

Working Towards a Culturally Competent Practice with Mexican Immigrants

Julie Anne Laser-Maira

University of Denver, Graduate School of Social Work

E-mail: julieannelaser@gmail.com

Elsa Campos

Managing Director of Carya, Calgary, Alberta Canada

E-mail: elsacampos@yahoo.com

Received: January 30, 2018 Accepted: March 6, 2018 Published: March 8, 2018

doi:10.5296/ijsw.v5i1.12572 URL: <http://doi.org/10.5296/ijsw.v5i1.12572>

Abstract

In this politically charged times, the plight of Mexican immigrants have been incorrectly characterized and ridiculed. We believe clinicians need to better understand who they are and how to become culturally competent to work effectively with Mexican immigrants. The United Nations High Commissioner for Refugees (1951) defines a political refugee as “a person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country...” In contrast, an economic refugee is a person seeking refugee status in another country for economic reasons. With political refugee status comes both legal and financial support by the U.S. government. However, an economic refugee is not afforded such opportunities. In the United States, there are 660,477 political refugees (Dovidio & Esses, 2001), additionally, it is estimated that there are five to eight million economic refugees who are without legal documents (Yakushko & Chronister, 2005). It is believed that of this five to eight million economic refugees, 95% are from Mexico (Yakushko & Chronister). This translates to 4,750,000 to 7,600,000 Mexican economic refugees. Though U.S. legislation has tried to control the number of economic refugees entering the country and expel economic refugees already living within its borders, the reality is that great majority of the 4,750,000 to 7,600,000 individuals are gainfully employed and

will probably stay in the United States until they have earned sufficient money to be able to return to Mexico and survive economic deprivation. With such staggering numbers of economic refugees seeking the opportunity to make a living within the United States, it is becoming increasingly important to address the mental health needs of such individuals. Although federal policy often dictates the exclusion of funding opportunities for services to economic refugees, the reality is that there is an ethical responsibility to provide services to all individuals despite legal status or country of origin.

Keywords: Mexican immigrants, Mental health needs, Clinical considerations

1. Introduction

To reside in the United States, Mexican economic refugees have experienced a myriad of personal traumas. Border crossings are frequently the site of human rights abuses: including disappearances, torture, murder, and rape (Hollander, 2006). These traumatic experiences can cause clinical depression, anxiety, and Post-Traumatic Stress Disorder (PTSD) (Hollander). Even those individual who have had an uneventful crossing are often plagued with loneliness, separation, and isolation from family, friends, and familiar culture.

Interestingly, acculturation has been found to be a risk factor for Mexican economic refugees (Escobar, Nervi, & Gara, 2000, Hollander, 2006). This is not similar to other refugee groups who seem to improve functioning by being in the United States for a longer period of time (Escobar, Nervi, & Gara). High levels of acculturation into mainstream U.S. culture for Mexican economic refugees have been found to increase levels of phobia, alcohol abuse, drug abuse and antisocial personality disorder (Escobar, Nervi, & Gara). U.S. born Mexican-American adolescents showed significantly higher rates of problematic drug use than Mexican born counterparts.

Thereby the entrance into the United States and the short and long-term residence of the Mexican economic refugees may have negative repercussions for their mental health. Since the actual numbers of Mexican economic refugees is significant, the number of individuals that may be facing mental health issues warrants concern and support for this vulnerable population. Particularly, from a clinical standpoint, how can we best understand, support, and serve this ever-growing population in a culturally competent manner?

Juxtaposed with trying to understand and create services for Mexican economic refugees, the mental health professions are faced with the challenge of access to services for this particular population. Research has shown that compared to Non-Latino Whites, “Latinos underutilize mental health services, are less likely to receive guideline congruent care, and rely more often on primary care for services” (Cabassa, Zayas, & Hansen, 2006, p. 316). It has also been shown that Latinos (among other minority groups) “experience a disproportionate burden of disability associated with mental disorders” (Cabassa et al., p. 316). Therefore, it is important to create a safe, comfortable environment for mental health service for Mexican immigrants.

Additionally, many Mexican immigrants are unfamiliar, misunderstand, and therefore distrust mental health services. From a traditional viewpoint, mental illness is caused by curses or bad intentions (De Rios, 1992). Therefore, traditional healers, *Curanderas*, often see their responsibility of curing mental illness as removing the curse from the afflicted individual. As a clinician, it is true that one needs to understand the root of the problem, but it is through

clinical work that the issue no longer grips the individual. For the traditional Mexican *Curandera*, a *limpieza*, ritual cleaning, would be required to remove the affliction from the individual. Once the cleaning had been performed the individual could return to her/his normal life. If the *limpieza* had not been successful the individual or the individual's family may try a more extensive *limpieza* or go visit a more powerful *Curandera*. If the mental illness persists *verguenza*, shame, would then follow the family and the individual and likely the individual would be cared for quietly in the family home away from the scrutiny of neighbors. The family would frequently understand the untreatable mental illness to be a smiting for bad behavior brought on by the individual or the family and a burden or *cruz* that the family must bear for these transgressions. If the traditional Mexican family has exhausted all other options, the family member with mental illness may be taken to a more contemporary treatment center, to see a physician or visit a health care center. It would only be as a last resort after the strong recommendation of the medical professionals, and *con mucho verguenza*, with a lot of shame, that the traditional Mexican family would consult a mental health practitioner. Therefore, when the Mexican immigrant enters the clinician's office, it should be considered, if not assumed, that they have tried other techniques prior to the visit. It also underscores the importance of knowing how to join with and support the individual who has not had success in alleviating their stress or anxiety in the traditional manners, which they are most familiar and feel safest receiving.

This article introduces practitioners with Mexican immigrant research on attachment and immigration issues, as well as addresses issues regarding culturally competent practice when working with this population. As policies to deport Mexican economic refugees become political mantras, the need for culturally sensitive and competent practice increases for those Mexican immigrants that remain in the United States. As more stress is felt over the risk of deportation and the lack of access to services, mental health issues are further exacerbated creating a vicious cycle of fear, anxiety, depression, and hopelessness.

2. Clinical Considerations

2.1 Immigrant Attachment Styles

Yolanda van Ecke (2005) argues that successful negotiation of the immigrant experience has been linked to differences in adult attachment statuses. In her article "Immigration from an Attachment Perspective", van Ecke (2005) describes the differences in adaptability to immigration as they are perceived by the individual. The three adult attachment statuses relating to immigration were described as: dismissive, preoccupied and unresolved. The two attachment styles identified by van Ecke (2005) as prominent as they relate to assimilation and immigration are dismissive and preoccupied.

A dismissive attachment style for immigration is evidenced by the sentiment that support will not be available and that the individual assumes no one but the individual is likely to meet his/her needs (van Ecke). A dismissive attachment style for immigration emphasizes independence and assigns less importance to the family of origin. It has been shown that individuals identified as dismissive attachment style are more adaptable to isolation and relate more easily to the new culture than their own after migration (van Ecke). It appears that those who have higher achievement, power motivation, and are more work oriented tends to emigrate at higher rates and are more likely exhibit a dismissive attachment style (van Ecke).

Individuals with dismissive attachment report less psychiatric distress and anxiety (van Ecke).

Individuals identified with preoccupied attachment style tend to focus intensely on the sources of support (van Ecke). However, immigrant adults with a preoccupied attachment style often find support to be unreliable (van Ecke). Preoccupied attachment style adults spend a great deal of energy focusing on other people's needs and relate less easily to the new culture than to their culture of origin (van Ecke). The preoccupied attachment style adult, though they left their country of origin, are much more centered on the events that are happening at home than anything that is currently happening in their current context. Long separation from family for preoccupied adults was linked to increased reports of depressive symptoms.

The last type of attachment style for immigration is unresolved (van Ecke). Individuals with an unresolved attachment style for immigration lack a clear strategy for immigration support (van Ecke). Although this particular attachment style has not been much investigated in the literature with regard to mental health and immigration, it is important to note that the foundation for attachment with an individual who has an unresolved attachment style is based on a disorganized style of relating to others. Therefore, the ability to acculturate or assimilate to a new culture would be challenging.

2.2 Acculturative Stress

Accompanied with attachment is the idea of acculturative stress. Acculturative stress has been defined as the "loss of familiar ways, sounds and faces, coupled with a sense of not knowing quite how to belong, connect, and get support" (van Ecke, 2005, p. 472). Acculturative stress is a disconnection between society's values and the individual's aspirations. Acculturative stress is seen not only as a separation from the familiar culture, but also a loss accompanied by idealized memories of one's culture and feelings of despair of the present context. Although not a disorder defined by the DSM V, it can be argued that acculturative stress is attributed to symptoms possibly leading to some mood disorders such as depression. It has also been suggested that: Immigrants often view their mother tongue as a symbol of their past, their family of origin, childhood landscapes, familial myths, and early memories. As such, language maintenance or language shift may reflect complex emotional processes both at the individual and familial levels, and even at the level of the group (Tannenbaum, 2005, p. 232).

Therefore, if the Mexican immigrant focuses primarily on the past and not the present or future, s/he will increase the likelihood of acculturation stress. Similarly, if s/he idealizes or romanticizes her/his life prior to entering the U.S. acculturation stress could be more prevalent.

2.3 Transference and Counter Transference

Stampley and Straight (2004) posit that transference and counter transference are particular issues for consideration when working with ethnic minority populations including refugees. Culturally competent practice takes into consideration the complex matrix of pre-existing cognitions and affects about cultural groups that operate at multiple levels of clinician's psyche and are involved in the therapeutic process regardless if the client and the clinician are from the same cultural group or not (Foster, 1999). Perceptions of the client's likeness to

her/his therapist have been shown to be related to counter transference. Emotions and behaviors that could denote counter transference are: anger, sadness, boredom, nurturing feelings, avoidance, and withdrawal. Intense isolation and emotional disregard by the mainstream population create a situation that is ripe for transference between the client and the therapist. Therefore, it is important when working with Mexican economic refugees to address transference and counter transference in order to create a safe therapeutic environment that will benefit the client.

2.4 Previous Trauma and Language

Previous trauma and current language issues have a profound effect on resettlement (van Ecke, 2005). As anyone knows who has spent time in a foreign country where they do not speak the language, it is both stressful and frustrating to not have the ability to communicate for basic needs and wants as an adult. Those that have had previous trauma may have greater difficulty asserting one's needs and wants, especially in a language that is not their own. The inability to effectively defend oneself in communication can re-traumatize the individual.

Similarly, the use of interpreters may inhibit the economic refugee to ask for help. If the economic refugee is having trouble coping with a previous trauma s/he may be embarrassed to share this information with an interpreter, especially if the interpreter is someone that the immigrant knows. In some instances, the interpreter may be a relative or a friend. Sharing personal information with an interpreter who is a family member, perhaps even a child, can keep the individual from getting the help that s/he needs.

2.5 Previous Trauma and Isolation

Additionally, previous trauma coupled with ongoing isolation from the larger society may cause behaviors that could be understood as attachment trauma: unresolved, painful, emotional wounds to an individual's internal working model of attachment relationships (van Ecke, 2005; Yakushko & Chronister, 2005). In Mexico, with a larger social support network at her/his disposal, and free time that is occupied by family and friends, the trauma history may have been lessened in one's memory. However, with long periods of time alone or being only in the company of those with which s/he cannot fully communicate, the possibility of ruminating about previous trauma increases.

2.6 Complex Trauma

In addition to previous trauma, issues that economic refugees may be facing are intertwined and profound. It can be argued that the combination of smaller traumas over an extended period of time may lead to a more complicated/complex form of trauma. The sense of isolation, multiple losses and complicated grief may exacerbate mental health issues for the immigrant (Schweitzer, Melville, Steel, & Lacherez, 2006). It must be cautioned that this is not the same as PTSD but may look similarly (Schweitzer et al.; van Ecke, 2005). Complex trauma may present itself similarly to symptoms of depression and/or anxiety and not meet the criteria for Post Traumatic Stress Disorder, but interfere with a person's ability to function on a basic level. Complex trauma disrupts feelings of personal safety, interpersonal relationships, a sense of justice and fairness, and an integrated identity, (Silove as cited in Schweitzer et al., 2006). Therefore, complex trauma can really undermine the immigrant's sense of personhood.

3. Theoretical Considerations

Three theories seem to be particularly salient for conceptualizing the Mexican immigrant experience: Human Ecological Theory, Maslow's Hierarchy of Needs, and Risk and Resiliency theory. Each helps the practitioner draw upon a theoretical base where they can be better aware of the issues that are relevant to the Mexican immigrant.

3.1 Human Ecological Model

An ecological orientation proposes that development is influenced by characteristics of the individual interacting with characteristics of the environment over time (Bubolz & Sontag, 1993). The developing person continually interacts with her/his environment and her/his environment continually interacts with her/him (Barrows, 1995; Griffore & Phenice, 2001). Furthermore, this interaction is always affected by the passage of time. As the immigrant is longer away from home, her/his relationship and feelings about her/his homeland may change. There is a constant and reciprocal interplay between the person and the environment throughout the life span (Bronfenbrenner, 1979, 1986, 1989). Thereby, as the environment changes, it changes the immigrant and at the same time, the immigrant also changes the environment. Furthermore, the individual develops in a number of different contexts. The initial structure where development occurs is called the microsystem (Bronfenbrenner, 1979, 1986, 1989). The microsystem has been defined "as a pattern of activities, roles and interpersonal relations experienced by the developing person in a given face-to-face setting with particular physical and material features and containing other persons with distinctive characteristics of temperament, personality, and systems of belief" (Bronfenbrenner, 1989, p. 227). The initial microsystem that the immigrant inhabits is the family home where the first interactions are most often between the parent and the child. As the child grows, s/he develops in many other microsystems: the school, the neighborhood, and the peer network. Once the immigrant moves to a new country, the microsystems where s/he resides is often the work place, housing unit, educational classroom, and health center. For the Microsystems to function best, Bronfenbrenner believes their needs to be a "mesosystemic interface", in which two microsystems inter-connect like the interrelationship between family and school. For the immigrant, these microsystems due to language and cultural barriers may not interconnect in any meaningful way. Thereby, increasing isolation and decreasing the opportunity for optimum functioning. The next environment from an ecological perspective is the exosystem, which is the environment that exerts a great deal of influence on the individual, but the individual is not actively involved (Bronfenbrenner). For the immigrant, the exosystem that s/he is not a part of but impacts their daily life includes immigration policies, education policies and health care policies. These policies have an enormous impact on the immigrants' sense of safety, feelings of protection, ability to improve oneself through education and physical and mental health services.

3.2 Hierarchy of Needs

Maslow posited that each individual is aware and influenced by previous experiences. Individuals have free will; thereby they can make conscience choices. However, these choice can be made more easily when they have had their needs met. Maslow's Hierarchy of Needs (1943) theorizes that there are five levels of needs beginning with physiological (food, shelter and clothing), followed by safety needs, then belonging needs, in turn esteem needs and

finally self-actualization needs. Caution should be used when applying Maslow's Hierarchy of Needs framework to immigrant populations. It should not be assumed that immigrants have not achieved a higher level of actualization, but rather to assess the current needs of the individual or family. However to be most successful, these basic needs should be satisfied and the higher needs should be attempted to endeavor. For the immigrant, the absence of most or all of the basic needs (food, shelter and clothing) could preclude them from being able to make the best choices for themselves and to realize his/her greatest potential.

3.3 Risk and Resilience Framework

Historically, research focused primarily on issues of risk and vulnerability. Risk factors were researched in much of the same way as was done in the field of epidemiology, cataloging conditions or variables that either compromised health or social functioning for the developing individual (Jessor, Van Den Bos, Vanderryn, Costa, & Turbin, 1995). Many investigators created lists of risks factors and then quantified the number of risks for any given individual or subset of the population. The individual's composite number of risk factors indicated the likelihood of the individual's attainment of a negative outcome. For the immigrant some of these risks include: trauma of entry, isolation, stigmatization, racism, and inability to communicate for oneself. Regardless of the myriad of risks that were found to reduce positive developmental outcomes, the risk research was unable to explain the small, but significant group of individuals that still flourished under the yoke of these risk factors. Continuing to look at risks did not shed light into why these individuals were successful; it only made their ability to cope with risks more perplexing and amazing.

By focusing on individual and environmental protective factors, a shift in the field was made, and the subject of resilience was created. Rutter (1987) explains "not only has there been a shift in focus from vulnerability to resilience, but also from risk variables to the process of negotiating risks situations" (p. 316). This shift allowed the investigator to view resiliency as one of the outcomes that could result from stressful life events. It also facilitated the study of the process of resiliency and not solely risks that increased vulnerability.

The concept of stress to the individual is also important to resilience. "Resilience refers to a dynamic process encompassing positive adaptation within the context of significant adversity. Implicit to this notion are two critical conditions: (1) exposure to significant threat or severe adversity, and (2) the achievement of positive adaptation despite major assaults on the developmental process" (Luthar, Cicchetti & Becker, 2000, p. 543). Supportive families, supportive workplace, open schools, accessible health care, social support, English language proficiency, cultural mentors and meeting basic needs are all protective factors for the Mexican immigrant. As a clinician, resource allocation and advocacy for these issues and activities promote greater resilience in the Mexican immigrant.

4. Treatment Approaches

4.1 Culturally Competent Treatment

Culturally competent treatment has been defined as "the possession of cultural self-awareness, knowledge, and skills that facilitate delivery of effective services to ethnically and culturally diverse clientele" (Hwang, 2006, p. 703). To develop a clinical program that has a culturally competent focus the therapist must gain a self-awareness, a culture-centered context and

implement skills that focus on the interactional perspective between client and therapist.

It has been found that a Cultural Genogram has been very successful in developing a better understanding the immigrant's culture and involvement in that culture. Hwang (2006) states that a cultural genogram elucidates the understanding of the influence of culture on family system and the formation of cultural identity. A clinician can help the client gain meaning of the importance of her/his culture of origin and the losses that they feel in their new culture through a genogram diagram. The client can begin by drawing her/his perceptions of components of her/his Mexican culture and how s/he fits into that culture. Then the client can draw another diagram of their relationship to their Mexican culture here in the United States, and a subsequent diagram of their relationship to mainstream American culture. A cultural genogram helps identify culturally based triggers or conflicts for the client. It also gives insight into feelings related to cultural losses and areas to develop to create a more integrated identity as an immigrant.

A cultural genogram can also be used to gain greater self-awareness by the clinician her/himself to become more culturally competent. A cultural genogram can also help the therapist identify, clarify and challenge culturally based assumptions of her/his own. A clinician can use the cultural genogram to better understand her/his own culture of origin and her/his assumptions about her/his client's culture. Furthermore for the therapist it helps her/him explore how cultural identities influence her/his therapeutic style and effectiveness.

Narrative Therapy

Story telling is a popular activity in Mexican culture and is often used to convey social norms and values. Narrative therapy is the use of stories as a means by which people organize, interpret, and communicate the meaning of lived experiences (Clarke, 2003). Using narrative therapy, the clinician can help the Mexican immigrant client gain greater insight in a culturally appropriate manner. The individual's identity is created through one's construction of a unique personal myth that guides her on how they will understand new events and interpret situations (McAdams, 1993). A personal myth is developed through the compilation of memories of past events, the interpretation of present events, and perceptions about the future (McAdams). It also serves as a lens by which the individual sees the world and her/his place in the world. The construction of the personal myth takes a lifetime to complete. This combined sense of purpose and future aspirations are important protective factors (Howard, Dryden, & Johnson, 1999; Wang, Haertel, & Walberg, 1994) that facilitate greater resilience. Both planfulness and aspirations are important for resilient outcomes (Garnezy, 1996). The creation of a personal myth allows the individual to have a goal to strive for and a future that holds better possibilities. From a clinical standpoint, helping the client understand the personal myth that s/he has created for her/himself and then reframing it and creating a new chapter in her/his personal myth that better supports her/his current life issues is a very dramatic and powerful experience for the client. To give meaning to her/his past and to better understand her/his role as a protagonist in her/his present and future gives the individual power over her/his present and control of her/his future.

To begin narrative therapy, the clinician can ask the client to tell the story of her/his life or of a particular incident. The therapist can ask the client to describe her/himself and those who are also in the story as vividly as s/he can. Once the story is told, the clinician can ask the

client to retell the story in the way s/he would like to hear the story happen. Then discuss the similarities and differences between the two stories and most importantly how could the original story become more like the second story. Questions that could be posed by the therapist are: What could be done to change her/his thinking and/or behaviors that could make the second story feasible? What could s/he do to make these changes now and what could be done as homework over time? How could the protagonist better face the challenges of the future? This may be done as a part of a journaling exercises as well if they enjoy writing or through painting or other mediums if they have an artistic ability.

5. Case Example

To give a personal face to the Mexican immigrant experience, we asked Chaco to share his story of crossing the border and recent arrival in the United States.

5.1 Chaco's Story

Chaco began traveling from his village in central Mexico in April 2007. He came to the border of Mexico at Laredo and contacted *Coyote*, an individual who traffics people across the border for a fee. Chaco contracted with a *Coyote* for a fee of \$750 to bring him across the border. Chaco had no previous contact with the *Coyote*. Part of the agreed upon transaction was that if Chaco crossed safely, he promised to help the *Coyote* transfer *cosas*, stuff, to California before the *Coyote* would allow Chaco to continue on his travel north to Chicago. Once at the agreed upon border crossing location, Chaco jumped over the fence right by the immigration station, fell on the ground and then had to run. Just in the United States, Chaco was transferred into the back of a van without windows and then brought to a hotel room by the *Coyote* where he was told to wait with several other new Mexican immigrants. The women and the men were separated into two groups. Chaco never saw the women again. He does not know what happened to them, but has heard many bad stories of rapes and forced prostitution. The *Coyote* locked all of the men in the room and were told to wait for the van that would transport them and the *cosas* to California. They were locked in the room for nearly a day, which was very frightening for Chaco, but were left food and water as they waited. He was afraid to sleep while he waited for fear of the others stealing the remaining money that he was hiding. He felt that he could not trust the other immigrants nor the *Coyote*. Once Chaco had accompanied the *cosas* to California, he was transferred to a friend of the *Coyote* in a hotel in Los Angeles, who told him that he would have to go to Florida before he was allowed to go to Chicago. Chaco became more afraid. He had not bargained for another trip. This other man had a lot of drugs and guns in his hotel room. Petrified by fear and feeling that if he stayed with this man he would probably die, he snuck out of the hotel room in the middle of the night. He ran through the empty streets in the middle of the night Los Angeles. He looked for someone or somewhere he might go, but he realized he had to return to the hotel room because he was further away from Chicago than he had been in Laredo and he had no idea where the bus station was to board a bus north and no one that he could ask. He returned to the hotel room unnoticed and went with the man to Florida. At one point in the trip, he and the man were stopped by a police officer that asked about his immigration status. The man just told the police officer that he had entered legally and let them go on their way. The police officer never asked for documentation. Chaco reported that during the entire trip to Florida, he was afraid for his life. He was also terrified by the thought that if he was killed

his family would never find his body because they would never think that he was in Florida. Finally, when he arrived at a hotel in Florida, he was able to escape from the man and ask someone in Spanish how to make a collect telephone call. Luckily, he was able to contact father. His father, who is living in Chicago, came to pick Chaco up in Florida and brought him back to Illinois.

5.2 Additional Information About Chaco

- Educational attainment: college degree as a Physician's assistant
- Current occupation in the US: grass cutter. Chaco said that it was hard to find a job without a work visa; it took approximately one month. He was able to find work through a Spanish speaking unofficial job-broker. Chaco now earns \$11/hour and works 11 hours day for 6 days per week.
- Intended length of stay in the US: Chaco wants to stay for 2-3 more years to save enough money to be able to buy a house in Mexico and marry his girlfriend.
- Losses: Chaco has put his career on hold in Mexico. He hopes his girlfriend will wait for him. He left 5 brothers and sisters and his mother in Mexico. He doesn't talk much with family right now since it is expensive to call home. He finds it hard to be away from family and girlfriend. He thinks about them all everyday.
- Acculturation stress: Chaco states that it is hard to adjust to culture where everyone does what he or she wants to do all the time. He also has a hard time negotiating basic life tasks if they require English. He feels more comfortable in the Mexican *barrio*, neighborhood, in Chicago. But he feels that many of the Mexicans who have been in the United States longer or Mexican Americans look down on him. He also feels that some of these people try to take advantage of him because of his naïveté and his fear about his undocumented status.

Chaco's story is not unique; it speaks to high levels of fear, anxiety and danger at his crossing, and isolation and loneliness in the ensuing months. Though Chaco is not seeking mental health services at this time, he has had numerous traumatic experiences that may undermine his ability to best function as an immigrant.

6. Conclusions

The Mexican immigrant population is increasing in the United States. With their arrival and continued stay in the United States, a myriad of needs for culturally competent mental health services is necessitated. By examining our own cultural biases and perspectives through the genogram we can better provide services. By gaining a better understanding of issues faced by Mexican refugees crossing the border and living in the United States an empathetic rather than a criminalizing approach can be achieved. Furthermore, by better understanding Mexican culture a more comprehensive method to working with Mexican refugees can be sought. In using ecological and risk and resilience theories a greater holistic practice can be achieved. In facilitating the use of narrative therapy we can help the Mexican immigrant construct a healthier experience of living in the United States. We have an ethical responsibility as social workers to increase our cultural competence in practice for this ever-growing population who deserve high quality mental health services.

References

Barrows, A. (1995). The ecopsychology of child development. In T. Roszak, M. Gomes, & A.

- Kanner (Eds.), *Ecopsychology* (pp. 101-110). San Francisco, CA: Sierra Club Books.
- Bronfenbrenner, U. (1979). *The Ecology of Human Development*. Cambridge, MA: Harvard University Press.
- Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: research perspectives. *Developmental Psychology*, 22(6), 723-742. <https://doi.org/10.1037/0012-1649.22.6.723>
- Bronfenbrenner, U. (1989). Ecological Systems Theory. *Annals of Child Development*, 6, 723-742.
- Bubolz, M., & Sontag, S. (1993). Human Ecology Theory. In P. Boss, W. Doherty, R. LaRossa, W. Schumm, & S. Steinmetz (Eds.), *Sourcebook of Family Theories and Methods: A Contextual Approach*. (pp. 419-448). New York: Plenum Press. https://doi.org/10.1007/978-0-387-85764-0_17
- Cabassa, L., Zayas, L., & Hansen, M. (2006). Latino adults' access to mental health care: A review of epidemiological studies. *Administration and Policy in Mental Health and Mental Health Services Research*, 33, 316-330. <https://doi.org/10.1007/s10488-006-0040-8>
- Clarke, J. (2003). Reconceptualizing empathy for anti-oppressive, culturally competent practice. In W. E. Shera (Ed.) *Emerging Perspectives on Anti-oppressive Practice*, (pp. 247-263.) Toronto: Canadian Scholars Press, Inc.
- De Rio, M. (1992). *Amazon Healer: The Life and Times of an Urban Shaman*. New York: Prism Press.
- Dovidio, J. F., & Esses, V. M. (2001). Immigrants and immigration: Advancing the psychological perspective. *Journal of Social Issues*, 57, 378-387. <https://doi.org/10.1111/0022-4537.00219>
- Escobar, J., Nervi, C., & Gara, M. (2000). Immigration and mental health: Mexican Americans in the United States. *Harvard Rev Psychiatry*, 8, 64-72. https://doi.org/10.1080/hrp_8.2.64
- Foster, R. M. P. (1998). The clinician's cultural countertransference: The psychodynamics of culturally competent practice. *Clinical Social Work Journal*, 26, 253-270. <https://doi.org/10.1023/A:1022867910329>
- Griffore, R., & Phenice, L. (2001). *The Language of Human Ecology*. Dubuque, Iowa: Kendall/Hunt.
- Hawng, W. (2006). The psychotherapy adaptation and modification framework. *American Psychologist*, 61, 702-715. <https://doi.org/10.1037/0003-066X.61.7.702>
- Hollander, N. (2006). Negotiating trauma and loss in the migration experience. *Studies in Gender and Sexuality*, 7, 61-70.
- Howard, S., Dryden, J., & Johnson, B. (1999). Childhood resilience: Review and critique of literature. *Oxford Review of Education*, 25(3), 307-324. <https://doi.org/10.1080/030549899104008>
- Jessor, R., Van Den Bos, J., Vanderryn, J., Costa, F. & Turbin, M. (1995). Protective factors in adolescent problem behavior: Moderator effects in developmental change. *Developmental Psychology*, 31(6), 923-933. <https://doi.org/10.1037/0012-1649.31.6.923>

- Luthar, S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guideline for future work. *Child Development, 71*, 543-562. <https://doi.org/10.1111/1467-8624.00164>
- Maslow, A. (1943). A Theory of Human Motivation. *Psychological Review, 50*, 370-396. <https://doi.org/10.1037/h0054346>
- McAdams, D. (1993). *The stories we live by: personal myths and the making of the self*. New York: Guilford Press.
- Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry, 57*, 316-331. <https://doi.org/10.1111/j.1939-0025.1987.tb03541.x>
- Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustments in resettled Sudanese refugees. *Australian and New Zealand Journal of Psychiatry, 40*, 179-187. <https://doi.org/10.1080/j.1440-1614.2006.01766.x>
- Stampley, C., & Slaght, E. (2004). Cultural Countertransference as a clinical obstacle. *Smith College Studies in Social Work, 74*, 333-347. <https://doi.org/10.1080/00377310409517719>
- Tannenbaum, M. (2005). Viewing family relations through a linguistic lens: Symbolic aspects of language maintenance in immigrant families. *The Journal of Family Communications, 5*, 229-252. https://doi.org/10.1207/s15327698jfc0503_4
- United Nations High Commissioner for Refugees. Retrieved on 5/01/07 from http://www.unhcr.org.uk/info/briefings/basic_facts/definitions.html
- Van Ecke, Y. (2005). Immigration from an attachment perspective. *Social Behavior and Personality, 33*, 467-476. <https://doi.org/10.2224/sbp.2005.33.5.467>
- Wang, M., Haertel, G., & Walberg, H. (1994). Educational resilience in inner cities. In M. Wang, & E. Gordon (Eds.), *Educational resilience in inner-city America: Challenges and prospects* (pp. 45-72).
- Werner, E., & Smith, R. (2001). *Journeys from Childhood to Midlife*. Ithaca, NY: Cornell University Press.
- Yakushko, O., & Chronister, K. (2005). Immigrant women and counseling: The invisible others. *Journal of Counseling & Development, 83*, 292-298. <https://doi.org/10.1002/j.1556-6678.2005.tb00346.x>

Copyright Disclaimer

Copyright reserved by the author(s).

This article is an open-access article distributed under the terms and conditions of the Creative Commons Attribution license (<http://creativecommons.org/licenses/by/3.0/>).