being asked vary greatly and this, naturally, greatly impacts the assessment. Social workers should use assessment tools that have been used and/or validated cross culturally and consider bringing in tools and using techniques to concretize unfamiliar concepts.

Expressions of Trauma, PTSD Symptoms in Context

Given the chronic and extreme nature of the trauma, survivors of torture are known to have higher rates of psychological distress than other refugee populations and most meet criteria for PTSD. There is ongoing debate about the relevance of the PTSD diagnosis for torture survivors, specifically its ability to capture the complex nature of experiences. Going beyond the PTSD, a more accurate picture for survivors would also include symptoms of depression, profound shame, and loss at the point of initial assessment (Herman, 1992). In terms of traumatic symptoms, research and experts have outlined a normative response to overwhelming and uncontrollable experiences: hyperreactivity to stimuli and traumatic reexperiencing coexisting with psychic numbing and avoidance (Van der Kolk, 1994; Herman, 1992). In many people who have undergone severe stress, the posttraumatic response fades over time, while it persists in others. Research has suggested that the most significant predictors for chronic PTSD are magnitude and type of exposure, prior trauma, and social support (Van der Kolk, 1994).

Reexperiencing: Most torture survivors report being disturbed by intrusive memories and nightmares that contain images of their own or witnessed torture experiences. Sadly, for many survivors, these memories and nightmares can persist over a period of many years and often despite significant reduction in other symptoms. Survivors remain vulnerable to flashbacks that are triggered by memories and thoughts of torture, interactions with others, or environmental cues. Triggers can be global (interactions with men or people from their country of origin) or those more specific to their experiences, such as sensory triggers. One woman stopped taking public transportation because she often encountered smells, like alcohol and cigarettes, that reminded her of the guards' breath when they tortured her. Another survivor was triggered by the smell of cooking meat because it was a sensory link to her experience of being kept among rotting corpses.

Avoidance: To minimize this type of distress, survivors often adapt a pattern of avoidance or repression of the traumatic memories. Symptoms

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of avoidance are known to accompany intrusive symptoms as a kind of compensatory mechanism in the posttrauma response. Many survivors may describe highly restrictive social interactions limited to very few people. They may prefer to stay home most of the day informed by a deep sense of mistrust for others and a wish to limit exposure to stimulating environmental triggers. These efforts at avoiding the memories reflect an attempt to regain an internal sense of control and to protect against overwhelming distress and fear. Contrary to their attempted purpose, survivors often expose themselves unwittingly to intrusive memories when they isolate themselves and have no activities to distract them from their most salient memories.

Hyperarousal: The threat of a traumatic event triggers a complex set of physiological responses in the body. Also referred to as the flight or fight response, this physiological response stimulates the nervous system. This leads to a persistent state of increased physiological vigilance of the autonomic nervous system referred to as hyperarousal (Van der Kolk, 1994; Taylor, 2006). Survivors of torture often describe hyperarousal in several characteristic ways including insomnia, feelings of irritability and anger, and difficulty concentrating.

Disturbed sleep is a very common symptom among torture survivors. Insomnia and disturbed sleep often relate to periods when survivors remember their traumas and losses more frequently, increased depression, and sense of vulnerability. For survivors in the asylum process, this is often experienced in relation to pending immigration hearings. The unresolved legal status often provokes thoughts of possible deportation (and further torture), which prevents survivors from being able to imagine a safe future.

Shame

The majority of female survivors describe sexual torture (e.g., rape, extreme sexual humiliation) as a central aspect of their persecution. Though to a lesser extent and frequently underreported, men have often also experienced sexual torture. Survivors of sexual torture often describe feelings of extreme shame associated with discussing their experiences. This particular pattern of avoidance should be understood in the context of sexual humiliation: the shame it evokes and the cultural stigma attached to rape. In most cultures, a woman is considered "bad" or "unclean" after being raped. This attempt to avoid disclosing a trauma that is highly stigmatizing, one for which she would be blamed in her own culture, and one that stimulates painful traumatic memories of the event is common among survivors of sexual torture (Herman, 1992, 2008). It has its place on the spectrum of opposing psychological states of intrusion and constriction that result from overwhelming trauma.

Depression and Loss

Feelings of depression are often most strongly associated with the loss of family, home, and community. After fleeing, survivors often describe ruminating worry for their family members who remain back in the home country, often in harm's way. Adapting to a new environment and mourning the loss of friends and family back home, survivors frequently describe profound

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loneliness. Across the spectrum, survivors mourn the loss of roles that gave them a sense of meaning and purpose. Fathers and mothers separated from children feel disconnected from their role as parents. Unable to work and send money back home, family members feel guilty for not being able to provide as parent, spouse, sibling, and eldest child.

Working With Interpreters

Because many survivors come from non-English-speaking countries, social workers may find themselves needing interpreters to facilitate communication. Like assessment or treatment, working with interpreters is a skill best honed with training and practice. Though there is frequently trepidation about working as a triad, used appropriately, interpreters contribute notably to the building of trust and safety and realizing the goals of treatment (National Capacity Building Project at the Center for Victims of Torture, 2005).

Even beyond this premise, there are several aspects of work with interpreters that should be highlighted. Some survivors may be reluctant to have interpreters from their own country in the room. This may be based on fact or rumor that some members are paid to report back on dissidents, with potentially harmful results for their families. Therapists must find the flexibility to respond to clients' fears, as their sense of safety remains vital, yet balance this concern with the challenge of providing adequate professional or volunteer interpreters. Existing models of interpreting (e.g., medical, diplomatic, legal) do not incorporate relational considerations. Some treatment centers have developed a volunteer corps of interpreters with in-house training for their unique role, and supplement the need with paid interpreters. Telephonic interpreting is frequently used in medical appointments, but in the context of psychotherapy, it is suboptimal. Social workers are advised to brief interpreters prior to the session about its purpose and to review specific terminology, to underscore the principle of confidentiality, and to review the interpreter's role during the session, and to debrief after the session concludes, especially if graphic or emotionally charged material is covered (Engstrom et al., 2010). When expanding the conventional therapeutic dyad into a triad, the therapist must adjust to the new dynamic and have confidence that the therapeutic relationship will transcend this new dimension.

Vicarious Trauma and Vicarious Resilience

Practitioners working with torture survivors run the risk of vicarious trauma. Vicarious trauma theory states that mental health providers may experience symptoms resembling PTSD, similar to those of their clients (McCann & Pearlman, 1990; Baird & Jenkins, 2003; Morrison, 2007). While vicarious trauma has been examined among clinicians dealing with domestic violence and child abuse, there is only one published study on practitioners working with torture survivors. Birck (2002) reported that therapists had increased PTSD-like symptoms and disruptions to their belief about the value and safety of other people. In an unpublished study, Engstrom found that a majority of torture treatment practitioners had experienced some symptoms of vicarious

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trauma. Because vicarious trauma is a normal response to trauma, a number of torture treatment centers have developed peer-to-peer debriefings to assist practitioners cope with it.

Torture treatment clinicians have also reported experiencing vicarious resilience. Vicarious resilience holds that "therapists who work in extremely traumatic social contexts learn about coping with adversity from their clients, that their work does have a positive effect on the therapists, and that this effect can be strengthened by bringing conscious attention to it" (Hernandez, Gangsei, & Engstrom, 2007, p. 237). Two separate studies of torture treatment practitioners have found that the vicarious resilience has three domains: being positively affected by the resilience of clients, alteration of perspectives on the therapist's own life, and valuing the therapy work (Hernandez et al., 2007; Engstrom, Hernandez, & Gangsei, 2008). The research on vicarious resilience suggests that it may help counter the toxic effects of trauma work.

Treatment

As has been emphasized throughout this chapter, effective and sensitive treatment for torture survivors starts with an understanding of the complex nature of torture and consequences it exacts over many years and even a lifetime. Even with good resolution of more short-term goals (symptom reduction, asylum status), a person will carry losses of culture, connections, and the knowledge that injustice is still present in their home country. By keeping the long view in mind from the start, practitioners avoid an overly reductionist approach to treatment and can more readily locate their role among many others needed.

Evidence-Based Best Practices

Debate over the role of evidence-based practice with survivors of torture has recently emerged among researchers and practitioners in the field. Noted trauma researcher Metin Basoglu (2006) asserted, "Most psychological treatments used in rehabilitation programs still appear to be a mixture of various psychotherapeutic elements, not based on a consistent theory, and lacking evidence on their effectiveness" (pp. 1230–1231). He went on to state that only cognitive behavioral therapy was the "treatment of choice" for dealing with PTSD. Practitioners reacted strongly to Basoglu's analysis by arguing that torture treatment involves a constellation of interventions beyond individual therapy (Jaranson et al., 2007). Moreover, some noted that the evidence supporting cognitive behavioral therapy was largely based on Western European and North American populations and the majority of torture survivors did not come from those areas. Fabri (2011) cautions us not to undervalue our clinical knowledge from experience.

Because torture treatment usually involves a range of medical, psychosocial, case management, and legal services, it has been difficult to conduct outcome research that adequately covers all components of treatment. In a recent review of torture treatment outcome research, Jaranson and Quiroga (2011) stated, "We don't know what treatments are most effective" (p. 102). At this point, there is growing consensus that evidence for the effectiveness of torture

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treatment is needed but the development of knowledge has been hampered by inadequate research funding.

Supportive Psychotherapy

The profound need for support among torture survivors resulting from intense isolation and multidimensional distress often makes supportive psychotherapy a natural step in treatment. This need often outweighs differences in help-seeking behavior and practice among cultures and trepidation that survivors may have about engaging in a trusting relationship.

A stage-based approach to treatment is recommended with the main order of business as restoring safety in the initial stage of therapy. This will be accomplished by focusing on building rapport and a therapeutic relationship with a nuanced understanding of how this phase becomes particularly salient for survivors. We must recognize and validate the self-protective tendencies each survivor has developed. Indeed, conscious and unconscious mechanisms of self-preservation have helped them to survive and brought them to relative safety. Survivors reluctant to engage should not necessarily be dismissed as uninterested. Many survivors are unfamiliar with an individual psychotherapy paradigm. The treatment team should be mindful of incorporating choices in their interactions with survivors: to slow the pace, to not disclose a detail until ready, to sit facing the provider or not, to accept medication or not. Clear information and descriptions of process help to shape realistic expectations. Providing choices becomes a therapeutic intervention whose effect is to convey sensitivity to their vulnerability, gradually instill trust and safety in the relationship, and restore confidence in the survivor's own inherent ability to heal (Fabri et al., 2009).

Providing basic psychoeducation in the first stage of treatment helps survivors contextualize their psychological symptoms rather than feel personally responsible. Many survivors fear they are "losing their minds," and learning they are having "normal reactions to abnormal circumstances" serves to normalize their distress. Psychoeducation also restores control to the survivor. Survivors of torture often lose the ability to self-regulate emotional states, prompting self-induced social isolation. Sharing basic concepts about how torture affects the central nervous system and teaching tools for regaining emotional regulation/balance is critical in initial phases of treatment. An effective toolkit for the first stage of treatment might contain relaxation techniques, grounding methods, labeling emotions, cognitive reframing, and mindfulness practices. Coconstructed rituals to open and close sessions are frequently necessary to promote a sense of safety (a safe container) and reflect cultural practice. When the process is anchored in dialogue and flexibility to understand what is helpful and what is not, the survivor's sense of agency and control is reinforced. Helping a survivor develop tools to improve affect regulation also emphasizes confidence in their own strengths and healing capacities.

Collaboration with psychiatric providers is effective particularly in the initial stage of treatment. Psychiatric medications very frequently bring needed relief from some of the more intense symptoms such as chronic insomnia, flashbacks, and depression. Integration of psychiatry into the

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treatment plan can provide the stability essential for a survivor to engage in other treatment modalities.

Over time, we continue to offer choices about treatment and develop a dialogue about how effective the strategies to alleviate distress have been, reminding the client she has a choice and she is the expert on the helpfulness (or not) of our interventions. In a safe environment, the survivor's voice gradually emerges to accept or decline ideas from the social worker, as the quality of the relationship becomes more secure and predictably supportive. Later, the survivor may feel confident enough to ask questions, share negative evaluations, and propose innovative strategies, and act in assertive partnership with the practitioner. In many cases, survivors of torture have been targeted because of their strong leadership qualities and effective voicing of opposition to corrupt and violent political systems. An empowerment paradigm pervading treatment will build a therapeutic milieu in which these voices may again emerge to denounce injustice—or to channel their energy toward goals of their choice.

Flexible approach to trauma integration: There is debate among torture treatment professionals about the appropriateness and use of exposure techniques with torture survivors. Survivors' core vulnerability extends in relation to structural obstacles such as immigration status, viable employment, and family members remaining at home in danger. Given a precarious level of baseline functioning, it can be difficult to identify when and how exposure can be used to amplify core objectives of safety and cohesion. And yet, exposure does enter into the treatment picture and often earlier than desired.

The political asylum process, for example, imposes a deadline on the trauma narrative, which impacts treatment. The preparation of a personal narrative quite often results in overexposure of the survivor to their trauma. While not optimal, social workers can utilize therapeutic accompaniment throughout the asylum process (to meetings with lawyers, court dates) as a way to help survivors prepare for, manage, and process repeated experiences of retraumatization.

Justice as defined by the client: Later stages of treatment may also address a survivor's capacity to exercise power, a much richer and complex goal than simply to speak English or hold a job (though these are important components). Recovering one's voice is a political act of demonstrating to the torturing regime that they failed to silence and incapacitate their political enemies. This view of treatment also facilitates the opportunity for a survivor to reconnect with parts of her identity and motivation that were intentionally harmed by torture.

Members of the survivor-founded organization Torture Abolition and Survivors' Support Coalition International (TASSC) speak to the media and lobby officials in Washington, D.C. Others have established activist organizations and filed civil lawsuits against torturers who reside in this country. Many treatment centers partner with a client advisory board. Some have provided therapeutic accompaniment for survivors who pursue justice through civil cases supported by the Center for Justice and Accountability (CJA). While these processes are emotionally draining, retraumatizing, and prolonged, many survivors have experienced deeply therapeutic and empowering aspects from their involvement.

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CONCLUSION

Clinical work with survivors of torture requires altering the traditional approach to helping that often emphasizes impartiality and neutrality. Survivors of torture are the victims of egregious human rights abuses that are deliberately and intentionally inflicted on them by agents of the state (or agents the state cannot or will not control). To remain neutral on this crime is to side with torturers. Social workers helping torture survivors must incorporate a human rights framework as part of their practice. Such a framework requires that social workers actively monitor world events with an eye toward identifying the human rights "hotspots" and with knowledge that clients from those "hotspots" have a reasonable chance of being torture survivors. A human rights framework grounded in knowledge of country conditions will aid in clinical assessment and treatment of torture survivors.

Work with survivors of torture also requires sensitivity to the power dynamics of clinical treatment. Because torture is an act of stripping one's power away, treatment must emphasize restoring agency. As this chapter has emphasized, treatment is best contextualized from a strengths perspective where clients are in control. And it should be emphasized that survivors are remarkably resilient: If they were not, few would have survived the trauma of torture, flight, and resettlement. Indeed, the resilience of torture survivors should anchor trauma treatment. Oftentimes, what torture survivors need from social workers is the reassurance that the pain and suffering they experience can be eased and they have the capacity within themselves for recovering from trauma. A strengths or resilience perspective reminds social workers that they are not responsible for healing but help facilitate it.

Working with survivors of torture takes social workers out of their comfort zone and forces them to confront oppression that is all too common in too much of the world. For many social workers, this means not only helping to heal the harm of torture but to take action to prevent it from occurring. After all, torture illustrates the intersection of how macro factors such as persecution and oppression create microlevel problems such as PTSD and depression. To only address torture from a microlevel perspective is to ignore the urgent need for macrolevel action such as advocacy and holding governments accountable for torture. Torture survivors inspire and compel social workers to stand in solidarity with them and others who speak out against torture. We may even be inspired to speak out or take action ourselves.

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Resources

Amnesty International: www.amnestyusa.org
Human Rights Watch: www.hrw.org
Center for Justice and Accountability: www.cja.org
Torture Abolition and Survivors Support Coalition (TASSC): www.tassc.org
National Consortium of Torture Treatment Programs: www.ncttp.org
The Center for Victims of Torture: www.cvt.org; www.HealTorture.org
United Nations High Commission for Refugees: www.unhcr.ch

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TWENTY

Latino Families Affected by HIV/AIDS: Some Practical Practice Considerations

Claudia Lucia Moreno

The Latino population in the United States is one of the fastest growing and in less than 40 years it will be the largest minority group in the United States (U.S. Census). This rapid growth presents some challenges for social workers who need to be equipped to adequately work and provide culturally relevant services. HIV is a virus that anyone can get if you are sexually active or use intravenous equipment. Therefore it is a condition that any social worker can encounter in any field of practice, not necessarily only in centers for HIV positive individuals. This requires that social workers be armed with awareness, knowledge, and skills about how to work effectively with this population. It is imperative to know about the biology of HIV, current discoveries, gender differences, and risk factors in the transmission, the impact, and the consequences of being HIV infected, stigma, proper treatment for HIV/AIDS, and issues of spirituality and end-of life. HIV/AIDS not only affects individuals, it affects families, friends, communities, settings, and society in general.

This chapter will focus specifically on Latino families. Families are valued and become essential for the functioning of the individual and communities. Traditionally, families are the source of support for those who become infected. HIV/AIDS because of the stigma associated can challenge and transform families and relationships and can have an impact on supports, relationships, nurturing, and the psychosocial well-being of the family. HIV not only affects individuals but also affects families: children and couples, relatives, and parents (Bor & Elford, 1998).

Latinos in the United States come from about 20 different countries with different histories and different journeys of immigration. Although the Latino community is very diverse, some of the literature that has been found for this chapter will include the major Latino groups. As the Latino community changes and transform itself, different Latino groups will need to be represented in the literature and research.

Biological or civil ties do not define the term “family” in this chapter; rather it is defined broadly as whom a person considers family.

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SCOPE AND SERIOUSNESS OF THE ISSUE

HIV is an immunodeficiency virus that destroys specific blood cells that fight disease (T-cells or CD4 cells) leading to an incurable life-threatening condition. People can get HIV by having unprotected sex (oral, anal, vaginal) and sharing infected needles. Infection is now rare by blood transfusions after a careful examination of blood supplies since 1985.

AIDS occurs when the T-cell count is below 200. There are two specific types of HIV: HIV1 and HIV2. Each type has different stains. HIV1 is the most common type around the world (Kanki et al., 1994). People with HIV1 can live many years if they have a healthy lifestyle and they are treated medically and comprehensively. HIV2 is less common and it is usually found in West Africa. It is less transmittable than HIV1 and people infected with this type of virus can live longer; once it is converted into AIDS it is more deadly (Kanki et al., 1994).

The HIV virus enters the body and it can take from 3 to 6 months to be detected by specific HIV tests. This is what is called the window period. If a person gets tested and is negative, it does not mean that the test is negative until the person uses protection for every sexual encounter or needle sharing for 3 to 6 months and then gets tested again. This will give a more adequate reading of the HIV status of the person.

The amount of HIV present in the body (viral load) varies from person to person, length of time living with HIV, and medications taken. Current medications can lower the viral load making HIV less transmissible. One of the problems that people taking HIV medications often face is adherence. HIV medications can have awful and compromising side effects but these medications have prolonged people's lives. Adherence can lead to resistance, making the medication ineffective, increasing the virus load, and leading to progression of HIV. People with HIV not only transmit the virus but also their resistance to medications and the viral load. Thus, a person receiving the virus not only gets HIV but also receives the transmitter's resistance to medications.

Currently we have a variety of medications on the market and new medications are being developed. HIV can be prevented by using condoms (female and male condoms). The science of HIV has advanced and there are new ways to decrease HIV transmission that include antiretroviral medication and microbicides. For instance, new medications have shown to reduce the virus in the person infected with HIV, making the virus less transmissible. Microbicides is a topical gel that can be applied before sexual encounters and some types of microbicides have been found to kill the HIV virus. Currently, clinical trials are taking place to estimate the effectiveness of the different types of microbicides. Another form of prevention is PreP (preexposure prophylactics), which means that if a person wants to have unprotected sexual encounters with an infected partner, both the infected and noninfected person will have to take antiretroviral medication to reduce transmission of the virus. PreP is also used when a person thinks that they have been exposed to the virus; they will have to take antiretroviral medication for a certain amount of time to reduce the possibility of the virus reproducing. Latinos are the second largest group to have a high incidence of HIV infection and

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to have the highest mortality rates due to AIDS (Centers for Disease Control and Prevention [CDC], 2010a).

Each year, about 50,000 people get infected with HIV in the United States. HIV/AIDS has grown in disproportionate numbers in the Latino families in the last 30 years. Latinos represent 20% of the new HIV infections when they represent 16% of the population (CDC, 2011a). Latinos MSM (men who have sex with men) are particularly affected by HIV accounting for 81% of the new infections and 20% among all MSM. At some point 1 in 36 Latinos will be diagnosed with HIV.

Latinas account for 21% of the new HIV infections. One of the concerns in the Latino community is the lack of testing for HIV; by the time Latinos get tested for HIV, the majority do not have HIV but AIDS because testing has been delayed for many years. What these statistics mean is that Latino men are developing AIDS at three times more than the rate of White men, and Latinas are developing AIDS six times more than the rate of White women. HIV is a silent virus that can remain in your body for many years without feeling any serious symptoms.

Another form of HIV transmission is perinatal, which might occur from mother to child during pregnancy, labor, and delivery, or breastfeeding. After knowing how children are infected, precautionary testing of all pregnant women is undertaken by giving medications to infected pregnant women. It reduces the amount of HIV in the mother by decreasing transmission and taking precautions during delivery such as delivering children via C-section and not breastfeeding babies (CDC, 2007).

HIV/AIDS still carry a huge amount of stigma among Latinos and many people do not get tested for fear of knowing the results. The CDC (2011a) estimates that about 1.2 million people are living with HIV in the United States but only about 240,000 don't know they are infected. This lack of testing creates the virus to be spread and affect many individuals and families.

PSYCHOSOCIAL CONCERNS SHARED BY LATINO FAMILIES

HIV/AIDS

HIV/AIDS has touched the lives of many Latinos living in the United States. Being HIV positive and/or having a loved one with HIV is an experience that varies for many families and individuals. Their responses are embedded in a psychocultural context that includes beliefs, norms, values, emotional patterns, socioeconomic factors, and perceived mode of transmissions. HIV/AIDS still carries a high level of stigma, creating significant barriers to obtain services and to provide bio-psycho-social support. HIV/AIDS also brings a transformative experience for individuals that bring empowerment, spiritual, and psychosocial renewed meaning.

Environmental/Structural Factors

Many socioenvironmental factors that impact HIV risk include poverty, limited educational and job opportunities, discrimination, immigration status,

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violence, and level of empowerment (Moreno, 2007). Most people affected around the globe with HIV are poor. Poverty is a concern for many HIV-infected individuals. Some studies have linked poverty to HIV and have found that HIV is more prevalent in poverty-stricken neighborhoods, and many poor neighborhoods in the United States have HIV-stricken epidemics as defined by the United Nations Joint Program on HIV/AIDS (UNAIDS) (CDC, 2010b). That means that living in certain neighborhoods can be a risk factor for someone getting HIV. Latinos in the United States represent 16% of the nation's population but make 26.6% of the poor. According to the 2010 census, poverty for Latinos has increased and it is the highest since 1997 (DeNavas-Walt, Proctor, & Smith, 2011).

Structural factors are becoming important in addressing HIV risk because they influence not only the risk of getting HIV but also about the access to services. Structural factors related to HIV include physical, social, cultural, organizational, community, economic, legal, and policy aspects of the macroenvironment that nurtures and impedes individuals avoiding HIV infection. Most HIV interventions adopted by the CDC focus specifically on individual behaviors without addressing the spaces of poverty, racism, gender inequality, and sexual oppression where the HIV virus thrives (Sumartojo, Doll, Hotgrave, Gayle, & Merson, 2000).

Poverty is not only a risk factor for HIV infection but also impedes access to services and exacerbates stress and poor health among Latinos who are already HIV-infected (Harris, Firestone, & Vega, 2005; Kalichman & Grebler, 2010). Latino families who live in poverty might suffer from more stressors when HIV enters their homes.

Most Latinos who are new immigrants are poor and have limited job skills. Some Latinos encounter HIV in poor neighborhoods and have to be in relationships that are riskier due to their economical dependency and immigration status. These structural circumstances exacerbate Latinos risk for HIV. Historically Latino women and the lesbian, gay, bisexual, trans, and queer (LGBTQ) community have been marginalized and disenfranchised and suffer from ethnic discrimination, homophobia, gender, and power imbalances. These factors contribute to their health status, stressors, treatment access, and medication adherence, and it is also implicated in their ability to negotiate safer sex (Moreno, 2007) and self-care.

Language barriers, stigma, and taboos have been associated with HIV in the Latino community. Some Latino families do not speak English well and this limits the ability to communicate with the medical field and social services and other related services.

Histories of violence and abuse are surfacing as being implicated in HIV risk and impacts on the care of an HIV-infected person. Groups such as women and transgenders have a high incidence of trauma and violence toward them.

It is imperative to understand the socioenvironmental context of HIV. HIV cannot be attributed to the individual's behavior but also to the larger environment. Socioenvironmental interventions and practices need to be included when addressing HIV in families of color. On the other hand, researchers have begun to address how gender, race, or ethnicity, and class

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interact to create a distinct set of challenges for lower income minorities with HIV/AIDS (Lekas, Siegel, & Schrimshaw, 2006).

Sociocultural Factors

There are some sociocultural factors that are related not just to HIV risk but also of how cultural families deal with HIV. There are many belief systems and cultural norms that relate not just to HIV infection but in how Latino families deal with HIV.

Gender Norms

Latinos have a marked tradition of power differentials (CDC, 2011a) between men and women that affect them in many dimensions of their lives (Cianelli, Ferrer, & McElmurry, 2008). These power differentials are characterized by the cultural scripts of *machismo* and *marianismo*. Although these two cultural scripts are not unique to Latinos and are found in other cultures, these power differentials mark both men and women among Latinos.

Machismo is characterized as being dominant, virile, and independent while *marianismo* emphasizes being passive, submissive, dependent, and chaste (Moreno, 2007). Not all Latino men and women adhere to these traditions but they are still very prevalent in Latin America and still influence relationships and ultimately HIV risk behaviors and HIV treatment. For men, machismo can be a risk factor because the more women you have the more of a man you are. For women, under a *marianista* tradition, women are not supposed to be knowledgeable about sex and they are expected to accept infidelity for the sake of the family and because "that is the way men are." Men's infidelity is tolerated but when a woman is unfaithful, she is rejected and her behavior is not accepted by many because she does not fit the culturally prescribed gender roles.

Machismo and marianismo affect the Latino gays. For Latino LGBT, the cultural ideas of masculinities and femininities are oppressive and homophobic and can damage self-worth and self-esteem for individuals who do not fit in those two systems (Diaz, 1998). It becomes very painful for someone with a LGBT orientation to be open about their sexuality.

For some, Latino men with HIV are seen as very different from women with HIV. There is a harder judgment for women who are HIV positive and often are given labels of a "slut," or a "druggy." Latinas with HIV have to stand more labels and misjudgments and many of them neglect their own health and take care of their HIV partners, but then no one takes care of them (Moreno, 2007).

Familism

The family is central to Latinos and is one of the most important cultural factors that influence the lives of many Latinos. The family is a very good source of support, nurture, and identity. Familism is an emphasis on family relationships and a strong value placed on childbearing as an integral part of family life and the women's gender role. There is a strong emphasis on family obligation, and family life that includes the children, church, and the

community. Familism emphasizes the importance of the family over individual needs and the importance of being connected to the family (Moreno, 2006). When a Latino family rejects a family member with HIV/AIDS, this can be detrimental for the person and can interfere with self-worth and self-care. Because of homophobia, Latino LGBT might find it difficult to disclose their HIV status to families because in many occasions it is not only to disclose their HIV status but also their sexual orientation. Some Latino LGBT prefer to disclose their sexual orientation and HIV status to others than to family members (Zea, 2004). A study conducted with Latina women with HIV (Moreno, 2007) found that families played a central role in the women's ability to successfully cope with the virus, and the family's ability to accept their status affected their levels of stress and self-esteem. It is imperative to work with Latino families of members with HIV/AIDS to provide successful coping, for families to understand more about HIV and the progression of HIV/AIDS.

Fatalismo is a cultural belief that is not unique to Latinos. It is entrenched in Catholicism as the belief that there is more to human events than a person has no control over. Fatalism has religious as well as cultural connotations, exemplified by the belief that it is God's fate and not the person who guides events and fate and that people have to make retributions for previous wrongdoings (Falicov, 1998). Fatalistic attitudes can lead to HIV infection because it is related to low efficacy and control to protect against HIV infection (CDC, 2011a). Once infected, fatalistic attitudes can interfere with medical care and reliance on the medical establishment. On the other hand, families need to be understood about their fatalistic views by incorporating views of control, and the importance of avoiding HIV and taking care of their health. For example, the social worker can tell the family "if you believe that it is God's fate, maybe God wants you to avoid HIV and take care of your health."

Management of Stigma and Privacy

HIV continues to be an illness that is highly stigmatized and it is related to homophobia. Many Latinos are afraid of disclosing risk behaviors and also their sexual orientation. Fear of being stigmatized prevents Latinos from seeking testing, treatment, and prevention services (CDC, 2011b). Stigma is a very important area in working with families. Disclosure to families varies and it is often a painful and difficult decision. It is sometimes done in stages and it might be complex and it might range from being a complete secrecy to complete disclosure. Some studies have found that Latinos have low rates to HIV disclosure to extended families, and usually disclosure is done based on the target and the relationship quality (Cusick, 1999).

Fear of disclosing risk behavior or sexual orientation may prevent Latinos from seeking testing, treatment, prevention services, and support from friends and family. As a result, too many Latinos lack critical information about how to prevent infection (CDC, 2011a).

Women are stereotypically considered vectors of infection and become targets of discriminatory behaviors and practices. Some studies have suggested

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that women experience stigma from medical and social care providers when they mention their desire to have children (Lekas, Siegel, & Schrmshaw, 2006).

Many Latinos' families who are undocumented delay testing and have less access to prevention services and receiving adequate HIV treatment when they are infected. They have more fear of disclosing their HIV status (CDC, 2011a).

Maternal Disclosure of HIV Status to Children

HIV/AIDS is the fifth leading cause of death among Latinas aged 35–44 (CDC, 2010b). Because of medical developments, HIV transmission from mother to child has decreased tremendously and more precautions are being taken to diminish vertical infection such as antiretroviral therapy during infection, C-section delivery, and absence of breastfeeding because many children can be infected this way.

The literature suggests that when a family member is HIV-infected, it can contribute to family stress and burden in the family. While caring for children parents have to deal with the stress and medical burden of their own medical condition such as medical challenges and medication adherence that can be stressful to families. Children of parents who are HIV positive display adjustment difficulties and stress especially when mothers are in the AIDS face and health problems are imminent (Dorsey, Watts, Morse, Forehand, & Morse, 1999).

Disclosing the HIV status to children and family carries a great deal of stigmatization and discrimination not only toward the mother but to the family. Because of the cultural value of *familismo,* some Latinos might find it difficult to disclose their HIV status to their own children for fear of being misjudged and as a way of protecting the family. Some studies have found that for women it is easier to disclose to friends and romantic partners but it is more difficult to disclose to your own children. When mothers disclose, they are more likely to disclose to older children and female children and also when they are more ill and the final day is closer (Shaffer, Jones, Kotchick, & Forehand, 2001). Because HIV/AIDS is highly stigmatized, Latino families find it difficult to disclose to children. Social workers should be attuned to this process and help families in the process of disclosing. Psychosocial support is imperative for families who have a family member who is HIV positive. This support should be tailormade and culturally relevant that includes issues of disclosure such as when to disclose, balancing the pros and cons, age-specific issues, and relationship and family context, dealing with emotions and fears in a way that embraces cultural values and traditions.

LGBT and Families

HIV among Latinos is more prevalent among the gay and transgender community. The Latino transgender community suffers from more stigma and discrimination than any other group. Many have to live hiding their gender and sexual orientation and they receive a lot of disapproval for not fitting the cultural norms. HIV/AIDS becomes another layer of stigma. Stigma can be

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harmful for a person because it makes you feel inferior to others, less valued, and it is related to higher risky behaviors and less self-care when HIV positive (Accion Mutua, n.d.). HIV/AIDS creates an added effect of stigma among the lesbian, gay, bisexual, and transgender (LGBT) community. Sexual orientation and gender expression is highly stigmatized in the Latino community. HIV is highly stigmatized and coming from a minority group results in a triple oppression that has detrimental effects on the health and well-being of the LGBT population. Due to the importance of family for Latinos, being rejected by the family because of sexual orientation and gender expression can have detrimental results on the mental health and health outcomes of Latino LGBT. Some studies have linked the Latino family rejection reactions in the LGBT community to higher levels of suicide attempts, substance abuse, depression, mental health problems, and health outcomes (Ryan, Huebner, Diaz, & Sanchez, 2009).

Disclosure to Partners

Disclosing HIV to a significant other can be very painful and can carry an immense amount of emotional baggage because it is not disclosing only a medical condition but also a condition that has emotional significance to the couple such as infidelity, risky behaviors, and guilt about the possibility to also have infected the significant other. Disclosure is emotionally charged. There is guilty, fear of rejection, shame, fear of being abused, and fear of abandonment. The literature has identified gender and contextual differences in the issue of disclosure to intimate partners (Ortiz, 2005). These gender differences relate to cultural norms. For Latina women who are HIV-infected, disclosing can have potential and serious consequences. When disclosing their HIV status, the literature reports that Latinas experience psychological distress and reduced physical and social resources, stigma, discrimination, social isolation, and violence (Moreno, 2007; Ortiz, 2005). Many Latinas fear disclosing to male partners for fear of being rejected and misjudged. Violence against women when disclosing their HIV status is an issue that is surfacing as a risk factor in the disclosing (Moreno, 2007).

Latino men who have sex with women and men find it difficult to disclose their HIV status, more because disclosing it is to reveal that they are having sex with men and they fear the stigma of homosexuality and the shame that homosexuality might bring to the family (Ryan et al., 2009). Latinos who have sex with men are selective in whom they disclose their status because their disclosure can result in positive outcomes such as closeness and support or in negative outcomes such as rejection and abandonment (Zea, 2004).

SOCIAL WORK RESPONSES

HIV/AIDS is a condition that affects Latino families in many different ways. Families play a critical role in the development of the individual. HIV can have a ripple effect spreading beyond the nuclear family to the extended family and communities. Families deserve comprehensive services that are

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culturally tailored and delivered in a culturally responsive way. HIV/AIDS require a comprehensive delivery that can involve different and complex systems. Often, individuals with HIV/AIDS are poor and their families too. HIV/AIDS posits challenges for Latino families affected by HIV. It reduces income, diminishes opportunities, and for many immigrant families, it changes their dream of reuniting with families and making a decent living (Moreno, 2007). Social workers should integrate these complexities when helping families affected by HIV. Families not only need to understand HIV and the medical and psychological challenges that it brings, but families also need access to resources, social support, ways to manage stigma, access to jobs, education, and ways of improving their situation. Social workers should assist families not just in dealing with the medical challenges of HIV/AIDS but with the challenges that poverty brings. For many Latino families, these challenges include language limitations, negotiating an unfamiliar sociopolitical system, a different culture, and for some dealing with challenges for being undocumented. Social workers should aim to assist families in their journey with HIV/AIDS, coping skills and mastery, psychoeducational services, family counseling, empowerment, and dealing with the stigma related to HIV, homophobia, and shame. Services for HIV-affected families should be delivered in a comprehensive way not just to focus on the individual with HIV but also with their romantic partners, families, and communities. Structural and policy interventions are also needed to better serve families affected by HIV/AIDS. Practice principles across interventions will be discussed next.

Practice Principles Common to All Interventions

Risk Factors

Families affected by HIV need to understand the risk factors, transmission, and management of HIV not only to help their family member who is infected but also to make sure that HIV stops there. Regardless of the social work setting, social workers should educate clients about HIV/AIDS, of how HIV is transmitted, and what we can do to avoid having HIV. Education about HIV is a tool that we can use to prevent infection and reinfection of the different strains of HIV. Anyone who is sexually active and/or is sharing needles can be at risk for HIV.

Stigma and Confidentiality

Latinos are a minority group and have histories of oppression, discrimination, and violence. Many have experienced a multitude of stigmas. Having a family member with HIV can exacerbate fear and shame and increase the stigma about HIV. Many Latinos find it difficult to disclose their status to others. Families choose carefully to whom they will disclose information about a HIV or AIDS diagnosis. It is imperative to understand the totality of their experience. Clients might be juggling not only the stigma of HIV but also other stressors such as poverty, drug abuse, unemployment, mental health issues, and other external factors. Social workers need to establish *confianza* (trust) and build a relationship that is conducive to explore how

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stigma might harm families and enable the family to feel secure in when, where, and whom to disclose their family member's status. Since HIV/AIDS is a condition that is highly stigmatized, clients need to be educated about what is HIV, health and nutritional factors, and medical management. High levels of stigma have been associated with poor medication adherence. Poor medication adherence can lead to medication resistance and eventually death. Social workers should explain to families about confidentiality and HIPPA guidelines, understanding, and contextualizing the family's concerns about privacy and providing support and guidance around difficult disclosure decisions.

Assessment

Assessment is an ongoing process and families open up as the relationship with the social worker develops. An individualized, contextual, culturally relevant, mutual, and ongoing assessment process that has a lens of strengths and needs is essential in working with families affected by HIV/AIDS. The social worker should assess families, and explore for cultural beliefs, secrets, worldviews, cultural norms, and meanings regarding relationships, coupling, and parenting, gender roles, caretaking roles, immigration history, spirituality, history of abuse and oppression, patterns of communication, meanings regarding HIV/AIDS, scapegoating, conflicts, and disengagement (Poindexter, 2005).

Social workers should be attuned and be cognizant that the needs of each group is different; for instance families of the LGTB population have different needs compared to heterosexuals because families might not be dealing with the stigma and health issues of HIV/AIDS alone but with the stigma of the illness and coping with having a member with a different sexual orientation and gender expression. For the LGBT population, research shows that when families reject individuals within this group because of their sexual orientation their health is compromised and risky behaviors increase (Ryan et al., 2009).

Medical advances in drug therapy have extended the lives of many individuals with HIV and now they can live longer and healthier lives. Many families affected by HIV/AIDS suffer from many overlapping stressors; their family member with HIV might have several medical challenges that include the management of fatigue, anemia, digestive problems, bone problems, and fat misdistribution. The psychological challenges include depression, dementia, isolation, fear, low self-esteem, and the awareness that death might come. In addition, stigma persists for people with HIV/AIDS, and some family members might have stigma toward family members. The social worker should provide psychoeducational services to families and inform them about HIV transmission and medical management (Lichtenstein, Sturdevant, & Mujumdar, 2010). Empowering families to help their family members with HIV/AIDS is imperative. Families eventually can organize, request, and shape services and resources for clients and become influential in social policy.

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Cultural Competence

In working with Latino families, it is imperative to have some familiarity with the culture and awareness that Latinos are very diverse and come from 20 different countries. Most models of cultural competence agree that a culturally competent social worker must have three specific elements: (a) self awareness, (b) knowledge acquisition, and (c) skill development (Smith & Montilla, 2006). Knowing one self is imperative and fundamental in cultural competency development. Negative stereotypes about Latinos and HIV/AIDS can get in the way in working with families. Knowledge about Latinos and the diversity of Latinos, cultural values, belief systems, and the intersectionality of socioeconomic status, language, gender norms, power and privilege, and family structure, that is, about Latino's worldview, is a lifelong process of knowledge acquisition. It is imperative that the social worker becomes knowledgeable with all the different dimensions of Latino families to personalize the treatment and to avoid a one-size-fits-all approach (Smith & Montilla, 2006).

Cultural competence must address all of the ways that families of HIV-infected clients experience stigma, oppression, discrimination, socioeconomic status, immigration status, sexual orientation and gender expression, geography, drug use, and health status (Werkmeister Rozas, & Smith, 2009). Social workers should be aware of the importance of the family and the extended family and also the different definitions of family. People are connected by blood, adoption, relationship agreement, emotional links, and a strong sense of connectedness. *Familism*, which is the strong belief in family, is central to Latinos and a source of support, care, guidance, and healing. When family ties are cut off, this can be the source of pain, isolation, depression, and stress for many Latinos. When working with families affected by HIV/AIDS, it is important to explore the meaning of family and to work with clients with a family perspective in mind. Many families in the United States are transnational, which means that "*no son de aqui ni son de alla*" (they are not from here and they are not from there), transnationalism also means having two identities, two countries, and two cultures, not having to decide one over the other one, which is contrary to the concept of acculturation.

When working with Latinos, the theme of personalismo is very important. *Personalismo*, which is a central cultural construct for Latinos, refers to interpersonal interactions and reciprocity that involve respect, honor, and courtesy (Werkmeister Rozas & Smith, 2009). Some families might have a greater need of *personalismo* with the social worker. *Respeto* signals clear lines of authority within the family structure. *Espiritismo* refers to spiritism, for some Latinos, sickness; in this case HIV/AIDS is thought to be caused by spiritual forces that lead to physical and emotional suffering. Some families might attribute HIV as a punishment of God for being homosexual. *Espiritismo* is also imbedded in fatalistic attitudes that behavior cannot be changed. Social workers must explore these beliefs and provide support and education about differences in sexual orientation and gender expression within families affected by HIV/AIDS.

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Greater education about the prevention and treatment of HIV/AIDS in Hispanic families coupled with respect for cultural differences will serve to improve health and social outcomes for those affected by HIV/AIDS and their families.

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TWENTY-ONE

Evidence-Informed Marriage and Family Treatment With Problem Drinkers: A Multicultural Perspective

Meredith Hanson and Yvette M. Sealy

Alcoholism and other forms of problem drinking are health and social problems that affect members of all societal groups. It is estimated that 7.9 million adults in the United States are alcohol dependent, and another 9.7 million adults are alcohol abusers (Grant et al., 2004). The enormity of these numbers suggests that either their own history of alcohol abuse, or that of a relative, has affected adversely at least 50% of all adults in the United States. In addition, 25% of all children and adolescents have been exposed to the negative effects of alcohol use through contact with an alcoholic parent (Fromme & Kruse, 2003; Johnston, O'Malley, & Bachman, 2003; Windle, 2003). Approximately 50% of all clients seeking help from mental health professionals experience problems associated with their own drinking or that of a family member (Drake & Mueser, 1996). Well over two-thirds of all social workers encounter clients with alcohol- or other drug-related problems in their professional practice (O'Neil, 2001).

The risk of developing alcohol-related difficulties is not the same for all population groups, and problem drinking has differential consequences for members of different cultural communities. National survey data reveal that among the four main ethnic minority groups in the United States, both current drinking and heavy drinking are most prevalent among American Indians, Native Hawaiians, and Alaska Natives, and lowest among Asian Americans and Pacific Islanders. Hispanics and African Americans have problem drinking rates between these extremes, with Hispanics having higher problem rates than African Americans (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2002; Substance Abuse and Mental Health Services Administration [SAMHSA], 2003). Among adolescents, African Americans appear to have some of the lowest rates of alcohol problems, while Hispanic adolescents have some of the highest rates of heavy drinking. Recent data, however, reveals increasing trends in alcohol abuse among African American women and men, especially in younger age groups (Grant et al., 2004).

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Among all ethnic and cultural groups, men drink more often than women, and they tend to consume larger quantities of alcohol when they drink (NIAAA, 2002; SAMSHA, 2003). The gap between the drinking rates of men and women has narrowed over the past 30 years (Morell, 1997; Straussner, 2001). Despite drinking less than men, women experience disproportionately more problems associated with drinking (Straussner & Zelvin, 1997).

Cultural norms and values are key determinants of the differences in drinking patterns among members of different communities. American Jews have lower rates of both abstinence and alcohol-related difficulties than do members of other cultural groups. African American and other Black women have higher rates of abstention than Caucasian women. Hispanic and Asian/ Pacific Islander women have even higher abstention rates than Black and Caucasian women. Within the Hispanic and Asian/Pacific Islander culture traditional values discourage alcohol use by women. Although some women in these groups still consume alcohol, the quantity is usually lower than that consumed by women of other ethnic groups (Caetano, Clark, & Tam, 1998).

Age, acculturation, marital status, and employment status also help to explain variations in drinking patterns. Young adults have the highest rates of alcohol consumption and problems associated with use. Employed women drink more frequently, but consume less alcohol when they drink, than do unemployed women. Likewise, women with lower incomes drink less often than women of higher socioeconomic status, but drink more alcohol when they drink. Married women and men tend to have lower rates of alcohol-related problems than unmarried women and men.

Findings about the association between acculturation and drinking patterns are mixed. In general, as members of ethnic minority groups become more acculturated to the "dominant" U.S. culture, their drinking patterns and problems seem to become more like those of this dominant culture. This seems to be the pattern among Asian immigrants, for example (Westermeyer, 1997). However, in some cases "acculturative stress" associated with language differences, poverty, loss of homeland, and racial discrimination may account for the higher levels of alcohol use among less acculturated individuals. Depression and anxiety are common psychological responses to stress, and excessive drinking may be an accompanying behavioral response (Caetano, 1987; Caetano et al., 1998; Randolph, Stroup-Benham, Black, & Markides, 1998).

TREATMENT FOR MEMBERS OF SPECIFIC ETHNIC AND CULTURAL GROUPS

Despite the fact that problem drinking has a differential impact on members of particular ethnic and cultural groups, with few exceptions, empirically supported interventions for drinking-related problems have not been validated for different cultural and ethnic groups. Thus, the research literature provides little persuasive evidence that members of different cultural and ethnic communities either benefit or do not benefit from specific intervention approaches.

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Two alcohol prevention programs and one treatment model have been evaluated to determine the effectiveness of culturally sensitive versions for the populations in question (NIAAA, 2002). Modified versions of the Strengthening Families Program (SFP) have been found to be effective in reducing family problems and alcohol use among urban and rural African Americans and urban Hispanics (Kumpfer, 1998). Likewise, a school-based Life Skills Training (LST) program designed to help adolescents cope with social pressures to drink and use other drugs has been modified to take into account the cultural heritages of inner-city African American and Hispanic youth. Researchers found that, although both the standard LST program and the modified version yielded significant decreases in drinking by Hispanic and African American youth, participation in the modified program was associated with a significantly greater reduction in drinking (Botvin et al., 1995). A version of the Community Reinforcement Approach (CRA), a well validated alcoholism treatment package that is designed to alter environmental and family contingencies that reinforce and sustain drinking behaviors (Meyers & Miller, 2001), was modified to include American Indian traditions. The modified version was found to be successful in helping Navajos in New Mexico achieve abstinence (Miller, Meyers, & Hiller-Sturmhofel, 1999; NIAAA, 2002). Finally, motivational interviewing (Miller & Rollnick, 2013) has been described as a "cross-cultural practice" (Hohman, 2012). A meta-analysis of 72 empirical studies, for example, found that the effects for motivational interviewing across studies was almost double for minority subjects when compared with nonminority subjects (Hettema, Steele, & Miller, 2005).

The small number of validated culturally responsive treatment approaches for people affected by alcohol problems has led many experts to call for more research and understanding of the impact of family and community values on alcohol use and treatment seeking (e.g., Yalisove, 2004). Others have proposed clinically derived treatment approaches for members of specific ethnic groups (e.g., Amodeo, Robb, Peou, & Tran, 1996). Still others have called for a greater awareness of practical, attitudinal, and other barriers that may limit access to treatment by members of different cultural and social groups (e.g., Durrant & Thakker, 2003). Each of these arguments has merit. We suggest that, in addition, social workers should use a client-centered, evidence-informed practice paradigm to adapt existing empirically validated treatment approaches so that they are more responsive to the needs, circumstances, and value preferences of members of specific cultural and ethnic communities. As articulated by Epstein (2009), evidence-informed practice is practice that is enriched by prior research but not limited to it.

EVIDENCE-BASED PRACTICE

Evidence-based practice (EBP), which developed initially in medicine as "a new paradigm for . . . practice" in the early 1990s (Evidence-Based Medicine Working Group, 1992), has spread rapidly to other human service and health fields. According to Kirk and Reid (2002), EBP (what they refer to as research-based practice) represents a culmination of the influence of science on direct social work practice. EBP complements Epstein's (2001) notion of

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practice-based research (PBR) in which "research-inspired principles" and tactics are used "within existing forms of practice to answer questions that emerge from practice in ways that inform practice" (p. 17).

The most widely disseminated definition of EBP is that it involves a practitioner using clinical expertise and experience to blend the best external research evidence, client values and preferences, and clinical state and conditions to make practice decisions (Gambrill, 2003; Haynes, Devereaux, & Guyatt, 2002; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). It is a collaborative approach to social work practice in which clients and practitioners (and often other concerned constituents) share decision-making power.

Two fundamental principles guide EBP. First, "evidence" may be drawn from any empirical observation about the relation between events. As such, evidence is hierarchical ranging from unsystematic observations extracted from clinical experience to systematic reviews of controlled clinical trials and "randomized controlled trials" of particular interventions with specific clients (Guyatt et al., 2000, 2002). Second, evidence by itself is never sufficient to make clinical decisions (Guyatt et al., 2002). Clinical judgments should reflect not only the best available evidence, but also personal, professional, and societal values and resources. As Haynes, Sackett, Gray, Cook, & Guyatt (1996) argue, in particular practice situations client preferences, as well as clinical expertise and constraints, may override the best evidence from systematic research findings. McNeece and Thyer (2004) suggest more forcefully that once a practitioner presents a client with information about the costs and benefits of different intervention options, the final decision on how to proceed rests with the client.

An evidence-based approach to decision making in practice involves five steps (Cournoyer, 2004; Sackett et al., 2000):

1. Problems and challenges that emerge in practice are transformed into searchable questions about a client's condition, intervention options, and/or prognosis. The questions should be client– and problem/need-focused. They must be specific enough to yield useful information about what social workers can do to help their clients achieve the outcomes they desire.
2. Using key words and other sources a social worker searches the literature (e.g., journals, bibliographic databases, and books) to locate evidence for effective interventions that address the questions posed in the first step. A key aspect of this step is determining the type of evidence needed to answer the questions. While many authorities suggest that systematic reviews of controlled clinical trials provide the best evidence for evaluating intervention related questions (e.g., Gray, 2004), other sources of evidence, including systematic case studies, may also provide valuable information (e.g., Epstein, 2001; Nathan, 2004).
3. Once relevant literature has been located a social worker must evaluate the quality of the evidence. The validity of the findings—especially their generalizability—must be determined. In addition, the clinical significance and utility of the findings must be assessed. Over and above

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the statistical significance of the findings, practitioners must determine if effect size is large enough to have clinical meaning and if interventions are described precisely enough to be replicated in practice (e.g., Cournoyer, 2004; Edwards & Steinglass, 1995).

4. When social workers have located evidence that is valid and meaningful, while fitting the constraints of their practice situations, they should discuss the evidence and various options with clients. This is the point where clinical expertise may be most crucial as social workers help clients arrive at informed decisions and as they tune into clients' preferences and concerns. It is in applying the best evidence in their practice that skilled clinicians use their expertise and experience to adapt the evidence and to improve its "goodness of fit" with clients' preferences and beliefs, their clinical conditions, and the practice contexts (e.g., Nock, Goldman, Wang, & Albane, 2004).
5. The final step in the process involves social workers evaluating the effectiveness of an evidence-based intervention with particular clients. As Cournoyer (2004) observes, "by itself, nomothetic information is insufficient. [One] also require[s] ideographic evidence that . . . practices are effective for the clients . . . actually serve[d]" (p. 187). Social workers may use single-system designs, standardized evaluation tools, and/or group designs to make this determination. The central idea from an EBP perspective is that ultimately the utility of any evidence is based on its relevance for particular practice situations.

EVIDENCE-INFORMED PRACTICE

Extending the notion of evidence-based practice to evidence-informed practice, builds on the strengths of the EBP paradigm and underscores the need for practitioners to be responsive to specific practice situations. An evidence-informed approach to practice places more value on the situated knowledge that emerges in the practice context. It values "practice wisdom" as a source of evidence, which can inform practice decision-making. Evidence-informed practice is culturally and methodologically pluralistic, it promotes practice-driven research as well as research-driven practice, and it empowers social work practitioners to be co-creators of knowledge (Epstein, 2009). It reduces the tendency to be hierarchical in knowledge construction and it encourages in-the-moment reflection in practice.

CLIENT-CENTERED FOUNDATION

Effective practice with problem drinkers is influenced not only by *what* one does, but also by *who* one is and *how* one works (Miller, Forcehimes, & Zweben, 2011). Among the most robust findings in clinical research across cultural groups is that the quality of the practitioner–client relationship as perceived by the client is the strongest single predictor of positive outcomes. How one interacts with clients affects their responsiveness to therapeutic interventions. From a culturally responsive perspective, this suggests that effective practitioners should demonstrate "respectful curiosity" about

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a client's experiences, "naivete" in which they are willing to approach each situation innocently and learn from the client, and a "not-knowing attitude" in which they assume that clients are experts in their own lives and can inform practitioners about their life experiences (Dyche & Zayas, 1995).

By being client-centered in one's practice, a practitioner will increase the likelihood that she will understand a client. The practictioner will increase the odds that the client views her as someone who can be of assistance. She will be more apt to select empirically supported and other practice strategies that are responsive to the client's needs.

FAMILY INVOLVEMENT IN ALCOHOLISM TREATMENT: AN EVIDENCE-INFORMED APPROACH

Over the past half century, the weight of the empirical evidence and comprehensive reviews of the alcohol treatment literature suggest that family and social network involvement are associated with beneficial treatment outcomes (e.g., Copello & Orford, 2002; Corcoran & Thomas, 2000; Edwards & Steinglass, 1995; Lam, O'Farrell, & Birchler, 2012; McCrady, Ladd, & Hallgren, 2012; Meyers & Miller, 2001; Miller & Wilbourne, 2002; Miller, Wilbourne, & Hettema, 2003; O'Farrell & Fals-Stewart, 2003; Smith & Meyers, 2004; Steinglass, 1976). The evidence seems strongest for involving family members to engage problem drinkers, especially unmotivated ones, into treatment (Edwards & Steinglass, 1995; O'Farrell & Fals-Stewart, 2003; Smith & Meyers, 2004). Interventions to teach effective communication and problem-solving skills also seem useful in reducing the overall level of family stress and problem drinking once a drinker has entered treatment (Edwards & Steinglass, 1995; Lam, O'Farrell, & Birchler, 2012; Miller et al., 2003). Finally, multidimensional family treatment, which includes interventions aimed at improving parent–child communication and parental understanding of adolescent substance use, has been found to be among the most effective treatments for adolescent substance abuse (Vaughn & Howard, 2004).

While family involvement in the therapeutic process is beneficial, its impact "is differentially felt" (Edwards & Steinglass, 1995). First, outcomes are somewhat better when men are the problem drinkers than when women have the drinking problems. Second, outcomes are more positive when family members have greater social and emotional investment in their relationships. Third, when family members agree that drinking is a problem that must be addressed and they are supportive of treatment their involvement is more helpful. Fourth, a family member's own substance abuse problem limits her ability to help another person resolve an alcohol-related problem. Finally, a history of domestic violence should preclude involving a spouse to engage an unresponsive problem drinker (e.g., Thomas & Agar, 1993).

Although none of the reviews cited above address cultural and ethnic factors systematically, by adopting a client-centered, evidence-informed perspective social workers can use the findings to assist members of different cultural groups. A case example is informative.

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Engaging an "Unmotivated" Problem Drinker

A 40-year-old Puerto Rican woman (Concerned Spouse, CS) sought the assistance of a social worker in a mental health clinic. According to the CS, her husband, a 42-year-old clerical worker, drank heavily, often spending his paycheck on drinking. The CS said that her husband drank to intoxication about three to four times per week, he missed work due to drinking, he was in danger of losing his job, and he had begun to drink in the mornings before breakfast. As a result, the family was behind in its bills. In addition, the couple's teenage children were embarrassed by their father's behavior. They rarely brought friends home, and their schoolwork was suffering. The CS said that she felt distressed. "I don't talk to my friends as much. I also do not like to call his job and say he is sick because he is hung-over." The CS added that her husband did not believe that he had a drinking problem and that they argued frequently about the drinking.

The CS had sought professional help before only to be told by a counselor that she was "co-dependent" and overly concerned about the drinking. The counselor advised her to give her husband some literature on alcoholism and let him decide whether or not to seek treatment. The CS said she took this advice, which only angered her husband more. She also expressed amazement that someone would think that her concern about her family was a problem (i.e., that she was codependent). She asserted, "I have a responsibility for my family. That is the way I was raised." Taking an empathic, client-centered stance, the social worker sensed from the CS's response that the counselor had not fully assessed her cultural values relative to her role in the family (e.g., "I have a responsibility for my family. That is the way I was raised."). Further, the CS should not have been advised to disengage and provide her husband with alcoholism literature without additional assessment and discussion about this strategy.

The social worker completed a social history and assessment and determined that the CS was very committed to her marriage and family ("I love my husband and children. Leaving my husband is not an option."), that she had no history of substance abuse, that she had a strong support network (family, friends, and church), and that there was no history of physical family violence. ("We argue, but my husband has never threatened the children or me. When he drinks, he withdraws into his own shell.")

The social worker scheduled a follow-up meeting with the CS to discuss different intervention options.

Transforming the Problem Into Searchable Questions

Transforming the problem encountered in this case situation into searchable questions requires a social worker to include words or phrases like "family member," "spouse," "unmotivated," "uncooperative," "reluctant," "engage," "problem drinker," and/or "alcoholic" in the questions. Two searchable questions are: "What, if any, intervention strategies are effective in working with spouses to engage unmotivated problem drinkers into treatment?" "What types of spousal interventions—such as making demands or using less harsh responses—are most helpful in engaging reluctant alcoholics into treatment?"

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Conducting a Literature Search

A hierarchical conception of evidence suggests that professionals should determine first if systematic reviews of the research literature, including reviews of controlled clinical trials, exist (Gray, 2004; Guyatt et al., 2000). Fortunately, a number of systematic reviews examine research on family involvement to engage reluctant or uncooperative problem drinkers (e.g., Edwards & Steinglass, 1995; O'Farrell & Fals-Stewart, 2003; Smith & Meyers, 2004).

Edwards and Steinglass (1995) conclude that family involvement is very effective in motivating problem drinkers to enter treatment and possibly reduce their alcohol consumption even before they enter formal treatment. O'Farrell and Fals-Stewart's (2003) analysis of 10 controlled studies involving "unmotivated" drinkers supports this conclusion. They add that coping skills training aimed at helping concerned family members understand their own motivations and disengage from the problem drinker's behavior, Al Anon involvement, and strategies to promote change in the drinker's behavior have all led to reduced emotional distress among concerned family members (see also, Smith & Meyers, 2004; Thomas, 1994; Thomas & Agar, 1993).

O'Farrell and Fals-Stewart (2003) found that approaches that relied on more aggressive confrontation by family members did not fare well in two systematic studies (Liepman, Nirenberg, & Begin, 1989; Miller, Meyers, & Tonigan, 1999). While most of the family members who completed the intervention training succeeded in getting problem drinkers into treatment, less than one-third of the families completed the training. Loneck, Garrett, & Banks (1996), who also studied this type of "hard" confrontational method, found similar results, but added that even when they entered treatment the drinkers did not necessarily complete it or benefit from it (see also, Miller, Meyers, & Tonigan, 1999). In a related study, Loneck and colleagues (1995) found that a focus on the negative impact of drinking on family members and concerned others (rather than on the drinker) was indirectly associated with acceptance of treatment by the drinker.

Although controlled clinical trials usually do not examine the differential contribution of treatment components on outcome, an examination of the studies cited above, as well as other literature (e.g., Smith & Meyers, 2004; Thomas & Agar, 1993), suggests that social workers who wish to involve family members to help problem drinkers enter treatment should target the following areas:

- Family members must be educated about the nature of alcoholism and problem drinking so that they can understand more fully the factors that contribute to excessive drinking and that may impede cessation of drinking.
- Social workers should focus not only on the drinker's behaviors but also on the family members themselves. Effective family interventions help family members to disengage somewhat from the drinker and his/her behaviors, find other social supports (e.g., Al Anon group involvement; family support), and enrich their own lives (e.g., engaging in hobbies and

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activities that they enjoy, which they may have discontinued due to the drinker's behavior).

- Successful interventions help family members learn how to communicate their concerns to problem drinkers more effectively, while at the same time communicating their love and support (e.g., learning assertiveness and conflict resolution skills).
- Family members must be helped to learn how to give positive feedback for desirable (e.g., sober) behavior, rather than responding only to the drinking behavior (e.g., through nagging and complaining behavior).

Evaluating the Quality and Clinical Utility of the Evidence

Family involvement studies generally have not been examined to determine the differential benefit of family involvement to engage problem drinkers from different ethnic and community groups. Many of the study samples have been ethnically diverse, however, and none of the studies have reported differential findings associated with ethnicity. For example, Hispanic persons made up over one-third of the sample in one study, and ethnicity was not a factor that affected outcome (Miller et al., 1999).

Two approaches that involve family members to engage reluctant problem drinkers have described interventions sufficiently to enhance their clinical utility; these are Community Reinforcement Approach and Family Treatment (CRAFT; Smith & Meyers, 2004) and Unilateral Family Therapy (Thomas, 1994; Thomas & Agar, 1993; Thomas & Santa, 1982). The developers of CRAFT have produced a highly practical treatment manual that thoroughly describes intervention responses, includes treatment forms and scales, and provides case illustrations, making the approach readily replicable and adaptable to client preferences and the constraints of practice situations.

Discussing the Evidence and Intervention Options With Clients

Once the social worker has completed an examination of the evidence, she must discuss the findings and different intervention options with the client. In the case situation presented above the social worker can feel confident in informing the CS that there are ways she can be assisted and that Hispanic individuals have found them to be useful (e.g., in the case of CRAFT). It will be important to underscore with the CS the time commitment involved (10–12 meetings), her responsibilities, and changes she may need to make (e.g., disengaging from her husband a little and focusing on other aspects of her life; learning new ways to speak with her husband). The social worker may also discuss the more aggressive confrontational approaches that have been evaluated. Although outcomes with these latter approaches have not been as positive as with less aggressive approaches, it may be important for the CS to have this information in making her decision and in understanding why some of her past responses to her husband's drinking have not produced the results she desired. The outcomes the CS can expect include less familial stress, her husband considering treatment, and changes in his drinking pattern.

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In discussing intervention options with the CS, the social worker must be mindful of the values, beliefs, and cultural practices that are prominent in Puerto Rican communities. As was pointed out in the case example, the first counselor apparently was not sensitive to these values and practices. Consequently, the CS may have been alienated from the helping process and the intervention strategy, itself, did not seem to be appropriate. The social worker must strive to understand the specific value preferences, wishes, and circumstances of the CS. The CS's strong commitment to her family, which is consistent with Puerto Rican values and traditions, is an important factor that will help her sustain her efforts. The importance of family, one's responsibility to family, and the adverse impact of the husband's drinking behavior on his family may also be important factors to emphasize in efforts to mobilize him to seek assistance. Discussion with the CS should explore social supports that are available and acceptable (e.g., her church, her friends). It also should examine communication styles and discussion topics that the CS is willing to undertake with her husband.

Evaluating the Intervention's Effectiveness With Particular Clients

When the social worker evaluates the intervention's effectiveness, she must keep in mind the multiple targets of family intervention. Although the presenting concern was the husband's drinking, other intervention targets include family stress (as reflected in the CS's statements and the children's behavior) and the CS's behavior (changes in communication patterns; her efforts to disengage and enrich her life). Each of these areas should be examined to ascertain the intervention's impact. The most desirable outcome would be that the husband entered treatment and eliminated the drinking problem. However, even if this outcome was not attained, intervention could be successful if the CS's stress was lowered, family functioning improved, and the family members learned more adaptive ways to live with a problem drinker.

The success of family involvement can be measured by examining whether or not the CS completes the treatment. In addition, by using a single-case study design with baseline and follow-up behavioral measures, scales to measure mood and distress, and clinical observation, a social worker can determine the extent to which target goals are reached. As she uses similar family interventions with other clients, a social worker can also draw on aggregate data to assess the value of family involvement with her clients.

CONCLUSION

In this chapter we have illustrated how a client-centered evidence-informed approach to practice, which builds on an evidence-based practice paradigm can be used to assist families that are experiencing alcohol-related difficulties. While the specific case example applied this paradigm to family involvement to motivate a reluctant problem drinker to enter treatment, the principles are equally applicable to marriage and family treatment once a problem drinker has entered treatment, and to situations involving adolescent substance abuse.

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Marriage and family treatments to assist people with drinking problems generally have not been validated for members of particular ethnic and cultural groups. Thus, we do not know if they are particularly beneficial for members of different communities or if they are contraindicated. Until more research is conducted to assess the effectiveness of family involvement in the treatment of drinking problems in different ethnic and cultural groups, it is probably wise to use approaches that have general evidence of efficacy with the assumption that these approaches are most likely to generalize.

When using validated treatment approaches, it is critical for social workers to be culturally sensitive. That is, they must be aware of values, beliefs, norms, and practices that characterize different ethnic communities, both in terms of alcohol consumption and in terms of marital and family roles and responsibilities. In addition, social workers must clarify how cultural and community norms are experienced by the clients with whom they are working. By appreciating the views, beliefs, and preferences of their clients and demonstrating a genuine interest in those preferences, social workers will be in a position to adapt empirically validated treatments to the needs and circumstances of clients from all ethnic and cultural groups. Responsible professional practice requires the use of empirically sound intervention options. It also requires social workers to work collaboratively with clients to help them select intervention options that not only have the best prospects of success but also are acceptable to them.

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TWENTY-TWO

Multicultural Social Work Practice With Immigrant Victims of Domestic Violence

Patricia Brownell and Eun Jeong Ko

Since the 1970s, social workers, along with lawyers, grassroots advocates, and progressive government officials and lawmakers, have sought legislative, regulatory, and procedural remedies to protect the safety and well-being of women who are domestic violence victims (Dziegielewski & Swartz, 2007). While the initial beneficiaries of these efforts were women and their children with citizenship status, advocates recognized that domestic violence victims without citizenship status remained at grave risk of continued abuse and exploitation, disadvantage in child custody contests, and deportation. The purpose of this chapter is to examine domestic violence and social work practice with immigrant women in a multicultural context.

Impressive social and legal remedies were achieved for victims of domestic violence in the beginning of the women's movement. However, legislative and regulatory changes were critically needed for domestic violence victims with immigrant and refugee status to ensure their ability to access needed social welfare services and public benefits such as income support, health care, employment, education, housing, and personal social services. In addition, social workers were challenged to develop new models of intervention and practice that addressed the needs of immigrant domestic violence victims.

Domestic violence has been a concern of social workers and social reformers since the early days of the social work profession. In the late 19th century, the social response was to attempt to remove children from families where there was wife battering (Brace, 1872). The social work profession began with charity organization and settlement house workers assisting poor urban immigrants (Gordon, 1988). This mission to assist people of diverse cultures obtain needed resources, services, and opportunities remains with the profession today, as reflected in the National Association of Social Workers (NASW) Code of Ethics (NASW, 2008).

The NASW Code of Ethics provides guidance for the professional social worker to practice in a culturally competent manner. Section 1.05 of the code is entitled Cultural Competency and Social Diversity. This section defines culturally competent social work practice as social workers' understanding culture and its function in human behavior and society, having a knowledge

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base about their clients' culture, demonstrating competence in the provision of services that are sensitive to clients' culture and differences among people and cultural groups, and understanding cultural diversity and oppression (NASW, 2008). Cultural awareness is defined as an understanding that an individual has different cultures, defined as races, religions, gender, ages, and physical disabilities (Fong, McRoy, & Hendricks, 2006). Domestic violence is a significant social problem in the United States. It is essential for social workers to detect and address domestic violence given its prevalence and consequences. Education and training for social workers should address the impact on race, ethnicity, culture, and immigration status: This enhances the ability of practitioner to offer more culturally responsive services (Davis, 2003).

DEMOGRAPHIC PROFILE OF IMMIGRATION IN THE UNITED STATES

The 2002 U.S. Census Bureau's March Current Population Survey (CPS) reports that 11.5% of U.S. residents were foreign-born (Schmidley, 2003). Of these, 7.3% were noncitizens and 4.2% were naturalized citizens. There were 32.5 million foreign-born persons living in the United States, of which about 63% or 20.5 million were noncitizens. Estimates from the latest CPS identify the largest proportion of the noncitizen population (60.3%) as Latin Americans, with the next largest (19.4%) as Asian (U.S. House of Representatives, 2004).

An estimated 8 to 9 million immigrants are undocumented, without any legal immigration status. Each year thousands of immigrant women who are married to United States citizens or lawful permanent residents (LPR) enter the United States (Raj & Silverman, 2002). Domestic violence occurs across ethnicity, gender, religion, age, and socioeconomic status (Kwong, 2002; Orloff, 2001; Rothwell, 2001). For battered immigrant women, immigrant status, lack of support, the language barrier, and low economic status add significant obstacles to their ability to terminate an abusive relationship (Orloff, 2001; Raj & Silverman, 2002; Rothwell, 2001; Romkens, 2001). In the second half of the 19th century and early 20th century, most immigrants came from European countries (Schmidley, 2003). The profile of immigrants has changed in the last century to include those from Africa, East and South Asia, and Central and South America. In 1890, 87% of foreign-born Americans came from Europe, compared with 1% from Asia and 1% from Latin America. In 1990, the change in immigration demographics compared with 100 years earlier was dramatic: the proportion of immigrants from European countries dropped to 22%, while the proportion of immigrants from Latin America increased to 43%, and the proportion of immigrants from Asia increased to 25% (Gibson & Lennon, 1999). The cultures, languages, familial expectations, and social service utilization patterns are different for newer populations of immigrants than for immigrants in the past.

DEFINITIONS

Domestic Violence

Domestic violence is defined as a social problem in which one's property, health, or life are endangered or harmed as a result of intentional behavior

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by another family member or significant other (Barker, 2003). Domestic violence is defined by state statute and penal code. For example, the State of Massachusetts defines domestic violence as actual or attempted physical harm, fear of imminent serious physical harm, or nonconsensual sex perpetrated by a current or former spouse, boyfriend, girlfriend, or fiancé, a current or former roommate or housemate, a blood relative, a current or former relative by marriage, or a person with whom the victim has had a child. This definition may vary from state to state.

According to Roberts (2007) more women in the United States are injured as a result of intimate partner violence than the combined total of muggings and accidents. Domestic violence is the main reason why women visit emergency rooms. Around the world, at least one in every three women has experienced physical, sexual, or other type of abuse in their lifetimes (www.info@womenslaw.org, 2003). Domestic violence also has severely affected children. Over 15 million U.S. children live in families in which partner violence occurred at least once in the past year, and 7 million children live in families in which severe partner violence occurred (McDonald, Jouriles, & Ramisetty-Mikler, 2006).

Domestic violence is believed to be more prevalent among immigrant women than among women who are U.S. citizens, and the majority of immigrants in the United States are women with children (Erez & Globokar, 2009).

Immigration status, coupled with gender and race, may place women and their children at increased risk of being trapped in an abusive situation because of their vulnerability within a family relationship and their social isolation within their communities (Zarza, Ponsoda, & Carrillo, 2009).

Immigration Status

While male immigrants may also be victims of violence, including domestic abuse, the focus of this chapter will be on immigrant women victims of domestic violence. Terms related to immigration and refugee status are defined here. An immigrant is a noncitizen who was born in a country other than the United States, and remains in the United States with or without lawful admission for temporary or permanent resident status, as defined by the U.S. government. Immigrants with documentation that enables them to remain in the United States pending citizenship proceedings have qualified immigrant status. Others may have entered the United States with work, student, or other temporary visas or permits: these may have current or expired status (Chang-Muy, 2009).

Immigrants without any formal immigrant status or history of formal immigrant status are referred to as nondocumented immigrants. Refugees include those who are outside their country of origin and are unable to return to that country because of persecution or a well-founded fear of persecution. Refugee status is determined by the U.S. government, based on assessment of level of risk of return based on race, religion, nationality, membership in a particular social group, or political opinion (U.S. Department of Homeland Security, 2004). For the purposes of this discussion, noncitizen domestic violence victims will be identified as immigrants regardless of their immigration status, unless otherwise specified.

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Domestic Violence and Immigration

Domestic violence advocates have broadened the definition of domestic violence for immigrant battered women. Categories of domestic violence and abuse related to immigrant women include emotional abuse, economic abuse, sexual abuse, use of coercion and threats, using children, using citizenship or residency privilege, intimidation, isolation and minimizing, blaming, and denying the abusive acts. Battering is also defined as the use of coercive behavior (physical, sexual, or psychological) by a man against his intimate cohabitating partner to force her to do what he wants her to do regardless of her own needs or desires, rights, or best interests (Dziegielewski & Swartz, 2007).

Advocates argue that these categories of abuse have special potency for immigrant women, because perpetrators can lie about immigration status as a form of emotional abuse, threaten to report any paid work to the Immigration and Naturalization Service (now the Bureau of Citizenship and Immigration Services or BCIS) as a form of financial abuse, threaten to report the woman to the government if she refuses sex, threaten to report her or her children to the BCIS, fail to file papers to legalize her immigration status, hide or destroy important papers such as passports, not allow her to learn English, and try to convince her that she is a burden and the source of blame for the abuse. It should be noted here that the INS has been renamed the Bureau of Citizenship and Immigration Services (BCIS) and is part of the U.S. Department of Homeland Security (Carey, 2003).

Not every woman married to a U.S. citizen or lawful permanent resident is sponsored for legal status by her spouse. In abusive relationships, spouses who are citizens or lawful permanent residents may not file immigration documents on behalf of their spouses (Dutton, Orloff, & Hass, 2000). Several studies have shown that women whose status depends on their spouse are at higher risk of becoming victims of domestic violence than others (Kwong, 2002; Orloff, 2001, 2003). Constant fear of deportation bars immigrant women from terminating abusive relationships. The abusers often use their victims' immigration status to control them (Romkens, 2001; Sitowski, 2001).

RISKS AND NEEDS OF IMMIGRANT DOMESTIC VIOLENCE VICTIMS

Immigrant battered women experience economic, social, and legal problems that are unique to their legal and cultural status in the United States. In the United States, there is pride in diversity and multiculturalism (Sue, 2006). However, new refugees, immigrants, and other minority groups often face misunderstanding and confusion when American traditional values conflict with their beliefs and customs. Immigrants may also experience conflicts with civil and criminal justice systems.

Patriarchy and belief in fate may make women feel they cannot control violence, and women from war torn countries may not recognize familial violence. Recent immigrants face multiple stressors, including pressures to assimilate. Conflicts between batterers who attempt to enforce traditional gender roles and their victims who want to take advantage of educational opportunities can escalate into domestic violence. Pressures on victims to

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present their ethnic immigrant community in a positive light by not reporting or speaking out about the abuse, and dependence on their batterers because of their immigration status, are also salient factors (Mills, 1998).

Barriers to protective services for immigrant domestic violence victims include those of gender, cultural norms, and fear of deportation. When people immigrate to other countries, they bring their cultural norms and values with them. Within the context of different norms and values, the behavior and philosophy of immigrant women toward domestic violence are differently expressed (Raj & Silverman, 2002). Unlike Western culture, that encourages women to preserve equality and be independent, some other cultures may expect women to be subordinate and obedient to their husbands (Liao, 2006; Ahmad, Driver, McNally, & Stewart, 2009; Orloff, 2001).

Data gaps in research on domestic violence include insufficient information on violence against women of color (Lee, Thompson, & Mechanic, 2002). Recent immigrants remain underrepresented in survey samples: Reasons such as cultural and language barriers, fears of deportation, and fears of affecting relatives' applications for immigration have been cited for this oversight. There is a paucity of research on the effects of acculturation on domestic violence risk factors for women in similar immigrant populations (Lee et al., 2002).

Nondocumented Battered Women

Many nondocumented women may refuse to seek help for fear of being deported, according to Erez and Hartley (2003). This may be because their country of origin has laws protecting husbands who beat their wives and deportation may place an undocumented battered woman at risk of further abuse by family members on whom she would be dependent for support. It may also be because of the felt need of the victim to protect the interests of her family.

Maria married an American citizen and left an impoverished life in South America to live with her husband in the United States. She and her husband had three children, who were provided with material advantages they would not have had in her country of origin. Her husband never applied for citizenship status for her, and continually abused her. Maria refused to press charges or leave him, however, for fear that she would either lose her children to him or be forced to return to her country of origin, where they would live the same impoverished life she had escaped.

In this case, the fact that Maria's husband never petitioned for her green card permits him to keep her in virtual slavery. She is in a vulnerable position if she tries to leave her husband and he reports her to the BCIS. Her status also precludes her from receiving public assistance and creates barriers to her obtaining a job that could enable her to support herself and her children.

Some options exist for social workers who service immigrant women who are domestic violence victims. They include working collaboratively with agencies that provide information and access to benefits and services to special ethnic populations in their language as well as English; legal service

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agencies that specialize in immigration law and advocacy; and domestic violence shelters and nonresidential domestic violence programs. Most shelters and domestic violence programs, even if they receive government funding, will provide crisis services to domestic violence victims and their children regardless of citizenship status.

Undocumented battered women are among the most difficult to assist. In addition to the psychological problems such women may have to address, formidable social problems can create practical difficulties as well. Resources like the National Center for Immigrants' Rights are available to provide information for social workers who are assisting undocumented women address issues of domestic abuse. Social interventions, in addition to clinical interventions and education, are critical to the success of undocumented women in freeing themselves from battering situations. According to Warrier and Rose (2009), however, racial and cultural factors are concerns in social work practice with domestic violence victims. It is important for social workers to understand how immigrant women from different cultural backgrounds may experience domestic violence and face different barriers to ensuring their safety.

Latina Battered Women

Rios, in her paper titled "Double Jeopardy: Cultural and Systemic Barriers Faced by the Latina Battered Woman" (n.d.), stresses the need for domestic violence workers to understand and respect the cultural differences presented by Latina battered women, and—at the community level—to advocate against those institutional factors, such as lack of social justice, that negatively impact on the Latino community, as well as other communities of color. A comparison of Anglo and Latino family values and structure reveal major differences that have important implications for effectively serving Latina battered women (Rios, n.d.).

In the Latino culture, individuals are seen first and primarily as members of the family, and family members are expected to actively work toward its unity and preservation. However, the Latino culture is also characterized by a patriarchal family structure and the expectation that traditional gender roles will be strictly adhered to. Consequently, the Latino woman is expected to be family identified: Her sense of identity and self-esteem is linked to her perceived ability to fulfill the ideal of the self-sacrificing mother and wife. These factors, according to Rios, make it difficult for the Latina battered woman to take action against abuse by seeking judicial or police protection, or assistance through a shelter or family service agency. She is accustomed to subordinating her needs on behalf of her family, even at the risk of her own personal safety. Also, her sense of identity is so linked with her role of wife and mother that she may consider herself a failure if she takes action to break up her family.

These concerns may be supported and reinforced by family, friends, and community, and the victim may be urged to give the relationship another chance. Religious beliefs in the sanctity of marriage can provide another barrier. Service providers must acknowledge the conflicts engendered by

a Latina woman's decision to confront the battering situation. This is compounded by Latinos' historical experience of oppression by the police and criminal justice system, which are viewed with suspicion. The lack of bilingual and culturally sensitive social workers can further alienate the Latina victim of family violence, should she choose to reach out for assistance in spite of the internal and structural barriers she faces in doing so.

Bonilla-Santiago (2002) provides an overview of cultural barriers and social service and legal needs of Latina battered women. A study conducted with Latina women demonstrated that most receive little or no assistance or protection from police, legal aid, welfare, mental health, or counseling services due to cultural and language barriers. Also, because Latina women are women from Latin America, Cuba, Mexico, the Dominican Republic, Central America, and South America, their differing immigration statuses complicate policy and practice issues. Many Latina women are isolated and trapped in violent homes (34% experience some form of violence). Their perceptions of physical and psychological abuse also differ from Anglo and other women.

Studies on domestic violence among immigrant populations have found a high incidence of abuse against immigrant women by spouses and partners. In one study, 48% of Latina women reported increased violence by a partner since immigrating to the United States (Dutton et al., 2000). Cultural, social, and structural explanations are proposed for this. Language barriers may limit an immigrant domestic violence victim's ability to understand and negotiate service and immigration systems, question social expectations and community pressures, and access financial resources independent of their partner or spouse (Warrier & Rose, 2009). Intimate partner violence among Hispanic women has been reported as related to economic problems, acculturation stress, alcohol use, impulsivity, and trauma (Zarza et al., 2009).

Asian Battered Women

Asian and Asia Pacific Americans may respond differently to domestic violence, based on the meaning they assign to their experiences of abuse (Tjaden & Thoennes, 2000). Asian women are often taught that in their roles as wives and mothers, they are responsible for keeping the family unit together under all circumstances (Kwong, 2002). In a domestically violent situation, women are often blamed for causing instability in their family by not conforming to the social norms and their native culture (Orloff, 2001). One study of Korean American families found that male-dominant couples were four times more likely to engage in wife abuse (Kim & Sung, 2000). Wife abuse in Asian cultures seems to be compounded by economic stress (Kurst-Swanger & Petrosky, 2003).

There is a need to address lack of knowledge about female victims from diverse ethnic/racial backgrounds as well as men who batter them. Prevalence of spouse abuse in the Chinese community is not available. Within the Chinese immigrant population there is an unfounded myth that abuse doesn't occur, because Chinese women underutilize formal services. In fact, there are culturally specific influences on spouse abuse in the Chinese community. For example, Confucianism suggests that the traditional Chinese

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sense of self is rooted in relationships with significant others in the family, primarily, and there is a de-emphasis on independence from the traditional family system (Yick, 2000). Women are encouraged to internalize values about endurance and submission to maintain the collective existence and family harmony. As a result, women face tremendous pressures in trying to break abusive cycles in their families. The family name is expected to be protected at all costs. Contextual factors, including immigration status, exacerbate these pressures.

Chinese men may use immigration status to psychologically threaten their female partners and keep them subservient in an abusive situation. Undocumented Chinese women are a vulnerable group as they are new immigrants without language, social skills, financial independence, and knowledge of American culture. Lacking refugee status creates an additional barrier. Women may get jobs more easily (such as low paying garment work), and men may resent this: Redistribution of power within the family can cause tension. Social isolation and immigration status further limits women's help-seeking behavior. They may need culturally sensitive social services and shelter, and access to language translation. Most choose to stay with their abusers, so access to couples therapy is also important. Community education, especially for the men, is another important intervention strategy.

Eastern European Battered Women

Russian Jewish immigrants were granted asylum in large numbers during and after the cold war. This recent large-scale immigration parallels that of the 19th century and has resulted in newly created ethnic enclaves in large urban centers like New York. Judaism teaches that the Jewish home is a Mikdash Me'at, a holy space, and traditionally, Jewish women are responsible for domestic tranquility. One identified barrier to battered immigrant Jewish women seeking help is a deep sense of shame, leading them to minimize or redefine the abuse to avoid humiliation. Another is the lack of services that meet the specific needs of Jewish battered women: shelters with kosher facilities and arrangements with Jewish educational institutions where children can continue their education and observance of non-Christian holidays.

Lack of multilingual staff and fear of anti-Semitism by non-Jewish staff may also create reluctance on the part of Jewish women to seek services in battered women's shelters. Alternatively, they may also feel constrained in seeking services from a Jewish agency, out of fear that their community will find out they have been battered. Effective service delivery to this population includes some provision for kosher cooking utensils, access to a rabbi, and the opportunity to select a Jewish or non-Jewish counselor, if desired. Advertising services for victims of domestic violence through temples, sisterhoods, or women's organizations in temples, Hadassah, B'nai B'rith, rabbis, Hillel, and Jewish community centers can be useful for outreach.

It is important to recognize that the actual dynamics of battering in Jewish families are the same as in non-Jewish families, although there is some evidence that Jewish women tend to stay in battering relations longer than non-Jewish women and those seeking shelter may be older

than non-Jewish women. The stress of migration and shifting roles in the household may contribute to domestic violence in the Russian immigrant family (Chazin & Ushakova, 2005). Key factors in serving Jewish victims of domestic violence are understanding the meaning of family in Jewish life and the deep humiliation Jewish women often feel about being battered.

Indian and South Asian Battered Women

Domestic violence against women is an issue that many Indian Americans refuse to acknowledge as a problem within their community by contending it only occurs within poor, uneducated families (Bhandari, 2008; Liao, 2006). Women advocates within the Indian immigrant community suggest that this is not the case. The story of Sita, heroine of the Indian epic *Ramayana,* mythologizes the self-immolating woman who becomes the "ideal woman" through her continuous efforts to prove herself worthy of her husband, Ram. It is this feminine model of subjugation that female Indian children are taught to emulate.

While the dynamics of domestic violence are not unique in the Indian immigrant community, Indian battered women face additional problems due to immigration status, level of acculturation, and culturally insensitive mainstream organizations that create barriers to obtaining needed assistance (Bhandari, 2008). Traditional arranged marriages create patrilocal joint family households that make Indian women vulnerable to abuse by extended family members as well as spouses. Often the Indian woman's family of origin will not extend assistance once she is married as she is not considered their concern anymore.

According to Bhandari (2008), social stigma and pressure from the larger Indian community not to break up the family constitute significant deterrents to women reaching out for assistance through the formal service network. In recent years, a number of Indian and South Asian women have organized their own service network, including shelter services, to assist battered women in their communities. SAKHI, a New York based women's support group, is one of a number of organizations that have formed out of the Indian and South Asian communities to assist battered women and their families.

INTERNATIONAL PERSPECTIVES ON DOMESTIC VIOLENCE: IMPLICATIONS FOR SOCIAL WORK WITH IMMIGRANTS IN THE UNITED STATES

Summers and Hoffman (2002) provide a cross-cultural comparison of domestic violence, which the authors state is a global problem. This includes overviews of domestic violence in 13 countries, including the United States. Studies of women who are domestic violence victims in native countries of origin can provide insight into cultural barriers faced by women from these countries who have immigrated to the United States.

Yoshihama (1998) reports that a Japanese nationwide study raised consciousness about physical and psychological abuse. A link between spouse abuse, child abuse, and abuse during pregnancy is reported with some frequency. Battered women in Japan sought help through women's centers and

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the health system. However, they didn't always seek help through formal systems, as they considered domestic violence a private and shameful matter. The belief that battered women caused their abuse limits access to services. Japanese women interpreted abuse somewhat differently than in other cultures (overturning the dinner table; having liquid thrown at them to "purify" them—considered psychological abuse). One-third of female murder victims in Japan are killed by intimate partners. Findings from focus groups with battered women in Japan suggest that they experience a web of entrapment with little hope of escape. Victim blaming by family, friends, and professionals, and lack of assistance programs and police protection exacerbate the feeling of entrapment.

REMEDIES

The U.S. Census Bureau reports that the number of immigrants in the United States has increased significantly within the past two decades (U.S. Census Bureau, 2002). It further estimates that by the year 2050 more than half the people in the United States will be from a non-Western European background. This dramatic increase in immigrants from developing countries has spurred an interest on the part of the social work profession in developing assessment tools and intervention techniques to facilitate their ethnicity-sensitive practice.

A notable example is the *culturagram* developed by Congress (1994, 2002, 2008), a family assessment tool developed for use by social workers to individualize families from diverse cultures, assess the impact of those cultures on family members, and facilitate empathy and ability to empower culturally diverse clients. More information on the *culturagram* can be found in Chapter 1. While professional social workers have increasingly acknowledged the growing cultural diversity of the client population (Harper-Dorton & Lantz, 2007), this has not always translated into the development of specialized interventions for clients with socially stigmatizing problems such as domestic violence.

Four categories of remedies are discussed here, including three categories of remedies or interventions that have evolved out of social work practice with victims of domestic violence: social interventions, clinical interventions, and empowerment oriented interventions that often utilize the criminal justice system as part of an intervention strategy. Legislative remedies are discussed as a fourth category in relation to access to needed benefits and services for immigrant domestic violence victims. Each presents opportunities and challenges for immigrant women and their social workers.

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Social Remedies

Social interventions for victims of domestic violence focus on practical problem-solving for battered women and their families. While short-term interventions are crisis-oriented, longer-term interventions are intended to assist the victim to live independently apart from the abuser. Examples include both residential and nonresidential services.

Mrs. L, who emigrated from China a year ago, was kept a virtual prisoner in the home by her husband and her mother-in-law, who forced her to do housework and care for all the family members as well as her children. She was beaten by her mother-in-law as well as her husband if she refused to comply with their demands. The victim, Mrs. L, experienced both physical and emotional abuse, and may be eligible for crisis counseling and case management services that include linkage and referrals to language appropriate social and health services. Mrs. L may also require assistance in relocating to a shelter residence that provides safety and transitional housing services.

Residential services encompass all the shelter service models that have evolved to provide temporary safe havens for victims of domestic violence and their families fleeing a battering situation. They are considered the most extreme of the victim-centered interventions: Victims entering a shelter system must not disclose their whereabouts to anyone, not even their closest relatives. They are also considered to be the most effective in protecting women and their children who are threatened by harm from their batterers. Currently, specialized shelters are primary resources for women and children seeking protection from domestic violence (Roberts, 2007).

Case management services are available for domestic violence victims through the shelters, which provide a maximum amount of time limited security for residents, or in the community. Nonresidential services for victims of domestic violence may include emergency hotline services, assistance with relocation, accessing emergency cash and other resources, and crisis counseling (Roberts, 2007). Longer-term social interventions may include income support for battered women and their children, rehousing, and job training. Public assistance is an important resource for some battered women and their families; it remains to be seen whether welfare reform initiatives that include block grants to states will eliminate this important safety net.

Most social interventions have built-in barriers for domestic violence victims from nondominant cultures. Shelters may not include multilingual staff. Those that are funded by public dollars may exclude nondocumented immigrants. Nonresidential programs may not offer culturally sensitive services or hire workers who are multilingual, although this is deemed essential for effective shelter-based interventions (Erez & Hartley, 2003). Victims of domestic violence from immigrant communities may not know about available services or understand how to obtain access to them.

Nondocumented immigrants could have an even more difficult time using long-term social interventions. Public assistance is not an option for them, housing may be too expensive to afford, and employment is difficult to obtain without exploitation. Social workers who work with immigrant women may find it useful to know how to make referrals to any organizations serving discrete immigrant communities. For example, in New York City, New York Agency for New Americans (NYANA) serves Russian and Central European immigrants, SAKHI specializes in working with South Asian and Indian Women, and The New York Asian Women's Center serves the Chinese community. One dimension of multicultural practice with victims of domestic violence is an in-depth knowledge of resources available to immigrants of all ethnic groups in the geographic area served.

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Many cultures do not recognize domestic violence, and immigrants' countries of origin may not have laws that define and set criminal and civil penalties for domestic violence. As a result, women and their children from these cultures may face abusive situations alone without adequate support or knowledge of legal protections. Stressful living conditions in the United States, including language barriers and economic hardship, foster violence and discourage battered immigrant women from leaving their abusive partners (Orloff, 2001).

Fear of deportation also impacts the help-seeking behavior of domestic violence victims. If the battered women are undocumented immigrants, they are less likely to contact the police than victims who are U.S. citizens or permanent residents (Orloff, 2003). Legal protection and accessibility to public assistance are essential in order for battered immigrant women to escape from domestic violence situations (Dutton et al., 2000; Orloff & Kaguyutan, 2001). While immigrant domestic violence victims have access to fewer remedies than citizens, some services and interventions exist that are targeted specifically to immigrants and refugees. All immigrants regardless of status are eligible for emergency medical services reimbursable under the federal Medicaid program. Other remedies include clinical or counseling services, legal and law enforcement strategies, and information and referral services.

Advocacy groups provide extensive information on social and legal services available for immigrant battered women on the Internet. Manuals with information on services and benefits offer information on all aspects of service provisions to immigrant battered women. These include overviews of domestic violence and immigrant women; cross-cultural issues; legal and policy issues in immigration cases and domestic violence; access to public benefits; and model programs. Other web-based information sources examine various immigration statuses of newcomers to the United States and discuss influences on service provision, access, and use, including service needs, and immigration legislation and its implication for services (NOW, 2012).

Clinical Remedies

Clinical interventions, developed as part of family service agencies by social workers influenced by the medical profession and psychiatry, moved social workers away from the activist tradition of Jane Addams and Florence Kelley. However, the women's movement of the 1970s began to influence clinical social workers to move away from traditional clinical interventions and begin to incorporate empowerment strategies into their practice (Gondolf, n.d.). Practice with immigrant battered women brings new challenges to professionals to develop culturally competent practice modalities. As the case example of Mr. and Mrs. D illustrates, immigrants engage in acculturation at different rates. This can cause tension to develop within families and between couples.

Mr. and Mrs. D sought counseling from an Indian therapist in their community. Mrs. D complained Mr. D had become abusive, both emotionally and physically, since they emigrated from India. Mr. D countered that

Mrs. D had changed since coming to the United States. In India, she had been compliant and a good and respectful wife. In America, she began to become more independent and to demand greater freedom and autonomy.

This speaks to the need for a family therapist who is culturally sensitive. Traditional psychoanalytic interventions have not been found to be effective with victims of domestic violence. Classical psychoanalysis defines victims of domestic violence as masochistic: they are assumed to be receiving some gratification from the battering situation. Critics suggest that the traditional psychoanalytic approach to treatment of domestic violence victims promotes a "blame the victim" approach that encourages self-blame in victims.

While some feminist practitioners (Shainess, 1984) have reframed it to be more applicable to women who are victims of domestic violence, psychoanalytic thinking is also grounded in Western European culture and thought. As such, it may have little meaning for domestic violence victims from developing countries, Eastern cultures, or communities of color. Family therapy is a controversial treatment modality for couples experiencing domestic violence. According to the American Medical Association, couples counseling or family intervention is generally contraindicated in the presence of domestic violence and may increase the risk of serious harm (American Congress of Obstetricians and Gynecologists, 2012).

Family systems theory has been criticized as inappropriate for use with couples where there is active battering (Wilback, 2007). In this approach, the family is looked upon as a system, and battering as a symptom of a dysfunctional system. No member is assigned blame: the victim is viewed as an active participant in the abusive situation. The abuser, in this model, can avoid responsibility for the abusive actions by claiming provocation or a desire to maintain the homeostasis of the family system. For immigrant families from cultures that emphasize the responsibility of the woman to maintain family stability at all cost, this approach could reinforce internalized cultural values encouraging her to remain in the abusive situation for the good of the family.

Previously, some therapists have claimed success in using conjoint family therapy to treat couples together where domestic violence results from marital conflict. The premise for this is that when a couple is seen together, they are treated "as a dynamic unit whose patterns of reactions are interdependent" (Geller & Wasserstrom, 1984, p. 35). Further, cultural background and ethnic identity can create barriers to help-seeking, particularly for immigrant couples experiencing domestic violence, and once a decision to seek help has been made, conjoint family therapy may be the only form of intervention the couple is willing to accept. While some practitioners support couples therapy for families where domestic violence is a factor, many therapists are adamantly opposed to couples being treated together when there is active battering. Reasons include the danger posed to both victim and therapist, and the concern that the hope of a "cure" will dissuade the victim from heeding danger signs or seeking protection when necessary.

Crisis intervention models of treatment are utilized both in domestic violence shelter settings as well as in community-based treatment for victims of domestic violence (Dziegielewski & Schwarz, 2007). In a crisis, people

respond to traumatic events according to their individual personality traits, coping mechanisms, and cultural values. The crisis intervention model suggests that in the face of emotional and physical abuse, victims can learn new coping mechanisms and problem-solving skills.

Cognitive and behavioral approaches have been identified as effective short-term treatment modalities for victims of domestic violence (Dziegielewski & Swartz, 2007). They can also be utilized to assist the victim in addressing the abusive situation within the preferred cultural context. One example of a cognitive-behavioral approach is rational emotive therapy (RET), which seeks to assist clients to address emotional disturbances and improve life situations by targeting irrational belief systems.

According to Lega and Ellis (2001), RET is the treatment modality of choice when doing cross-cultural therapy or counseling. RET encourages the client to maintain their cultural reality and provides a basis for examining and challenging long cherished cultural assumptions only when they lead to dysfunctional emotions, behaviors, and consequences. It also provides clients with the tools to comprehend the link between beliefs, emotions, and behaviors but does not force clients to think, feel, or behave like members of the dominant culture in order to change (Lega & Ellis, 2001).

Feminist therapy models have been developed specifically to address the empowerment of women (Bricker-Jenkins & Hooyman, 1986; Peled, Eisikovits, Enosh, & Winstok, 2000). For example, survivor therapy, developed by Walker (2000), is an example of an intervention model intended to respond to the problems of battered women. It is based on the treatment approaches of both feminist therapy theory and trauma theory. By analyzing power and control factors in an abusive relationship, survivor therapy treats victims of violence by focusing on their strengths, a practice known as strengths-based therapy by social workers.

This model takes into account the woman's sociopolitical, cultural, and economic context, reflecting the dimensions of the nested ecological theory proposed by Dutton (2006). It also explores victims' coping strategies and assists them in building new ones, using many techniques from cognitive and behavioral therapeutic models. As a feminist model of psychotherapy, it explicitly incorporates the feminist therapist's goal of uncovering and respecting each client's cultural and experiential differences as an ethical guideline.

Objectives of feminist therapeutic intervention models include the empowerment of clients using strategies to assist the abused partner redefine herself or himself as a survivor (not a victim). They also seek to enhance feelings of competence, strength, self-worth, and independence from the abuser (Walker, 2000). The feminist therapeutic models, as well as crisis intervention and cognitive-behavioral models like RET, seek to assist victims of domestic violence with the immediate crisis, as defined by the client, as well as to develop a new life philosophy that is based on empowerment and strength, not victimization.

Even feminist therapists may sometimes work with immigrant couples, particularly those who are self-referred. According to Lipchik (1994), if the identified problem is a lack of understanding of the laws governing family

violence and both members of the couple are willing, the abusive husband may be referred to a batterers group as a way to learn about male–female relations in American culture and the legal ramifications of spouse abuse. This may be included as part of an intervention strategy if an assessment finds the couple is not knowledgeable about this country's laws against physical abuse. This represents part of a solution focused approach that can assist the special needs of some immigrant families whose members are in different stages of assimilation and acculturation. For other family violence situations and particularly for those involving an undocumented partner who is the victim of abuse, the issues are much more problematic.

Recognizing the impact of cultural variables on battered women's responses to battering as well as other situational factors is essential to effective assessment and intervention. In addition, the effectiveness of clinical interventions depends in part on the ability of social workers and clients to verbally communicate. Even if clients can understand English, misinterpretations of meanings—mediated by cultural values—can result in the failure of the social worker to assist a client with whom she or he does not share a common culture.

Legal Remedies and the Criminal Justice System

The criminal justice system was perceived by domestic violence advocates in the 1970s as not demonstrating responsiveness to abuse of women. Increasingly, domestic violence advocates seek stronger protection for victims and punishment for perpetrators of abuse. Laws were passed to increase protections and sanctions in domestic violence situations. Again, however, many immigrant domestic violence victims were unable or unwilling to utilize these protections due to their ambiguous relationship with immigration and the law. This is another reason why social workers serving immigrant domestic violence victims need to work closely with immigrant lawyers or in an interdisciplinary social work and law setting.

Since the 1960s, the family court system has provided some protection and redress for victims of domestic violence through orders of protection and adjudication of family disputes. In addition, federal, state, and local funding has been appropriated for services to domestic violence victims and their families, obtained through the criminal justice system. While to date, most domestic violence service dollars have targeted victims and their families, attention is increasingly focusing on treatment for batterers as well. These treatment modalities range from mandatory arrest and court-ordered counseling to peer group support similar to the Alcoholics Anonymous (AA) model. Success with any of the available modalities for batterers has been intermittent, at best, and subject to mitigating circumstances (National Institute of Justice, 2003).

Remedies available through the criminal justice system may not be useful for immigrant battered women. In immigrant communities, both husband and wife may be unaware of laws that prohibit abuse of one spouse by another. The nondocumented domestic violence victim may not want to utilize the criminal justice system, out of concern for exposure to BCIS. The

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court system may be intimidating or confusing to new immigrants, who may have difficulty communicating in English.

Domestic violence situations involving immigrant domestic violence victims present special challenges for social workers and advocates. The immigration issues at stake may require the services of an immigration attorney knowledgeable about domestic violence and immigration.

Social workers and immigration attorneys collaborating on cases involving the court system should make every effort to ensure that translators, if used in the court proceedings, are unbiased and knowledgeable about the domestic abuse situation. Translators should also be familiar with language dialects used by the victims, if applicable. Victims and their children may be especially vulnerable to efforts on the part of the abusers to seek deportation of victims as a way of gaining custody of their children and using the court system to assert their power and control.

Legislative Remedies

Most of the social, legal, medical, and income services and benefits available to immigrant domestic violence victims in the United States are defined by federal and state laws and regulations, and funded through legislative appropriations at the federal, state, and local levels of government. Social workers who serve immigrant women in social service, legal, medical, and other settings must be knowledgeable about these laws and regulations to undertake effective assessments and work with victims to plan and implement effective safety strategies. Social workers must know how to work collaboratively with attorneys who specialize in immigration law and domestic violence. Finally, social workers are in excellent positions to identify service gaps and unmet needs of immigrant battered women, and the consequences of these on the well-being of immigrant battered women and their children. By providing legislative testimony and sharing the stories of their clients in a manner that protects confidentiality while highlighting needs for policy change, social workers can influence policy changes that improve and even save lives.

Social welfare policies can affect access to services and benefits in the United States for immigrant women who are domestic violence victims. These include the Violence Against Women's Act (VAWA I) of 1994; the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996; the Illegal Immigrant Reform and Immigrant Responsibility Act (IIRIRA) Act of 1996; and the Violence Against Women's Act (YAWA II) of 2000. Each of these federal laws changed conditions under which immigrant battered women may be able to leave a battering situation and obtain social welfare services and benefits without facing deportation and separation from their families.

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Violence Against Women Act 1994

As a first systematic attempt to address the issue of domestic violence, the Violence Against Women's Act (VAWA) (Title IV of the Violent Crime Control and Law Enforcement Act of 1994—P. L. 103–322) was passed in 1994 with

bipartisan support recognizing the significance of domestic violence as a serious problem. Congress passed the VAWA in 1994 to prevent domestic violence and also to promote the well-being of domestic violence victims. Congress also recognized that many U.S. citizen or lawful permanent resident spouses abuse their battered spouses and use their immigration status as a weapon to control them (Kwong, 2002; Orloff, 2001).

In order to provide relief to battered immigrant women by providing more opportunities for them to acquire legal status, Congress included protections for battered immigrant and children under VAWA 1994 (VAWA I) (Kwong, 2002; Orloff, 2001; Raj & Silverman, 2001; Orloff & Kaguyutan, 2001). VAWA I provided avenues for battered immigrant women to obtain lawful permanent residency without relying on their abusive spouses to file the document (Orloff, 2001; Kwong, 2002).

Personal Responsibility and Work Opportunity Reconciliation Act (1996)

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA—P. L. 104–193), Title I, created the Temporary Assistance to Needy Families, a block grant program that replaced Aid to Families and Dependent Children, a federal cash grant entitlement program for poor families with dependent children enacted originally as part of the Social Security Act of 1935. In Title I and other titles of the PRWORA, immigrant eligibility was narrowed for federal and state welfare benefits, food stamps, Medicaid, and cash grant public assistance. Welfare reform has affected more than 500,000 legal immigrants who received federal benefits including SSI and food stamps (Orloff & Little, 1999).

With the leadership of the late Senator Paul Wellstone (D-MN) and Senator Patty Murray (D-WA), an amendment to ease eligibility requirements for domestic violence victims was passed and incorporated into the Act as the Family Violence Option (FVO). However, many immigrants (both documented and nondocumented), including victims of domestic violence victims, are barred from applying for these benefits for 5 years after entering the United States. The entry date was August 26, 1996—the date of the signing of this legislation by President Clinton.

PRWORA does allow certain categories of qualified immigrants to receive public assistance, assuming they also meet other categorical and financial requirements. The categories of qualified immigrants include lawful permanent residents, refugees, and asylees, persons granted conditional entry into the United States, aliens paroled into the United States for at least one year, and women and children who have been battered or subjected to extreme cruelty by a U.S. citizen or lawful permanent resident and have a VAWA approved pending family based petition on file with the INS (now BCIS).

Illegal Immigrant Reform and Immigrant Responsibility Act (1996)

After the enactment of the PRWORA, Congress recognized the double jeopardy for battered immigrant women receiving financial assistance (Orloff, 2001;

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Orloff & Kaguyutan, 2001; Kwong, 2002). Previously undocumented battered immigrant women were not able to access public benefits because they were not "qualified immigrants."

Under the Illegal Immigrant Reform and Immigrant Responsibility Act of 1996 (IIRIRA—P. L. 104–208), Congress enacted a remedy by granting immigrant women access to the welfare safety net by enabling them to apply for qualified immigrant status. This was based on the recognition of the crucial role that economic independence plays in enabling battered immigrant women to extricate themselves from domestic violence (Orloff, 2001; Orloff & Little, 1999).

Violence Against Women Act 2000

Included in the Victims of Trafficking and Violence Protection Act of 2000 is a section, Division B—Violence Against Women's Act of 2000, Title V—Battered Immigrant Women (P. L. 106–386) that reauthorizes and amends the Violence Against Women's Act of 1994. The amendments to VAWA I that were incorporated into VAWA II included improved access to cancellation of removal, suspended deportation, and other immigrant protections for domestic violence victims. It also permitted programs funded by grants under VAWA to be used for immigration assistance to immigrant victims of domestic violence. Finally, it removed the U.S. residency requirement, and established a new category of visa, the U-visa, for victims of serious crimes related to domestic violence, stalking, and sexual assault (Kwong, 2002; Orloff & Kagunuyan, 2001).

Implications for Social Work Practice

The cultural diversity of American society has stimulated the growth of social work models of practice since the inception of the profession in the 19th century. Service delivery to victims of domestic violence was an integral part of family services among the profession's forerunners in the charity organization and settlement house movement. Charity organization agents serving the urban immigrant communities addressed problems of domestic violence, although in the early days of social work, this was done as part of the prevailing "child saving" mission.

Early social work reformers were also maternalists, and advocated against domestic abuse and for prohibition and women's pensions in order to achieve their (White middle-class) goal of assisting women to remain in the home caring for their children (Gordon, 1988). Their clients were immigrant women, often from rural areas in their countries of origin, who were forced to cope with the harshness and uncertainties of urban industrial life. Early social workers rarely attempted to empathize with the subjects of their ministrations, instead projecting values that were often quite alien to their female clients and advice that was often counterproductive.

However myopic these early reformers were regarding the problems facing immigrant families of the progressive era, they fought hard for solutions to social problems that affected all women. As social work began to turn inward in the 1920s, it began to look for solutions to social problems

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in psychotherapeutic techniques. The civil rights era and the women's movement of the 1960s and 1970s brought social workers back to a politicized and structural perspective in relation to social problems, including that of domestic violence.

At the beginning of the 21st century, the social work profession is responding to the globalization of social issues and the widespread immigration of families from cultures significantly different from the dominant European American culture, by developing multicultural approaches to working with clients. To address the problem of domestic violence within a multicultural context, social workers must develop a multidimensional understanding of the victim in relation to her family, community, and culture of origin, as well as intrapsychic processes. The ecological model of social work practice suggests intervention strategies that represent a synthesis of social and psychological techniques. It also requires a broad knowledge base and understanding of domestic violence victims from different cultures and their responses to new and existing service systems and modalities. Since the 1960s, social work has been struggling toward a multicultural model of service delivery that better reflects the basic tenet of social work practice: Begin where the client is. The 20th century feminist movement—although begun by White middle-class professionals—has also reached immigrant communities of color.

Research by social workers into domestic violence as a multicultural phenomenon can yield important information about characteristics of abuse in immigrant communities, barriers to service utilization, and successful practice models. This is a recognized gap in knowledge about domestic violence and how it affects immigrant women in the United States. Lack of access to study subjects has made this a difficult area of study. However, researchers are beginning to learn more about immigrant domestic violence victims through targeted surveys (Yoshihama, 2000; Yick, 2000) and in-depth interviews (Yoshioko, Gilbert, El-Bassel, & Baig-Amin, 2003).

The elimination of domestic violence by one adult family member against another—a key issue in the 20th century women's movement—has challenged activists and social workers alike to evolve culturally sensitive models of service delivery. This reflects a new respect for diversity, as well as the commitment to reach underserved populations that have been isolated by language and culture. In doing so, social work is challenged to continually incorporate culturally sensitive values and techniques, in order to remain vital, relevant, and effective into the 21st century.

Culturally competent social work practice with immigrant victims of domestic violence requires professional social workers to be knowledgeable about social welfare and immigration policies, including federal and state laws and regulations. The ability of an immigrant domestic violence victim to ensure safety for herself and her children, as well as avoid deportation and possible separation from her children, rests on the informed application of existing policies by her service providers and advocates in her community.

The highly technical nature of many of these processes as defined by law and regulation require interdisciplinary collaboration between social workers and attorneys experienced in welfare and immigration law. Often,

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however, a social worker will be the first professional contact for an immigrant battered woman who seeks assistance through a medical facility, family service agency, or victims service program. This makes it essential that social workers have sufficient understanding of social welfare and immigration laws to enable them to provide support and empowerment, as well as interdisciplinary referrals as needed for legal counsel and advocacy, to immigrant clients who are victims of domestic violence.

The gaps and flaws in existing social welfare and immigration laws and regulations can mean continued danger and hardship for many immigrant battered women and their families. Section 6.04 of the NASW Code of Ethics states that "social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice" (NASW, 2008, p. 27). Social workers can use clinical interventions to assess, treat, and empower clients who are victims of domestic violence to leave an abusive relationship and seek safety for themselves and their children. However, as long as legal barriers remain, clients will have difficulty achieving the safety and stability essential to their well-being. By engaging in social action and change through political advocacy, social workers can enable and empower their clients to achieve their treatment goals through access to needed benefits, services, and legal protections.

Social workers need to understand social welfare policies and the implications for practice so that they can empower clients to access needed services for themselves and their families, and to learn how to influence and shape relevant policies to better serve their clients. Policy practice is an important dimension of social work practice (Jansson, 2010). The ethical responsibility for professional policy practice is stated in the NASW Code of Ethics under Section 6: Social Workers Ethical Responsibility for the Broader Society. This section emphasizes the social worker's responsibility not only to promote the general welfare of society and advocate for the fulfillment of basic human needs, but also to engage in social and political acts to promote social justice for all (NASW, 2008).

According to Jansson (2010), policy practice is defined as efforts to influence social policy development, enactment, implementation, and assessment. Policy advocacy is defined as a form of policy practice that is focused on assisting populations lacking power to effect social and political change on their own. Policy practice and advocacy on behalf of immigrant domestic violence victims transcend controversies within social work about whether the profession should focus on the needs of individuals or the larger society. Social work practitioners who engage in clinical or administrative practice or research with this population must become effective policy practitioners to ensure the best possible service outcomes for their clients.

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CONCLUSION

New immigrants remain as vulnerable today as they were over a century ago. In spite of the growing interest and understanding of the need to ensure culturally competent and sensitive social work practice, there is still

a dearth of knowledge about the incidence and prevalence of domestic violence among immigrant women and communities of color. Even more essential is a systematic study of the impact of existing services and interventions on victims of domestic violence from cultures other than the dominant European American culture, and the need for changes in the service delivery system.

Many immigrants are from developing countries with cultures and languages significantly different from mainstream America. The influx of immigrants from Asia, South Asia, and Spanish-speaking countries like Puerto Rico and Central and South America, represent communities of color that are often marginalized in American society. Case examples of battered women from Asia, Eastern Europe, and India, as well as the nondocumented in general, illustrate the difficulties of their obtaining needed services in the United States. An understanding of how different immigrant communities view domestic violence can help social workers begin to reformulate their practice, advocate for policy changes, and formulate effective responses to assist battered immigrant women.

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TWENTY-THREE

Multicultural Populations and Suicide

Dana Alonzo and Robin Gearing

Suicide rates around the world have been on the rise over the past 50 years and are predicted to continue to increase to 1.53 million per year by the year 2020 (Khan, 2005). This growing and concerning trend in universal suicide rates exists despite the advancements that have been made regarding the identification and empirically supported treatment of depression and other psychiatric disorders associated with suicide as well as the introduction of safer, more effective psychotropics. This increase is even more disturbing considering the fact that there are scarce or no data on suicide for more than half of the countries in the world (Khan, 2005).

It is estimated that by the year 2050, Caucasians will no longer be the majority population in the United States (Department of Health, 2002). It is also recognized that in the United States, minorities, particularly those who are depressed and suicidal underutilize mental health services (Hough et al., 1987; Wells, Golding, Hough, Burnam, & Karno, 1987; Vega & Lopez, 1999). The importance of mental health service utilization is concerning as approximately 90% of individuals who complete suicide have a mental illness, with depression being the most commonly diagnosed mental disorder (Brent, Baugher, Bridge, Chen, & Chiappetta, 1999; Malone & Lartey, 2004; Shaffer Gould, Fisher, Trautman, Moreau, & Kleinman, 1996; Worchel & Gearing, 2010). If cultural, racial, and ethnic characteristics are not adequately factored into clinical processes, prevention and intervention efforts may not be successful at reducing suicide rates. It is increasingly essential to identify and understand the unique risk and protective factors for suicide among diverse ethnic populations in order to effectively target prevention and intervention strategies to include these factors in assessing and treating specific populations.

This chapter will explore the diverse demographic profile of suicidal behavior in the United States, and the review of known psychosocial risk factors for suicide within these cultural groups. Critical factors related to culture to be considered when conducting a risk assessment with suicidal clients will be reviewed. Treatment of suicidal individuals from culturally competent and evidence-based practice perspectives will be presented.

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DEMOGRAPHIC PROFILE OF SUICIDAL BEHAVIOR IN THE UNITED STATES

Suicide rates in the United States vary greatly across ethnicities and age groups. The largest ethnic groups in the United States include Caucasians, Hispanics, African Americans, and Asians and are important to consider (U.S. Bureau of the Census, 2011). Caucasians currently comprise the largest ethnic group in the United States with approximately 72% of the U.S. population (U.S. Bureau of the Census, 2011). Among Caucasians, males have a higher rate of suicide than females, with males aged 85 and older having the highest suicide rate in the United States (Joe, Baser, Breeden, Neighbors, & Jackson, 2006). Research has found that Caucasians generally have a higher rate of suicide than African Americans. This trend is further pronounced with age, with elderly Caucasians' male suicide rates exceeding elderly Black male suicide rates by more than 2 to 1 (Joe et al., 2006). Although to a lesser degree, Caucasian adolescents have a higher rate of completed suicide than do African Americans and Hispanics (Rutter & Behrendt, 2004). At 18 to 1, Caucasian female suicide rates are found to be much higher than African American female suicide rates (Joe et al., 2006).

Hispanics represent the largest minority group in the United States, comprising 16.3% of the population (U.S. Bureau of the Census, 2011). As a group, Hispanics have a lower rate of suicide than Caucasians and a higher rate than African Americans (Oquendo et al., 2004). Evidence shows that Hispanics report less suicidal ideation and make fewer lethal attempts than non-Hispanics despite having similar suicide intent (Oquendo et al., 2005). However, this picture varies greatly once Hispanic subgroups are examined. Cuban Americans have the lowest rate of lifetime suicide attempt (2%) followed by Mexican Americans (3%) (Oquendo et al., 2004), even when considering Caucasians and African Americans. Puerto Ricans have the highest rate of suicide attempt (9.1%) of all Hispanic subgroups, Caucasians, and African Americans (Oquendo et al., 2004; Ungemack & Guarnaccia, 1998). Yet, the completed suicide rate for Puerto Ricans is lower than the completed suicide rates for other Hispanic ethnic subgroups and for Caucasians (Oquendo, Ellis, Greenwald, Malone, Weissman, & Mann, 2001). Mexican Americans also have been found to have a lower rate of completed suicide than Caucasians (Oquendo et al., 2001). Latina adolescents have a higher rate of suicide attempts than adolescent females from other ethnic groups (Zayas, Lester, Cabassa, & Fortuna, 2005).

At 12.6% of the population, African Americans are the second largest minority group in the United States (U.S. Bureau of the Census, 2011). Overall, African American females have a lower rate of suicide than African American males (approximately 1 to 3) (Joe, Baser, Breeden, Neighbors, & Jackson, 2006). African American females also have a lower rate of suicide than Caucasian females (approximately 1 to 2) (Joe et al., 2006). Historically, African American youths have had lower suicide rates than have Caucasians; however, this gap is slowly decreasing (Borowsky, Ireland, & Resnick, 2001; Centers for Disease Control and Prevention, 2006; Garlow, Purselle, & Heninger, 2005; Joe et al., 2006; Joe & Kaplan, 2001).

Asians are the third largest minority group in the United States, representing 4.8% of the population (U.S. Bureau of the Census, 2011). Among

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Asians, males and older individuals have higher suicide rates. Overall, Asians have a lower rate of suicidal behavior than Caucasians (Evans et al., 2005). This is especially the case for Asian adolescents (Evans, 2005). However, when considering gender, more Asian females engage in suicidal behavior than Caucasian and African American females (Shiang, Bonger, Stephens, Allison, & Schatzberg, 1997). This finding is more pronounced among the elderly (Shiang et al., 1997).

PSYCHOSOCIAL RISK AND PROTECTIVE FACTORS

Several studies have attempted to identify risk and protective factors that are generalizable across cultures and ethnicities that may be used to inform assessment of suicide risk; however, such research is limited. A history of previous suicide attempt is the most consistent risk factor for further attempts across ethnicities (Hispanic, African American, and Whites), particularly for males (Borowsky et al., 2001; Colucci, 2007). Adolescence, old age, low socioeconomic status, substance use, and recent stressful life events have also been identified as relevant risk factors across cultures (Colucci & Martin, 2007; Rew, Thomas, Horner, Resnick, & Beuhring, 2001). Exposure to family or friend suicide appears to be another risk factor for suicide shared across cultures (Colucci, 2007; Rew et al., 2001). Conversely, parent–family connectedness (Borowsky et al., 2001) and religiosity (Gearing & Lizardi, 2009; Lizardi & Gearing, 2010) have been identified as a general protective factor against suicidal behavior.

To effectively assess and treat suicidal individuals, it is essential to understand culture-specific risk factors relevant to the cultural group of a particular client. Several studies have examined risk factors for suicidal behavior by ethnicity, with most studies comparing Caucasians and African Americans. Overall, results indicate that, more often than African Americans, Caucasians who engage in suicidal behavior are older and more often have anxiety disorders (Garlow et al., 2005; Vanderwerker et al., 2007). Caucasians also commit suicide more frequently in the context of a major depressive episode than African Americans do (Hollis, 1996; Malone, Oquendo, Haas, Ellis, Li, & Mann, 2000; Oquendo et al., 2001; Shaffer et al., 1996). A major risk factor for suicide among Caucasians is disrupted family environment (Handy, Chithiramohan, Ballard, & Silveira, 1991). Suicide attempts among Caucasians have also been shown to be associated with alcohol use (Groves, Stanley, & Sher, 2007; Vanderwerker et al., 2007), with Caucasians consuming alcohol before committing suicide twice as often as African Americans (Groves et al., 2007). Loss of a family member or friend to suicide (Borowsky et al., 2001; Brent, Bridge, Johnson, & Connolly, 1996; Brent, Perper, & Moritz, 1993), access to firearms (Brent et al., 1993), and female gender (Grossman, Milligan, & Deyo, 1991; Lefebvre, Lesage, Cyr, & Toupin, 1998; Moscicki, O'Carroll, Rae, Locke, Roy, & Regier, 1988; Pirkis, Burgess, & Dunt, 2000; Schmidtke et al., 1996; Suominen, Isometsa, Haukka, & Lonnqvist, 2004; Woods, Lin, Middleman, Beckford, Chase, & DuRant, 1997) have also been identified as risk factors among Caucasians. Among elderly Caucasians, physical illness has also been shown to be associated with increased risk of suicidality (Vanderwerker et al., 2007).

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Conversely, African Americans aged 15 and older are twice as likely as Caucasians of the same age group to commit suicide via the use of firearms (Joe, Marcus, & Kaplan, 2007). Research has reported that African Americans are twice as likely as Caucasians to choose a violent method of suicide (Stack & Wasserman, 2005). African Americans who engage in suicidal behaviors are more likely than Caucasians' peers to use cocaine (Garlow, 2002). Interpersonal conflict, male gender, and younger age have been shown to be consistent predictors of suicide among African Americans (Gibbs, 1997; Groves et al., 2007). In terms of socioeconomic status, lower levels of education have been found to be associated with increased suicide risk (Kellerman et al., 1992), and African Americans are more likely than Caucasians to have lower levels of education (U.S. Bureau of the Census, 2005). Additionally, unemployed individuals have more than twice the suicide risk of employed white-collar workers (Cubbin, LeClere, & Smith, 2000), and both African American males and females are more likely to be unemployed than Caucasians (Bureau of Labor Statistics, 2004).

CLINICAL ASSESSMENT

It may be useful to frame a suicide risk assessment within a model of suicidal behavior that allows for examination of culturally relevant factors. Although no one universal model exists as an explanation for suicidality, a stress-diathesis model of suicidal behavior has been proposed (Goldney, 2002; Mann, Waternaux, Haas, & Malone, 1999), which is gaining acceptance (Grunebaum et al., 2006). According to this model, environmental factors (referred to as triggers or stressors) may exist at certain times and can be considered state-dependent (Mann et al., 1999). In addition, genetic and biochemical factors or mechanisms (referred to as a threshold or diathesis) exist that are considered trait-dependent. When only one type of risk factor is present (state OR trait), it is not sufficient to elicit suicidal behavior (Mann et al., 1999). However, when both types of risk factors are present (state AND trait), the likelihood of the occurrence of suicidal behavior is increased (Malone, Haas, Sweeny, & Mann, 1995). This vulnerability may be innate, as a result of genetic or familial factors, such as having a first-degree relative with a history of suicide attempts (Malone et al., 2000; Mann et al., 1999; Pfeffer, Normandin, & Kakuma, 1994; Roy, 1983, 1986; Roy, Segal, Centerwall, & Robinette, 1991), or it may be the result of traumatic experiences, such as parental loss, childhood physical and/or sexual abuse (Adam et al. 1982; Briere and Runtz 1990; Farber et al. 1996; Levi et al. 1966), or alcoholism or substance abuse (Malone, Haas, Sweeny, & Mann, 1995).

The stress-diathesis model allows for variance in several areas that may account for the differential rates of suicidal behavior seen across cultures and ethnicities, as state factors are subject to cultural influences. For example, substance abuse, physical abuse, sexual abuse, unemployment, undereducation, immigration status, migration experiences, and acculturation experiences occur in varying rates across cultures, have a direct influence on an individual's vulnerability toward suicidal acts, and should be included in any suicide risk assessment (Worchel & Gearing, 2010). Several of these

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state factors, such as immigration, acculturation, and mental health service utilization will be explored in more detail as they may directly and indirectly impact the risk of suicidal behavior of individuals across cultures.

Immigration and the Risk of Suicide

Immigration has been found to be associated with increased levels of stress, mental illnesses (Shoval et al. 2007), and suicide risk (Kushner, 1991; Lester, 1997, 1998). Although often considered a stressful life event, the process of immigrating often represents a crisis event (Ponizovsky, 1999). Immigrating individuals are forced to deal with the process of acculturation while simultaneously having to deal with the loss of previously established protective factors, particularly one's social support network (Sorenson & Shen, 1996). Immigrants also tend to experience heightened prejudice and discrimination (Shoval, 2007). In addition, immigrants often earn less money (Sorenson & Shen, 1996), and lower socioeconomic status is associated with increased risk of suicidal behavior (Worcheh & Gearing, 2010). They are also less likely to seek out mental health services, which may potentially support the individual through the difficult transitions resulting from immigrating (Sorenson & Shen, 1996).

Research on the association between immigration and suicide, however, is relatively limited. However, Kushner (1991) conducted a pivotal study examining this issue and found that during the mid-20th century, migration increased the risk of suicide. Results indicated that foreign-born persons had nearly twice the suicide rate of native-born persons (Kushner, 1991). Kushner (1991) proposed that foreign-born persons from countries with higher suicide rates maintain a higher suicide risk after immigration. Lester (1997) and Lester (1998) found similar results, providing further support for the association between immigration and suicide risk.

However, research is inconsistent. In a study of Ghanaian immigrants to the United States, for example, a significant association was found between length of residency in the United States and negative suicide attitudes, and also between psychological acculturation and negative suicide attitudes (Eshun, 2006). Similarly, Sorenson and Shen (1996) studied suicide trends and ethnicity in California. Findings indicated that foreign-born persons are generally at lower risk of suicide than U.S.-born persons (Sorenson & Shen, 1996). However, the risk varied by ethnicity in that there was a higher risk for foreign-born Caucasians than for native-born Caucasians, while foreign-born Hispanics had lower risk, and foreign-born Blacks and Asians shared similar risks with native-born persons (Sorenson & Shen, 1996). These findings may indicate that the risk of suicide as related to immigration is culture-specific, and that other factors may mediate the relationship between immigration and suicide risk.

Acculturation and Suicidal Behavior

Acculturation is defined as the process that immigrants experience as they adjust to their host culture. It is characterized by the struggle to maintain the identity, traditions, values, and customs associated with their culture

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of origin, while adapting to the mainstream culture to which they have emigrated. This period is often associated with increased feelings of depression, anxiety, isolation, and suicidality (Hovey & King, 1997), referred to as acculturative stress (Berry & Kim, 1988; Hovey & King, 1996, 1997; Padilla, Cervantes, Maldonado, & Garcia, 1988; Williams, 1991).

Risk or protective factors for suicide risk related to acculturation have been identified and should be included in any culturally competent suicide risk assessment. These factors include availability of social supports in the new community, level of familial support from both immediate and extended family networks, religiosity, socioeconomic status, including changes in work status, education and employment, language ability, expectations for the future, preimmigration level of cognitive functioning, and quality of coping skills (Hovey & King, 1997; Williams, 1991).

Research regarding the association between suicide risk and acculturation has found that for many cultural groups in the United States, individuals with higher levels of acculturation are at more risk for engaging in suicidal behavior than those with lower levels of acculturation. Among Native Americans, for example, acculturative stress is a strong predictor of suicide (Lester, 1999). Similar results have been found for native Hawaiians (Yuen, Nahulu, Hishinuma, & Miyamoto, 2000) and Hispanics (Gutierrez, Osman, Kopper, & Barrios, 2000; Vega, Gil, Warheit, Apospori, & Zimmerman, 1993; Zayas, 1987). For example, Mexican Americans born in the United States have higher rates of suicide and suicidal ideation than Mexican Americans born in Mexico (Sorenson & Golding, 1988; Swanson et al. 1992). High levels of acculturative stress have also been found to be a risk factor for suicide among Central Americans (Hovey, 2000) and Puerto Ricans (Monk & Warshauer, 1974; Oquendo et al., 2004).

Mental Health Service Utilization and Ethnicity

Universally, stigma regarding mental illness is a major factor impeding mental health service utilization (Worchel & Gearing, 2010). However, among minority suicidal individuals, limited awareness of mental disorders, limited understanding of the mental health system, lack of information, language barriers, and lack of insurance (Sadavoy, Meier, Ong, & Yuk, 2004; Snowden, 2003; Fiscella, Franks, Doescher, & Saver, 2002; Strug & Mason, 2001; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999; Wells et al., 1986) have been linked to lower service utilization.

Mental health help-seeking behavior varies according to ethnicity (Alegría et al., 2002; Cauce et al., 2002; Hough et al., 2002) with research finding that Asians are less likely to seek help outside of the family than Caucasians and African Americans (Lin, Tardiff, Donetz, & Goresky, 1978). Also, Caucasians have the shortest period of delay in seeking help postonset of symptoms (Lin, Inui, Kleinman, & Womack, 1982). Asians and African Americans also show greater extended family involvement in help-seeking decisions than Caucasians (Lin et al., 1982).

As compared to their Caucasian counterparts, Hispanics have been shown to underutilize mental health services (Hough et al., 1987; Wells, Hough,

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Golding, Burnam, Karno, 1987; Vega & Lopez, 1999). Research has found that the lower rates of initiating mental health treatment of Hispanics as compared to Caucasians remain even after controlling for sociodemographic factors and psychiatric illness (Hough et al., 1987; Wells et al., 1987; Vega & Lopez, 1999). Studies also indicate that Hispanics have poorer treatment retention once starting psychiatric care, reporting greater levels of premature termination than their Caucasian counterparts (Marcos & Cancros, 1982; Sánchez-Lacay et al., 2001) and attending fewer sessions overall (Hough et al., 1987; Padgett, Patrick, Burns, Schlesinger, 1994; Temkin-Greener & Clark, 1988).

Despite these differences, what remains consistent across ethnicities is that suicide attempters have a very low rate of treatment engagement and adherence (Lizardi & Stanley, 2010). Studies indicate that up to 50% of suicide attempters who present to emergency rooms refuse outpatient treatment referrals altogether or drop out of outpatient therapy very early on (Kurz & Moller, 1984). Research has shown that up to 60% of suicide attempters drop out of treatment as soon as one week postdischarge from the emergency room (O'Brien, Holton, Hurren, Wyatt, & Hassanyeh, 1987), almost 40% drop out after 3 months postpsychiatric hospitalization (Monti, Cedereke, & Ojehagen, 2003), and approximately 70% drop out after one year postpsychiatric hospitalization (Krulee & Hayes, 1988).

Consequently, a suicide risk assessment needs to consider more than merely the rates and trends of suicidal behavior among various cultural/ethnic groups. An effective culturally competent suicide risk assessment is recommended to include examination of the individual's process of immigration, her acculturation process and signs of acculturative stress, her degree of cultural affiliation with her culture of origin, level of connection to her host culture, and the nature and degree of barriers to service utilization (Worchel & Gearing, 2010).

TREATMENT

While evidence-based practices for the treatment of suicidal behavior have been developed in recent years, there remains a dearth of research regarding the cultural relevancy of such treatments for minority populations. Suicidal individuals are an extremely difficult population to engage in treatment, with low rates of initial entry into treatment and even lower rates of on-going treatment adherence (Lizardi & Stanley, 2010). Efforts to improve treatment engagement and adherence of culturally diverse clients will be unsuccessful if they fail to consider the treatment expectations of clients and how such expectations are influenced by one's culture. At present, no treatment model exists that has evidence to support its efficacy for the treatment of suicidal behavior across cultures.

Cognitive behavior therapy (CBT) is among the most widely researched psychosocial intervention. While there is significant research on this approach as a psychotherapeutic treatment model in general, research specifically examining the treatment of suicidal behavior using CBT is much more limited (Worchel & Gearing, 2010). Nevertheless, it has gained more support for the treatment of suicidal thoughts and behaviors, particularly within the context

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of depression, than any other intervention approach. Even further limited is the research examining CBT as an effective intervention for suicidal thoughts and behaviors across cultures. Most research regarding the effectiveness of the intervention for suicidal thoughts and behaviors either fails to report on the ethnicity of samples altogether or is based largely on Caucasian populations. Thus, currently, CBT can be said to be an effective approach for the treatment of suicidal behavior among Caucasian individuals.

CBT attributes suicidal behavior to vulnerabilities resulting from negative cognitive characteristics including cognitive rigidity, poor problem-solving skills, and poor coping skills (Brown et al., 2005; Coleman & Casey, 2007; Freeman & Reinecke, 1994; Joiner, 2006; Pollock & Williams, 1998). Suicidal individuals tend to endorse negative views of themselves and of their future. They typically have experiences based on cognitive distortions and/or irrational beliefs regarding themselves, others, and the world.

Tarrier and colleagues (2008) conducted a meta-analysis comparing 28 studies that examined the use of CBT as a treatment for suicidal behavior. Results indicated that CBT is effective at reducing suicidal behavior in the immediate, short, and medium term. However, the findings were limited to the treatment of adults with suicidal behavior. Overall, research did not find the intervention to be effective for suicidal adolescents (Tarrier, 2008). This may have been the result of a lack of power due to the small sample size of studies focused on adolescents. Another study that focused on negative schemas and maladaptive thoughts found that decreasing maladaptive automatic thoughts is associated with a decrease in suicidal ideation (Coleman, 2007). Other studies focused on the problem-solving and coping skills aspects of CBT found support for the notion that increasing problem-solving skills can lead to a reduction in suicidal behavior (Asarnow et al., 2009; Bilsker & Forster, 2003; Eskin et al., 2008; Salkovskis et al., 1990).

Given the focus on the nature of one's thoughts, CBT may be able to incorporate an examination of the cultural context of the individual. That is, the model requires examination of one's thoughts and how these thoughts are formed. A culturally competent clinician practicing CBT should be questioning how the individual's culture is influencing the way she interprets events and the meanings they are assigned. In this respect, CBT has the potential to be effective across a variety of cultures. Future research, however, is needed to provide support for the application of the model for the treatment of suicidal thoughts and behaviors across cultures.

Given the important role of families in mental health help-seeking among minority populations, treatment approaches that emphasize family involvement would have the greatest likelihood of success. In particular, brief strategic family therapy (BSFT) is an evidence-based treatment model that has received support as an effective treatment for youth behavioral problems including but not limited to problematic family relationships, substance abuse, and delinquency among culturally diverse populations, particularly Hispanics and African Americans (Santisteban, Szapocznik, Perez-Vidal, Kurtines, Murray, & LaPerriere, 1996; Szapocznik, et al., 1988; Szapocznik & Kurtines, 1993). BFST is a short-term, structured intervention typically delivered in 12–15 sessions over a 3-month period.

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Based on the structural approach of Minuchin (1974), and the strategic approaches of Haley (1976) and Madanes (1981), BFST is grounded in the idea that family relationships play a critical role in the development of behavior problems and thus are the main target for intervention. BSFT proposes that a family is part of and is influenced by a larger social system (Szapocznik & Kurtines, 1993). Sensitivity to this larger social system and contextual factors, including an understanding of the influence of peers, schools, and neighborhoods on the development of children's behavior problems, is a core component of the model (Szapocznik & Kurtines, 1993). Understanding the impact of immigration, socioeconomic status, and acculturation on family processes is central to BFST (Szapocznik, Santisteban, Kurtines, Perez-Vidal, & and Hervis, 1984). This approach suggests that the behavior of one family member can only be understood by examining the family in which it occurs and that for interventions to be successful, they must be implemented at the family level and must account for the complex relationships within the family system. It is equally important to understand the structure of the family and the repetitive patterns of interactions that occur among family members that either serves to meet the family's goals or to trigger and maintain behavior problems (Szapocznik & Kurtines, 1993).

BSFT is focused on process (patterns of interactions) rather than on content (what is being said) and utilizes a strategic approach that employs practical, problem-focused, and planned interventions that are tailored to individual families. These interventions identify and modify patterns of interaction within the family system that are considered to be directly related to the negative behavioral symptoms of the youth. Change occurs by modifying the process (Szapocznik & Kurtines, 1993).

Given the short-term nature of the intervention, the family involvement, and the consideration of culturally based contextual factors affecting families, specifically immigration and acculturation, this intervention has the potential to serve as an effective intervention for the treatment of suicidal behavior among culturally diverse youth populations. Future research should focus on assessing the effectiveness of this intervention specifically for suicidal behavior.

CONCLUSION

Suicide is a problem that knows no cultural boundaries. As the minority population in the United States continues to grow, it is essential to develop culturally relevant prevention and intervention efforts to address these at-risk populations. Cultural competency is characterized by refraining from making assumptions based on a client's cultural group. Emphasizing cultural nuances may lead to increasing prejudice toward different cultures and the reinforcement of overgeneralizations (Takahashi, 1997). However, a fine line exists between lending too much importance to cultural distinctions and overlooking culturally significant factors that may better inform practice. Thus, following a model that allows room for a tailored, personalized assessment is critical. Future research focused on developing evidence-based, culturally competent models for suicide assessment and treatment is warranted.

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TWENTY-FOUR

Ethical Issues and Future Directions

Elaine P. Congress

Family therapy is often the most value-conflicted and ethically challenging of therapies, because family therapy often evokes strong countertransference of feelings in the practitioner. Although professionals may not have had the same experiences as their individual clients, almost all family therapists share a similar experience with their clients, as the former have also grown up in families. Often family therapists must guard against imposing their own values on families with whom they work. Practitioners' beliefs about families may be highly influenced by their own individual experiences and cultural backgrounds. Research suggests that even highly experienced third or fourth generation clinicians may still be powerfully affected by their own cultural background (McGoldrick, 1998). Ethical practice with culturally diverse families necessitates that clinicians understand their own cultural background before undertaking work with families from different cultures (Congress, 1999; McGoldrick, Almeida, Preto, & Bibb, 1999).

The current National Association of Social Workers (NASW) Code of Ethics (2008) stressed the need for social workers to understand their clients and "to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups" (NASW, 2008, p. 9). The NASW Code of Ethics (2008) also advises social workers to oppose discrimination based on immigration status. The *culturagram* (Congress, 1994, 2002, 2008) discussed in Chapter 1 can help clinicians better understand their own cultural backgrounds, as well as those of their clients.

In the last 25 years, clinicians have increasingly focused on values, ethical issues, and dilemmas in work with individual clients (Congress, 1999; Lowenberg, Dolgoff, & Harrington, 2000; Reamer, 1999). There has been some attention in the literature to family therapy from a multicultural perspective (Cole, 2008; Fallicov, C., 2009; Keeling & Piercy, 2007; Pakes & Roy-Chowdhury, 2007; Shibusawa, 2009; Singh, 2009). Despite an attempt to integrate a social justice perspective into a family therapy program with a focus on cultural diversity (McGoldrick et al., 2008), attention to ethical issues in work with families has been limited (Congress, 2005). A review of literature indicates only one recent book on ethics in family therapy (Wilcoxon, Remley, & Gladding, 2011) and only a few articles on ethical practice with culturally diverse families (Bryan 2000; Cole, 2008; Donovan, 2003). The current NASW

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Code (2008) includes only one reference to family work and that only in terms of confidentiality. It has been suggested that attention to ethical rules that one has learned as a family therapist may be contraindicated in family therapy with culturally diverse families (Cole, 2008).

Although most family therapists believe in self-determination and confidentiality, how are these values translated into ethical practice? How does family therapy affect self-determination? Are individual family members and the family as a whole able to freely determine their own behavior or is a certain type of behavior considered “bad” or “dysfunctional”? These questions may be particularly relevant for the family from a cultural background very different from that of the practitioner. The clinician often assumes the role of expert “knower,” evaluating the family in terms of his or her perception rather than understanding the family through each member’s perception (Laird, 1995). Narrative therapy emerges as a value-based model that requires the therapist to not begin family therapy with any preconceived understanding of the family, and to permit each family member to tell his or her own story. Allowing families to tell their own cultural stories (McGill, 1992), using genograms in a multicultural perspective (Estrada & Haney, 1998), developing family culturagrams (Congress, 1994, 2002), and using postmodernist approaches (Donavan, 2003) seem to maximize self-determination.

The importance of family relationships to culturally diverse families has been stressed (McGoldrick, 2008). Family therapists from cultures that stress an individualist approach must guard against viewing a family from a culture that stresses family connectiveness as too “enmeshed” if family members seem very close to each other. For example, a mother who must have her adolescent children accompany her shopping or is reluctant to allow her child to attend an out of state college may be described as not establishing appropriate boundaries by encouraging her adolescents to separate and individualize. A family in which older children are asked to care for younger children or to work in family businesses may be seen as exploitative of children. The family therapist must avoid labeling families from different cultures as dysfunctional because they favor a more collective modus operandi than the practitioner.

An important question is how much family therapy promotes individual self-determination. Often the family therapist is faced with a situation in which the goals of different family members conflict. For example, one spouse may see family therapy as a means to strengthen a marriage, while the other spouse envisions family therapy as helping them move toward separation and divorce. What goal does the family therapist promote? The family therapist may be asked to support one member’s right to self-determination over the other, especially if there is conflict. How does a family therapist make decisions of this type?

Family therapists must struggle with maintaining their own objectivity. At times family therapists may find themselves supporting what is familiar to them from their own background and experience. Family therapists who believe that families should stay together and that all areas of conflict can be resolved, are more likely to support the spouse who wants to continue the relationship. Family therapists who see separation and divorce

as valid options for seriously conflictual relationships may tend to support the spouse who wants to terminate the relationship.

Often ethical dilemmas arise in helping families reconcile conflicts. How should the family therapist intervene when family conflicts arise around acculturation differences? It is well known that children and adolescents, possibly because of their greater association with the American educational system and peer culture, often become acculturated faster than their parents. This may lead to family conflict, especially during adolescence. How does the family therapist support individual self-determination when adolescent clients seek more association with peers and activities outside the home, while parents maintain that adolescents should primarily pursue home and family responsibilities? This conflict may be challenging for family therapists raised and trained within an American culture that usually views peer contacts outside the home as part of normal adolescent development. These therapists must avoid allying themselves with adolescents in the family they see, lest they lose the adults within the family. On the other hand, family therapists from a similar culture as the family often run the risk of supporting the parents and thus losing the children. Family therapists must strive to maintain a focus on the total family system and not ally with any one member or subgroup of the family.

Confidentiality is often a challenging issue for the family therapist. Practitioners often have differing opinions as to what information should be kept confidential and from whom. Some believe that whatever is discussed during individual sessions should be kept confidential, while others maintain that whatever is shared individually must be discussed by the family as a whole (Corey, G., Corey, M., & Callahan, 2002). Informing clients about the agency's policy in regard to handling individual communication in family work is considered an ethical practice (NASW, 2008).

The NASW Code of Ethics addresses the importance of confidentiality in family work by stressing that the therapist "should seek agreement among [families] concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others" (NASW, 2008, p. 11). Clients should be informed, however, that confidentiality cannot be guaranteed.

The handling of confidentially is especially challenging for those who work with families from cultures who have a very different understanding of confidentiality. In a previous article on culturally diverse children this author noted that often children and parents from different cultures have a very different concept of confidentiality than the prevailing social work value of confidentiality (Congress & Lynn, 1994). Neither children nor adults believed that group leaders would keep confidential information shared in group sessions. Healy (2001) notes that in Africa often extended families and community networks are involved in working with families, which mitigates a strict definition of confidentiality. African families, as well as those from other countries who favor a more collective approach, may question the American concept of confidentiality. Increasingly we work with families from many parts of the world that have a family community approach to problem solving that contrasts with the prevailing American concept of maintaining individual confidentiality.

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Since I wrote the second edition of *Multicultural Perspectives in Working with Families*, I have become increasingly aware of how much the U.S. NASW Code of Ethics and the way we work with families is based on an Anglo Saxon perspective. Even compared to the codes of other developed countries, the provisions about confidentiality in the U.S. Code of Ethics are the most comprehensive and include the most specific practice situations (Congress & McAuliffe, 2006; Congress & Kim, 2007). The focus on strict confidentiality is particularly challenging at a time during which more and more families come from diverse backgrounds. Professionals must continually struggle with promoting confidentiality with families for whom the concept has limited meaning. Often a dilemma arises between enforcing American concepts of confidentiality and being sensitive to cultural differences in the use of confidentiality. The International Federation of Social Workers' (IFSW) Ethical Standards (2004) represents an attempt to develop ethical standards for social workers around the world. The standards make a general statement about confidentiality, that social workers should maintain confidentiality about people who use their services except when there is "a greater ethical requirement" (such as the preservation of life) (IFSW, 2004, p. 1). It is interesting to note that this international standard uses an individualist approach to confidentiality and does not recognize a more collective perspective in providing social work services. There is a statement, however, that social workers should also adhere to the codes of their respective countries, which does provide for cultural differences in the use of confidentiality.

Although rights to privacy and confidentiality are stressed in American culture in general and social work practice in particular, these values may not have the same meaning for families from different cultures. For example, undocumented families may be reluctant to talk with family therapists. They may fear that practitioners whom they view as unknown authority figures possibly associated with government, may share information about them with immigration officials, thus leading to deportation. This may be particularly true now, as subsequent to 9/11 and the passing of the Patriot Act, there is greater government scrutiny of those who are not American citizens. Even if the family has legal status, past oppression, and discrimination experienced by family members may make them reluctant to share information with outsiders (family therapists) from different cultural backgrounds.

All families have different ways of communicating and sharing personal information. In some families, there is very open communication (perhaps too open) between family members. Other families have many secrets that are kept confidential and especially not shared with children. Not only do family therapists have different ways of handling confidentiality, but also different families handle confidentiality in different ways. Some families from a similar cultural background may handle confidentiality in a similar way; others may approach confidentiality in a way unique for the family. It is necessary for the family therapist to explore a family's unique beliefs about privacy, confidentiality, and maintaining secrets. The family therapist must then be careful not to impose his or her own beliefs about maintaining secrets in family therapy. For example, a family therapist who insisted that there be no secrets in family therapy, and then insisted that an unemployed

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father discuss his feelings of inadequacy in a family session alienated the father and the family never returned for additional sessions.

Different family members may have different understandings about confidentiality. Parents from cultures that believe that adolescents should share openly their beliefs and behaviors and not maintain secrets may be in conflict with their adolescents influenced by American teenage culture, who may want to hide personal information from other family members. Recent court decisions that support adolescents' right to confidentiality for health care decisions may also affect family therapy with families from diverse backgrounds.

Informed consent is considered essential for ethical social work practice (NASW, 2008). Because of the vulnerability of many poor multicultural clients, the use of informed consent has been seen as strengthening and empowering to families from diverse backgrounds (Palmer & Kaufman, 2003). Furthermore, informed consent is a required component for evidence-based social work. Informed consent can occur, however, only if clients and families understand the nature of the treatment they will receive.

How can the family therapist facilitate informed consent with families from diverse cultural and linguistic backgrounds? Family therapists must be able to communicate with families in a language they can understand. This points to the need for family therapists to speak in the same language as the families whom they see. This is often challenging given the diversity of languages spoken by American immigrant families.

Using children as interpreters can be problematic, as communication can be distorted and parent's power within the family can be threatened. An example of distorted communication occurred when a social work student asked a 10-year-old daughter to inquire of her mother how she felt. The mother spoke for 10 minutes. At the end, the daughter interpreted her mother's response as, "She says she feels fine." Another, perhaps more troubling, communication problem occurred when a 15-year-old boy with behavior problems was asked to interpret for his parents when they came for a family session. By using the adolescent as an interpreter the tenuous power relationships in a family were weakened even more.

Even if the therapist is able to communicate in the language of the family, ensuring informed consent can be problematic. Whereas informed consent can occur with parents, how much informed consent do children have? This is an issue in all family therapy, but may be more acute in families from cultures in which children are not seen as having rights. Family therapy can be affected by parents who have not explained to children why they are coming for therapy and furthermore do not see the need for family therapy. The ethical family therapist must strive to enable all members of a family to exercise informed consent. The purpose of family therapy may have to be explained in a way that children and those not familiar with family therapy can understand.

What new trends have influenced family therapy in the 21st century? Mental health treatment has already been greatly affected by the need for evidence-based models can demonstrate positive results after a short number of sessions. The current focus on more short-term solution focused

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models of treatment may be very effective with immigrant families who have limited resources and want treatment that is time limited with very specific treatment objectives. The emphasis on evidence-based treatment also necessitates a specific focus on clear goals and objectives that will appeal to culturally diverse families who want to see clear results within a limited amount of time.

With the current limits on covering mental health treatment, there is concern that family therapy is not always reimbursable. There is no accepted diagnostic system for families comparable to the *DSM IV,* which is used to measure individual dysfunction and symptomatology. A challenge is that mental health family treatment often involves billing at full rate for the primary client (identified patient) and billing for other family members as collaborative visits. Thirty-five percent of mental health treatment is paid by private insurance, while 44% are paid for by Medicaid and Medicare, a total of 80% (OAS, 2011). Thus immigrants especially those who are undocumented and on limited income may have difficulty in paying for family therapy.

Evidence-based practice is conducive to family therapy with diverse families. First, an exploration of client values is conducted. This is essential in work with families that may have a different value system from that of the therapist. A second major component is the need for informed consent so that the family may choose from different family therapy models. As stated previously, this is challenging given the diversity of cultural backgrounds and languages. Some culturally diverse families may rely on the therapist as the expert and not want to choose among different options. Also, the therapist may believe that he is the expert and knows what model would work best with the family. A third major component of evidence-based practice that is firmly supported by the Code of Ethics is that social workers should only rely on models that have proven to be effective. This is challenging as there has been limited research on the effectiveness of the different family models, and even less research on the effectiveness of different family therapy models with clients from different cultural backgrounds.

Practice wisdom suggests that family work would be advisable for people from diverse cultures that favor a collective approach to resolving problems. Family therapy seems particularly appropriate when families seek treatment as a group, in contrast to the many Americans who seek individual treatment. Certain treatment models such as narrative therapy that encourages families to tell their own stories may be particularly useful in working with culturally diverse families (Freeman & Couchonnal, 2006). One challenge, however, might be that those families from cultures in which there is a male-dominated hierarchy within the family may be resistant to therapy in which each member has an equal voice, and there is an expectation that each is open in discussing feelings and problems.

The rise of the Internet has greatly affected the field of family therapy. First there is a new array of diagnosis for the family therapist including cyber sex and cyber addiction (Goldberg, Peterson, Rosen, & Sara, 2008; Delmonico & Griffin, 2008). There may also be new forms of web-based treatment (Gilkey, Carey, & Wade, 2009) that may pose new ethical challenges.

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The United States, similar to other countries around the world, is becoming increasingly culturally diverse. In New York City, 40% of the population is foreign-born, for the United States as a whole, the average percentage of foreign born is 20% (U.S. Census Bureau, 2010). Because of increased poverty and violence, many communities where new immigrants live are currently under siege and can provide only limited support to their residents. One can predict that this situation will not improve very soon with cutbacks in financial and social service resources for poor people. Culturally competent family treatment that focuses on strengthening families provides much support for families in a challenging social environment.

Family therapists work more and more with families from many different cultural backgrounds. Also, as many people from diverse cultural backgrounds seek professional education, one can predict that family therapists will increasingly come from diverse cultural backgrounds. There is some evidence to suggest, however, that it has been difficult to attract and retain trainees of color, as "family therapy is not the world in which they are familiar . . . though their own values are very family oriented" (McGoldrick et al., 1999, p. 194). Other explanations that McGoldrick and colleagues offer for the limited number of trainees of color is that many from non-White backgrounds view the family therapy field as White-dominated, and secondly, therapists of color must contend with many life stresses that may prevent them from pursuing specialized training in family therapy. There is some evidence however that family therapists may be more receptive to complementary and alternative medical practice (Becvar, Caldwell, & Winek, 2006). Also the current focus on narrative therapy that encourages the family therapist to let the family tell their own story may build more connections between the therapist and the culturally diverse family. There is some evidence that family therapists from different countries and cultural backgrounds may work differently with issues of gender, culture, and power (Keeling & Piercy, 2007).

One anticipates that this will change as more people of color move into the middle class and seek professional education. Many begin to work with families after pursuing a masters in social work. Currently the Council on Social Work Education (CSWE) reports that approximately 20% of graduating MSW students are from other than Caucasian backgrounds (Lennon, 2002). The focus in social work education is to prepare students for culturally competent practice with families, as well as individuals, groups, and communities. In the years to come, an increasing number of families from diverse cultural backgrounds will be able to receive culturally competent family therapy from professional social workers.

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