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Fall 2011 Spotlight on Culture: Working with Immigrant Latin-American Families Exposed to Trauma Using Child-Parent Psychotherapy

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Acknowledgments

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Introduction

by Griselda Oliver Bucio, LMFT

The NCTSN Culture Consortium dedicates this Spotlight on Culture column to all families affected by the 9/11 disaster. Our thoughts are with immigrant families in particular, and with the clinicians who specialize in helping young children (ages 0-5) cope with the impact of trauma. The effects of 9/11 continue to influence society's sense of safety and our views of immigrants. At this 10-year anniversary, we remind the public and professionals alike that even young children can be impacted by trauma and need the caring support and services of clinicians in order to resume a healthy developmental path

Working with Immigrant Latin-American Families Exposed to Trauma Using Child-Parent Psychotherapy

The cumulative risk factors associated with immigration trauma can place undocumented children and families—who have fled their native countries as a result of violence and oppression—at considerable psychological vulnerability (Aisenberg & Herrekol, 2008; Bernal & Saenz-Santiago, 2006). These factors may include toxic experiences before migrating from their home countries (e.g., historical trauma, intergenerational trauma), during the period of immigration (e.g., parental separation, rape, exploitation by human smugglers), and/or after they arrive in the host country and begin the acculturation process (e.g., poverty, inadequate housing, social isolation, language barriers, intergenerational family conflicts, acculturation and discrimination issues; Perez Foster, 2001). Being undocumented is particularly challenging for children and their caregivers since their “illegal” status often leaves them feeling afraid and deprived in a new culture where they remain invisible, marginal, and vigilant in order to preserve their physical and emotional safety (Fong & Earner, 2007).

The following vignette represents many Latin-American immigration experiences post 9/11.

After witnessing a murder, Manuela—a survivor of child abuse, civil war, and ethnic cleansing—fled her home country with her 12 month-old daughter Luisa. She crossed the US-Mexican border aided by a human smuggler who abducted her, robbed her, held her captive for weeks, repeatedly raped and impregnated her in Luisa's presence. Manuela escaped, delivered a healthy baby boy, and now lives in a shelter with Luisa and baby Nino. Shelter staff are concerned about Luisa's lack of exploratory behavior, hypervigilance, and tendency to withdraw, and Manuela's “not talking or playing much” with either child. Manuela is afraid to leave her home because of her fears that immigration officials or “la migra” are following her to take away her children and deport her. Her fears are easily triggered and exacerbated by trauma reminders, including anyone wearing military-themed clothing or accessories, the anniversaries of the civil wars in her home country, and the 9/11 attacks on her host country.*

Manuela's story highlights why providers and service systems must implement interventions that address the intersection of culture, development, immigration experience, trauma history, and language with undocumented, monolingual, Latin-American caregivers and their young children. In addition, providers should pay close attention to the possible consequences of societal norms and values of the host country (discrimination, fear of detention, isolation) for these families. Culture provides meaning to the experiences of young children and their caregivers, as "right from birth, babies become reflections and products of their culture" (Lieberman, 1990, p. 101). The particular expression of children's behavior, developmental skills, and attachment styles depends on the socio-cultural context (system of values, beliefs and socialization practices, racial and ethnic background, socio-economic status, immigration and discrimination history, ecological factors) in which they and the significant adults in their lives are embedded (Lieberman, 1990; Mawani, 2001; Artico, 2003; Ghosh-Ippen & Lewis, 2006). This context also shapes the perception and interpretation of what young children and their social group experience as traumatic, as well as their responses to traumatic events and potential trauma reminders (Chemtob, 2006; Ghosh-Ippen & Lewis, 2006). Young children cannot be understood or treated for exposure to trauma without taking into consideration the cultural lens embodied by their primary attachment figures (Lieberman, 1990). Immigrant caregivers with young children may be more likely to engage and stay in treatment if they feel that their cultural beliefs about attachment, childrearing, and coping with pain, loss, and adversity are recognized and respected, and when efforts are made to help them feel safe and to provide them with treatment in their primary language (Ghosh-Ippen & Lewis, 2006).

Child-Parent Psychotherapy (CPP) is a relationship-based treatment for children under age six who have been exposed to domestic violence and other traumas. An empirically supported model of psychotherapy, CPP can be tailored to address the unique psychological experiences of Latin-American children and their caregivers (Lieberman, Weston & Pawl, 1991; Katoaka et al., 2003 as cited by Weiner et al. 2009, p. 1999; Lieberman, Van Horn & Ghosh-Ippen, 2005; Lieberman, Ghosh-Ippen & Van Horn, 2006). CPP takes into consideration the role of the child-parent relationship, the family's cultural beliefs, parenting practices, immigration experiences, and the intergenerational transmission of trauma (NCTSN, 2007, 2009). In CPP, clinicians see children and caregivers in dyadic sessions and use caregiver/child attachment as an agent of change. The core components of this modality include (1) offering assistance with problems of living or case management; (2) providing reflective developmental guidance to the caregivers; (3) helping caregivers provide physical safety; (4) helping caregivers provide emotional safety; (5) constructing a joint trauma narrative; (6) attending to family's cultural norms and values; (7) collaborative engagement with the family; and (8) reflective supervision (Florida State University, 2010; NCTSN, 2007).

The Child Witness to Violence Project (CWVP), an NCTSN Early Trauma Treatment Network category II site, has implemented and adapted CPP to meet the needs of the community population that it serves. Specifically, CWVP places special emphasis on the following CPP core components in its work with undocumented, monolingual, Latin-American caregivers and their young children:

Assistance with problems of living, case management, and crisis intervention. CWVP therapists pay strict attention to anti-immigrant sentiment and its ramifications for immigrants' rights and immigration policy. For immigrants like Manuela, being followed, detained, arrested, and/or deported are imminent threats. In immigrant communities, individuals may not venture out of their homes during daylight and, subsequently, risk their jobs and income; others suffer with symptoms of anxiety and depression; and many like Manuela are reminded of their trauma by the presence of law enforcement. Young children like Luisa are spared neither the news of these events, nor the panic among their parents and neighbors, reactivating for them overwhelming fears of harm or losing their caregivers.

To ensure basic safety and stabilization in immigrant client families, and utilizing lessons learned during previous raids, the CWVP has incorporated the following practice plan: (1) to be familiar with and stay up-to-date on immigration laws, policies, and resources; (2) to connect with legal, community, and human rights organizations that advocate for undocumented victims; (3) to support families, as needed, in developing specialized safety plans, including steps to take in the event of a raid or arrest (e.g., identifying a meeting place for separated family members, locating places children could stay if parents were detained, preparing a Family Preparedness Wallet Card with contact information for caregivers and children, helping caregivers designate and secure guardianship of their children in the event they are detained); and (4) to identify, partner with, and refer families to community service agencies that are not mandated to report individuals to immigration authorities.

Providing reflective, unstructured, developmental guidance. Women like Manuela may be reluctant initially to receive treatment; indeed, some Latin-American families might feel shame when accepting mental health services. As CPP seeks to decrease caregivers' anxieties by addressing their immediate needs and questions, in the first meeting with the bicultural, Spanish-speaking clinician, Manuela was able to explain that her primary concern was Luisa's "not listening" and "disobeying." The clinician helped Manuela to reframe and make meaning of Luisa's behavior (e.g. aggression as an expression of fear or need for attention, oppositional behavior as a way of self-assertion), and collaborated with her to identify strategies to increase the child's cooperation (e.g., visible expressions of affection in response to desired behaviors).

CPP pays careful consideration to how the family's socio-cultural context shapes children's developmental skills, the patterns and function of attachment, the caregivers' developmental expectations about their children, and their views on mental health symptoms. From Manuela's viewpoint, Luisa's development was on target, and that Luisa's lack of exploratory behavior and hypervigilance were characteristics that Manuela value as adaptive qualities that had helped Manuela and her siblings survive the civil war in her home country. Understanding Manuela's perspective, the clinician gave her feedback on Luisa's developmental strengths and needs and information on how traumatic experiences may influence children's development, increase disruptive behaviors, and threaten parents' ability to respond effectively. Simultaneously, the clinician assisted Manuela to recognize situations that reminded Luisa (e.g., abrupt or unannounced separations from

her mother) and herself (e.g., crowded and over-stimulating environments, individuals wearing military gear) of their past traumatic experiences. Together, they also developed a plan to decrease stress in the mother-child dyad, including emotional co-regulation and relaxation skills in a manner congruent with Manuela's cultural mores (e.g., praying, taking baths and naps together, keeping close physical contact, physical activity). All of these interventions enhanced the child-parent attachment and increased Manuela's sense of competence as a parent.

Attending to family's cultural norms and values. CPP clinicians have applied this core skill in several areas:

- **Linguistic competency.** An essential aspect of treatment is the ability of the clinician to conduct therapy and assessment fluently in English and Spanish (Marcos, Eisma & Guimon, 1977; Sciarra & Ponterroto, 1991; Perez Foster, 2001; Santiago-Rivera & Altarrabia, 2002; Mennen, 2004) and to conceptualize the clinical work in both languages. Families who come to treatment may be represented by members with varying language skills and acculturation levels; a common scenario is that of monolingual Spanish-speaking caregivers accompanied by children who have begun to master and prefer to speak in English. Gaps in communication can affect child-parent attachment and the parental image and role. Trauma may reduce the ability to communicate verbally in one's mother tongue. Bilingual clinicians need to assess how each language is used in the family (and who uses it and when) and to identify the level of language proficiency and acculturation of each member of the family (Sciarra & Ponterroto, 1991; Artico, 2003; Aronson Fontes, 2005; Lopez & Vargas, 2011). If bilingual clinicians are not available, interpreters should be trained to work collaboratively with English-speaking clinicians. In addition, standardized assessments must be administered in the person's primary language and translated measures should meet psychometric standards.

In CWVP, CPP treatment with families is conducted by bilingual, bicultural clinicians who are knowledgeable about the function of native and second languages, either as organizers or as vehicles for the expression of symptoms in adults and children exposed to traumatic events (Marcos & Urcuyo, 1996; Marcos, Eisma & Guimon, 1997; de Zulueta, 1994; Madrid, n.d.; Pavlenko, 2005). These clinicians understand the importance of mechanisms of language switching, language choice, and language mixing in the therapeutic process (Pitta, Marcos & Alpert, 1978; Sciarra & Ponterroto, 1991; Santiago-Rivera & Altarrabia, 2002; Madrid, n.d.). For example, a trauma survivor can present as symptomatic when speaking in their language of origin but may be able to articulate a coherent trauma narrative in a second language. Clinicians also have a dual role as translators of the parent and child's psychological realities (Lieberman & Van Horn, 2005) and as translators of language when differing degrees of acculturation in child and caregiver cause breaches in communication.

In CWVP, clinicians and caregivers together write treatment plans in Spanish, and utilize infant and toddler books, therapeutic books (e.g., Ramon el Preocupón, Tortillitas Para Mamá, Cara de

Bebé), “cuentos” (tales), and music and games in Spanish that represent the different traditions of the many cultural groups of the Latin-American families served.

- ***Use of immigrant clinicians to facilitate cultural transition and to serve as cultural intermediaries/brokers for recently migrated families.*** Even in the best of circumstances, immigration is a process that affects an individual’s identity and feelings of belonging. Latin-American immigrant clinicians are not exempt from these challenges and losses. They may find themselves “racialized, biologized, minoritized” (Mostofi, 2009, p. 289) in the host country and must constantly construct and deconstruct their cultural backgrounds, as well as their professional and personal identities, while psychologically inhabiting a space between borders. If processed and integrated, these experiences not only help clinicians develop insight and empathy in their clinical work, but also may result in strategies that support their immigrant clients’ transition to the host country. Such strategies may include informing caregivers of laws and regulations that pertain to their safety and that of their children (e.g., use of corporal punishment); connecting them with community organizations (e.g., church, parenting groups); pairing them up with other immigrant parents to prevent isolation and to increase safety; encouraging the development of skills to access services (e.g., using the transportation system, enrolling in ESL classes); and assessing for acculturative stress and immigration trauma. By offering their clinical skills, linguistic abilities, and knowledge gained from their own immigrant experience, these clinicians have the opportunity to help bridge cultural gaps, support caregivers countering oppression or discrimination, build effective parenting skills in a foreign culture, and facilitate the construction of safe relationships and social networks for undocumented families, all of which have the potential to increase resiliency factors in immigrant communities.
- ***Broadening of expectations of caregiver/child interaction and play.*** In some Latin-American cultures, parents do not play with their children by sitting with them on the floor or participating in activities that, from a western point of view, are considered developmentally appropriate and stimulating. They may communicate physically (cues or contact) rather than verbally (words or narrative). Manuela’s parents, for example, did not play with her or allow her to explore the environment. Her family was in hiding for many years; she and her siblings had to be quiet and still for many hours to avoid detection and murder by the military. For some Latin-American caregivers, being asked to sit on the floor and play may be offensive and disrespectful. In these cases, clinicians should adapt the office to accommodate the parent’s preferences (e.g., by always giving him/her the option of sitting on a chair or the floor), and they should ask caregivers to identify activities that they already enjoy and engage in with their children (e.g., dancing, reciting Latin-American nursery rhymes, doing pretend play such as “making tortillas for dinner”).
- ***Inclusion of extended family and transnational relationships in treatment.*** Clinicians may find it useful to include extended family members (e.g., grandparents, aunts, godparents) in treatment. However; to ensure predictability for the child, the family is invited to identify at least one adult caregiver who will consistently attend therapy with the child. Immigrant families often maintain strong relationships with remote family members who, while still in the country of origin, remain

almost present in their daily lives. In her play, Luisa included a doll that represented her maternal grandmother, the primary caregiver after her birth. This helped in constructing the narrative of Luisa's early life in their country of origin and the immigration experiences that so deeply affected her family.

- ***Integration/acknowledgment of cultural beliefs and practices in dealing with emotional pain.*** Clinicians should strive to understand families' religious and cultural rituals, value the roles these rituals play in their lives, and attempt to incorporate them in treatment. This includes practices that give meaning to life transitions and emotional pain such as, the use of shamans, healers, "limpias," communication with ghosts, and for Manuela, her beliefs in the power of prayer and in "good" ghosts who protect her and her family.

Conclusion

Undocumented families affected by trauma present unique challenges and opportunities for practitioners and systems of care. The challenges involve shifting from interventions based on dominant cultural tendencies and ethnocentric perspectives to practices that accept limitations, embrace diversity, and are relationship-based: interventions tailored to a family's constellation, their history of immigration and oppression, their mother tongue, their unique cultural values and expressions of psychological distress, their spiritual beliefs and religious practices, and their preconceptions of mental health and mental health treatment, along with child-rearing customs, expectations, and their socio-ecological context. The opportunities for practitioners and systems of care reside in developing diversity-informed trauma treatments (like CPP) that are inclusive of marginalized families—like Manuela and her children—and that recognize family strengths. Innovative and flexible models of care can decrease the barriers that prevent undocumented immigrant young children from accessing services essential to their processing traumatic events and resuming a healthy developmental path.

* In 2007, a study by the Urban Institute reported that 361 undocumented workers were arrested during immigration raids. Over 300 children under age six were separated from their parents, and many were placed in the custody of the Department of Children and Families. (National Council of La Raza & The Urban Institute, 2007).

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