REPORT OF THE APA PRESIDENTIAL TASK FORCE ON IMMIGRATION

CROSSROADS

THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY

AMERICAN PSYCHOLOGICAL ASSOCIATION

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Report of the APA Presidential Task Force on Immigration

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publicinterest@apa.org

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CROSSROADS

THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY

APA Presidential Task Force on Immigration

Carola Suárez-Orozco, PhD, Chair
New York University

Dina Birman, PhD
University of Illinois at Chicago

J. Manuel Casas, PhD
University of California, Santa Barbara

Nadine Nakamura, PhD
University of La Verne

Pratyusha Tummala-Narra, PhD
Boston College

Michael Zárate, PhD
University of Texas, El Paso

Melba Vasquez, PhD (ex officio)
2011 APA President
Vasquez & Associates Mental Health Services

APA Children, Youth, and Families Office

Mary Campbell, Director

Alex Agiliga

Efua Andoh

Amani Chatman

Felicia Swafford

Kaitlin Varner

CONTENTS

PREFACE

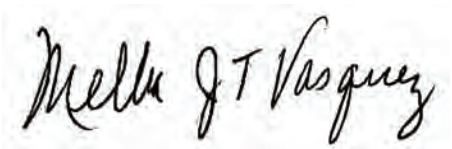
One of the benefits of serving as president of the American Psychological Association is the opportunity to select projects or initiatives that are personally meaningful. The topic of immigration surfaced as a priority for me and is a topic of concern for many. Over the past few decades, psychology—and APA in particular—has periodically applied its science and knowledge to issues of societal interest and social justice that may be the subject of media attention, pending legislation, and/or court proceedings. At times, the societal context and political focus on social problems have influenced APA's topics of study. Immigration fell into that category, in my view. In addition, although I am fourth-generation Mexican American (my parents were both born in the United States, and my mother's family lived in the Texas area when it was still part of Mexico), I identify personally with the community of immigrants.

Immigrants significantly contribute to the ever-expanding diversity of the population of the United States. Further, many challenges have resulted from inadequate federal immigration policy as well as anti-immigration legislation in several states. My Presidential Task Force on Immigration, chaired by Carola Suárez-Orozco, PhD, was charged with developing an evidence-based report on the psychological factors related to the immigration experience. Our hope is that increased understanding of the psychological factors related to various aspects of the immigrant experience will improve decision making with regard to immigration. The effective integration of immigrants in educational, work, and community settings is essential to the well-being of this country and its future.

A call for potential task force members was sent out, and we were very pleased to have 99 experts respond who were interested in serving on the work group. Unfortunately, we could only choose six members. The six task force members selected represent a high level of expertise in the research on and study of the immigrant population. Other nominees were invited to serve on an advisory committee, and I am grateful that many provided reviews of drafts of this report. I appreciate tremendously the dedication and expertise of the task force members, advisors, and APA staff members who devoted a significant part of their working lives to contribute to this important project.

Their report describes, in broad strokes, the diverse population of immigrants and then addresses the psychological experience of immigration, focusing on factors that impede and facilitate adjustment. Specifically, the report reviews the recent theoretical and empirical literature on immigration with the goals of raising awareness about this growing but poorly understood group; deriving evidence-informed recommendations for the provision of psychological services for the immigrant-origin population; and providing recommendations for the advancement of training, research, and policy efforts for immigrant children, adults, older adults, and families.

This report represents the current state of psychological scientific and professional knowledge with regard to immigration. In particular, I hope that widespread negative views of immigrants and their children will be informed and challenged by the increasing data available in the literature, rather than by ideological impulses, and that this data will reduce the "disconnect" between research and policy.



Melba J.T. Vasquez, PhD, ABPP
President, American Psychological Association, 2011

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External Experts

Ricardo Ainslie, PhD
Margarita Alegría, PhD
Gonzalo Bacigalupe, EdD, MPH
Sandra Barrueco, PhD
Joseph Cervantes, PhD
Lillian Comas-Díaz, PhD
Oliva Espín, PhD
Pam Flattau, PhD
Richard Lee, PhD
Alejandro Morales, PhD
Loreto Prieto, PhD
Antonio Puente, PhD
Mihaela Robila, PhD
Guy Seymour, PhD
Marcelo Suárez-Orozco, PhD
Lisa Suzuki, PhD
David Thronson, JD
Alberto Valencia, EdD
Christauria Welland, PsyD
Hirokazu Yoshikawa, PhD

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Representatives of APA Divisions

8 Society for Personality and Social Psychology
20 Adult Development and Aging
37 Society of Child and Family Policy and Practice
43 Society for Family Psychology
45 Society for the Psychological Study of Ethnic Minority Issues
48 Society for the Study of Peace, Conflict, and Violence: Peace Psychology Division
51 Society for the Psychological Study of Men and Masculinity
52 International Psychology
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Committee on Socioeconomic Status
Committee of Teachers of Psychology in Secondary Schools
Committee on Women in Psychology
Membership Board
Policy and Planning Board

Additional Assistants

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Mona Abo-Zena, PhD (Tufts University)
Efua Andoh (APA Public Interest Directorate)
Kerry Bolger, PhD (APA Public Interest Government Relations Office)

Diane Elmore, PhD (APA Public Interest Government Relations Office)

Tasha Darbes (New York University)

Sandra Diaz (New York University)

Cathy Grus, PhD (Deputy Executive Director, APA Education Directorate)

Gwendolyn Puryear Keita, PhD (Executive Director, APA Public Interest Directorate)

Heather Kelly, PhD (APA Science Government Relations Office)

Nonie Leseaux, PhD (Harvard Graduate School of Education)

Gabriele McCormick, MFA (External editor)

Loy McGaughy (External editor)

Marie Onaga, MEd (New York University)

Andres Pumariega, MD (Reading Hospital)

Sukhmani Singh (New York University)

Karen Studwell, PhD (APA Science Government Relations Office)

Rena Subotnik, PhD (Associate Executive Director, APA Education Directorate)

Benjamin Vonachen (APA Public Interest Government Relations Office)

EXECUTIVE SUMMARY

The United States today has approximately 39.9 million immigrants—the largest number in its history (Passel & Cohn, 2012; U.S. Census Bureau, 2011c). As a nation of immigrants, the United States has successfully negotiated larger proportions of newcomers in its past (14.7% in 1910 vs. 12.9% today) and is far from alone among postindustrial countries in experiencing a growth in immigration in recent decades. Notably, nearly three quarters of the foreign-born are naturalized citizens or authorized noncitizens (Congressional Budget Office [CBO], 2011). One in five persons currently residing in the United States is a first- or second-generation immigrant, and nearly a quarter of children under the age of 18 have an immigrant parent (Mather, 2009). As such, immigrants and the second generation have become a significant part of our national tapestry.

Just as this demographic transformation is rapidly unfolding, the United States is facing international, domestic, and economic crises (Massey, 2010). Like other historical economic downturns (Simon, 1985), the current recession has served as a catalyst to make immigration a divisive social and political issue (Massey & Sánchez, 2010). Across the nation, immigrants have become the subject of negative media coverage (Massey, 2010; M. Suárez-Orozco, Louie, & Suro, 2011), hate crimes (Leadership Conference on Civil Rights Education Fund, 2009), and exclusionary political legislation (Carter, Lawrence, & Morse, 2011). Given the demographic growth, however, we now face an "integration imperative" (Alba, Sloan, & Sperling, 2011)—not only for the well-being of this new population but also for that of the nation's social and economic future.

Psychologists are, and increasingly will be, serving immigrant adults and their children in a variety of settings, including schools, community centers, clinics, and hospitals, and thus should be aware of this complex demographic transformation and consider its implications as citizens, practitioners, researchers, and faculty. This report aims specifically to describe this diverse population and address the psychological experience of immigration, considering factors that impede and facilitate adjustment. The report, which includes the recent theoretical and empirical literature on immigrants, (a) raises awareness about this growing (but poorly understood) population; (b) derives evidence-informed recommendations for the provision of psychological services for the immigrant-origin population; and (c) makes recommendations for the advancement of training, research, and policy efforts for immigrant children, adults, older adults, and families.

GUIDING FRAMEWORKS

There are three guiding principles throughout this report. First, immigrants are resilient and resourceful. Second, immigrants, like all human beings, are influenced by their social contexts; the report thus takes an ecological perspective in framing their experience. Third, as it is essential to use the lens of culture with the increasingly diverse immigrant-origin population, the report follows the *APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2002).

Immigrant Resilience

Within political and media discourse, immigration is generally framed as a social problem in need of solving (M. Suárez-Orozco et al., 2011). Yet a careful reading of the research from a variety of disciplines suggests that immigrants demonstrate a remarkable pattern of strengths (APA, 2007a; Chiswick, 2011; Hernandez & Charney, 1998). This body of data examining the well-being of immigrant-origin populations across generations reveals a counterintuitive pattern that contradicts conventional expectations: First-generation immigrant populations demonstrate the best performance on a variety of physical health (L. S. Morales, Lara, Kington, Valdez, & Escarce, 2002), behavioral health (Pumariega, Rothe, & Pumariega, 2005; Takeuchi, Hong, Gile, & Alegría, 2007), and some educational (Fuligni & Witkow, 2004; García Coll & Marks,

2011; C. Suárez-Orozco & Suárez-Orozco, 1995) outcomes, followed by a decline in subsequent generations.

Although many recently arrived immigrants face a wide range of stressors and risks (e.g., poverty, discrimination, taxing occupations, fewer years of schooling, and social isolation), they do better than their counterparts who remain in the country of origin, as well as second-generation immigrants, on a wide range of outcomes (Alegría, Mulvaney-Day, Woo, et al., 2007; Corral & Landrine, 2008; García Coll & Marks, 2011). Despite these strengths and evident resilience, immigrants also face a series of challenges in their new land. Thus, while recognizing resilience, this report also considers a number of the challenges immigrants and subsequent generations face across a variety of developmental phases, focusing on the educational and clinical contexts where psychologists are likely to encounter and serve them.

Social-Ecological Framework

The social contexts and resources of immigrants vary widely, and they settle in an array of settings, some more welcoming than others. This report uses a broadly defined *social-ecological* theoretical framework, adapted from Bronfenbrenner (Bronfenbrenner & Morris, 2006) and others (Serdarevic & Chronister, 2005). An ecological framework proposes that the human experience is a result of reciprocal interactions between individuals and their environments, varying as a function of the individual, his or her contexts and culture, and over time. In describing the immigrant experience, this report focuses on the influence of context—in particular, contextual risks and protective factors that detract from or enhance healthy adaptation.

APA Multicultural Guidelines

Research suggests that culture—in the form of cognitive schemas, value systems, and social practices—powerfully shapes human experience (APA, 2002), including cognition (D'Andrade, 1981; Rogoff, 2003), emotion (White, 2010), and identities (Shweder & Sullivan, 1993). Immigrants who have arrived in the United States over the last 4 decades represent a wide range of cultures, ethnicities, and races (see Glossary for definition of terms). This diversity of cultural values, beliefs, and practices provides a challenge to the practice and science of psychology. Psychologists carry their own sets of cultural attitudes that influence perceptions as they encounter the culturally different (APA, 2002). Further, research strategies including population definition, concept development, measurement tools, and methodology and analysis choices demonstrate cultural limitations (Hughes, Seidman, & Williams, 1993; Solano-Flores, 2008; C. Suárez-Orozco & Carhill, 2008). To effectively and ethically conduct research and provide mental health services to immigrant children, adults, older adults, and families, the lens of culture must be used. The *APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2002) can serve as a tool in promoting cultural competence in the many roles and contexts in which psychologists work.

CONTENTS AND ORGANIZATION OF REPORT

This report begins by providing an overview of the new wave of immigration, briefly considering the principal motivations that propel migration as well as demographic profiles of the U.S. immigrant population based on multidisciplinary research from demography, sociology, and economics. Recognizing the significance of the receiving social context to psychological functioning, the report next considers the role of social attitudes toward immigrants, discrimination, and neighborhood contexts in immigrant adaptation.

The next section examines acculturation and identity formation as they relate to immigration research in the field of psychology and then considers challenges relevant to several vulnerable populations and specific developmental challenges across the life span. Issues of assessment and testing with immigrants and second-language learners, central to the field of psychology, are addressed in educational, clinical, forensic, and legal contexts. The educational setting, a context critical for the well-being and future success of the children of immigrants, is then examined, followed by a discussion of the critical mental health challenges of immigrants in clinical settings, addressing classic presenting problems as well as issues pertinent to diagnosis, assessment, treatment, and intervention.

The concluding discussion chapter reviews the demographic imperative of attending to issues related to immigrant-origin individuals and their families, considers the current implications of the evidence, and draws conclusions about where psychology should be going as a field to better serve immigrant populations. The report provides bulleted recommendations for culturally and developmentally informed services and supports, research, education and training, and collaboration and advocacy. A brief synopsis of the report is presented below.

THE DIVERSE NEW IMMIGRANT POPULATION

Diverse Origins

While immigrants to the United States come from all over the world, in the last 3 decades migration has primarily originated from Latin America, the Caribbean, and Asia. One third of the foreign-born population in the United States is from Mexico, and a total of 55% originate from Latin America (U.S. Census Bureau, 2010). The four states with the largest numbers of immigrants (California, Hawaii, New Mexico, and Texas) have already become "majority/minority" (less than 50% White) states (U.S. Census Bureau, 2011a).

Educational and Professional Diversity

Immigrants arrive in the United States with varied levels of education. At one end of the spectrum are highly educated immigrant adults (Portes & Rumbaut, 2006) who comprise a quarter of all U.S. physicians, 24% of the nation's science and engineering workers with bachelor's degrees, and 47% of scientists with doctorates. Many highly educated and skilled immigrant adults, however, find a dramatic decrease in employment opportunities when they immigrate (Yakushko, Backhaus, Watson, Ngaruiya, & Gonzalez, 2008) and may experience unemployment, underemployment, and downward mobility (Davila, 2008; G. Lee & Westwood, 1996; Yost & Lucas, 2002). These issues are magnified for ethnic or racial minority adults (Catanzarite & Aguilera, 2002; Fernandez, 1998; M. C. Morales, 2009).

At the other end of the spectrum, some immigrant adults have educational levels far below native-born contemporaries (CBO, 2011; Portes & Rumbaut, 2006). Some sectors of the U.S. labor market (e.g., unskilled manual and service work), are particularly reliant on "low-skilled" immigrant adults, including agriculture, service, and construction industries (CBO, 2011; Schumacher-Matos, 2011).

Language Diversity

An estimated 460 languages are currently spoken in homes in the United States (Kindler, 2002). The National Center for Education Statistics estimates that between 1979 and 2008, the percentage of children who spoke a second language at home increased from 9% to 21% (U.S. Department of Education, 2010). Of those individuals speaking a language other than English at home, 62% speak Spanish, 19% speak another Indo-European language, 15% speak an Asian or a Pacific Island language, and the remaining 4% speak another language (Shin & Komiski, 2010). Although in the United States there have been recurring concerns about the immigrant population's inability or unwillingness to learn English (Bayley & Regan, 2004), research finds a consistent pattern of language assimilation within a generation (Alba, Logan, Lutz, & Stults, 2002; Portes & Schauffler, 1994; Wong Fillmore, 1991).

XENOPHOBIA AND DISCRIMINATION IN THE SOCIAL CONTEXT OF RECEPTION

In the current anti-immigrant climate, xenophobia and discrimination significantly impact the lives of immigrants in the United States (Deaux, 2006). Immigrant adults and their children may be identified by their accented English, "unusual" names, and manners of dress. Because native-born Americans sometimes view immigrants as taking away jobs (Transatlantic Trends, 2010) and bringing undesirable cultural practices (Zárate, Garcia, Garza, & Hitlan, 2004), many immigrants are discriminated against in the workplace (Dietz, 2010) and across a range of other microsystems, including their neighborhoods, service agencies, and schools (Rumbaut, 2005; Stone & Han, 2005).

Many immigrants from Asia, Latin America, the Caribbean, and Africa encounter racial discrimination for the first time in the United States, which can have a substantial impact on their health and mental health.

Immigrants who are racially distinct from the majority are at greater risk for experiencing discrimination than those who are not (Berry & Sabatier, 2010; Liebkind & Jasinskaja-Lahti, 2000). Many immigrants from Asia, Latin America, the Caribbean, and Africa encounter racial discrimination for the first time in the United States, which can have a substantial impact on their health and mental health (T. N. Brown et al., 2000). Xenophobia affects both immigrants and U.S.-born minority populations and is an increasing problem for Latinos in the United States (M. H. Lopez, Morin, & Taylor,

2010; M. H. Lopez & Taylor, 2010). Asian immigrants, often referred to as "the model minority," are perceived as doing well educationally and economically (Fuligni & Witkow, 2004) but also experience negative attitudes (Maddux, Galinsky, Cuddy, & Polifroni, 2008; Zárate et al., 2004). Notably, immigrant Asians report they experience more discrimination than Asian Americans born in the United States (Yip, Gee, & Takeuchi, 2008). As there is clear evidence that there are negative consequences to living with prejudice, this is an issue of grave concern (see *Report of the Presidential Task Force on Reducing and Preventing Discrimination* [APA, 2012] and the APA Resolution on Prejudice, Stereotypes, and Discrimination [APA, 2006]).

ACCULTURATION

Psychological acculturation refers to the dynamic process that immigrants experience as they adapt to the culture of the new country (Berry, 1980). Psychological acculturation occurs against the backdrop of the local community of resettlement (Birman, Trickett, & Buchanan, 2005; Schnittker, 2002), the experience of the immigrant group (Gibson, 2001), and the economic context of the larger society. Immigrants of color in particular may encounter discrimination that limits their acculturation options. The age of immigration is also an important factor that shapes how acculturation unfolds. Children learn the host country's language and culture relatively quickly, while adults take longer, having been fully socialized into their heritage culture prior to migration. Acculturation to the new culture is particularly slow for immigrants of retirement age (Jang, Kim, Chiriboga, & King-Kallimanis, 2007; A. M. Miller, Wang, Szalacha, & Sorokin, 2009).

Acculturation is a multidimensional process that involves changes in many aspects of immigrants' lives, including language competence and use, cultural identity, attitudes and values, food and music preferences, media use, ethnic pride, ethnic social relations, cultural familiarity, and social customs (see Yoon, Langrehr, & Ong, 2010, for a review). Acculturation may occur in stages, with immigrants learning the new language first, followed by behavioral participation in the culture (Birman & Trickett, 2001; M. Gordon, 1964; R. M. Lee, Yoon, & Liu-Tom, 2006). Immigrants who have lived in the United States for a long time and appear to have adopted the American lifestyle may nonetheless continue to maintain strong identification with the values of their culture of origin. This has important implications for providing psychological services to this population.

Acculturation and Mental Health

The process of acculturation may lead to *acculturative stress* (Berry, 1997; Lazarus, 1997), defined as stressful life events thought to be associated with the acculturation process that lead to psychological difficulties. Increasingly, researchers are using independent or bilinear measures of acculturation to both cultures. They are finding that immigrants benefit from acculturation to both the new and the native culture. From a contextual perspective, there is no "best" acculturative style independent of context (Birman, Trickett, & Buchanan, 2005). Rather, whether a particular way of acculturating is beneficial depends on the kinds of cultural skills needed for successful adaptation within each particular microsystem. Thus, acculturation to both cultures provides access to different kinds of resources that are useful in different settings, which in turn are linked to positive mental health outcomes (Birman & Taylor-Ritzler, 2007; Oppedal, Roysamb, & Sam, 2004; Shen & Takeuchi, 2001).

Intergenerational Differences in Acculturation

Because parents and children acculturate in different ways and at different rates, immigrant parents and children increasingly live in different cultural worlds. Immigrant parents often understand little of their children's lives outside the home. For immigrant children, it can be difficult to live with the expectations and demands of one culture in the home and another at school. Children may not turn to their parents with problems and concerns, believing that their parents do not know the culture well enough to provide them with good advice or assistance or are already overburdened with the multiple stresses of resettlement (Birman, 2006; C. Suárez-Orozco & Suárez-Orozco, 2001). Extensive research with a variety of immigrant groups has documented the problems caused by acculturation gaps in studies with Asian (Buki, Ma, Strom, & Strom, 2003; Farver, Bhadha, & Narang, 2002; Ho & Birman, 2010; R. M. Lee, Choe, Kim, & Ngo, 2000), Latino (C. R. Martinez, 2006; Schofield, Parke, Kim, & Coltrane, 2008; Smokowski, Rose, & Bacallao, 2008), and European (Birman, 2006; Crul & Vermuelen, 2003) immigrant families.

ASSESSMENT WITH IMMIGRANT-ORIGIN ADULTS AND CHILDREN

The classic tools of the field of psychology—normed psychological tests and psychological batteries—have a long history of misuse in the field, particularly with minority populations (Strickland, 2000). At the most basic level, the assessment tools at psychologists' disposal are not often normed on the cultural and linguistic populations to which they are applied (Suzuki, Kugler, & Aguiar, 2005).

The challenge of appropriately assessing immigrants and English language learners affects this population in three general areas: placement in special education (Lesaux, 2006; Solano-Flores, 2008); ability, achievement, and aptitude testing (Menken, 2008; Solano-Flores, 2008); and the use of clinical assessment and diagnostic measures (Suzuki, Ponterotto, & Meller, 2008). There are several potential errors that may arise in assessment with immigrants. Content knowledge may go unrecognized, disguised behind language acquisition challenges (Solano-Flores, 2008). Information presented on tests may depend on exposure to cultural knowledge that test-takers have never encountered, deflating test scores (Solano-Flores, 2008). Timed tests penalize second-language learners, who are processing two languages as they settle on an answer (Solano-Flores, 2008). When culturally sensitive approaches are not used, individuals can either be overpathologized or, conversely, their needs may go unrecognized (Leseaux, 2006; Suzuki et al., 2008).

Approximately 20,000 mental, personality, and educational tests are published and developed each year, yet many of these tests suffer from assessment biases that can lead to misdiagnosis and inappropriate interventions (Cohen & Swerdlik, 1999; Suzuki et al., 2005). This is an area of professional practice that has often been criticized for perpetuating the social, economic, and political barriers confronting ethnic minority and immigrant groups (Padilla & Borsato, 2008). For testing and assessment to be culturally appropriate, there needs to be a continuous, intentional, and active preoccupation with the culture of the group or individual being assessed. Appropriate multicultural assessment requires that practitioners "arrive at an accurate, sound, and comprehensive description of the client's psychological presentation" (Ridley, Tracy, Pruitt-Stephens, Wimsatt, & Beard, 2008, p. 27) by gathering data on historical, familial, economic, social, and community issues. This knowledge is critical in choosing appropriate tests and assessment language, as well as in interpreting test results (Suzuki et al., 2005).

IMMIGRANT POPULATIONS IN EDUCATIONAL CONTEXTS

The size and diversity of today's immigration flow is reflected in U.S. public schools. As of 2011, 23.7% of school-age children in the United States were the children of immigrants (Migration Policy Institute [MPI], 2011), with the majority (77%) second-generation-citizen children and the rest (23%) foreign-born (Mather, 2009). Approximately 10.7% of all U.S. public school students are classified as English language learners (MPI, 2011). These children, like their parents, represent a tremendous diversity in their socioeconomic, cultural, and linguistic backgrounds. While some do remarkably well in school, many others struggle (García Coll & Marks, 2011; C. Suárez-Orozco & Suárez-Orozco, 1995; C. Suárez-Orozco, Suárez-Orozco, & Todorova, 2008).

The patterns of high achievement among many in the first generation are remarkable given the myriad challenges they encounter, including xenophobia, economic obstacles, language difficulties, family separations, underresourced neighborhoods and schools, and struggles to gain their bearings in a new educational system (V. W. Huynh & Fuligni, 2008; Pong & Hao, 2007; Portes & Zhou, 1993). On a number of educational outcomes, immigrant youth outperform their U.S.-born peers (García Coll & Marks, 2011; Perreira, Harris, & Lee, 2006).

First-generation immigrants demonstrate certain advantages; they enter U.S. schools with tremendous optimism (Kao & Tienda, 1995), high aspirations (Fuligni, 2001; Portes & Rumbaut, 2001), dedication to hard work, positive attitudes toward school (C. Suárez-Orozco & Suárez-Orozco, 1995), and an ethic of family support for advanced learning (Li, 2004). First-generation immigrant students show a number of positive academic behaviors that often lead to stronger than expected academic outcomes (García Coll & Marks, 2011; C. Suárez-Orozco & Suárez-Orozco, 1995). On the other hand, immigrant students tend to perform poorly on high-stakes tests of academic achievement because of language acquisition challenges (Menken, 2008).

Newcomer students, and especially students with interrupted formal education, must surmount daunting obstacles, including developing academic English skills (Carhill, Suárez-Orozco, & Páez, 2008) and fulfilling graduation requirements (Ruíz-de-Velasco, Fix, & Clewell, 2000), all in a high-stakes testing environment not

designed with their educational obstacles in mind (Hood, 2003; Menken, 2008). Some of these youths may never enroll in school, arriving with the intention to work (C. Suárez-Orozco, Gaytán, & Kim, 2010). Others enroll and quickly drop out, encountering frustrations with language acquisition as well as schools that are not equipped to serve them (Ruiz-de-Velasco et al., 2000; C. Suárez-Orozco et al., 2008).

Immigrant-origin students of the second generation face experiences similar to those of the first generation. Though born in the United States, if they grow up in non-English-speaking homes, they enter schools needing to acquire English just as they are learning to read. This places them at a transitory disadvantage if they are not provided adequate educational supports (O. García, 2009). Compared with the first generation, however, immigrant-origin students of the second generation have some unique advantages. All are automatically U.S. citizens, and some will not have the language acquisition hurdle, particularly if they live in neighborhoods where they are regularly exposed to English-language models (C. Suárez-Orozco & Suárez-Orozco, 2001). Yet the second generation may be disadvantaged, as they are less buffered by immigrant optimism (Fuligni, 2011; Kao & Tienda, 1995; C. Suárez-Orozco & Suárez-Orozco, 2001).

The successful incorporation of children of immigrants into the educational system is one of the most important and fundamental challenges today, particularly in a knowledge-intensive economy.

Meeting the needs of immigrant-origin students has not been a national priority in today's high-stakes testing, school-reform environment (Menken, 2008; C. Suárez-Orozco et al., 2008). This population is largely continuously "overlooked and underserved" (Ruiz-de-Velasco et al., 2000). More systematic attention must be focused on their educational needs, and a systematic research and public policy agenda is required to establish efficacious educational practices addressing the specific learning needs of immigrant-origin students.

The successful incorporation of children of immigrants into the educational system is one of the most important and fundamental challenges today, particularly in a knowledge-intensive economy. Understanding the specific needs that different immigrant populations face vis-à-vis the education system is critical to determining appropriate interventions. Given the diversity of the immigrant student populations entering schools, it is clear that a one-size-fits-all model will not work (see C. Suárez-Orozco, Suárez-Orozco, & Sattin-Bajal, 2009). Programs that support newcomer students by creating a community of peers experiencing the same dramatic transitions may provide educational innovations and insights for immigrant students, but further research on their efficacy is necessary (see C. Suárez-Orozco et al., 2009).

Some of the fiercest debates over immigrant education center on the issue of second-language development. Cross-country comparisons of good practice demonstrate that it is essential to make "long-term investments in systematic language support" (Christensen & Stanat, 2007, p. 2) as well as to provide pre-service and professional development training for teachers. To effectively educate and integrate all immigrant-origin students, every educator and school support staff member must consider immigrant children's education as part of their responsibility. These students' needs go beyond second-language development to include cultural adaptation, social support, and assistance in general academic subjects. Therefore, schools should provide ongoing professional development to all faculty and staff on how to work with immigrant-origin children.

Recognizing the varieties of cultural models of family involvement that immigrant families bring with them will reduce the inaccurate stereotyping of immigrant parents' commitment to their children's education that educators often carry with them (Birman & Ryerson-Espino, 2007; C. Suárez-Orozco et al., 2008). In addition, for immigrant families unfamiliar with American higher education, it is critically important to assist them in the process of preparing for college, applying for admissions, and securing scholarships and financial aid. Without such assistance, a generation of youths may end up undereducated, underemployed, and unable to participate optimally in society (C. Suárez-Orozco et al., 2010; see Immigrant Populations in Educational Contexts for more details).

IMMIGRANT POPULATIONS IN CLINICAL CONTEXTS

Many immigrants adapt well to their new living circumstances. They do so by navigating multiple sociocultural contexts in positive ways that contribute to their well-being and success in the United States. Studies suggest that immigrants may not experience more mental illness or psychological distress than nonimmigrants (Alegría, Canino, Stinson, & Grant, 2006), though it is important to note that refugees are a particularly vulnerable subpopulation of immigrants (see *Resilience & Recovery After War: Refugee Children and Families in the United States*; APA, 2010c).

When immigrants do experience mental health difficulties, for many it is related to the immigration experience. A wide range of mental health problems, including anxiety, depression, posttraumatic stress disorder, substance abuse, and a higher prevalence of severe mental illness and suicidal ideation have been observed among immigrant populations in the United States (Desjarlais, Eisenberg, Good, & Kleinman, 1995; Duldulao, Takeuchi, & Hong, 2009). The immigration process as a whole—loss of and separation from country of origin, family members, and familiar customs and traditions; changes in social class and/or socioeconomic status; exposure to a new physical environment; and the need to navigate unfamiliar cultural contexts—has the potential to serve as a catalyst for the development of a great variety of psychological problems.

Given such experiences, many first-generation immigrants confront a variety of psychological problems, including stress. The constellation of presenting issues for immigrants tends to fall within the areas of *acculturation-based presenting problems* (see McCaffrey, 2008; Ponce, Hays, & Cunningham, 2006; Tummala-Narra, in press; Vasquez, Han, & De Las Fuentes, 2006), *trauma-based presenting problems* (see Chaudry et al., 2010; Foster, 2001; Yoshioka, Gilbert, El-Bassel, & Baig-Amin, 2003), and *discrimination, racism, and xenophobia–based problems* (see Alegría et al., 2004; Cheng et al., 2010; Gee, Spencer, Chen, Yip, & Takeuchi, 2007; M. H. Lopez et al., 2010; A. G. Tran, Lee, & Burgess, 2010; Tummala-Narra, Alegría, & Chen, 2011).

It is important to note that immigrant-origin adults, children, older adults, and families also often demonstrate resiliency and benefit from protective factors rooted within their specific cultural contexts, including the greater use of protective traditional family networks (Escobar, Nervi, & Gara, 2000) and collectivistic coping strategies (e.g., seeking help from family or similar ethnic peers). When immigrants require clinical treatment, it is important to incorporate a resilience and coping perspective into the treatment process. Some immigrants may draw strength from family structures that U.S. therapists may judge negatively or misunderstand (Hong & Domokos-Cheng Ham, 2001). It is important to note that what may be considered a strength in one cultural context may be considered deviant or undesirable in another (Harvey, 2007; Tummala-Narra, 2007a). Culturally competent treatment attends to culture-specific coping among immigrant clients. Consistent with the ecological perspective (Bronfenbrenner & Ceci, 1994), this report highlights the interaction of person and environment and related intersections of social identities (i.e., gender, race, ethnicity, age, sexual orientation, social class, disability/ability, and immigration status) in addressing mental health needs among immigrant communities.

A number of barriers to culturally sensitive and appropriate mental health services for racial/ethnic minority and immigrant populations have been well documented in the literature. Both distal and proximal barriers (Casas, Raley, & Vasquez, 2008) have an impact on the effective use of mental health services by immigrant persons:

- *Social-cultural barriers* include differences in symptom expression (e.g., somatic symptoms) (Alegría et al., 2008) and conflicting views about the causes of (i.e., attributions) and ways of coping with mental problems (Atkinson, 2004; Koss-Chioino, 2000).

- *Contextual-structural barriers* include lack of access to appropriate and culturally sensitive mental health services (Lazear, Pires, Isaacs, Chaulk, & Huang, 2008; M. C. Wu, Kviz, & Miller, 2009), lack of knowledge of available and existing mental health services (C. M. Garcia & Saewyc, 2007), shortage of racial/ethnic minority mental health workers and/or persons trained to work with racial/ethnic minority persons (APA, 2009a), older persons and culturally diverse elders (APA, 2009b), lack of access to interpreters, and lack of resources (e.g., lack of child care or transportation) for accessing services (M. Rodríguez, Valentine, Son, & Muhammad, 2009).

- *Clinical-procedural barriers* include the lack of culturally sensitive and relevant services (Maton, Kohout, Wicherski, Leary, & Vinokurov, 2006), "clinician bias" (Maton et

al., 2006), communication problems related to language differences and cultural nuances (Kim et al., 2011), misdiagnosis of presenting problems (Olfson et al., 2002), failure to assess cultural and linguistic constructs and procedural appropriateness of tests for targeted populations (Dana, 2005; Kwan, Gong, & Younnjung, 2010, Suzuki et al., 2008), lack of attention to culturally embedded expressions of resilience (Tummala-Narra, 2007a), and failure to use the most efficacious mental health interventions (McNeill & Cervantes, 2008) (e.g., evidence-based interventions adapted for use with minority and immigrant populations).

There is a growing body of research that documents life experiences (e.g., the immigration experience itself) and contextual conditions (e.g., poverty and discrimination) that put some immigrants and their families at risk for experiencing diverse mental health challenges. Further, some types of challenges faced by immigrants, such as interpersonal, racial, and political trauma, are especially important for clinicians to recognize, as they tend not to be discussed openly and yet often compromise positive adjustment and well-being (APA, 2010c). It is also important to recognize that various factors (e.g., social-cultural, contextual-structural, and clinical-procedural) contribute to an underutilization of mental health services among immigrant populations. Much of what is known about the use of evidence-based treatments with immigrants has been extrapolated from research on ethnic minorities (Miranda et al., 2005), and only a few studies have examined the effectiveness of evidence-based treatments with immigrant populations (Beehler, Birman, & Campbell, 2011; G. Constantino, Malgady, & Rogler, 1988; Duarté-Vélez, Bernal, & Bonilla, 2010; Kataoka et al., 2003; Santisteban & Mena, 2009).

While research on evidence-based treatments is clearly needed to address the utility of interventions with immigrants, clinicians and researchers can benefit from attending to practice-based evidence that offers important lessons in culturally competent interventions (Birman, Beehler, et al., 2008). To increase the accessibility and efficacy of services, clinicians and practitioners should adhere to the following guiding principles:

- Use an ecological perspective (Bronfenbrenner & Morris, 2006) to develop and guide interventions.
- Integrate evidence-based practice with practice-based evidence (Birman, Beehler, et al., 2008).
- Provide culturally competent treatment (APA, 2002; Birman, Ho, et al., 2005; Marmol, 2003; Nastasi, Moore, & Varjas, 2004; Pedersen, 2003; Vera, Vila, & Alegría, 2003).
- Partner with community-based organizations (Birman, Beehler, et al., 2008; Casas, Pavelski, Furlong, & Zanglis, 2001).
- Incorporate social justice principles in providing service (Crethar, Torres Rivera, & Nash, 2008).

Additionally, evidence suggests that awareness of context in every stage of planning and implementing assessment and intervention is essential for ethical and effective practice with immigrant clients (see Immigrant Populations in Clinical Contexts, for more details).

SUMMARY OF RECOMMENDATIONS

Recommendations to ensure positive outcomes for immigrant-origin adults (including older adults), children and adolescents, and families are embedded throughout this report. Positive outcomes require stakeholders within clinical practice, research, education, and public policy sectors to become culturally competent as well as cognizant of an array of diverse interacting factors (i.e., immigrant generation, gender, race, age, sexual orientation, religion, social class, education, English language proficiency, and disability/ability) that may influence immigrant mental health and adjustment.

Stakeholders should collaborate with family members, community members, and one another to provide effective and ethical mental and behavioral health and educational support for immigrant-origin adults (including older adults), children and adolescents, and their families.

The recommendations in this report (see Summary of Recommendations, pp. **78–80**). focus broadly on ways in which the field of psychology can address the needs of this population across practice, research, education, and policy domains. These recommendations require further communication and collaboration within the field and in interdisciplinary collaboration with other fields involved in the care and adaptation of immigrants across the life span.

INTRODUCTION

PURPOSE

The APA Presidential Task Force on Immigration was commissioned by Melba Vasquez, PhD, during her 2011 tenure as president of the American Psychological Association (APA). This report is the first comprehensive report on the topic of immigration undertaken by APA. Our mission was to develop an evidence-based report that addresses the **psychological factors related to the experience of immigration**, with particular attention to the mental and behavioral health needs and strengths of immigrants across the life span. We examined the effects of acculturation, prejudice/discrimination, and immigration stressors on individuals, families, and society, considering relevant subpopulations of immigrants (e.g., children/adolescents, refugees/asylum seekers, individuals from diverse countries of origin, documented and undocumented individuals, and other vulnerable subpopulations). We looked at the benefits and consequences of immigration as well as other relevant and timely issues.

The specific aim of this report is to address the psychological experience of immigration. Considering factors that impede and facilitate adjustment and using an ecological perspective, the report reviews the recent theoretical and empirical literature on immigrants with the goal of (a) raising awareness about this growing but poorly understood population; (b) deriving evidence-informed recommendations for the provision of psychological services for the immigrant-origin population; and (c) making recommendations for the advancement of training, research, and policy efforts for immigrant children, adults, older adults, and families.

CONTEXT FOR THIS REPORT

U.S. immigration has reached historic numbers. Currently 39.9 million people who reside in the United States are foreign-born—12.59% of the total population (Passel & Cohn, 2012; U.S. Census Bureau, 2011c). As the foreign-born population has grown over the last few decades, so has the population of their children. Another 33 million individuals (11%) are native-born with at least one foreign-born parent. Today, one in five persons residing in the United States is a first- or second-generation immigrant. Thirty percent of young adults between the ages of 18 and 34 are first- or second-generation immigrants (Rumbaut & Komaie, 2010), and immigrant-origin children have become the fastest growing segment of the national child population, with one in three children under the age of 18 projected to be the child of an immigrant by 2020 (Mather, 2009). Thus, immigrants and the second generation have become a significant part of the national tapestry.

The historical record shows that in times of economic malaise, immigration nearly always becomes a divisive social and political issue.

Just as this demographic transformation is rapidly unfolding, the United States is facing international and domestic crises. The terrorist attack of September 11, 2001, and subsequent wars have added deep public concerns over border security and the flow of new arrivals into this country (Massey, 2010). The economic crisis that began in late 2007 has placed this country in the worst recession since the Great Depression (Congressional Budget Office [CBO], 2009). The historical record shows that in times of economic malaise, immigration nearly always becomes a divisive social and political issue (Massey & Sánchez, 2010; Simon, 1985). Thus, in recent years, immigration has become a polarizing issue (Massey, 2010; M. Suárez-Orozco, Louie, & Suro, 2011; Transatlantic Trends, 2010). Concerns with undocumented immigration have shifted much of the nation's attention away from a demographic "integration imperative" (Alba,

Sloan, & Sperling, 2011) and toward enforcement-only policies (i.e., increased border security, deportations, etc.) aimed at reducing the number of immigrants without required documentation from entering the United States.

Psychologists should be aware of this complex demographic transformation of the United States and consider its implications as practitioners, researchers, and faculty. Psychologists are, and increasingly will be, serving immigrant adults and their children in a variety of settings, including schools, community centers, clinics, and hospitals. Psychologists have a unique and important contribution to make to the immigration discussion in several domains. Specifically, the field advances scientific research, promotes the delivery of culturally and linguistically appropriate services, and educates and trains psychologists and others who work with immigrants. The goal of this report is to provide evidence and direction that will enhance research, service delivery, and education and training, as well as inform policy.

GUIDING FRAMEWORKS

Immigrant Resilience

We were keenly aware of the sociohistorical climate in which we initiated this report. Within the political and media discourse, immigration is generally framed as a social problem in need of solving (M. Suárez-Orozco et al., 2011). Newspaper headlines, editorials, and blogs, as well as talk radio and television, reveal a number of widely held negative misperceptions about immigrants, including that they are reluctant to learn English, take jobs from native-born Americans, add to the crime problem, and contribute less to the tax revenue system than they use (Chiswick, 2011).

Yet a careful reading of the research debunks each of these myths (APA, 2007a; Chiswick, 2011). Research from a variety of disciplines suggests that immigrants today are highly motivated to learn English (Pew Hispanic Center, 2006; C. Suárez-Orozco, Suárez-Orozco, & Todorova, 2008) and do so more quickly than in previous generations (Foner, 2002). In addition, as the second generation learns English, they rapidly lose command of their parent's language (Portes & Hao, 1998; Wong Fillmore, 1991). Immigrants tend to be overrepresented at both the highest and lowest ends of the educational and skill continuum (Hanson, 2007; Schumacher-Matos, 2011). Lastly, contrary to popular perceptions, undocumented immigrants are unable to access a host of services (Yoshikawa, 2011) but regularly contribute to the federal system because taxes and social security payments are automatically deducted from their wages (Chiswick, 2011; Schumacher-Matos, 2011).

While reviewing the research literature, we found that immigrants demonstrate a remarkable pattern of strengths. They have very high levels of engagement in the labor market (Chiswick 2011; Schumacher-Matos, 2011), and the children of immigrants go on to outperform their parents (Waters, 2011). The vast majority of immigrants in the United States are legal (Passel, 2011), and immigrants tend to report high levels of trust in key U.S. institutions (Lopez & Taylor, 2010). These broad strengths are highlighted in a consistent finding across diverse and seemingly unrelated areas of research.

This finding, variably referred to as the "Latino paradox," the "epidemiological paradox," and the "immigrant health paradox," demonstrates counterintuitive positive outcomes in the face of multiple contextual stressors. Often first-generation immigrant populations demonstrate the best performance on a variety of physical health (L. S. Morales, Lara, Kington, Valdez, & Escarce, 2002), behavioral health (Pumariega, Rothe, & Pumariega, 2005; Takeuchi, Hong, Gile, & Alegría, 2007), and educational (Fuligni & Witkow, 2004; García Coll & Marks, 2011) outcomes, followed by a decline in subsequent generations. This pattern has also been identified for populations emigrating from Asia and the Caribbean to the United States (Razum & Twardella, 2002; Takeuchi, Hong, et al., 2007), as well as various immigrant groups arriving in Canada, Europe, and other prevalent immigrant destinations (Beiser, Dion, Gotowiec, & Vu, 1995).

Although many recently arrived immigrants face a wide range of risks, including poverty, discrimination, taxing occupations, fewer years of schooling, and social isolation, they do better than expected on a wide range of outcomes compared with their counterparts who remain in their country of origin and second-generation immigrants born in the new land (Alegría, Mulvaney-Day, Woo, et al., 2007; Corral & Landrine, 2008; García Coll & Marks, 2011). While the significance of the paradox has been challenged by some as an artifact of statistical bias (L. S. Morales et al., 2002) and on other methodological grounds (C. Suárez-Orozco & Carhill, 2008; N. Tran & Birman, 2010), these limitations do not invalidate the widespread nature of this phenomenon.

Although the immigrant health paradox was initially noted for physical health outcomes, such as obesity, diabetes, and infant mortality rates (see Hernandez & Charney, 1998, for an early meta-analysis by the National Research Council), this same

pattern has also been found in the domains of psychological, behavioral, and educational outcomes. U.S.-born (second-generation) Latino, Asian, and Black individuals have been found to be at greater risk than first-generation immigrants for depression and anxiety (Alegría, Mulvaney-Day, Torres, et al., 2007; Takeuchi, Alegría, Jackson, & Williams, 2007), suicidal ideation (Duldulao, Takeuchi, & Hong, 2009), behavior disorders (Corral & Landrine, 2008), conduct and eating disorders (Pumariega, Rogers, & Rothe, 2005), and substance abuse (Caetano, Ramisetty-Mikler, Wallisch, McGrath, & Spence, 2008). This immigrant paradox has also been documented in the domain of several educational outcomes (see García Coll & Marks, 2011, for details). Compared to their second-generation peers, immigrant students have better attendance rates, demonstrate more positive attitudes toward their teachers (C. Suárez-Orozco & Suárez-Orozco, 1995) and school (Fuligni, 1997), have higher attachment to school (García Coll & Marks, 2011; C. Suárez-Orozco & Suárez-Orozco, 1995), and demonstrate higher grades when controlling for parental education (García Coll & Marks, 2011; Portes & Rumbaut, 2006).

Several explanatory models have been proposed to account for the immigrant paradox, but even though several have been tested, none fully accounts for it (see C. Suárez-Orozco & Todorova, 2008, for a discussion). Explanations include the notion that individuals who undertake the migration journey are selectively healthier than those who remain in the country of origin (Palloni & Morenoff, 2001); that continual hardships of migration select for persistence and resilience (Abraido-Lanza, Dohrenwend, Ng-Mak, & Turner, 1999); and that immigrant populations bring with them cultural values and behaviors that are health enhancing, whereas acculturation to the host country leads to the loss of these patterns (Pumariega, Rothe, & Pumariega, 2005).

Indeed, one pathway that accounts for the worsening of health indicators for subsequent generations is the adoption of high-risk behaviors that predominate in the host country, such as drug abuse and changes in dietary practices (e.g., a drastic increase in "supersized" fast-food meals). The stress of racial/ethnic minority status and the concomitant experience of discrimination—in terms of both structural obstacles and negative social mirroring—are also potential contributors (García Coll & Magnuson, 1997; C. Suárez-Orozco, 2000). Other proposed cultural characteristics that contribute to first-generation advantages include greater family cohesion and the availability of community supports for recent immigrant groups from countries with collectivistic traditions (Fuligni, Tseng, & Lam, 1999; Iannotta, 2003). It has also been hypothesized that the optimism immigrants bring with them as they arrive in their new nation contributes to this pattern (Kao & Tienda, 1995; Portes & MacLeod, 1996; C. Suárez-Orozco et al., 2008).

Despite these strengths and evident resilience, immigrants also face a series of challenges as they arrive in the new land. Many navigate these challenges with remarkable resourcefulness, but others may falter and need services in the process of adaptation. Other families will find transgenerational tensions and difficulties emerging in the second generation. While recognizing resilience, this report considers a number of the challenges immigrants and the next generation face across a variety of developmental phases and contexts.

Social-Ecological Framework

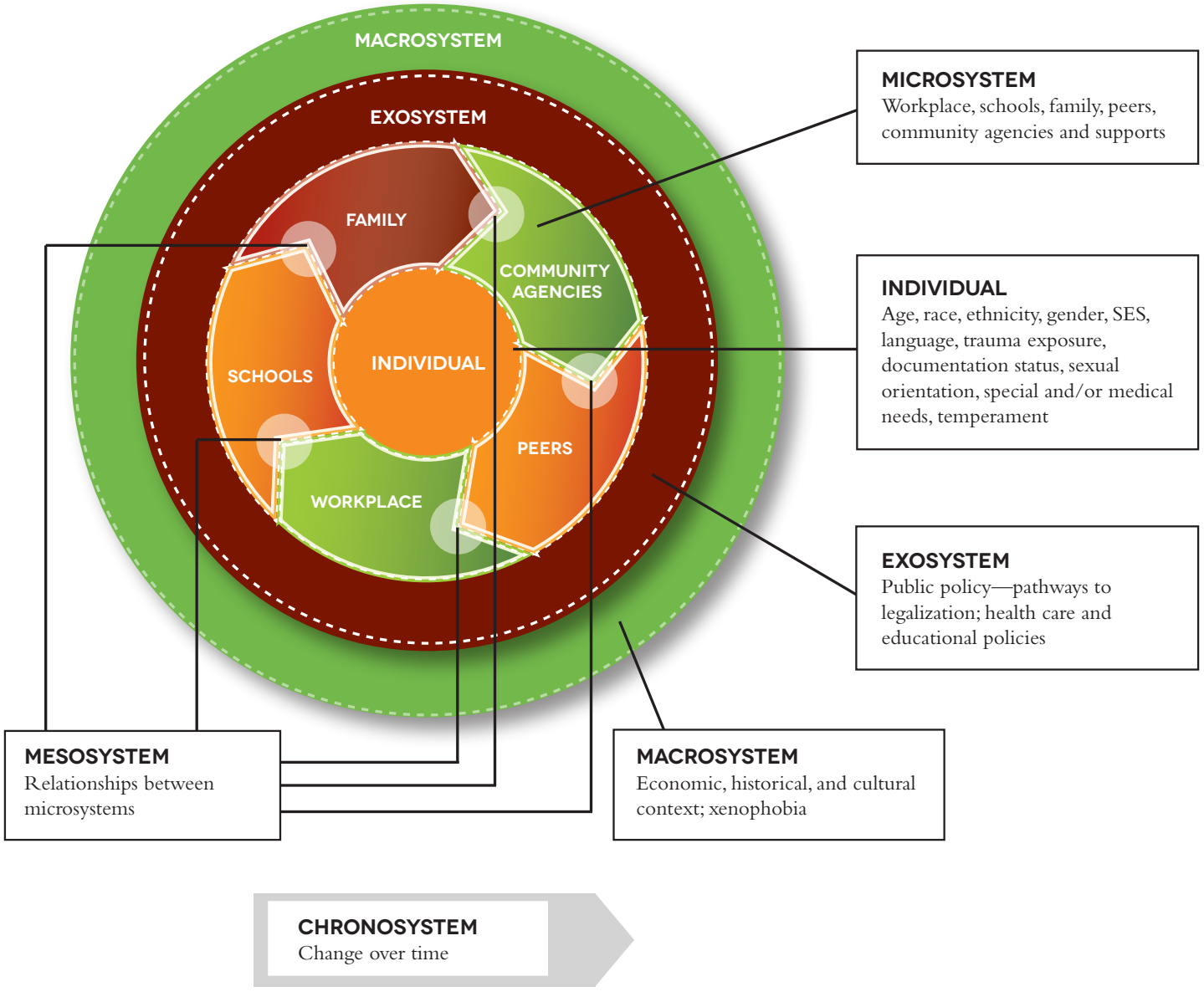
Immigrants are not all the same. Indeed, a great deal of heterogeneity marks their experience. The social contexts and resources of immigrants vary widely, and they settle in an array of settings, some more welcoming than others. This report uses a broadly defined *social-ecological* theoretical framework, adapted from Bronfenbrenner (Bronfenbrenner & Morris, 2006) and others (Serdarevic & Chronister, 2005). An ecological framework proposes that the human experience is a result of reciprocal interactions between individuals and their environments, varying as a function of the individual, his or her contexts and culture, and time. This report focuses on contexts that immigrants encounter and interact with on a sustained basis. Each context offers particular risks as well as protective factors, which either detract from or enhance a healthy adaptation that needs to be understood in framing the immigrant experience (see **FIGURE 1**).

Each immigrant has his or her own set of characteristics that in interaction with the environment may place him or her in varying positions of resilience or vulnerability. A comprehensive list of characteristics is too large to enumerate, but some critical issues include age, race, ethnicity, gender, socioeconomic status, language skills, exposure to trauma, documentation status, sexual orientation, learning or medical needs, and temperament. Interactions between the individual and the environment take place within nested systems that move from most proximal to most distal.

- **Microsystems** are made up of settings and systems that the individual comes into direct contact with, such as the workplace, schools, family, peers, and community agencies and supports.

- The **mesosystem** is made up of interconnections between microsystems, and these interactions have an indirect influence on the individual. For example, the relationship between the immigrant child's parents and school, or consultation provided by the local mental health agency to the child's school, may have implications for the kinds of services the immigrant child will receive from the school.
- The **exosystem** is an extension of the mesosystem and is made up of interconnections between settings and larger social structures, such as governmental entities that have influential but indirect effects on the individual's life. Examples include public policies concerning pathways to legalization or health care and education policies that affect microsystems, such as local agencies and schools. The macrosystem is the most distal context but nonetheless has implications for well-being. For immigrants, these include the cultural,

FIGURE 1. Ecological Model of Immigration



economic, and historical contexts in both the sending and receiving nations.

- The **chronosystem** represents change over time. For immigrants this can mean many things across systems, including developmental changes at the individual level; obtaining documentation at the individual or family level; acculturation at the individual and family level (Serdarevic & Chronister, 2005); a decision to pass immigration reform at the exosystemic level; or wars, economic booms, or downturns at the macrosystemic level.

APA Multicultural Guidelines

Research suggests that culture in the form of cognitive schemas, value systems, and social practices powerfully shapes cognition (D'Andrade, 1981; Rogoff, 2003), emotion (White, 2010), and identities (Shweder & Sullivan, 1993). Human beings make meaning of their lives and are motivated to act according to culturally shared narratives (Greenfield, 2009; Mattingly, Lutkehaus, & Throop, 2008). Culture is a life-guiding force (APA, 2002), and it becomes particularly salient when individuals encounter those culturally different from themselves.

Immigrants who have arrived in the United States over the last 4 decades are more diverse than ever before (see The Why and Who of Immigration). As such, they represent a wide range of cultures, ethnicities, and races (see the Glossary for definition of terms). This diversity of cultural values, beliefs, and practices provides both a challenge and an opportunity to the practice and research of psychology (APA, 2002). Research strategies, including population definition, concept development, measurement tools, and methodology and analysis choices, provide evidence of cultural and methodological limitations (Hughes, Seidman, & Williams, 1993; Solano-Flores, 2008; C. Suárez-Orozco & Carhill, 2009). To effectively and ethically conduct research and provide mental health services to immigrant children, adults, older adults, and families, psychologists must use the lens of culture. We therefore used the *APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2002). The guidelines advocate cultural competence in the many roles and contexts in which psychologists work (see sidebar).

APA GUIDELINES ON MULTICULTURAL EDUCATION, TRAINING, RESEARCH, PRACTICE, AND ORGANIZATIONAL CHANGE FOR PSYCHOLOGISTS

GUIDELINE 1: Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves. (*Note*: The task force would add *culturally* and *nationally different* to this list for consideration.)

GUIDELINE 2: Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially individuals. (*Note.* The task force would add *culturally* and *nationally different* individuals.)

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

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

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

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

CONTENTS AND ORGANIZATION OF THIS REPORT

Approaching the Evidence

We selected the literature by drawing on our collective expertise and by searching PsycINFO, Medline, and ERIC for English language peer-reviewed empirical articles. Keyword combinations paired *immigrant* or *immigration* with a number of words: *acculturation, assimilation, xenophobia, stereotyping, discrimination, identity, social trust, civic engagement, children, adolescent, emerging adult, young adult, older adult, undocumented, migrant worker, day labor, refugee, asylum seeker,*

lesbian, gay, bisexual, disabilities, education, educational paradox, assessment, testing, immigrant paradox, epidemiological paradox, Latino paradox, anxiety, depression, intervention, best practice, and *evidence-based practices*, among others.

The terms *Latino, Hispanic, Asian, African*, and *Caribbean* were cross-referenced with these same terms, considering whether or not first- and second-generation immigrants were part of the study. The focus was on research conducted in the U.S. context. In keeping with good practice with diverse populations (APA, 2010c), we included quantitative as well as qualitative and mixed-methods research as available. To promote effective psychological practice, the best-available research was integrated "with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2005).

We found notable patterns of limitations to the available data. There was relatively little empirical research in the literature to guide clinical interventions by mental health service providers for immigrant adults, children, older adults, and families. There was a paucity of evidence to determine which interventions were likely to be efficacious within and across particular immigrant groups because of lack of systematic evaluations of immigrant-group-specific interventions. As is the case with services for ethnic minority groups (U.S. Department of Health & Human Services, 2001), some potentially excellent mental health care delivered to immigrants has not been documented or studied in standardized ways. Thus, we made recommendations for practice-based evidence as potential guides for intervention and for setting directions for needed research based on available evidence.

This report attempts to include data representing immigrants from a wide array of origins, though there were several challenges to this task. First, immigrants originating from Spanish-speaking countries have been arriving through long-standing immigration corridors over several generations, and as a result, Latinos constitute the largest group of immigrants to the United States (U.S. Census Bureau, 2010). Thus, not surprisingly, the preponderance of research on immigrant populations in the United States has been conducted with immigrants of Latino origin. Second, most studies of Latinos and Asians do not specify or differentiate immigrants from later-generation descendants. Therefore, it was not always possible to report on evidence specific to immigrants versus Latino and Asian Americans. Third, because of the sheer range of origins of immigrants to the United States, it is beyond the scope of this report to represent every immigrant group.

Presentation of the Data

This report begins by providing an overview of the new wave of immigration, briefly considering the principal motivations that propel migration as well as demographic profiles of the U.S. immigrant population based on multidisciplinary research from demography, sociology, and economics. Recognizing the significance of the receiving social context to psychological functioning, the report considers the role of social attitudes toward immigrants, discrimination, and neighborhood contexts in immigrant adaptation.

The next section examines two of the central contributions of psychology to immigration research—acculturation and identity formation. The report then considers challenges relevant to several vulnerable populations and specific developmental challenges across the life span. Next, the report addresses issues central to the field of psychology: the assessment and testing of immigrants and second-language learners in educational contexts and clinical settings.

The educational setting, a context critical to the well-being and future success of the children of immigrants, is also considered. The report examines the important mental health challenges of immigrants in clinical settings, addressing classic presenting problems as well as issues pertinent to diagnosis, assessment, treatment, and intervention.

The concluding chapter reviews the demographic imperative of attending to issues related to immigrant-origin individuals and their families, considers the current implications of evidence to the field of psychology, and draws conclusions about where psychology should be going as a field to better serve the immigrant population. The report ends with a series of bulleted recommendations for culturally and developmentally informed services and supports, research, education and training, and collaboration and advocacy. The report also provides a Glossary for definitions of commonly used terms in the field.

WHAT PROPELS IMMIGRATION?

Mass migrations are seldom random. Shocks to the cultural and natural ecology create the potential for mass migration as a way to adapt to a crisis. Great economic transformations, wars or violence, and environmental cataclysms create crises in countries of origin that then set off mass migrations (Gould & Eldredge, 1997). Three factors in particular have been identified as driving migration trends: family reunification, search for work, and humanitarian refuge (Massey, 1995; Zhou, 2001). These factors also parallel this country's national immigration policy. According to the CBO (2006, p. vii), U.S. policy officially

- "serves to reunite families by admitting immigrant adults and children who already have family members living in the United States";
- "seeks to admit workers with specific skills and to fill positions in occupations deemed to be experiencing labor shortages";
- "attempts to provide a refuge for people who face the risk of political, racial, or religious persecution in their country of origin"; and
- "seeks to ensure diversity by providing admission to people from countries with historically low rates of immigration to the United States."

Three factors in particular have been identified as driving migration trends: family reunification, search for work, and humanitarian refuge.

Search for Work

A century ago, the Industrial Revolution served as a catalyst for immigration; an increasingly global economy serves much the same role today (Foner, 2002; M. Suárez-Orozco et al., 2011). The global production, distribution, and consumption of goods and services stimulate migration because where capital flows, immigrants tend to follow (Massey, Durand, & Malone, 2002). Labor markets in globally coordinated economies are reliant on foreign workers in both the highly remunerated knowledge-intensive sector and the more labor-intensive sector (Cornelius, 1992; Saxenian, 1999). Absence of economic opportunities in the homeland along with wage differentials in many well-traveled migration corridors lead large numbers of migrants to seek jobs in regions other than those of their birth (Polaski, 2004).

For those in search of work, pathways for entry into the United States can be complicated. Highly skilled workers face highly restrictive visa requirements and quotas. The U.S. Citizenship and Immigration Services (USCIS) H1-B program is used by U.S. businesses to "employ foreign workers in specialty occupations that require theoretical or technical expertise in specialized fields, such as scientists, engineers, or computer programmers" (USCIS, 2012) and is capped annually at low numbers by country; thus, Iceland—a country with a population of 319,000, has the same quota as India—a country with over a billion inhabitants (Anderson, 2010).

Pathways for lower skilled jobs have been largely unregulated in recent decades. Historically, many undocumented immigrant workers have circulated back and forth to their own countries, following the cycles of work, but this "back door" system became a trap door after September 11, 2001. Increasingly strict border control policies have effectively stopped the circular flow; it has become too costly and dangerous to cross the border multiple times (Massey, 2008). The combination of inadequate opportunities in the country of origin and the draw of employment opportunities in the United States, along with the lack of opportunities or mechanisms to regularize documentation status, has

contributed to the growth of undocumented immigration over the last 2 decades (Anderson, 2010; Massey, 2008).

Humanitarian Refuge

Humanitarian refuge also contributes to U.S. immigration. By the first decade of the 21st century, there were approximately half-a-million refugee adults and children in the United States—1.3% of its entire foreign-born population and 8% of the world's refugee population (United Nations Development Programme [UNDP], 2010). Refugees usually apply for entry to the United States from overseas processing centers, often in refugee camps located in countries of first asylum, but the United States also considers asylum claims from individuals already in this country. The stated U.S. immigration policy goal is to provide shelter to those fleeing their native countries who face risk of persecution (CBO, 2006). U.S. refugee policy has historically tended to favor individuals coming from countries with which it has political conflicts (e.g., Cuba, Vietnam, and Iraq). In the last decade, the top 10 nation sources for asylum seekers have been China, Mexico, Haiti, Ethiopia, Nepal, Russia, Guatemala, India, El Salvador, and Colombia (Wasem, 2011). During the same period, successful asylum has been granted to seekers from the following top 10 countries: China, Colombia, Haiti, Ethiopia, Venezuela, Armenia, Somalia, Iran, Iraq, and Indonesia (Wasem, 2011).

The rate of asylum denial is quite high, depending on national origin, presiding judge, and whether the individual is represented by an attorney (Kanstroom, 2010). Over the course of the last decade, the rate of denial has ranged nationally from 50% to 63% (Transactional Records Access Clearinghouse, 2010). When denied, many asylum seekers disappear into the morass of undocumented status for fear of returning to their home countries (Kanstroom, 2010). Reasons for seeking humanitarian refuge include war and violence as well as environmental catastrophes.

War and violence. After nearly every war, there is a subsequent movement of people (Rumbaut, 1995; U.N. High Commissioner on Refugees [UNHCR], 2009). For example, following the end of the Spanish-American war in 1898, migration began out of the Philippines and Puerto Rico to the United States. Likewise, migrants flowed out of Korea after the Korean War ended in 1953 and out of Vietnam, Laos, and Cambodia when the Vietnam War ended in 1975. The current conflicts in Iraq and Afghanistan are resulting in large-scale displacements and substantial flows to the United States (UNHCR, 2009). Worldwide, the number of people forcibly uprooted by conflict and persecution stood at 42 million at the end of 2009 after sharp slowdowns in repatriation and ongoing conflicts resulted in protracted displacements. This includes 16 million refugees and asylum seekers and another 26 million internally displaced people uprooted within their own countries (see UNHCR, 2009).

Environmental catastrophes. Environmental catastrophes destabilize social systems and generate mass migration. When a devastating hurricane forced over 2.5 million Hondurans to flee their homes in 1998, many immigrated to the United States, which had not previously been a primary destination point. The Honduran experience might be a harbinger of future migrations. Approximately 25 million people are now "environmental refugees." Environmental migration is a fairly new domain to be recognized in scholarship, and thus limited data are available. Yet according to some estimates, environmental degradation, especially deforestation and rising sea levels, is projected to cause 200 million people to become refugees by 2050 (United Nations Environment Programme, 2010).

Family Motivations

Regardless of whether immigrants migrate for economic reasons or to seek refuge, they are likely to bring family members with them. Many economic immigrants are propelled to migrate to help support family members. Remittances to relatives left behind in the country of origin have grown substantially over the last 2 decades (World Bank, 2011). Even in the context of the global recession, remittances from immigrants in the United States and high-income countries have surpassed "325 billion dollars in 2010 far exceeding the volume of official aid flows and gross domestic product (GDP) in many developing countries" (World Bank, 2011, p. vii). Family reunification can be a long and arduous process. Immigrant family members originating from the largest "sending" countries (where the largest numbers of immigrants originate) typically face decade-long bureaucratic gridlocks (Anderson, 2010) and legal complications (Thronson, 2004, 2008).

DEMOGRAPHIC CONTOURS OF THE U.S. IMMIGRANT-ORIGIN POPULATION

Historical and International Perspectives on Immigration

In the 21st century, millions of people around the world are being affected by the experience of migration—214 million as transnational migrants and many millions more as immediate relatives left behind (UNDP, 2010). Immigration is transforming nations the world over. The average percentage of immigrants in "more developed" nations is 7 times higher than the percentage in "less developed" nations (10.3% vs. 1.5%) (C. Suárez-Orozco, 2004).

The United States has more than 3 times the number of immigrants than the Russian Federation—the country with the next largest number. Every year since 1990, approximately one million new immigrants have entered the United States. Approximately 17 million (43%) foreign-born persons currently living in the United States are naturalized citizens, another 11 million (28%) are authorized noncitizens, and the remaining 11 million (28%) are undocumented (CBO, 2011). Notably, after 3 decades of continuous growth, the undocumented immigrant populations have decreased by approximately one million during the last 2 years following the onset of the economic downturn that began in late 2007 (Hoefer, Rytina, & Baker, 2009).

While the absolute number of immigrants in the United States is at an all-time high, the rate of immigration today is actually lower than during the last era of mass migration, when Europeans began a massive exodus from the Old World (see **FIGURE 2**). In 1910, the rate of immigration reached a peak of 14.7%, while in 2009 the rate was 12.5% (UNDP, 2009; U.S. Census Bureau, 2009b). Further, while there was a peak in unauthorized migration in 2000, the rate has dropped dramatically (over 60%) a decade later according to Homeland Security data (Sapp, 2011).

To provide some international perspective, the average migration rate of the 30 OECD (Organization for Economic Cooperation and Development) nations is 10.2%. Thus, the United States is just slightly over the international average (United Nations, 2006). Europe, which shed over 50 million people in the last great migration (1880–1920), has now approximated U.S. rates of migration nationally (e.g., Germany, 12.3%; Spain, 12.2%; and France, 10.2%) and has reached extremely high rates in certain cities (e.g., 48% in Leicester, England; 45% in Rotterdam, the Netherlands; and 30% in Frankfurt, Germany) (United Nations, 2006). Other nations that traditionally receive immigrants have significantly exceeded the percentage of immigrants entering the United States (e.g., Canada, 18%; New Zealand, 19.5%; and Australia, 28%) (United Nations, 2006).

Diverse Origins

With the exception of Canada, by 2009, 9 of the top 10 leading countries of origin were in Asia, Latin America, or the Caribbean (see **FIGURE 3** for the top 10 sending nations.) One third of the foreign-born population in the

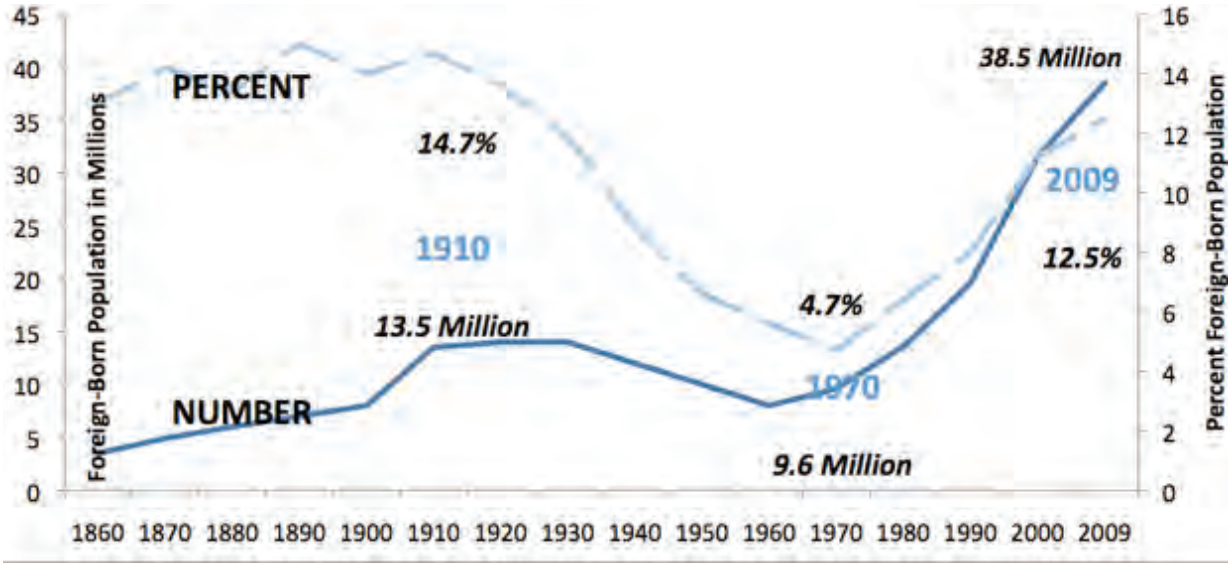


FIGURE 2. Foreign-Born Population, 1860–2009: Number and Percentage of Total Population.
From *A Description of the Foreign-Born Population: An Update,* by the Congressional Budget Office, 2011, Washington, DC: Author.

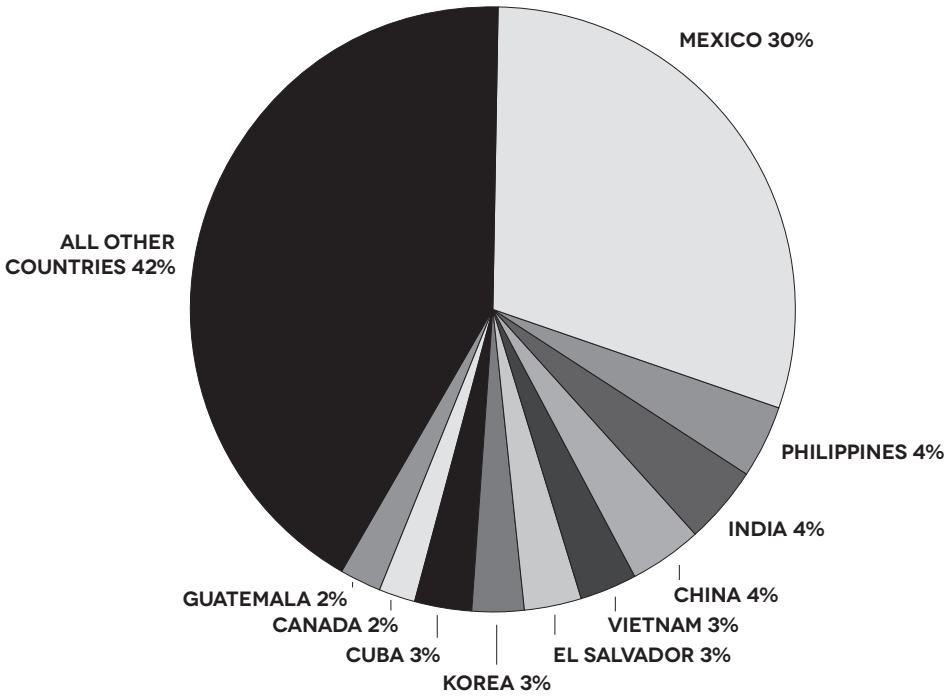


FIGURE 3. Ten Source Countries With the Largest Populations in the United States as Percentages of the Total Foreign-Born Population: 2009.

Source. Originally published on the Migration Policy Institute Data Hub, www.migrationpolicy.org/datahub. Copyright 2010 by the Migration Policy Institute. Reprinted with permission.

United States is from Mexico, and a total of 55% originates from Latin America (U.S. Census Bureau, 2010).

Racial and Ethnic Diversity

During the previous great wave of migration, most new arrivals originated from Europe. It was only in the mid-1960s that immigrants began to contribute to the great diversification of the United States. Since 1965, more than three quarters of new immigrants arriving in the United States are "of color," with origins in Asia, Latin America, the Caribbean, and Africa (U.S. Census Bureau, 2010). By far, the largest group of immigrants comes from Latin America, a racially and ethnically complex region consisting of indigenous origin, White European origin, African origin, and mestizo (or mixed origin) populations (M. Suárez-Orozco & Páez, 2009). Asians account for 28.2% of the foreign-born (U.S. Census Bureau, 2011b). Although Africans comprise only 3.9% of today's immigrants, the African-born population in the United States has increased dramatically since 1960, from 35,555 to 1.4 million, with most of that growth occurring in the last decade (McCabe, 2011).

Many of these immigrants arrive at the most fertile stage of their lives, which further contributes to diversification (CBO, 2011; Rumbaut & Komaie, 2010). According to the U.S. Census Bureau, four states with large numbers of immigrants have already become "majority/minority" states (less than 50% White)—California, Hawaii, New Mexico, and Texas—with Maryland, Mississippi, Georgia, New York, and Arizona projected to reach this designation next (U.S. Census Bureau, 2011a).

Educational Diversity and Employment

Immigrants arrive in the United States with varied levels of education. At one end of the spectrum are highly educated immigrant adults (Portes & Rumbaut, 2006). These immigrants comprise a quarter of all U.S. physicians, 24% of the nation's science and engineering workers with bachelor's degrees, and 47% of scientists with doctorates (Kerr & Lincoln, 2010). These highly educated immigrant adults are participating in and driving innovation, research, and development and contributing substantively to technological progress. One measure of this contribution is the issuance of patents. The United States issues far more

patents than any country in the world, and immigrant adults are responsible for 24% of them, creating patents at twice the rate of native-born Americans (Gauthier-Loiselle & Hunt, 2010; Kerr & Lincoln, 2010). Another measure of the immigrant contribution to technological development and the economy is that of all U.S. engineering and technology companies started between 1995 and 2005, 25% had at least one immigrant founder. These companies were responsible for $52 billion in sales and employed 450,000 people in 2005. Another 27% of the companies founded during those years had a foreign-born chief executive or chief technology officer (Wadhwa, Saxenian, Freeman, & Salkever, 2009).

Many highly educated and skilled immigrant adults, however, experience a dramatic decrease in employment opportunities when they immigrate (Yakushko, Watson, & Thompson, 2008). They may experience unemployment, underemployment, downward mobility, and disqualification of previously held professional credentials (Dávila, 2008; G. Lee & Westwood, 1996; Yost & Lucas, 2002). These issues are magnified for ethnic or racial minority adults (Catanzarite & Aguilera, 2002; Fernandez, 1998; M. C. Morales, 2009).

At the other end of the spectrum, some immigrant adults have educational levels far below their U.S.-born contemporaries (CBO, 2011; Portes & Rumbaut, 2006). Some sectors of the U.S. labor market are particularly reliant on "low-skilled" immigrant adults, including those in the agriculture, service, and construction industries (CBO, 2011; Passel & Cohn, 2009; Schumacher-Matos, 2011). American farms produce more than 9% of U.S. exports and almost all the food consumed in the United States (Schumacher-Matos, 2011). The U.S. agricultural industry is very reliant on the immigrant population (CBO, 2011; Schumacher-Matos, 2011). Approximately 75% of all hired farm workers in the United States, and nearly all those involved in the production of fresh fruits and vegetables, are legal or undocumented immigrant adults (Kandel, 2008).

Economists have routinely debated the relative costs and benefits of immigration for the U.S. economy. These debates are often based on rivaling methodologies and modeling (Schumacher-Matos, 2011) as well as on the challenges involved in capturing economic activity in the informal economy (Thukral, 2010). Nevertheless, meta-analyses on the topic seem to indicate that on balance, immigration benefits the U.S. economy (Griswold, 2009; see Schumacher-Matos, 2011, for a comprehensive review on the topic), although the overall contribution of immigrants is relatively modest given the size of the total U.S. economy (Schumacher-Matos, 2011).

There is, however, a general tension between the federal government and state governments when it comes to the economic consequences of immigration. The federal government keeps the lion's share of taxes generated by immigrants, whereas local governments must bear many of the costs and provide the services immigrants consume, particularly for education (National Research Council, 1997; Schumacher-Matos, 2011). Notably, in the United States, women with graduate educations are particularly likely to benefit from the services of low-skilled immigrant labor, as it decreases the time they devote to housework and increases the purchases they make (Cortes & Tessada, 2009).

Language Diversity

An estimated 460 languages are currently spoken in homes in the United States (Kindler, 2002). The National Center for Education Statistics estimates that between 1979 and 2008, the percentage of children who spoke a second language at home increased from 9% to 21% (U.S. Department of Education, 2010). Of those individuals speaking a language other than English at home, 62% speak Spanish, 19% speak another Indo-European language, 15% speak an Asian or Pacific Island language, and the remaining 4% speak another language (Shin & Komiski, 2010). Though Spanish is the predominant foreign language spoken in the United States, there are 2 million speakers of Chinese (including its various dialects) and more than one million speakers of Tagalog, French, German, Korean, and Vietnamese. There is a total of 26 languages with more than 100,000 speakers over the age of 5 in the United States today (Bayley & Regan, 2004).

Many of these non-native English speakers also speak English with varying degrees of fluency (Shin & Komiski, 2010). In general, higher levels of education and longer residency in the United States correlate to greater fluency in English (Shin & Komiski, 2010). Within one generation of immigrating, however, bicultural competency drops dramatically, and by the third generation, very few retain even minimal language skills from their grandparents' country of origin unless there has been intermarriage or a multigenerational living arrangement (Alba, Logan, Lutz, & Stults, 2002; Portes & Schauffler, 1994; Wong Fillmore, 1991).

In the United States, there have been recurring concerns about the immigrant population's inability or unwillingness

to learn English (Bayley & Regan, 2004). The research is quite clear, however—there is consistent language assimilation within a generation (Alba et al., 2002; Portes & Schauffler, 1994; Wong Fillmore, 1991). Latinos/as, frequently charged with being most resistant to learning English, are acquiring fluency. The National Center for Education Statistics reports that 76% of Latinos 16–24 years of age self-report speaking English "well" or "very well" (U.S. Department of Education, 1995). Further, a Pew national survey found that 96% of foreign-born Latinos reported that it was important to them that their children learn English (Pew Hispanic Center/Kaiser Family Foundation, 2004).

In a study of 5,000 first- and second-generation immigrant adolescents from diverse origins in Florida and California, a rapid loss of language was found from the first to the second generation (Portes & Hao, 1998). Indeed, because of the historical pattern of rapid new language acquisition and home language loss for immigrants across generations, the United States has been called a "cemetery for languages" by Harvard sociologist Stanley Lieberson (Lieberson, Dalto, & Johnston, 1975).

Religious Diversity

Religion is a fundamental part of life for most people throughout the world (Holden & Vittrup, 2009). Newly arrived immigrant adults and children who are feeling disoriented in their new land are particularly likely to turn to their religious communities in times of transition (Levitt, 2007; Stepick, 2005).

During the last 3 decades, the immigrant population in the United States has had an impact on the country's religious makeup (Eck, 2001; Levitt, 2007). Although participation in the Catholic Church by U.S.-born residents has decreased in recent decades, participation by the U.S. immigrant population from Latin America and the Caribbean has increased (Eck, 2001). In addition, immigrants from Central America and the Caribbean who were converted to evangelical churches prior to migration continue their participation after migration, and networks of relatives perpetuate further conversions as immigrants are drawn to religious institutions in search of support networks (Levitt, 2007). Largely because of migration, participation in the non–Judeo Christian religions combined (Islam, Hinduism, Sikhism, and others) has grown in the United States from 0.8% to 2.6% from 1970 to 2000 (Eck, 2001; Pew Forum on Religious Life, 2008). The "world religions" predictably account for the most significant nexus and religiosity in the United States (Eck, 2001; Pew Forum on Religious Life, 2008).

Diverse Destinations

The top destination states for immigrants have and continue to be California, New York, Florida, Texas, and Illinois (CBO, 2011). In the past 2 decades, however, a growing number of locales with no previous immigrant population have experienced unprecedented rates of new migration (CBO, 2011; Massey, 2010). Proportionally, southern states have experienced the most dramatic change in immigrant population. Between 2000 and 2007, the largest increases in foreign-born population growths occurred in South Carolina (63.8%), Arkansas (60.7%), Tennessee (56.9%), and Alabama (56.4%) (Terrazas & Batalova, 2010). Growth is occurring in other new destination states as well, including places like Nevada and Massachusetts (Massey, 2010). New rural destinations with little or no previous experience with immigrant populations have found the transition particularly challenging (Fennelly & Federico, 2008; Massey, 2010) due to cultural isolation, lack of ethnic resources, and xenophobia.

THE SOCIAL CONTEXT OF RECEPTION AND IMMIGRATION ADAPTATION

Ecological approaches (Bronfenbrenner & Morris, 2006) acknowledge that behavior does not occur in a vacuum but is affected by the larger culture and society, the local community, and its institutions. Thus, the social climate and receiving context into which immigrants arrive help shape their experience and adaptation in the new land (Deaux, 2006; Portes & Rumbaut, 1996; Schwartz, Unger, Zamboanga, & Szapocznik, 2010; C. Suárez-Orozco et al., 2008).

A rapid growth of the immigrant population, the terrorist attacks on September 11, 2001, and the recent economic recession have served to stimulate unease toward newcomers for many (Massey, 2008; Sirin & Fine, 2008). Xenophobia, defined as the fear or hatred of foreigners and their culture, has been on the rise, especially toward newer immigrants, particularly Muslims (Sirin & Fine, 2008) and Latinos (L. Chavez, 2008), as evidenced by negative media coverage (Massey, 2010; M. Suárez-Orozco et al., 2011), an increase in hate crimes (Leadership Conference on Civil Rights Education Fund, 2009), and exclusionary legislation on the municipal, state, and federal levels (Carter, Lawrence, & Morse, 2011).

The current political debates around immigration reform mirror more general societal processes showing increased tensions and anxiety about immigration and its consequences on the American cultural and economic landscape.

For some segments of the U.S. population, the "war on terror" and the growth of undocumented migrations have legitimatized expressions of prejudice. Immigrants in general, but undocumented immigrants in particular, are viewed as deserving of disparagement and poor treatment (L. Chavez, 1997; Massey, 2008). Within the media, immigrants are regularly portrayed in a negative light, emphasizing the burden they place on the economic and social well-being of the United States (L. Chavez, 2008). There may also be a link between the recent rise in hate crimes and the political debates that surround immigration (Holthouse & Potok, 2008; S. S. Hsu, 2009; Michels, 2008). A report by the Leadership Conference on Civil Rights Education Fund (2009) summarized recent years of FBI hate crime data showing that hate crimes against Latinos increased nearly 40% from 2003 to 2007. The report also related these xenophobic acts to the contentious debate over immigration and immigration reform. Thus, the current political debates around immigration reform mirror more general societal processes showing increased tensions and anxiety about immigration and its consequences on the American cultural and economic landscape.

IDEOLOGIES OF ASSIMILATION VERSUS MULTICULTURALISM

Historically, American national identity has been in part premised on the notion of being a nation of immigrants (Foner, 2002). The recent rapid growth in immigration has fueled a new debate about what it takes to become an American. Early in the 20th century, when the vast majority of immigrants came to the United States from Europe, theoretically anyone could become American through assimilation and achieve the "American Dream" of upward socioeconomic mobility. Across immigrant generations, offspring lost their accents, changed their names, and moved on to "pass" as full-blown Americans (Alba, 2009; Foner, 2002). The gradual elimination of distinctions between ethnic groups occurred through increasing intermarriage of second- and later-generation immigrant adults, resulting in Americans who had few recognizable ties to their countries of origin (Alba & Nee, 1997).

Prior to 1965, immigration policy heavily favored European immigrants and severely limited immigration from other parts of the world. Over the years, policy (e.g., the Chinese

Exclusion Act of 1882) specifically prohibited some groups from immigrating to the United States. With the arrival of a new racially diverse wave of immigration, public discourse in the United States has highlighted the distinctions between assimilation (i.e., the melting pot) and multiculturalism (i.e., the salad bowl). This new immigrant wave, unlike the previous wave of 1880–1920, has been largely non-White and arriving mainly from Latin America and Asia. Opportunities for assimilation for people of color, if passing is the standard, are limited (Gibson, 2001; Murguia & Telles, 1996; Portes & Zhou, 1993; Waters, 1996):

- Asian Americans are burdened by the "perpetual foreigner" image held by mainstream Americans that all Asian Americans are foreigners no matter how many generations their family has resided in the United States because they look different from Whites (S. Sue & Okazaki, 2009; Yogeeswaran & Dasgupta, 2010).
- Although Americans of Latino ethnicity may be of any "race," being Latino in the United States has been "racialized" (Golash-Boza, 2006), making it difficult to "blend in" with the White middle class. Immigrant Latinos, in particular, face difficult challenges, as their opportunities to move up the economic ladder are often limited by targeted racism and limited resources (Murguia & Telles, 1996; Orfield & Yun, 1999).
- Arab Muslims, a particularly excluded group at this time of war, are often made to feel like perpetual outsiders with limited ability to join the society that distrusts and excludes them (Sirin & Fine, 2008).
- Other non-White groups, (e.g., South Asians and Africans) that arrive with social and cultural capital may attain access through "selective assimilation," successfully participating in the American economy and moving into the middle class while retaining their native culture in strong ethnic enclaves outside the mainstream (Gibson, 2001).

European immigrants, on the other hand, continue to assimilate economically, politically, and socially into the White middle class as they have in previous generations (Alba, 2009). In summary, the possibility of being treated as an equal American now seems more elusive for most immigrant-origin individuals than it was during the previous great wave of immigration. One is unlikely to pass the bar of acting, speaking, and looking like a mainstream citizen.

RESEARCH ON ASSIMILATIONIST AND MULTICULTURAL IDEOLOGIES

The debate on assimilation versus multiculturalism parallels experimental research on prejudice reduction (Dovidio, Gaertner, & Validzic, 1998). Research in social psychology has focused on understanding the nature and consequences of ideologies that individuals hold about living in a diverse society. In particular, two cultural ideologies are contrasted in social psychological research: cultural assimilation versus multiculturalism (Richeson & Nussbaum, 2004).

Proponents of the cultural assimilation ideology believe that the best approach to managing differences across cultures is for immigrants (and other minority groups) to rapidly assimilate to the dominant culture. They argue that assimilation toward common norms and rules is the desired end state and that by eliminating ethnic group boundaries, intergroup prejudice will be drastically reduced. For example, "English-only" laws, which require all government activities to be conducted in English (e.g., banning Spanish-language voting ballots), can be viewed as strategies to aid rapid assimilation, though some suggest they are instead motivated by concerns some U.S. citizens have about their own changing cultural and economic landscape (Zárate & Shaw, 2010).

Conversely, those holding a multicultural ideology believe that all cultural groups should have the opportunity to retain their basic cultural norms, values, traditions, and language within a greater cultural framework. Those who advocate for multiculturalism believe that prejudice is reduced and self-esteem enhanced through an appreciation of group differences (Zárate & Garza, 2002). According to this perspective, the country benefits from the presence of diverse groups that bring a broad array of skills. For example, diverse language skills are necessary for many jobs in the business and service sectors (Kristoff, 2010).

Perceiving others as belonging to an "outgroup" can lead to prejudice and discrimination. Consistent with the assimilationist ideology, the common in-group identity model posits that prejudice is best reduced through the creation or identification of a common group membership (Gaertner, Rust, Dovidio, Bachman, & Anastasio, 1996). In the context of immigration, by creating a shared national in-group identity, people who were originally perceived as out-group members become recategorized as members of a shared common group, and prejudice is reduced. Within this framework, terms like *Asian American* or *Mexican American* are seen as divisive

because they highlight between-group differences rather than a common in-group identity such as "American."

In contrast, the mutual identity differentiation model hypothesizes that attention to salient group identities is important for bias reduction (R. Brown, Vivian, & Hewstone, 1999). When applied to the context of immigration, the mutual identity differentiation model mirrors multicultural ideologies in that it suggests that highlighting group differences actually reduces prejudice. Because ethnic identity is often an important part of the self-concept (Carpenter, Zárate, & Garza, 2007; Zárate & Garza, 2002), attempts to force people to relinquish or hide that identity can produce negative reactions. Some research demonstrates that attention to a salient group identity is actually more effective at reducing intergroup bias than attention to a common identity (Hornsey & Hogg, 2000).

Findings from common group identity and group distinctiveness research imply that assimilation and multiculturalism may mean different things to different groups (Zárate & Shaw, 2010), depending on their structural position in society. When the majority group enforces norms expecting other groups to assimilate, the underlying message is that the majority group does not want to change and prefers other groups to change to fit its norms. Further, within an assimilated world, the majority group standing is preserved and the status quo remains intact. At the same time, when minority groups espouse multiculturalism, the underlying message is that they do not want to change but rather to preserve their cultural traditions.

A solution to this impasse may involve combining both perspectives and articulating ideologies in which immigrants may preserve their cultural distinctiveness while simultaneously developing a shared American identity with those born in the United States. An important issue to understand is how people view the concept of "American." For some, being "American" means being "White." While not explicit, for many Americans there is an implicit attitude that persons of color are less "American" than Euro-Americans (Devos & Banaji, 2005). Thus, to reduce prejudice, it is important that in the national dialogue about what is "American," this shared identity is constructed in ways that expand current perceptions of what an "American" looks like.

THE IMMIGRATION DEBATE, XENOPHOBIA, AND DISCRIMINATION

In the current anti-immigrant climate, xenophobia and discrimination significantly impact the lives of immigrant populations (Deaux, 2006). Immigrant adults and their children may be identified by their accented English, "unusual" names, and manners of dress. As a result of native-born Americans viewing them as taking away jobs (Transatlantic Trends, 2010) and bringing with them undesirable cultural practices (Zárate, Garcia, Garza, & Hitlan, 2004), immigrants are discriminated against in employment (Dietz, 2010) and across a range of other microsystems, such as their neighborhoods, service agencies, and schools.

Immigrants who are racially distinct from the majority are at greater risk for experiencing discrimination than those who are not (Berry & Sabatier, 2010; Liebkind & Jasinskaja-Lahti, 2000). Many immigrants from Asia, Latin America, the Caribbean, and Africa encounter racial discrimination for the first time in the United States. Stress associated with racial discrimination has been well documented, particularly for African Americans (Hughes et al., 2006), and racism has a substantial impact on minority health and mental health (T. N. Brown et al., 2000).

Xenophobia affects both immigrants and native-born minority populations. According to a recent Pew Hispanic Center survey (M. H. Lopez, Morin, & Taylor, 2010), 61% of Latino U.S. citizens believe discrimination against Latinos is a major problem—an annual increase from 47% in 2002. The reasons respondents most cited for discrimination included immigration status (36%), skin color (21%), language skills (20%), and income and education levels (17%). A considerable proportion (32%) of U.S.-born nonimmigrant Latinos worry either a lot (19%) or some (13%) about being deported (M. H. Lopez et al., 2010). Thus, it is not just immigrant Latinos who feel the effects of xenophobia, prejudice, and discrimination.

In contrast, immigrant Asians report they experience more discrimination than Asian Americans born in the United States (Yip, Gee, & Takeuchi, 2008). Thus, while Asian Americans do feel the "perpetual foreigner" stigma, the burden of discrimination they encounter may be of a different intensity. Moreover, for every group, the effects of extended prejudice and discrimination are generally stressful (Pascoe & Richman, 2009).

In a recent meta-analysis, Pascoe and Richman show that perceived discrimination negatively influences both physical

and mental health outcomes. Discrimination negatively impacted stress-based responses and health behaviors and increased unhealthy behaviors. The meta-analysis also revealed that both recent and chronic discrimination negatively impacted health outcomes. In a later study, Q.-L. Huynh, Devos, and Dunbar (2012) reported that both high stress but rare events and high frequency but less severe events increase the perceived anxiety and reported depression associated with the events.

Conducting research on stereotyping, prejudice, and discrimination is often difficult. People rarely explicitly identify racial prejudice as a motive for their own behavior (Greenwald, Poehlman, Uhlman, & Banaji, 2009) or as the reason for their dislike of immigrants (Pérez, 2010). Rather, a host of implicit and explicit processes work to provide a hostile environment for immigrants. This line of research suggests that some reactions toward immigrants are based on implicit negative attitudes or implicit beliefs (APA, 2010c) toward them.

For example, Pérez (2010) used an Implicit Association Test (IAT) to test attitudes toward White versus Latino immigrant populations. With varied samples, White participants expressed more negative implicit attitudes toward immigrant Latinos than toward immigrant Whites. More important, participants' implicit prejudice predicted attitudes about immigrant Latinos beyond political conservatism and other variables. Thus, prejudice, not other variables, is predicting attitudes toward immigrant Latinos. Thomsen, Green, and Sidanius (2008) similarly showed that social-dominance orientation and right-wing authoritarianism predict prejudice toward immigrants, albeit in slightly different ways. Individuals high in social-dominance orientation dislike immigrant groups if they intend to assimilate, whereas persons high in right-wing authoritarianism dislike immigrant groups if they do not intend to assimilate. It can become, in essence, a catch-22.

It might be argued that some stereotypes are justifications for an out-group bias rather than its cause. Some stereotypes are widely held even though evidence suggests they are untrue. For example, anti-immigrant rhetoric often focuses on the perceived refusal of immigrant populations to learn English (see the Introduction). Research, however, suggests that current Chinese, Cuban, and to a lesser extent, Mexican immigrant groups are learning English at the same rates as European groups in prior immigration waves (Alba et al., 2002; Portes & Hao, 1998; Wong Fillmore, 1991). Yet attitudes suggest a greater perceived threat from the current Spanish-speaking immigrant population, perhaps because of the sheer numbers of individuals involved (Barker & Giles, 2004; Huddy & Sears, 1995) (see the first paragraph of the Guiding Frameworks section for other common misperceptions about immigrants).

Even positive stereotypes can be used to reinforce prejudice and discrimination. Often referred to as "the model minority," Asian immigrants are generally perceived to do well educationally and economically (Fuligni & Witkow, 2004). However, this stereotype is overgeneralized (see Maddux, Galinsky, Cuddy, & Polifroni, 2008). For instance, not all Asian groups are doing uniformly well (Choi, 2008), but this stereotype can mean that those who are struggling get overlooked for remediation. Also, despite the positive stereotypes, these groups are not well liked, possibly stemming from a sense of realistic threat (Maddux et al., 2008; Zárate et al., 2004) to the privileged position of Whites.

Thus, regardless of how highly skilled a group is, immigrants are often negatively stereotyped, either for being poorly skilled or for being highly skilled. In either case, stereotypes mask the unique psychological experiences and concerns of different immigrant communities. As there is clear evidence that there are negative consequences to living with prejudice, this is an issue of grave concern (see the Immigrant Populations in Clinical Contexts section and the APA Resolution on Prejudice, Stereotypes, and Discrimination [APA, 2006]).

NEIGHBORHOOD AND COMMUNITY CONTEXTS

A final aspect of the context of reception that is important to note for immigrant adjustment is the local community and neighborhood context. Where immigrants settle has profound implications for the experiences and adaptation of immigrant youth. The few psychological studies conducted on the phenomenon of immigrants living in ethnic enclaves or neighborhoods with greater co-ethnic concentration suggest that this experience may be quite different depending on where they settle (Birman, Trickett, & Buchanan, 2005; A. M. Miller, Birman, et al., 2009; Schnittker, 2002). While within the larger culture there is generally a negative perception of ethnic enclaves as "ghettos" (Walks & Bourne, 2006), living in ethnic neighborhoods can be beneficial for immigrants. They are more likely to retain their native culture (Birman, Trickett, & Buchanan, 2005; A. M. Miller, Birman, et al., 2009; Padilla, 1980), and there may be psychological benefits to doing so (A. M. Miller, Birman, et al., 2009; Schnittker, 2002).

Living in ethnic communities seems to protect immigrant individuals from cultural isolation, which in turn benefits their psychological adjustment (Liebkind, 1996; Noh & Avison, 1996; T.V. Tran, 1987). Pressure to assimilate can be strong outside ethnic enclaves (A. M. Miller, Birman, et al., 2009; Schnittker, 2002) and may lead to greater incidences of discrimination and its consequences.

Latino new arrivals, in particular, often settle in highly segregated and impoverished urban settings (Orfield & Yun, 1999) with a series of negative consequences. New immigrants of color who settle in predominantly minority neighborhoods often have virtually no direct, systematic, and intimate contact with middle-class White Americans (Massey & Denton, 1993). This can affect their opportunities to hear and use English, the quality of schools their children attend, and the access to desirable jobs (Orfield, 1995; Portes & Hao, 1998). Concentrated poverty is associated with the "disappearance of meaningful work opportunities" (Wilson, 1997), and youth in such neighborhoods are chronically under- or unemployed.

In neighborhoods with few opportunities in the formal economy, underground or informal activities tend to flourish. Exposure to violence in both neighborhoods and schools is an everyday reality for many immigrant youth today (R. Collier, 1998). Some sociologists argue that these structural features interact to generate a pattern they have termed "segmented assimilation," whereby, over time, many poor immigrant youth of color will tend to assimilate toward the American underclass rather than to middle-class norms (Portes & Rumbaut, 2001). Neighborhood characteristics are directly reflected in the schools attended by immigrant children and youth. Immigrant youth today enroll in schools that cover the range—from well-functioning, with a culture of high expectations and a focus on achievement, to dysfunctional institutions characterized by ever-present fear of violence, distrust, low expectations, and institutional anomie. Unfortunately, poor immigrant youth who need the most academic help tend to enroll in inferior schools with triple segregation—by poverty, race, and language (Orfield & Lee, 2006). These poorly resourced schools offer the fewest opportunities for the students who most need them (Orfield & Yun, 2006; C. Suárez-Orozco et al., 2008).

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Further, networks of relationships provide immigrant families with tangible aid (such as baby sitting, helping with translations, or providing loans), as well as guidance and advice (such as job and housing leads). These supports are particularly critical for newcomers, for whom many aspects of the new environment can be quite disorienting. Relationships also serve a critical function in maintaining and enhancing self-esteem by providing acceptance, approval, and a sense of belonging (C. Suárez-Orozco et al., 2008). The more resources that the neighborhoods and the networks of relationships have to offer, the better off new immigrants are as they assimilate into the new land (Putnam, 2000; Portes & Rumbaut, 1996; C. Suárez-Orozco et al., 2008).

IN CONCLUSION

It is evident that much on the research on reception and intergroup relations has failed to explore immigrants' points of view. The bulk of evidence on discrimination concerns how Euro-Americans perceive minorities or how stress influences ethnic populations. There is minimal research on the psychological factors that predict attitudes toward immigrants and how those psychological processes predict support for related policy. Similarly, there is little evidence merging negative attitudes and actual discriminatory behaviors, such as workplace discrimination, hate crimes, and more subtle forms of discrimination.

Considering the ample evidence for the role of racial discrimination in psychological distress (Gee, Spencer, Chen, Yip, & Takeuchi, 2007; Jang, Chiriboga, Kim, & Rhew, 2010; Wei, Ku, Russell, Mallinckrodt, & Liao, 2008; Yoshikawa, Wilson, Chae, & Cheng, 2004), future research should address the unique ways in which discrimination is experienced by immigrants, considering variations in gender, generation (first vs. second vs. third) and social class. Additionally, future research should consider the intersectionality of social identities (race, culture, language, immigration status, gender, sexual orientation, social class, religion, and ability/disability status) and its relationship to the experience of, and coping with, discrimination among immigrant communities.

ADAPTATION: ACCULTURATION, CULTURAL IDENTITY, AND CIVIC ENGAGEMENT

ACCULTURATION

Psychological acculturation refers to the dynamic process that begins when immigrants enter the new country and begin to adapt to its culture (Berry, 1980). Acculturation[1] is often thought to be a matter of personal choice or preference (Berry, 1980), but the socioecological context it occurs in is important to consider. Acculturation occurs against the backdrop of the local community of resettlement (Schnittker, 2002) and the immigrant group's experience in the larger society (Gibson, 2001). For example, while some may adopt American culture quickly, immigrants in large urban areas with thriving ethnic communities may continue to stay connected to their native cultures (A. M. Miller, Birman, et al., 2009). Immigrants of color in particular may encounter discrimination that limits acculturation options.

Today's immigrants may acculturate to the American culture without severing their connection to the heritage culture, and some research suggests that there are advantages to biculturalism.

Immigrants' age is also an important factor that shapes how acculturation unfolds. Children learn the new language and culture relatively quickly, while adults take longer, having been fully socialized into their heritage culture prior to migration. Acculturation to the new culture is particularly slow for immigrants of retirement age (Jang, Kim, Chiriboga, & King-Kallimanis, 2007; A. M. Miller, Wang, Szalacha, & Sorokin, 2009). Because such a variety of personal, community, and societal factors shape individual immigrants' cultural experiences, acculturation refers to more than the mere passage of time in a new country or to one's generational status (Schwartz, Pantin, Sullivan, Prado, & Szapocznik, 2006). Rather, there are diverse and multifaceted ways that immigrants navigate their way through living in a culture that is different from the one they were born into.

An important distinction has been made in psychology between *acculturation* and *assimilation*. Acculturation has been defined as a bilinear[2] process occurring with respect to both the new and the heritage culture.[3] Assimilation, on the other hand, refers to a particular type of acculturation that involves adopting the new culture while simultaneously letting go of attachment to the heritage culture. Early theories of acculturation assumed that such an either/or acculturation process was the only possible and desirable outcome for immigrants (Stonequist, 1937). However, today's immigrants may acculturate to the American culture without severing their connection to the heritage culture, and some research suggests that there are advantages to biculturalism (Berry, 1980; LaFromboise, Coleman, & Gerton, 1993; Szapocznik, Scopetta, Kurtines, & Aranalde, 1978).

Acculturation is a multidimensional process that involves changes in many aspects of immigrants' lives. A number

1 The amount of research on acculturation in psychology is large and growing. A search for *acculturat* in PsycINFO produced 19,679 entries (15,363 since the year 2000), of which 8,469 were empirical articles in peer-reviewed journals. However, there is little consistency in the methods or terminology used in this large volume of literature (Rudmin, 2003). In reviewing the literature, we have attempted to clarify the terminology and highlight the complexity of presenting an integrative summary of findings.

2 In addition to *bilinear*, the terms *bidimensional* (e.g., Ryder, Alden, & Paulhus, 2000) or *orthogonal* (Oetting & Beauvais, 1991) have been used to describe this process.

3 Acculturation to the heritage culture has been sometimes called *enculturation* (e.g., N. A. Gonzales, Knight, Birman, & Sirolli, 2004; Yoon, Langrehr, & Ong, 2010). However, in developmental psychology, enculturation describes a more general process of socialization that occurs within the child's cultural context. Immigrant adults arrive having been fully "enculturated" into their culture of origin, and for them the term does capture both their cultural socialization experience and their attachment to their heritage culture. But for immigrant children, enculturation, or the process of socialization into the culture and society that surround them, occurs with respect to both cultures, as the family is embedded within and is reacting to the host cultural context. Therefore, to avoid confusion, the term *acculturation* refers to the process of affiliation with the heritage culture and is seen as part of the overall acculturation process that involves balancing affiliation to both.

of dimensions of acculturation have been theorized and assessed in research, including language competence and use, cultural identity, attitudes and values, types of food and music preferred, media use, ethnic pride, ethnic social relations, cultural familiarity, and social customs (see Yoon, Langrehr, & Ong, 2010, for a review). Acculturation may occur in stages, with immigrants learning the new language first, followed by behavioral participation in the culture (Birman & Trickett, 2001; M. Gordon, 1964; R. M. Lee, Yoon, & Liu-Tom, 2006, cited in Yoon et al., 2010). Less observable aspects of acculturation, such as changes in identity and values, are thought to take longer than behavioral changes (Birman & Trickett, 2001; Marino, Stuart, & Minas, 2000). Thus, immigrants who have lived in the United States for a long time and appear to have adopted the American lifestyle may continue to maintain strong identification with, and hold the values of, their culture of origin. This has important implications for providing psychological services to this population (see Immigrant Populations in Clinical Contexts).

Language Acculturation

Learning the new language is a critical task for immigrant adults and children in accessing the schooling and employment necessary for survival in the new country. For adults, learning a new language is more difficult than it is for children, and some never attain English-language fluency. But sociological research suggests that immigrant groups today are learning English (Waters & Jiménez, 2005), and language assimilation is occurring by the second and third generations as it did in prior immigration waves (Alba et al., 2002; U.S. Department of Education, 1995).

School-age immigrant children learn the new language relatively quickly, becoming conversationally fluent within 2 years after arriving in the new country, though cognitive-academic language proficiency takes much longer, 5 or more years (August & Shanahan, 2006; V. P. Collier, 1987; Cummins, 1984; Klesmer, 1994; Muñoz-Sandoval, Cummins, Alvarado, & Ruef, 1998). English becomes the dominant language for most immigrant children within 4 to 5 years following immigration (Birman & Trickett, 2001), and for many, their native language atrophies (Wong Fillmore, 2000).

Behavioral Acculturation

Behavioral acculturation refers to the extent of immigrants' participation in their culture of origin and/or new culture. While adopting American ways, immigrant adults continue to participate in their heritage culture, have friendships with others from the same country with whom they can share interests and values, consume ethnic foods, and read/view native-language print and electronic media. Immigrant children, however, behaviorally adapt to the U.S. culture quickly. Adolescents in particular are exposed to American culture through movies, music, television, and many other increasingly available electronic outlets. Even before immigrating, many youth have been exposed to, and perhaps have idealized, these aspects of American culture. The pull of American culture, with the freedoms it allows to young adults, can be very enticing. Perhaps for this reason, research suggests that acculturation to American culture is related to high-risk behavior for immigrant adolescents, including high-risk sexual behavior (Afable-Munsuz & Brindis, 2006; Jimenez, Potts, & Jimenez, 2002; Upchurch, Aneshensel, Mudgal, & McNeely, 2001), smoking, drinking (Castro, Stein, & Bentler, 2009; Gil, Wagner, & Vega, 2000), and substance use (Chen, Unger, Cruz, & Johnson, 1999; Hahm, Lahiff, & Guterman, 2003; Unger et al., 2002).

Cultural and Ethnic Identity

The ways in which immigrants identify with their heritage, host, or both cultures is part of the acculturation process (Birman & Trickett, 2001; Phinney, 1990). *National identity* refers to immigrants' sense of belonging to the new society (Phinney, Horenczyk, Liebkind, & Vedder, 2001; Verkuyten & Brug, 2001) and *cultural* or *ethnic identity* involves immigrants' sense of belonging to, positive regard for, and pride in their native culture (Phinney, 1996). As with other types of acculturation, immigrants may assimilate (give up their native cultural identity and consider themselves American), identify themselves only with their native culture, or develop a "bicultural" identity. Some studies have found that a combination of strong ethnic identity and strong national identity promotes the best adaption for immigrants (Birman, Persky, & Chan, 2010; Deaux, 2006; Phinney et al., 2001; C. Suárez-Orozco & Suárez-Orozco, 2001).

However, studies have also found that when subjected to sustained discriminatory experiences, immigrant adolescents may not become bicultural (Berry, Phinney, Sam, & Vedder, 2006) but may instead adopt "reactive identification," embracing their cultural identity while rejecting American culture, after having been rejected by it (Birman & Trickett, 2001; Portes & Zhou, 1993; Rumbaut, Gonzales, Komaie, Morgan, & Tafoya-Estrada, 2006; Sirin & Fine, 2008; C. Suárez-Orozco & Suárez-Orozco, 2001).

In a number of studies, strong identification with one's ethnic group has been found to be associated with positive feelings toward the self for immigrant adolescents, producing more positive educational, health, and family outcomes, particularly for Latino adolescents (R. O. Martinez & Dukes, 1997; Phinney, Cantu, & Kurtz, 1997; N. Rodriguez, Mira, Páez, & Myers, 2007; Schwartz, Zamboanga, & Jarvis, 2007; Smokowski & Bacallao, 2007). Ethnic identity is theorized to be particularly beneficial to immigrants who encounter extensive discrimination in the host society (Deaux, 2006; Kasinitz, Mollenkopf, Waters, & Holdaway, 2008; C. Suárez-Orozco & Suárez-Orozco, 2000). At the same time, if the larger society expects immigrants to assimilate, becoming more "ethnic" in identity and behavior can elicit even further discrimination and marginalization. This may be one reason why a few recent studies with Asian college students (R. Lee, 2003, 2005) and Americans of Chinese descent (Yip et al., 2008) suggest that ethnic identity may not have a protective effect or may even exacerbate the impact of discrimination on mental health. These findings suggest that discrimination limits acculturative options, and even strong identification and positive regard for one's own ethnic group can have negative consequences for mental health, as may be the case for Asian Americans.

Other dimensions of acculturation have also been studied, such as values. Adopting values of the new society may be the most subtle aspect of culture change (Marino et al., 2000) that occurs over the span of generations. Several studies suggest that immigrant parents continue to socialize their children into traditional values of the heritage culture (Kwak & Berry, 2001; Patel, Power, & Bhavnagri, 1996; Phalet & Schonpflug, 2001).

In summary, a multidimensional process of acculturation occurs differently for children and adults. As a result, acculturation "gaps" develop between parents and children in immigrant families. While such acculturation gaps are normative in immigrant families, they have been found to be linked to intergenerational conflict in some studies (Birman, 2006).

ACCULTURATION AND MENTAL HEALTH

The process of acculturation may lead to *acculturative stress* (Berry, 1997; Lazarus, 1997), defined as stressful life events thought to be associated with the acculturation process. The process of learning a new language and culture may be stressful in its own right, as immigrants may feel a threat to their sense of self-efficacy. In addition, reconciling the norms and values of the new and the old culture may be difficult (Berry, 1997; N. Rodriguez, Myers, Mira, Flores, & Garcia-Hernandez, 2002), particularly when they conflict (Liebkind & Jasinskaja-Lahti, 2000; Rudmin & Ahmadzadeh, 2001). Discrimination as an immigrant and/or as a member of a racial minority group is also considered a component of acculturative stress (D. Chavez, Moran, Reid, & Lopez, 1997; Hwang & Ting, 2008; Suarez-Morales, Dillion, & Szapocznik, 2007; Vinokurov, Trickett, & Birman, 2002).

Much research in psychology has addressed the question of whether the ways in which immigrants acculturate may hold advantages for their mental health (e.g., Rogler, Cortes, & Malgady, 1991), but the findings are inconsistent across studies and immigrant groups. For example, assimilation has been found to have benefits for Asian immigrants. It was associated with less acculturative stress, with reduced depression for Korean immigrants in California (Ayers et al., 2009), and with better mental health indicators in several other Asian immigrant groups (Hwang & Myers, 2007; Schnittker, 2002; Yeh, 2003). However, assimilation has also been associated with poor mental health for Latino immigrants (Burnam, Hough, Karno, Escobar, & Telles, 1987; F. I. Rivera, 2007; Torres, 2010).[4]

Unfortunately, interpretation of findings from studies that use assimilation measures is difficult because they assume that acculturation to the host and to native cultures are mutually exclusive (Cuellar, Harris, & Jasso, 1980; Suinn, Knoo, & Ahuna, 1995). Items in such measures generally ask respondents to choose their cultural affiliation, so that those endorsing high acculturation to the host culture are simultaneously endorsing low attachment to their heritage culture. As a result, the negative impact of assimilation on psychological adjustment found in some studies may not be a function of American acculturation but rather of loss

4 Some authors have suggested that studies consistently show that acculturation is linked to negative mental health outcomes for Latino Americans (Escobar & Vega, 2001; S. Sue & Chu, 2003). However, this evidence comes largely from sociological studies that rely on place of birth and other demographic markers as proxies for acculturation (e.g., Burnham et al., 1987; Vega & Amaro, 1994). By comparing the mental health of different generations of immigrants, sociologists and epidemiologists assess the extent to which these groups differ and study the process of assimilation of immigrant groups over the course of generations. However, such proxy measures do not capture the psychological acculturation experience of individuals as explored in the psychological literature with bilinear measures and do not address the question of whether individual immigrants' acculturation is related to mental health outcomes.

of attachment to the native culture, which is confounded with American acculturation on these measures (Birman & Taylor-Ritzler, 2007; Schwartz et al., 2010).

Increasingly, researchers are using independent or bilinear measures of acculturation to both cultures and finding that immigrants benefit from acculturation to both the new and the native culture. For example, Y. Oh, Koeske, and Sales (2002) found that English language use and association with Americans reduced depression for Korean immigrants, as did maintaining Korean traditions. For Latino adolescents, acculturation to American culture was associated with reduced acculturative stress and increased self-esteem (Schwartz et al., 2007). Acculturation to the heritage culture also predicted increased self-esteem.

From a contextual perspective, there is no "best" acculturative style independent of context (Birman, Trickett, & Buchanan, 2005). Rather, whether a particular way of acculturating is beneficial depends on the kinds of cultural skills needed for successful adaptation within each particular microsystem. While some settings, such as workplaces or schools, are predominantly culturally American, others, such as an immigrant's ethnic neighborhood and home environment, are predominantly of the heritage culture. From this perspective, acculturation to both cultures provides access to different kinds of resources that are useful in different settings and that, in turn, are linked to positive mental health outcomes (Birman & Taylor-Ritzler, 2007; Oppedal, Roysamb, & Sam, 2004; Shen & Takeuchi, 2001). For example, Oppedal et al. found that for immigrant adolescents in Norway, increased competence in both their ethnic and host culture was linked to improvement in mental health over the course of a year. Specifically, those with higher ethnic cultural competence had more support from family, and those higher on host cultural competence had more support from classroom teachers and peers. In turn, family and classroom support were both related to mental health.

Increasingly, researchers are using independent or bilinear measures of acculturation to both cultures and finding that immigrants benefit from acculturation to both the new and the native culture.

Similarly, Birman & Taylor-Ritzler (2007) found that both Russian and American acculturation were predictors of reduced symptoms of distress for Soviet adolescent immigrants to the United States. While American acculturation had a direct effect, the impact of Russian acculturation on distress was through improving family adjustment.

In summary, acculturation to both heritage and host cultures provides immigrants with important cultural skills and repertoires that assist them across the culturally different microsystems. The implications are that settings and programs designed to assist immigrants with adapting to life in their new country must value both the need to learn the ways of the new culture and the need to maintain a connection with the old.

INTERGENERATIONAL DIFFERENCES IN ACCULTURATION

Family acculturation gaps extend across a variety of dimensions of acculturation and aspects of parent–child relationships, and immigrant parents and children increasingly live in different cultural worlds. Because parents are immersed predominantly in one culture and children in another, immigrant parents often know little of their children's lives outside the home. Immigrant parents are unfamiliar with how U.S. schools operate and may not have the English language skills to communicate with the school (Delgado-Gaitan, 1985, 1992, 1994; Grolnick, Benjet, Kurowski, & Apostoleris, 1997). Immigrant parents may also lack knowledge and connection to a variety of programs and resources available to their children outside or after school, and they may find it difficult to provide guidance and monitor their children's activities (Hao & Bonstead-Bruns, 1998; Mau, 1997).

For immigrant children, it can be difficult to live with the expectations and demands of one culture in the home and another at school. Children may not turn to their parents with problems and concerns, believing their parents do not know the culture and its institutions well enough to provide them with good advice or assistance. In addition, they may see their parents as burdened with the multiple stresses of resettlement and therefore psychologically unavailable (Birman, 2006; C. Suárez-Orozco & Suárez-Orozco, 2001). Extensive research with a variety of immigrant groups has

documented the problems caused by acculturation gaps in studies with Asian (Buki, Ma, Strom, & Strom, 2003; Costigan & Dokis, 2006; Farver, Bhadha, & Narang, 2002; Ho & Birman, 2010; R. M. Lee, Choe, Kim, & Ngo, 2000), Latino (C. R. Martinez, 2006; Schofield, Parke, Kim, & Coltrane, 2008; Smokowski, Rose, & Bacallao, 2008), and European (Birman, 2006) immigrant families.

SOCIAL TRUST AND CIVIC ENGAGEMENT

A marker of whether new immigrants feel welcomed and accepted in U.S. society is whether they are able to develop social trust and become civically engaged.

Social Trust

Democratic societies require citizens to interact regularly with each other for political, economic, and social reasons (Gardner, 2007; Hardin, 2002; Portes, 1998; Putnam, 2000). For this interaction to occur, individuals must be willing to extend a certain level of trust to those with whom they come in contact. Thus, social trust and civic participation are inextricably linked (Cook, 2001; C. Flanagan, 2003; Levine, 2008; Putnam, 2000). Without such trust, people will close themselves off from others as a means of protection. When people refuse to "talk to strangers" (Allen, 2004), democratic society suffers (Putnam, 2000; Uslaner, 2000). The current atmosphere of general social distrust in the United States (Putnam, 2000; Putnam & Feldstein, 2004) coincides with, and is complicated by, the highest levels of immigration since the last great wave of migration from 1880 to 1920.

The ways in which immigrant-origin youth are integrated into U.S. society and participate civically will no doubt affect the kind of society the United States will become in the next decades.

Civic Engagement

The ways in which immigrant-origin youth are integrated into U.S. society and participate civically will no doubt affect the kind of society the United States will become in the next decades (Stepick, Stepick, & Labissiere, 2008). To date, research on the civic engagement of immigrant-origin youth has been conspicuously sparse (Jensen & Flanagan, 2008). While civic engagement has historically been defined as voting, it is now conceptualized as a more complex and differentiated phenomenon. Definitions of civic engagement include attitudes toward political participation, knowledge about government, commitment to society, activities that help those in need, and collective action to fight for social justice (C. Flanagan, Gallay, Gill, Gallay, & Nti, 2005; Metz & Youniss, 2005; Morsillo & Prilleltensky, 2007; Torney-Purta, Barber, & Wilkenfeld, 2007). For immigrant individuals, such involvement in U.S. society, politics, and communities represents successful integration into the life of the country.

Some researchers, including Huntington (2004), have claimed that the immigrant population represents a threat to American civil society because of its alleged divided loyalties. Yet the few existing studies suggest these fears may be misplaced. Children born in the United States to immigrant parents show levels of civic engagement that "match or exceed those of natives" (M. H. Lopez & Marcelo, 2008, p. 66). Similarly, South Asian and Latino/a immigrant youth were found to be highly civically engaged and view this engagement as an important part of their identities (Jensen, 2008). Likewise, immigrant civic engagement was found to be similar to that of nonimmigrant college freshmen in a large comparative mixed-methods study (Stepick et al., 2008).

It is important to note that immigrant civic engagement may be underestimated in many studies because immigrant-specific forms of civic engagement, such as interpreting, translating, advocating, and filling out official documents, are often overlooked in traditional measures in the field (Jensen & Flanagan, 2008; Stepick et al., 2008). As is true of other marginalized groups, immigrants may become engaged in their own ethnic communities (Bedolla, 2000; Hill & Moreno, 1996; Rhoads, Lee, & Yamada, 2002) through acts of civil protest or by working in local community organizations rather than engaging with mainstream institutions where they may not feel welcomed.

Although non-naturalized immigrant adults cannot vote, they can be involved in an array of civic projects. With citizenship and second-generation status come greater civic and political participation (M. H. Lopez & Marcelo, 2008; Stoll & Wong, 2007). Not speaking English blocks participation in some activities for the first generation. On the other hand, bilingual competencies can serve as tools for civic engagement among

immigrant youth (Ramakrishnan & Baldasarre, 2004) who become involved as culture brokers.

Trust and civic engagement do not occur in a vacuum. Context and current events set the stage for trust and mistrust in all their empirical and conceptual iterations. It remains to be seen, for instance, how the general climate of distrust in the United States and the current crisis over immigration shape immigrant youths' civic trust and engagement. Research is needed on how the current political climate influences trust in the culture and future civic engagement. There is some evidence that immigrant adults tend to be generally optimistic (Kao & Tienda, 1995) and have an inclination to be appreciative of the opportunities afforded to them in their new land (Levitt, 2008; C. Suárez-Orozco & Suárez-Orozco, 2001). Indeed, Latino immigrant participants were more likely than nonimmigrant participants to trust the 2010 Census Bureau enumeration (M. H. Lopez & Taylor, 2010).

IN CONCLUSION

The large body of research on acculturation in psychology contradicts many of the assumptions in the popular culture about immigrant acculturation and assimilation. While some in the popular press suggest immigrants are not interested in acculturating to the American culture, evidence suggests that many immigrants learn English, participate in the culture, and adopt hyphenated American identities, and that doing so benefits them. In fact, "overacculturation" (Szapocznik et al., 1986) may be harmful for immigrant children who pick up not only the new language but also negative cultural norms that are out of sync with their families. Interventions designed to help immigrant youth maintain native language fluency while acquiring English prevent behavioral overacculturation (Szapocznik et al., 1986) and maintain a strong ethnic identity. They can be helpful in reducing family acculturative gaps and stress and improving immigrant mental health. Further, contrary to popular opinion, immigrants are engaged in civic activities and contribute to such activities even before becoming citizens.

POPULATIONS FACING UNIQUE CHALLENGES

This section addresses populations that face unique challenges through the migratory process. Their particular needs or viewpoints are typically overlooked or unrecognized in both the research scholarship and treatment interventions.

WOMEN AND GIRLS

In the past 2 decades, there has been a worldwide trend toward the "feminization" of migration, with more women migrating than men. In 2009, the U.S. Census estimated there were equal distributions of foreign-born men and women (U.S. Census Bureau, 2009b). Women, however, tend to have higher rates of legal migration (52% vs. 48% in 2004), while men are more likely to be unauthorized (58% vs. 42%) (Fry, 2006). In 2008, immigrant women were twice as likely as immigrant men to be widowed, divorced, or separated; were less likely than immigrant men to have a bachelor's or an advanced degree; and were more likely than immigrant men to live in poverty (Migration Policy Institute, 2009).

One salient challenge that immigrant women face involves changing gender roles and conceptualizations of sexuality. As gender roles can vary significantly between country of origin and the United States, women sometimes experience increased sexual freedom and are less likely to adhere to traditional roles, but at other times they may feel oppressed by the demands of the new cultural context (Espín, 2006; I. López, Dent, Ecosto, & Prado-Steiman, 2011). For example, many women report feeling burdened by the demands of family life without the support of extended family in the country of origin. For many lesbian and bisexual women, relocating to the United States may provide an increased sense of freedom and more opportunities to openly express and explore their sexual orientation. However, they may continue to feel vulnerable and marginalized in both mainstream society and their respective ethnic communities (Espín, 2006; I. López, Dent, et al., 2011).

While many immigrant women feel empowered when they adopt more egalitarian roles in the United States (Morash, Bui, Zhang, & Holtfreter, 2007), they are also challenged by increased stress within their family units as gender roles become redefined. Changes in gender roles not only shape family dynamics but also can pose a serious risk to immigrant women. Several studies highlight the risk of violence against immigrant women fostered in patriarchal family structures by disagreements about gender roles and family life (Ahmad, Riaz, Barata, & Stewart, 2004; Morash et al., 2007). Furthermore, women may be reluctant to seek help for interpersonal violence situations for various reasons, such as stigma associated with abuse within the ethnic community; lack of awareness of where to seek help; limited financial resources; anxiety about seeking help from professionals not knowledgeable about their cultural values; a wish to preserve close family ties; cultural and religious beliefs about divorce; and fear related to loss of immigration status, deportation, and separation from their children (Tummala-Narra, in press).

Stress within the family is sometimes compounded by experiences of multiple forms of discrimination outside the home, including sexism, racism, ageism, classism, and homophobia. For example, in the case of Muslim immigrant women, ongoing scrutiny in the media and mainstream society more broadly concerning women's dress and religious beliefs perpetuate negative stereotypes. In fact, research indicates that Muslim women who cover their hair report more discrimination than those who do not (Sirin & Fine, 2008). With respect to policy, the 2010 Arizona immigration legislation is an example of a xenophobic policy that poses a danger to women immigrants, who are vulnerable to interpersonal and political violence (e.g., rape, physical assault, and separation from their children), lack access to physical health care, and fear detention and deportation. This is particularly true for Latina immigrants, who are at an increased risk for continued exploitation by police and immigration authorities in U.S. states bordering Mexico (Comas-Díaz, 2010; Tummala-Narra, in press).

Immigrant mothers tend to be highly motivated to provide new opportunities for their children. This is also true of immigrant mothers who work in the new country to help provide financially for their children who still reside in the country of origin (Paris, 2008). Many immigrant women become the carriers of cultural and spiritual traditions for their families. At the same time, the transmission of these traditions can be complicated when immigrant mothers do not have regular communication with their mothers or maternal caregivers who live in the country of origin. Additionally, immigrant mothers may contend with conflicting norms concerning the role of mothers in their children's lives, such as Western conceptions of healthy attachment rooted in values of individualism compared with collectivistic values of interdependence within the family.

Paralleling the trajectories of immigrant women, immigrant adolescent girls tend to develop stronger connections with their ethnic heritage and communities when compared with boys, who may be more concerned with overcoming social inequalities within the dominant culture (C. Suárez-Orozco & Qin, 2006). During adolescence, parents also tend to monitor immigrant girls more closely than boys (C. Suárez-Orozco & Qin, 2006).

Immigrant mothers may contend with conflicting norms concerning the role of mothers in their children's lives, such as Western conceptions of healthy attachment rooted in values of individualism compared with collectivistic values of interdependence within the family.

Immigrant girls and women also adapt to changing body ideals. While body image can be important for both men and women, it has been found to be disproportionately associated with mental health problems in women (Grabe & Hyde, 2006). Immigrant women are often faced with new norms concerning physical features such as skin color, hair texture, and eye shape after moving to the United States, all of which are rooted in racial and political histories of different ethnic groups. These new norms concerning the body are not only relevant to how immigrant women's bodies may become "raced" but also can have important implications for acculturation, cultural identity, and racial identity (Tummala-Narra, 2007b). For example, in one study, immigrant Latinas with darker skin were found to experience lower self-esteem, lower feelings of attractiveness, and a desire for lighter skin color when compared with U.S.-born Latinas (Telzer & Vazquez Garcia, 2009).

Despite the numerous types of stress that immigrant women face, their participation in and contribution to their families, communities, and broader society raises important questions about stress, coping, and resilience. Future research can investigate how immigrant women negotiate contradictory expectations concerning gender, race, ethnicity, and sexual orientation within their ethnic communities and mainstream contexts. Additionally, future studies can examine issues particularly salient to immigrant women, such as discrimination, parenting, family and peer relationships, interpersonal and political violence, body image, employment, and academic and professional development.

UNDOCUMENTED IMMIGRANTS AND THEIR CHILDREN

Undocumented immigrants are those who live in the United States without legal authorization to do so. These individuals are not U.S. citizens, do not hold current permanent resident visas, and have not been permitted admission under a specific set of rules for longer term residence and work permits (Passel & Cohn, 2009). During the boom economic years in the last quarter of the last century and the coinciding period of deregulation, the undocumented immigrant population grew dramatically from less than one million in 1980 to a peak of nearly 12 million in 1996 (Hoefer et al., 2009). Between 2007 and 2009, however, the undocumented population declined by one million, coinciding with the economic downturn (Hoefer et al., 2009; Passel & Taylor, 2010). The current estimate of the undocumented population is 10.8 million.

Approximately 19% entered the United States prior to the 1990s, 44% entered during the 1990s, and another 37% have entered since 2000 (Hoefer et al., 2009). An estimated 60% arrive "uninspected" across the U.S. southern or northern borders, and an estimated 40% are "visa overstayers" (Hoefer et al., 2009). It is estimated that 8.5 million undocumented immigrants in the United States are from the North

American region (Mexico, Canada, Central America, and the Caribbean), followed by 980,000 from Asia and 740,000 from South America (Hoefer et al., 2009). Approximately 1.1 million undocumented immigrants arrived in the United States as young children, were raised and educated in this country, and are aging into adulthood as undocumented persons. All told, undocumented immigrant adults and children make up approximately 4% of the total U.S. population (Passel & Taylor, 2010).

Undocumented immigrants are more likely than their authorized counterparts to work full time (Mather, 2009), but their jobs are low paying, often below minimum wage, and unstable (Yoshikawa, 2011). They are most likely to work in what have been termed dangerous, dirty, and demanding jobs (Cornelius, 1994). It is worth noting that immigrants seek work opportunities in the United States to support their families. A recent interview study (DeLuca, McEwen, & Keim, 2010) of undocumented immigrant men who were returned to Mexico after temporarily working in the United States indicated that these men took risks inherent in crossing the U.S.–Mexico border for the financial sake of their families rather than for their own individual needs.

Undocumented students face particular struggles as they move up the educational ladder. Some leave school. Others stay but find access to college limited, with few choices or funding opportunities. . . . Once these students graduate from high school, there are no legal work options for them, nor can they drive, vote, or participate in the society in which they grew up.

Citizen Children of Undocumented Immigrants

The contentious debate about "illegal immigration" and immigration policy has often failed to take into account the children of undocumented parents (Motomura, 2008; C. Suárez-Orozco, Yoshikawa, Teranishi, & Suárez-Orozco, 2011; Yoshikawa, 2011). Because the undocumented immigrant population disproportionally tends to be young adults with high birth rates, their children make up a large share of both the newborn population (8%) and the school-age population (7%) (Passel & Taylor, 2010). Seventy-nine percent of the children of undocumented immigrant adults are citizen children, as the 14th Amendment grants them automatic citizenship (Passel & Taylor, 2010). Notably, more than 4 million citizen children live in homes with undocumented parents, and another 1.1 million children are undocumented themselves. Most immigrant children live in mixed-citizen-status families whereby some members are citizens and others are not (Passel & Taylor, 2010). This creates complicated dynamics and ambivalent relationships within the family (C. Suárez-Orozco, Yoshikawa, et al., 2011). Although children who grow up in homes with undocumented parents are more likely to live in two-parent families, they are also more likely to live in poverty because their parents work in poorly remunerated and precarious jobs (Yoshikawa, 2011). These citizen children are less likely to be enrolled in programs that could help to foster their early learning (e.g., preschool) or to have access to health care (Yoshikawa, 2011).

Undocumented students face particular struggles as they move up the educational ladder (C. Suárez-Orozco, Singh, Abo-Zena, Du, & Roeser, 2012; C. Suárez-Orozco, Yoshikawa, et al., 2011). Some leave school. Others stay but find access to college limited, with few choices or funding opportunities (R. G. Gonzáles, 2009). Once these students graduate from high school, there are no legal work options for them, nor can they drive, vote, or participate in the society in which they grew up (Abrego, 2006; R. G. Gonzáles, 2009; C. Suárez-Orozco, Yoshikawa, et al., 2011; M. Suárez-Orozco, 2009; Yoshikawa, 2011).

Immigration Laws and Immigrant-Origin Children

While at first glance, U.S. immigration law appears oriented toward advancing children's interests and family unity through a system of family-sponsored immigration, upon closer inspection, parent–child relationships receive favored treatment only if the parent holds legal immigration status. Though myths that parents are afforded easy and unwarranted pathways to U.S. citizenship through their U.S. citizen children stubbornly persist in public discussion, these are unfounded. Although citizen and legal permanent resident parents can petition for their children, the converse is not true; children may not petition for their parents until they have reached the age of 21 (Anderson, 2010; Thronson, 2008).

An asymmetrical devaluation of children in immigration law extends to other aspects of the family-sponsored immigration law as well. Since 1996, for example, U.S. immigration law has included provisions barring the reentry of people who leave the United States for 3 years after remaining here unlawfully for periods of more than 180 days (Thronson, 2008). Individuals who remain in the United States unlawfully for a year or more and then leave are barred from reentry for 10 years (Thronson, 2008). Recognizing the hardship that a bar to admission for 3 or 10 years can impose, immigration law provides for a "waiver on grounds of inadmissibility" by establishing that it would result in hardship to family members (Thronson, 2008). Under the terms of the waiver provision, however, only hardship faced by adult family members, specifically spouses and parents, is considered; hardship to children is considered statutorily irrelevant to the waiver process (Thronson, 2008).

Individuals who face removal proceedings before an immigration court (who can demonstrate physical presence in the United States for 10 years as well as good moral character) may apply for cancellation of the removal if they establish that removal would cause "exceptional and extremely unusual hardship" to a legal permanent resident or U.S. citizen spouse, parent, or child (Thronson, 2004). While hardship to children is considered in this form of immigration relief, the standard is remarkably high and difficult to satisfy. To qualify, parents must demonstrate hardship to children "substantially different from, or beyond that, which would normally be expected from the deportation of an alien with close family members here" (Thronson, 2004).

This legal standard is extremely difficult to establish, however. Previous legal appeals have established that "[d]eportation rarely occurs without personal distress and emotional hurt" (cited in Thronson, 2010). Arguments that hardship will result from children accompanying deported parents abroad are equally difficult. Diminished access to education, health care, and economic opportunities for U.S. citizen children are common results of deportation and thus do not meet the "exceptional and extremely unusual hardship" standard (Thronson, 2010). The Board of Immigration Appeals considers the decision to leave the child in the United States to be a matter of parental choice, not as a result of the parent's deportation (Thronson, 2010).

Undocumented parents can be and are deported during their children's childhood; indeed, the parents of more than 100,000 citizen children have been deported over the last decade (U.S. Department of Homeland Security, 2009). Immigrant children and youth in households with undocumented members often live in fear of being separated from family members if they or a relative are apprehended or deported. This psychological and emotional duress can take a significant toll on the psychological experiences as well as the health of children growing up in these circumstances (see Chaudry et al., 2010, for details).

Notably, assessments by psychologists can play a critical role in establishing requisite hardship. In keeping with the statutory standard above, such assessments should not rely on boilerplate evaluations of the harm that routinely would be expected from family separation or child relocation. Successful assessments must highlight the uniqueness of the situation that each family faces, drawing on particular challenges to adjustment that families and individuals would face if forced to separate or relocate (see Thronson, 2004, 2008, for more on this topic; more information relative to such issues is found in the Assessment in Forensic and Legal settings section).

Unaccompanied Minors

While every year 80,000 unaccompanied immigrant children seek entry to the United States, only a small fraction of those children remain in the country—most are deported within a span of 72 hours (Littlefield, 2005). In any given year, 5,000–6,000 "unaccompanied alien children" enter the custody of the Office of Refugee Resettlement (ORR), and in 2004, 6,200 children entered federal custody (Littlefield, 2005). These youths have a median age of 16 and typically originate from the following countries: Honduras (30%), El Salvador (26%), Guatemala (20%), Mexico (10%), Brazil (3%), and China (2%) (Littlefield, 2005). Most children are detained by U.S. Immigration and Customs Enforcement (ICE) when they attempt to cross a port of entry. A small number are discovered after the death of a parent or guardian, when they encounter child abuse or neglect, attempt to work, or are arrested (Littlefield, 2005).

Unaccompanied minors have two legal options: either apply to remain in the United States or seek an order of voluntary departure to avoid incurring a future penalty. Based on their circumstances, minors wishing to remain in the United States can apply for asylum or a visa. To meet the Immigration and Nationality Act definition of a refugee, a child must prove fear of persecution on the basis of race, religion, nationality, or membership in a social/political group and the source of the persecution must be

the government or a group the government cannot or does not control (Littlefield, 2005). This is a difficult standard to prove for both adults and children, and meeting these asylum criteria is nearly impossible.

For many unaccompanied children, especially those from Central and South America, economic hardship, not persecution, led to their migration (Littlefield, 2005). An option for some of these children is to prove "abuse, neglect, or abandonment" and show that a return to their home countries is not in their best interest. They can apply for a special immigrant juvenile visa that enables them eventually to obtain permanent legal residence and naturalize after 5 years (Littlefield, 2005). While waiting for a hearing before an immigration judge, unaccompanied children are housed in federally funded care as determined by ORR. These children can be held in a variety of places, including foster care, group homes, transitional housing, mental health centers, detention facilities, juvenile and adult jails, and locked hotel rooms (Littlefield, 2005). Though ORR attempts to reunify unaccompanied children with relatives and most leave federal custody within 45 days, concerns regularly emerge about the lack of legal representation and conditions of detainment for unaccompanied minors (Littlefield, 2005).

Victims of trafficking have limited or no access to structural supports that can provide them with physical and psychological safety and are subsequently trapped in cycles of exploitation.

Victims of Human Trafficking

Human trafficking refers to the illegal trade of human beings through the use of coercion and deception with the purpose of sexual and/or labor exploitation, and as such, constitutes a type of modern day slavery (Bernat & Zhilina, 2010). Human trafficking violates human rights and is typically rooted in economic deprivation and political instability, as well as in gender inequality (Bernat & Zhilina, 2010; Blackburn, Taylor, & Davis, 2010). Men, women, and children can become victims of trafficking through manipulation by traffickers who promise them opportunities for education and employment (Adepoju, 2005). Sex trafficking victims, many of whom have previously experienced sexual and physical violence, are led to believe they can escape this violence by leaving their homes (Bernat & Zhilina, 2010).

On arriving in the United States, however, victims of trafficking have limited or no access to structural supports that can provide them with physical and psychological safety and are subsequently trapped in cycles of exploitation. Many are working to pay off human smugglers or recruitment agencies in a form of indentured servitude that can last for many years. Immigrant adults from many countries can be caught in these kinds of exploitative schemes—from Chinese garment workers in New York City, to Mexican domestic workers across the country, to Filipino teachers recruited to teach in the public schools (Southern Poverty Law Center, 2011). The United States is now among the top destinations for human trafficking victims, with reports of trafficking in over 90 cities (Hepburn & Simon, 2010). While various types of exploitation occur in human trafficking, sexual exploitation is a growing concern.

A particularly vulnerable group is the growing number of women and children who are brought to U.S. destinations where there is a demand for prostitution (e.g., military bases, tourist and conventions sites, and migrant communities) (Ugarte, Zárate, & Farley, 2004). These sexually exploited women are reluctant to seek medical or psychological services for various reasons, including lack of financial resources, limited ability to speak English, lack of understanding of the criminal justice system, fear of being reported to immigration authorities, and fear their traffickers will kill them or their families (Bernat & Zhilina, 2010). They also fear returning to their countries of origin, where they might face rejection or be unable to readjust to their previous cultural surroundings. Their isolation from supports in the United States and the country of origin and their repeated experiences of violation place these women at high risk for physical and psychological stress (Bernat & Zhilina, 2010). Interventions that are trauma-informed and culturally responsive are sorely needed for these exploited women and children.

Migrant Workers and Day Laborers

Migrant farm workers and day laborers are a particularly vulnerable immigrant group, as most are not authorized to work in the United States. Because there is not a census of farm workers, farm labor researchers draw on a number of data sources to estimate the number of farm workers. For example, data from a combination of sources, including the Census of Agriculture, which was last conducted in 2007,

can be used to estimate that there are approximately 1.4 million crop workers and nearly 430,000 livestock workers (Martin, 2009). Another study has estimated that there are approximately 3 million migrant and seasonal farm workers in the United States (Larson & Plascencia, 1993); an estimated 78% are men, 71% are foreign-born, and the majority were born in Mexico (U.S. Dept. of Labor, 2009). They migrate from one rural location to another in search of agricultural work, typically have low levels of education, live below the poverty level in substandard housing, are exposed to stressful working conditions, and experience discrimination and abuse from employers and social and geographical isolation (Magaña & Hovey, 2003). They also experience many health challenges, including infectious diseases, chemical and pesticide-related illnesses, dermatitis, heat-related illnesses, respiratory conditions, musculoskeletal disorders, traumatic injuries, reproductive and child health problems, tooth decay, cancer, and lack of access to health care (Hansen & Donohoe, 2003).

Day laborers, as distinct from migrant workers, typically live in urban and suburban settings; the vast majority are men (Duke, Bourdeau, & Hovey, 2010). In a national study, 97% were foreign-born and almost 75% were undocumented (Valenzuela, Theodore, Melendez, & Gonzalez, 2006). Work is not steady, and most day laborers live at or below the poverty level (Valenzuela et al., 2006). Approximately 25% had experienced homelessness in the past year, and almost 40% reported problems with alcohol (Duke et al., 2010).

In a study of day laborers in San Francisco, participants reported working an average of 15 hours a week and earning an income of $145 per week (Duke et al., 2010). They are employed mainly as construction workers, gardeners/landscapers, painters, roofers, and drywall installers (Valenzuela et al., 2006). Day laborers have few of the traditional legal rights established for most workers, including being paid the wage originally agreed on and the expectation of workplace safety (Seixas, Blecker, Camp, & Neitzel, 2008). Almost half of all day laborers experienced at least one instance of wage theft in the 2 months prior to being surveyed, and 44% were denied food, water, or breaks while on the job (Valenzuela et al., 2006).

In a study of day laborers in Seattle, immigrant workers were 1.5–2 times more likely to experience exposure to hazardous conditions and had a higher rate of injury (Seixas et al., 2008). Workplace injuries are common, with 20% of day laborers having suffered a work-related injury. More than half of those injured in the past year did not receive medical attention (Valenzuela et al., 2006). Many workers did not report concerns to employers for fear of losing their jobs, a lack of choice in work due to undocumented status, and an awareness that employers hired them believing they would be easier to exploit (Seixas et al., 2008).

Migrant workers and other rural immigrants are at a distinct disadvantage for a number of reasons. One primary reason is that settlement patterns have changed dramatically in recent years to include regions that were previously relatively homogenous (Massey & Capoferro, 2008). California, for instance, has a long migrant worker history that has included rural areas, but migrants are now moving to areas across the country that lack that history. It is notable that immigrants tend to work in dangerous industries, often located in rural settings (such as logging, fishing, hunting, trapping, and agriculture) and are thus at high risk for workplace injuries (Orrenius & Zavodny, 2009). Rural areas are also often poorly equipped to provide the infrastructure needed to support these new populations. Infrastructure can include churches, bilingual school programs, social support networks, and access to adequate mental health services (Grzywacz, Quandt, et al., 2010).

One concern for many rural immigrant populations is that their relatively recent arrival reflects a dramatic cultural shift for the rural populations. Thus, it is unknown if cultural and social support systems often found in urban areas are developing in rural areas. Because of their relatively recent arrival, it is also unknown how well immigrants are received by the local populations and how that influences immigrants' attempts at cultural integration. Thus, most of the research regarding immigrant populations has derived from the major research institutions, which tend to reside in more urban settings. More research is therefore needed that addresses the unique contexts provided by rural settings, both in terms of access to care and in their receptive contexts.

Migrant workers and day laborers face a host of clear challenges. The mobile lifestyle, language barriers, insecure job and undocumented status, poverty, discrimination, social isolation, and long working hours are highly stressful experiences and are associated with a number of negative outcomes, including depression, anxiety, and substance abuse (Finch, Catalano, Novaco, & Vega, 2003; Hiott, Grzywacz, Davis, Quandt, & Arcury, 2008; Kiang, Grzywacz, Marin, Arcury, & Quandt, 2010; Kim-Godwin & Bechtel, 2004). The majority of migrant farm workers report not having a support system (Kim-Godwin & Bechtel, 2004).

Notably, in 2000, approximately 650,000 children and adolescents were thought to accompany their parents in their seasonal work (Huddle, 2000). Not surprisingly, these children, many of whom are U.S.-born citizens, are particularly vulnerable to both educational and health risks (Green, 2003). As one might predict, contextual stressors like crowding increase depressive symptoms as well (Grzywacz, Quandt, et al., 2010). Simply having a place to put one's belongings appears to help reduce the stress of crowding. Mental health problems are buffered by strong social support systems and are exacerbated by acculturative stress, particularly for recent migrant families.

REFUGEE AND ASYLUM-SEEKER POPULATIONS

While the numbers of refugees and asylum seekers are relatively small compared to the overall number of arriving immigrants, these populations face multiple stressors that can have an impact on their mental health. Refugees are admitted to the United States because of humanitarian concerns after being forced from their homes by war and/or persecution based on their race, religion, membership in a political or social group, or political opinions. Since 1975, the United States has resettled over 3 million refugees, with annual admissions figures ranging from a high of 207,000 in 1980 to a low of 27,110 in 2002 (U.S. Department of Homeland Security, 2010). Current U.S. refugee admission policies focus on "warehoused populations"—those who have been living for extended periods of time in refugee camps with no foreseeable hope of repatriation or resettlement (Negash, 2010).

The experience of refugees and asylum seekers differs from that of other immigrants. Refugees leave their countries of origin involuntarily in the context of war and political upheaval and experience traumatic events in the process (APA, 2010c). They experience loss of loved ones and of their native country without the possibility of return, a process referred to as "cultural bereavement" (Eisenbruch, 1988). A legacy of loss and exposure to trauma accompanies already complex acculturation and adjustment processes and is associated with psychological symptoms (Masuda, Lin, & Tazuma, 1980). Survivors of torture and those who had been in detention facilities have especially high mental health needs and may require long-term treatment (Carlsson, Mortensen, & Kastrup, 2005; Ehntholt & Yule, 2006; Robjant, Hassan, & Katona, 2009). Ongoing separation from loved ones who continue to be in danger also predicts psychological symptoms (Nickerson, Bryant, Steel, Silove, & Brooks, 2010). As a result, refugee adults and children are at particularly high risk for mental health problems (APA, 2010c), including posttraumatic stress disorder (PTSD), depression, anxiety, psychosis, and dissociation (Keyes, 2000).

While premigration trauma is an important factor in refugee mental health, particularly in the early stages of resettlement (Beiser, 2006), postmigration factors also have an important impact (Birman & Tran, 2008). Postmigration factors such as accommodation in private and permanent housing and economic opportunity have been found to be associated with better mental health outcomes, although higher levels of education and socioeconomic status prior to displacement were associated with worse outcomes, which may reflect loss of status (Porter & Haslam, 2005). Social support, particularly from others from the same refugee community (Simich, Beiser, & Mawani, 2003), and English-language use (Ngo, Tran, Gibbons, & Oliver, 2001) and fluency (Beiser, 2006) were also found to have a positive impact on mental health. Experiencing discrimination, on the other hand, can have negative mental and physical health consequences (APA, 2010c; Kira et al., 2010).

LESBIAN, GAY, BISEXUAL, AND TRANSGENDER (LGBT) IMMIGRANTS

The United States has a history of denying entry to immigrants based on race, ethnicity, gender, and sexual orientation (Howe, 2007). In 1990, U.S. immigration law changed, no longer denying entry to individuals based solely on their sexual orientation (Rank, 2002). However, many obstacles still remain, which can make immigration especially challenging for LGBT individuals.

Asylum Seekers

Homosexual behavior is illegal in 76 countries. In 7 of these countries, it is punishable by death (Iran, Mauritania, Saudi Arabia, Sudan, Yemen, and some parts of Nigeria and Somalia; International Lesbian, Gay, Bisexual, Trans and Intersex Association, 2010). In 1994, U.S. asylum policy changed to include persecution based on sexual orientation (Rank, 2002). Psychologists may encounter clients who have been persecuted or tortured because of their sexual orientation or gender identity in their country of origin and should be prepared to recognize this issue and related client needs (Heller, 2009; Pepper, 2005).

The process of seeking asylum as an LGBT person is complicated. Yoshini (2006) coined the phrases "covering" and "reverse covering" to describe the experience of LGBT asylum seekers. Covering refers to minimizing "traits that visibly mark one as having a disfavored or disadvantaged identity" (Heller, 2009, p. 296), whereas reverse covering refers to an individual's putting his or her sexual identity on display. LGBT asylum seekers must often do both—covering in their country of origin and then reverse covering when seeking asylum to convince decision makers they are in fact LGBT and would be persecuted in their home country (Heller, 2009).

This transition can be difficult for asylum seekers who previously hid their sexual or gender identity for safety reasons (Heller, 2009). The expectation that LGBT asylum seekers should reverse cover in the United States ignores the fact that they may also face discrimination in their ethnic immigrant communities and in mainstream U.S. society if others are aware of their LGBT identity (Heller, 2009). In keeping with the *Guidelines for Psychological Practice With Lesbian, Gay, and Bisexual Clients* (APA, 2011) and in particular with Guideline 1 ("Psychologists strive to understand the effects of stigma [i.e., prejudice, discrimination, and violence] and its various contextual manifestations in the lives of lesbian, gay, and bisexual people"), psychologists who work with LGBT asylum seekers should be aware of the stress related to covering and reverse covering.

Binational Couples

There are currently 25 countries that recognize same-sex couples for immigration purposes, but the United States is not one of them (Konnoth & Gates, 2011). While a married U.S. citizen can sponsor a different-sex spouse for immigration, same-sex partners or spouses of U.S. citizens and permanent residents are not recognized as family members, even if they get married in a state or country where same-sex marriage is legal (U.S. General Accounting Office, 2004). This government-sanctioned exclusion means that same-sex binational couples must separate, obtain a "green card" for the non-U.S. partner through other means (e.g., employment), live in the U.S. illegally, or leave the United States and immigrate to a country that permits both partners to live there (Human Rights Watch/Immigration Equality, 2006). The majority of same-sex binational couples (53%) are unable to pursue permanent residency as a couple in either partner's country of origin (Konnoth & Gates, 2011).

As of 2010, there are an estimated 79,200 same-sex couples in the United States with at least one partner who is not a U.S. citizen, representing 12% of all same-sex couples counted in this country (Konnoth & Gates, 2011). Of these, approximately 28,574 are binational couples, 11,442 are dual noncitizen couples, and 39,176 are dual citizen couples with at least one naturalized partner (Konnoth & Gates, 2011). These numbers do not take into account couples who are separated because of immigration problems, did not disclose their relationship status due to fear of being reported for overstaying or not having proper documentation, or left the United States to remain together. Thirty-nine percent of female binational couples and 25% of male binational couples are raising an estimated 17,000 children (Konnoth & Gates, 2011), demonstrating that current immigration policy does not only harm LGBT individuals but their families as well.

While a married U.S. citizen can sponsor a different-sex spouse for immigration, same-sex partners or spouses of U.S. citizens and permanent residents are not recognized as family members.

Sixty-four percent of noncitizens in same-sex binational relationships are ethnic minorities; of those, 54% are Latino/a and 14% are Asian Pacific Islander. Mexico is the home country for 25% of noncitizens in same-sex binational couples, followed by Canada with 8% and the United Kingdom with 6% (Konnoth & Gates, 2011). U.S. citizens in same-sex binational relationships are 54% White, 33% Latino/a, 7% Asian Pacific Islander, and 3% African American (Konnoth & Gates, 2011). A bill that would recognize same-sex partners for immigration was first introduced in Congress in 2000 (Human Rights Watch/Immigration Equality, 2006). Since it was first introduced over a decade ago, countless same-sex binational couples have been separated or have made the difficult decision to leave the United States.

Homophobia in Immigrant Communities

Just as homophobia exists in mainstream U.S. culture, it also exists in immigrant communities (Espín, 1999). Immigrants

often rely on their ethnic immigrant community as a safe harbor, but for LGBT immigrants it can be inhospitable (Boulden, 2009). In a sample of gay immigrant Latinos, 84% grew up hearing that homosexuals are not normal, 68% were made fun of for their sexual orientation as children, and 59% had pretended to be straight in order to be accepted (Bianchi, Zea, Poppen, Reisen, & Echeverry, 2004). In a sample of mostly immigrant LGBT South Asians, 70% experienced homo/trans/biphobia in their ethnic community, 77% felt they were living a double life, 72% felt lonely or isolated, and 45% experienced suicidal thoughts (Choudhury et al., 2009).

While LGBT immigrants and nonimmigrants reported equal access to mental health services, nonimmigrants were twice as likely to use them, indicating that many LGBT immigrants are not accessing care (Choudhury et al., 2009). In a study of mostly immigrant Asian gay men, support from family and gay friends about discrimination had a protective effect against risky sexual behavior (Yoshikawa et al., 2004).

While in mainstream U.S. LGBT culture there is pressure to "come out," this can be more complicated for LGBT immigrants. In immigrant communities, coming out is often blamed on "America's excessive freedoms" (Fisher, 2003). Language complicates matters—for example, when there are no words for "gay" in some languages (Boulden, 2009). In a sample of mostly immigrant LGBT South Asians, 80% said most or all of their friends knew their sexual orientation, compared to 54% who said most or all immediate family knew, and 18% who said most or all extended family knew (Choudhury et al., 2009). Not only do LGBT immigrants potentially face risks by coming out in an immigrant community, but this action may also negatively affect their families (Boulden, 2009). Conversely, some who come to the United States alone may feel a sense of liberation to be able to live their lives openly without worrying about stigma impacting their families or rejection from family back home (Bianchi et al., 2007).

LGBT immigrants, particularly from racial/ethnic minorities, may not feel welcome in mainstream gay environments, where many LGBTs turn for support. In studies of mostly immigrant LGBT South Asians (Choudhury et al., 2009) and gay Latinos (Ibañez, Van Oss Marin, Flores, Millet, & Diaz, 2009), more than half reported experiencing racism in the LGBT community. In a sample of gay immigrant Latinos, 44% were turned down for sex because of their race/ethnicity (Bianchi et al., 2004). Feeling disconnected from the LGBT community because of discrimination or language barriers may put LGBT immigrants at risk. Some gay immigrant Latinos, for example, reported using public sex venues to find sex partners, which does not require communicating in English (Bianchi et al., 2007) but may then put them at increased risk for sexually transmitted infections.

IMMIGRANTS WITH DISABILITIES

The experiences of individuals with physical disabilities have largely remained ignored until the past decade. Some factors constraining research on disabilities outlined by Olkin and Pledger (2003) include the underrepresentation of minority individuals; significant problems with tests, measures, and norms; and a narrow range of research focus. Despite the lack of attention to contextual factors, including gender, age, ethnicity, sexual orientation, and socioeconomic class, new perspectives on disability recognize that people with disabilities belong to a minority cultural group (Mona, Romesser-Scehnet, Cameron, & Cardenas, 2006; Olkin & Pledger, 2003).

Immigrants with disabilities have unique struggles with discrimination, as they identify with multiple social groups (e.g., ethnic and disability communities) and may have more difficulty receiving social support (Block, Balcazar, & Keys, 2001). Views on disability also vary within immigrant groups, from negative or shameful to positive. Language barriers may impede communication, impacting immigrants' ability to understand disability rights in the United States, participate in individual education plans in schools, and advocate on behalf of a child with a disability (Lo, 2008; McHatton, 2007). There also may have been fewer opportunities for education and/or employment in the country of origin, in which case immigrant adults and children may arrive in the United States with fewer skills in educational and workplace settings (Xiang, Shi, Wheeler, & Wilkins, 2010).

Other differences between resources available in the country of origin and the United States may include the lack of assistive technology (AT) in the country of origin, contributing to a greater likelihood of secondary disabilities, and unfamiliarity with AT in the United States. When immigrants with disabilities relocate from contexts of poverty, victimization, and/or ostracism, they may need political asylum in the United States that does not

necessarily fit typical definitions of need (Burke & Lopez, 2009; Kirkbride & Jones, 2010).

There is also an increased risk of interpersonal trauma among immigrants with disabilities. For example, women and children with disabilities are 3 times as likely to have been sexually assaulted when compared with their peers without disabilities (Saxton, 2005). Abuse of people with disabilities can include neglect; interpersonal violence; prostitution; mercy killing; forced beggaring; social isolation; gender-specific violence; and condemnation to dangerous facilities, travel, and institutions (H. Brown, 2002). All contribute to mental health problems and further stigmatization.

Some studies have noted the importance of social support in coping with anxiety among immigrants with disabilities (Jarama, Reyst, Rodriguez, Belgrave, & Zea, 1998), with immigrants more likely than U.S.-born individuals to stigmatize disabilities (Saetermoe, Scattone, & Kim, 2001). Banks (2003) has noted the difficulties for families coping with disability and the ways in which sociocultural factors shape how family members conceptualize the meaning of disability. Research on immigrants with disabilities should seek to clarify the intersections of identification across different minority cultural groups, unique ways of approaching disability within specific immigrant communities, and pathways to social support and culturally competent mental health care.

IN CONCLUSION

The populations noted here face unique sets of challenges as they navigate their way into their new land. Many of their needs are unrecognized and as such may go untreated. Researchers should seek to document the specific needs of these underserved groups and work to develop appropriate interventions to suit these needs.

Looking at foreign-born versus U.S.-born populations across the life span reveals some interesting comparisons. According to the U.S. Census Bureau (2009a, 2009b, 2011c), most of the foreign-born population is found within the stage of adulthood (see **TABLE 1**). When the immigrant population is compared with the U.S.-born population, the immigrant population has less than one third the proportion of children. A comparison across regions of origin indicates that European immigrants have double the percentage of older adults than do other foreign-born groups and U.S. native groups, while Mexican immigrants have a much lower percentage of individuals over 65 years of age.

A review of the literature revealed a noticeable lack of studies with a life span perspective on immigrant populations; there is a small body of work on older adults and some research conducted with immigrant children and adults. Nonetheless, this report addresses the various stages of the life span through an ecological lens. We briefly examine the interactions of individuals and their environments, and the systems in which they operate, while recognizing the diversity of today's immigrants.

CHILDREN AND ADOLESCENTS

As noted previously, foreign-born children and adolescents make up a relatively small share of this age group nationally, but considering the first and second generations together, this group is now recognized to be the fastest growing sector of the child population. In 1970, immigrant-origin children (first or second generation) constituted 6% of children living in the United States. By 2010, nearly 23% of U.S. children had immigrant parents (16 million under the age of 18). By 2020, it is thought they will account for a third of the U.S. child population. Well over three quarters of these children are U.S. citizens (Mather, 2009), and these predominantly Latino and Asian families are driving the diversification of the United States (Hernandez, Denton, & Macartney, 2007). Despite their growing numbers, they have been largely ignored in the national conversation on immigration (Mather, 2009), in the

TABLE 1

ESTIMATES OF POPULATION DISTRIBUTION (%) BY LIFE SPAN

	LIFE SPAN			
POPULATION DISTRIBUTION	CHILDHOOD & ADOLESCENCE 0–19 YEARS	YOUNG ADULTHOOD 20–34 YEARS	ADULTHOOD 35–65 YEARS	OLDER ADULTHOOD 65+ YEARS
U.S.-BORN[a]	**27.4**	20.4	39.6	12.6
FOREIGN-BORN[b]	8.7	26.5	**52.8**	12.0
ASIAN	8.6	23.3	55.1	13.0
EUROPEAN	6.6	16.7	49.7	**27.0**
TOTAL LATIN AMERICAN	9.3	31.5	51.8	8.4
MEXICAN	10.5	34.3	49.6	5.8

Note. *These are the best available estimates based on the U.S. Census Bureau's (2009a, 2009b) American Community Survey. They are estimates only, as these tables claim 36,750,000 as the total number of foreign-born in the United States, whereas the most recent Census data indicate 39.9 million (U.S. Census Bureau, 2011c). Nonetheless, these percentages provide a sense of perspective (to be interpreted with caution).*

[a]Based on U.S. Census Bureau (2009a). [b]Based on U.S. Census Bureau (2009b).

psychological research literature (C. Suárez-Orozco & Carhill, 2008), and in clinical training (APA, 2007a).

Immigrant children demonstrate both resiliencies and vulnerabilities compared with their nonimmigrant peers. For example, children in immigrant homes are more likely than nonimmigrants to have parents who are married and work full time (Passel & Cohn, 2009). Many children in immigrant homes, however, are at greater risk for growing up in poverty, with 21% of immigrant-origin children living in poverty versus 17% in U.S.-born families, and 49% living in low-income homes versus 36% in U.S.-born families (Mather, 2009). Though their parents tend to be working, their jobs often pay below subsistence wages (Mather, 2009). Those whose parents are not proficient in English, do not have U.S. citizenship, have low levels of education, and have lived in the U.S. fewer than 10 years are the most likely to live in poverty (Mather, 2009). Poverty rates vary widely by country of origin. Children from India, the Philippines, China, Korea, Canada, and Europe are at the least risk, and those from Africa and the Caribbean are less likely to be at risk than U.S.-born Black children, while Latino and refugee children from Iraq, Somalia, Sudan, and Yemen are at greatest risk for poverty (Mather, 2009).

Immigrant Family Separations

For the first generation, the immigrant journey often results in serial migration and prolonged family separations (Mitrani, Santisteban, & Muir, 2004). A study of 400 immigrant newcomer early adolescents from China, the Dominican Republic, Haiti, Mexico, and Central America found that 75% spent between 6 months to 10 years apart from one or both parents during the migratory process (C. Suárez-Orozco, Bang, & Kim, 2011). Immigrant parents often have to make the difficult decision to leave their children behind with relatives for a period of time as they establish themselves (Foner, 2009).

Other examples of disrupted families due to migration include when upper-middle-class families from such places as Hong Kong and Taiwan send middle- and high-school students to study abroad as "astronaut kids," living with the mother while the father remains in the country of origin (Ong, 1999), or as "parachute kids," living with extended or fictive kin while both parents remain in the country of origin (Zhou, 2009). Another long-documented practice is sending children, such as unruly adolescents, back to the country of origin to be resocialized by their grandparents (R. C. Smith, 2005).

Increasingly, infants and toddlers are being sent back to extended family while parents remain in the United States to work, reuniting in the United States with their parents at school age (Bohr, Whitfield, & Chan, 2009; Gaytán, Xue, & Yoshikawa, 2006). In recent years, families with unauthorized parents have involuntarily been wrenched apart by workplace and in-home raids conducted by immigration authorities (Chaudry et al., 2010).

Separated families often desire reunification, which may take years, especially when complicated by financial hurdles and immigration regulations (Menjívar & Abrego, 2009). If children immigrate to a new country separately, parental contact during the separation period (e.g., letters, phone calls, or personal visits) contributes to the well-being of the children, but the separation–reunification processes can create negative psychological experiences for the children (C. Suárez-Orozco, Todorova, & Louie, 2002). The longer the separation, the more complicated the family reunification and the greater the likelihood that children will report psychological symptoms (C. Suárez-Orozco, Bang, & Kim, 2011).

YOUNG ADULTS

In 1970, approximately 4% of the young adult population between the ages of 18 and 34 were either first or second generation (Rumbaut & Komaie, 2010), while today almost 30% are of immigrant-origin (U.S. Census Bureau, 2007). This percentage is approximately a third higher than the total U.S.-born young adult population (20.4%). Most are second generation, but the first generation makes up a significantly high percentage (26.5%) and is particularly prevalent in this age group among Mexicans (34.3%). Nearly half of the foreign-born in the United States in this age group are unauthorized (Hoefer et al., 2009), which has implications for available opportunities (C. Suárez-Orozco, Yoshikawa, et al., 2011) (see Populations Facing Unique Challenges—Undocumented Immigrants and Their Children).

These young adults tend to be concentrated in particular states and urban centers. In California, 55% of young adults are first or second generation; in the New York metropolitan area, 56% of young adults are of foreign parentage; and in Miami and in Texas cities along the Mexican border, two thirds of young adults are of immigrant origin (Rumbaut & Komaie, 2010).

Transition to adulthood in the United States is marked in a number of ways, such as by moving out of the parental home, attending college, working full time, getting married, and having children (Setterson, Furstenburg, & Rumbaut, 2005). With more training required to enter the labor force and postponement of marriage until the mid- to late 20s, transition to adulthood in the United States is marked by development of individual character, self-reliance, and independence. For young adults in the Western middle-class world, this phase of "emerging adulthood" is often an age of intense self-focus and identity exploration in the areas of love and work, as well as a time of possibilities, optimism, and transformation accompanied by instability (Arnett & Tanner, 2006). In contrast, in many non-Western countries, adulthood is associated with interdependence, reliance on family, and a sense of obligation and responsibility to the family (Russell, Coughlin, El Walily, & Al Amri, 2005). Youth coming from less prosperous families are also more likely to see mutual family obligations as a responsibility of adulthood (Fuligni & Pedersen, 2002).

Using the 2008 Current Population Survey data, Rumbaut and Komaie (2010) found that the traditional markers of adulthood were not the same for immigrant and nonimmigrant generations:

- The first generation—the group that had often initiated the migration themselves—was most likely to have achieved the classic adult milestones of living away from the parental home (as their parents often remained back in the homeland), working, being married, and having children, but they were least likely to attend college.
- Second-generation young adults, on the other hand, were more likely to live with their immigrant parents, attend school and work part time, and postpone marriage and having children. They were able to minimize expenses by pooling collective resources, continuing to live in the parental home, and sharing housing and food expenses (Kasinitz et al., 2008). In addition, they often juggled other responsibilities, including working in a family business, contributing to family expenses, providing child and elder care, and translating for and aiding parents and extended kin in navigating medical and legal bureaucracies (Fuligni & Pedersen, 2002).
- By the third generation, they were largely independent and free from family responsibilities, leaving home and sharing expenses with roommates rather than family (Rumbaut & Komaie, 2010), and they could rely on parental support in emergencies, much like Western middle-class youth (Schoeni & Ross, 2005).

ADULTS

The majority of the U.S. population, immigrant and nonimmigrant alike, fall into the adult stage of development. A search of the literature found nothing at the intersection of immigration and adult development research or theory. We consider work transitions, parenting, and caregiving to be of particular importance for immigrants in this developmental group.

Work Transitions

Most immigrant adults come to the United States in search of employment opportunities, and many send income to family in their home countries (Menjívar, DaVanzo, Greenwell, & Valdez, 1998). The percentage of educated immigrants (ages 25–64) has risen from 19% with bachelor's degrees in 1980 to 30% in 2010 (M. Hall, Singer, De Jong, & Graefe, 2011). During this time, high-skilled workers increased from 19% to 29.6%, while low-skilled workers decreased from 39.5% to 27.8%. Almost half of high-skilled immigrants in the 100 largest metropolitan areas were overqualified for their jobs, and 11.3% were greatly overqualified.

High-skilled immigrants were also more likely to be underemployed than their U.S.-born counterparts (M. Hall et al., 2011). Skilled immigrant workers with professional backgrounds are not always able to continue in the line of work they performed prior to immigration. Many face underemployment with the disqualification of previously held work credentials and concomitant loss in status (Yakushko, Backhaus, Watson, Ngaruiya, & Gonzalez, 2008; Yost & Lucas, 2002). While low-skilled immigrants in large metropolitan areas are more likely to be employed than U.S.-born low-skilled workers, they have lower incomes (M. Hall et al., 2011). Immigrant adults who come to the United States with little formal education or training may find employment as domestic workers, hotel workers, garment workers, day laborers, or migrant farm workers (see Populations Facing Unique Challenges—Migrant Workers and Day Laborers). Zamudio and Lichter (2008) found that hotel managers preferred Latino/a immigrant workers over White or African American workers because they perceived Latinos/as as easier to control and willing to do hard work for less pay.

Immigrant workers may experience employer discrimination based on race, ethnicity, immigration status, and socioeconomic status (de Castro, Fujishiro, Schweitzer, & Oliva, 2006). They report that nonimmigrant workers receive better treatment and that there is a hierarchy among immigrant groups, with preferential treatment given in various contexts (de Castro et al., 2006). Some immigrant workers lack English proficiency, which affects their employment prospects. However, some are disadvantaged by their accents because some employers prefer certain accents to others. In a comparison of French- and Japanese-accented job applicants, those with Japanese accents fared worse in employment-related decisions, particularly for jobs with high communication demands, even after controlling for applicant understandability, while French-accented applicants were viewed as favorably as, or more favorably than, standard American English-accented applicants (Hosoda & Stone-Romero, 2010).

Employment difficulties have been found to impact immigrants' mental health. Loss of occupational status can lead to feelings of frustration, uselessness, and anger (G. Lee & Westwood, 1996). Employment difficulties have been associated with depression and anxiety (Grzywacz, Quandt, Arcury, & Marín, 2005) and are among the risk factors for perpetrating intimate partner violence (World Health Organization, 2002). Meaningful employment can help the immigrant adjustment process by decreasing feelings of isolation; contributing to the building of new social networks; and providing opportunities for new friendships, cultural learning, and development of English-language skills (Yakushko, Backhaus, et al., 2008).

Parenting and Caregiving

Being a parent in a new country can pose unique challenges and opportunities. An important goal for immigrant parents is increasing opportunities for their children. This is also true in the case of immigrants who, for financial reasons, leave their children in their country of origin (Paris, 2008). In cases of separation from children, parents may be at risk for psychological stress, including isolation, depression, anxiety, and substance abuse. Immigration often requires family members to change roles and often strains normative gender and generational hierarchies (Tummala-Narra, 2004). Further, separation from the usual country of origin supports (e.g., extended family and friends) can create further stress for parents and caregivers (C. Suárez-Orozco & Suárez-Orozco, 2001).

Another potential source of stress may be differences in what is considered "good parenting" by teachers, mental health providers, and parents. For example, Domenech Rodríguez, Donovick, and Crowley (2009) found that the majority of Latino immigrant parents did not fall into any of the four primary parenting styles recognized by the literature and instead fit best into a new category labeled "protective." This study calls into question the efficacy of mainstream parenting interventions for Latino immigrant parents if these parenting interventions are based on assumptions that are not valid for many Latino immigrant parents. Immigrants who simultaneously care for their children, their parents, and extended family members in the new country and in the country of origin face challenges in navigating multiple social and cultural contexts and tend to endure high levels of stress due to the breadth of their caregiving roles (Brownell & Fenley, 2009).

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OLDER ADULTS

Some immigrants have been in the United States for much of their lives and are aging into older adulthood. Others may return to their countries of origin in older adulthood or immigrate with their adult children. Many immigrant older adults are no longer in a position to enter the labor force, becoming dependent on their adult children (A. M. Miller, Sorokin, et al., 2006) and at times isolated from mainstream society due to difficulties with language, employment, new neighborhoods, and transportation (A. M. Miller, Birman, et al., 2009). Acculturation tends to occur slowly and not always in the expected direction. In one study of older immigrants from the former Soviet Union, English-language competence slightly increased at first and then declined the longer they lived in the United States (A. M. Miller, Wang, et al., 2009).

In a study of Korean elders, there was almost no loss of culture of origin over time, with most remaining strongly acculturated to their native culture (Jang et al., 2007). However, the few findings that exist suggest that isolation from American culture is harmful. For example, older Korean immigrant adults who were classified as separated, rather than integrated, experienced more mental health symptoms (Jang et al., 2007). A. M. Miller, Sorokin, et al. (2006) found that acculturation to the new culture was associated with less alienation. This in turn reduced personal and family stress and then reduced depression. Further, a perceived cultural gap between adults and children has been found to predict depression in older adults (Mui & Kang, 2006).

Among immigrant groups, older adults are the most vulnerable to mental health problems, with the exception of victims of warfare and torture (Pumariega, Rothe, & Pumariega, 2005). Studies of older immigrant adults from several countries of origin, including Korea, China, Mexico, and Russia/Eastern Europe, show they are at high risk for depressive symptoms, somatization, and a variety of traditional culture-bound syndromes (Black, Markides, & Miller, 1998; Mui, Kang, Chen, & Domanski, 2003; Stokes, Thompson, Murphy, & Gallagher-Thompson, 2002; T. Tran, Khatutsky, Aroian, Balsam, & Conway, 2000). For example, in a study of Soviet immigrant women over age 65, over 80% met criteria for depression (A. M. Miller, Sorokin et al., 2006).

In a study of older Mexican Americans, the prevalence of depression was 30.4% among immigrants compared with 20.5% among U.S.-born (H. M. González, Haan, & Hinton, 2001). The rate of depression in an older adult sample of diverse Asian immigrants was 40% (76% for Japanese, 64% for Vietnamese, 50% for Indian, 46% for Chinese, 24% for Koreans, and 15% for Filipino) (Mui & Kang, 2006). Considering that prevalence of depression in the general older adult population is reported to be 15% to 20% (Gallo & Lebowitz, 1999), these statistics are alarming. Notably, the expression of distress in older immigrant adults is often more consistent with traditional symptomatic patterns than with Western-oriented psychiatric disorders (Pang, 2000). Older immigrant adults, however, access formal services at an even lower rate than the already low rate seen in immigrant populations and are more likely to rely on traditional healers and remedies (Pumariega, Rogers, & Rothe, 2005). Undocumented immigrants are not eligible for full-benefit Medicaid coverage, which can also impede access to care (Siskin & Lunder, 2009). Further, older immigrant adults may not be eligible for government health care if they have not been present in the United States for over 5 years (Schlosberg, 2000). When they do access mainstream services, there can be misdiagnosis related to measurement issues (Mejía, Miguel, Gutierrez, Villa, & Ostrosky-Solis, 2006).

Aside from the challenges facing immigrant older adults, this group can be an important resource for immigrant families. For example, some older adults immigrate later in life to provide regular care for their grandchildren. These older adults often play a critical role in fostering a sense of cultural continuity for younger generations. At the same time, they may face conflicts related to the discrepancy between their life in the country of origin and the new culture in the United States, potentially contributing to intergenerational strain within the household (C. Suárez-Orozco & Suárez-Orozco, 2001). For example, stressors identified by older Asian Indians included loss of authority due to role reversals within the family, changes in family roles related to household duties, different sets of cultural values and experiences among members of the household, limited ability to speak English, and increased isolation in contrast to more regular social interactions in India (Kalavar & Van Willigen, 2005). Additional factors affecting immigrant older adults include poverty, lack of access to health care, fraud perpetrated on them, severe isolation in their own ethnic/racial groups, and potential physical and emotional abuse by family members and caregivers.

IN CONCLUSION

There is a clear dearth of research on immigrant populations from a life span, developmental perspective. As the immigrant population continues to grow, psychological research is needed in order to understand the complexities of the immigrant experience across the life span and the reciprocal interactions with their environments. For example, research is needed to understand the psychological implications of familial separation on children, emerging adults who grew up in the United States but do not have legal status to work, adults whose work credentials are disqualified and who are unable to work in their profession in the United States, and older adults who immigrate to the United States to care for their grandchildren. In addition, clinical training is needed to enable psychologists to provide culturally competent services to these populations and to better understand how to support and promote resilience.

ASSESSMENT WITH IMMIGRANT-ORIGIN ADULTS AND CHILDREN

For decades, tests have been administered to members of diverse racial/ethnic groups and immigrant groups without considering cultural or linguistic contexts and environmental factors (e.g., limited English exposure and limited educational opportunities or cultural exposure) and without conducting a proper initial assessment of the individual. These are essential steps for choosing the appropriate test and for the interpretation of test results (Suzuki, Kugler, & Aguiar, 2005).

Historically, during the last big wave of immigration (1880–1920), IQ tests were used as a sorting mechanism and were associated with eugenics, hereditarian theories of intelligence, and immigration restrictions (Strickland, 2000). More recently, the misuse of psychological tests with ethnic minorities continues to be detrimental to their well-being (Menken, 2008; Solano-Flores, 2008; Strickland, 2000). The rapidly changing cultural and linguistic landscape in contemporary American society requires a significant shift in the way psychologists approach testing and assessment in educational and clinical settings as well as testing that occurs in forensic and legal settings (L. M. Rivera, 2008; Tsytsarev & Landes, 2008).

CHALLENGES IN ASSESSING CULTURALLY AND LINGUISTICALLY DIVERSE POPULATIONS

The challenge of appropriately assessing immigrant adults and children and second-language learners affects this population in three general areas: placement in special education (Lesaux, 2006; Solano-Flores, 2008); ability, achievement, and aptitude testing (Menken, 2008; Solano-Flores, 2008); and the use of clinical assessment procedures and measures (i.e., the Minnesota Multiphasic Personality Inventory [MMPI]) (Suzuki, Ponterotto, & Meller, 2008).

There are several potential errors that may arise in immigrant assessment:

- Content knowledge may go unrecognized, disguised behind language acquisition challenges, and information presented on tests may depend on exposure to cultural knowledge and to procedures that test-takers have never encountered, deflating test scores (Rhodes, Ochoa, & Ortiz, 2005; Solano-Flores, 2008) and contributing to faulty conclusions.
- Timed tests penalize second-language learners, who are processing two languages as they settle on an answer (Solano-Flores, 2008).

When culturally sensitive approaches are not used, individuals can be overpathologized or their needs can go unrecognized.

When culturally sensitive approaches are not used, individuals can be overpathologized or their needs go unrecognized (Leseaux, 2006; Suzuki et al., 2008).

Many tests used in both educational and clinical settings are norm-referenced, where an individual's score is compared to the scores of a group of people who have already taken the same test, called "the norming group" (Padilla & Borsato, 2008). However, most tests are not normed on the appropriate population but on the mainstream majority population, with its inherent values, language, and cultural knowledge. This creates significant challenges for minority and immigrant groups (D. P. Flanagan, Ortiz, & Alfonso, 2007; Grzywacz, Alterman, et al., 2010; Mpofu & Ortiz, 2009; Ortiz, Ochoa, & Dynda, 2012). Creating separate norms by race/ethnicity and parental education could assist in creating more appropriate comparisons (Suzuki et al., 2005), although this may be impossible to accomplish with small refugee or immigrant groups.

Research has indicated repeatedly that the test scores of English language learners (ELLs) are substantially lower than

those of native English speakers and that as the language demands of individuals' test items decrease, so does the achievement gap between ELL and native English-speaking individuals (D. P. Flanagan et al., 2007; Mpofu & Ortiz, 2009; Ortiz et al., 2012; Padilla & Borsato, 2008). To produce valid measures of academic achievement, Solano-Flores (2008) proposed that test developers and clinicians view language as a dynamic factor and take into account "different language and dialect patterns, different migration histories, different kinds of exposure to formal instruction both in students' first language (L1) and in their second language (L2), which are among the many factors that make ELL populations so heterogeneous" (p. 189).

Approximately 20,000 mental, personality, and educational tests are published and developed each year. Most of these tests have been developed and normed on mainstream populations or minority populations who are English speakers. All too often tests are administered in ways that lead to (mis)diagnosis and inappropriate interventions (Cohen & Swerdlik, 1999; Suzuki et al., 2005). This is an area of professional practice often criticized for its contribution to the perpetuation of social, economic, and political barriers confronting minority and immigrant groups (D. P. Flanagan et al., 2007; Mpofu & Ortiz, 2009; Ortiz et al., 2012; Padilla & Borsato, 2008). For testing and assessment to be culturally appropriate, there needs to be a continuous, intentional, and active preoccupation with the culture of the group or individual being assessed. The construction and development of tests and assessments need to include methodological insertions and adaptations designed for the cultural and linguistic characteristics of the group being assessed, including age of migration, length of residency in the United States, generational status (e.g., first, 1.5, or second), English-language proficiency, and the extent of acculturation (Padilla & Borsato, 2008).

There is a critical need to focus on the cultural context of testing practices, since individuals from racial and cultural minority groups may not value or understand the practice of standardized, and at times, time-limited testing situations. Therefore, the process of assessment, which includes both qualitative (e.g., background information and observation) and quantitative (e.g., standardized test scores) data gathering, is an integral part of maintaining multicultural assessment validity (MAV). MAV requires that practitioners "arrive at an accurate, sound, and comprehensive description of the client's psychological presentation" (Ridley, Tracy, Pruitt-Stephens, Wimsatt, & Beard, 2008, p. 27) by gathering data on historical, familial, economic, social, and community issues, which are critical in choosing appropriate tests and language and interpreting test results (Suzuki et al., 2005).

ASSESSMENT IN EDUCATIONAL SETTINGS

Schools have limited assessment strategies to differentiate between adjustment and learning disorders with regard to ELLs, or non-English learners, and often lack the means or ability to adapt tests or make appropriate administration, translation, or assessment adaptations. Thus, many errors are made that result in both over- and underdiagnosing adjustment and learning disorders in school settings (Agbenyega & Jiggetts, 1999; Birman & Chan, 2008; Blanchett, Brantlinger, & Shealey, 2005).

Adjusting to school demands is particularly difficult for children with limited literacy or interrupted education. In addition, some of these children may have experienced extensive trauma in their native country or during the flight to safety or border crossing. Finally, as is true for all children, some immigrant children may experience learning, developmental, or emotional disabilities unrelated to their migration. When a newly arrived immigrant child is exhibiting academic or behavioral problems, it may not be clear which of these possibilities is creating difficulties. For example, a child who is making little progress in reading may be having a difficult time learning literacy and English language skills simultaneously; may be suffering from poor concentration, which is a symptom of PTSD; or may have difficulties with language processing due to a learning disability. Given the lack of assessment instruments that accurately assess and diagnose the nature of the problems children experience (Birman & Chan, 2008), schools are frequently faced with providing services without adequately understanding the problem.

In fact, many school systems do not assess newly arrived immigrant students for mental disabilities for at least one year because they deem it impossible to differentiate adjustment difficulties from mental disabilities. Research suggests that poor, immigrant, and racial/ethnic minority children are disproportionately placed in low-ability groups early in their education (Blanchett et al., 2005). Students from Spanish-speaking ELL backgrounds are overly referred to specialized programs for students with speech and language learning disabilities (Brantlinger, 2006). Teachers referring immigrant students for special education testing

may inappropriately pathologize their behavior because they misunderstand that these students are behaving according to the norms of their heritage culture (Chamberlain, 2005). At the same time, some children who need such services do not receive them because valid assessment instruments do not exist in most immigrant languages.

Teachers and psychologists have limited tools at their disposal to accurately assess immigrant children from a variety of cultural and language groups. Academic tests commonly used in the special education referral process tend to be socially, economically, and culturally bound toward a White, American, middle-class upbringing (Agbenyega & Jiggetts, 1999). While several standardized tests have been used to screen immigrant children (Birman & Chan, 2008), almost all have been adapted from measures developed for U.S. and European populations or refugee adults (Birman & Chan, 2008). The high-stakes testing, national education reform environment placed pressure on many U.S. school districts to reclassify ELL students as fluent English proficient (FEP) and to increase their academic achievement in subject area content (Lesaux, 2006). It is important to remember that the classification of ELL is a temporary one, and states are only required to monitor ELL progress for 2 years after reclassification as FEP (reclassification to FEP varies from state to state and from district to district). Furthermore, there is a significant percentage of children who live with parents or caretakers who speak a language other than English at home who are not classified as ELLs (Lesaux, 2006).

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Much of the field of psychoeducational testing and scoring is plagued by the challenge of differentiating between measurement error (i.e., examinees' observed test scores and their true scores) and error attributable to the interaction between the learner's characteristics (e.g., language, acculturation, and socioeconomic status) and learning conditions (e.g., school district, bilingual vs. full-immersion program, and lack of appropriate instruction) (Lesaux, 2006; Solano-Flores, 2008; see Ortiz, 2011, for an innovative strategy for dealing with this assessment challenge). This inability to disentangle learning characteristics from learning conditions and their interactions is a problem when diagnosing learning disabilities in ELL students. The past 15 years of research on assessing learning disabilities with native English speakers have been turbulent ones involving definitional issues and a lack of consensus on a valid and reliable model of identification of learning disabilities.

Researchers propose that to establish a valid model of identification for English language learning and learning disability, four important changes need to take place:

- Development of a single, operational definition of ELL.
- Better understanding of the normative developmental trajectories of all ELLs, with or without learning difficulties (Lesaux, 2006).
- Better understanding of longitudinal normative developmental trajectories of language and literacy skills and the influence of instruction and demographics on these trajectories over time.
- Consideration of heterogeneity of immigrant communities by disaggregating factors such as culture and language of origin, content learned in country of origin, socioeconomic status (pre- and postmigration), and ability to negotiate language development between the two languages (Lesaux, 2006).

While technical issues clearly contribute to cultural fairness in testing, some have argued that fairness in testing and assessment "is fundamentally a sociocultural, rather than a technical issue" (Stobart, 2005, p. 275). To assure valid measures and avoid misdiagnoses of ELL students, immigrant groups, and racial/ethnic minority groups, our field must seriously consider revising testing and assessment practices. Further, clinicians and practitioners need to be provided significant training in multiculturalism. If testing and assessment are to be fair, then the issue of one group's performing differently from another cannot be resolved simply at a quantitative level.

Realistically, in the U.S. context, it is unlikely that completely valid assessments will be available in any language other than English (Ortiz, 2008a). Even for the most frequently encountered non-English-speaking

linguistic group in the United States—Spanish speakers—there are only two tests with Spanish adaptations: the Weschler Intelligence Scale for Children Spanish (WISC-IV Spanish; Wechsler, 2005) and Bateria III (Muñoz-Sandoval et al., 1998). There are two more with Spanish administrations but English norms: the Kaufman Assessment Battery for Children (2nd ed.; Kaufman & Kaufman, 2004) and the Differential Ability Scales (2nd ed.; Elliot, 2007). There are no appropriate intelligence tests for Cantonese, Hmong, Somali, Farsi, Urdu, and myriad other linguistic groups found in the United States. If accurate diagnosis is not possible, teachers and psychologists may need to work with these students without it. For example, individualized attention and scaffolding approaches can be helpful to children regardless of whether they are having difficulties due to cultural adjustment, learning/emotional disabilities, or both (Birman, Weinstein, Chan, & Beehler, 2007). Studying how to intervene with newly arrived immigrant children in the absence of valid assessments as well as through the medium of interpreters and translators is an important direction for future research.

ASSESSMENT IN CLINICAL SETTINGS

In clinical settings, many of the same problems exist concerning reliability and validity of the actual instruments available as well as adequately trained clinicians who are linguistically and culturally astute. As standardized psychological instruments are conceived and developed from the perspective of a particular culture and language (e.g., the majority culture) and are thus fundamentally culturally bound and driven (Vazquez-Nuttall et al., 2007), it may be necessary to use varied assessment methods such as qualitative and dynamic testing (Vazquez-Nuttall et al., 2007).

Concerns about the validity of standardized tests come to the forefront when using tests that were originally developed and standardized for one group (e.g., U.S.-born, monolingual, English-speaking, European American youth) with racial/ethnic and linguistic minority youth (Vazquez-Nuttall et al., 2007). Theory and evidence to support interpretations of test scores obtained through the use of such tests are also compromised for this population (American Educational Research Association [AERA], APA, & National Council on Measurement in Education, 1999). While the scope of this report does not permit an in-depth discussion of test validity, reliability, bias, and fairness in reference to racial/ethnic minority, older adult, and immigrant groups, the reader is encouraged to go to the following sources for further information: ABA and APA (2008), Aiken (2002), AERA et al. (1999), Helms (2006), and Wall and Walz (2004).

In deliberating which standardized instruments to include in an assessment battery for immigrant and linguistic minority clients and whether these instruments can be used, clinicians should examine the extent of cultural and linguistic differences between the clients and the dominant culture (Hambleton, Merenda, & Spielberg, 2005; Ortiz, 2008a). For example, the WISC-III Spanish and the WISC-IV Spanish (Wechsler, 2005) have been developed for youths (ages 6–16) who are ELLs and relatively new to American culture. Despite limitations, the WISC-IV Spanish, when properly administered, provides a generally reliable and valid measure of overall intelligence and more specific cognitive processes for children who report greater linguistic proficiency in Spanish than English and who are relatively new to the United States (Ortiz, 2008b; Park-Taylor, Ventura, & Ng, 2010).

In the area of projective personality assessment, Tell Me a Story (TEMAS; G. Constantino, Malgady, & Rogler, 1988) was created as a culturally sensitive revision of the Thematic Apperception Test (TAT; Dana, 1977). TEMAS has promising construct-related validity but has yet to establish criterion-related validity and demonstrate it is better than the TAT in assessing the personality characteristics of minority children (Center for Psychological Studies, 2008). (For more information regarding accommodating steps that can be taken, see Ortiz, 2008a; Park-Taylor et al., 2010.)

The past decade has witnessed the development and publication of a number of important frameworks, procedures, and/or models for undertaking culturally inclusive assessment procedures (Dana, 2005; Grieger, 2008). A procedure that has been well received by researchers and practitioners alike is the multicultural assessment procedure (MAP) formulated by Ridley, Li, and Hill (1998). This procedure is designed to offer an assessment protocol that is practical, driven by theory, and can be scientifically validated. The MAP comprises four phases: collecting culturally salient data via multiple methodologies; formulating a working hypothesis through accurate interpretation of the data; testing the hypothesis as necessary; and providing an assessment report that is accurate, complete, and reflects a process of hypothesis testing (McKitrick, Edwards, & Sola, 2007).

Another notable multicultural assessment model is the Multicultural Assessment-Intervention Process (MAIP; Dana, 2005). Both MAP and MAIP incorporate culturally sensitive assessment interviews, collecting essential information on acculturation, language, religious practices, racism and prejudice, and cultural values as part of the assessment process. Culturally sensitive assessment is dynamic, not static; is cyclical, not linear; and seeks to incorporate cultural variables as central to all phases of the assessment process (Yeh & Kwan, 2010).

Experts in cultural assessment have advocated for a contextual approach to psychological testing and diagnosis (Comas-Díaz & Grenier, 1998; Grieger, 2008). A contextual approach is consistent with the ecological perspective in that it considers both internal and external factors that contribute to clients' presenting problems. For example, a contextual approach considers the role of the client's explanatory models or views of illness and recovery in the interpretation of test data and in providing feedback concerning test data to the client in a culturally sensitive way. The contextual approach further considers the role of clinician as a part of a larger system of mental health care. As such, it is important that clinicians examine their own biases and expectations that may affect the testing process and routinely consult with colleagues and supervisors who may be important sources of knowledge concerning the client's sociocultural context and provide support throughout the assessment process.

ASSESSMENT IN FORENSIC AND LEGAL SETTINGS

While issues relative to the assessment of immigrants are most frequently addressed in the context of educational and clinical settings, the significance of culturally and linguistically valid assessment also has crucial bearing within forensic and judicial/legal settings, including family courts, immigration courts, and criminal courts. Using psychological assessment tools that significantly affect the lives of immigrants and their families, psychologists may be called on to make critical decisions regarding deportation or asylum, preservation or denial of citizenship, unification or separation of families, and incarceration or freedom.

A significant and growing number of both documented and undocumented immigrants are facing issues that require adjudication in legal settings (Ochoa, Pleasants, Penn, & Stone, 2010). The numbers of noncitizen prisoners in both federal and state prison systems vary significantly according to the source of data. According to the U.S. Department of Justice (2006), 20% of inmates in federal prisons were noncitizens in 2005; when federal and state prisons were combined, 6.4% of the nation's prisoners were noncitizens at that time. In addition, over the last decade, U.S. policy has tripled its number of deportations. With respect to the immigrant population in detention, the Detention Watch Network and Mills Legal Clinic (2010)[5] projected that by 2010, the U.S. government would hold more than 400,000 persons in immigration custody at an annual cost of more than $1.77 billion.

In terms of the number of detainees suffering with mental health problems, U.S. Immigration and Customs Enforcement (ICE) reported that in the fiscal year 2008, it performed 29,423 mental health interventions and managed a daily population of between 1,350 and 2,160 detainees with serious mental illnesses (U.S. ICE, 2008a, 2008b). Based on ICE population data, this represents approximately 4–7% of detainees. Estimates of this population from other sources put it closer to 15% (Ochoa et al., 2010).

Unfortunately, until recently, relatively little attention had been paid to forensic mental health assessments in immigration cases (Frumkin & Friedland, 1995). The question of how to fairly assess immigrants with all of the linguistic and cultural issues discussed earlier is equally pertinent. The same kinds of challenges apply to legal contexts as to educational and clinical contexts—for example, lack of standardized translations, absence of appropriate normed standards for the specific population, and psychologists who are not linguistically or culturally familiar with their clients. Thus, given the cultural and linguistic biases of the instruments at our disposal, caution must always be exercised when making assessments that have critical bearings on individuals' and families' lives.

In addition, the forensic and legal fields currently suffer from an absence of clear, consistent procedures for screening, diagnosing, and accommodating mental disabilities and establishing hardship (Cervantes, Mejía, & Guerrero Mena, 2010), as well as guidelines to establishing mental, psychological, and cultural competency in immigration courts (see Legal Action Center, 2010). Such standards and guidelines should be applicable to all key personnel in the respective setting (e.g., lawyers, psychologists, and judges). In cases in which immigrants are incarcerated, detained, and/

5 Stanford Law School's Immigrant Rights Clinic.

or deported, immigration officials and other key personnel should honor U.S. human rights commitments and ensure fair legal procedures (e.g., access to counsel and assessment of cognitive abilities) and accurate court decisions (Legal Action Center, 2010).

All relevant personnel within the legal system should also be trained to work with immigrants in general and those with mental disabilities in particular. A continuing and well-designed training program oriented toward cultural and psychological sensitivity and a basic social science framework concerning immigrant issues should be developed and offered to all actors. The content and the process of being part of a legal procedure need to be understood from the cultural perspective of the defendant. It is thus important to recognize that a combination of cultural and situational stressors may lead to disorganized and confusing behaviors that may be perceived by key personnel as pathological. Finally, the training should be approached from an ecologically framed understanding (see the Guiding Frameworks section of this report) and an appreciation of the immigrant experience (Tsytsarev & Landes, 2008).

IN CONCLUSION

The classic tools of the field of psychology—normed psychological tests and psychological batteries—have a long history of being misused. At the most basic level, assessment tools are often not developed for or normed on the cultural and linguistic populations to which they are applied (Ortiz, 2011; Suzuki et al., 2005). The challenges of the field when assessing immigrants and second-language learners are aptly summed up by the question, "Who is given tests in what language by whom, when, and where?" (Solano-Flores, 2008). Individuals assessing immigrants and second-language learners often do not speak the language and are not familiar with the culture of the person they are assessing. Newcomers are too often assessed too early in their language acquisition process (Cummins, 2000), with major life implications (Menken, 2008). The contexts in which they are assessed are often unfamiliar and in less than optimal testing conditions (Solano-Flores, 2008).

Clearly, given the multiplicity of languages and cultural backgrounds represented by the new immigration, it is unrealistic to expect that normed tests will be available for every immigrant and language group encountered. It is simply not possible to evaluate immigrant populations with the degree of fairness and equity that is desired. This phenomenon is also related to the underperformance of bilinguals on both native language and English language tests. These issues are not well understood by psychologists in general practice and there are very few, if any, approaches that can be used in all cases to evaluate individuals in truly nondiscriminatory ways. Psychology as a field needs to recognize these limitations. It is also essential, given the rapid diversification of the United States, that research be conducted to increase our understanding of these issues.

At the very least, appropriate assessment instruments and qualified psychologists should be used in settings where there are high densities of particular languages and cultures represented (e.g., Spanish in areas where many students or clients whose first language is Spanish are being served). When this is not possible and an assessment is done through an interpreter, extreme caution must be taken in making diagnoses and interpretations. Psychologists should be mindful of making high-stakes decisions about individuals' lives based on what might be considered speculative assessment strategies with immigrant populations.

IMMIGRANT POPULATIONS IN EDUCATIONAL CONTEXTS

The size and diversity of today's immigration flow is reflected in U.S. public schools. As of 2011, 23.7% of school-age children in the United States were the children of immigrants (MPI, 2011), the majority (77%) of whom were second-generation citizen children and the rest (23%) foreign-born (Mather, 2009). Approximately 10.7% of all public school students in the United States are classified as English language learners (ELLs)[6] (MPI, 2011). There is tremendous diversity in the socioeconomic, cultural, and linguistic backgrounds of these children. For example, elementary and middle-school children in New York City public schools speak 167 languages and come from 192 countries (Stiefel, Schwartz, & Conger, 2003).

A RESILIENCE PERSPECTIVE

The pattern of high achievement among many first-generation immigrants is remarkable given the myriad challenges they encounter, including xenophobia, economic obstacles, language difficulties, family separations, underresourced neighborhoods and schools, and the struggle to get their bearings in a new educational system (V. W. Huynh & Fuligni, 2008; Pong & Hao, 2007; Portes & Zhou, 1993). Immigrant children demonstrate certain advantages. They enter U.S. schools with tremendous optimism (Kao & Tienda, 1995), high aspirations (Fuligni, 2001; Portes & Rumbaut, 2001), dedication to hard work, positive attitudes toward school (C. Suárez-Orozco & Suárez-Orozco, 1995), and an ethic of family support for advanced learning (Li, 2004). As mentioned in the introduction, immigrant youth often educationally outperform their U.S.-born peers (Perreira, Harris, & Lee, 2006).

First-generation immigrant students show a number of positive academic behaviors and attitudes that often lead to stronger than expected academic outcomes. For example, compared wth their U.S.-born peers, they have better attendance rates (García Coll & Marks, 2011), demonstrate more positive attitudes toward their teachers (C. Suárez-Orozco & Suárez-Orozco, 1995) and school (Fuligni, 1997), have higher attachment to school (García Coll & Marks, 2011; C. Suárez-Orozco & Suárez-Orozco, 1995), and earn higher grades (García Coll & Marks, 2011; Hernandez, Denton, McCartney, & Blanchard, 2011; Portes & Rumbaut, 2006). Some age groups have higher scores on standardized tests than do their American-born peers (García Coll & Marks, 2011), particularly on standardized math tests (Kao & Tienda, 1995). At the same time, a decline in academic aspirations, engagement, and performance has been documented over time (C. Suárez-Orozco, Gaytán, Bang, et al., 2010) and across generations (Fuligni, 1997; Portes & Rumbaut, 2001; C. Suárez-Orozco & Suárez-Orozco, 1995).

On some measures of achievement and for some groups, first-generation students do not perform as well as their U.S.-born peers. First, because the first generation must contend with language acquisition, their performance suffers on tests of reading and English (Kao & Tienda, 1995; Ruiz-de-Velasco, Fix, & Clewell, 2000; C. Suárez-Orozco et al., 2008; N. Tran & Birman, 2010) when competing with U.S.-born peers. Second, a particularly difficult situation emerges for the group of immigrant children with interrupted or no prior education.

6 *Emerging bilinguals* is a term preferred by some scholars (see O. García, 2009; O. García, Kleifgen, & Falchi, 2008; Reyes & Azuara, 2008) who emphasize the bilingual competencies of immigrant-origin children and advocate for educational policies that develop their home language and cultural understandings. In this report, we use the term *English language learner* (ELLs), as it emphasizes the common experience of acquiring English primarily (though not exclusively) in a school environment and is more inclusive of multilingual and multidialectal children (e.g., indigenous peoples from Oaxaca of Mexico speak dialects of Mixteca; for them Spanish is already their second language. Such is also the case for individuals from the Fujian province in China; Mandarin is their second language). The use of this term is in no way intended to denigrate the value of home language and cultures or advocate for the superiority of English monolingualism; in fact, ELL replaces *limited English proficient,* a term used by the federal government, which did perpetuate a deficit perspective of this population. While the term English language learner refers to a fluid category of students who do not meet levels of proficiency in school settings (variously defined across contexts) and is problematic in this respect, it is the term currently most widely used by researchers, policymakers, and school districts.

Immigrant students whose education has been interrupted, or who have had no prior education, face particular challenges in making a transition to U.S. schools. This includes children coming from conditions of poverty where older children are expected to work and secondary schooling is unavailable. Many refugee children arrive after prolonged stays in refugee camps, never having been in school, and some come from cultures with no traditions of literacy in any language (e.g., Van Lehman & Eno, 2003). It is estimated that 20% of all ELL high school students and 12% at the middle-school level have missed 2 or more years of schooling (Ruiz-de-Velasco et al., 2000).

Students with interrupted formal schooling arrive with limited literacy skills in their native language, and they need to master a new language, literacy, and gaps in knowledge across academic subjects at the same time (Birman & Tran, in press). Lacking the expected skills to complete homework assignments or participate in most classroom activities (Cassity & Gow, 2005; Dooley, 2009)—or in extreme cases, even knowledge of how to act in the classroom and perform on pencil-and-paper tasks (Alsleben, 2006; Birman & Tran, in press; Brock, 2007)—they face distinctive challenges in adjusting to school.

All arriving newcomer students must surmount daunting obstacles, including developing academic English skills . . . and fulfilling graduation requirements . . . in a high-stakes testing environment not designed with their educational obstacles in mind.

All arriving newcomer students must surmount daunting obstacles, including developing academic English skills (Carhill, Suárez-Orozco, & Paéz, 2008) and fulfilling graduation requirements (Ruíz-de-Velasco, Fix, & Clewell, 2000) in a high-stakes testing environment not designed with their educational obstacles in mind (Hood, 2003; Menken, 2008). Some of these youths, arriving with the intention to work (C. Suárez-Orozco, Gáytan, & Kim, 2010), may never enroll in school. Others enroll and quickly drop out, encountering frustrations with language acquisition and schools not equipped to serve them (Ruiz-de-Velasco et al., 2000; C. Suárez-Orozco et al., 2008). In general, first-generation youth are about 3 times more likely (29%) to drop out of school than their U.S.-born counterparts (10%). That effect, however, is primarily attributed to immigrant Latinos/as, who drop out at an alarming rate of 46.2%. It is important to note that graduating from high school portends positive outcomes. In a longitudinal study, Fuligni and Witkow (2004) reported that the postsecondary educational attainment patterns of immigrant students who graduated from high school were similar to their native-born peers.

Immigrant-origin students face some distinctive experiences similar to those of the first generation. Both groups share immigrant parents who tend to expect respectful behaviors toward authorities like teachers (García Coll & Marks, 2011; C. Suárez-Orozco & Suárez-Orozco, 2001) but who often do not have the knowledge to navigate the unfamiliar educational system in the United States (C. Suárez-Orozco et al., 2008). Though born in the United States, if students grow up in non-English-speaking homes, they enter schools needing to acquire English just as they learn to read. This places them at a transitory disadvantage if they are not provided adequate educational supports (Bialystok, Majumder, & Martin, 2003; O. García, 2009).

On the other hand, they have some unique advantages that the first generation did not. All are automatically U.S. citizens, and some will not have the language acquisition hurdle, particularly if they live in neighborhoods where they are regularly exposed to English language models (C. Suárez-Orozco & Suárez-Orozco, 2001). Yet, the second generation may be disadvantaged, as they are less buffered by immigrant optimism (Kao & Tienda, 1995) and the dual frame of reference of recognizing that although their life may be difficult in the new context, they may have unique opportunities as well (Fuligni, 2011; C. Suárez-Orozco & Suárez-Orozco, 2001).

CONTEXT MATTERS

The context of resettlement shapes the experience of immigrant students in their neighborhoods, families, and schools. A number of factors, including family capital and school resources available to newcomer students, can bolster or undermine academic integration and adaptation (C. Suárez-Orozco, Gaytán, & Kim, 2010).

Family-of-Origin Capital

Immigrant students arrive in the United States with an array of parental resources (Portes & Rumbaut, 2006; C. Suárez-Orozco, Gaytán, & Kim, 2010). Although some immigrant students come from privileged backgrounds, children living in families headed by immigrant parents are more likely to be living in poverty than their nonimmigrant-origin peers (Mather, 2009). This is a significant issue to consider, as immigrant children are more likely to be raised in circumstances of poverty than any other group of children residing in the United States (Mather, 2009). Educational attainment within the first generation is closely, but not exclusively, tied to parental educational levels (Portes & Rumbaut, 2001). Youths arriving from families with lower levels of education tend to struggle academically, while those who come from more literate families and with strong skills often flourish (Kasinitz et al., 2008; Portes & Rumbaut, 2001). Highly literate parents are better equipped to guide their children in studying, accessing educational information (Goldenberg, Rueda, & August, 2006), and supporting literacy development either in their native language (U.S. Census Bureau, 2007) or in English (Páez, 2001; Portes & Hao, 1998).

School Resources

U.S. schools are often not well prepared to serve immigrant-origin students. Schools that serve ELL students have chronic shortages of teachers with specialized training, and principals, counselors, and other support staff rarely have such specialized training either (Ruiz-de-Velasco et al., 2000). In general, education of immigrant-origin students is conceived of "as a special or add-on activity outside what school staff often considers the 'normal' functions of the secondary school" (Ruiz-de-Velasco et al., 2000, p. 58). Thus, programming to meet the needs of these students often happens in the absence of sufficient expertise or clear standards.

Immigrant-origin students are often segregated in neighborhoods marked by poverty and low-performing schools (Hernandez et al., 2007). Nationally, immigrant Latinos/as in particular tend to settle in highly segregated and deeply impoverished urban settings and attend the most segregated schools of any group in the United States. In 1996, only 25% of Latino/a students attended majority White schools (Orfield & Lee, 2006). In school, ELL students are often taught in classrooms separated from the other students (Olsen, 1997), and in many cases, they do not have much meaningful contact with their U.S.-born English-speaking peers (Carhill et al., 2008; C. Suárez-Orozco et al., 2008). Such separations have been associated with reduced school resources and a variety of negative educational outcomes, including low expectations, difficulties learning English, lower achievement, greater school violence, and higher dropout rates (Gándara & Contreras, 2008; Orfield & Lee, 2006).

Through a parallel process, ELL (bilingual and ESL) teachers also experience marginalization in the broader school context (Bascia, 1996; Lucas, 1997; Olsen, 1997; Portes & Rumbaut, 2001; Stanton-Salazar, 2001; C. Suárez-Orozco & Suárez-Orozco, 2001; Trickett et al., 2012) reflected in insufficient access to needed educational resources, inadequate teaching space and facilities, exclusion from educational decision making, and lack of feedback or support from colleagues who teach in mainstream classrooms (Markham, 1999; Olsen, 1997). With limited resources and support and a wide range of English-language skills and educational backgrounds, ELL teachers struggle to create individualized educational opportunities for their increasingly diverse immigrant-origin students (Trickett et al., 2012).

LANGUAGE-RELATED EDUCATIONAL CHALLENGES AND MODELS OF LANGUAGE INSTRUCTION

Acquiring the language of the new country is a critical aspect of academic transition for first-generation immigrant students. According to an Urban Institute report (Capps et al., 2005), 62% of foreign-born children speak English less than "very well." However, there is a great distinction between interpersonal communicative English and academic English. Although developing academic second-language skills generally requires between 4 and 7 years of optimal academic instruction (V. P. Collier, 1987, 1992; Cummins, 1991, 2000), students in the United States are generally expected to transition out of second-language acquisition programs within 3 years.

While schools place an emphasis on learning English, research, though counterintuitive, consistently suggests that a greater degree of literacy instruction in the native language leads to greater academic success in English (Goldenberg, 2008). Goldenberg (2008) cited five meta-analyses (August & Shanahan, 2006; Greene, 1997; Rolstad, Mahoney, & Glass, 2005; Slavin & Cheung, 2005; Willig, 1985) and a comprehensive review (Genesee, Lindholm-Leary, Saunders, & Christian, 2006) that concluded that learning

to read in the home language promotes reading in the second language. When students are well grounded in their native language and have developed reading and writing skills in that language, they are better able to apply that knowledge efficiently to the new language when provided appropriate instructional supports (Butler & Hakuta, 2005). Unfortunately, however, many immigrant students do not encounter robust second-language-acquisition educational programs and often face individual disadvantages and structural linguistic isolations that may hinder their adequate academic English development (V. P. Collier, 1992; C. Suárez-Orozco et al., 2008).

Cognitive Effects of Being Bilingual

There is extensive literature on the effects of linguistic experience on cognitive performance that suggests there are positive and negative effects of being bilingual (Bialystok, 2009). Although, as Bialystok pointed out, "knowing more has never been a disadvantage when compared with knowing less" (p. 192), bilingual individuals do generally have a smaller vocabulary in each language than do monolingual speakers. Similarly, bilingual persons tend to score lower on verbal fluency and lexical access tasks and are slower in naming pictures (Bialystok, 2009). As a result, timed tests of verbal ability that are used as markers of cognitive development may erroneously suggest some degree of impairment in bilinguals compared with monolinguals.

In direct contradiction to this kind of evidence, however, it also appears that multiple language fluency leads to better executive functioning. Because being bilingual entails a constant need to control access to different language memory stores, bilingualism appears to improve controlled inhibition tasks, selective attention, attention shifting, and updating of working memory (Bialystok, 2009). Thus, compared with monolinguals, bilingual populations appear better able to resolve linguistic tasks with ambiguous or contradictory meanings. In fact, multilingualism may provide protection against some aspects of age-related cognitive loss. In general, bilinguals show improved performance on tasks that require response selection decisions and conflict resolution tasks (Bialystok, 2009).

Second-Language Instruction

Second-language instruction is a critical component to ensuring the academic success of immigrant-origin youth (Batalova, Fix, & Murray, 2007). There are numerous models of bilingual and language assistance programs for a wide array of practices, programs, and philosophical approaches (Thomas & Collier, 2002):

- Limited pull-out instruction in ESL classrooms is most often used with learners from different countries who speak different languages; the rest of the day is spent in regular classes.
- Transitional bilingual programs provide academic support after students transition out of their language of origin into English.
- In one-way developmental bilingual programs, students of one language group are schooled in two languages (e.g., English and Spanish) so they can keep up with academic material in their native language as they learn English.
- In structured immersion programs, the curriculum is simplified and is taught more slowly in English and with a great deal of repetition.
- In sheltered English programs, all lessons in every subject are at least in part a second-language lesson; thus a science class is also an opportunity to learn new vocabulary.
- Dual-language immersion classes involve students learning half of the time in English and half in their native language, with half of the class being English speakers and the other half native speakers of another language. This kind of program offers greater opportunity for students to truly become bilingual and expand their academic skills by drawing on both languages.

Research suggests that bilingual education programs produce better results in terms of academic success than English language immersion programs (Goldenberg, 2008). Proficiency in the native language is related to academic achievement in the second language (Riches & Genesee, 2006). For younger students, children's native language skills support literacy development because literacy skills transfer. When learning to read, learning to recognize phonetic symbols in their native language can speed up the literacy process (August, 2002; G. E. García, 2000; Lindsey, Manis, & Bailey, 2003). Advantages to native language instruction in later grades have also been found (Slavin & Cheung, 2005), though few published studies of educational programs are of high quality (longitudinal, randomized), and more research is needed to understand the process of second-language acquisition in school (Goldenberg, 2008).

Finally, none of the educational structures for ELL students reviewed previously are designed to meet the specific needs of students with interrupted or no prior education. Newcomers with interrupted education are generally placed in the same bilingual or ESL classrooms as other students, leaving ELL teachers to struggle with how to meet their complex educational needs without additional support. While other countries such as Australia and Israel place newly arrived students into special year-long newcomer programs, the United States has essentially adopted a "sink or swim" approach, placing these students directly into mainstream classrooms with limited pull-out ESL support. Although a range of "newcomer" programs has been tried across varied U.S. school systems, there is no systematic research describing variations among them and testing their effectiveness for "underschooled" students (R. Constantino & Lavadenz, 1993).

In general, well-designed and implemented programs offer good educational results and buffer at-risk students from dropping out by easing transitions and providing academic scaffolding and a sense of community (Padilla et al., 1991). There is, however, a huge disparity in quality of instruction among settings. While it has been well demonstrated that high-quality programs produce excellent results, those plagued with problems produce, not surprisingly, less than optimal results (August & Hakuta, 1997; Thomas & Collier, 2002). Many bilingual programs unfortunately face real challenges in their implementation: inadequate resources, poor administrative support, and a dearth of fully certified bilingual teachers who are trained in second-language acquisition and can serve as proper language models to their students (U.S. Department of Education, 2002).

SCHOOL BELONGING

In addition to language-related challenges, immigrant students must transfer their academic skills to the U.S. school environment and form relationships with peers and school adults. A sense of school belonging has been defined as the level of attachment, commitment, involvement, and belief students have in the value of their school (Kia-Keating & Ellis, 2007). This sense of belonging, in turn, has implications for increasing social involvement, motivation, school attendance, academic engagement, and, ultimately, achievement (Hamre & Pianta, 2001). In addition, for immigrant students, sense of school belonging has been found to predict better mental health (Kia-Keating & Ellis, 2007), indicating the importance of feeling "at home" in their new environment.

Sense of school belonging can be fostered by social support from school peers and adults. Social support in the school has been linked to academic adaptation of immigrant students (Portes & Rumbaut, 2001; Zhou & Bankston, 1998). Positive relationships with school adults can help bridge the gap between home and school cultures and create important linguistic and cultural connections to the new society (Wang, Haertel, & Walberg, 1994). Supportive relationships with caring adults in the school context also provide emotional sustenance and practical help and advice for newcomers, sometimes sparking active participation in subject areas that may have traditionally held little interest for students. Conversely, students may lose interest in the subject matter if they perceive a diminished interest in their progress on the part of the teacher.

English language learner (bilingual and ESL) teachers play a critically important role in the school experience of newcomer students. As "first responders" to the nation's immigrant students, they tend to spend more time, in smaller classrooms, getting to know them and becoming their advocates in the school (Birman, 2005). Bilingual teachers have the additional advantage of being able to communicate with parents in their native language and serve as a bridge between home and school. These teachers are asked to fill a number of roles inside and outside the classroom often not formally recognized or valued by school authorities (Bascia, 1996; Trickett et al., 2012). They are often asked to fill gaps in educational programs that do not meet the needs of their students, provide professional development for mainstream teachers, reach out to students' families, and search for additional resources unavailable at school to support their students (Bascia & Jacka, 2001). They are also blamed when their students do not perform well in mainstream classes (e.g., Olsen, 1997). Despite the tremendous importance of their work for immigrant-origin students, research suggests that ELL teachers are not sufficiently supported in this role (Trickett et al., 2012).

PARENTAL INVOLVEMENT

Parental school involvement (e.g., participating in parent–teacher organizations, volunteering in class, and chaperoning field trips) has shown profound effects on performance and adaptation to school for U.S.-born students (Henderson

& Mapp, 2002). Teachers, in turn, view those parents as supportive of their children's learning (Moles, 1993). For immigrant parents, however, such involvement may be neither a familiar cultural practice in their countries of origin nor a luxury their current financial situation allows (Birman & Ryerson-Espino, 2007; García Coll et al., 2002). Not speaking English and having limited education may make them feel inadequate when communicating with teachers. Lack of documentation may make them worry about exposure to immigration raids (Capps, Castaneda, Chaudry, & Santos, 2007). Low-wage, low-skill jobs with off-hour shifts typically do not provide much flexibility to attend parent–teacher conferences. The impediments to coming to school are multiple and frequently interpreted by teachers and principals as "not valuing" their children's education.

Ironically, despite the prevalence of this perception among educators, most immigrant parents describe providing better educational opportunities for their children as the goal of immigration (G. López, 2001; C. Suárez-Orozco et al., 2008). Parents may be involved, but not necessarily in ways expected by U.S./Western schools. Many immigrant parents come from cultural traditions in which parents are expected to respect teachers' recommendations rather than advocate for their children (Delgado-Gaitan, 2004). They see their role as supporting their children's education at home and deferring to teachers during the school day. In addition, not having gone to U.S. schools themselves, immigrant parents often do not understand how schools are organized, what they expect from children (e.g., expressing opinions rather than rote memorization), or how to deal with learning problems or communicate with the school. Thus, teachers perceive immigrant parents as disinterested, reach out to them less, and as a result, the parents know even less about school matters (Huss-Keeler, 1997). Ideally, schools will make contact with immigrant parents in positive circumstances rather than wait for a crisis (Adams & Christenson, 2000). Immigrant parents' knowledge of school practices has been found to predict higher grades for immigrant students (Birman & Ryerson-Espino, 2007), suggesting the unique importance of such knowledge.

IN CONCLUSION

The successful incorporation of children of immigrants into the educational system is one of the most important and fundamental challenges of our time. In a knowledge-intensive economy, how they fare educationally will play a critical role in their future, and given their high numbers, in the kind of society we will become. Our education system faces a demographic "integration imperative" (Alba et al., 2011, p. 395) to prepare immigrant origin youth for "robust membership in the host society" (Alba et al., 2011, p. 397). Understanding the specific needs that different immigrant populations face vis-à-vis the education system is critical in determining appropriate interventions. Given the diversity of the immigrant student populations entering schools, it is clear that a one-size-fits-all model will not work. A number of common factors, however, have positive implications for the school performance and educational integration of immigrant students.

The successful incorporation of children of immigrants into the educational system is one of the most important and fundamental challenges of our time.

Newcomer youth typically face substantial language barriers, social isolation, and difficulty understanding and adjusting to new teaching styles and academic expectations. In response, some school districts have begun to adopt strategies designed to meet the specific needs of newcomer students (R. Constantino & Lavadenz, 1993). Special schools and programs within schools have been developed to support newcomer students and create a community of peers who are experiencing the same dramatic transition to a new educational system, culture, and language. While some schools and programs serve newcomer students for a short period of time, working toward the goal of moving them into a mainstream school, other schools serve these students for multiple years with the same academic offerings as the other schools in the district. Many of these schools and programs have developed innovative pedagogical methods that could be useful to all schools and teachers working with immigrant students and ELLs, though research that evaluates effectiveness remains critically lacking.

Some of the fiercest debates related to immigrant education center around the issue of second-language development. Cross-country comparisons of good practice demonstrate

that it is essential to make "long-term investments in systematic language support" (Christensen & Stanat, 2007, p. 2) and to provide preservice and professional development training for teachers to help them appropriately support their ELL students. Although ideology often competes with scientific evidence in determining how children should be taught to develop new language skills, some efforts are demonstrating real promise in facilitating language acquisition. The diversity of political and ideological climates means that in each district, certain programs are more or less likely to be adopted, regardless of their proven effectiveness. However, innovative approaches are being developed in divergent contexts and offer a range of options worthy of study and emulation (see Christensen & Stanat, 2007; C. Suárez-Orozco, Suárez-Orozco, & Sattin-Bajal, 2009).

To effectively educate and integrate all immigrant-origin students, every educator and support staff member in the school should consider immigrant students' education as part of their responsibility. Instruction of immigrant-origin children resides almost exclusively in the domain of a small cohort of ELL teachers, who are marginalized along with their students and receive little guidance or support (Trickett et al., 2012). As a result, the rest of the school community may not feel sufficiently involved in ensuring these students' academic success (C. Suárez-Orozco, Pimentel, & Martin, 2009). These students' needs go beyond second-language development to include cultural adaptation, social support, and assistance in general academic subjects. Therefore, schools should provide ongoing professional development to all faculty and staff on how to work with immigrant-origin children.

Just as teachers across academic disciplines are being called on to incorporate literacy-building activities into their lessons, the same must be true for taking on the education of immigrant-origin students as a schoolwide endeavor. School personnel will also require training in effectively communicating with parents of different national, cultural, and linguistic backgrounds. The importance of family involvement in children's education has been well substantiated in the research literature (Fantuzzo, McWayne, Perry, & Childs, 2004). Immigrant children's need for parental involvement and support may be particularly acute, given that they are simultaneously adapting to a new country, a new educational system, and often a new language (Birman & Ryerson-Espino, 2007).

Recognizing the varieties of cultural models of family involvement immigrant families bring with them will reduce some educators' inaccurate stereotyping of immigrant parents' commitment to their children's education (C. Suárez-Orozco et al., 2008). Regardless of parents' preferred form of involvement, keeping them abreast of their children's academic progress, sharing important notices and events, and communicating information about school policies are some of the most critical ways in which school districts can work to promote parental involvement.

In many cases, however, immigrant parents face substantial challenges to engaging with their children's school and understanding the information they receive, not the least of which are language and communication barriers. Efforts to provide professional, culturally relevant translation and interpretation services can go a long way toward improving home–school relationships, bolstering communication, and increasing immigrant families' sense of comfort with their children's school and their teachers' understanding of the family's circumstances. Ultimately, children can benefit tremendously when their parents are well-informed about their education, but this can only happen when parents have access to the information they need to support their children and intervene when necessary (Birman & Ryerson-Espino, 2007; C. Suárez-Orozco, Suárez-Orozco, & Sattin-Bajal, 2009).

Increasingly, higher educational credentials have become basic requirements for entry into the skilled labor market. Awareness of the importance of acquiring postsecondary credentials and the process it takes to access these opportunities is a key issue related to the successful integration and education of children of immigrants. Navigating the maze of colleges, universities, and vocational and technical programs that exist in different societies is a challenge for anyone who is among the first generation of his or her family to go to college, but even more so for those with parents who do not speak the language and have no familiarity with the national educational system (C. Suárez-Orozco, Gaytán, & Kim, 2010). It is critically important to assist immigrant families in the process of searching for schools, applying for admissions, and securing grants and loans. Without such assistance, a generation of youth may end up undereducated, underemployed, and unable to participate in the global economy and our society (C. Suárez-Orozco, Gaytán, & Kim, 2010).

In a knowledge-intensive economy, higher education has become more important than ever before. While immigrant-origin youth from some countries are finding themselves highly competitive in college access and completion, other groups fail to access higher education (Baum & Flores, 2011; Hagy & Staniec, 2002). The status of being of immigrant origin is not in and of itself the impediment to higher education—indeed, there is evidence that for most immigrant-origin groups, first and second generation fare better than third generation in both college access and attainment of bachelor of arts degrees (Hao & Ma, 2011). Rather, it is individual and familial characteristics (such as parental education, race, generation, country of origin) as well as school, community, and legal barriers encountered in the host setting that serve to explain the variation in higher education attainment (Baum & Flores, 2011). Notably, more immigrant students attend community colleges than any other type of postsecondary institution, as they are affordable, provide English-language courses, have open admissions policies, and offer the promise of preparing students for the labor market (Teranishi, Suárez-Orozco, & Suárez-Orozco, 2011).

Meeting the needs of immigrant-origin students has not been a national priority in today's high-stakes testing, school reform environment (Menken, 2008; C. Suárez-Orozco et al., 2008). This population is indeed continuously "overlooked and underserved" (Ruiz-de-Velasco et al., 2000). Moving forward, more systematic attention should be focused on their educational needs. This requires a comprehensive research and public policy agenda to establish efficacious educational practices addressing the specific learning needs of immigrant-origin students.

IMMIGRANT POPULATIONS IN CLINICAL CONTEXTS

A RESILIENCE PERSPECTIVE

Many immigrants adapt well to and thrive in their new living circumstances. They do so by navigating multiple sociocultural contexts in positive ways that contribute to their well-being and success in the United States. Studies suggest that first-generation immigrants may actually experience less psychological distress than second-generation immigrants (Alegría, Canino, Stinson, & Grant, 2006). While the "immigrant paradox" (see the Introduction) may lead to the conclusion that the first generation has reported lower than expected negative mental health outcomes, several caveats should be considered. It may be that the first generation is healthier than subsequent generations, but it may also be that several different issues are artificially deflating or confounding these prevalence rates. It may be possible that first-generation persons

- experience different disorders than ones included in Western psychiatric classification systems (e.g., neurasthenia) (S. Sue & Chu, 2003);
- have different idioms of distress (e.g., *ataque de nervios*) (Guarnaccia et al., 2007; I. López, Dent, et al., 2011);
- experience their symptoms in culturally different ways (e.g., fatigue or malaise instead of "depression") (Pumariega, Rothe, & Pumariega, 2005);
- are less likely to report their symptoms if they feel self-conscious about doing so (Nadeem et al., 2007); and
- are less likely to avail themselves of services either because this is not a culturally normative practice or because they simply do not trust outsiders (Whaley, 2001).

The tools used to assess clinical symptomatology are usually not calibrated for immigrant populations either linguistically or culturally.

In addition, the tools used to assess clinical symptomatology are usually not calibrated for immigrant populations either linguistically or culturally (Dana, 2005).

It is important to note that while those who immigrate voluntarily may, on the whole, be hardier or more resilient than nonimmigrant comparison populations, there are particularly vulnerable immigrant subpopulations (e.g., refugees, older adults, and LGBT populations) that are likely to constitute a very different profile with additional stressors that can have a negative impact on their mental health. Whether there is evidence to support the notion that immigrants are less likely than U.S.-born populations to experience mental illness, there is no evidence in the literature that immigrants are any more likely to experience mental illness or psychological distress than nonimmigrants, taking into account who does and does not seek treatment.

When immigrants do experience mental health difficulties, however, many are particular to the immigration experience. A wide range of mental health problems, including anxiety, depression, PTSD, substance abuse, and higher prevalence of severe mental illness and suicidal ideation, have been observed among immigrant populations in the United States (Desjarlais et al., 1995; Duldulao et al., 2009). Recent studies have also noted the unique presentation of psychological problems among immigrant children, such as a relationship between *ataques de nervios* and somatic complaints (I. López, Ramirez, Guarnaccia, Canino, & Bird, 2011).

The immigration process has the potential to serve as a catalyst for the development of a great variety of psychological problems and has been conceptualized as consisting of different phases (Akhtar, 2010; Tummala-Narra, 2009). Each of these phases involves negotiating loss and

separation from country of origin, family members, and familiar customs and traditions; exposure to a new physical environment; and the need to navigate unfamiliar cultural contexts. Given such experiences, many first-generation immigrants, particularly those individuals emigrating from countries in which the sociocultural context sharply contrasts with that of the United States, experience a variety of psychological problems, including stress.

While many immigrants experience considerable psychological distress in the face of unique stressors, it is worth noting that they also demonstrate resiliency, often making use of protective factors rooted within their specific cultural contexts. For example, some studies with Mexican-born immigrant adults found they have better mental health profiles than subsequent generations despite significant socioeconomic disadvantages. Possible explanations include greater use of protective traditional family networks, a lower set of expectations for "success" in America, and lower substance abuse (Escobar, Nervi, & Gara, 2000).

Difficulties that immigrants may experience as a result of such cultural differences are viewed as a dissonance that exists between their cultural frameworks and those of the receiving society.

Some studies have noted the ways in which ethnic identity is negotiated in the face of discrimination. For example, Hallak and Quina (2004), in their focus group study of young immigrant Muslim women in the United States, found that the women experienced both pride in their identifications with Islam and considerable hostility and prejudice directed against them. They coped with their distress by seeking spiritual meaning through religious faith support from their families and other members of their communities. These collectivistic coping strategies (e.g., seeking help from family or similar ethnic peers) have also been noted among Chinese and South Asian immigrants (Yeh, Inman, Kim, & Okubo, 2006).

When immigrants do require clinical treatment, a resilience and coping perspective is important to incorporate into the treatment process. Some immigrants may draw strength from family structures that U.S. therapists may judge negatively or misunderstand (Hong & Domokos-Cheng Ham, 2001). For example, a client who closely identifies with her Sri Lankan roots may be concerned about whether a mental health professional will be able to understand her distress concerning conflicts with her husband and her in-laws. She may find that a Western therapist judges her to be overly enmeshed with her husband and her extended family, rather than helping her to negotiate her position within her family, which she deeply values as a source of pride and self-esteem.

The present state of knowledge suggests that the therapist should attend to her distress in a way that recognizes and mobilizes her strengths as an individual who values her position and role in her family. It is important to note that what may be considered a strength in one cultural context may be considered deviant or undesirable in another (Harvey, 2007; Tummala-Narra, 2007a). Culturally competent treatment therefore requires an understanding of the complex interplay of pathology and resilience for immigrant clients.

CONTEXT MATTERS

This report focuses on understanding the immigration experience from a contextual perspective, with attention to the impact of cultures, societal institutions, and local settings. Consistent with an ecological perspective (Bronfenbrenner & Ceci, 1994), the report highlights the interaction of person and environment and related intersections of social identities (e.g., gender, race, ethnicity, age, sexual orientation, social class, disability/ability, and immigration status) in addressing mental health needs among immigrant communities.

From a cultural perspective, the experience of immigrants can be understood as encompassing efforts to fit between cultural frameworks. Immigrants bring with them cultural values, beliefs, and attitudes that may fit well or clash with those in the United States. From a contextual perspective, difficulties that immigrants may experience as a result of such cultural differences are viewed as a dissonance that exists between their cultural frameworks and those of the receiving society. For example, a 19-year-old male immigrant may receive conflicting messages concerning his career plans. His parents may believe he has an obligation to follow the wishes of older members of the family concerning his career choice, while his peers tell him he should not feel guilty for diverging from his family's plans for his career. In such a case, there is dissonance between the

value of family interdependence and the broader societal values of autonomy and independence.

With respect to mental health, the executive summary of the report of the surgeon general on mental health (U.S. Department of Health and Human Services, 2001) called attention to the importance of culture in the clinical context. Specifically, cultural context shapes the ways in which clients conceptualize and express psychological distress and resilience, cope with distress, and seek help. The report further states that the significance of culture is relevant not only to the client but also to the mental health professionals who provide help and the care system in which it is provided.

The societal and local community context can also be a source of stress for immigrants. One example of the interaction between macrolevel stressors and mental health is the intersection of high levels of poverty and a greater risk for mental disorders in immigrant communities. Other stressors that can affect immigrants' mental health and use of mental health services include the reception by the mainstream society (macrosystem), policies that restrict access to health care for immigrants (exosystem), limited networks of social support and opportunities (microsystem), and lack of knowledge about mental health services (mesosystem) (Pumariega & Rothe, 2010). Individual factors such as exposure to trauma during the migration process can further shape the ways in which immigrants experience, express, and cope with psychological distress.

Family cohesion and support from extended family have been associated with psychological well-being (Lueck & Wilson, 2010; Masood, Okazaki, & Takeuchi, 2009). A positive ethnic identity or a sense of belonging and involvement with one's ethnic community has also been associated with self-esteem and general psychological well-being (Phinney & Ong, 2007). Bearing in mind the complex interplay between person and context, the following sections describe some major presenting problems experienced by many immigrants: barriers to treatment, assessment and diagnosis, and intervention.

PRESENTING PROBLEMS

While most immigrants adapt well to their new lives, some face considerable psychological distress that may go unnoticed for various reasons, including cultural differences in views of psychological distress and coping. Differences in perceptions of mental health, preferred sources of help, and alternate coping styles have been thought to contribute to the underutilization of mental health services by immigrants (S. R. López & Guarnaccia, 2000). For example, informal sources of support, such as relatives, authority figures, community members, friends, or religious leaders, are an important resource for immigrants from collectivistic cultures (Yeh, Arora, & Wu, 2006). Further, some immigrants may express distress through somatic symptoms, which family and friends may not perceive to be psychologically driven. In this case, a primary care physician or someone familiar with traditional Western conceptualizations of psychological distress may note the individual's distress. Many of the mental health problems particular to the immigrant experience can be linked to experiences of acculturation, discrimination, and trauma.

Acculturation-Based Presenting Problems

Acculturation is a naturally occurring process that can result in either positive or negative outcomes, depending on existing contextual conditions (see Adaptation: Acculturation, Cultural Identity, and Civic Engagement). A variety of outcomes can ensue from the process. For example, acculturation processes can shape the expression of psychological distress, including culture-bound syndromes. In other instances, immigrants' experiences of gender roles can vary significantly between the country of origin and the new culture, at times characterized by feelings of increased sexual freedom and less adherence to traditional roles, and at other times by feelings of increased oppression and demands.

Changes in gender roles are at times connected with economic demands in the new environment, presenting opportunities for improved psychological well-being in some cases and psychological distress in others (Tummala-Narra, in press; Vasquez, Han, & De Las Fuentes, 2006). For example, a woman who might have had limited experience outside the home in her country of origin may be exposed to new ideas and gain greater independence now by working. At the same time, her husband may resent her freedom and independence and attempt to tighten the reins of his authority when she returns home. In another case, a child who immigrates to the United States may suddenly notice that the parents are working in different roles in the home when compared with their life in the country of origin. These shifts in gender roles can contribute to conflicts within families and affect an individual's adjustment to school and workplace.

As individuals negotiate their identities in a new cultural environment and find ways to cope with immigration-related stress, they may experience increasing tensions among family members. Intergenerational conflicts are common in immigrant households, reflective of an acculturation gap between parents and children and spouses and partners (Birman, 2006). Some manifestations of these conflicts are verbal arguments between parents and children regarding friendships, dating, marriage, and career choices and between spouses about gender role expectations (Varghese & Jenkins, 2009). In some cases, second-generation children and adolescents may experience role reversal when they are in a position to translate for their parents from their native language to English or to help their parents and/or grandparents navigate mainstream culture (C. Suárez-Orozco et al., 2008). Many older adult immigrants, particularly those who immigrate late in life and have limited English proficiency, experience loneliness and isolation related to difficulties in navigating a cultural context in which they may no longer be revered or sought out as respected elders by family and younger members of their communities (McCaffrey, 2008; Ponce, Hays, & Cunningham, 2006).

Intergenerational conflict can be experienced as a threat to the parent–child relationship, particularly when collectivism and interdependence within the family unit are valued. Several studies reveal that greater conflict with parents, particularly mothers, is associated with psychological distress, such as depressive symptoms (Varghese & Jenkins, 2009). Acculturative conflicts are often at the root of what brings immigrant families into treatment.

Trauma-Based Presenting Problems

A significant number of immigrants have had previous, recent, and/or ongoing experiences with traumatic, stressful immigration-related situations. Traumatic experiences can occur at various stages of the immigration process: premigration trauma or events that are experienced just before migrating; traumatic events that are experienced during the transit to the new country; ongoing traumatic experiences in the new country; and substandard living conditions in the new country due to unemployment, inadequate supports, and discrimination and/or persecution (Foster, 2001). Any of these traumatic events can affect the ways in which immigrants adjust to their new cultural context. For example, a woman who leaves her country of origin with her children to escape ongoing community violence and poverty and is raped while in transit faces not only the challenges of adjusting to a new cultural context and caring for her children but also the traumatic aftermath of the rape, involving overwhelming states of anxiety and hypervigilance.

Research on interpersonal violence among immigrant communities in the United States has focused primarily on intimate partner violence (Raj & Silverman, 2003). Several studies with immigrant women have documented the relatively low rate for reporting domestic violence. The likelihood of reporting abuse incidents and seeking help may increase only when the violence reaches a severe level (Abraham, 2000; Krishnan, Hilbert, & VanLeeuwen, 2001). Other studies indicate that immigrant women experiencing more severe abuse may be the least likely to disclose the abuse to others (Yoshioka, Gilbert, El-Bassel, & Baig-Amin, 2003). These divergent findings may be accounted for, at least in part, by the prevalent use of shelter samples and the tendency to lump together groups of ethnically diverse women (e.g., using a Vietnamese sample to represent Asian Americans as a group) (Liang, Goodman, Tummala-Narra, & Weintraub, 2005).

Aside from emerging research in the area of domestic violence, research on childhood sexual abuse, physical abuse, rape, and political and racial trauma in immigrant communities is sparse. Traumatic experiences place immigrants at risk for mental health problems, including depression and anxiety disorders, and particularly posttraumatic stress disorder (Maddern, 2004; Radan, 2007). Risk factors affecting the degree of symptomatology and impairment include poverty, education, subsequent unemployment, low self-esteem, and poor physical health (E. Hsu, Davies, & Hansen, 2004). The research and clinical literature has noted the ways in which interpersonal and collective violence compromises immigrant adults' and children's identifications with both the country of origin and the adopted country. In addition, such violence can impact the way psychological distress is manifested in culturally specific ways (e.g., anxiety can be expressed through somatic symptoms) (Radan, 2007; Tummala-Narra, 2007a). Culture-bound illness expression, culture-bound syndromes, and cultural bereavement in response to the stresses of the acculturation process are significant problems that can resemble, but are distinct from, Western-oriented psychiatric symptoms and disorders (Davis, 2000).

Undocumented immigrant children and youth are frequently subject to particularly traumatic experiences (Capps et al., 2007), including racial profiling, ongoing discrimination (Parra-Cardona, Bulock, Imig, Villarruel,

& Gold, 2006), exposure to gangs (Passel & Cohn, 2009), immigration raids in the community, the arbitrary checking of family members' documentation status (e.g., Arizona SB 1070, Secure Communities Act), forcible removal or separation from their family for an indeterminate period of time (Capps et al., 2007), discovery upon returning home that their family has been taken away, violation of their home by authorities, placement in detention camps or in child welfare, and deportation to their country of origin.

A report by the Urban Institute (Chaudry et al., 2010) titled *Facing Our Future: Children in the Aftermath of Immigration Enforcement* documents the effects of these traumatic experiences on children. The report indicates that the vast majority of children whose parents were detained in U.S. Immigration and Customs Enforcement raids in the workplace and home exhibited multiple behavioral changes in the aftermath of parental detention, including anxiety, frequent crying, changes in eating and sleeping patterns, withdrawal, and anger. Such behavioral changes were documented 2 to 3 months after the arrest, as well as at a 9-month follow-up. It is disturbing to note that the children also experienced dramatic increases in housing instability and food insecurity, which are both dimensions of basic well-being (Chaudry et al., 2010).

Such traumatic and challenging experiences and transitions can produce a range of psychological problems (Capps et al., 2007), including poor identity formation, inability to form relationships (R. G. Gonzáles, 2010), PTSD, acculturation stress, intergenerational conflict (Kohatsu, Concepción, & Perez, 2010), feelings of persecution, high distrust of institutions and authority figures, fear of school, inability to concentrate, acting-out behaviors, eating disorders, loss of motivation (i.e., lowered aspirations and expectations), depression, anxiety, difficulties in school performance and matriculation (C. Suárez-Orozco et al., 2008), and dropping out of school (Capps et al., 2007). Research on various types of traumatic exposure—interpersonal, political, and racial—within different immigrant communities is sorely needed to better understand how sociocultural context supports and/or burdens trauma survivors.

Discrimination- and Racism-Based Presenting Problems

Immigrants, especially those of color, are often the targets of discriminatory practices (M. H. Lopez et al., 2010) or at least the victims of microaggressions (D. W. Sue et al., 2007) (see the Social Context of Reception and Immigrant Adaptation section). Whether subtle or overt, the negative impact of discrimination on the psychological well-being of an individual is still the same (D. W. Sue et al., 2007). Both overt and aversive forms of racism and microaggressions have important implications for immigrant individuals' sense of well-being and belonging (Dovidio & Gaertner, 2004; D. W. Sue, 2010). Specifically, experiences of racial/ethnic discrimination have been associated with mental health problems, including depression, anxiety, substance abuse, and suicidal ideation (Alegría et al., 2004; Cheng et al., 2010; Gee et al., 2007; A. G. Tran, Lee, & Burgess, 2010; Tummala-Narra, Alegría, & Chen, 2011) (see the APA Resolution on Prejudice, Stereotypes, and Discrimination; APA, 2006).

Negative and potentially hurtful stereotypes, when ascribed to immigrants, can further result in a loss of personal control, especially for young immigrants (Flores & Kaplan, 2009). Profiling contributes to a social atmosphere that produces fear and anxiety for those immigrants, especially those of color, who might possibly live in fear of being spotted and deported. This is especially relevant in the context of some highly publicized laws that allow law enforcement to actively seek out perceived immigrants (e.g., Arizona SB 1070). A unique factor relative to undocumented immigrants is that they may experience guilt and shame and are often treated as "second-class" persons (M. M. Sullivan & Rehm, 2005). In summary, the racial and political contexts of the adopted country affect immigrant adults' and children's (both authorized and unauthorized) sense of safety and belonging and their ability to trust that systems of care will be able to help them when they are facing mental health challenges.

Research has also demonstrated a relationship between perceived discrimination and decreased use of mental health services, as well as the use of collectivistic coping strategies (Gee et al., 2007; Jang et al., 2010; Tummala-Narra, Inman, & Ettigi, 2011; Yoshikawa et al., 2004). Considering evidence for the role of racial discrimination in psychological distress, future research is necessary to investigate the unique ways in which discrimination is experienced by immigrants and differences across gender, generation (first vs. second vs. third), and social class. Additionally, future research can address the intersectionality of social identities (e.g., race, culture, language, immigration status, age, gender, sexual orientation, social class, religion, and ability/disability status) and its relationship to immigrants' experience of and ability to cope with discrimination.

BARRIERS TO TREATMENT

While an increasing number of immigrants are seeking mental health services, most immigrants underutilize these services. A number of barriers to culturally sensitive and appropriate mental health services for racial/ethnic minority and immigrant populations have been well documented in the literature. Both distal and proximal barriers (Casas, Raley, & Vasquez, 2008) affect the use of mental health services by immigrants. These barriers can be broadly grouped into the following categories: social-cultural, contextual-structural, and clinical-procedural.

Some important **social-cultural barriers** include differences in symptom expression (e.g., somatic symptoms) (Alegría et al., 2008) and conflicting views about the causes of (i.e., attributions) and ways of coping with mental problems (Atkinson, 2004; Koss-Chioino, 2000). For example, some immigrants may view self-help as the best means of dealing with mental health problems (Donnelly et al., 2011) or may lack an understanding of how psychological problems can be treated from a Western perspective (Inman & Tummala-Narra, 2010; Leong & Lau, 2001; M. C. Wu, Kviz, & Miller, 2009). Others may prefer alternate sources of help rooted in their cultural contexts (e.g., curanderos, Ayurvedic healers, priests, and imams) (Comas-Díaz & Greene, in press; McNeill & Cervantes, 2008).

Another social-cultural barrier involves stigma, which some cultures associate with mental health problems (Brach & Fraser, 2000; Leong, Wagner, & Tata, 1995; Nadeem et al., 2007; Wu, Kviz, & Miller, 2009). More specifically, some cultures that maintain strong family ties see individuals with mental health problems as bringing shame to the family, destroying the family reputation, exemplifying an overall family weakness, or as retribution for family wrongs (Hong & Domokos-Cheng Ham, 2001). In some cases, individuals may believe that mental health care should be sought for more severe problems, such as psychosis, but not for problems thought to be less serious (e.g., anxiety, depression).

Contextual-structural barriers include lack of access to appropriate and culturally sensitive mental health services (Lazear, Pires, Isaacs, Chaulk, & Huang, 2008; Wu et al., 2009), lack of knowledge of available mental health services (Garcia & Saewyc, 2007), shortage of racial/ethnic minority mental health workers and/or persons trained to work with racial/ethnic minority persons (APA, 2009a), older persons and culturally diverse elders (APA, 2009b), lack of access to interpreters, and lack of resources (e.g., lack of child care, transportation, finances) for accessing services (M. Rodríguez et al., 2009).

Unauthorized immigrants face additional challenges related to documentation status (e.g., ineligibility for services provided by the county or state, fear of identification as undocumented, and deportation) (Yoshikawa, 2011). Those who live a migrant existence typically do not seek help, either due to fears related to unauthorized status or to moving from place to place in search of work (Hadley et al., 2008). Immigrants in rural areas may face additional barriers including lack of access to culturally competent services and service providers (Cristancho, Garces, Peters, & Mueller, 2008).

Clinical-procedural barriers include lack of culturally sensitive and relevant services (Maton, Kohout, Wicherski, Leary, & Vinokurov, 2006); "clinician bias" (Maton et al., 2006); communication problems related to language differences and cultural nuances (Kim et al., 2011); misdiagnosis of presenting problems (Olfson et al., 2002); failure to assess cultural, linguistic, and procedural appropriateness of tests for targeted populations (Dana, 2005; Kwan, Gong, & Younnjung, 2010; Suzuki et al., 2008); lack of attention to culturally embedded expressions of resilience (Tummala-Narra, 2007a); and failure to use the most efficacious mental health interventions (McNeill & Cervantes, 2008) (e.g., evidence-based interventions adapted for use with minority and immigrant populations). Clinicians may also use Western-based theories of development that may not be suitable when working with immigrants from collectivistic cultures (Zeigenbein, Calliess, Sieberer, & Machleidt, 2008). For example, a clinician may downplay the role of religion and spirituality in the client's life (McNeill & Cervantes, 2008) and overemphasize autonomy and independence as therapeutic goals (Dwairy, 2008).

While contextual-structural and clinical-procedural barriers can be found across varied regions of the United States, they are becoming ever more prevalent in small towns and rural communities of the South and Midwest, where a growing number of immigrants from Mexico, Central America, and South America in search of low-skilled labor opportunities are settling. Unfortunately, these communities particularly lack the service infrastructure that is necessary to meet the mental health needs of Latino immigrants (e.g., access to health care, immigration assistance, and breaking down language barriers) (Buki & Piedra, 2012).

TREATMENT CONSIDERATIONS

Assessment and Diagnosis

There is extensive literature suggesting that assessment and diagnosis are challenging when working with immigrants in clinical settings (Comas-Díaz, 1997; Park-Taylor et al., 2010; Vazquez-Nuttall et al., 2007). Having previously addressed these challenges in some detail in the section on Assessment in Clinical Settings, we now highlight a few that are directly tied to the culturally encapsulated assessment instruments themselves: a lack of standardized translations of assessment instruments, as well as a lack of appropriate normative standards and studies concerning the reliability of test scores with various immigrant groups. From a more comprehensive perspective, it is important that the role of sociocultural context be comprehensively understood and seriously dealt with in the clinical process in order to provide ethical and appropriate standards of care in assessment, diagnosis, and treatment.

A challenge in assessment with immigrants is the lack of valid and culturally appropriate diagnostic tools sensitive and comprehensive enough to capture cultural variability in the symptomatic expression of and coping with psychological distress. This presents significant challenges to psychologists who may rely on established testing and assessment strategies and instruments. For example, failure to take culture into consideration can result in "clinician bias," which may be manifested in the tendency to universally apply Eurocentric models of illness, contributing to overpathologizing and a lack of attention to resilience (Dana, 1998) (see Assessment With Immigrant-Origin Adults and Children).

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It is important to note that the system of diagnosis outlined in the fourth edition (text revision) of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–IV–TR*; American Psychiatric Association, 2000) has been thought to have universal applicability even though this diagnostic system is culturally constructed in a way that privileges Western or Eurocentric notions of mental illness (Pieterse & Miller, 2010). While the most recent edition of the *DSM* does offer guidelines for culture-specific diagnosis, it fails to acknowledge that the diagnostic system in the *DSM–IV–TR* is culturally specific (Pieterse & Miller, 2010). The diagnostic process itself can emphasize pathology and weakness over resilience and resources (Atkinson, 2004). Although it is true that the *DSM–IV–TR* includes a culture-specific section in the text, an appendix of culture-bound syndromes, and an outline for cultural formulation to enhance the cross-cultural applicability of the manual, it continues to be insufficient in addressing cultural variability (Park-Taylor et al., 2010; Roysircar, 2005).

Alternative diagnostic methods that supplement traditional psychiatric diagnostic approaches can be used to better assess and describe immigrant clients' psychological distress (Pedrotti & Edwards, 2010), such as looking at disorders as lying on a continuum as opposed to being "present" or "absent" (Oldham & Morris, 1995). Further, it is important that clinicians self-assess the extent to which their socialization informs their evaluation of the racial and cultural data of the client (see Suzuki et al., 2005).

Because of the limitations of existing diagnostic systems, scholars recommend that all phases of assessment and diagnosis, including the clinical and/or diagnostic interview, test administration, interpretation, report writing, and feedback to the client, consider the social, cultural, and linguistic context of immigrant clients and the coexistence of pathology and resilience (Harvey, 2007). Clinicians should consider the fairness and utility of diagnostic tests in the context of language, educational background, and cultural norms. It is also important that clinicians understand the implications of psychological testing and diagnosis on an individual basis and recognize that many immigrant clients are concerned about diagnostic labels due to cultural stigma and/or immigration status. Additionally, routine consultation with colleagues who may be more familiar with the client's sociocultural context, the specific diagnostic tests being considered, and culture-bound syndromes would be especially helpful in tailoring a culturally competent approach to assessment and diagnosis (see Assessment Challenges).

Up to this point, assessment has mainly and quite appropriately been addressed in reference to educational

and traditional mental health settings. However, given the increasing number of contacts that a significant number of immigrants are likely to have with such institutions as law enforcement, the judiciary system, and immigration services (i.e., Immigration and Customs Enforcement), it behooves us to address assessment issues and challenges that exist in these settings.

INTERVENTION

The present state of knowledge concerning clinical practice suggests that to provide the most effective mental health services to immigrants, clinicians should apply the following guiding principles:

- Use an ecological perspective (Bronfenbrenner & Morris, 2006) to develop and guide interventions.
- Integrate evidence-based practice with practice-based evidence.
- Provide culturally competent treatment.
- Use comprehensive community-based services.
- Use a social justice perspective as a driving force for all services.

While these principles are referenced throughout the report, they are presented here in more detail to underscore their importance in guiding clinical interventions.

Ecological Framework

In line with one of the underlying perspectives inherent in this report and with recommendations put forth by various multicultural psychologists (e.g., Casas et al., 2008), it is recommended that clinicians give serious consideration to the use of an ecological framework (Bronfenbrenner & Morris, 2006). As previously noted in this report (see the Introduction), such a framework is based on the belief that the human experience is a result of reciprocal interactions between individuals and their environments, varying as a function of the individual, his or her contexts and culture, and time. Each context offers particular risks as well as protective factors that either detract from or enhance healthy adaptation. They need to be understood in framing the immigrant experience and considered in the development and implementation of mental health treatments.

Using this framework, a clinician should gather relevant information from the five systems that subsume the client's contexts and culture (i.e., the micro-, meso-, exo-, macro- and chronosystems) (see the Introduction). As noted in *Resilience and Recovery After War: Refugee Children and Families in the United States* (APA, 2010c, p. 4), the information that should be gathered to inform interventions includes effects of migration (before, during, and after), legal/documentation status, acculturation, risk and resilience, cultural and religious beliefs, age of migration/developmental stage, race, ethnicity, gender, social class, sexual orientation, disability/ability, experiences of racism and discrimination, language and educational barriers, and access to services and resources. This information is often critical to developing a complex understanding of the individual's experiences of distress.

Evidence-Based Practice and Practice-Based Evidence

An important dialectic in mental health intervention research involves evidence-based practice and practice-based evidence. Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise. The purpose of EBPP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention (Kazdin, 2008).

Evidence-based practice approaches psychological treatment with the assumption that individual characteristics and sociocultural context both play important roles in assessment and intervention (La Roche & Christopher, 2009; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). There has been growing discussion in the field about prioritizing evidence-based treatments (EBTs) over practice-based adaptations of these treatments or practice approaches judged appropriate by clinicians but not empirically tested in randomized clinical trials.

Efficacy research that identifies EBTs incorporates randomized controlled trials and focuses specifically on outcomes that result from care provided by well-trained mental health professionals. To make causal inferences about intervention effectiveness, randomized clinical trials use tightly controlled designs, carefully select their client populations, maintain strict fidelity to the intervention model, and use well-trained mental health professionals proficient in the service model being tested (La Roche & Christopher, 2009). But many such studies have been

criticized for limited generalizability outside the university clinic settings where they are developed and particularly to ethnic minority and immigrant populations.

A few studies have examined the effectiveness of evidence-based practice with immigrant clients in treatment. For example, Duarté-Veléz, Bernal, and Bonilla (2010) described a culturally adapted cognitive–behavioral therapy (CBT) for a Latino adolescent coping with depression. This adaptation of CBT involved the consideration of specific cultural values concerning sexual orientation, masculine identity, spirituality, and family. Two other examples of treatments that have demonstrated effectiveness with immigrant populations include the Culturally Informed and Flexible Family-Based Treatment for Adolescents (Santisteban & Mena, 2009), which combines family and individual CBT with educational interventions to treat intrafamily stress and conflict, and Cuento Therapy (TEMAS; G. Constantino et al., 1988), a culturally sensitive cognitive therapy-based intervention aimed to reduce anxiety and improve academic self-esteem and performance with Latino/a students.

Research on culturally adapted interventions indicates that interventions in clients' native languages are more effective than those conducted in English, culturally adapted interventions are more effective than those not targeted to specific cultural groups, and ethnic matching in the therapeutic dyad is likely to improve client retention and therapeutic outcome.

Despite these studies, research documenting the effectiveness of EBTs with diverse communities is still in its infancy. In fact, much of what is known about the use of EBTs with immigrants has been drawn from research on the impact of evidence-based mental health treatments on ethnic minorities, particularly African American and Latino/a American clients. Miranda et al. (2005) found substantial evidence demonstrating that evidence-based treatments for depression (e.g., CBT) improve outcomes for African Americans and Latinos and that these results are equal to or greater than those for White Americans. Research on the EBTs with Asian Americans has been very limited, and the evidence that does exist seems to suggest that cognitive therapy is effective for the treatment of anxiety and depression (C. G. Hall & Eap, 2007; Miranda et al., 2005).

C. G. Hall and Eap (2007) cautioned, however, that "this evidence is based on relatively few patients" (p. 455) and that these studies have been criticized for their methodology. Implementation of EBTs in real-world settings, such as community clinics and schools, involve numerous challenges. In particular, extensive adaptations to the intervention are often required, though researchers reporting on intervention effectiveness rarely report on the various adaptations made in the implementation process.

In recent years, another approach has been evolving in the field among those advocating for learning from practice-based evidence (Birman et al., 2008). While empirically based researchers generally treat existing community practices, or "treatment as usual," as substandard practices, many clinical programs have developed creative ways of working with immigrant populations that have not yet been documented in the literature. For example, the Latino Mental Health Clinic, the Haitian Mental Health Clinic, the Portuguese Mental Health Clinic, and the Asian Mental Health Clinic at the Cambridge Health Alliance are outpatient clinics staffed by immigrant and multilingual mental health practitioners who have provided direct clinical services (assessment, psychotherapy, and psychopharmacology) to immigrant communities for over a decade.

Rural areas also have needs for these types of services, though access can be difficult. In Maine, for example, the Maine Migrant Health Program provides integrated primary care from a mobile van to address this barrier. Although several clinicians have written about their experiences with clients in these clinics (Desrosiers & St. Fleurose, 2002; Halperin, 2004; Tummala-Narra, 2009), a lack of resources for systematic research has precluded documentation of the lessons learned in clinical practice with these different immigrant communities. Nonetheless, it is important to learn from the wisdom of these clinicians and how they have modified traditional approaches to treatment in their work with immigrant clients. Thus, the practice-based evidence approach seeks to understand "practice as usual" and gather evidence on its effectiveness (Beehler, Birman, & Campbell, 2011; Birman et al., 2008).

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effective than those conducted in English, culturally adapted interventions are more effective than those not targeted to specific cultural groups, and ethnic matching in the therapeutic dyad is likely to improve client retention and therapeutic outcome (Alegría, Vallas, & Pumariega, 2010; T. Smith, Domenech Rodríguez, & Bernal, 2011). As such, it is particularly important to understand "practice as usual" because when evidence-based treatments are implemented, they are integrated into existing practice settings. With increasing pressure to implement evidence-based treatments, providers who have been serving immigrant communities for many years are faced with integrating their existing practices with intervention approaches developed for different populations than the ones they serve.

For example, the mental health clinics at the Cambridge Health Alliance have developed ways to provide psychotherapy that integrate psychodynamic and CBT approaches with the client's specific cultural beliefs and practices. These clinics have also implemented these practices with clients coping with mental illness and immigration-related stress within constraints of limited economic resources and managed-care models.

It is worth noting that evidence-based treatments frequently target a particular constellation of symptoms. Although in a university clinic, where such interventions are developed, clients are selected to fit the intervention criteria, in community-based clinics, providers must find treatments that work for a range of clients seeking services. This is particularly true for clinics that provide culturally sensitive services to immigrants because referral to other clinics or treatments may not be an option. As a result, evidence-based treatment must be implemented into an overall practice model.

Research is also needed to support the continued use of those interventions rooted in practice-based evidence. In addition, while some graduate students in psychology are exposed to training in community-based clinics that provide services to immigrant communities, it is important to consider that most graduate and postgraduate students in psychology do not have access to training specific to immigrants' concerns or practice-based interventions.

Culturally Competent Treatment

According to APA, cultural competency should be an inherent principle that underscores all work performed by psychologists. This position is aptly presented in the APA mission statement as well as in varied documents and publications, including the *APA Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change* (APA, 2002). The fact that these guidelines were developed not only for individuals from minority ethnic and racial groups but also for other groups, including immigrants, makes them quite relevant in reference to the targeted populations of this report.

For the sake of clarity and consistency, the definition of *culturally competent* used here is the same as the one provided in the APA's (2010c) report on refugees: "the capacity of programs to provide services in ways that are acceptable, engaging, and effective with multicultural populations" (Birman, Ho, et al., 2005, p. 12). Over the past 2 decades, numerous researchers have addressed cultural competency from a variety of perspectives and across differing contexts (APA, 2002; Marmol, 2003; Mason, Benjamin, & Lewis, 1996; Nastasi, Moore, & Varjas, 2004; Pedersen, 2003; Vargas & Koss-Chioino, 1992; Vera, Vila, & Alegría, 2003) and have clearly shown that to obtain effective clinical outcomes, both clinicians and the services provided need to be culturally sensitive and competent.

Cultural competence involves three broad dimensions: therapists' cultural knowledge, therapists' attitudes and beliefs toward culturally different clients and self-understanding, and therapists' skills and use of culturally appropriate interventions (Helms & Cook, 1999; D. W. Sue, Arredondo, & McDavis, 1992). Cultural competence in practice includes attending to actual treatment practices and promoting access to services, such as interpreters and legal assistance. In addition, in recent years scholars from different theoretical orientations (e.g., cognitive–behavioral, psychodynamic, family systems, humanistic, and integrative) have increasingly addressed issues of diversity and cultural competence.

For example, cognitive–behavioral scholars have noted the importance of the client's cultural context in evaluating thought patterns and behaviors (Hays, 2008; Newman, 2010). Psychodynamic scholars have focused on the analysis of culturally and racially based transference and countertransference in the therapeutic relationship (Ainslie, 2009; Comas-Díaz & Jacobsen, 1995; Tummala-Narra, 2007b). As different types of therapy (e.g., cognitive–behavioral and psychodynamic) have been found to be efficacious (Newman, 2010; Shedler, 2010), future research should address the ways in which clinicians from different theoretical orientations can further develop cultural competence to meet the mental health needs of immigrant clients.

Comprehensive Community-Based Services

To ensure positive outcomes for the client, clinicians must find ways to collaborate with the various contexts/systems that are a part of the client's life, thereby validating and empowering the client. In line with systems of care models (Casas, Pavelski, Furlong, & Zanglis, 2001), an outcome of such collaboration is the establishment of comprehensive community-based services that provide mental health, social, legal, and educational assistance and are located in settings where the target immigrant population is likely to be found (e.g., schools, churches, and community centers) (Birman et al., 2008; Hernandez et al., 2007). These services offer an alternative to clinic-based services (Birman et al., 2008). From a contextualist perspective, comprehensive community-based services are critical because they address the larger context of immigrants' lives. For them, therapy in a clinical setting is but one component of the overall treatment model.

Educational settings, including public, parochial, and community colleges, have been identified as effective sites from which to provide diverse mental health services to immigrant children and their families (Ehntholt, Smith, & Yule, 2005; Fazel, Doll, & Stein, 2009; Kataoka et al., 2003; O'Shea, Hodes, Down, & Bramley, 2000; Rousseau, Drapeau, Lacroix, Bagilishya, & Heusch, 2005; Rousseau et al., 2007; Stein et al., 2003). Educational sites are effective sites from which to reach adults, families, and their children because services (like ESL classes) are often already in place, helping to facilitate ready bonds of trust within the community (Kataoka et al., 2003). Further, schools are frequently spaces in which familial acculturative and adjustment struggles unfold (Birman et al., 2007).

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One example of an effective intervention is Cultural Adjustment and Trauma Services (CATS), a school-based mental health program for immigrant children and adolescents (Beehler et al., 2011). This program provides a range of clinical and case management/support services to students and families (e.g., food pantries, job placement, afterschool support groups, and guidance regarding class schedules and college admissions), their teachers (e.g., consultation on classroom practices, assistance in academic placement decisions, and phone calls with parents in their native language), and administrators and staff (e.g., orientation to immigrant students' cultures and translation services). The intent of this program is to intervene to prevent relatively simple adjustment problems from progressing to more serious psychological difficulties.

By attending to mental health concerns, such services can reduce barriers to learning (Adelman & Taylor, 1999). Mandatory school attendance ensures access to a broad range of children, creating opportunities for screening and early intervention (Birman & Chan, 2008). Stigma surrounding mental health services can be reduced when provided as an educationally connected intervention in a safe, familiar setting, and schools have natural access to families who may be reluctant to seek mental health services for their children in more traditional settings. There is evidence that when varied services are provided together, there is an increase in the use of mental health services.

Social Justice Perspective

The social justice perspective in psychological treatment is rooted in the belief that all people have a right to equitable treatment and a fair allocation of societal resources, including decision making (Crethar, Torres Rivera, & Nash, 2008). Psychologists committed to a social justice perspective must work toward making society a better place for all by challenging systemic inequalities (Corey, Corey, & Callanan, 2011). The social justice framework requires a paradigm shift in the way psychologists, counselors, and other service providers perceive the therapeutic process (Herlihy & Watson, 2007).

Counseling or psychotherapy may not necessarily be a one-on-one, in-office encounter, nor do the client's presenting problems necessarily originate within the self. To this end, Atkinson (2004; Atkinson, Thompson, & Grant, 1993) suggested that in the process of selecting roles and strategies when working with racial/ethnic minority and immigrant clients, counselors need to take into consideration three factors, each of which exists along a continuum: (a) client level of acculturation to the dominant society (high to low), (b) locus of problem solving (external to internal), and (c) goals of helping (prevention, including education/

development, to remediation). Therapists may take on a variety of roles depending on client needs and points of intersection along the continuums of acculturation, locus of problem solving, and goals of helping: advisor, advocate, facilitator of indigenous support and healing systems, consultant, change agent, counselor, and psychotherapist (Atkinson et al., 1993).

To successfully follow a social justice perspective, clinicians must make use of the ecological framework to conceptualize all of the contributing factors associated with a presenting problem. By so doing, clinicians will have the kind of sociocultural information necessary to develop and/or identify the most appropriate and potentially effective EBTs and interventions. Successful implementation of such interventions with immigrants and other groups that share similar characteristics will require that clinicians be prepared to assume new and diverse helping roles. Therapeutic interventions should seek to help individuals both change themselves and take steps to change the conditions contributing to the problems they face (Homan, 2008). Change must occur not only within the client but also across the systems, structures, organizations, and policies that impact them (Yeh & Kwan, 2010). Such changes are necessary to improve access and equitable conditions for oppressed and marginalized groups (Goodman et al., 2004).

IN CONCLUSION

There is a growing body of research that documents life experiences (e.g., the immigration experience itself) and contextual conditions (e.g., poverty and discrimination) that put some immigrants and their families at risk for experiencing diverse mental health challenges. Further, some types of challenges faced by immigrants, such as interpersonal, racial, and political trauma, are especially important for clinicians to recognize, as they tend not to be discussed openly and yet often compromise positive adjustment and well-being (APA, 2010c). It is also important to recognize that various factors (e.g., social-cultural, contextual-structural, and clinical-procedural) contribute to an underutilization of mental health services among immigrant populations. Evidence from research and clinical practice calls for increased attention to the interplay between resilience and pathology to better understand the nature of mental health challenges and intervention effectiveness.

Much of what is known about the use of evidence-based treatments with immigrants has been extrapolated from research on ethnic minorities (Miranda et al., 2005); only a few studies have examined the effectiveness of evidence-based treatments with immigrant populations (Beehler et al., 2011; G. Constantino et al., 1988; Duarté-Veléz et al., 2010; Kataoka et al., 2003; Santisteban & Mena, 2009). While research on the utility of evidence-based treatments with immigrants is clearly needed, clinicians and researchers can benefit from attending to practice-based evidence that offers important lessons in culturally competent interventions (Birman et al., 2008).

This report outlines five recommendations regarding ways in which practitioners can increase the accessibility and efficacy of services: (a) use an ecological perspective (Bronfenbrenner & Morris, 2006) to develop and guide interventions, (b) integrate evidence-based practice with practice-based evidence (Birman et al., 2008), (c) provide culturally competent treatment (APA, 2002; Birman, Ho, et al., 2005; Marmol, 2003; Nastasi et al., 2004; Pedersen, 2003; Vera et al., 2003), (d) partner with community-based organizations (Birman et al., 2008; Casas et al., 2001), and (e) incorporate social justice principles in providing service (Crethar et al., 2008). Additionally, we underscore the importance of providing accessible and affordable mental health services for immigrant communities.

Evidence suggests that awareness of context at every stage of planning and implementation of assessment and intervention is necessary for ethical and effective practice with immigrant clients. Attention to context is also essential to accurately assess pathology and resilience, as exemplified in the unique presenting issues and approaches to coping with distress among immigrant clients. Thus, it is recommended that clinicians and researchers consider the critical role of social, cultural, economic, and political contexts in the experience of immigration, acculturation, and psychological well-being.

Clinicians would benefit from using knowledge from multiple sources of evidence in their approaches to assessment and treatment with immigrant clients. In particular, evidence from empirical studies and from practice that is adapted to suit the mental health needs of specific groups can be used to guide the development of innovative clinical practices in clinics and community settings. It is important that research be conducted to ascertain the generalizability of findings emanating from EBT research to diverse populations (National Implementation Research Network, 2003; Miranda et al., 2005). As in all interventions,

cultural competency must be an inherent part of EBPs. As noted succinctly by Isaacs, Huang, Hernandez, and Echo-Hawk (2005),

> evidence-based practices could exacerbate and deepen existing inequalities if they are implemented without sufficient attention to cultural competence and/or if policy makers fail to take into account the many practices within diverse communities that are respected and highly valued by these groups. (p. 5)

Research that focuses on systematic application and measurement of operationalized indicators of cultural competence is needed to improve access to services and reduce mental health disparities across diverse groups in general (Isaacs et al., 2005).

Although the field has made important strides in adopting cultural competence as a core value in clinical practice and research, the implementation of the *Multicultural Guidelines* has met with varied challenges (Vasquez, 2010). There is a dearth of literature on the specific ways in which cultural competence is implemented in clinical practice with specific immigrant populations and, more important, the actual impact that such implementation has on outcomes (Miranda et al., 2005). Thus, there is a need for research that addresses the unique applications and outcomes of cultural competence within different immigrant communities.

At the present time, mental health practitioners have limited access to the lessons learned in clinical and community settings in which traditional approaches have been modified effectively with immigrant clients. Furthermore, there is limited knowledge about psychological tests and assessment procedures (e.g., clinical interviews) that are contextually driven (see Assessment With Immigrant-Origin Adults and Children). To improve the assessment of immigrants, future research can address the need for relevant psychological tests and procedures that address contextual factors.

Most training programs do not offer cultural-competency training specific to the needs of immigrant clients (APA, 2010c). In addition, most practice settings are not staffed by clinicians of immigrant backgrounds or by interpreters. Clinicians are also not trained in how to work through and in tandem with interpreters (APA, 2010c). The lack of access to immigrant practitioners is of particular concern, as many immigrant clients prefer to work with a therapist of a similar background and/or with a therapist who is fluent in their native languages. The growing gap between the increasing need for mental health services among immigrant communities and the disproportionately low number of immigrant and ethnic minority mental health practitioners is a problem that needs to be addressed at the systemic level. At present, there is a dire need for more immigrant-origin, multicultural, and multilingual clinicians. To address this need, the APA's commitment to provide needed resources to recruit and train mental health service providers that can understand and effectively address the diverse social and psychological needs of immigrants is especially important. It is not sufficient to recruit trainees to programs. Rather, provisions for financial and professional support and mentoring are essential to ensure successful training.

These recommendations address the research, training, and practices that must be put in place to effectively and equitably meet the mental health needs of the immigrant populations that now constitute a significant part of the total U.S. population. Overcoming barriers to services can and should build on the inherent strengths and resources of this complex population. By better meeting the needs of this country's immigrant-origin population, not only will psychologists step up to the APA mission to "improve people's lives" but help strengthen the very foundation of this diverse nation.

CONSIDERATIONS FOR THE FIELD

The United States today is host to its largest number of new immigrants in history. But as a nation of immigrants, the United States has successfully negotiated larger proportions of newcomers in its past, and it is not alone among OECD nations in encountering immigrant populations today (see The Why and Who of Immigration). In this time of economic crisis, immigrants are routinely becoming the subjects of negative media coverage, hate crimes, and strict legislation on the municipal, state, and federal levels (see Introduction). This adverse climate can have negative repercussions for immigrants themselves and for their citizen children, many of whom, as previously mentioned, are U.S. citizens (see the Social Context of Reception and Immigrant Adaptation).

In comparison to the disciplines of sociology, demography, and economics, psychology has been slow to recognize the growth in the immigrant population over the last few decades (C. Suárez-Orozco & Carhill, 2008; C. Suárez-Orozco & Qin, 2006). Yet these individuals and their children are an ever-growing presence in U.S. schools, communities, clinics, and the larger society. Scholarship in psychology has only recently acknowledged this demographic shift, often confounding immigrants with other ethnic minority populations and rarely considering first- or second-generation distinctions (see the Introduction). Given the demographic imperative, the field of psychology is long overdue to take stock of the situation.

In this report, the APA Presidential Task Force on Immigration aimed to provide an account of what is known and what needs to be known about immigrant adults (including older adults), children and adolescents, and families. We were particularly interested in addressing the psychological experience of immigration by considering factors that both facilitate and impede adjustment and using ecological and strength-based perspectives. We concurred with the surgeon general's recommendation that a culturally congruent perspective is essential when working with diverse populations. The intent was to provide clear guidelines to frame research, practice, education, and policy agendas. The literature, however, revealed that evidence in the field is flawed for a variety of reasons. Summaries of these limitations and recommendations to move the field of psychology forward in its approach to immigration follow.

METHODOLOGICAL CHALLENGES

In many studies, immigration status or generation is ignored or omitted. When it is considered at all, it is often confounded with race or ethnicity or used as a "controlled variable." To do so is misleading, as immigration, culture, race, and ethnicity are separate categories and are embedded within the context of several potential mediators, moderators, and outcomes (APA, 2010c). While constructs may be shared across groups, their expression may be culturally and socially defined. Thus, it is not sufficient to conduct research on ethnically diverse populations without documenting the diversity of patterns across groups.

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Further, much of the research with immigrants has not considered the heterogeneity within different immigrant communities (García Coll & Marks, 2011; C. Suárez-Orozco & Carhill, 2008). Research should examine similarities and differences in mental health and use of services across immigrant generations (i.e., first, 1.5, second, and third), and by gender, race, heritage, age, sexual orientation, religion, social class, education, English language proficiency, and disability/ability, as well as country of origin. To conduct valid research with immigrant-origin populations and

develop a robust evidence base for practice and policy interventions, researchers must address a number of issues.

Sampling

Research must not focus solely on clinical samples (i.e., individuals demonstrating adaptational problems or reactions that require clinical attention). Relying on such samples makes it impossible to get an accurate picture of the distribution of mental health and adjustment problems in the general U.S. immigrant population (APA, 2010c). Drawing from clinic populations will lead to overestimates of pathology (APA, 2010c). On the other hand, drawing from large-scale national studies that have not parsed out generational status or national origins will underestimate prevalence rates.

Further, accurate estimates of characteristics of diverse immigrant populations are impossible to draw from national studies unless they purposely oversample from the smaller immigrant communities. A representative, comprehensive general population survey of first- and second-generation immigrants is difficult to conduct for a variety of reasons, including funding, the difficulties of validating and translating instruments across groups and obtaining widely representative community samples, and historically low rates of participation. Without such research, however, knowledge about this important and growing population will remain limited. Concomitantly, such research should incorporate a strength- and resilience-based focus (Vasquez, 2010).

Cultural Validity and Reliability of Constructs

Valid and meaningful assessment of mental health constructs within and across different cultural groups and settings is essential to educational outcomes and the mental health of immigrant-origin adults (including older adults), children and adolescents, and families. To construct valid and culturally meaningful research, psychology must further the understanding of how different cultural groups vary in beliefs and cultural practices around well-being, distress, and healing (see APA, 2002, for a discussion of multicultural issues in the context of assessment). Contributions from cultural psychology and anthropology are particularly instructive in this regard (see Kleinman's [1987] work on "category fallacy" for an example).

In addition to identifying cultural-specific expressions of well-being and distress, researchers must critically examine constructs developed in a Western middle-class context before applying them to non-Western, non-middle-class participants (APA, 2010c). Combining "outsider" (etic) and "insider" (emic) approaches to diverse populations is important in both data collection and analysis (APA, 2010c; Cooper, Jackson, Azmitia, & Lopez, 1998; C. Suárez-Orozco & Carhill, 2008). Bicultural and bilingual researchers are better able to establish rapport and trust within immigrant communities and gain entry into populations that might otherwise be difficult to access.

Further, insiders are essential for appropriate linguistic and cultural translations of protocols. Their perspective is also necessary for accurate and culturally relevant interpretations. Expressions of distress may vary considerably from one cultural group to another, with somatization or malaise being the predominant presentation of depression rather than the "classic" sadness or difficulties with concentration. Once culturally specific measures are developed, they can be assessed for validity through a number of strategies, including the measure's correlation with similar measures, assessment of its relationship with theory, and assessment of its capacity to reliably discriminate between the populations it is intended to assess (APA, 2010c; K. E. Miller, Omidian, et al, 2006).

Triangulation of Data and the Use of Multiple Informants

Using triangulated data collected from a variety of perspectives and including a variety of strategies is crucial when conducting research with groups of diverse backgrounds. Such an approach provides more confidence that data are accurately capturing the phenomenon under consideration. By gathering a variety of perspectives—self-reports, parent reports, teacher reports (in the case of youth), and community member reports (in the case of adults)—and considering these alongside researcher observations, concurrence and disconnections can be established among what informants say they do, what others say they do, and what the researcher sees them do. Researchers should consider various levels of analysis in their research, including the individual, interpersonal relations (e.g., peers and family), context-specific social groups (e.g., work, school, neighborhood, and place of worship), and cultural dimensions (APA, 2010c; C. Suárez-Orozco & Carhill, 2008).

Developmental and Longitudinal Perspectives

The majority of available studies with immigrants are cross-sectional in nature. While valuable in their own right, these data by nature limit the ability to detect changes over

time. For example, under what conditions do patterns of distress diminish or worsen as immigrants adjust to life in the United States? Though time consuming and expensive, longitudinal research has much to offer and should be pursued when possible (Fuligni, 2001; C. Suárez-Orozco & Suárez-Orozco, 2001; C. Suárez-Orozco et al., 2008). Future studies should also examine mediating (variables that explain the relationship between two other variables) and moderating (variables that explain the strength between two other variables) factors related to mental health and psychosocial adaptation and development (APA, 2010c).

Use of Mixed Methods

A wide range of methodological strategies is required to identify cultural variations in the expression of well-being and distress (Betancourt & Williams, 2008). Research with culturally and linguistically diverse populations requires a fundamental alteration of the most common investigative frameworks (i.e., rather than approaching culture through a pre-set middle-class American framework, the researcher should use methodologies to understand the worldview of the immigrant population) (APA, 2010c). Using multiple methods will help address these complex methodological challenges (APA, 2010c; Betancourt & Khan, 2008; C. Suárez-Orozco & Carhill, 2008).

When working with immigrant-origin populations, research methodologies should include:

- **Qualitative data—**collecting data to describe meaning (e.g., ethnographic observation, interviews, and focus groups).
- **Quantitative data—**collecting data with an emphasis on statistical inference (e.g., questionnaires, surveys, and experiments).
- **Mixed methods—**combining qualitative and quantitative strategies in varying sequences depending on the research questions and intent of the study (APA, 2010c; Creswell, 2008)

Well-designed large-scale quantitative surveys can make it possible to generalize findings to particular immigrant populations; however, without qualitative research it can be difficult to interpret that data. Qualitative methods provide a better understanding of local terms and cultural norms of well-being, mental distress, and the meanings of what is considered "normal" and "abnormal" (APA, 2010c; Betancourt, Speelman, Onyango, & Bolton, 2009). Expressions of distress are not uniform across cultures (APA, 2010c; Hinton & Good, 2009). By recognizing the cultural expression of symptoms for the population under consideration, appropriate interventions can be developed. The potential for client engagement, retention, and treatment success will, in turn, be much improved (APA, 2010c; Bernal, 2006; K. E. Miller, Kulkarni, & Kushner, 2006).

Ethical Considerations

There are particular ethical considerations when working with immigrant-origin populations. Power dynamics between researcher and participant are always a concern but are accentuated (APA, 2010c) between the researcher and immigrant participant, particularly when the participant is less educated or undocumented. Researchers must articulate how a study may contribute to improving the lives of its participants and/or the larger community and delineate any potential risks. Researchers must also take steps to protect participants.

Since some portion of first-generation participants may be undocumented, researchers must give thought to that issue when formulating the study, recruiting participants, and conducting the study. In the current climate of deportation, extra precautions must be taken to shield the identities of participants. We recommend the use of the usual research protections, including assigned numbers to de-identified records, locked paper and digital records, and consent forms signed with a pseudonym. If psychologists think they might be in contravention of federal or state laws, they should consult the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2010a) to resolve conflicts. The strictest ethical standards must be upheld to maintain the trust of the community and not place the research participants at risk.

If psychologists' ethical responsibilities conflict with the law, regulations, or other governing legal authority, they should clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict, consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights (see http://www.apa.org/news/press/releases/2010/02/ethics-code.aspx).

A METADISCIPLINARY REFLECTION

Psychology needs to consider an important metadisciplinary issue. While the field's imperative to look to evidence in guiding decisions for practice and policy is commendable, when it comes to immigration, psychologists must pause and ask a series of fundamental questions:

- What is the nature of our evidence when we have, by and large, failed to adequately consider the rapidly growing immigrant population over recent decades?
- What is the nature of our evidence when we have not framed research questions with the immigrant population in mind?
- What is the nature of our evidence when the research questions do not carefully delineate exactly who is and is not included within that population?
- What is the nature of our evidence when many of our research tools are not culturally sensitive?
- What are the trade-offs when quality data are simply unavailable to make what are otherwise ethically urgent and clear recommendations?

To date, the answer is that "evidence" is limited in scope and requires cautious interpretation. It is urgent that psychologists make immigrant-origin populations a key population in psychological research agendas at every phase of development. Only in so doing will the field discover the kinds of meaningful findings needed to inform practice and policy.

SUMMARY OF RECOMMENDATIONS

Recommendations to ensure and maintain positive outcomes for immigrant-origin adults (including older adults), children and adolescents, and families are embedded throughout this report. Positive outcomes require stakeholders within clinical practice, research, education, and public policy sectors to become culturally competent as well as cognizant of an array of diverse interacting factors (e.g., immigrant generation, gender, race, age, sexual orientation, religion, social class, education, English-language proficiency, and disability/ability) that may influence immigrants' mental health and adjustment. Stakeholders should collaborate with family members, community members, and one another to provide effective and ethical mental and behavioral health and educational support for immigrant-origin adults (including older adults), children and adolescents, and families.

The following recommendations focus broadly on ways the field of psychology can address the need of this population across practice, research, education, and policy domains. These recommendations require further communication and collaboration within psychology and in interdisciplinary collaboration with other fields involved in the care and adaptation of immigrants across the life span.

RESEARCH

The field of psychology should make immigrant-origin populations a population considered in research agendas at every phase of development. Only by doing so will the field discover the kinds of meaningful findings needed to inform practice and policy. To advance the mental and behavioral health of immigrant-origin adults (including older adults), children and adolescents, and families, the task force recommends that APA advocate for support of research that does the following:

- Examines the broad range of migration, acculturative, and family stressors that can affect the mental and behavioral health of immigrant families and identifies culturally specific definitions of well-being, distress, and healing, as well as coping strategies and strengths that immigrant adults (including older adults), children and adolescents, and families use.
- Uses qualitative, quantitative, and mixed methods in a complementary fashion to improve validity and cultural significance of research.
- Examines the feasibility, adaptation, and efficacy of evidence-based interventions, including clinic-, community-, and school-based interventions and evaluates practice-based evidence using rigorous scientific designs for use with immigrant adults (including older adults), children and adolescents, and families. This research should include the role of factors that enhance treatment access, engagement, and retention.
- Encourages culturally competent, multicultural, and multilingual research teams to improve the validity and cultural significance of findings.
- Uses both longitudinal and cross-sectional design to identify trajectories of risk as well as resilience in immigrant-origin individuals across the life span from a variety of origins.
- Examines the ways in which various settings (e.g., schools, community centers, neighborhoods) serve to enhance and impede acculturation, language acquisition, identity development, academic performance, peer relationships, and mental and behavioral health for immigrant-origin individuals across the lifespan.

SERVICES AND SUPPORTS

Immigrant-origin adults (including older adults), children and adolescents, and families may need supportive services to promote and maintain health and well-being after migrating to the United States. Such services may address a range of needs, including basic daily living, education, and physical

and mental health, across the numerous contexts in which immigrants function. Such services should be accessible, affordable, and culturally and linguistically appropriate. To promote this standard of care, the task force recommends that APA:

- Support opportunities for the sharing of practice methods and theories within the field of psychology that are developed to address the special needs of immigrant-origin individuals and their families across the life span, recognizing there may be methods of treatment that incorporate culturally syntonic techniques into practice.
- Advocate for the implementation of comprehensive, community- and school-based mental health programs and interventions that demonstrate clinical effectiveness with immigrant-origin children and adolescents.
- Support and advocate for federal policy initiatives that assist in the adjustment and self-sufficiency of immigrant-origin adults (including older adults), children and adolescents, and families.
- Advocate for initiatives that provide case-management services for immigrant-origin individuals across the life span that address basic needs and access to essential resources (e.g., physical health care, mental and behavioral health care, job placement, and housing).
- Support the development of and access to a range of services for unaccompanied immigrant minors, such as physical and mental health services, adequate housing and provision of daily needs, and school placement and support.
- Support the development and dissemination of culturally and linguistically appropriate evidence-informed practices for prevention, intervention, and treatment of mental and behavioral health problems among immigrant-origin individuals across the life span in both traditional and nontraditional settings (e.g., home, community, school, and detention facilities).

EDUCATION AND TRAINING

To significantly improve and enhance education and training opportunities related to immigrant issues for students in psychology and encourage education and training for, and retention of, professionals who work with immigrant adults and children across the life span, the task force recommends that APA:

- Promote education and training on methods to ensure that research and assessment are conducted in a culturally competent manner.
- Continue to promote psychology education and training in multicultural practice and research.
- Advocate for federal policy initiatives that support education and training opportunities in psychology to work with diverse populations such as:
  - *Minority Fellowship Program:* Train immigrant-origin minority mental health professionals to provide culturally and linguistically competent and accessible mental health services for diverse populations.
  - *Graduate Psychology Education Program:* Support the interdisciplinary training of psychology graduate students while the students provide supervised mental and behavioral health services to underserved populations (e.g., immigrant populations, other diverse populations, and victims of abuse and trauma).
- Encourage continuing education programs for practicing psychologists and mental health professionals that include information on multicultural practice and the importance of effective collaboration between psychologists and interdisciplinary colleagues, resource agencies, community leaders, paraprofessionals, and cultural brokers to address the needs and strengths of immigrant-origin individuals and their families across the life span.
- Provide training and effective supports to teachers and other service providers in the fields serving immigrant populations, including prejudice reduction.
- Support policies and practices in testing and assessment of immigrant-origin individuals consistent with APA's standards for educational and psychological testing.

COLLABORATION AND ADVOCACY

To improve collaboration and advocacy between and among individuals, organizations, and systems that provide care to immigrant-origin adults (including older adults), children and adolescents, and families in need, the task force recommends that APA:

- Support opportunities for dialogue and formal collaboration between researchers and practitioners who work with immigrant-origin adults (including older adults), children and adolescents, and families to enhance the evidence base for effective treatment with this population and strengthen the effectiveness of clinical services being offered.
- Advocate for systematic collaboration and communication among the interdisciplinary systems (i.e., health care, education, legal/immigration, refugee resettlement, and social services) that provide services to immigrant-origin adults (including older adults), children and adolescents, and families to enhance service effectiveness, reduce redundancy of care, and create strong networks of support for this vulnerable population.
- Provide opportunities for collaboration and bidirectional training between psychologists and community leaders, paraprofessionals, and cultural brokers.
- Continue to support relevant United Nations (UN) initiatives that are consistent with APA policy, such as the UN Convention on the Rights of the Child, which recognizes the rights of every child, including immigrant and refugee children, to human dignity and the potential to realize their full capacities.
- Continue to raise awareness of the mental and behavioral health effects of detention and deportation processes on immigrant adults and their families, including policies that promote humane detention requirements, and the importance of family reunification in immigrant proceedings, as consistent with the APA Resolution on Immigrant Children, Youth, and Families (1998).
- Continue to highlight the psychological implications of racism, discrimination, and racial profiling on individuals, families, communities, and society as consistent with APA's Resolution on Racial/Ethnic Profiling and Other Racial/Ethnic Disparities in Law and Security Enforcement Activities (2001); APA's Resolution on Prejudice, Stereotypes, and Discrimination (2006); and the recommendations of the report of the APA Presidential Task Force on Preventing Discrimination and Promoting Diversity (2012).
- Continue to promote the full equality of LGBT persons and families in federal immigration laws and policies, including the recognition of "permanent partner" status eligibility for same-sex couples in the Immigration and Nationality Act as consistent with the APA Resolution on Opposing Discriminatory Legislation and Initiatives Aimed at Lesbian, Gay and Bisexual Persons (APA, 2007b).
- Support activities that underscore the importance of providing fair access to educational opportunities for immigrant-origin children and adolescents.

GLOSSARY

Acculturation: A bilinear process occurring with respect to both the new and the heritage culture.

Acculturative stress: Stressful life events thought to be associated with the acculturation process.

Adultification (or Parentification): Occurs when children or adolescents prematurely take on mature adult or parental roles, possibly before they are emotionally or developmentally ready.

Assimilation: Refers to a particular type of acculturation that involves adopting the new culture while simultaneously letting go of attachment to the heritage culture.

Assimilation ideology: Belief that the best approach to managing differences across cultures is for immigrants and other minority groups to assimilate to a dominant culture. Assimilation toward the common norms and rules is the desired end state. Eliminating ethnic group boundaries thereby eliminates intergroup prejudice.

Assistive technology: Refers to any rehabilitative device for individuals with disabilities.

Asylum seekers: Individuals who travel to the United States on their own and apply for asylum, which they may or may not be granted. These individuals arrive in the United States via student, tourist, and business visas or may be unauthorized. Asylum seekers apply to the U.S. Department of Homeland Security in the hope that they will be approved for refugee status based on their previous, often traumatic, experiences prior to migration.

Authoritarianism: A form of social organization characterized by submission to authority. In politics, an authoritarian government is one in which political authority is concentrated in a small group of political elite, typically unelected by the people (but not necessarily), who possess exclusive, mostly unaccountable, and arbitrary power. Authoritarianism differs from totalitarianism in that social and economic institutions exist that are not under the government's control.

Aversive racism: Refers to a theory proposed by Gaertner and Dovidio (1986) based on the idea that evaluations of racial/ethnic minorities are characterized by a conflict between Whites' endorsement of egalitarian values and their unacknowledged negative attitudes toward racial/ethnic outgroups.

Ayurvedic healers: Individuals who practice a traditional medicine native to India.

Behavioral acculturation: The extent of immigrants' or foreign-born individuals' participation in their culture of origin and/or new culture.

Bilingual education: Any form of education in which academic content is taught in two languages (usually a native and a secondary language), with varying amounts of each language used in accordance with the program model.

Children of immigrants: Parents are immigrants; it includes both first- and second-generation immigrant children and adolescents (used interchangeably with *immigrant origin*; see C. Suárez-Orozco & Suárez-Orozco, 2001, for rationale).

Clinician bias: Failure to take culture into consideration when attempting to service the mental health needs of individuals outside of clinician's own culture.

Collectivism: Any philosophic, political, economic, or social outlook that emphasizes the interdependence of every human in some collective group and the priority of group goals over individual goals.

Culture: See *APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2002).

Culture-bound syndrome: Any combination of psychological or somatic symptoms that are only considered a recognizable disease by a particular culture or society.

Culture brokering: When children of foreign-born parents act as an aid for their parents to help them with the culture and language of a new society (e.g., doctor appointments, parent–teacher conferences, financial and legal situations).

Cultural identity (also known as **ethnic identity**): Immigrants' or foreign-born individuals' sense of belonging to, positive regard for, and pride in their native culture.

Curandero: Traditional folk healer in Latin America who works to cure physical and spiritual illness.

Conservatism: Political or social philosophy based on the disposition to preserve or restore what is established and traditional and to limit change.

Day laborer: Any worker who is hired but only paid one day at a time, with no agreement between employer and employee that future work/pay will be available.

Discrimination: Unfair treatment of a person, racial group, minority, etc.; action based on prejudice.

Diversity immigrant visa: Also known as the Green Card Lottery. Congressionally mandated lottery program for receiving a U.S. Permanent Resident Card.

Downward assimilation: Process of assimilating or integrating into a new culture that results in foreign individuals finding themselves in a poor community.

Ecology: The study of the relationships between living organisms and their environment.

Employment-based immigration: Situations in which individuals migrate from their country of origin to seek employment. This can apply to those who cannot find work in their country of origin, as well as highly skilled individuals who are sought after by companies outside their country of origin.

Ethnicity: See *APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2002).

Essentialism: Belief system in which "races" are considered distinct entities with immutable biological differences.

Evidence-based practice (EBP): Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. This definition closely parallels the definition of EBP adopted by the Institute of Medicine (2001, p. 147), as adapted from Sackett and colleagues (2000): "Evidence-based practice is the integration of best research evidence with clinical expertise and patient values." The purpose of EBP in psychology is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention. Retrieved from http://www.apapracticecentral.org/ce/courses/ebpstatement.pdf

Family preference system: Refers to a replacement system for simple "quotas" of visas distributed to immigrants from various regions. This system places immigrants into different groups called "preferences," which are based on their relationship with U.S. citizens, and each of these groups is allotted a certain number of visas that can then be distributed to those who qualify.

Fictive kin: Kinship that is not based in genetics or marriage.

First generation: Born abroad to non-U.S. citizen parents (used interchangeably in the literature with *foreign-born* and *immigrant*. *Immigrant* is the generic term of choice in this report unless referring to others' research or making a distinction between generations).

Some researchers distinguish between several subcategories, as each has distinct acculturative, linguistic, and educational advantages and challenges (see Rumbaut, 2004, for details). Few studies provide this level of analysis, however, and these categories are generally subsumed under the first generation:

- **1.75 generation** (born abroad, arriving prior to school age)
- **1.5 generation** (born abroad, arriving after school age but prior to adolescence)
- **1.25 generation** (arriving after adolescence but before adulthood)

Foreign-born: Born abroad to non-U.S. citizen parents (used interchangeably in the literature with *first generation* and *immigrant*).

Full immersion or native-language education: Any form of education in which academic content is taught only in one language.

Gender-based asylum claims: Refers to requests for asylum (see Asylum Seekers) based on violence related to

one's own gender. For example, women may request asylum in an effort to escape female genital mutilation, rape, forced marriage, domestic violence, sexual slavery, and many other acts of violence committed against them because of their gender.

Green card: A U.S. Permanent Resident Card (USCIS Form I-551), formerly an Alien Registration Card or Alien Registration Receipt Card (INS Form I-151), is an identification card attesting to the permanent resident status of an alien in the United States. It is known informally as a green card because it had been green in color from 1946 to 1964, and it reverted to that color again in May 2010.

Human capital: Competences, knowledge, and personality attributes embodied in the ability to perform labor that produces economic value; attributes gained through education and experience (A. Sullivan & Sheffrin, 2003).

Humanitarian relief: Material or logistical aid presented in response to an event that represents a critical threat to the health, safety, security, and well-being of a particular community or region.

Imam: Islamic leadership position, frequently the spiritual leader of a mosque or a particular Islamic community.

Immigrant: Born abroad to non-U.S. citizen parents (used interchangeably in the literature with *first generation* and *foreign-born*).

Immigrant health paradox: Also referred to as epidemiological paradox or Latino paradox. Pattern of research findings that indicate that first-generation immigrants demonstrate the best performance on a variety of physical/behavioral/and educational outcomes, followed by a decline in subsequent generations.

Immigrant-origin: Includes both first- and second-generation immigrant children and adolescents with immigrant parent(s).

Implicit Association Test (IAT): A social psychological measure meant to gauge the strength of an individual's automatic association between two or more concepts.

Legal permanent residence: A noncitizen of the United States authorized to live, work, and study in the United States permanently. These individuals are holders of what is commonly referred to as the "green card."

Microaggression: A theory that examines aggressive behavior between different cultures or races in the form of subtle, nonaggressive actions.

Migrant worker: Can refer to (a) individuals who work outside their country of origin or (b) individuals who migrate within a country to pursue work, such as seasonal employment.

Minority stress: Chronic social stress that results from stigmatization from being part of a minority group.

Mixed status: Some members of the family are authorized/documented while some are not (Fix & Zimmerman, 2001).

Multicultural ideology: Belief that all cultures should retain their basic cultural norms, style, and language within a greater cultural framework. Individuals learn to adapt to other cultures. In multicultural models, an appreciation for group differences reduces prejudice and enhances self-esteem.

National identity: Immigrants' or foreign-born individuals' sense of belonging to a new society.

Naturalized citizen: A foreign-born individual who has become a U.S. citizen by fulfilling requirements set forth in the Immigration and Nationality Act, including, in most cases, having resided in the United States for at least 5 years.

Neurasthenia: A psychopathological condition in which an individual may feel fatigue, anxiety, headache, neuralgia (generalized pain), and depressed mood.

Newcomer: First-generation immigrants arriving within the last 4 years.

Posttraumatic stress disorder (PTSD): A severe anxiety disorder experienced after traumatic events, particularly those involving psychological trauma. Typical symptoms include flashbacks or nightmares, avoidance of stimuli associated with the trauma, and increased arousal (through difficulty staying or falling sleep, anger, or hypervigilance). Formal diagnosis through *DSM-IV-TR* requires that symptoms last more than one month and cause significant impairment in social, occupational, or other important areas of functioning.

Prejudice: Unreasonable feelings, opinions, or attitudes, especially of a hostile nature, with regard to a racial, religious, or national group.

Protective factors: Conditions in families and communities that, when present, increase the health and well-being of children and families. These attributes serve as buffers, helping parents find resources, supports, or coping strategies that allow them to parent effectively, even under stress (U.S. Department of Health and Human Services, 2011).

Race: See *APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2002).

Racial profiling: Authority figures use race or ethnicity as a basis for deciding whether or not to enforce laws or regulations.

Racism: The belief that some races are inherently superior (physically, intellectually, or culturally) to others and therefore have a right to dominate them.

Reactive identification: Immigrants or foreign-born individuals who embrace their cultural identity (from country of origin) while rejecting the new culture, after having been rejected by it.

Refugee: A person outside of his or her habitual residence who has a well-founded fear of persecution because of race, religion, nationality, or membership in a particular social group or political opinion and who is unable or unwilling to avail himself/herself of the protection of that country or return there for fear of protection (APA, 2010c).

Refugee status: A legal status granted by the United States to refugee adults and children admitted for permanent resettlement. These individuals receive social, English-language, and job-placement services during the initial 4–8 months in the country through a system of voluntary agencies and with funding from the Office for Refugee Resettlement, U.S. Department of Health and Human Services.

Second generation: Born in the United States of foreign-born parent(s). Currently, all second-generation immigrant adults and children are citizens as mandated by the 14th Amendment (1868).

Selective assimilation: Assimilation to a new country in which foreign-born individuals maintain their native culture in strong ethnic enclaves but successfully participate in the new culture as well, particularly economically.

Social dominance orientation: A measurable personality trait that indicates the amount of preference an individual has for hierarchy in any society.

Social justice perspective: Psychological treatment that is rooted in the belief that all people have a right to equitable treatment and a fair allocation of societal resources including decision making. To this end, social justice addresses issues of oppression, privilege, and social inequities. Psychologists committed to such a perspective direct efforts toward making society a better place for all by challenging systemic inequalities.

Third-generation: U.S. citizen of immigrant grandparent(s).

Somatization disorder: A psychiatric diagnosis given to patients who present physical symptoms that have no underlying physical cause.

Undocumented: Individuals without legal authorization who reside in the country. These individuals are not U.S. citizens, do not hold current visas, and have not been permitted admission under a specific set of rules for longer term residence and work permits (Passel & Cohn, 2009) (interchangeable term is *undocumented*; legal but pejorative term is *illegal*).

U.S. Citizenship and Immigration Services (USCIS) H1-B program: Used by U.S. businesses to employ foreign workers in specialty occupations that require theoretical or technical expertise in specialized fields, such as scientists, engineers, or computer programmers; capped annually at low numbers by country.

U-VISA in the Violence Against Women Act II (VAWA II): The VAWA II created a new type of nonimmigrant visa known as the U-VISA. To be eligible for this "U" visa, the applicant must have suffered "substantial physical or mental abuse" because of a variety of crimes, including domestic abuse and involuntary servitude. The applicant must have information relating to this crime that would be of assistance to law enforcement in investigating or prosecuting it. There is an annual limit of 10,000 U visas. U visa holders are work authorized and able to apply for adjustment of status after 3 years.

One of the eligibility requirements is that a self-petitioner must demonstrate he/she is a person of good moral character. A VAWA-based self-petition will be denied or revoked if the record contains evidence to establish that the self-petitioner

lacks good moral character. The inquiry into good moral character focuses on the 3 years immediately preceding the filing of the self-petition, but the adjudicating officer may investigate the self-petitioner's character beyond the 3-year period when there is reason to believe the self-petitioner may not have been a person of good moral character during that time. A self-petitioner's claim of good moral character is evaluated on a case-by-case basis, taking into account the provisions of section 101(f) of the act and the standards of the average citizen in the community. Other provisions in the VAWA II allow people who have adjusted status under it to apply for naturalization in 3 rather than 5 years.

Visa: A document (or in many cases a stamp in a passport) showing that a person is authorized to enter a territory. Typically a visa is attached to several conditions, such as the territory it applies to and the dates for which it is valid. A visa does not generally give a noncitizen any rights, including a right to enter a country or remain there. The possession of a visa is not in itself a guarantee of entry into the country that issued it, and a visa can be revoked at any time. The visa process merely enables the host country to verify the identity of the visa applicant before, rather than coincident with, applicant entry. Visas are associated with the request for permission to enter (or exit) a country, and are thus, for some countries, distinct from actual formal permission for an alien to enter and remain in the country.

Xenophobia: Hatred or fear of foreigners or strangers or of their politics or culture.

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