WORKING WITH IMMIGRANT FAMILIES

A PRACTICAL GUIDE FOR COUNSELORS

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Chapter 2

Theories of Acculturation and Cultural Identity

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Key to understanding the life experiences of immigrants is obtaining an appropriate understanding of what the term *immigrant* means. Immigrants may be legal or undocumented residents, permanent residents or short-term guest workers, refugees, asylum seekers, naturalized citizens, or, in the case of Puerto Ricans, American citizens who migrate to the continental United States (L. A. Miller, 2007). In short, the term *immigrant* encapsulates a variety of experiences and historical legacies that may often mask important distinctions between subgroups. However, despite these varied definitions and experiences, there are a host of commonalities that immigrants may share as they migrate to the United States and acculturate to their new environment. In this chapter, we will review the research and various models associated with acculturation and immigrants to demonstrate how working with immigrant families may be different from working with domestic clients.

Definition of Acculturation

Historically, *acculturation* has been defined a variety of ways (Chun, Organista, & Marín, 2003). In 1936, anthropologists Redfield, Linton, and Herskovits offered one of the first formal definitions of acculturation as "those phenomena which results when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups" (p. 149). This definition, with its focus on bidirectional change and sustained group contact, was then further expanded by Graves (1967) to include specific behavioral changes that individuals may incur as a result of culture contact.

Since then, acculturation has been understood to include group and individual changes resulting from sustained intercultural contact. From a psychological perspective, this would entail changes in the behavior, values, and identity that individuals undergo when they are in continuous contact with others who may hold different values, norms, beliefs, and customs (Negy & Woods, 1992; Padilla, 1980). However, recent research has noted these definitions do not fully acknowledge the role of human agency in interpersonal relationships (see Chirkov, 2009, for further review). Thus, acculturation is not a process that occurs to an individual. Instead, an individual may affect how acculturation can occur.

To this effect, one recently proposed definition of individual acculturation, or second-culture acquisition, defines it as "a process that is executed by an agentic individual ... after meeting and entering a cultural community that is different from the cultural community where he or she was initially socialized" (Chirkoc, 2009, p. 178). Furthermore, within this revised definition, acculturation "involves a deliberate, reflective, and, for the most part, comparative cognitive activity" and is "an open-ended, continuous process that includes progresses, relapses, and turns which make it practically impossible to predict and control" (Chirkoc, 2009, p. 178).

Models of Acculturation

Unidimensional and Linear Models

Just as there has been controversy regarding the definition of acculturation, there has been equal difficulty in devising models and methods that best capture the experience of cultural acquisition. Despite earlier definitions that understood acculturation as an ongoing bidirectional process, many models of acculturation focused exclusively on the life experiences of immigrants and conceived of this experience as a unidimensional process (Cuéllar, Harris, & Jaso, 1980; Gordon, 1964). Within this framework, immigrants moved linearly from one polar extreme (i.e., low acculturation) to another (i.e., complete assimilation). The assumption of these models was that assimilation would be related to better psychological functioning. However, further elaborations of this model, subsequently conceived of the notion biculturalism, or dual cultural involvement, as an alternative to complete assimilation. Expanding on these models' biculturality was conceived as occurring at the midpoint of these two extremes.

However, despite these changes in measurement and conceptualization, the association between acculturation and psychological outcome remained unclear. According to Rogler, Cortés, and Malgady (1991), acculturation was associated with psychological functioning in three contradictory ways: (a) a positive association, indicating that as acculturation increased, adjustment increased; (b) a negative association, indicating that as acculturation increased, adjustment decreased; and (c) a curvilinear association, in which acculturation could be correlated with either optimal or worse adjustment at the extreme ends of the acculturation spectrum. In addition, there was, of course, an unstated fourth outcome in which acculturation was not at all related to adjustment.

Bidimensional and Multidimensional Models

Many have argued that such contradictory findings were in part due to the variety of ways that acculturation was conceptualized and measured, as well as the use of research designs and samples used (Cabassa, 2003; Rogler et al., 1991; Ryder, Alden, & Paulhus, 2000). For example, assessing acculturation has been difficult because many measures have relied on proxy measures, such as generational status (e.g., first or second generation), frequency of language use (e.g., English vis-à-vis language of origin), length of U.S. residency, socioeconomic

status, and even food use. Yet, because many of these variables are often correlated, it can be difficult to assess the unique predictive value of each variable (Cabassa, 2003; Negy & Woods, 1992).

However, one of the most prominent criticisms of the unidimensional models was that acculturation did not occur in such a zero-sum manner. Instead, immigrants could hold and adapt to various aspects of their heritage and host cultures without relinquishing either culture. Therefore, acculturation to these different cultures needed to be assessed on separate dimensions (or orthogonally), rather than assumed to occur on a single bipolar continuum.

The most prominent bidimensional model has been Berry's Acculturation Model (Berry, 1990). Briefly, according to this model, individuals had a variety of strategies for dealing with the process of acculturation. In particular, involvement in the host and immigrant culture was assessed separately with regard to whether individuals believed (a) it was of value to maintain their immigrant identity and (b) it was of value to maintain contact with other groups. On the basis of responses to these questions, individuals were categorized into one of the four strategies: assimilation, separation, marginalization, and integration (or biculturality). Although this model has been subsequently critiqued (Rudmin, 2003), at least recent research is indicating that newer measures of bidimensional acculturation scores are quite robust (see Huynh, Howell, & Benet-Martínez, 2009 for meta-analytic review).

Of all of these strategies, much emphasis has been placed on understanding the experiences of biculturality. In contrast to earlier definitions, within this model biculturality is conceived no longer as occurring at the midpoint of two polar opposites but rather as an experience that needs to be assessed along two separate dimensions (Cortés, Rogler, & Malgady, 1994; Szapocznik, Kurtines, & Fernandez, 1980; Szapocznik, Santisteban, Kurtines, Perez-Vidal, & Hervis, 1984). Currently, the latest research indicates that there are multiple types of biculturals and that individuals can acculturate to multiple domains (Benet-Martínez & Haritatos, 2005; Guo, Suarez-Morales, Schwartz, & Szapocznik, 2009; Schwartz & Zamboanga, 2008; Zea, Asner-Self, Birman, & Buki, 2003). Furthermore, individuals can acculturate at different rates, to different domains, during the process of acculturation (Kang, 2006). Bicultural individuals thus represent the possibility of an infinite host of value sets, making a portrayal of the typical "bicultural individual" almost impossible.

Models of Ethnic and Racial identity

In addition to the difficulties of assessing acculturation and biculturality, there has been growing concern that variables assessed in these models do not fully

capture the values associated with acculturating to another environment, such as changes that might occur in cultural or group awareness and affiliation (Padilla, 1980). Thus, researchers have expanded their studies to include this mode of identity development (Atkinson, Morten, & Sue, 1993; Bernal, Saenz, & Knight, 1991; Cross, 1971; Helms, 1984; Phinney, 1992). Many of these models have drawn from identity development models developed by Marcia (1980) as well as social identity models (Tajfel, 1981). Among the most influential of these theories have been Phinney's conceptualization of ethnic identity (Phinney, 1992; Phinney & Ong, 2007) and Cross's (1971) model of psychological nigrescence.

Ethnic Identity Models

Briefly defined, ethnic identity reflects the attitudes or emotional significance people attach to their social group (Phinney, 1990; Phinney & Ong, 2007), such as a group with a common nationality or culture (Betancourt & López, 1993). For many it is an integral part of their sense of self and their interactions with the world. Although various ethnic-specific models have been proposed to understand the experience of ethnic identity, most theorists have assumed that this process typically occurs in stages. For example, according to Phinney's (non-ethnic-specific) model of ethnic identity, minority adolescents may go through periods of having an unexamined identity, then go through a period of searching or moratorium, and proceed to achievement (Phinney & Ong, 2007).

Within this framework, there has also been attention paid to the multidimensional components of ethnic identity. For example, one definition of ethnic identity offered by Bernal and Knight (1993) integrates the variables of self-concept and group membership, including related constructs such as knowledge, understanding, values, behaviors, and feelings, and defines ethnic identity as "a construct or set of self-ideas about one's own ethnic group membership" (p. 33).

Racial Identity Models

Concurrent with the development of ethnic identity models was the development of racial identity theories. In contrast to ethnic identity, racial identity refers to the significance and meaning that individuals ascribe to being a member of their racial group (Sellers, Smith, Shelton, Rowley, & Chavous, 1998). Cross (1971) developed the first model of racial identity development, the nigrescence model, which offered a framework in which to understand Black identity development. Like early acculturation models, Cross's model offered a series of sequential developmental stages of Black identity, beginning with preencounter, moving to encounter and immersion, and ending with internalization and commitment.

Subsequently, other models of racial identity development have expanded on Cross's model, moving toward a more fluid view of the process of identity formation and adding elements reflecting the ethnic minority individual interaction with an oppressive environment (Atkinson et al., 1993; Helms, 1984). The Racial/Cultural Identity Development Model (Atkinson et al., 1993) further elaborates on the work of Helms (1984) and Helms and Carter (1990).

The strengths of these models are that, unlike previous acculturation models, they have focused more directly on issues of identity development. In addition, unlike acculturation, there appears to be a more consistent relation between higher levels of ethnic and racial identity and greater adjustment. In fact, a growing body of research indicates that, in particular, ethnic identity can suffer as a buffer against psychological distress (López, 2008). Furthermore, with regard to racial identity, exploratory research indicates that among some immigrant groups, preencounter racial attitudes are related to more depressive symptomatology (Kibour, 2001).

However, in general, the applicability of these ethnic and racial models to various immigrant groups has been lacking. This is unfortunate because immigrant groups can identify in a variety of ways. For example, although some Latinos(as) can racially self-identify in a multitude of ways, for a variety of reasons, some may still find it important to ethnically identify as Latinos/Latinas (López, 2008; Itzigsohn, Giorguli, & Vazquez, 2005). In contrast, African immigrants migrating to the United States may sometimes feel forced to choose between identifying as Black and holding on to their native identity. In short, although many of the models presented have discussed the role of cultural contact, they have not explicitly discussed how these processes specifically affect the lived experiences of immigrants who may come to therapy.

Application of the Acculturation and Identify Models to Immigrants

For clinicians working with immigrants, it is important not only to understand the various models of acculturation, ethnic identity, and racial identity but also to understand how these processes can differ for various family members. Although the formation of the family can differ according to how preexisting immigration laws are executed, a review of the research indicates a number of clinical issues that appear to be similar across groups.

Acculturation and the Immigrant Man

In the United States, roughly 58% of the unauthorized immigrant population is male compared to only 42% of the immigrant population being female. In

contrast to immigration patterns around the globe, most of the immigration to the United States occurs in some unauthorized form (Fry, 2006). Within this group, men are most likely to be the first to migrate and arrive in the host country, leaving behind important extended support networks. In addition, recently arrived immigrant men, who mostly arrive from Latin America and Asia, generally moved into established communities of like individuals, often largely composed of males.

This encapsulation thus engenders some of the first barriers to seeking mental health care, low acculturation, and self-reliant attitudes (Cabassa, Zayas, & Hansen, 2006). These patterns often translate into multiple barriers for male immigrants. Men who have immigrated to the United States using an unauthorized form face barriers such as lacking health insurance, having limited to no English-language skills, and not having a network that can point them to available local mental health resources (Cabassa et al., 2006).

Another particular difficulty that has been noted in the clinical research on immigrant men is substance abuse (Gil, Wagner, & Vega, 2000; Karriker-Jaffe & Zemore, 2009; Zamboanga, Raffaelli, & Horton, 2006). For example, Karriker-Jaffe and Zemore (2009) examined drinking patterns among Latino males with both high and low levels of acculturation and with a sample of U.S.-born English speakers and foreign-born Spanish speakers and found that Latino males with a high level of acculturation were significantly more likely to be drinkers than Latino males with low levels of acculturation. However, this was true only for high-level income (i.e., above average) Latino men and not for Latino men with high levels of acculturation who have below-average incomes. Thus, although the general research on acculturation and mental health is still debated, at least for men there appears to be a relation between migration and substance abuse.

Acculturation and Immigrant Women

For immigrant women, current profiles indicate that those who arrive are typically older, are better educated, have a tendency to have never been married, and are less likely to have children than earlier streams (Fry, 2006). However, although there are differences between earlier and later cohorts, on the whole, these differences are not dramatically different. For example, in 2004, only 30%, as opposed to 27% in 1980, of female migrants were never married. Furthermore, there was only a slight drop in the percentage of women who reported that they had children of their own, from 51% in 1980 to 47% in 1994 (Fry, 2006).

Thus, large portions of immigrant women still come to the United States previously married and currently caring for their children. Therefore, it is not surprising that many of the therapeutic concerns of immigrant women concern

their children. These concerns can range from postpartum issues to concerns over how to raise their adolescent children who, along with them, are undergoing the process of acculturation. In addition, although there is great heterogeneity in the life experiences of different immigrant groups, the growing feminization of poverty indicates that worldwide women are at much higher risk for poverty (Brady & Kall, 2008). These "push factors" can consequently affect whether a woman immigrates to the United States and what types of jobs she acquires or is forced into.

In conjunction, at least on the basis of clinical observations, immigrant women can also face a number of psychological issues. For example, past clinical studies have reported an increase in the relationship between past trauma, relocation, and post-traumatic stress disorder (PTSD) and depressive symptomatology, with one study finding that abused women had three times the odds of meeting PTSD criteria (Fedovskiy, Higgins, & Paranjape, 2008). In addition, some have debated whether immigrant women, when compared to nonimmigrant women, are at higher risk for abuse or if immigrant-specific factors, such as language difficulties, isolation, discrimination, restriction to resources, and issues related to their legal statuses, exacerbate an already elevated problem in a vulnerable population (Menjívar & Salcido, 2002). Still, recent studies, such as by Hass, Dutton, and Orloff (2000), have found lifetime prevalence rates of domestic violence to be as high as 49.8%, and more recent research with 78 Pakistani and Indian women found the prevalence rate to be as high as 77% (Adam & Schewe, 2007).

One factor that has been linked with increased abuse, and that is intimately tied to the process of acculturation, is the laws that were associated with the immigration of women. With the passage of the Immigration and Marriage Fraud Amendment in 1986, immigrant women who migrated were subject to a two-year conditional resident status before they could become citizens (Bhuyan, 2008). During this two-year period, the immigrant woman's U.S. husband, who could be either a U.S. citizen or a legal resident, was in effect a woman's legal guardian and responsible for her acculturation. The notion was that a woman could be introduced to American culture and, through a man's assistance, could learn all the appropriate skills to become a knowledgeable citizen.

However, although this arrangement was assumed to not cause any undue hardships for those marriages that had occurred in good faith, advocates for immigrant women have argued that this "legal dependence" in effect created situations of abuse and control (Bhuyan, 2008). As a result, fearing deportation, immigrant women sustained physical and psychological abuse at the hands of their spouses because they either were unaware or were too fearful to seek civil protection orders against their abusive partners (Conyers, 2007). This is on top

of the fact that many times immigrants may not fully know the status of their immigration because of the changing and complex laws (L. A. Miller, 2007).

We can see how patriarchal notions, viewed from a feminist perspective, of how men should provide for the acculturation of women in effect led to the abuse of women. Thus, in recognition of the abuses that immigrant women, and their children, could be subject to, a series of Violence Against Women and Department of Justice Reauthorization Acts (e.g., VAWA, 2000, 2004, 2005) were passed. Each subsequent act enlarged the class of immigrant victims protected. Specifically, abused women could now formally identify as a "battered immigrant" and self-petition for their legal status, without the fear of deportation (Conyers, 2007).

Although these laws have increased the protection afforded to immigrant women, recent research based on community samples, with different immigrant groups, using a variety of methodologies, suggest abuse is still occurring (Lee, 2007; Rianon & Shelton, 2003; Salcido & Adelman, 2004). Clinical observations, as well as interviews with treatment providers, have also documented the difficulties of service delivery for this population (Keller & Brennan, 2007; Latta & Goodman, 2005; Liao, 2006; Nicolas et al., 2007). Still, although the stressors of acculturation are clearly linked to the life experiences of women, it is yet unclear if this relationship is linear or whether there are multiple feedback loops that can better explain the relationship between acculturation and the mental health of immigrants. This is especially of concern because there are only a limited number of epidemiological and longitudinal studies on the mental health of immigrants.

Finally, a dominant theory in the immigrant-acculturation literature concerns the differences in the rate of acculturation between men and women, as well as between women and their children, who are often assumed to acculturate faster than their parents. In fact, research has also documented conflicts between mothers and their adult children, namely, daughters (Usita & Du Bois, 2005).

Acculturation and Immigrant Youth

As such, differences in acculturation are not only gender based but also generational. Because of issues of faster acquisition of the new culture's language, developmental stages, and the adopted country's mainstream culture, the acculturation of children and adolescents must be viewed as its own phenomenon. With specific regard to acculturation, because of adolescents' ability to understand and speak various languages at a more rapid pace than their adult counterparts, children are more prepared to engage in social interactions within their adopted culture, resulting in a faster level of acculturation. In addition, children and adolescents are more likely to have the opportunity to acquire English,

by way of participation in school-sponsored English as second language (ESL) classes or more informal means such as contact with classmates or teachers, for whom English is the primary language.

In examining retention of the adolescents' original language, immigrant children often do retain a tight hold on their ethnic roots for practical purposes, including communication with their parents and other adult family members (who perhaps struggle with learning English) or to assist their families in navigating North American society, for which English is the "unofficial" official language. Outside of this, retention of native languages also serves the purpose of maintaining a connection to one's ethnic identify and reinforcing acceptance of one's native culture (Lu, 2001). When one is working with immigrant children or adolescents, the role their native language serves for them must be taken into consideration, especially for how the provision of services occurs (whether in the native language or in English), as well as what role language holds in their lives. For instance, it is not uncommon for adolescents to feel a social pressure to speak English only (Shi & Lu, 2007). Such pressure must also be taken into consideration as it relates to the child's acculturative stress. Unable to insulate themselves from the requirement to speak English (because of societal constraints in and out of school), adolescents are required to learn English in greater proficiency than their original language and at an increased speed. Providers of services to children and adolescents and their families must be cautioned to not fall into the trap of contributing to the pressures of English-only mental health provision, as it has the potential to impact willingness to seek services and serves to further marginalize immigrant clients.

As children and adolescents are often quicker to speak the language of the new country (English in the United States), they are often relied on to serve as informal translators and guides for their parents in both language and cultural norms (Padilla, 2006; Weisskirch & Alva, 2002). This new role as the cultural brokers has been shown to cause a burden on children and adolescents because of the awkward role reversal of their parents relying on them for their English skills (Padilla, 2006). In addition, because of the need to serve as translators for their parents in areas of business and with other facets of the new culture, children and adolescents are often put in the uncomfortable situation of being privy to adult discussions, issues, and so on that their parents would otherwise keep from them (Weisskirch & Alva, 2002). Although these children simultaneously act as guides and mentors for their parents, these same adolescents will then be expected to maintain the role of being children within the household, even when they must mediate adult disputes.

Language is often tied to the level of assimilation of children and adolescents and their parents. Farver, Narang, and Bhadha (2002) noted that the acculturation gap is common within families based on generation. As many immigrant parents choose to come to the United States because of better opportunities for themselves and their families (perhaps enduring evading conditions such as wars, famines, and so on in their homeland), parents at times struggle to determine which culture deserves more emphasis: their ethnic background or the U.S. culture. In this acculturation process, it is often the family who plays a major role. The way in which this is undertaken can occur in actual verbal directives being given by parents, modeling of immigrant cultural norms, and parenting style.

Children and adolescents may feel torn between these two worlds, neither of which do they feel a part of. This isolation from both cultures contributes to problems in their relationships with parents and other adult family members. Parents with low-level acculturation may push their children to also maintain the native culture, including its values and ideas, which may not necessarily be in sync with those of the mainstream U.S. culture or what the children or adolescents want (Cote & Bornstein, 2005). Therefore, when the children or adolescents choose to acculturate more than their parents would like, it may be taken as sign of rebellion and may cause additional problems in the parent–child relationship. This conflict may be even greater within immigrant cultures where parents were separated or marginalized by the majority culture, as noted in a study of Asian American immigrants (Farver et al., 2002). The level of assimilation of caregivers, as well as the acculturation gap that may exist between children and adolescents and their parents or caregivers, may influence service delivery as well as issues presented in counseling sessions and how they may be viewed differently by the parents and children or adolescents.

The Provision of Culturally Appropriate Services

The multitude of concerns that some immigrant families face makes it especially important that we provide culturally competent and accessible resources for this population. However, the first issue to realize is that on the whole, immigrant groups, typically defined as those who are first generation, in fact overall have better mental health outcomes than those who are born in the United States (Alegria et al., 2008; Takeuchi et al., 2007). Thus, as clinicians we must understand that those patients who come to our clinical practice are not always fully representative of the population at large. In part, because of issues surrounding stigma (Abu-Ras, 2003; Nadeem et al., 2007), differences in self-perceived need (Nadeem et al., 2007), and difficulties in resource allocation, immigrants who come to therapy can vary substantially from those who do not and from immigrants in general. Providing culturally competent services would first recognize the overall resiliency among immigrant groups.

Furthermore, as clinicians we need to understand that the expression of distress and psychopathology can vary extensively by culture, and thus any intervention would need to be specifically tailored to the group (Bernstein, Lee, Park, & Jyoung, 2008; Cabassa, 2003; Sellers, Ward, & Pate, 2006). Unfortunately, there is still much more work that needs to be done in providing such services. In fact, a review of the research shows that there were a limited number of community-based studies that explicitly targeted immigrant populations in their treatment protocols. Furthermore, to our knowledge, there were no randomized clinical trials that specifically targeted the mental health problems of immigrants.

Clearly, the most effective types of treatment programs are the ones that targeted the family (Paris, 2008; Pearl, 2008; Seto & Woodford, 2007). In our view, the most effective types of treatment would also require that clinicians not only address current problems but also work with the community to improve and address its needs. The most effective programs understand that structural forces, such as the ever-changing laws that govern immigration, can encourage or discourage the settlement of immigrants into this country, and the consequences of these laws have affected the possibilities for acculturation. For example, depending on the immigrant group, some residential laws have been extremely restrictive and as a result have strongly impacted the establishment of ethnic enclave. Neighborhood characteristics, such as the density of its ethnic population, can lead to different trajectories of acculturation and subsequently can change mental health outcomes (A. M. Miller et al., 2009).

Thus, in discussing the life experiences of immigrants, it is important not only to understand the interpersonal factors that can influence these issues but also to have an appreciation of the laws that can influence the stratification of immigrant communities and to appreciate the context from whence immigrants emigrated and of where they resettled. In short, the acculturation of immigrants, and their subsequent mental health, is simultaneously constrained and buffered by interpersonal and structural forces.

Discussion Questions

1. How can changes in the definition and measurement of acculturation affect therapeutic practices?
2. How does gender or one's relationship in the family affect the acculturation process? What clinical issues are most salient in these groups?
3. What individual and social factors contribute to resiliency among the individuals, ethnic groups, or immigrants as a whole?

4. What are the individual or social factors that contribute to lower rates of mental health concerns among immigrants that could be translated to native-born populations in the United States?
5. In what ways can a mental health professional balance the native cultural values of parents with the bicultural values of their children when determining services goals and issues?
6. What are the different issues that may arise based on the age of immigrants at time of immigration?

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