
Theory & Review

When Immigration Is Trauma: Guidelines for the Individual and Family Clinician

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This paper considers two pertinent strands in the contemporary immigrant mental health literature: 1) the distinction made between stressors that are endemic to most immigrant experiences vs. those migration stressors that precipitate trauma per se; and 2) clinical guidelines that continue to refine the assessment of immigrants' presenting mental health problems, given the provision of services in institutions that are foreign to both the language and idioms of distress of the populations being served. Case vignettes highlight the research findings and practice recommendations.

Emigrations of human groups have taken place since the dawn of time, and they are recorded in ancient texts. Seeking safety, shelter, food, farmable lands, and human freedom, people have sought to escape hunger, incarceration, torture, and oppression of the spirit. However, the two decades immediately preceding this millennium have witnessed the largest migratory patterns ever recorded in history. Civil wars in Africa uprooted centuries-old tribal communities. The fall of the Soviet Union unearthed genocidal aggressions in Western Europe. And struggling economies in the Latin American world failed to enhance the lives of a large underclass. Natural and human-made disasters also moved people to seek safety, as droughts in Haiti, floods in Guatemala and Mexico, and nuclear accidents in the former Soviet Union caused the relocation of several million refugees in the last 20 years, either to areas within their own countries or outside of their borders.

According to the United Nations High Commission of Refugees (1993), there are upward of 20 million people in the world today who are designated refugees. These are people who fled to an-

other country either because of war or scarcity of food. Another 70 million have relocated around the world outside their native countries, primarily in search of work. A large number of these immigrants are known to be at significant risk for poor living conditions, economic exploitation, and racist or prejudicial treatment from their host locations.

Many countries have come to serve as a safe haven in the diaspora for many of these people. The United States has traditionally assumed such a role; however, the tremendous influx of immigrants to this country in the last decade has forced the American social service and mental health systems to generate new services, new sensitivities, and new interventions for large groups of people who are recognizably needy, but unrecognizably foreign. As a result, clinicians and researchers are now pressed to understand how best to serve the nation's new immigrants—and have been led to investigate questions such as: How compromised are people who have been forced to leave behind all they know? Does the trauma of war and disaster permanently impair the human psyche? Do people ever recover from psychological and physical tor-

ture? And the pragmatic question at the center of this paper: How do clinicians intervene so that people ultimately adjust to new host environments, and move on with productive lives?

This paper will consider some of the pertinent knowledge that has been generated to answer these questions, and will seek to distill specific clinical guidelines for assessing the complex subjective experiences of immigrant patients, who may present for services alone or in the context of their family group.

IMMIGRANT STRESS AND TRAUMA

First and Second Generations of Investigation

Moved by the needs of increasing numbers of immigrant newcomers for social and mental health services, investigative agendas designed by both public and private institutions in the United States focused initially on describing the important biopsychosocial features relevant to these varied immigrant groups. Basically following a needs-assessment approach, this research attempted to delineate the uniqueness of new immigrants' mental health and social-environmental needs, investing in those groups that have comprised the largest numbers of emigres to this country since World War II. These have been populations from Mexico, Puerto Rico, and other Latin American countries and, more recently, immigrants from China, Southeast Asia, Africa, the former USSR, and Eastern Europe. This needs-assessment research comprises what I would call the *first generation* of immigrant mental health investigation.

This literature reports a myriad of complex emotional and physical tasks that must be accomplished by people who leave their homelands. The immigrants' loss of family, community, and physical environment are themes that reverberate through both clinical and creative literatures, alike. The loss of familiar social networks is especially hard on families and women, who often find themselves isolated, forced to deal on their own with the multiple demands of life in a foreign environment (Boylan 1991; Desjarlais, Eisenberg, Good, & Kleinman, 1995). A downturn in socioeconomic status is the unfortunate norm for most immigrants across the social and educational spectrum (Canadian Task Force, 1988). This is often a bitter surprise for those who harbored hopes of fresh horizons in a country of new opportunities. Thus, a former school teacher from Bosnia distributes leaflets for McDonald's; a Chinese mechanic de-

livers food on a bicycle, while his family of six awaits him in a rented room; and a physician from Guatemala drives a cab in New York. Lack of fluency in the host language is frustrating, shameful, and sometimes terrifying for newcomers (Perez Foster, 1996a, 1998a), for whom a subway ride or a trip to the emergency room with a sick child can turn into a grueling nightmare.

While immigrants who relocate as a family fare better than those who migrate alone (Kinzie, Relkin, Lee, & Hirsch, 1986; Mollica, Wyshak, & Lavelle, 1987), family units are faced with the daunting task of frequent redefinitions of gender roles (Comas-Diaz & Greene, 1994; Gil & Vazquez, 1996); host country mores and values that are completely dystonic with ethnic traditions; and children who quickly seek to conform to their new community and new peers (Harkness & Super, 1996; McGoldrick, Pearce, & Giordano, 1982; McNicol, 1993). Elderly people who relocate with their extended families tend to do more poorly than their younger relatives, feeling isolated and overwhelmed by the acculturation tasks that need to be tackled. Immigrant women often encounter a dual-edged phenomenon: more willing than men to accept menial and low-paying jobs, they more quickly become wage earners and are thereby introduced to new configurations of traditional gender roles, especially in North American countries. However, those with male partners are often confronted by unemployed and despondent men who feel threatened by the power shifts in the dyadic relationship and family system. Indeed, for some recent immigrant groups, these conditions have been associated with an increase in domestic violence and substance use (Comas-Diaz & Greene, 1994; Straussner, 2000).

The migration process is unquestionably linked to major adjustment stressors. The impact of these stressors on mental health are variable and complex. As has been described in excellent reviews of the literature in these areas (Desjarlais et al., 1995; Loue, 1998), anxiety, depression, posttraumatic stress disorder (PTSD), substance abuse, and higher prevalence of serious psychiatric disorders have all been associated with multiple immigrant populations both in and outside of the United States.

Currently, through both our clinical experience with diverse groups and our slowly growing sophistication in assessing multicultural samples via better-validated methodological instruments and designs, a more multifaceted understanding of the

immigrant trauma experience is evolving. In what I call the *second generation* of immigrant mental health research, clinician/researchers have begun to 1) refine the phenomenology of what we actually term "immigrant trauma"; and 2) establish guidelines for the assessment of immigrant mental health problems, as people present for intervention in host-country institutions that are foreign to both their language and their unique cultural idioms of distress. These domains will be discussed separately in the material that follows.

Stages of Immigrant Trauma

As noted above, the formidable immigrant mental health literature that has emerged in the last decade attests to the complex psychosocial stressors that appear to be endemic to the immigrant experience. However, the most recent reports in this area have begun to identify specific stressors and their cumulative effect as precipitants of the symptoms of distress—i.e., PTSD and clinical levels of anxiety and depression—associated with immigrant trauma. Desjarlais et al (1995) concluded that it is not migration alone but, rather, traumatic or derailing events before, during, or after dislocation that lead to psychological distress of clinical proportions.

This new literature identifies four migration stages at which there is significant potential for traumatogenic experiences that may lead to serious psychological distress: 1) premigration trauma, i.e., events experienced just prior to migration that were a chief determinant of the relocation; 2) traumatic events experienced during transit to the new country; 3) continuing traumatogenic experiences during the process of asylum-seeking and resettlement; and 4) substandard living conditions in the host country due to unemployment, inadequate supports, and minority persecution.

Premigration trauma. Those who work in institutional settings know of the contained anxiety that is so frequently a part of the recent immigrant's presentation when soliciting mental health or social services for the first time. Preoccupied with the obstacles of a new language they can barely speak, fearing clinicians/institutions as representatives of the group in power, shamefully experiencing themselves as the beleaguered "other," and sometimes hiding their illegal alien status (Chavez, 1992; Chavez, Cornelius, & Jones, 1985; Malgady, Rogler, & Constantino, 1987; Marcos & Alpert, 1976; Marcos, Urcuyo, & Kesselman, 1973a; Perez

Foster, 1998a), recent immigrants often avoid or obfuscate the pressing circumstances that moved them to seek safer haven. In just the half-century since World War II, the United States has received, among many other groups, Jews who were tortured in the Holocaust camps, Cambodians whose families and villages were destroyed in front of their eyes, Chileans whose children permanently disappeared, and Russians who escaped homes contaminated by the Chernobyl nuclear accident. Both the clinical and quantitative mental health literature show robust evidence that these experiences prior to and during migration are directly associated with psychological sequelae that will be experienced for years to come, as these immigrants make their adjustments to a new life and culture (Chung & Kagawa-Singer, 1993; Havenaar, Rumansteva, & Ven Den Bout, 1994; Havenaar et al., 1995; Mollica, McInnes, Pham et al., 1998; Sack, Clark, Kinney, & Belestos, 1995).

Trauma during transit. Intimately related to both the impetus for and contextual circumstances of the migration decision are modes of exodus from the native country that can either extend the noxious experiences of premigration events or, by themselves, constitute formidable assaults on the body and psyche. We are now hearing, for example, especially from the southwestern United States, narratives of women who are crossing the borders from Central to North America unaccompanied by partners or families. Engaging "coyotes" (illegal travel brokers) for passage, some have been subjected to months-long sexual assaults and forced labor, as forms of "added payment," before reaching their destinations (Martin, 1999). Hundreds of Haitians and Cubans have been lost crossing the Caribbean Sea to the United States every year, and those who survive (like Elian Gonzalez) may witness the drowning of loved ones or the terror of being adrift at sea before being rescued (Bragg, 1999). Historically, and at present, we have seen large groups of forced or voluntary immigrants transported between continents, and confined to small, squalid quarters for months at a time. Currently, these are the rural workers from China whose indentured servitude begins in the hulls of ships crossing the Pacific ("*Chinese found in Georgia...*", 1999; *United Press International*, 1999); in the seventeenth and eighteenth century United States, they were West Africans whose forced migration on slave ships opened a tradition of bondage and cumulative

trauma that merits discussion well beyond the scope of this paper. Studies of many groups over the past decade have linked trauma during the migratory process itself to clinical levels of psychological distress, with symptom severity being associated with the level of risk and anxiety involved in the escape experience (*Cernovsky, 1997; Ursano, McCaughey, & Fullerton, 1995*).

Asylum/temporary resettlement. Host countries are not always the most hospitable environments for newcomers, especially if they are themselves economically hard-pressed and receive immigrants in large numbers, in wartime, or as a result of some environmental or geopolitical crisis. Thus, residence in temporary resettlement areas can be a harrowing experience, with overcrowding, fear, and lack of provisions exacerbating the existing stressors of forced migration. Currently, the most salient examples of these conditions are zones that house residents of the former Yugoslavia; Ugandan refugee camps for the south Sudanese (*Paardekooper, de Jong, & Hermans, 1999*); and areas of the Ivory Coast and Sierra Leone that received Liberian refugees (*Jarbo, 2000*). Reports from these three asylum areas indicate a common atmosphere of anxiety, fear of loss, or the threat of repatriation. High risk for psychiatric disorders has been noted in all these reports. (*Sinnerbrink, SiLoue, Field, Steel, & Manicavasgar, 1997*).

The process of seeking permanent, legal asylum in a host country carries its own set of acute stressors, as applicants can be held in detention centers for months, even years, before being formally processed (*Postero, 1992*). Examples of this in the United States include undocumented emigres from Haiti, Cuba, and Southeast Asia, who have left their countries and traveled under formidable risk. At this stage of the immigration process, individuals are in a state of limbo; conditions of quasi-imprisonment often fuel existing symptoms of isolation and anxiety. The acute symptoms of PTSD may be interpreted by correctional guards as "uncooperative behavior." Many detainees at an immigration center in the Northeast, to which I provided consultation, had been imprisoned and abused in their own countries. For many of them, the atmosphere and treatment at the center aroused disturbing memories of their earlier trauma, and served as a contextual cue for awakening of trauma symptoms.

Settlement in the host country. Studies in both Canada (*Canadian Task Force, 1988*) and the United

States (*Nicholson, 1997*) have reported employment issues, inadequate living conditions, and the need to rebuild social networks as key factors in refugees' psychological distress. Emigrating in the hope of finding work and a new life in an adopted land, only to find themselves confronting isolation and exploitative living conditions, leaves immigrants at significant risk. These postmigration conditions painfully compound the distress experienced by many who have already suffered persecution in their homelands, followed by the myriad risks of difficult transit and relocation.

The Pivotal Influence of Premigration Trauma

Clinicians exposed to immigrant populations, particularly those in institutional or agency settings, are generally cognizant of the four stages of migration outlined above, especially the final phase, involving issues of adjustment to a strange host country. However, the second generation of immigrant mental health investigations presses for clinicians to become equally adept at dealing with migration abuses and traumatogenic events experienced just prior to resettlement (*Westermeyer & Williams, 1998*).

Often, a substantial barrier to these inquiries is an unstated collusion between immigrant client and clinician to avoid the details of traumatic migration experiences. There is the conscious shame of the immigrant in recounting the horrors of subjugation and vulnerability to a clinician who is both an ethnic stranger and a powerful representative of the mainstream culture. There is also the less conscious urge to suppress recollection of extremely distressing and ego-disruptive experiences. These concerns of the client often reinforce the clinician's own anxious resistances and the wish to keep the horrors of the client's experiences at bay and outside of the therapeutic work (*Davies & Frawley, 1994; Bremner & Marmar, 1998; Perez Foster, 1998b*).

At a less clinically interactive and more phenomenological level, there is also a call for clinicians to become more refined in their distinctions between the functional impact of current resettlement stressors and traumatic experiences occurring proximally to the migration. Examining the antecedents of posttraumatic stress symptoms in fairly recent immigrants to Australia, Steel and colleagues (*1999*) found that trauma exposure just prior to migration accounted for 20% of the variance in psychiatric symptoms, while current post-

migration stressors contributed to 14% of the symptomatic distress. Hinton et al. (1997) similarly discerned the differential influences of pre- and postmigration stressors in predicting depression among Vietnamese immigrants.

The Dose-Response Concept

The most recent studies of traumatized immigrant populations have provided a devastating picture of the violence that can be perpetrated on people by factions in power—and the chaos that individuals and families withstand when migration is determined by threats to their livelihood and daily safety. This work has also elucidated the psychological impact of trauma, and the factors that can move people toward extreme levels of distress and decompensation. In particular, recent investigations of Southeast Asian refugee groups that survived the violence of the Pol Pot regime in Cambodia, and the political civil wars recently waged in Vietnam and Laos, have yielded key findings on the relationship between the severity of experienced premigration stress and the intensity of its subsequent impact on relocated populations.

Mollica, Poole, and Tor (1998), in their comprehensive work with Cambodian refugees, have begun to establish “dose-response” relationships between cumulative trauma experiences and symptom severity of depression and PTSD. A recent report of Vietnamese ex-political detainees newly arrived in the United States specifically described this dose-effect relationship between torture experiences and psychiatric symptoms (Mollica, McNees, Pham et al., 1998). Similarly, the severity of PTSD symptoms in Bosnians emigres subjected to “ethnic cleansing” was found to be correlated with the number and types of traumatic experiences suffered throughout the violent ouster from their homeland and ensuing transit toward a final safe haven (Weine, Becker, McGlashan, & Laub, 1995).

These relatively recent investigations of the traumatogenic factors that influence the lives of people who migrate to host countries and seek mental health services seem to follow broad phenomenological paths that are similar to the combat, environmental, and sexual/physical trauma literatures with which we are more familiar (Bremner & Marmar, 1998). Thus, the premigration trauma literature likewise illuminates, for example, the long-term effects of such experiences on daily life. Chung and Kagawa-Singer (1993) found that, among several Southeast Asian groups, premigra-

tion trauma exposure remained predictive of psychological distress five years or more after migration. Similar long-term findings have been reported for Cambodians living in the United States (Carlson & Rosser-Hogan, 1991; Sack et al., 1995). The present author is conducting an epidemiological investigation of the effects of the Chernobyl nuclear disaster on survivors who now reside in the United States. Reports from both the Ukraine and Belarussia have noted the presence of psychological sequelae in survivors up to seven years after the event (Havenaar et al., 1994, 1995; Viinamaki et al., 1995). My own interest is in the potential interaction and compounding effects of these environmentally induced traumatic sequelae with postmigration acculturation stressors (Perez Foster, 1999, 2000).

Migration Trauma as a Compounding Factor

Clinical reports from a range of ethnic groups that have migrated to new countries typically underscore the cumulative impact of multiple migration-related stressors on mental health (Desjarlais, 1995). Indeed, the concept of compounding stressors is now an important frame through which aspects of human development are conceptualized, especially with regard to socioeconomically vulnerable populations (Anthony & Cohler, 1987; Garbarino, 1992). Thus, more recent quantitative assessments of the compounding effects of migration stressors on mental health come as no surprise to front-line clinicians, who are well aware that premigration exposure to life threats, beatings, rape, murder, imprisonment, torture, and disappearance of family are only further exacerbated by the severe stress that can be induced in the new host country through such conditions as potential repatriation, poverty, unemployment, loss of family, prejudice, and barriers to obtaining social and clinical services (SiLoue, Sinnerbrink, Field, & Manicavasagar, 1997; Sinnerbrink et al., 1997).

Using path analysis, Nicholson (1997) examined the direct and indirect effects of a number of premigration and postmigration factors on the mental health status of 447 Southeast Asian refugees. The most reliable predictors of current mental health were the premigration factor of experienced trauma and the postmigration factors of current life stress and perceived physical health. Current life stress was measured by the degree of discomfort these immigrants associated with acculturative tasks in the new country, e.g., finding employ-

ment, learning a new language, building social networks. Various other reports corroborate the compounding stress of acculturative tasks on people who have been traumatized prior to migration (Hinton et al., 1997; Loue, 1998). Additionally, those who are alone in a new country and separated from family are more likely than those who are accompanied to suffer the psychological sequelae of premigration trauma (Hinton et al., 1997; Kinzie et al., 1986; Mollica et al., 1987). Clearly, the sense of isolation and absence of familial support serves as yet another strike against the already stressed newcomer.

The Maternal Buffer

A consistent theme in the immigrant mental health literature has to do with the role of maternal anxiety, and the mother's own psychological reaction to premigration stressors as a predictor of the mental state of the child. Children recently studied in the refugee camps of Croatia showed significantly more signs of distress if their mothers had difficulty coping with displacement (Ajdukovic & Ajdukovic, 1993). The mental health of politically displaced Guatemalan Mayan children was also strongly correlated with the physical and mental health of their mothers (Miller, 1996). Afghan refugee adolescents likewise showed levels of psychological distress that were related to their parents' reactive states (Mghir, Freed, Raskin, & Katon, 1995). These phenomena are probably embedded in basic aspects of the parent-child interaction, wherein parents, despite the context of crisis, are able to maintain a semblance of both the physical and emotional holding environment that is nodal to the child's psychic stability.

In addition, recent investigations of childhood anxiety within normative, non-trauma-laden contexts, have begun to quantify aspects of parental behavior and interaction that are significantly related to child affective states (Beebe, Lachmann, & Jaffe, 1997; Cobham, Dadds, & Spence, 1998). These quantitative assessments of concurrent anxieties between mother and child are described at a more trenchant, intersubjective level of experience in various clinical and qualitative accounts of families in the process of recovery from or treatment for premigration abuses (Ferrada-Noli, Ashberg, Ormstak, Lundin, & Sundbom, 1998; Shuzki, 1990). These accounts underscore the powerful transmissions of anxiety that are experienced by families who live in terrorist states, where the unspoken is

so often enacted within the family system at multiple levels of expression and interaction between children and their caretakers.

Case Illustration: Magaly

Those of us who are both clinicians and researchers move between the world of individual, subjective experience and the quest to understand whether these experiences occur in the context of particular circumstances at probabilities greater than chance. For professionals focused on immigrant mental health issues, the sheer numbers of immigrants who increasingly request clinical services propels the search for reliable descriptions of phenomena that can inform and guide clinical practice with those whose cultural worlds may markedly differ from that of the clinician.

While the research reviewed above suggests guidelines for our clinical work, these data attain real meaning only when associated with real lives:

Magaly, a 30-year-old Latin American woman, was referred to me by her internist after she had been in the United States for four years. She lived alone, had few friends, and was employed as a bookkeeper. She presented for help with depression, significant weight loss, and insomnia, about which her physician was concerned. She said that she had been treated once before for her "down moods" with medication. She had no significant intimate relationships. Her command of English was good; she had learned the language on the job and in evening classes at a local high school, after her arrival in the United States. She lived as a boarder with an elderly American couple in a non-Hispanic neighborhood. She was attractively groomed in contemporary clothing that connoted a New York City stylishness. While depressed, she seemed to project an air of social assertion in her surroundings. The following is Magaly's story, in her words:

"In my country, my family was comfortable. My mother was a school teacher and my father was an accountant who worked for the Department of Highways. I had two older brothers. They died. My brothers were funny and a little on the wild side when they were young. But they were good boys—they just had big mouths, and when they got together with their school friends they would get into all sorts of talk about how our country should be, how people were treated unfairly, and how things should change.

"Our neighborhood was quiet and pretty. People used to say that it was like that because military types lived around there and no one would dare cause a ruckus or leave anything in a mess [in] their yard. Across the street...lived a family whose two children were my best friends. The father was quiet whenever I saw him and didn't say much, but I never liked him. As I grew older and became a teenager I felt uncomfortable about the way he looked at me. One day, I saw him at the movies when I was with my boyfriend. On another day, he invited me to have a coffee with him—which I found strange and declined. I told my parents about this; they said to always treat Don J with respect. Next thing I heard was that he had separated from his wife and family and moved away. My mother

started to get sick around that time with cancer—I remember because, for my first dance, it was my aunt who dressed me and my mother was saying how nice I looked, from her bed.

“When I came home from school one day...in my last year, I saw...aunts’ and uncles’ cars in the driveway...and heard crying as I walked in. My two brothers had not come home from their night jobs and there was a rumor that they may have been arrested for questioning. My family spent...three horrible days going from precincts to hospitals, putting the word out about their disappearance. We finally located them in a precinct...out of the city—a place where few people go but all... know is...dangerous...My brothers and their group of friends had been taken in for “interrogation” about the nature of their regular gatherings and the possibility that they belonged to an insurgent group that harbored antigovernment ideas.

“The story at this point is not so clear in my mind, but what I know is that the man who lived across the street was contacted and asked if he could intercede in the release of my brothers. My father was desperate. My mother was sicker. Months passed and everyone knew that [my brothers] were being mistreated at the precinct. We knew...they were not dead because Don J would now stop by every week with some small news. He was paying a lot of attention to me, asking me to take walks with him, to tell him how I missed my brothers. He made me feel terrible. My father told me to do whatever he said.

“I was ‘given’ to Don J in exchange for my brothers’ release. It was all done in a very quiet and, some would say, social way. He took me out on dates to clubs and bought me gifts. My father acknowledged that he was now my suitor. I was a virgin. When he touched me, I felt dead. He raped me every day on our dates. Finally, I was brought to live with him where I had little contact with my family. Sometimes, when other men came to play cards all night, he would force me to have sex with them.

“I think that I lost my mind during this time. I have no recollection of what I felt or was thinking. About three or four years later, the government of our country changed and Don J no longer had his position, I think. Anyway he lost his money and had to move from the fancy place where he lived with me. In a way, I began to see that he was maybe letting me go. My mother died and my oldest brother was taken by police one day and disappeared.

“I found my way to New York. I came by myself with just the name of a girl I had met in a nightclub when Don J used to take me to those places. I found her and she helped me find my job, but didn’t want to be friends with me. I don’t mix with the people from my country. They know what happened to me and I feel ashamed in front of them; they talk about me. I keep to myself. My oldest brother committed suicide a few months after I came to this country. They say that he was out of his mind from the tortures...and knowing what happened to me.

“I have trouble sleeping and I have been feeling so depressed that I can’t go to work. They are trying not to fire me but I can’t get myself together. All the things that happened to me are crowding my mind. I’m not even sure when my own mother died.”

Magaly’s experiences, beginning some four years prior to her emigration, have left the indelible marks of psychic trauma. Burdened with the death of her own mother and the horrible deaths of her brothers, due directly or indirectly to the ter-

rorist activities sanctioned by the government of her country, she has managed some semblance of acculturation and stability in a host country. Her painful current life is an example of an immigrant newcomer whose cumulative migration assaults have left her compromised by posttraumatic stress and a serious clinical depression, accompanied by vegetative features. Her avoidance of social interaction with her own Latin American community is aimed at circumventing the contextual arousal of increasingly persistent flashbacks to the man/men who held her captive. All young Hispanic men remind her of the brothers she loved and lost so brutally.

Magaly’s valiant and extremely resilient effort to accommodate to her surroundings highlights a mechanism that is beginning to emerge in the complex and multifaceted acculturation literature: namely, a behavioral adaptation to the style, language, social behavior, attire, and activities of the host country that does not necessarily correlate with the affective and cognitive aspects of affiliation that denote genuine fuller acceptance and integration in one’s current milieu. This is a phenomenon well known to psychodynamic clinicians, whereby manifest behavior can be isolated or split off from meaningful connection. Thus, Magaly, while managing most impressively to cope with her new life, remained bereft and emotionally frozen by her earlier experiences.

CLINICAL ISSUES IN THE ASSESSMENT OF IMMIGRANT PATIENTS

Advances in clinical assessment that have emerged from the recent wave of immigrant mental health research—the “second generation” investigations, which have been referred to above and reviewed in greater detail elsewhere (*Perez Foster, 1998a*)—have moved the field toward both a further recognition of the ways in which culture and language shape the expression of psychological distress in diverse populations and an acknowledgment of the ethnocentric biases inherent in North American assessment measures. They address issues that are encountered daily by clinicians in the consulting room who attempt to use Western European criteria to distinguish idiosyncratic pathology from culture-specific behavior in new immigrants, and by researchers who administer assessment instruments that have not yet been standardized for the

*Portions of this section on clinical assessment are drawn from that earlier work (*Perez Foster, 1998a*).

ethnic group being studied. There is now a growing body of literature that critiques the universal application of Western perspectives on psychological function and dysfunction (Bruner, 1986; Cirillo & Wapner, 1986; Kirschner, 1990).

In the domain of psychological testing of ethnic groups, there are the pervasive problems of testing bias and the ethically questionable practice of using psychological instruments designed, standardized, and validated from American majority perspectives (Malgady et al., 1987). While the controversy in this area has focused mainly on intelligence testing and its impact on African-American subjects, there is now an emerging concern about the instruments used to assess personality characteristics and psychopathological functions, particularly as they are applied to people whose cultural and semantic systems may differ markedly from the U.S. norm.

Integrated within the administrative procedures, factor construction, and parametric criteria of any diagnostic instrument are ethnocentric assumptions about what constitutes mental health and mental pathology. Thus, in diagnostic instruments that assess psychopathology, test items are often keyed to reflect pathology on an empirical basis, constructed and standardized on Anglo-American diagnostic samples (Guernaccia, Rivera, France, & Neighbors, 1996). The works of Padilla and Ruiz (1973), Malgady et al. (1987), and Guernaccia (1992, 1993) on the assessment of psychopathology in Hispanic subcultures, for example, all point to the disturbing frequency with which culturally syncretic behavior, affects, and belief systems are erroneously diagnosed as pathological when assessed along the diagnostic criteria of Anglo-American functioning. Similar findings have been reported for Asian-American samples (Sue & Sue, 1990).

In an effort to overcome what is erroneously believed to be simply a "language barrier" effect, and make assessment scales designed in English suitable for use by different ethnic populations, authors have sought to translate testing instruments into various other languages. An example of this, in the pressured and overcrowded agency systems of multiethnic urban centers, is the hasty and often unsystematic translation of instruments for administration to recently arrived immigrant children and adults. These translated instruments (if translated systematically) often demonstrate acceptable correlations with their English counterparts when administered to bilingual subjects; however, inde-

pendent evidence of criteria-related validity with the separate ethnic groups has usually not been established.

Simply put, a translated instrument becomes a new measure, one in need of its own validity, reliability testing, and standardization norms for the particular group it is meant to assess. Furthermore, the question of content validity in the factor construction of U.S. test products stands as a scientific and epistemological problem when these instruments are used with immigrant subjects. When administering our instruments to other ethnic groups, are we essentially testing for "American depression," "American intelligence," and "American psychosis"? Yanagida and Marsella (1978), Lutz (1988), Jenkins (1994), and others have noted variations in culturally constructed meanings of numerous affective states, demonstrating noticeable differences in the factors that are mainstays of clinical diagnostic criteria for the Western affective disorders.

More recently, investigators have explored the heuristic, clinical, and research value of using the PTSD concept with cross-cultural and, especially, immigrant refugee populations (Friedman & Jaranson, 1994). Fawzi et al. (1997) and Carlson and Rosser-Hogan (1994), in their work with Vietnamese and Cambodian refugees, respectively, found that the number of traumatic events experienced by these groups was significantly related to the severity of their symptoms as assessed on various measures traditionally used in Western research and clinical settings. However, in a study that conforms more closely to previous reports of work with non-Western cultural populations (Sue & Sue, 1990), Peltzer (1998) noted that the diagnostic assessment of clinical responses to trauma in various African subgroups should emphasize somatic vs. psychic symptoms, as these are more consistent with indigenous idioms of distress.

Adding further to the complexity of clinical assessments of ethnically diverse people is the recognition in the literature of what are broadly termed "culture-bound syndromes" (Guernaccia, 1993; LaBruzza & Mendez-Villarrubia, 1994). These refer to coherent patterns of psychological distress manifested through affective, cognitive, and behavioral symptoms that are indigenous to certain cultural groups. Whereas they often overlap with DSM-IV categories, they seldom have a symptom-to-symptom relationship to DSM-IV diagnoses. In addition, Guernaccia (1992, 1993) has

noted that culture-bound syndromes, unlike the criteria sets of DSM-IV diagnostic categories, do not confine their definitions to psychological symptoms; rather, they may also integrate the social, moral, or spiritual state of the person to identify a clinical state of distress.

Clinical Assessment and Bilingualism

There is by now a substantial multidisciplinary literature (*Amahti-Mehler, Argentieri, & Canestri, 1993; Perez Foster, 1998a*) on the ways in which bilingualism affects the expression of symptoms and their subsequent assessment by clinicians. For example, there is evidence of differences in the neurocognitive organization of language in the bilingual speaker's mind, such that significant segments of languages learned after the initial developmental language acquisition period appear to be stored in different areas of the cortex (*Kim, Relkin, Lee, & Hirsch, 1997; Ojemann, 1991; Paradis, 1977*). Potential ramifications are suggested for the functional access of experiential memory when stored in one language code, and retrieved through a different code (*Marcos & Alpert, 1976; Perez Foster, 1992, 1996a, 1998a*).

Psychodynamically oriented clinicians have described the anxiety-reducing value of narrating traumatic or conflictual experiences in the language in which the events did *not* take place. In particular, it has been proposed that a second language can serve a defensive function, allowing a bilingual individual to isolate the affect associated with trauma and narrate the charged material, stripped of its affective and potentially ego-disruptive charge (*Marcos & Alpert, 1976; Greenson, 1950; Perez Foster, 1992*).

However, as succinctly stated by Oquendo (*1996*), "the evaluation of patients in a second language presents many pitfalls" (*p. 616*). This perspective has been corroborated by a number clinical reports of work with bilingual clients (*Aragno & Schlachet 1996; Bradford & Muñoz, 1993; Javier, 1996; Perez Foster, 1996a*). These pitfalls may be viewed as occurring within two related spheres that have an impact on symptom expression: 1) language differences in cognitive organization and 2) second-language anxiety.

Language and Cognitive Organization

In metropolitan urban centers, and throughout North America, mental health service providers encounter a wide variety of immigrant patients

who present for treatment. A key concern of the clinicians who work with immigrants is whether bilingual individuals can be adequately evaluated in their new, second language. While the tides of ethnic representation in the mental health professions are very slowly changing to bring greater diversity into our ranks, the most common cross-cultural clinical situations are those of English-speaking clinicians evaluating patients who function at varying levels of English proficiency.

The small body of research that has focused on how the language of the interview affects the assessment of severe psychopathology has yielded contradictory results. In different studies, both the native and second languages have been identified as the idioms in which patients manifest the most severe forms of cognitive pathology. Del Castillo (*1970*) and, later, Price and Cuellar (*1981*) found fewer psychotic symptoms in their hospitalized psychiatric patients when they were interviewed in English—their second language. Del Castillo conjectured that this served as a buffer against further cognitive disorganization and helped maintain patients in better contact with reality, a position espoused earlier by others (*Buxbaum, 1949; Greenson, 1950; Thass-Thienemann, 1973*). The second language, acquired later in life, was thought to be associated with higher-level ego functions. The native language, on the other hand, recalled and aroused the regressive associations and primitive cognitive functions of the early infantile period. A case study reported by Laski and Taleporos (*1977*) similarly noted that the native language was the consistent venue utilized by a bilingual patient for the expression of hallucinatory symptoms.

This set of neatly corroborating findings was contradicted, however, by the work of Marcos and colleagues (*1973a; 1973b*), who found the exact opposite: in their controlled assessments, Spanish-American psychiatric inpatients manifested more psychopathology when they were assessed in English. The researchers reasoned, interestingly, that their patients, who were already experiencing subjective inner turmoil due to their condition, became further disorganized with the pressure and effort of being assessed in their second language.

While these contrasting findings leave us with questions that remain to be answered by future research, they should alert clinicians that the diagnostic assessment of any bilingual patient is no simple matter. Evaluation needs to proceed with caution and an acceptance of the need to do clini-

cal assessments in both languages, so that results can be compared. This language-diagnosis conundrum is further deepened, though, by Gonzales's (1977) finding of no significant differences in the expression of psychopathology when bilingual inpatients were assessed in both of their languages.

Further research in this area will need to integrate consideration of various methodologic, clinical, and dynamic factors. From the standpoint of methodology in psycholinguistic research, proficiency in each language needs to be more carefully assessed, with a further distinction made between those bilinguals who learned their two languages in the same versus distinct environmental or developmental contexts. This is a factor that has been heavily implicated in the psycholinguistic concept of language independence. A core clinical issue needing attention is the deep relationship between symbolic expression in language and cognitive organization. Are the observed differences in level of cognitive organization simply a function of verbal expression, or are they manifest expressions of thought disorder *per se*?

The heuristic and clinical fascination for those of us interested in bilingual processes is whether the supposed (neuro)cognitive separations, as observed in those who have learned their languages in different environmental contexts, are paralleled by differences in psychic and characterological functioning. The notion of a bilingual self has already been proposed elsewhere on the basis of neuro-organizational factors in dual language storage, projective testing data on language differentials in personality characteristics, and psychodevelopmental factors (Perez Foster, 1996a, 1996b, 1998a). In addition, these language-related self-organizations have been associated with distinct ego-defensive structures and coping mechanisms (Greenson, 1950; Marcos, Eisma, & Guimon, 1977; Perez Foster, 1992, 1994, 1996a, 1996b, 1996c). The intriguing question for clinicians who are in the position of assessing bilingual clients is: Would formal evaluation of each language-related self-state render a separate mental status, or a different level or type of pathology?

We clearly have a long road ahead in the exploration of this area, with a need for well-designed methodologies (Vazquez, 1982) and controls for linguistic proficiency, language acquisitional contexts, and diagnostic refinement. On this latter point, it should be noted that the research reviewed here on the bilingualism-psychopathology interac-

tion was done primarily on hospitalized schizophrenics or symptomatically psychotic patients (Del Castillo, 1970; Gonzales, 1977; Laski & Taleporos, 1977; Marcos et al., 1973a, 1973b). Notwithstanding the need for research on diagnostic groups with milder degrees of cognitive pathology, it should be noted that the studies of schizophrenic inpatients confounded both acute and chronic schizophrenic types as well as paranoid and nonparanoid dimensions. These are parameters in the schizophrenia spectrum that are well established as manifesting significant differentials in cognitive processes, and thus may have influenced assessed level of pathology in the bilingual studies (Herron, 1977; Magaro, 1980). Del Castillo's (1970) subjects were longer term hospitalized patients, whereas those studied by Marcos and colleagues (1973a, 1973b) were recently hospitalized schizophrenics in an acute state of psychotic decompensation. In addition, despite the markedly different pattern of cognitive symptom presentation in paranoid and nonparanoid types of schizophrenics, none of the studies distinguished between these types in their subject pools (Neufeld, 1977; Perez Foster, 1981; Ross & Magaro, 1976). This was another source of symptom variance in the mixed subject pools studied for language differences.

The role played by the clinician's bias, which emerges from culture-related differences in worldview, sense of self in the world, and so on, also needs to be more clearly understood for its impact on these language and diagnosis studies. The clinician's cultural countertransference (Perez Foster, 1998b; Rendon, 1996) has been recognized as an important influence in the assessment of ethnic groups. Price and Cuellar (1981) reviewed the findings of Marcos and colleagues (1973a, 1973b) and proposed that their raters' lack of bicultural sensibility accounted for findings that generally differed from those of other research in the area. Gonzales (1977), on the other hand, found the rater's cultural background to have no significant influence on assessment of psychopathology. While more careful explorations of the interaction between clinician and bilingual patient factors need to be pursued, the bulk of the research suggests that the language in which the assessment is done does have an impact on the manifest expression of psychopathology—although the direction of this effect appears to be variable.

The following case example is offered as an illustration of the desirability of performing separate

assessments in each language. It is also indicative of the way in which events attendant to the migration experience can function as acute precipitating stressors for those with latent or prodromal indications of schizophrenia.

Case Illustration: Nina

Nina, a 68-year-old single Central American woman who had migrated to the United States at age 25 with her four adult siblings, was equally proficient in Spanish and English. She and her extended family, with whom she had always lived, had just relocated to the New York area from South Carolina, where she had been treated successfully for more than 25 years as an outpatient with a diagnosis of chronic paranoid schizophrenia. She presented at the geriatric psychiatric clinic of a New York hospital, referred by her former facility for psychiatric evaluation and an assessment of her psychopharmacologic regimen.

Psychosocial evaluation of the patient, an interview with family, and review of psychiatric records that were brought in hand revealed a complex and interesting history. Nina and her family's original migration to the United States was instigated by political upheaval in their native Central American country. Living on a coffee plantation, the family was the focus of politicized indigenous groups who raided farms as a way of regaining lands they originally owned. After the violent murder of her parents and firesettings on the property, Nina left the country with her siblings. At the time, she was a graduate of a teacher's high school in her country and a gifted linguist, fluent in Spanish, English, and Portuguese. In fact, her initial employment in the United States was as a multilingual secretary and translator.

Three years after her arrival, Nina suffered her first psychotic break. She was diagnosed with acute schizophrenia, paranoid type, and hospitalized for two years after being found roaming her neighborhood, disoriented, floridly delusional, and carrying a kitchen knife in her bag. She was terrified that indigenous mountain people from her country were following her and wanted to kill her. Nina was treated with the standard clinical intervention for schizophrenia at the time: hydrotherapy, physical restraint, and electroconvulsive therapy. However, in 1955, with the advent of antipsychotic medications, Nina was in one of the first cohorts of psychiatric patients in the United States to be treated with phenothiazines. Her primary symptoms abated markedly, and she was able to return home to her family, who were supportive and extremely creative in reintegrating her into active functioning. She was given a job in the family business and included in all family social life. Nina's own self-initiated social contacts were minimal, however, she maintained an essentially schizoid posture, and spent most of her free time reading in her room.

Nina was maintained, essentially stable, for 40 years by a combination of antipsychotic medication and daily functioning in her work and family milieu. In her thirties, she experienced some psychotic decompensation; however, these episodes were treated at their onset with pharmacologic readjustment. Monthly evaluation and follow-up of her mental status over the years eventually moved Nina into the chronic schizophrenic designation and, as has been noted for some across the lifespan of this diagnostic group, there was an amelioration over the years of her cognitive symptoms of schizophrenia (Cohen 1990).

Throughout, given Nina's language fluency, she had always been evaluated and interviewed in English. Now, upon her presentation at the New York clinic, which is part of a large teaching hospital, available bilingual clinicians astutely proceeded to conduct her interview and mental status evaluation in both English and her first language, Spanish. Strikingly, her English narrative projected cognitive functioning that was fairly organized, cohesive, reality oriented, and devoid of autistic or idiosyncratic intrusion. Spanish assessment, however, manifested thinking processes which, while organized, were intruded upon by repetitive themes of a fairly fixed delusional nature. These themes did not emerge in her current English narrative, nor were they recorded in her earlier records. This ideation consisted of some of the paranoid beliefs that were prominent during her early psychotic episodes. In fact, she still harbored the belief that indigenous people from her country were looking to harm and kill her.

To the best of Nina and her family's knowledge, she had never received any form of protracted psychotherapy where, within the context of a long-term therapeutic relationship, albeit in English, these beliefs and their associations might have emerged. It would appear that her brief monthly psychiatric follow-ups and her circumscribed daily routine on the job allowed Nina to maintain a level of stable cognitive functioning in English that may have been symbolically and affectively removed from the more primitive resonances and associations of her native language. Based on the psychodynamic bilingualism literature, it might be surmised that Spanish would be the language of her deepest fears, conflicts, and potential psychic disintegration. Indeed, initial superficial exploration of Nina's fears in Spanish by the bilingual clinician suggested that their very personalized meanings had their origins in the patient's early developmental and adolescent history, were associated with the details of the family's traumatic premigration experiences, and had never been fully explored in a therapeutic situation.

When questioned closely about the context and content of her differential language usage, Nina divulged that at the end of her workday, her going to her room to "read" was also her special time to talk to herself, think about her concerns, and analyze the "progress" that her persecutors were making in finding her. "I think to myself in Spanish," Nina said. The family confirmed that her sometimes audible "muttering" was always in Spanish, not clearly comprehensible, and something that was always gently reprimanded, "*¡Para!*" ("Stop it!"). This was followed by their engaging Nina in some English conversation. Inadvertently, the family had created its own operant conditioning protocol: negatively reinforcing manifest psychotic Spanish verbal behavior, and positively rewarding English verbalizations that were coherent and reality oriented. While these conditions had, on the one hand, created functional and adaptive behavior in the English-speaking domain (in which the entire extended family mostly lived), they had also reinforced a deep linguistic separation in Nina's psychic life.

We can only speculate, in the case of this 68-year-old woman, as to whether some earlier working through and reformulation of Spanish ideation in the context of a psychodynamic engagement with a therapist would have so shifted elements of her psychic structure and internalized object rela-

tions as to have promoted some movement of the schizoid posture maintained throughout her relational functioning. My own belief is that a more thorough bilingual assessment across the span of her psychiatric treatment could have exposed Nina's active psychotic thinking in Spanish, and encouraged formulation of a more comprehensive treatment plan. Long-term dynamic treatment in this case might have provided the milieu for some reconstruction of Nina's inner life and expression of the terror and losses she experienced just prior to her arrival in the United States. In fact, Nina, in her Spanish mutterings, was the "narrator" for siblings who never spoke of the premigration trauma. Clinging together as a family of siblings, they essentially kept their parents and homeland alive.

Second-Language Anxiety and Symptom Expression

Anxiety or pervasive discomfort can accompany the bilingual patient's clinical presentation in a second language, especially when these patients are markedly more proficient in their native idiom. The notion of self-expression in an acquired language as being distant from immediate subjective experience is frequently voiced by patients, and has been entertained from several perspectives by both clinicians and theorists. Distance from experiential truth (*Lacan, 1977; Rozensky & Gomez, 1983*), defensive intellectualization of emotion (*Buxbaum, 1949; Greenson, 1950; Marcos & Alpert, 1976; Perez Foster, 1992*), and linguistic inaccessibility (*Javier, 1989; Kolers, 1968*) have all been cited as explanations for this phenomenon. However, adding to this multilayered veil of dulled expression, as it were, is the further derailing function of the bilingual immigrants' anxiety when speaking their non-dominant tongue.

The thought of appearing passive, inarticulate, simple-minded, or unsophisticated in a second language, which one knows is not expressing the full complement of one's thoughts and feelings, is anxiety-provoking to many, and depressing to others. Several investigators have noted that, when speaking in their nondominant language, bilinguals perceive themselves as less intelligent and self-confident (*Segalowitz, 1976*). As *Marcos et al. (1973b)* wisely pointed out, the monolingual clinician must take care not to misinterpret the halting quality, sparse words, and emotional preoccupation of the struggling bilingual as psychopathology.

A related issue in the English-language assessment of immigrants from poor and disenfranchised

ethnic groups is that the language in which these clients are attempting to express disturbing and charged experiences is, in fact, the language of the group in power—and thus, to some, the oppressor. It should be kept in mind that both the clinician and the clinician's very language may symbolize the "other." When viewed in the context of dynamic transference processes, this type of interaction can evoke tension sufficient to inhibit a host of expressive functions in the patient (*Perez Foster, 1998a*).

Viewed from a relational perspective, English, the language of the psychological assessment, may also be the language acquired from this "oppressive other," the one who begrudgingly tolerates one's stay in his country. Consequently, in interactions with this "other," one is cautious, inhibited, unexpressive, passive, and possibly deferential. The learning of a second language in contexts in which one is repeatedly made to feel inferior, and is confronted with an intimidating other, begins to organize a particular self-configuration that can subsequently be evoked by future English usage.

USE OF THE MENTAL STATUS EXAM AND PSYCHOSOCIAL HISTORY

Individuals presenting at a mental health facility in psychological distress are likely to be assessed with procedures that include some form of mental status examination and the recording of a psychosocial history. Aspects of both of these procedures will be considered here in light of the pitfalls that have been noted in the assessment of bilingual immigrant patients.

Mental Status Examination

Cognitive Sphere

The research that explores the influence of language on the projection of cognitive psychopathology in the diagnostic interview has yielded confusing results, to be sure, but stimulates compelling questions regarding the role of language in both the organization and symbolic representation of ideas. With the work of *Gonzales (1977)* standing as an exception, the consensus of the literature reviewed is that, for the bilingual patient, the language of the assessment has some impact on the manifest expression of cognitive pathology. Although assessment in a second language has been reported to elicit confused and regressed cognitive pathology from some bilingual patients (*Marcos et al., 1973a, 1973b*), the majority of clinical and ex-

perimental reports suggest the contrary: that it is in the native language that more regressed psychopathology is manifest (Buxbaum, 1949; Del Castillo, 1970; Greenson, 1950; Javier, 1989; Kraph, 1955; Laski & Taleporos, 1977; Perez Foster, 1992; Price & Cuellar, 1981). It is on this basis that the present paper recommends dual assessments, one in each of the patient's languages, with clinicians who are also cognizant of the cultural context of the patient's life and experience. The case of Nina further underscores the value of bilingual assessment, and highlights the ways in which a second language may mask the presence of cognitive pathology that would be quite readily evident in a native-language mental status examination.

Affective Sphere

Detached affect and lack of integration between affect and narrative are descriptions that have been applied to patients assessed in their second language (Bamford, 1991); frequently, but not exclusively, these are patients who are not proficient second-language speakers. Caution should be exercised here not to facilely ascribe these terms to the affective blunting that distinguishes more severe pathological states, since what Marcos and colleagues (1973b) described as the impact of the "language barrier" may be very much in operation. Those who are markedly less fluent in a second language than they are in their native language have to exert a great deal more effort in their verbalizations. Not only do they have a smaller vocabulary to rely on, and less facility with grammar and pronunciation, they are burdened as well with the work of constant translation into or from the dominant language (Marcos & Alpert, 1976; Marcos et al., 1973a, 1973b).*

One of the effects of the language barrier on clinical presentation is a deflection of attention and affect, which may be subsumed in the difficulties of coping with a second language. This can result in a splitting, or lack of integration of experience and emotion, wherein the patient may verbalize seemingly upsetting and charged material without displaying appropriate emotion (Balkányi, 1964; Marcos & Alpert, 1976). A striking and unfortunate example of this is that bilingual patients are frequently misdiagnosed as more depressed when

interviewed and assessed in their second language than when assessed in their native tongue (Rendon, 1996). It has been noted that, for patients who are prone to obsessive mechanisms, the extra cognitive demands of language translation serve to enhance the use of intellectualized defenses, creating even greater emotional distancing from the material (Marcos & Alpert, 1976).

It is also the case, however, that the emotional coolness and the distancing achieved by recounting traumatic material in a language other than that of the experience can sometimes serve a facilitating function. Especially for survivors of migration-related or other trauma, presenting the experience in a language foreign to the actual events can, at times, assist a patient in recounting it without feeling the full force of its ego-disruptive charge. Two brief vignettes may serve to highlight the point:

Upon her admission to the hospital, a Middle Eastern woman informed me in affectless, deadpan tones of the systematic shooting of each of her five family members in front of her when she was age 10. The struggle and effort of translation into English during our interview seemed to contain her, and to consume some of the deep emotional edge of her story. However, alone in her room, it was in her native Turkish that she wailed, and attempted to lacerate herself for the crime of surviving. Beginning with the initial diagnostic interview, our sessions in English, because of their affective distance, functioned as a form of titrated entrée into the toxic world of her internal grief. The experience-distant medium of the second language provided, for this extremely fragile woman, a controlled form of exploring her early trauma at a level of felt experience, beyond which she could probably not venture at the time of her acute hospitalization.

A 25-year-old, bilingual Chilean woman presented with a wide range of inhibitions. The language pattern of her particular treatment followed facile shifting from one language to the other. Only recently having become sexually active, she began speaking of her first fully aroused sexual experience with her partner, also Chilean, in Spanish. She stopped herself suddenly and said, "I can't handle this; I'm switching to English to tell you this. It sounds much too funky and dirty in Spanish!"

Behavioral Sphere

Functional attributes in the behavioral sphere of bilinguals that may be related to language issues include potential suspicion and caution on being in the presence of a person of another culture. Many of us can conjure up some personal recollection of travel in a country whose language and customs

*Linguistic research in the area of second-language acquisition has indicated that various cognitive and linguistic strategies are used by individuals in the process of second-language learning, only one of which is literal translation from the dominant language (Grosjean, 1982; E. Klein, personal communication, 1997). For the purpose of the present discussion, the issue is the subjective and emotional burden of expressing experience in a new and limited language.

were totally foreign. The feeling of vulnerability and the shift toward hyperawareness of external cues are circumstances to which we can all relate. Trepidation, ambivalence, and conflicted presentation, especially on the part of those with poor command of the therapist's language, may be due to more than the halting search for words in a foreign tongue. The fear and frustration of not being understood—particularly when such high stakes as psychiatric hospitalization are involved—can be paralyzing for some. For example:

A Yugoslavian man was brought into the emergency room of a city hospital to be evaluated psychiatrically after threatening to kill himself. In a difficult interview, he finally said in his halting English, "You don't know me. The only thing you have to tell you whether I am mad is my words, and I don't speak English that well. So why should I tell you all that I am thinking?"

Do we assess this as paranoid suspicion or good reality-testing?

For the bilingual patient, then, optimal treatment calls for administration of the mental status exam in both the native and second languages, even for the bilingual who is a proficient English speaker. To avoid bias, these evaluations should be done blindly and then integrated in a team consultation format. Dual-language evaluations also offer the opportunity to clarify potential discrepancies in interpreting the cultural meaning of certain symptom phenomenology. If dual-language evaluations are not available, and a moderate to poor English speaker is being assessed, the clinician must remain aware that such characteristics as halting speech, disorganization of ideas, and flattened affect may simply be symptomatic of substandard English, and not necessarily indicators of more serious psychopathology. Also, with regard to diagnostic specificity with the bilingual in general, and given the different clinical picture that might exist in the alternate language system, a conservative posture should be maintained pending the collection of more complete information.

The Psychosocial History

The psychosocial history marshals, among other things, information about the client's personal development, the environments in which developmental experiences took place, the people who played significant roles in those experiences, and, of vital importance for immigrants, the circumstances surrounding entry into the host country. As has been noted, it is specifically in the area of lan-

guage and environmental contexts that reconstruction of personal experience may be most affected by language. While the issue of bilingual language organization is complex and still controversial in the field of psycholinguistics, there is a body of research suggesting that separate contexts of language acquisition, i.e., cultural settings, can enhance the functional separation of the bilingual's two languages and, of great interest to the clinician, render separate streams of associations (Kolers, 1968; Lambert & Moore, 1966; Taylor, 1971).

These findings have formidable implications for the language in which a bilingual patient's psychosocial history is taken. The research suggests that different associations may be aroused by the respective idioms, which may, in turn, result in the reconstruction of respectively different psychosocial products. Typical of this bilingual situation might be the patient whose childhood development spanned a change in locale and, with it, a change in language; this situation is best represented by the child who migrates from a native country—and language—to a host country where the youngster adopts both the new culture and the new language.

Confounding the language-related associations produced in a psychosocial history are the psychodynamic factors that render a second language an efficient vehicle for the functional repression and emotional isolation of conflictual material experienced in the early developmental language. Thus, strong repressive forces that circumscribe the narrative product may also accompany the bilingual's second-language reconstruction of psychosocial history.

Thus, in mental health settings where bilingual staff is available, the language of the psychosocial assessment should coincide with the particular segment of experiential history being considered. This will help to ensure that the optimal amount of information is reconstructed as a result of language-specific associational links. For example:

A Chinese male patient who migrates to the United States as a boy of ten and quickly (as is the case with so many immigrant children) becomes acculturated and fluent in his new, English-speaking world, will have transacted and symbolically internalized much of his learning, his latency experiences, and his basic adolescent identifications in English. Many of these experiences would best be accessed in that language. On the other hand (again, as is often the case for immigrant children) there may be a "grand divide" in this child's language life: experiences at home during the latency and adolescent years may have continued to be carried out, and presumably internalized, in Chinese. In a psychosocial narrative, these intimate experiences might very well be best accessed in that language.

Integrated within the developmental data that this paper has proposed as being best accessed through the use of phase-specific language will also be a wealth of information on what I have referred to in earlier work as "language-bounded self-organizations" (Perez Foster, 1998a; 1996a). These may have their own particular defensive constellations, operational ego functions, and language-specific self-schema. Thus, in the course of an assessment, the clinician needs to be aware of the contexts of the bilingual patient's language usage during both development and current functioning. This further suggests the utility of dual-language assessments for dual-language lives. While this may already be standard operating procedure in many biculturally oriented treatment programs (Guernaccia, 1992), the perspective of language-related memory reconstruction and access has not been sufficiently emphasized.

CONCLUSION

This paper has selectively reviewed findings in the immigrant mental health literature that have implications for both individual and family clinicians. The distinction delineated here between immigrant stressors and the conditions that foster immigrant trauma per se should serve to alert clinicians to those potentially traumatogenic migration experiences that tend to be divulged only reluctantly by patients, and that are easily missed by those not conversant with the multiple points at which assaults can occur along the migration trajectory. Thus, premigration abuse/disaster; migration transit; asylum seeking; and substandard living conditions in the host environment all can serve as individual or cumulative assaults on human beings already stressed by having left behind the world they know.

Secondly, recent developments from the clinical literature have been highlighted that have emerged as nodal to the mental health assessment of immigrants who seek our care. Ethnocentric bias in diagnostic criteria and clinical instruments is a pervasive problem in clinical practice, forcing us to be diligent in discerning whether an immigrant patient's presenting complaint stands as a projection of idiosyncratic pathology or an expression of culture-specific behavior. Given the less prevalent awareness of the complex role of language and bilingualism in the immigrant client's clinical presentation, both clinical material and assessment guidelines have been offered here.

We practitioners are indeed in a complex dialectic with all of our immigrant patients as they struggle to express their unique idioms of distress. We must strive to alleviate the inevitable anxiety that comes from offering clinical care to people whose worlds may so markedly differ from our own.

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