The United States is described as a nation of immigrants. Currently, about 13% of the U.S. population is comprised of immigrants. There appear to be pockets of immigrants and some areas, such as northern Virginia, are more heavily settled than others. In Virginia in 2007, 18% of children lived in a family where one or both parents were foreign-born. Northern Virginia showed higher statistics with 43.2% of children living in an immigrant family.

Immigrants typically fit into one of four categories, each category or status carrying different benefits, entitlements, services, and legal rights (Torrico, 2010). **Lawful permanent residents** are noncitizens residing in the United States with permission to permanently live and work in the U.S.A. These individuals are sometimes referred to as having “green card” status and they may apply for naturalization after 5 years (or after 3 years if they are married to a citizen).

**Naturalized citizens** are persons who were born as noncitizens who are granted citizenship through a process of meeting requirements such as English literacy, knowledge of civics, and demonstration of good moral character. After naturalization the new citizen has the same rights as a natural citizen except that of being eligible to become president or vice-president of the U.S. Persons must be at least age 18 to naturalize and children generally become citizens automatically when parents naturalize. **Refugees** are persons who have fled their country due to fear of persecution for reasons of race, religion, social group, or political opinion. Refugees are unable or unwilling to return to their country of origin. Those granted permission to reside in the United States are termed refugees and those granted permission to remain after entry to the U.S. are called asylees. Both may apply to adjust their status to Lawful Permanent Resident after a period of one year. **Nonimmigrants** are granted permission to enter the United States for a limited time and a specific purpose such as work or study. A fifth group, **undocumented immigrants** (sometimes termed “unauthorized immigrants”), are in the country illegally. They either entered the United States illegally or entered legally and then violated the terms of stay, remaining after their visa expired.

According to Torrico (2010), almost all children of immigrants who are under the age of 6 (93%) are citizens of the United States. Some live with mixed-status families. An example of a mixed-status family is one where young children are citizens, a parent is a Lawful Permanent Resident, and the other parent or a grandparent is undocumented. In 2007, lawful permanent residents characterized about 29% of immigrants; naturalized citizens were 32%; refugees were 7%; undocumented immigrants were 29%; and non-immigrants were 3% of the foreign-born population (George Mason University, 2007).

**What are some of the effects of immigration?**

Imberti (2008) is a clinical social worker who left Argentina in the late 1980’s while in graduate school studying psychology. Her husband was in law school but the couple felt they had few prospects in Argentina. Imberti described four basic losses that immigrants experience when they come to a new country: a loss of mastery over surroundings; a concrete loss of family networks (after Imberti left Argentina in the late 1980’s while in graduate school studying psychology. Her husband was in law school but the couple felt they had few prospects in Argentina. Imberti described four basic losses that immigrants experience when they come to a new country: a loss of mastery over surroundings; a concrete loss of family networks (after Imberti left Argentina, she never saw her mother again); a critical loss of language (Imberti spoke no English prior to arrival. She writes that the worst part was being 26 and feeling infantilized when she lacked words to express herself); and an erosive loss of everyday life. Daily pleasures and patterns often cannot be replicated in the United States (or any new country).

Effects of immigration may vary but always imply a certain degree of culture shock and mourning the loss of the former country (Espin, 1987). The process may be somewhat different for men than for women or children of varying ages. Some of the many factors to consider are:

- Was the immigration forced or by desire of the family?
- How difficult was the migration?
- Is the family responsible for persons left behind?
- Does the family have friends and relatives or a support group already living in the U.S.?
- What is the family’s language proficiency?
- What resources did the family bring? Is the family living in poverty?
- Do the parents have education and job skills?

A few studies have measured the adjustment of refugees and immigrants over periods of several years (Kivling-Boden and Sundbom, 2001; Lie, 2002; Singh, et al., 2010). (For studies about child adjustment, see separate article, this issue). Some authors note that research on Holocaust survivors and World War II veterans show that trauma symptoms, especially of torture, have been documented 50 years or more later and can persist throughout the victim’s lifetime. War or ongoing conflicts that threaten friends and family in the country of origin can be extremely distressing, interfere with the acculturation process, and distract immigrants from daily tasks such as parenting. For ex-

continued on page 2
THE ACCULTURATION PROCESS

As different cultures come into contact, conflicting cultural child-rearing practices create potential disputes about the presence of child maltreatment. Families confront the question of how to become American without losing their own heritage. Families must choose the extent to which members seek relationships with those in the dominant cultural group (Castillo & Caver, 2009; Berry, 2001). In the early 1990’s, Berry proposed a model of acculturation describing ways that individuals confront these two basic issues. The process is bidirectional; the intersection of acculturation and intergroup relations requires both the immigrants and members of the dominant culture to redefine cultural boundaries and social relationships.

Berry’s model describes a process of mutual change and describes acculturation attitudes for both immigrants and the receiving society. Strategies for the immigrants are: integration (maintaining one’s original culture while engaging in daily interactions with other groups); assimilation (embracing the new culture and not maintaining one’s original culture); separation (holding onto the original culture and resisting the new culture); and marginalization (little interest in adopting the new culture accompanied with inability to maintain the original culture).

Members of the dominant culture also have options: multiculturalism (valuing cultural diversity with low levels of prejudice and discrimination); melting pot (expecting immigrants to assimilate); segregation (wanting to remain separate from immigrants); and exclusion (opposing immigration). Depending upon the attitudes adopted, outcomes can range from conflicted and stressful to relationships where mutual accommodations are achieved (Berry, 2001). Berry makes a case that the strategies of integration and multiculturalism yield mutual accommodation and positive adaptation.

The acculturation process has multiple dimensions. Castillo and Caver (2009) also suggest that acculturation is an interpersonal process. They propose that acculturation occurs at three levels of functioning. The behavioral component includes language usage and daily living habits such as choices of food, type of music, or television shows. The cognitive component consists of cultural values such as beliefs about cultural customs and traditions, gender role beliefs and expectations, and beliefs and attitudes about health status and illness. The affective component involves cultural identity and attitudes towards and comfort with people of one’s ethnic or indigenous group and members of the dominant culture.

April, a follow up of 462 refugees in Norway found only half had good or very good health. Psychiatric symptoms were chronic and showed a persistently high symptom level. The level of current social support (support while in exile) was an important predictor of the severity of both PTSD symptoms and depression (Lie, 2002).

Post-traumatic stress is likely for both parents and children who immigrate. Cumulative losses add to the stress of becoming part of the culture. Racism, likely poverty, and sometimes neighborhood violence combine to increase the likelihood of developing clinically significant symptoms (Fortuna, 2009). Further, some research suggests that the symptoms can be protracted (Kivling-Boden & Sundbom, 2001).

THE PROCESS OF MIGRATION

Espin (1987) and others (Fazel & Stein, 2002) conceptualize the process of immigration in stages. At each stage, there is possible trauma and at each stage there are different challenges.

First is the decision to leave the current location and migrate. If the family has a choice, women and older children may not even be consulted about a decision to immigrate. Others are forced to flee their homes. Children may have witnessed combat or torture or even seen people killed. The children may have no memories of any stability and their schooling, if any, likely was disrupted.

Second is the actual move, which can range from planned and organized to chaotic and harrowing. The journey may have taken months and exposed the family to additional dangers. Children may have been separated from their parents for their safety or even entrusted to smugglers in the hope that the child had a better chance of acceptance and refugee status if the child was sent alone. Refugees may spend years waiting for permission to immigrate and their children may know little except life in the refugee community.

Third is acculturation once immigrants arrive in the host country. Families face many stresses and “secondary trauma” as they encounter problems gaining legal status. Parents must find employment and children need to adjust to schools and find playmates. Children may learn the new language more quickly and assume the role of interpreters for their parents.

The acculturation process may have several stages and is not linear. Initially, there may be joy and relief, which can be followed by disillusionment. If the process is successful, gradually the immigrant family will accept the country with its positives and negatives and adjust while reorganizing and adapting to the new living situation (Espin, 1987).

Serving Immigrant Families

continued from page 1
tion of cultural competence, but, at minimum, the concept suggests that professionals be familiar with the cultures and norms of the ethnic populations served (Fong, 2007). The Child Welfare League of America (CWLA) defines cultural competency as “the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and faiths or religions in a manner that recognizes, affirms, and values the worth of individuals, families, tribes, and communities, and protects and preserves the dignity of each” (CWLA, 2001).

It is less clear what culturally competent practice entails, how to measure it, and how to train providers to be sensitive towards those with ethnic differences. Fong (2007) suggests that cultural competence encompasses knowing the client’s cultural values, migration history, client strengths, indigenous help-seeking and help-receiving patterns, cultural traditions, and indigenous practice interventions. The CWLA recommends that cultural competence includes a commitment to incorporate the cultural knowledge into agency policy and the development of a comprehensive strategy for service delivery that considers linguistic and literacy issues. It is a dynamic process that evolves over time (National Technical Assistance and Evaluation Center for Systems of Care, 2009).

The concept of cultural competence is further complicated by no clear definition of culture. Betancourt and Lopez (1993) discuss culture as learning shared by a people or identifiable population group. They speak of “designs and ways of life” that are transmitted from one generation to another (p. 630). They note, however, that the term culture is often used interchangeably with race, ethnicity, or nationality. Stuart (2004) discusses the issue of cultural sensitivity versus cultural stereotypes. He notes that cultures are diverse and changing. The term Asian American implies commonalities among 3.6 billion people living in countries including Japan, China, India, Syria, and Afghanistan. Likewise, the term African American suggests that 33.9 million people in the U.S.A. share characteristics with 797 million people of Africa who live in 50 countries and speak more than 1,000 different languages as well as peoples from the West Indies, South America, Australia, and New Zealand. The 2.5 million Native American represent over 500 different tribes. Stuart notes that the 36 million Americans identified as Hispanic in the U.S. 2000 census hailed from Mexico, Central and South America, Puerto Rico, Cuba, and many other regions. Some spoke Spanish but others spoke Portuguese or indigenous languages. Thus, the “myth of uniformity” is implied when providers be

What is the Population of Immigrants?

National Data

There are several sources of information and statistics about the numbers of immigrants in the U.S.A. The American Community Survey Reports (2005; January, 2010), the Urban Institute (Capps, et al., 2005; Chaudry et al., 2010), the Pew Hispanic Center (Pessell, 2005; 2006), the U.S. Office of Homeland Security, and the U.S. Census Bureau (2006) all offer data. The following draws from these sources.

The total population of the United States is currently about 307 million. About 38.5 million of this number are foreign-born and represent 10.4% of the population. Half of the foreign-born individuals are Hispanic and 64% of those are of Mexican origin. Unauthorized resident immigrants (often termed “undocumented”) are defined by Homeland Security as “all foreign-born non-citizens who are not legal residents” (Hoefler, Ryina & Baker, 2010, p. 1). The undocumented population is estimated at 10.8 million (American Community Survey Reports, January, 2010). Approximately one-sixth (about 1.7 million) of undocumented individuals are children (Pessell, 2005).

Since 1990, there has been rapid change in undocumented persons. Most undocumented individuals have arrived since 1990. On average, the U.S. population of Mexican origin has grown by at least half a million people per year (Pessell, 2005). Homeland Security (Hoefler et al., 2010) estimates that of all unauthorized immigrants living in the United States in 2009, 63% entered before 2000 and 62% were from Mexico. Pessell (2006) estimates that 500,000 undocumented immigrants have entered the United States each year since 2000. The total of undocumented immigration may be as high as 1.5 million people per year (U.S. Census Bureau, U.S. Department of Homeland Security). After a peak in 2007, the unauthorized population is thought to have declined to 10.8 million in January of 2009 due to the economic downturn (Hoefler et al., 2010).

From 1970 to 2000, children of immigrants increased from 6% to 19% of school-aged children representing 11 million of America’s 58 million school-aged children. In 2000, 16% of all students in pre-Kindergarten were children of immigrants (2% were foreign-born). In the upper grades, 19% of schoolchildren had immigrant parents (with 7% foreign-born) (Capps, et al., 2005). In 2005, children in immigrant families who were foreign-born or had at least one foreign-born parent were 21% of all children (ACSR, 2005). The Urban Institute (Chaudry et al., 2010) estimates that 5.5 million children live in the U.S. with unauthorized immigrant parents and three-fourths of these children are U.S. citizens. By 2030, it is projected that Hispanic/Latino children will be 31% of the child population.


Refugees and Asylees

Refugees and asylees deserve separate mention. These are persons who cannot return to their homeland due to persecution or a well-founded fear of persecution. Refugees arrivals averaged over 100,000 each year in the early 1990’s and then declined. According to Homeland Security, a total of 74,602 persons were admitted to the United States as refugees during 2009. The leading countries of nationality were Iraq, Burma, and Bhutan (Martin, 2010).

The first refugee legislation in the United States was the Displaced Persons Act of 1948, which brought 400,000 Eastern Europeans to the United States. Other refugee-related legislation included the Refugee Relief Act of 1953 and the Fair Share Refugee Act of 1960. In 1967, the United Nations Protocol relating to the status of refugees, which the U.S. ratified in 1968, prohibited any nation from returning a refugee to a country where his or her life or freedom would be threatened. Congress brought U.S. law into compliance with the Protocol by passing the Refugee Act of 1980.

Before the start of each fiscal year, the President consults with Congress to establish an overall refugee admissions ceiling, as well as regional allocations and an unallocated reserve. The total ceiling for refugee admissions in 2009 was 80,000 (Martin, 2010).

Virginia Data

According to data in a 2004 report by the Joint Legislative Audit and Review Commission (House Document No. 9) to the Virginia legislature, from 1900 to the 1960’s the foreign-born population in Virginia was fairly stable, at about 1% of the population. The percentage doubled in the 1970’s to 2% of Virginia’s population. By 1980, foreign-born were 3% of Virginia’s population and they were 5% by 1990. By 2000, the foreign-born population was 8% of the Commonwealth.

Different sources offered somewhat different figures for Virginia’s immigrant population. For example, the JLARC report (2004) stated that the 2000 U. S. Census found 570,000 foreign-born residents in Virginia, representing 8% of the Commonwealth’s population. The American Community Survey (data set 2005-2007) found that Virginia’s foreign-born, numbering 768,974, were about 10% of the population.

In 2005, according to the American Community Survey Report, 16% of Virginia’s children lived in immigrant families. Most (81%) of the children were born in the United States and are citizens. Alexandria City had the highest percentage (50%), followed by Arlington County (43%); Fairfax County (42%); Prince William County (31%); Loudoun County (30%); Shenandoah County (18%); Henrico County (14%); Albemarle County (13%); Fairfax County (12%); Virginia Beach City (11%); Chesterfield County (11%); Stafford County (10%); and Rockingham County (10%).

See also data from Voices for Virginia’s Children (this issue) which differ somewhat from data above. According to Voices for Virginia’s Children, in 2007, about 18% of Virginia’s children (324,000) lived in immigrant families where one or both parents were foreign-born.

The U.S. Census data (2010) indicate that the population estimate for Virginia in 2009 is 7,882,590. The estimated Latino population is 569,921 (7.23%) and the Asian population is estimated at 454,987 (5.77%).

Recent refugee arrivals in Virginia (FFY 10 arrivals from 10/01/09 to 08/31/10) show 1,894 resettlements, down from the 2,192 arrivals for the same time period in FFY 09. Thirty-six percent settled in northern Virginia, 14% in Richmond, 12% in Roanoke, 12% in Hampton Roads, 11% in Charlottesville, 11% in the Shenandoah Valley, and 5% in Fredericksburg. Most resettled persons were from the Middle East, Asia, and Africa (Virginia Office of Newcomer Services, 2010).

Since 1975, Virginia has resettled more than 50,000 refugees. Virginia ranks 11th in the nation for the numbers of refugees resettled. Virginia’s refugees historically have arrived from Africa, the Caribbean, Eastern Europe, the Middle East, and Southeast Asia. Approximately 55% of refugees relocate in the Northern Virginia Area (Virginia Office of Newcomer Services, 2010).

References Available on the Website or By Request

continued on page 4
Serving Immigrant Families

continued from page 3

lieve that persons belonging to a particular group will share similar characteristics. There is, according to Stuart, a fine line between sensitivity to a person’s group membership and losing sight of a person’s individuality.

Stuart (2004) also suggests that providers be aware of areas of culture that are potentially relevant to clients. Thus, the provider should be sensitive to cultural differences without over-emphasizing them. Ethnicity may dominate a person’s decisions and behavior, or it may only influence the person, or it may be inconsequential to decision-making. Ethnicity also operates in interaction with many other factors such as developmental stage, gender, occupation, disability status, religion, and education. An immigrant mother from Iran may, for example, be the victim of domestic violence but also recently diagnosed with cancer. Her decisions may be more influenced by her health status, her occupation, and her extended family and community support, than by her ethnicity.

Hughes (2006) addresses why training staff to be culturally competent is so difficult. She notes that cultures are not static, but always changing, with nebulous boundaries. Culture is also heterogeneous. Not all individuals from a single culture are similar. Asking a person to be culturally competent is asking that person to shed the belief that individuals from a single culture are similar. Culture is also heterogeneous. Not all individuals from a single culture are similar. Asking a person to be culturally competent is asking that person to shed the belief that others view the world in the same fashion.

As Hughes (2006) notes, there are not clear guidelines about how to create a “culturally competent” professional. Such a professional will be able to maintain a welcoming environment, build rapport with families, and show the family respect. The need is not simply for training and understanding on the part of a particular professional, but also at an agency level to ensure that services are nondiscriminatory.

Bryant (2001) discusses the process of training attorneys to show cross-cultural competence. First is an understanding of the reactions that clients may have towards the legal system and the reactions the legal system, including the attorneys, may have towards clients. One goal is to avoid reinforcing stereotypes. Bryant also notes that cross-cultural learning occurs in different spheres: cognitive, behavioral, and emotional, and all spheres must be addressed in training.

Bryant (2001) suggests four guiding principles that express underlying assumptions about cross-cultural competence for attorneys. These are: all “lawyering” is cross-cultural; using a non-judgmental approach towards the client; remaining present with the client; and knowing oneself as a cultural being. In addition to awareness and knowledge, attorneys need analytical and communication skills sufficient to engage in cross-cultural interactions. These include “deep listening skills,” a capability to focus on content rather than style, the ability to read verbal and nonverbal behaviors, and the ability to adapt conversation to accommodate differing styles of communication. It is important to make judgments based on facts rather than stereotypes and bias. Attorneys must have motivation to learn cross-cultural skills and sufficient coping skills to manage the stress that comes from intercultural interactions.

Thinking Points for Service Providers

A short article can only highlight some of the challenges and methods that can be effective for serving immigrant and refugee families. Readers are referred to some of the comprehensive works that are reviewed in this issue and on the website such as works by Lisa Fontes, Ph.D.

Immigrant populations may be more likely to seek help for emotional disorders from primary medical care settings rather than mental health clinics. Others may rely upon clergy who are easily available and do not charge a fee (Fortuna, 2009). Collaborations with clergy and primary providers and training these individuals to recognize trauma symptoms may help identify those in need of mental health intervention.

Latino clients are one group who may present with somatic, rather than emotional, complaints. Espin (1987) suggests that practitioners must address the physical complaints as well as attend to mental health issues. If the therapist fails to show attention to the somatic complaints, clients from traditional cultural orientations may see the treatment as irrelevant and terminate the therapy.

All clients who present for treatment with chronic somatic symptoms should be screened for a history of trauma. Ethno-cultural values and histories should be considered in order to enhance and validate the experiences of traumatized clients (Hien et al., 2008). A full medical evaluation can be helpful since conditions such as diabetes and heart problems can be associated with chronic stress (Fortuna, 2009) and since some medical conditions may be present in higher rates in immigrant populations. For example, Mexican-Americans are known to have high rates of type 2 diabetes (Castillo & Caver, 2009).

Therapists should think in broad terms and consider all the sources of stress, both...
This report covers ten different standards that should be followed for cultural competence in social work practice. These standards include: ethics/values; self-awareness; cross-cultural knowledge; cross-cultural skills; service delivery; empowerment and advocacy; diverse workforces; professional education; language diversity; and cross-cultural leadership. It discusses diversity not only with respect to race and ethnicity, but also with respect to gender, social class, religions, sexual orientations, ages, mental abilities, and physical abilities. This resource can help service providers understand how to work effectively with diverse populations.


Available from: American Humane Association: The Migration and Child Welfare National Network, 63 Inverness Drive East, Englewood, CO 80112 (800) 227-4645 or (303) 792-9900, FAX: (303) 792-5333, E-mail: CWNN@american humane.org or info@americanhumane.org Available for free download at: http://www.americanhumane.org/assets/docs/protecting-children/PC-migration-sw-toolkit-flowchart.pdf

This resource is part of a multi-component resource guide developed by the Migration and Child Welfare National Network. It was adapted from a California resource and modified for a national audience. The Flowchart illustrates how and when immigration issues may arise during the chronology of a child welfare case. It begins at the point of a child abuse report and continues through assessment, diversion or intervention, removal of the child, dependency issues and permanency planning. At each stage of the Flowchart, potential immigration issues are noted and explored in italics. The resource is not meant to be legal advice. It can help workers recognize the importance of collecting culturally crucial information as part of the case plan and can help workers identify relevant immigration information and how it affects the sequence of decisions in child welfare.

Using Language Interpreters

All sources consulted by VCPN and all providers interviewed agreed that best practice involves the use of professional interpreters. Children and family members should not be used as accurate translation can not be assured and confidentiality is compromised.

Without a solid grounding in mental health, interpreters who work with psychotherapists can actually do “more harm than good” (DeAngelis, 2010). It is imperative that interpreters keep information confidential. Matthew Lee, Ph.D., is a James Madison University Psychology faculty member with a specialty in diversity issues. He remarks, “Confidentiality must be described to the health care consumer, especially if the individual comes from a region where confidentiality is not emphasized or commonly practiced. Understanding confidentiality can help reduce the stigma that can be associated with seeking mental health services.”

Interpreters should be trained and reminded to report all information and refrain from censoring psychotic, profane or sexual content through embarrassment or a desire to protect the client. Interpreters should also avoid subjective decisions about what a client means. Instead, the interpreter should strive to become “invisible” and facilitate the flow of information.

According to Fontes (2009), interpreters not only shape the content of the communication in an interview or exchange, they also make choices about when to speak, whom to interrupt when they speak, and information they will ignore without interpreting. Speaking in short phrases can help the interpreter. Sources differed on advice about where to position the interpreter. Fontes recommends having the interpreter seated next to the client and slightly back so that the emotional contact is between the provider and the client. Others (DeAngelis, 2010) suggest a seating arrangement to promote conversation with the interpreter at the provider’s side so both directly face the client. With this arrangement, the client maintains con-
Serving Immigrant Families

continued from page 5

tact with both the clinician and the interpreter.

Practitioners can check with local language interpretation services, hospitals, and universities for recommendations of interpreters. Best practice is to avoid using the client’s family members or ad hoc bilingual personnel as interpreters, as the result could be inaccurate translations. If an agency uses ad hoc bilingual staff to interpret, there should be periodic formal assessment of the employee and consideration of ways to advance interpretation skills of such staff. Studies have found that clients prefer interpreters of the same gender (Ngo-Metzger et al., 2003). Having an interpreter of the same gender can be especially important if the topic is a sensitive one, such as sexual victimization.

If interpreters are not familiar with therapy or service provision, the clinician should brief the interpreter about the basics of the therapy. Debriefing is also important. Plan to meet briefly after the session to share feedback. The interpreter could have personal experiences and trauma that is triggered by client’s revelations. Also, the interpreter might be from a country that is an enemy to the client’s. Thus, translators bring their own agenda to the service delivery. Interviewers may want to be certain that interpreters are comfortable with the topic of the interview prior to starting.

Needed Services

Poverty rates are higher among children of immigrants than their native peers and rates are even higher for younger children living in immigrant families (sources cited in Torrico, 2010). Lack of resources can cause overcrowding homes and unsupervised children while parents are at work. Regardless of economic hardship, immigrant families access public benefits less frequently than native families (sources cited in Torrico).

Babies born to mothers who receive early prenatal care have better outcomes and are less likely to be stillborn or to need expensive post-natal care. Babies born to mothers with adequate prenatal care are less likely to experience developmental delay. Therefore, it is sensible to outreach to immigrant women who are pregnant.

Early education services can enable children of immigrants to enter elementary school with more advanced English skills, making them more prepared to learn. Programs can also connect families to needed health and social services and provide immigrant parents with an introduction to the community. However, children of immigrants are less likely to participate in any type of non-relative child care arrangement than are children of U.S.-born citizens. Participation in day care could be especially helpful for the one-third of young children who live in linguistically-isolated homes where no one over age 13 speaks English fluently or exclusively (Matthews & Ewen, 2006). While federal TANF assistance (Temporary Assistance to Needy Families), including TANF-funded child care, is generally denied to legal immigrants during their first five years in the United States, state funds or Child Care Development Block Grants (CCDBG) can be used for funding (Matthews, 2010).

Future Directions

Fong (2007) suggests that there are three basic options for child welfare and child protective services to accommodate the differing needs and presentations of immigrant and refugee populations. First, agencies can choose to simply incorporate the immigrant populations into the existing framework of child protection and child welfare services. A second approach is to make structural changes to the existing systems so that the system specifically better serves the immigrant population. Third, an agency could incorporate elements of both of these approaches.

An example could involve family group decision-making (an initiative being implemented in Virginia through the Children’s Services Transformation Program, see VCPN, volumes 85 and 88). In family group decision-making, families are included in determining child welfare outcomes. Immigrant families may have fictive kin (i.e., individuals not related by blood or marriage but who have important emotional ties to the client) who should be included, even though the meetings are generally limited to designated relatives.

It is important to note that federally-conducted programs and activities require provision of services to persons with limited English proficiency. Executive Order 13166 requires meaningful access to federally-funded programs for those with limited English proficiency. Further, Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discrimination based on national origin by (among other actions) failure to serve persons with limited English. State or local “English-only” laws do not relieve an entity that receives federal funding from responsibilities under federal anti-discrimination laws. A copy of the Executive Order and general guidance can be found at: www.usdoj.gov/crt/cot/

References Available on the Website or By Request

There are more than 16 million children living in America’s immigrant families. Most are U.S. citizens born in the United States to foreign-born parents (Mather, 2009). One in four young children in the United States lives in an immigrant family (Matthews, 2010). How do immigrant children fare in adjusting to their new country? What factors make a difference in their functioning? How can service providers be helpful?

Child Characteristics

There is considerable evidence that immigrant and refugee children are at risk of developing mental health and emotional problems. The most common presenting symptoms are those of post-traumatic stress disorder; anxiety disorders; depression; and conduct disorders (Fazel & Stein, 2002; Tousignant, et al., 1999). For example, in a sample of 1,004 recent immigrant school children ages 8 to 15 years old, 32% reported PTSD symptoms in the clinical range and 16% reported depressive symptoms in the clinical range. The children’s history included very high rates of exposure to violence with only 12% of children reporting no violence exposure (Jaycox et al., 2002).

A survey of immigrant children and youth in London found some strengths as well as greater likelihood of emotional and behavioral problems. The youth reported less use of alcohol, better pro-social behaviors and fewer problems with hyperactivity and conduct. The immigrants did less well on measures of peer relationship and emotional difficulties (Leavey, 2004). Some studies have found girls to be at higher risk for emotional disorders, except for conduct disorders (for example, Tousignant et al., 1999).

Many immigrant children live with parents who do not speak English. For example,
in California in 2005, 29 percent of immigrant children (2,163,242) lived in a linguistically-isolated household. Parents and other adults in these families have less formal education than the general population. For instance, in California in 2005, 30 percent of adult immigrants had fewer than 12 years of schooling compared to 8 percent in the general population (Children Now, 2009).

Children in immigrant families are less likely than their peers to attend preschool or nursery school and are less likely to attend high school (Children Now, 2009). Three quarters of immigrant children are bilingual and a fourth of them have not yet mastered English (Children Now, 2009). About half (51%) of Hispanic youth who begin attending college graduate, compared to 59% of their White peers.

Immigrant children are less likely to arrive at school healthy and ready to learn. The Urban Institute (Capps et al., 2003) reported that children in immigrant families were more likely to be in fair or poor health than children of natives. For children ages 12 to 17, 13% of children in immigrant families, compared to 5% of children in native families, were in fair or poor health. For children ages 6 to 11 years, the figures were 7% versus 3% and for children 0 to 5 the discrepancy was similar. For example, children may have physical conditions that require medical attention such as: parasites; dental caries; anemia; hepatitis B; infected with tuberculosis bacterium (Fazel & Stein, 2002). In California, only about half of the children with immigrant fathers are in good health, compared to 76% of the general population of children (Children Now, 2009).

Immigrant children are also less likely to be covered by health insurance. The Urban Institute (Capps et al., 2003) found that nationally, children of immigrants were twice as likely to lack health insurance when compared to children of natives. Lack of health insurance can mean delay in seeking treatment, more school days missed because of illness, and reliance on more expensive medical care at Emergency Departments in hospitals rather than from a consistent practitioner who knows the child and family.

Risk Factors

Many parents leave their homes and countries of origin as a last resort. Therefore, many immigrant children have been exposed to harsh conditions or to trauma (e.g., war, natural disaster, political violence) prior to immigration. Not only do they suffer the stress of being uprooted, but these children also may suffer post-traumatic reactions. Children may have experienced malnutrition, separation from caregivers, and other traumatic experiences. The trauma can be repeated and prolonged (Fazel & Stein, 2002). Studies have documented wide range of mental health symptoms particularly in immigrant and refugee children that are linked to exposure to trauma prior to migration (Birman et al., 2008; Lustig et al., 2004). Further, the parents and family members may have been victims of violence in the homeland and may themselves have post-traumatic stress reactions that compromise their ability to care for their children. Migration can take a toll on marital relationships and divorce or discord is not uncommon in refugee families (Almqvist & Broberg, 1999).

Immigrant families are more likely than native citizens to be living in poverty. For example, in California, in 2005, 39% of immigrant households were low-income compared to 25% of the general population. Overcrowded housing is common. The majority of immigrant parents are employed, but as a group, their earnings are about one-third less than non-immigrant households (Children Now, 2009). A more than six-month period of unemployment for parents has been shown to be associated with diagnosable psychopathology in the children (Tousignant et al., 1999).

Elizabeth Lutjen is the Regional Director of Refugee & Immigration Services for Commonwealth Catholic Charities in Virginia. She notes that there are many different definitions of child rearing. “It is important to respect their practices,” she emphasizes. Lutjen says that children often develop adjustment issues as they become acculturated more rapidly than the parents. The family may be accustomed to a strict patriarchal system and there is friction between the prior culture and what the children learn in school. “Some parents simply ‘give up’ on discipline. They have been told they can’t hit their children, and they have no other discipline methods,” explains Lutjen.

Immigration is seen as especially difficult for adolescents (Rousseau et al., 2005). Their process of transition into adulthood encompasses all the usual conflicts, as well as pronounced self-identity issues if the typical American position on autonomy and independence contrasts with the immigrant family’s values. Caught between two worlds with conflicting demands, there is increased pressure on immigrant adolescents trying to navigate into adulthood. Added to this burden is the process of grief and loss for all that was left behind in the country of origin.

Protective Factors

Fazel and Stein (2002) discussed risk and protective factors for mental health of immigrant children. Protective factors in the child can include temperament, health, success in development, and social abilities. A second set of protective factors are provided by a supportive family. The strength and functioning of parents can have a profound effect upon the child. The quality of child care is also a key factor in the child’s adjustment. A third set of protective factors are external to the family. These are the response of the community that can reinforce a child’s coping efforts.

Castillo and Caver (2009) provide examples of protective factors. They note that reliance on family members and friends for support, low-fat nutritious eating habits, and positive attitudes towards motherhood and children act as protective factors for the health of immigrants from Mexico. Protective factors can contribute to lower levels of perceived stress and mitigate the detrimental effects of poverty.
continued from page 7

What determines functioning?

It appears that a complex relationship exists between different risk factors and protective factors (Almqvist & Broberg, 1999). Adjustment appears harder for:

- Male children
- Those who lack peers to play with in the new country
- Children whose parents are struggling with their marriage
- Children whose fathers have poor mental health
- Children whose mothers have decreased well-being (the mother’s mental health predicts the emotional well-being of their children)
- Children who were compromised by ill health prior to immigration

There are some data suggesting that children’s adjustment improves over time (Almqvist & Broberg, 1999). However, the prevalence of post-traumatic stress does not decrease over time (Almqvist & Broberg, 1999). Severe traumatic stress exposure in children is associated with severe traumatic stress of parents (Almqvist & Broberg, 1999).

Providing Services to Immigrant and Refugee Children

Many immigrant children need trauma-specific treatment, as between 50 and 90 percent of refugee children meet criteria for post-traumatic stress disorder (Lustig et al., 2004). However, several issues complicate the development of evidence-based treatment for these children. Many studies on children’s trauma have been conducted after a single event (such as a flood or a school shooting) and don’t account for repeated, prolonged exposure to trauma, and most interventions have developed due to urgent need with little opportunity to research their effectiveness (Fazel & Stein, 2002).

The cultural diversity of the refugee population is great and is in constant flux. It is challenging to provide competent mental health services to a wide range of populations simultaneously. Interventions developed for a particular cohort may not be as effective for subsequent individuals or may not generalize to members of other ethnic groups. Therefore, Birman et al. (2008) suggest identifying and studying clinical treatment models currently in use as well as considering experiential reports by service providers.

Providers have the complex task of dealing with their clients’ stressors of acculturation and resettlement while also attending to the longer-term post-traumatic stress. The parents may prioritize general survival and economic stability over dealing with effects of trauma. Thus, comprehensive or “wrap-around” programs may be more effective as well as more appealing to the families (Birman et al., 2008).

The general consensus is that a variety of treatment options (such as individual therapy; family interventions; group; and school-based interventions) should be available. Success has been reported with cognitive behavioral therapies, with play therapy, with art therapy, music therapy and story telling. Some practitioners even try to incorporate traditional healing methods into more conventional treatment models (Fazel & Stein, 2002).

Success has been reported for use of drama therapy with children ages 7 to 18 (Rousseau, et al., 2004; 2005; 2007). Drama has a number of advantages over group discussion therapy. It can be less threatening, it is an interactive method, and it facilitates nonverbal expression (which might be useful for youth with verbal limitations and limited language proficiency). Conflicts can be “visited” through drama and acted out in different contexts with different paths and endings. “Playback theatre” (a type of improvisational theatre) has been used extensively in over 30 countries with varying age groups and in a variety of settings (hospitals; schools; community centers).

Rousseau, et al. (2005) report on a drama therapy program piloted in selected schools. Participants enacted scenes based on their personal experiences. Sometimes facilitators suggested a topic; sometimes participants each wrote a three-sentence ‘story’ and the group chose scenes from the story topics. The drama workshop was “very well received” by both students and school personnel. The workshops made the adolescents feel safe. In this forum, many were able to express themselves. In later qualitative evaluations, the authors found four elements associated with the success of the workshops (Rousseau et al., 2007). These were: constructing a safe space; acknowledging and valuing multiplicity; establishing continuity; and transforming adversity. The program resulted in increased self-esteem and a decreased level of social and emotional problems for elementary students (2004).

Attempts to measure direct effects with adolescents were equivocal for emotional and behavioral symptoms, but the participants did show academic improvement. The therapy showed a decrease in impairment for girls and appeared to prevent its increase in boys (2007).

continued on page 22

CHILDREN OF IMMIGRANTS
Data Tool

Available from: The Urban Institute, 2100 M Street, N.W., Washington, DC 20037 (202) 833-7200.

The Children of Immigrants Data Tool allows the comparison of statistics (population characteristics) on children across populations. There is a choice of location (individual states or the United States), population, data type (count or percentage), and statistic type. A chart displays the comparisons. The population type has groups such as: the citizenship of parents; the citizenship of parents and children; the origin of the parents; the age of the children; and the income status of the household. In choosing the statistics about the population there are many options for characteristics of the child, parent, and family. The results are expressed in percentages as well as direct numbers.

Reaching all Children? Understanding Early Care and Educational Participation Among Immigrant Families,
by Hannah Matthews and Danielle Ewen, January, 2006, 26 pages

Available from: Center for Law and Social Policy (CLASP) 1015 15th Street, NW, Suite 400, Washington, DC 20005 (202) 986-8000, FAX: (202) 842-2885, Web site: www.clasp.org E-mail: ahouse@clasp.org

Early education programs can enable children of immigrants to enter elementary school with more advanced English skills, making them prepared to learn and to succeed. Additionally, programs that contain a high-quality comprehensive services component can connect families to health services and social services and provide recently-arrived immigrants with an introduction to the community.

According to the 2000 U.S. Census, children in immigrant families are the fastest-growing segment of the nations’ child population. During the 1990’s, the population of children of immigrants grew at a rate of seven times that of children of native-born families. By 2015, children of immigrants are projected to rise from 20 to 30 percent of the nation’s school population. This paper summarizes evidence about the participation of young children of immigrants in early care and education programs. It discusses policy recommendations for state and local administrators of preschool and other early care and education programs.
The demographics of Virginia are changing. In 2007, 18% of Virginia’s children (324,000 children) lived in immigrant families where one or both parents were foreign-born. Most of these children were born in the United States and are U.S. citizens. Northern Virginia had a larger proportion of children in immigrant families (43.2%), but other areas also showed high concentrations of immigrant families as well. For example, in Albemarle County 13% of children lived in immigrant families; in Shenandoah County 18% of children had parents who were immigrants and in Henrico County, 14% of children were living in immigrant families (Voices for Virginia’s Children, 2008; 2010).

Most children in immigrant families have parents who are U.S. citizens. In 2008, 113,000 children (35% of children in immigrant families) had parents who were not U.S. citizens.

Based on an analysis using data from 2005-07, Virginia’s immigrant children when compared to other Virginia children were:

- more likely to live in a two-parent family (82% versus 67%).
- more likely to speak two languages.
- more likely to live in low-income housing (49% versus 35%).
- less likely to be living below the poverty line (11% versus 14%).
- more likely to have a grandparent living in the home (13% versus 6%).
- more likely to have a parent who did not complete high school (14% versus 6%).

Virginia’s immigrant children shared some characteristics with the average Virginia child. Most lived in homes owned by their parents. Employment levels were similar for fathers. They were equally likely to be considered low income.

Averages mask great diversity, however. For example, while the majority of Virginia’s children in immigrant families had a parent who spoke English well, one in five (20%) lived in a linguistically isolated household in which no person over age 13 spoke English well. Still, children were learning English with only 3% considered to have difficulty speaking English.

Immigrants are an important part of Virginia’s economy. They generally fall into two categories: unskilled labor with less than a high school diploma or skilled professionals with advanced degrees. Some are entrepreneurs who start businesses, invest in and help revitalize communities, and contribute to economic vitality. Most immigrant families are hard-working, stable contributors to the community (Voices for Virginia’s Children, 2008).

According to Voices for Virginia’s Children, understanding the assets and challenges facing immigrant families in Virginia will allow policy-makers to consider the best ways to meet the needs of children and families who will be a significant part of Virginia’s future. Voices for Virginia’s Children stresses that immigrants are large contributors to Virginia’s economy and they are climbing the socio-economic ladder. They are taxpayers, workers, and homebuyers. Voices for Virginia’s Children advocates that communities that strive to meet the needs of all children, including children of immigrant parents, will be stronger communities and better positioned to encourage a robust economy.

Source: Voices for Virginia’s Children, see www.vakids.org (Note: original data sources include the 2007 American Community Survey which represents data collected from 2005-07.)

**Final Report of the Illegal Immigration Task Force**

by: The Virginia State Crime Commission, 2008, 94 pages, Patrick Henry Building, 1111 East Broad Street, Suite B036, Richmond, VA, 23219

(804) 225-4534 Fax: (804) 786-7872

Website: http://vssc.virginia.gov/ Email: vsscinfo@vssc.virginia.gov

Available for free from: http://leg2.state.va.us/dls/h&xdocs.nsf/B+y+Year/ RD452008/$file/RD45.pdf

The Virginia State Crime Commission was created to study, report, and make recommendations on all areas of public safety and protection. The Commission’s Illegal Immigration Task Force was created to study the impact of illegal immigration on Virginia’s criminal justice system. The final report of this task force contains findings on many topics such as the effect of illegal immigrants on Virginia’s jails and prisons and how to bridge the gap between immigrants and law enforcement. The report also summarizes federal immigration law and the role of the U.S. Immigration and Customs Enforcement. There is a small section on the victimization of immigrants through employment abuse, domestic abuse, sexual abuse, and human trafficking. The report ends with thirty-two recommendation proposals for improvement in many areas concerning illegal immigrants including enforcing laws, collecting data on illegal immigrant inmates, and educating law enforcement about language and cultural barriers.

**Governor’s Commission on Immigration Final Report**

by: The Virginia Commission on Immigration, 2009, 94 pages, 1000 Bank Street, Richmond, VA 23219 (877) 391-FACT Email: hinformation@house.state.va.us


The Virginia Commission on Immigration was created to examine the impact of immigration on education, health care, law enforcement, local demands for services and the economy, and the effect on the Commonwealth of federal immigration and funding policies. This Commission addressed impacts of both legal and undocumented immigrant populations. The final report addressed differences in immigration legislation between other states and Virginia and what challenges Virginia faces that other states might not. Effects on the Commonwealth were addressed in the areas of employment, economy, human services, and education. Information is given on how to help immigrants transition to American society. Six pages of both federal and state recommendations were made in the categories of employment, health care, education, transition, data collection, and public safety.
Catholic Charities of Roanoke serves 200 refugees a year through its Refugee and Immigration Center. Beth Lutjen, Regional Director, coordinates staff and services. She brings a background of 13 years with the American Red Cross, a degree in Christian Education, and experience working in public television to her current position.

Lutjen explains that most of their refugees are from Iraq, Burma, and Bhutan (a small country between India and Nepal). Catholic Charities works closely with the U.S. Department of State and are part of the United Council of Catholic bishops which sponsors eight resettlement agencies. Lutjen says that they have a contract to handle a certain number of refugees and the agency is sent appropriate cases according to their capacity to handle them. Individuals and families have been living in a refugee camp and they have no home to return to. They sign a note to repay their travel costs to the United States.

“The work is very gratifying,” remarks Lutjen. “We work with a small number of persons and we can truly understand their stories.” Families and individuals must remain in a refugee camp for at least five years before they can relocate to the United States. It must be determined that they can not return to their original location before they are approved for resettlement. Lutjen says some stay as long as 30 years, with an average stay of 10 years. “Refugees learn patience,” she remarks.

It is a monumental transition from the refugee camp to becoming an ordinary citizen of this country. The refugee camps do have schools and teach English skills. Some refugees even have advanced degrees. “We provide a home, utilities, and culturally appropriate food. A case worker helps enroll the children in school. We connect them with community resources and volunteer mentors,” explains Lutjen. The agency strives to have the adults employed within four months.

One of the challenges for families is lower paying jobs with odd schedules. “The families have similar problems to native families who are working poor. Child care is difficult, especially at unconventional hours,” adds Lutjen. Additionally, families may be suspicious and reluctant to leave children with strangers.

Depression can set in as there is no “going back.” “Nothing is ever as good as you think it will be while waiting to be resettled,” notes Lutjen. “Everything is different- the sounds, the smells, the sights. It stops being exciting and fun and is simply stressful.”

Catholic Charities is limited in follow up with families. There is a school liaison. “We want them to become integrated into the community and not remain dependent upon the agency,” Lutjen explains. “We are a warm, welcoming, and caring community.” Indeed, the local Colors Festival, held the second Saturday in May, has been recognized in the past with a Diversity Award from the Governor.

For more information, contact Commonwealth Catholic Charities at: www.cccofva.org
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Court Appointed Special Advocates (CASA) for children is a national program that recruits, trains, and supervises community volunteers to advocate for abused and neglected children whose cases are in the juvenile court system. CASA volunteers meet the child and meet the people who are important in that child’s life: family members, teachers, social workers, therapists, and others. CASA volunteers give all the information gathered to the juvenile Court Judge, along with their recommendations as to what course of actions is in the child’s best interest. CASA volunteers advocate for a safe and permanent home as quickly as possible. VCPN devoted an entire issue to the CASA program (see volume 35). Currently there are 27 local CASA programs in Virginia.

SCAN’s Alexandria/Arlington CASA program started in 1989 in Alexandria and expanded to Arlington in 2005. Last year, the program was appointed to 177 abused and neglected children (123 children in Alexandria and 54 children in Arlington) by Juvenile Court Judges. In recent years, the Northern Virginia region has had tremendous growth in immigrant families. VCPN staff interviewed CASA director Carrie Cannon about the program’s experience advocating for children whose families have immigrated to the area from other countries. She described the population that the program is serving. “The large majority of the children to which the program is appointed were born in the United States. About 32 percent of the families have at least one parent, and many times, both parents, that are first-generation immigrants,” she explained.

Volunteers must be able to devote time and energy, remain objective, and make a commitment to advocate for abused and neglected children. The court experience can be overwhelming for children and families, especially if they are new to our country. SCAN’s Alexandria/Arlington CASA initiated a multicultural volunteer recruitment campaign to better meet the needs of children living in immigrant families. Bilingual and/or bicultural volunteers were recruited. “We use interpreters only as a last resort,” says Cannon, “since speaking through a third party can hinder building rapport with..."
children and families.” She cites a vast network of contacts for recruiting volunteers, which includes their website, articles in local papers, outreach to businesses and organizations that are culturally diverse, using current volunteers to recruit new volunteers, and partnering with other community agencies that are also seeking multicultural volunteers.

Since the first goal is to try to reunify children safely with their parents, Cannon believes that CASA volunteers can be helpful in establishing trust with government agencies. “The immigrant families seem to have more mistrust of government and the child welfare system. Sometimes, in their country of origin, the governments have been corrupt and some families don’t understand at first that the social workers and the required services are there to help them. CASA volunteers can encourage parents to work with social services and the CASA workers can help the families understand why the services are important to reunification.”

Cannon provides an example. When a social worker learned of a volunteer in the CASA program who was from the same African country as one of the families on her caseload, she asked the Judge for CASA to be appointed for the children. The school-aged children were desperate to be reunited with their mother and were very sad to be in foster care. However, the mother was very resistant to working with the social workers. After the first meeting with the CASA volunteer, the mother called the CASA office and thanked the program for assigning the volunteer to advocate for her children. The mother was overjoyed that someone involved understood their culture and her native language. The children were thrilled that they were able to spend more time with their mother, and they were eventually able to be reunified after their mother remedied the issues that brought the children into care.

In order to become a CASA volunteer, each applicant must pass background checks, submit references, and complete a 32-hour pre-service training which includes a courtroom observation. The applicant must pass a final panel review. The program asks for a year’s commitment, but prefers that volunteers remain until the child achieves permanency. It requires an average of 10 to 20 hours a month to be a CASA volunteer. Volunteers work closely with a CASA staff member who provides guidance, support, and supervision. Volunteers also complete 12 hours of continuing education each year, which includes cultural competency training.

For more information, contact: Carrie Cannon, CASA Director, SCAN of Northern Virginia, 1705 Fern Street, 2nd floor, Alexandria, Virginia 22302, (703) 820-9001, FAX: (703) 820-9002 E-mail: ccannon@scanva.org Web site: www.scanva.org/casa.htm

**Virginia’s Newcomer Services**

Virginia’s Office of Newcomer Services (ONS) is responsible for coordinating, planning, implementing, and evaluating Virginia’s refugee program. The Refugee Resettlement Program provides support for men, women, and children from all parts of the world who have been forced to flee their homelands because of war, armed conflict, and/or gross violations of human rights. Kathy Cooper, Director of the Office, notes that the term “refugee” also includes asylees, Cuban-Haitian immigrants, unaccompanied minors, victims of trafficking, and Iraqi individuals who risk their lives to help U. S. troops in the war.

Virginia’s Refugee Resettlement Program mirrors the national program by promoting self-sufficiency and personal responsibility. Cooper comments, “Employment and English-language proficiency are the focus of our efforts. We want the refugees to become self-sufficient as soon as possible.” The resettlement program offers specialized support services and time-limited benefits to assist refugees and their families.

Virginia’s Refugee Resettlement Program offers:

- Health screenings and medical assistance
- Employment assistance
- English language training
- Financial assistance
- Social and support services
- An unaccompanied minors program
- The Virginia Refugee Student Achievement Project

The Virginia Refugee Student Achievement Project (VRSAP) targets school-aged refugee children, grades K through 12, in Richmond, Fairfax, Falls Church, and Fredericksburg. The project assists with English language education, after-school tutorials, counseling, and parent-teacher counseling. The project provides school liaisons to help connect adult family members to the school and to train teachers about refugee cultural issues with the goal of improving the connections between the families and the schools. “We applied for and received federal grant funding to offer this service,” notes Cooper. “The school liaisons are very successful in offering a ‘bridge’ between school and home.”

Cooper notes that the refugee resettlement program is 100% federally funded. Refugees are eligible for the same public services as citizens. “We first serve new arrivals,” states Cooper, “although if we have resources, refugees are eligible for 5 years of service.

However, few need this extended time of dependency. Most move along the path to self-sufficiency very nicely.” Cooper does note that the economic downturn has affected the ability of refugees to obtain jobs and housing, so in the recent years, some have been dependent longer than in the past.

Since 1975, Virginia has resettled more than 50,000 refugees. Last year, said Cooper, Virginia resettled 2,400 individuals. Virginia ranks 11th in the nation for the numbers of refugees resettled. Virginia’s refugees historically have arrived from Africa, the Caribbean, Eastern Europe, the Middle East, and Southeast Asia. Approximately 55% of refugees relocate in the Northern Virginia area. According to Cooper, in the past large groups of immigrants from one or two countries were resettled. Currently, individuals or small groups from diverse locations are being served. “It is an interesting and diverse group,” reflected Cooper. “Some are highly educated or have extensive training while others are at the other end of the spectrum and need to acquire skills.”

Cooper is especially proud of Virginia’s unaccompanied minors program which she describes as “outstanding.” “We have had decades of experience and utilization of best practice methods. The staff members are astute and able to anticipate changes. More and more of the children come from detention centers or are victims of trafficking. We have various options such as foster care, independent living, or a group setting with a ‘step-down’ program to less intensive services. Our case management is very rigorous,” she explains.

The Office of Newcomer Services is always on the lookout for federal grant opportunities. For example, a recent federal grant is funding classes and services for Cuban immigrants in Harrisonburg and in Virginia Beach where there is a concentration of Cubans. “There never seem to be enough classes and modalities, so we take advantage of any federal offerings,” Cooper notes.

Cooper says her Office tries to be a ‘point of contact’ for a wide range of inquiry rather than strictly a consultation service to refugee programs. She supports communities in applying for funding to assist with local initiatives and maintains very close contact with local contractors.

More information is available from: Kathy Cooper, (804) 726-7927 or E-mail: Kathy.cooper@dss.virginia.gov
For more than forty years, Virginia’s Legal Aid Justice Center has worked to provide civil legal representation for vulnerable low-income individuals with the least access to legal resources. The staff of 36 provides a wide range of civil legal assistance from offices in Charlottesville, Falls Church, Petersburg and Richmond. The Center has several advocacy programs: JustChildren (child advocacy); the Virginia Institutionalized Persons Project; an Elder Law Initiative; Civil Advocacy Program; and the Immigrant Advocacy Program. Of greatest interest to this particular issue of VCPN is the Immigrant Advocacy Program.

Tim Freilich, Legal Director of the Immigrant Advocacy Program, explains the development of the program. “Much of Virginia’s agricultural industry depends on migrant workers to harvest crops and process food,” he began. “We started the Immigrant Advocacy Program in 1998 to work with migrant farm workers around the Commonwealth. We wanted to make certain that they were paid properly and receiving fair treatment in the workplace. We also work to make certain that housing conditions for migrant workers at least meet the basic requirements of the law,” he continued.

The Program accepts a range of cases, from those addressing the concerns of an individual worker to those cases impacting a large number of workers. Freilich says he is inspired by the stories of the immigrant workers he meets to continue to work with them to help them improve their lives. In addition to legal representation, the Legal Aid Justice Center also uses community organizing and advocacy to raise awareness of issues facing Virginia’s immigrants. One such issue is the ongoing effort to ensure that undocumented youth who grow up in Virginia and graduate from high school are not barred from continuing their education in Virginia’s public colleges and universities.

Freilich comments that immigrant workers face the same challenges as other low-income persons but bear additional burdens due to language barriers, cultural differences, and being unfamiliar with the judicial systems in the United States. Some of the ways the Immigrant Advocacy Program’s bilingual staff work to accommodate the schedules and special needs of their clients are by being available to meet outside traditional business hours, by producing outreach materials in both English and Spanish, and by allowing parents to bring children with them to appointments.

The Immigrant Advocacy Program’s accomplishments over the years are impressive. The Program’s clients have won judgments and settlements totaling more than $5 million. The Program has helped groups of migrant workers obtain improved housing. Advocacy efforts have strengthened laws that protect immigrant workers. The Center has also worked to educate Virginians about the importance and contributions of immigrant workers throughout the Commonwealth.

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Web site: www.justice4all.org

Spotlight:
LEGAL AID JUSTICE CENTER

The Multicultural Clinical Center (MCC), located in Springfield, Virginia provides outpatient diagnostic and treatment services for children, adolescents, and adults. They have bilingual and bicultural staff members who are proficient in 13 languages: English; Spanish; Vietnamese; Urdu; Korean; Cambodian; Farsi; Hindi; Amharic; Krio; French; Pashtu; and Bangla. The Center was featured in VCPN, volume 62.

The diagnostic clinic provides psychological and neuropsychological evaluations, psychiatric evaluations, and assessments. Four types of specialized treatment are available: child and adolescent services; sex offender services; substance abuse services; and gang intervention services. In addition to individual, group, family, and couples therapy, MCC offers home-based counseling and play therapy.

VCPN staff spoke with Aaron Whitehead, M. Ed., a therapist with the Sex Offender Treatment Program. He explained that most of his clients are court-ordered. The immigrant families, he says, often lack information about the U.S. court system and are unaware of services. They are disinclined to seek treatment because they fear it will result in more trouble for the family and they are afraid that child protective services will remove their children.

One major challenge for immigrant families, says Whitehead, is transportation. Many immigrants do not have driver’s licenses. The Center can provide transportation if the family has a home-based counselor. If the family is covered by Medicaid, there might be funding for a taxi. A second challenge is to work with the job schedules of the family. MCC offers flexible appointments, says Whitehead. Immigrants struggle because of poverty, and they are unaware of resources. MCC helps their clients connect with resources.

MCC also offers professional training, workshops and seminars to outside service providers, including local and county government personnel.

For more information, contact:
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E-mail for director Gladys Santiago is gsantiago@mccva.com
Web site: www.mccva.com
A family, recently immigrated to the United States, alarms neighbors by allowing their preschool children to roam the neighborhood unsupervised. The neighbors return the children to the parents and try to explain about the potential dangers of traffic and older youth. The next day, the children are again unsupervised and the neighbors call child protective services.

A girl tells her school counselor that her parents sometimes punish her by having her kneel on gravel. The school counselor is unsure about whether or not this treatment constitutes physical abuse. The girl appears other wise well cared for, attends school regularly, and she is an excellent student. The parents do not speak English well and the counselor is unsure about how to approach them.

An adolescent from an immigrant family develops interest in music that her parents find unacceptable. When they discover her listening to it anyway, they react with what appears to be unjustified anger and physical abuse. When she appears in school with belt marks all over her back, the guidance counselor calls child protective services.

Two middle school children arrive home to find their mother badly beaten once again. This time they can not rouse her and they call the rescue squad. Their father believes that men at his wife’s place of work who talk with her have ulterior motives and he blames his wife for their friendliness towards her. In their country of origin, men are not allowed to talk with other men’s wives. The husband cannot get used to the idea that his wife is in a workplace all day with unrelated men, far from his supervision. The rescue squad calls the police and notifies child protective services.

Service providers including child protective services workers have been hampered by limited familiarity with the experiences of some immigrant populations. They can benefit from training and resources geared towards the cultural backgrounds of newly-arriving immigrant groups. Agencies are also challenged to retain trained staff, with many agencies experiencing high percentages of staff turn-over (National Technical Assistance and Evaluation Center, 2009). Achieving cultural and linguistic competence in service provision can require dramatic shifts in both personal and organizational cultural beliefs, values, policies, and practices. The National Technical Assistance and Evaluation Center (2009) suggests that child welfare agencies establish a baseline of system performance, and then make a comprehensive plan to improve culturally competent practices and to set expectations for system performance. Administration can provide reinforcements for improved practices.

Differing Child-Rearing Practices

Immigrant families may not understand that parenting styles relying upon corporal punishment, while widely accepted in their culture of origin, can contribute towards involvement of the U. S. child welfare system. A lack of resources may cause some families to violate housing codes and crowd themselves illegally into housing designed and restricted to use by fewer people. Other families, not trusting child care providers or accustomed to leaving children unsupervised, may fail to make adequate supervision arrangements for their children while they work or are away from their home (Torrino, 2010).

Should Immigrant Families be Required to Adopt U. S. Standards for Parenting?

This is an important question. If immigrant and refugee parents are judged by different or more lenient standards than their American counterparts who are native to the country, what is the effect on their children? Reluctance to intervene or protect children simply because of a perception that their families are pursuing methods acceptable in their country of origin would mean that immigrant and refugee children would not receive the same care and protection as other children. Additionally, it is difficult to know for certain whether a given family’s practices are traditional to that family’s culture of origin or if the actions or inactions might be considered maltreatment in their native country as well.

VCPN staff found no literature that supported maintaining a different standard for immigrant families in regards to child care and child maltreatment. Fontes (2002) noted that professionals and others required to make reports of suspected child maltreatment must do so regardless of the child’s cultural background. She also notes that solutions, interventions, and prevention programming are likely to be more effective if those who seek to help consider the cultural context of the abuse.

Factors that Impact Effects of Maltreatment

Clemmons et al. (2003) suggest that factors associated with ethnicity may impact the long-term effects of maltreatment (either to help or hinder the youth’s development into adulthood). The authors speculate that religion may help provide a protective factor and thus decrease the psychological effects of childhood maltreatment or religion could intensify long-term negative effects by heightening self-blame and lowering reporting rates and access to help. Another possibility is that family-oriented cultures may be disinclined to report relatives or family members who are abusing children in an effort to avoid dishonor to the family. Clemmons et al. asked if acculturation might affect long-term adjustment of children and youth in immigrant families who experienced sexual abuse. They surveyed 112 female Latino college students and found that the degree of affiliation with Mexican versus Anglo culture did not impact long-term adjustment following maltreatment.

continued on page 14
Child Maltreatment

continued from page 13

Examples of the Influence of Differing Ethnic Groups on Maltreatment Patterns

Child maltreatment patterns appear to vary somewhat by ethnic group. For example, Zhai and Gao (2009) studied maltreatment in Asian-American families. They found that Asian-American families tended to a low rate of child neglect and a high rate of physical abuse in comparison to the national average and other racial/ethnic groups. In general, child victims were older. Asian boys tended to experience more frequent but less severe physical punishment than girls.

According to Dr. Fontes, many departments of social services do not consider such practices to be abusive because the intention was to assist the child medically.

Clemons et al. (2003) surveyed 112 Latina undergraduate students about their experiences with childhood maltreatment. In this sample, 38.4 percent reported sexual abuse; 10.7 reported physical abuse; and 33.9 percent reported witnessing domestic violence, most often by fathers towards their mothers (30.4%) but also mothers’ abuse of fathers (19.6%). Many subjects (29%) experienced two or more forms of maltreatment. Those who experienced multiple forms of maltreatment reported more trauma symptoms than those who experienced a single form of maltreatment or none at all. These individuals also reported more severe forms of abuse.

Fontes (2002) claims that the literature on Latino families is so incomplete that it is not possible to determine whether the child maltreatment rates for Latino families are higher or lower compared to other groups. Additionally, she challenges the utility of such generalizations, noting that people from vastly diverse countries of origin and social backgrounds are all considered “Latino.” She notes that Latino parents who practice traditional forms of childrearing may be comfortable with an authoritarian style and occasionally use harsh physical punishment, accompanied by high levels of intimacy and support, and even indulgence of younger children.

Protective Factors

Cultures have practices and beliefs that protect children from abuse or sexual abuse. For example, shared parenting and community supervision can allow more adults to be involved with the child and more potential for input and early corrective feedback. Fontes and McCloskey (2011) discuss protective factors that might protect children from sexual abuse. The culture might endorse intolerant attitudes of adult-child sexual interaction and/or view children as nonsexual beings. A culture that places a high value on women and children and strong sanctions against child maltreatment offers societal support for protecting children and youth from harm. A culture might encourage strong relationships between mothers and children and support children in making their needs known. Involvement of extended family in childrearing can be a protective factor, as isolation is one variable often found in families where maltreatment occurs. Fontes and McCloskey note that research has not yet examined protective factors in diverse populations, so these possibilities are speculative at this point in time.

Reporting Issues

Immigrant children appear less likely to be reported for child maltreatment. Some immigrant families are isolated and have few contacts with the larger society. Traditional values in some immigrant groups (such as Asian-Americans according to Zhai & Gao, 2009) stress avoiding public embarrassment at all costs. Children absorb these values, are taught to place family integrity above their individual well-being, and are reluctant to share information with investigators and people outside the family.

Public perceptions can also impact reporting. According to Rhee, et al. (2008) there is a stereotype of Chinese Americans as the “model minority.” This subgroup is perceived to be “intelligent, problem-free math whizzes whose parents are uncomplaining, politically invisible, very agreeable, and hard working” (p. 270). This positive image distorts the life challenges of Chinese immigrant families and leads to a perception that the families don’t have as much need for government assistance, social services, or mental health care. These misconceptions translate into a lack of child welfare research and attention to the population, say the researchers.

For the immigrant family, “reporting costs” can be high. These can include not only social embarrassment, but also financial, emotional, legal, and cultural losses. If these negative consequences are ignored and no help is given to remedy them, a retraction can occur and subsequent instances of abuse will be hidden (Fontes & Plummer, 2010).

Suspected Child Maltreatment Investigations

Immigrants may distrust public systems such as child welfare. Fear and distrust can keep immigrant families from seeking or cooperating with services that are needed for their children (Torrico, 2010). For example, children in immigrant families are more likely to be in fair or poor health, without health insurance or medical care, and lacking access to a consistent preventative health care setting (Lincroft & Resner, 2006, cited in Torrico).

Numerous immigrant households are comprised of mixed-status families where different family members hold different legal
status (Torrice, 2010). A report of suspected child abuse or neglect may impede an undocumented immigrant from gaining legal status. Fear of deportation may cause the family to flee. If law enforcement becomes involved, the risk of flight is heightened. Many immigrants left countries with harsh or corrupt governments and have considerable distrust of government agencies.

During the investigation, workers need to remain aware that cultural norms and child-rearing practices may differ from usual practices in the United States, but may still not be abusive. Communication problems or lack of appropriate translation services may lead to inaccurate or insufficient information (Lincroft & Borelli, 2009).

Lisa Fontes, Ph.D. is the author of Child Abuse and Culture: Working With Diverse Families and also authored Interviewing Clients Across Cultures: A Practitioner’s Guide. She summarizes some of the challenges to interviewers who talk with immigrant or refugee families about child maltreatment (Fontes, 2009). She notes that biases, cultural differences and linguistic misunderstandings can have powerful effects on the interview process, even when the interviewer has the best of intentions. There is little research to guide the practitioner.

Fontes stresses the importance of an interview in the parents’ native language with someone who is competent in that language, not merely familiar with the language. She notes that the parents will likely provide more detail and be able to demonstrate the full range of their competence if they are comfortable with the language and the communication. To help avoid misunderstandings, she suggests keeping the questions short and direct, without embedded clauses. The interviewer should occasionally check with the persons interviewed about the pace and their understanding of the questions. A successful interview will convey respect and caring to the parents. However, it is important that the parents and caretakers realize the focus of the interview and understand the purpose (Fontes, 2009). Allowing the parent to ask questions and understand the basics of the child protection system is also important. Checking with the person being interviewed about how they are doing with the interview can be helpful. Fontes encourages interviewers to be cognizant of their tone and pacing. Interviews with immigrants may take considerable time and interviewers should be prepared to spend additional time and avoid being rushed. Extra interview sessions, especially with the children may be required in order to establish a working relationship. Interviewers can facilitate disclosure by children of diverse cultures by being respectful, open, nonjudgmental, and engaging and using the child’s preferred language (Fontes & Plummer, 2010).

**Interviewing Clients Across Cultures,**
by Lisa Aronson Fontes, Ph.D., 2008, 334 pages,
Available from: The Guilford Press, 72 Spring Street, New York, NY 10012 (800)365-7006 Fax: (212) 966-6708 Website: www.guilford.com Email: info@guilford.com

This book is a useful guide to conducting accurate and constructive interviews with diverse clients, as well as offering methods to build trust and rapport. Fontes discusses biases that an interviewer might unintentionally convey and details how to handle language differences, whether using an interpreter or speaking in English with non-native speakers. She conveys helpful strategies for avoiding misunderstandings, conveying respect, and obtaining accurate information. The author focuses special attention on preparing for the interview; observing boundaries; verbal and nonverbal communication; interviewing children and adolescents; and writing reports based on cross-cultural interviews. The volume is practical and reflects current research findings, while also containing examples from a wide range of cultures.

Lisa Aronson Fontes, PhD, has dedicated over two decades to making the social service and mental health systems more responsive to culturally diverse people affected by family violence. She is the author of Interviewing Clients Across Cultures: A Practitioner’s Guide and Child Abuse and Culture: Working with Diverse Families (see reviews, this issue). Dr. Fontes has also written numerous journal articles and chapters on cultural issues in child maltreatment and violence against women, cross-cultural research, and ethical issues in research. She teaches at the University of Massachusetts.

Dr. Fontes has worked as a family, individual, and group therapist in a variety of settings, including managed care, emergency services, and protective outreach services, and has conducted research in Santiago, Chile, and with Puerto Ricans, African Americans, and European Americans in the United States. As a volunteer, Dr. Fontes worked for three years with Somali refugees in Springfield, Massachusetts. She is fluent in Spanish and Portuguese.

Dr. Fontes earned a Ph.D. in Counseling Psychology from the University of Massachusetts and a Master’s degree from Columbia School of Journalism. She is a popular conference speaker and workshop facilitator for diverse groups of professionals and parents.

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Child Abuse and Culture: Working With Diverse Families,
by Lisa Aronson Fontes, Ph.D., 2005, 239 pages,
Available from: The Guilford Press, 72 Spring Street, New York, NY 10012 (800)365-7006 Fax: (212) 966-6708 Website: www.guilford.com Email: info@guilford.com

This book provides effective strategies for assessment and intervention when diverse families are referred due to child maltreatment. Fontes provides insight into many cultural practices that can be mistaken for child maltreatment and helps readers distinguish between harmless cultural practices and abuse. She offers practical tips for conveying sensitivity to clients’ backgrounds, including ways to overcome language barriers, build rapport, improve accuracy of data-gathering, and create a welcoming environment. The reader will learn how to use interpreters effectively and will increase appreciation for how other cultures view parenting and child maltreatment. Fontes also offers concrete suggestions for making agencies more culturally competent. This readable and comprehensive volume will enhance front-line staff providing services as well as administrators and policy-makers. Some agencies have offered a reading group, using one chapter a week as the basis for a lunch discussion.

continued on page 16
Child Maltreatment

continued from page 15

Child welfare and child protective service workers should be aware that trauma for immigrant children may include multiple past instances of severe trauma in their home countries, during the migration process, in refugee camps which can be dangerous places, and even as part of their experience in the United States (Fong, 2007). Reports of witnessing or experiencing starvation, rape, torture, and challenging living situations may be common. These experiences include events of a nature and severity that native-born Americans are unlikely to ever experience. Compounding the trauma is the frustration of daily coping with a new language. Past trauma can interact with present child maltreatment and complicate therapy tasks and service provision, and can even confuse investigations of current allegations.

Since immigrant children may have faced terror, assault, sexual abuse, and trauma external to the family prior to migration or in a refugee camp, it can be difficult for professionals to interpret symptoms and interactions in immigrant families. Trauma symptoms may not reflect the child’s current care or may present as a confusing mixture of past and more recent events. It is important to obtain a full trauma history and learn about the child’s behavior changes over time. Parents from some cultures may not want to discuss the past due to shame or parents may not be emotionally able to relate the events without triggering a negative and emotional reaction in themselves. In these cases or for adopted children, a full trauma history may not be feasible. In any case, one can not assume without careful evaluation that the parents’ current actions are responsible for trauma symptoms in the children.

After the investigation, the case may be unfounded and either opened for services or closed. If the report of maltreatment is substantiated (found), the child may qualify for a U visa as a victim of serious crime. If the child is removed from the home, he or she may qualify for Special Immigrant Juvenile Status (SIJS). This application should be submitted while the court has jurisdiction over the child. Other options are T visas or relative petitions (including international placements). If maltreatment is substantiated and the child is not removed, the family can enter voluntary services for family preservation (Lincroft & Borelli, 2009).

Since child abuse allegations can affect immigration status, public child welfare workers need to be able to refer families to appropriate service providers who have expertise on immigration law. Finding appropriate resources can be challenging.

Undocumented immigrants or lawful permanent residents may be ineligible for income maintenance or direct public-funded services. However, children born in the United States are eligible for all service programs, regardless of their parents’ status. Special rules can apply to children and youth in foster care as well. For example, Torrico (2010) notes that an undocumented youth who is unable to return home and who is in a long-term foster care placement may be eligible for a Special Immigrant Juvenile Status and can become immediately eligible to become a U.S. permanent resident if the process is completed while the youth is in the custody of the child welfare system.

Fong (2007) suggests that agencies could benefit from designating at least one position as an immigrant specialist. Immigrant specialists can assist with CPS investigations and also focus on developing cross-system collaborations to address the special needs and concerns of immigrant families in the areas of health, mental health, and child welfare. Partnerships with experienced community-based agencies and local U.S. Citizenship and Immigration Services agency staff are essential (Torrico, 2010). Having supervision and consultation available with experts who are familiar with the cultures of referred families could be another way to enhance worker’s and provider’s skills (Fong & Plummer, 2010).

Interventions

Fontes (2002) offers many ideas to counselors and others who seek to intervene with immigrant populations. She begins by noting that preventive efforts are most likely to be effective if they are tailored to the needs of the group they are meant to address. If professionals offend or alienate parents, the messages about change will not be respected.

If the professional needs to report a situation to Child Protective Services, Fontes (2002) recommends informing and including the family, unless doing so would place the child in danger. If the family is aware of the report, and if the process is explained, then the investigation will be less threatening. The parents should understand the legal basis for the report and the procedures as well as their rights during the process.

As professionals work with families who would benefit from adjusting their parenting practices, they should seek ways to reinforce positive practices already in effect and seek to develop a positive sense of rapport. If physical punishment is to cease, the parents must learn other methods to discipline and accomplish their goals. Immigrant parents have come to this country to forge a better life for themselves and their children. It may interest them to learn that children who are raised in a nonviolent fashion succeed better, have higher paying jobs, and have better upward mobility than children who experience harsh physical discipline. Children who are raised nonviolently are less likely to commit crimes or have behavioral problems in school. They are more likely to confide in parents and be close to them (Fontes, 2002).

Latino parents may be sensitive to any implication that brings their own parents’ child rearing into question. Fontes (2002) notes that one useful tactic is to acknowledge that the grandparents undoubtedly did what they thought was best. However, in today’s world in the United States, a different approach is necessary. If the counselor can enlist help from Latino parents who have made the transition, their input, support, and encouragement may be very meaningful in allowing the family to try new techniques. Those who intervene may want to include a wider group of family members, as the parents may experience pressure or even ridicule from other adults in their environment as they switch from use of harsh physical punishment to other methods.

Asian-American families referred for treatment may require attention to somewhat different variables than other groups. Asian-Americans, similar to Latinos, are a very diverse group, differing in language, education, religion, occupational level, socioeconomic status, and acculturation levels. Still, there may be some dominant similarities that can impact the treatment process (Larsen et al., 2008).

Larsen et al. outline values that clinicians should accommodate. First, the father is regarded as someone with unlimited power in the family. He can, for example, use physical force with a child when he has been drinking and no one in the family would dare to intervene. In Asian cultures, individual needs and desires are sacrificed for family stability and harmony. Suffering is considered an inevitable part of life. The parent-child relationship is vertical with communication flowing only in one direction from parent to child. The strong sense of family-centeredness can lead to unrealistic expectations for children, such as having children be responsible for younger siblings while parents work. Parents may have unreasonable goals for academic achievement and put their youth under excessive pressure to achieve top grades and top honors in
Serving Immigrant Victims of Intimate Partner Violence

Domestic violence (sometimes called intimate partner violence or IPV) occurs throughout the globe and in all social, religious, and cultural groups. Interviews with 24,000 women in 15 sites in 10 countries, found that between 15 and 71 percent disclosed physical or sexual violence by an intimate male partner at some point in their lives (CDC Fact Sheet, 2006). At some point in their lives, nearly one-third of women in the United States experience physical or sexual abuse by a husband or boyfriend (The Commonwealth Fund, 1999).

Victims of domestic violence often have challenging and complex decisions to make while under considerable stress and time constraints. VCPN has reported in prior issues (see volumes 60 and 19) about the effects of domestic violence on children and the difficulties faced by families if the victim wants to establish independence. In addition to the enormous challenges faced by all domestic violence victims, battered immigrants face many additional hurdles. Immigrant families who display the courage to break the cycle of violence can be further challenged when public benefits essential for rebuilding their lives are not available to them due to eligibility requirements.

According to a survey of literature conducted by Yoshihama (in Runner, Yoshihama & Novick, 2009), available research suggests that intimate partner violence is not more prevalent and may be less prevalent among immigrant and refugee population groups than among native-born U.S. citizens. However, while non-fatal IPV may be lower for Latinas and Asian immigrants and refugees, immigrants of Hispanic and Asian descent experience a higher risk of homicide in general than U.S.-born persons.

Susheela Varky, Staff Attorney at the Virginia Poverty Law Center, questions the finding that intimate partner violence is less prevalent in immigrant populations. “The finding may reflect different rates of reporting between immigrant communities and populations who have been in the United States longer. I believe that newer immigrants are less likely to report domestic violence,” she commented.

The few prevalence studies yield data for Latinas and Asian women and no population-based estimates of domestic violence are available for other immigrant and refugee groups. Casa de Esperanza (2010) compiled what it knows about Latinas in an evidence-based fact sheet. They note that nearly 1 in 4 Latinas will experience intimate partner violence during their lifetime (Tjaden & Thoennes, 2000) and in 1 in 20 will experience IPV in the previous 12 months (McFarlane et al., 2005). Reported rates of IPV were lower for Mexican-born individuals than for persons of Mexican origin born in the U.S. (Aldarondo, Kantor, & Jasinski, 2002).

Latinas reported seeking access to shelters less often than women from other ethnic/racial groups, and this was especially true for immigrant Latina survivors (Ingram, 2007). Latinas prefer to tell family members, female friends, or neighbors about IPV, while non-Latinas were more likely to tell health care workers or clergy (Ingram, 2007; Zara & Adleer, 2008). Casa de Esperanza’s fact sheet notes that Latina survivor’s help-seeking appears closely tied to the woman’s level of acculturation with more recent immigrants often unaware of laws, options, and possibilities of responding to abuse.

Different sources offer differing estimates for Virginia’s foreign-born population. In 2005, an estimated 10 percent of Virginia’s population was foreign-born. In some areas of northern Virginia, the figure is between 30 and 50 percent (American Community Survey, 2005). The 2010 U.S. census estimated Virginia’s Latino population to comprise 7.23% and the Asian population 5.77% of the Commonwealth. The growing presence of immigrant families means that shelters for domestic violence victims need to become better prepared to assist immigrant families as well.

Barriers to Help

There are “usual” factors that discourage immigrant women from seeking help and services. These include practical barriers such as language; isolaion; lack of support networks; lack of awareness of what help is available; and little understanding of one’s rights. There are also socio-cultural factors that may influence a victim’s decisions, such as acceptance of domestic violence; fear that separation or divorce will disgrace the family; fear of authorities. Economic factors such as dependence on the abuser and lack of work authorization also impact help-seeking.

Smoot (2008) discusses some less well-understood factors deterring help-seeking of immigrants who are victims of domestic violence. If a woman is being abused by a spouse who is a U.S. citizen or lawful permanent resident on whom her own legal status depends, there are many barriers and threats. Tactics of the abuser can include: refusing to file the paperwork needed to give her his wife and children legal status or threatening to withdraw the paperwork; refusing to give his wife documents needed for legal status; threatening to call immigration and report her and the children as illegal; telling her if she calls the police that he will have her deported; forcing or duping her into immigration fraud by having her apply for the wrong type of visa, then hold that as a threat; hiding from her that she was supposed to appear before an immigration Judge; threatening to use her legal status as a way to gain an advantage in a custody dispute.

The cultural context and “way of thinking” of some immigrant families may preclude separation from family as an option. For example, Latina women are commonly socialized with an extended family structure that is interdependent and highly relational. Great importance is placed on traditions, cultural celebrations, sharing of food, music, art, and dance. The emphasis is living in the moment, not planning for the future. Family comes first—“good or bad” and decisions are made, not for individual betterment, but based on the welfare of the unit. Effective advocacy for Latina families requires an understanding of these cultural factors and how the cultural background affects the Latina woman’s decisions (Casa de Esperanza, continued on page 18)

Potential Barriers to Help-Seeking for Intimate Partner Violence

- Cultural norms of gender inequality
- Acceptance of violence as usual and normal
- Feelings of loyalty to the partner
- Self-blame and shame
- Fear and stigma of being single
- Women placing their value on marriage and bearing children
- Immigration status
- Limited employment opportunities
- Language barriers
- Lack of support systems in the U.S.
- Lack of awareness of help sources
- Limited understanding of victim rights
- Fear of authorities
- Belief that separation will disgrace the family
times higher than in the general U.S. population. Ting and Panchanadeswaran (2009) explain some of the dynamics that can occur. They report that rather than becoming acculturated and more accepting of gender equality, some African men become more controlling when they realize their wives will have greater freedom in the United States. In order to maintain the traditional male dominance and patriarchal privilege they enjoyed in Africa, they become more psychologically and physically abusive, oppressive and paranoid. African women in their initial sample of 15 women reported being less free after immigration to the United States.

The vulnerability of immigrant women can translate into more severe abuse, more frequent in marriages between U.S. citizens and immigrant women- it is believed that the rates are more than three times higher than in the general U.S. population. Ting and Panchanadeswaran (2009) explain some of the dynamics that can occur. They report that rather than becoming acculturated and more accepting of gender equality, some African men become more controlling when they realize their wives will have greater freedom in the United States. In order to maintain the traditional male dominance and patriarchal privilege they enjoyed in Africa, they become more psychologically and physically abusive, oppressive and paranoid. African women in their initial sample of 15 women reported being less free after immigration to the United States.

The Violence Against Women Act (VAWA) offers a few types of nonimmigrant visas such as VAWA Self-Petitions and Battered Spouse Waivers. According to Varky, these petitions are available to victims who have endured “battery or extreme cruelty” by a U.S. citizen or Lawful Permanent Resident status spouse. Varky explained that the immigrant victim must demonstrate a number of elements, including that she is a victim of domestic or sexual violence. Also, the victim must be married to an abuser who is a U.S. citizen or Lawful Permanent Resident. There must be evidence that the marriage was in good faith and there must be evidence of the good moral character of the petitioner. An approved VAWA Self-Petition will allow the victim to apply for an Employment Authorization Document (or “work permit”) and for Lawful Permanent Resident status.

The Battered Spouse Waiver is available to the immigrant victim spouse who already has conditional permanent residency through her abusive U.S. citizen or Lawful Permanent Resident spouse. Upon filing by a U.S. citizen or Lawful Permanent Resident, the immigrant spouse is granted a conditional permanent residency that expires after two years. When the two-year period is about to end, the conditional resident and her spouse must file jointly to have the conditions removed from her Lawful Permanent Residency (this procedure is done to deter marriage fraud). To qualify for a waiver of the joint requirement because of domestic violence, the conditional resident must demonstrate that she entered the marriage in good faith and that she or her child was subject to battery or extreme cruelty by the U.S. citizen or Lawful Permanent Resident spouse/parent.

The U Visa was created as part of the Victims of Trafficking and Violence Prevention Act of 2000. The person applying for a U Visa must demonstrate that she has suffered substantial physical or mental abuse as a result of being a victim of certain criminal activity (including domestic violence) that occurred in the United States or violated U.S. laws. The applicant must have been helpful to law enforcement (or be likely to be helpful to them). The temporary U Visa status is for four years. After 3 years, an approved U Visa holder may apply for a special “green card” available to U Visa holders under certain conditions.

A T Visa is for victims of severe trafficking. The person must have been brought to this country for sex or labor trafficking and must be in a position where they will be subject to extreme harm or hardship if they returned to their country of origin. The victim must be available to respond to any reasonable request for assistance by law enforcement. Like the U Visa, the T Visa gives approved T Visa holders temporary lawful status for four years. As with the U Visa, a T
Visa holder may apply for a special “green card” available to T Visa holders under certain conditions.

Virginia Poverty Law Center (VPLC) may be able to assist some of these victims. VPLC is described further in the Resources section.

Public Benefits

Public benefits are programs funded by federal, state, and local government that provide assistance to families. The term can include many programs such as Medicaid, Unemployment Insurance, TANF (Temporary Assistance to Needy Families) and SNAP (Supplemental Nutrition Assistance Program). Ty Jones, who was the Public Benefits Staff Attorney for the Virginia Poverty Law Center at the time, offered a workshop about public benefits for immigrants at the Action Alliance conference on August 30, 2010.

According to Jones, the 1996 welfare and immigration laws restricted access to public benefits for many low-income immigrants in the United States. Immigrants fall into two broad categories—qualified or not qualified. The list of qualified immigrants includes certain abused immigrants, their children, and/or their parents. Undocumented immigrants and many other immigrants who do not have “green” cards but are still lawfully in the United States are not qualified.

Jones comments, “In addition to severely restricting immigrant eligibility for benefits, policies leave a legacy of institutional barriers that deter eligible immigrants from applying for public services.” According to Jones, state agencies verify immigration and citizenship status when individuals apply for public benefits. The agency, she says, may seek information about the person requesting benefits, but may not inquire about family or household members who do not request benefits. For example, a parent can choose not to apply for benefits herself but could instead apply only for a U.S. citizen child.

Immigrants fear being reported to immigration authorities, and reporting is required by three benefits programs (SSI; public housing; and TANF) if the applicant is known to be unlawfully present in the United States. “This is a barrier for many immigrant families because they may be worried about having to divulge information about other family members and there is a fear that state agencies may report the information to ICE (Immigration and Customs Enforcement),” Jones explains. Jones notes that the rules apply to all immigrants, but may also impact immigrant women who are domestic violence victims.

Additionally, Jones comments that many immigrants are concerned that if they accept a public benefit, they will be labeled as a “public charge” and be unable to obtain a “green card” or re-enter the United States if they leave. However, Jones says that in May, 1999, the Immigration and Naturalization Services (INS) issued guidance clarifying the receipt of health care and other noncash benefits will not jeopardize the immigration status of recipients or their family members.

Language barriers are considerable, says Jones, despite efforts to accommodate immigrants. In Virginia, for example, a positive example is the Department of Social Services website which can be translated into 8 different languages. While all agencies are required by Title VI of the Civil Rights Act of 1964 to provide linguistic access, Jones maintains that many agencies do not meet these legal requirements.

An additional barrier, says Jones, is a provision effective on December 19, 1997 that requires relatives and some employers to sign a long-term contract called an “affidavit of support.” This agreement requires relatives to maintain the immigrant at 125% of the federal poverty level and to repay any means-tested public benefits that the immigrant may receive. Immigrants do not want to expose their sponsors to government collection efforts, and thus refrain from applying for benefits.

At the conference, Jones reviewed the regulations for four public benefits programs. Each had different requirements and exclusions as well as possible ramifications for the domestic violence victim and her children. Networking with local agency staff and guidelines for each type of assistance can help workers support and guide victims and their families to sources of help for becoming independent. Jones recommends consulting the National Immigration Law Center (www.nilc.org) and a manual “Guide to Immigrant Eligibility for Federal Programs” available from the NILC.

continued on page 20
Intimate Partner Violence

continued from page 19

Intervention

Hidalgo, speaking at the Action for Alliance training on August 30, comments that as hard as it is for any victim of domestic violence, situations with immigrant domestic violence victims are more complex. “There are other risks such as being homeless and without support. We must put decisions in the hands of the women, respecting their choices,” she adds. Her philosophy is to use strengths as a starting point and use the survivor’s strengths to help her meet her goals.

Sylvia Torres

Sylvia Torres, the Latina Victim Services Coordinator with the Rappahannock Council on Domestic Violence, provides direct victim advocacy services to Latina victims of domestic violence. She also oversees the delivery of bi-lingual and culturally-appropriate support group services for survivors. She relates that a Latina victim often involves children, extended family, and religious leaders in decisions about responses to domestic violence. “When Latina victims talk,” says Torres, “maybe the first half hour is about spiritual matters. These beliefs are very important to the client.” Latina women may even believe that the abuse is a punishment from God and is their “cross to bear.”

Torres notes that the lack of services available in Spanish (or other languages) limits options further. Limited literature translated into Spanish is also a barrier, although Torres notes that many immigrant women are unable to read or write in their native language. However, some immigrant women are highly educated but not fluent in English and these women can benefit from translated materials.

Nationwide, domestic violence shelter staff are crafting methods to meet the needs in the increasingly numerous and diverse immigrant populations. The literature examined above suggests some best practices. First, shelters should be prepared to meet the needs of all victims in their catchment area and not assume that someone else can help. Language services need to be provided by trained interpreters. It is especially important to avoid using children of the victim for interpreters, as children can be further harmed by learning details about the abuse. Also, it is best if interpreters are not a part of the local culture. If an interpreter is local and connected to the victim, the interpreters must be trained in confidentiality procedures, as a breach in confidentiality could put the victim in danger. It is recommended that a toll-free number be available for callers who speak various languages.

Domestic violence staff can partner with law enforcement to have bilingual individuals available to explain court procedures to victims with limited English proficiency. Additionally, shelter staff can join with advocates, law enforcement, local prosecutors and others to arrange trainings to enhance awareness and best practices in providing services to those with limited English-speaking skills.

Service also means outreach, according to Hidalgo. “We can’t sit in a Shelter waiting for people to come to us. We need to introduce ourselves to the community,” she asserts. “It is the community that must end domestic violence, not a Shelter or an organization.” She notes that Latina women report seeking access to shelters less often than women from other ethnic groups, and the disparity is especially great for immigrant women. She suggests training other workers in domestic violence. For example, public health workers who assist with diabetes may be accepted in Latina populations. Ethnic, religious, or social organizations frequented by immigrants could include information about domestic violence services in their newsletters or post information in accessible places.

Published research supports Hidalgo’s assertions. Kim-goh and Baello (2008) examined attitudes towards domestic violence in Korean and Vietnamese immigrant communities. Gender, education, and acculturation level emerged as significant predictors of attitudes towards domestic violence. Males in these communities who were less acculturated and less educated were more likely to endorse pro-violence attitudes. Domestic violence, they maintain, is a significant issue in Asian American communities and abuse can worsen due to the stresses of moving to the United States. The authors suggest active community education and outreach targeting the less acculturated, more recent immigrant groups.

Outreach must include men, according to Hidalgo. “If we aren’t working with men, we aren’t ending the violence. We need to ask, ‘How do we engage men as allies?’” she comments.

Organizations must include members of diverse groups in the development of policies, according to Hidalgo. These individuals will bring their community’s strengths and perspectives to share. Being part of the decision-making makes it more likely that services will be utilized.

All of the experts consulted stressed the importance of respect for the individual victim, her culture, and her decision-making. Torres summarizes her philosophy of service delivery. “Differences make us special and unique. I respect the experience that everyone brings. We are here to support them.”

Prevention

Changing cultural norms about violence against women is a daunting and long-term task. It is especially challenging in a multicultural context. Even basics such as definitions of violence can vary by culture.

According to Fontes and McCloskey (2010), prevention, in general, remains a relatively impoverished area within the field of violence against women. Their recent survey of the literature revealed a “glaring lack of information on how to achieve cultural competence in the prevention of violence against women” (p. 163).

Fontes and McCloskey (2011) suggest two ways that prevention programs can be culturally competent. First, prevention programs can be open and meant to reach diverse groups. They offer the example of a public service announcement that is delivered in a way that addressed needs of various ethnic communities or a school-based prevention program that uses examples relevant to a variety of cultures. A second approach is to create culture-specific messages, targeted to the needs of a specialized group. An example offered is a violence prevention announcement on a Spanish-language television station.

Summary

It is encouraging that many in the field of domestic violence attended the training offered by Virginia Sexual and Domestic Violence Action Alliance in August, 2010. There is obvious concern about reaching immigrant women and children and providing immigrant families the same level of care that is available to others. That mission is reflected in their mission statement which stresses that ALL people have the right to a life free of violence.

References Available on the Website or by Request.
Spotlight:

Since 1989, The James House has offered intervention and prevention services for persons affected by domestic violence, sexual violence, and stalking. They serve those in the Tri-Cities area, including Colonial Heights, Hopewell, and Petersburg and the counties of Dinwiddle, Prince George, Chesterfield, Surry, and Sussex. The James House is accredited by the Virginia Sexual and Domestic Violence Action Alliance to provide a comprehensive spectrum of cost-free services. The services include a 24-hour crisis line, emergency shelter, court and hospital accompaniment, safety planning, individual peer counseling, support groups, case management, a resource library, transitional services, food vouchers, emergency pet placement, and referrals to community resources.

Bilingual Volunteer

Some of the children are bilingual,” she explains. “The younger ones don’t always speak English. If the children only speak Spanish, then I speak Spanish. If the group is mixed, I use both languages as much as I can. The James House is fortunate to have a bilingual volunteer who is able to assist with the children’s group. Some of the children who don’t speak English are still able to understand English, even if they are responding to me in Spanish.” Her focus is “hands-on” activities where the children are able to relate and communicate with each other.

Pyatt explained that immigrant children have a difficult time understanding the changes that their families undergo due to the dynamics of domestic violence. They also face issues such as adjusting to school and poverty. “Children may feel confused because of the changes they are facing. Often they see their mother as the one who has made them leave a living situation that they are accustomed to, taking them to court and other appointments, and she has made the decision for them to have to live in a new place. These circumstances can cause resentment towards their mother,” she adds. “Depending upon how long they have been living in this country, they may feel very out-of-place in social situations.”

The REACT program that Pyatt uses has a variety of modules. “REACT is a 12-week program for children ages 4 to 18 that covers issues such as how to express oneself, family structure; assertiveness; grief and separation; safety planning; conflict resolution; bullying; self-esteem, abusive behavior; healthy and unhealthy relationships, and coping,” she says. Pryatt stresses the importance of seeing the children’s viewpoints. For example, some immigrant children who have participated in the program fear police. They may have the notion that police are bad and think that the police may separate them from their families. “From the child’s viewpoint, police are the ones who come to the home and take away mom or dad. For any child who loves their parent, this is an upsetting experience,” remarks Pryatt.

Elvira De la Cruz, Advocacy Services Program Manager, came to the United States at age 30. “I had 30 years with other rules and a different police and justice system,” she said. “Everything is different here.” De la Cruz says the justice process is quite confusing for immigrant women. “I can explain the process and go with them to get the protective order, file for custody and divorce, and connect the women with resource persons such as lawyers, doctors, and immigrant services advocates. English speakers have more resources to help them understand the process. When you have a language barrier, it is very difficult.”

De la Cruz views separation as a process. Immigrants have other variables that affect the separation process such as knowledge of the language and justice system, having a support system, and their immigration status. “Not all immigrant people feel that marriage is forever. There are differences in the support system. If the woman has few friends and family here in the U.S., then that adds power and control to the abuser.”

De la Cruz offers groups specifically for immigrant women, as well as individual peer counseling. While the topics are similar to what is offered in other support groups, an additional focus is learning the American system. Additionally, De la Cruz can assist the women with finding work and resources.

For domestic violence programs without staff who are bilingual, De la Cruz suggests partnering with other agencies. “The language lines are very expensive,” she explains. “Partnerships with other agencies are sensible.” The James House has a full-time Spanish-speaking advocate and is affiliated with the Virginia Sexual and Domestic Violence Action Alliance which provides bilingual hotline services to cover hours when De la Cruz is not available. De la Cruz said that last year the James House served 350 women who had English as a second language. “The need is clear,” she said, “and domestic violence prevention and intervention programs need to be able to work with diverse populations.”

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Children’s Adjustment

continued from page 8

Not only is there a high percentage of immigrant children who experience adjustment disorders, anxiety, and post-traumatic stress, but some literature indicates higher risk in populations of immigrant children for less usual psychiatric conditions such as mutism (Zelenko & Shaw, 2000) and eating disorders (Timimi & Adams, 1996). Many smaller communities have no providers who specialize in these conditions, making provision of treatment of immigrant children even more challenging.

The Supreme Court has ruled that all children living in the United States, regardless of citizenship, are entitled to a public school education (Matthews, 2010). Schools are uniquely positioned to undertake primary prevention efforts. In addition to monitoring academic progress, schools can enhance resilient behaviors in the children and assist with social adaptation by providing stable social support (Fazel & Stein, 2002). Immigration and verification of citizenship is not required for Head Start/Early Head Start collaborations.

School psychologists are increasingly challenged by the task of trying to advocate and program for immigrant children. In an October, 2010 workshop at the Virginia Psychological Association Fall conference, Patricia Warner, Ph.D. and Tammy Gilligan, Ph.D., school psychology faculty at James Madison University, discussed the need for a commitment to culturally responsive practice. “All individuals must be treated with fairness and respect and all children who qualify are entitled to services,” noted Dr. Gilligan.

It can be difficult to determine whether academic deficiencies are due to disabilities or due primarily to English as a Second Language. For example, Quinn & Jacob (2000), writing in a National Association of School Psychologists publication, mention that ESL students who have graduated from the ESL program with adequate conversation skills may still need 7-10 years to develop the academic language skills needed for success in mainstream classrooms. Lack of proficiency in academic English can interfere with accurate assessment of students’ capabilities. If the learning problems are considered primarily due to cultural disadvantage, the child will not qualify for special education services.

Working with children always requires interventions with the parents. Parental attitudes and behavior can influence children’s attitudes, behaviors, and academic performance (Quinn & Jacob). Even in comprehensive programs such as FACES (described in Birman et al., 2008) less than half of families served were able to be matched linguistically with a clinician. Furthermore, immigrant parents may not be literate in their native language or any language, meaning that written materials in any language will not be helpful to the parents. Research shows that participants will remain in services longer if there is a language match with the service provider (Birman et al.).

Domestic violence can be an issue both pre and post migration. If children are witnessing or experiencing domestic violence, then safety in the present is an issue that takes precedence over healing from the past.

Unaccompanied minors or those with Special Immigrant Juvenile Status (SIJS) may be eligible for certain child welfare services such as foster care. These children should be included under transitional care along with adolescents in foster care who are “aging out” of the foster care system (Fong, 2007).

Long-term Adjustment

Lo (2010) reviewed more than 50 publications between 1970 and 2009 retrieved from data bases of many disciplines. As acculturation occurs, youth change behaviors, attitudes, values, and identities. Integrative acculturation (a balance between maintaining one’s own cultural and participating in the host’s culture) is associated with positive outcomes, while marginalization (disinterest in both one’s own culture and the host culture) is accompanied by low self-esteem, alienation, and identity loss. Both assimilation (renouncing one’s own cultural heritage to engage in the host culture) and separation (segregating oneself from the host culture to maintain one’s own heritage) are both linked with negative ethnic identity, low self-esteem, and high stress levels.

According to Lo (2010), the “tug of war” between two cultures can place youth as a foreigner in their own country and negatively impact upon their well-being. For example, youth with strong traditional values often report conflict as their urge for autonomy becomes strong over time. These internal conflicts contribute to tensions in the parent-child relationship and lower well-being of the youth. In contrast, parents who achieved an integrative approach, providing warmth and engaging in their children’s daily lives, were more likely to have offspring who were well-adjusted.

Asian American youth have been noted to have high rates of suicide attributed to acculturation maladjustment. Asian American parents consider diligence and tolerance as the way to cope and view academic success as a key to their children’s future (Lo, 2010). These values can result in positive outcomes, leading to the perception that Asian Americans are the “model minority.” However, the strong values can also be the foundation for tragedy. Asian American children may have parents with unreasonably high expectations for academic performance and failure to meet these demands or the pressure to meet the demands can contribute to the high suicide rates of their youth. Traditional values also inhibit Asian American youth from seeking professional help, as this, in their view, could disgrace the family (Lo, 2010).

Future Directions

Schools and social services systems are gradually learning how to meet the unique needs of children and youth who are newcomers to our country. VCPN staff found limited literature addressing long-term adjustment and outcomes and few models for successful programs for providing mental health and child welfare services to immigrant children and youth. With populations of immigrants increasing, it is apparent that today’s immigrant children will be a significant part of tomorrow’s workforce and community leadership. Learning how to serve diverse populations is imperative in order to remain a strong nation where all children can learn and grow.

References are on the Website or Available by Request
The objective of the Newcomer Health Program (NHP) is to identify and eliminate health-related barriers to successful resettlement of Virginia’s refugee population while protecting the health of the U.S. population. The VDH Newcomer Health Program coordinates and facilitates, with Virginia Department of Health local health departments, the initial health assessments of all newly arriving immigrants with a refugee or asylum status.

The mission of the Hispanic Committee of Virginia is to enable Hispanic immigrants to more fully contribute to and participate in American society. It is a community-based non-profit organization offering Employment, Immigration and Social Services as well as Youth and Adult Education programs for Arlington County, Fairfax County and the City of Alexandria.

Through a partnering with the Challa Law Offices, Virginia Poverty Law Center has begun with offering free clinics to low-income, undocumented immigrants who are victims of domestic or sexual violence. The quarterly pilot clinics started in October, 2009. While the clinics are held in Richmond, they are open to any undocumented immigrant victims of domestic or sexual violence who live in Virginia and who can get to the clinics in Richmond. Victims will have the opportunity to meet with attorneys to discuss their cases and determine whether they are candidates for U Visas or VAWA Self-Petitions. Attending this clinic does not guarantee eligibility for a U Visa or VAWA Self-Petition nor does it guarantee free legal representation. Potential clients must first complete an intake and send it to Susheela Varky for pre-screening. They should also be prepared to bring someone to translate if they cannot speak English and a translator cannot be found before the clinic they attend.

The Somali Family Care Network is a national nonprofit organization dedicated to helping all Somali groups in the United States work together to improve social and economic opportunities for the Somali community.


Available from: NILC Publications, 3435 Wilshire Blvd., Suite 2850, Los Angeles, CA 90010 (213) 639-3900 Fax: (213) 639-3911 Website: www.nilc.org Email: info@nilc.org

This guide is a useful resource for any provider who has immigrant clients who may need resources and help with medical bills, nutrition assistance, financial aid for higher education, or job training. The updated fourth edition of this guide includes a section on children’s programs and an expanded glossary with over 250 immigration and public benefit terms. The guide is very easy to use and explains the complexities of immigration and public benefits law. Some important topics covered are: explanations of immigration statuses; chapters on 23 major federal programs; listing of states with replacement programs for those restricted from federal services; safety net programs; work authorization/social security cards; and special programs for victims of abuse. Information is organized in easy-to-read tables for quick reference, and pictures of typical immigration documents are provided as well as keys to understanding INS codes.
Child Maltreatment

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Child Maltreatment

continued from page 16

school.

Because of the importance of family structure, it is imperative to work with the entire family when treating Asian-American families. The clinician should structure the family in terms of how each member can contribute to the solution. The therapist can assuage some of the family’s feelings of shame by framing the therapy as a mechanism to restore the family’s health and honor. Simple things that show respect (such as always starting the session by addressing the parents) can increase the family’s therapeutic alliance with the therapist. Likewise, coming to an understanding of how much the parents have sacrificed for their children is imperative. Helping the family reframe their definitions of “success” and redefining what is acceptable will likely be important.

Larsen et al. (2008) suggest an educational approach as part of the therapy. The Asian-American parents may need to understand the laws in the United States. They may also need to learn ways to communicate effectively and to problem-solve when children are not performing up to expectations. Learning behavioral management alternatives to physical discipline might be an important component. Such teaching should be accomplished in an egalitarian fashion rather than a “pupil-teacher” fashion.

Prevention of Maltreatment

Research data offer some ideas for prevention. Prevention efforts can be tailored to the risk factors of particular subgroups. For example, community-based outreach and parent education to Chinese American parents could teach alternatives to physical discipline and shaming (Rhee et al., 2008). Likewise for parents from Mexico who are used to shared community supervision of children, programs aimed to prevent neglect and lack of supervision may be the most helpful.

Benefits of Improvements in Cultural Competence

Promoting the ability to offer effective interventions with diverse populations is imperative. The nation’s demographic profile is changing. The children who will lead this nation are increasingly culturally and ethnically diverse. Systems of care, including child welfare systems, must be able to serve the diverse populations in effective ways. The health of children, as well as their safety and well-being depends upon families and communities meeting their needs.

References Available on the Website or Upon Request

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