The Experiences of Mental Health Practitioners Working

With Undocumented Immigrants from Mexico Along the U.S./Mexico Border

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ABSTRACT

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The largest percentage of new immigrants to the United States is from Mexico (Chomsky, 2007). One half of all immigrants from Mexico living in the United States are undocumented, totaling 5.9 million adults and children (Passel & Cohn, 2009; Passel, Van Hook, & Bean, 2005). There is a significant gap in the psychological literature with regard to recommendations for providing mental health services with undocumented immigrants from Mexico. The purpose of this study was to contribute to the multicultural psychology literature by gathering the clinical experiences of mental health professionals who work with undocumented immigrants from Mexico along the U.S./Mexico border and to define culturally responsive interventions while highlighting potential opportunities for clinicians to engage in socially-just professional practice. The study utilized a qualitative methodology by which first-person narratives were gathered via interviews with 12 social workers, psychologists, and counselors who work with undocumented immigrant clients in the border states of New Mexico and Texas. The resulting interview transcripts were analyzed using a consensual qualitative research (CQR) approach (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005). The results of the study were distilled into promising practices for service provision highlighting the role of feminist multicultural counseling psychology in the development of cultural competency, expansion of professional roles, provision of culturally- and linguistically-appropriate treatment, and

encouragement of clinician self-care.

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Chapter 1

Introduction

In her influential work, Gloria Anzaldúa (1987) describes the U.S./Mexico border as,

> [*U*]*na herida abierta* (an open wound) where the Third World grates against the first and bleeds. And before a scab forms it hemorrhages again, the lifeblood of two worlds merging to form a new country – a border culture. Borders are set up to define the places that are safe and unsafe, to distinguish us from them. A border is a dividing line, a narrow strip along a steep edge. A borderland is a vague and undetermined place created by the emotional residue of an unnatural boundary. It is in a constant state of transition. The prohibited and forbidden are its inhabitants (p. 25).

The borderland Anzaldúa evokes is the also the site of mass migration, it is estimated that 168,348,000 people traveled across the international boundary from Mexico into the United States in 2010 (North American Transportation Statistics Database, 2011). The largest percentage of new immigrants to the United States is from Mexico (Chomsky, 2007), numbering six times those from any other nation (Hansen & Bachu, 1995). In addition, half of all Mexican immigrants are currently undocumented, totaling 5.9 million men, women, and children (Passel & Cohn, 2009; Passel, Van Hook, & Bean, 2005). The majority of these immigrants enter the United States through the 2,000-mile international border between the two nations.

Introduction

For the undocumented, this passage can be dangerous and potentially deadly. In the year between October 1, 2010 and September 30, 2011, U.S. authorities arrested 327,577 immigrants along the border with Mexico (Medrano, 2011). During the same period, Arizona law enforcement recovered the bodies of 192 immigrants who died during their attempt to enter the United States, most succumbed to exposure in isolated desert regions in an effort to avoid areas with increased border patrols (Medrano, 2011). The border security tactics of U.S. Operation Gatekeeper have clamped down on the more traditional, and historically safer, migration routes

and this has resulted in an average of one immigration-related death each day as Mexicans attempt more remote crossings (Ong Hing, 2011). Ong Hing (2011) highlighted the many factors that have made these new routes "deathtraps".

> While the distances migrants may have to travel in places like Texas are far, Arizona and the eastern part of the southern California border are hazardous. Arizona is home to the Sonora Desert. California has the Imperial Desert, the All-American Canal, and a mountain range that features rugged canyons, high desert, and desolate stretches. The Otay Mountains are rugged and steep, with canyon walls and hills reaching 4,000 feet. Extreme temperatures ranging from freezing cold in the winter to searing heat in the summer can kill unprepared travelers. The American Canal parallels the border for 44 miles. It is unfenced and unlighted, 21 feet deep and nearly as wide as a football field, with strong currents and one of the most polluted rivers in the United States.

For the fortunate immigrants whose journeys do not end in arrest or death, a host of factors leading to negative mental health outcomes awaits them once in the United States. As they settle in the U.S. borderlands of California, Arizona, New Mexico, and Texas, immigrants "face identity concerns, challenging socioeconomic and environmental conditions, vulnerability to trauma, stress", and "multiple barriers to obtaining needed treatment" (Flores & Kaplan, 2009, p. 5). Understanding the specific challenges faced by undocumented immigrants from Mexico is paramount to the development of culturally responsive mental health treatment strategies for this population.

Identity Concerns. Mexican immigrants may experience negative mental health outcomes associated with the process of acculturation. Immigrants may experience stress related to language acquisition, perceived cultural incompatibilities, and discrimination (Alegria & Woo, 2009; Suárez-Orozco & Suárez-Orozco, 2001). Values and cultural norms may shift as immigrants adjust to life in the United States, causing relationships within the family to become strained. In turn, this strain can lead to stress and the increased potential for domestic violence as adherence to traditional gender roles and level of parental control change (Coltrane, Parke, &

Adams, 2004; Fontes, 2002). Acculturative stress has been linked to depression, anxiety, substance abuse, decline in physical health, and reduction in coping skills and the risks for mental health problems due to acculturation appear to increase over time (Alegria & Woo, 2009; Thoman & Suris, 2004).

Undocumented immigrants from Mexico may also encounter prejudice and discrimination (Guarnaccia, Martinez, & Acosta, 2005; Zuniga, 2004). The exposure to racial and ethnic discrimination by Latinos has been linked to higher rates of PTSD symptoms (Flores, Dimas, Tschann, Pasch, & de Groat, 2010). Many undocumented Mexican immigrants may experience workplace exploitation, being forced to work in unhealthy conditions while receiving substandard wages. Undocumented immigrants may also face housing discrimination and may be charged excessive rent for hazardous living conditions (Falcon, 2001). In addition, there have been numerous cases of harassment and abuse of undocumented immigrants from Mexico by police (Falcon, 2001).

Socioeconomic and Environmental Conditions. Many Mexicans choose to migrate to the United States in search of work, as there are few economic opportunities in Mexico's agricultural communities (Guarnaccia et al., 2005; Zuniga, 2004). High interest rates in Mexico may also be a barrier to financial stability, preventing the opportunity to secure loans to purchase land, homes, or businesses (Massey & Espinosa, 1997). As a result, some undocumented workers migrate temporarily, and after earning enough money to finance homes and businesses, return to Mexico (Guarnaccia et al., 2005; Taylor, Arango, Hugo, Kouaouci, Massey, & Pelligrino, 1996). Other undocumented immigrants decide to settle in the US permanently with the hopes of provide greater economic and educational opportunity for their families.

Undocumented immigrants from Mexico may experience employment related difficulties

in the United States. Government restrictions in concert with discrimination and prejudice result in fewer desirable job opportunities for undocumented immigrants from Mexico (Ugarte, Zarate, & Farley, 2003). Ninety-five percent of U.S. farmworkers were born in Mexico (National Agricultural Workers Survey, 2000). In addition to enduring long hours in physically grueling conditions, Mexican farmworkers risk being in contact with hazardous pesticides, exposure to which has been shown to cause cancer, cognitive impairments, and neuropathy (EPA). The experience of discrimination and decreased economic mobility also results in an increase in psychological distress and disorder (Guarnaccia et al., 2005).

Vulnerability to Migration-Related Trauma. Mexican families may experience trauma even before they begin the arduous border crossing. There has been increased violence as a result of Mexico's drug war and in the five years between 2006-2011, the government reported that 47,515 people were murdered, although this figure may underestimate the true number of dead by as much as half (Cave, 2012). In light of the murder and drug-related violence, many immigrants might begin their journey to the U.S. experiencing negative health outcomes associated with living in communities impacted by the war and mourning the loss of loved ones.

During the migratory process, undocumented immigrants from Mexico may experience theft, violence, and sexual assault (Falcon, 2001; Martinez, 1998; Ugarte et al., 2003). Immigrants may choose more remote border crossings to avoid areas with a greater U.S. Border Patrol presence (Falcon, 2001; Zuniga, 2004). These more treacherous routes might include the crossing of contaminated rivers, freezing mountain terrain, or dehydrating desert landscapes (Gross, 2000; Zuniga, 2004). In order to navigate the crossing, *coyotes* or smugglers, might be hired at exorbitant rates by families (Dwyer, 2010). These traffickers have been known at times to abduct, rape, or murder the immigrants in their care (Ugarte et al., 2003). Bandits also engage

in assault, rape, and robbery along the border (Zuniga, 2004). As a result, undocumented immigrants may experience vulnerabilities to PTSD and other mental health conditions due to migration-related trauma (Zuniga, 2004).

Once in the United States, the increase in arrests associated with working without legal immigration status has resulted in fear among many undocumented immigrants of incarceration and deportation (Bacon, 2008; The Pew Hispanic Center, 2008). Stressors associated with undocumented status may result in insomnia, recurrent nightmares and sleep disruption, symptoms of paranoia, and PTSD (Carbonell, 2005). In addition to the forced separations created by deportation, financial factors may dictate that Mexican families immigrate in stages (Partida, 1996). Similar to forced separations, separations "by choice" have been shown to cause anxiety, depression, and PTSD among family members (Smart & Smart, 1995).

Barriers to Treatment. Many factors serve as barriers to mental health and medical treatment among undocumented immigrants from Mexico. First, U.S. policy has limited the availability of publicly funded health services for undocumented immigrants (Kullgren, 2003). Undocumented immigrants do not have access to Medicaid, Social Security, Supplemental Security Income, Aid to Families with Dependent Children, subsidized housing, and food stamps. As a result, undocumented immigrants from Mexico rarely utilize social services designed for adults, but they are more likely to access programs for children such as The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), public education, and free-lunch programs (Berk, Schur, Chavez, & Frankel, 2000). In addition, fear of deportation is an oft-cited barrier to access to medical care (Smart & Smart, 1995) and results in the absence of needed prescription drugs, dental care, and eyeglasses (Berk & Schur, 2001).

Poor communication with physicians and decreased access to social support from family

also contributes to less contact with medical services in the U.S. (Bergmark, Barr, & Garcia, 2010). In addition, the high cost of health care in United States often motivates undocumented immigrants to seek treatment in Mexico (Bergmark et al., 2010). Furthermore, undocumented immigrants from Mexico report that American physicians focus too much on diagnostic procedures, recommend lengthy treatments that make working difficult, and often require many costly follow-up appointments (Bergmark et al., 2010). Undocumented immigrants from Mexico may also experience stigma associated with mental illness and the utilization of mental health services, as these communities often connect with religious leaders and family to address symptoms (Guarnaccia et al., 2005). Many choose to rely on spiritual support and or use the services of indigenous healers (Guarnaccia et al., 2005).

The Proposed Study

A significant gap exists in the literature with regard to recommendations for providing mental health services with undocumented immigrants from Mexico. The purpose of the proposed study is to augment the multicultural psychology literature by collecting clinical experiences of mental health professionals who work with undocumented immigrants from Mexico along the U.S./Mexico border, in the states of Texas and New Mexico. The development of new knowledge about the perceptions and experiences of these practitioners could be used to make recommendations about culturally responsive and effective interventions for this population. The results of the study may also inform treatment provided by clinicians who work outside of the border as they address both immigration-based mental health issues and sociocultural factors that may lead to negative health outcomes for undocumented immigrants from Mexico across the nation.

More specifically, the study incorporates a qualitative methodology by which first-person

narratives will be gathered via interviews with social workers, psychologists, and psychiatrists who work with undocumented immigrant clients. The resulting transcripts will be analyzed using a consensual qualitative research (CQR) approach. CQR provides guidelines for collecting and analyzing qualitative data that are both systematic and flexible (Hill, Thompson, & Williams, 1997). The CQR process can be viewed as a feminist and egalitarian approach to conducting empirical research in that the researcher and participant are understood to work together to co-construct meaning (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005).

Throughout the process, the researcher works in the context of a team where assumptions, biases, and interpretations are uncovered and challenged through extensive auditing procedures. Many counseling psychologists have used CQR to conduct studies that address issues of social justice in psychotherapy (Hill et al., 2005). Accordingly, the proposed study will make possible the development of recommendations that describe the components of multiculturally competent mental health services for undocumented immigrants from Mexico. The goals of the study are to make a unique contribution to the literature and to highlight new culturally responsive interventions while identifying potential opportunities for practitioners to work toward social change.

The Researcher's Worldview

My commitment to multicultural psychology and social justice has joined with my connection to the southwest to bring me to this project. I was raised in the Mesilla Valley of southern New Mexico and have been enhanced by living in a largely Mexican American community along the Rio Grande River. Due to our close proximity to the border, I grew up climbing the steep slope of the pedestrian sidewalk of El Paso's Stanton Street Bridge in order to spend the afternoon in Ciudad Juárez and am saddened that many have largely abandoned this

crossing for fear of violence associated with Mexico's drug war. I also realize that my experience of the borderland has been impacted by my multiple group memberships and that the easy journey that I often made between the U.S. and Mexico was not the perilous migration that many others encounter. As a White, middle class woman, I have benefitted from my race and class privilege as well as my citizenship status, which have buffeted me from the danger, disorientation, and oppression experienced by many of those who also lived and worked in curve of the Rio Grande, especially undocumented immigrants from Mexico.

As I enter into this research I am humbled by the responsibility of accurately conveying the perceptions of my participants and distilling their experiences into recommendations for best practices for providing mental health services with undocumented immigrants from Mexico. I also feel a great sense of excitement to learn from my colleagues in New Mexico and Texas and feel a sense of pride to share their knowledge with professionals across the nation. It is important to acknowledge that the lessons learned by the mental health professionals of the U.S./Mexico borderlands are not only for those practitioners who provide services in the region. As Anzaldúa reminds us, "the borderlands are physically present whenever two or more cultures edge each other, where people of different races occupy the same territory, where under, lower, middle and upper classes touch, where the space between two individuals shrinks with intimacy" (1987, Preface, para. 1). The experiences and perceptions of clinicians in the U.S./Mexico border are invaluable to professionals who work with undocumented immigrants outside of the region and ultimately may shed light on effective practice for any mental health practitioner who finds themselves occupying the space where "two or more cultures edge each other."

Chapter 2

Review of the Literature

Introduction

Multicultural competence and the inclusion of social justice considerations are essential to the work of psychotherapists. In 2002, The American Psychological Association (APA) approved their Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists. This document encourages psychologists to commit to "developing a cultural awareness and knowledge of self and others" and charges psychologists to "strive to apply culturally–appropriate skills in clinical and other applied psychological practices" (APA, 2002). These recommendations also form the cornerstone of the APA's framework for multicultural competence when working with undocumented immigrants. An important component of this competence is an understanding of immigration status and how it impacts the mental health of our clients. Therefore, it is essential that we give "explicit attention to the unique experiences of immigrant populations, including the negative attitudes towards the group held by the host community" (Yakushko, 2008, p. 37).

Many researchers have highlighted the need for clinicians to adopt a social justice approach when working with immigrant clients (Chung, Bemak, Ortiz, & Sandoval-Perez, 2008; Sue, 2001). As mental health practitioners begin to address the sociopolitical environment, oppressive forces such as racism and classism, and discrimination encountered by their clients, they may need to expand their professional identity to include new roles. These additional roles may include adviser, consultant, advocate, change agent, and facilitator of indigenous healing systems (Atkinson, Thompson, & Grant, 1993). A social justice perspective necessitates that clinicians shift their focus from individual clients and broaden their diagnostic view to include

participation in large-scale change at societal level (Sue, 2001). Unfortunately, many graduate programs do not offer guidance or training experiences in incorporating non-traditional roles into a psychotherapeutic context (Sue, 2001).

Deepening our understanding of the factors that increase mental health practitioners' ability to work effectively with undocumented immigrants from Mexico is important because many counseling psychologists are already and many more will soon begin to provide services to these communities (Yakushko, 2008). The U.S. foreign-born population has reached its highest level since before the Second World War (Hood, Morris, & Shirkey, 1997). In 2005, more than 35 million people living in the U.S. were foreign-born, and Mexico currently contributes the largest percentage of new immigrants (Chomsky, 2007). Specifically, about one-third of foreign-born people living in the U.S. are from Mexico, representing six times more immigrants than from any other nation (Hansen & Bachu, 1995). Furthermore, 30% of all foreign-born individuals do not have legal status to reside in the country, representing 11.9 million individuals and accounting for 4% of the total population of the United States (Passel & Cohn, 2009). Currently, one half of all immigrants from Mexico living in the United States are undocumented, representing the largest national group and totaling 5.9 million undocumented immigrants (Passel & Cohn, 2009; Passel, Van Hook, & Bean, 2005). As a result, undocumented immigration from Mexico is a politically and culturally charged issue in the United States.

We can surmise that there are a significant number of issues that can potentially impact the effectiveness of mental health practitioners' ability to provide services to this population in a culturally competent manner. Studies have demonstrated that race, ethnicity, and other group memberships have been associated with anti-undocumented immigrant attitudes associated with racism, classism, and other forms of oppression. Research has also highlighted the potential for

these oppressive dynamics to lead to ineffective psychotherapeutic treatment, resulting in early termination and potential psychological damage to the client. What is not known, however, are the specific experiences of clinicians currently working with undocumented immigrants from Mexico, and how these clinicians are meeting the complex needs of this population.

A substantial gap in the literature exists with regard to clinicians' ability to juggle the sometime competing roles and responsibilities that characterize service provision for undocumented immigrants. The proposed study is designed to make a unique contribution to the multicultural psychology literature by gathering the clinical experiences of mental health practitioners with experience working with undocumented immigrants from Mexico in the traditional settlement states of Texas and New Mexico. Learning more about the unique challenges faced by these clinicians could potentially shed light on the most effective interventions for this population; it could also encourage best practices for therapists outside of the region in acknowledging and addressing immigration-based mental health issues and the sociocultural factors that may be negatively impacting the mental health of their clients.

The following review of the literature begins with a summary of the history of U.S. immigration policies aimed at Mexicans. It will also present current trends impacting Mexican immigration to the United States, specifically the unique characteristics of the border region. Next, the discussion will turn to traditional settlement states among Mexican immigrants and will include a state-based services case study. This case study will demonstrate a collection of innovative interventions associated with providing services to undocumented immigrants from Mexico. Various migratory factors that negatively impact the mental health of undocumented immigrants will be addressed, followed by factors limiting the access and impacting the use of health care services by undocumented Mexican immigrants. Research findings on U.S. citizens'

attitudes towards undocumented immigration from Mexico will then be discussed. The literature review will conclude with implications for mental health practice with undocumented Mexican immigrants.

History of Policies to Address Undocumented Immigration to the United States

Undocumented immigration can be understood as the process of entering or remaining in a nation without government authorization, either through unauthorized border crossings or overstaying a visa. Whether an immigrant from Mexico has been labeled "legal" or "illegal" at any given time in American history has been greatly influenced by the evolving laws and policies established by the U.S. government. The first U.S. policies created to address unauthorized immigration were bills passed in 1888 and 1891 that sanctioned the deportation of undocumented immigrants (Espenshade, 1995). During the period between 1880 and 1930, beginning with the process of industrialization, the United States actively encouraged Mexican immigration and maintained an open border policy to meet labor needs (Spotts, 2002). Due to The Chinese Exclusion Act of 1882, Chinese immigrants were no longer granted entry into the U.S. and many employers turned to Mexico for rail and agricultural workers. In the early 20th century, labor contractors and private recruiters emerged as middlemen who acted as intermediaries between laborers in Mexico and employers in the United States (Cardenas, 1975).

The Immigration Act of 1917 further demonstrated U.S. preference for Mexican labor, as Mexican nationals were exempted from completing mandated literacy tests that other groups needed to pass in order to gain entry. Furthermore, Mexicans were also exempt from the National Origins Acts of 1921 and 1924, which created a quota system that capped immigration levels to 3 percent of the population of that nationality group already residing in the United States (Cardenas, 1975). At this time, Mexicans were also racially classified as "White" by the

U.S. in an effort to prevent immigration restrictions made on individuals who had more than fifty percent of Indian ancestry. 1924 also saw the creation of the United States Border Patrol, a federal law enforcement agency to deter and unauthorized migration by foreign-born nationals and to apprehend those who made the attempt.

Mexico was also instituting policies that were driving citizens northward for economic opportunity (Spotts, 2002). During this era, Mexico began to privatize land that was originally communally held, which led to the displacement of poor farmers. In addition, railways were built that linked more remote areas of the nation to the U.S./Mexico border region, which allowed for more convenient access to the United States. Soon 1.5 million Mexicans were living and working in the United States. At a result, the Mexican government opposed these migrations to the U.S. as it appeared to threaten the sense of nationalism and was viewed to contribute to the policies of U.S. expansionism.

The Great Depression effectively turned the tide on U.S. border policies and many Mexican workers returned to Mexico as a result of the lack of employment. This was short-lived however, because the New Deal and the onset of WWII made provisions for a revitalization of Mexican immigration. In 1943 and 1944, the Bracero Program was instituted and U.S. employers legally imported temporary workers. Despite the legal status offered to Mexican laborers through the Bracero Program, workers continued to enter the nation without appropriate documentation and in 1954 the U.S. Border Patrol instituted "Operation Wetback" which deported over one million immigrants who entered the country illegally back to Mexico (Espenshade, 1995). The name given to this policy exemplifies the racial tensions within the U.S. at the time, as the term *wetback* is an ethnic slur that has historically been used to denigrate undocumented immigrants from Mexico who "cross the Rio Grande without the benefit of a bridge" (Bustamante, 1972).

The bill allowed the U.S. Border Patrol to scour private property within 25 miles of the Mexico border in an effort to apprehend undocumented workers.

Ernesto Galarza's groundbreaking book, *Strangers in Our Fields* (1956), exposed the treatment of workers in the Bracero Program. His work galvanized labor advocates and civil rights groups, calling attention to the exploitation experienced by Mexican laborers in the U.S. As a result of the efforts of Cesar Chavez, The United Farm Workers, and other groups who protested the ill treatment and substandard housing of the Braceros by their American employers, the program was terminated in 1964 (Bean, Vernez, & Keely, 1989). When the Bracero program ended, many Mexican laborers returned to Mexico, but others stayed on in the United States as undocumented workers. "Circular migration" also began to gain momentum, where Mexicans would enter the U.S. for periods of time to work and then would return home. Those in the Mexican government began to change their attitudes towards immigration, because they viewed the influx of money entering the nation from Mexicans working in the U.S. as a way to partially ameliorate the poverty experienced by Mexican families.

In 1965, Congress passed another Immigration Act, this one aimed at reducing discriminatory racial and ethnic admission policies and instead favoring immigrants with family members already living in the U.S. Soon thereafter, there was a limit placed on immigrants from Western nations and this extended the visa waiting period for Mexicans to over two and a half years. In 1978, a ceiling was placed in immigration from all nations. By 1980, there were an estimated 1,780,000 Mexicans without documentation living and working in the United States and as a result, immigration gained national prominence.

Congress passed the Immigration Reform and Control Act (IRCA) and Ronald Reagan signed the bill into law in 1986. It provided legalization programs that offered 2.7 million

undocumented workers already in the U.S. with amnesty, 80 percent of whom were from Mexico (Spotts, 2002). The bill increased funding to the Border Patrol in an effort to reduce future undocumented immigration and established sanctions on employers who hired undocumented immigrants insisting that they solicit papers verifying the eligibility of their employees to work legally in the U.S. (Espenshade, 1995). The bill also,

> [M]ade it possible for local law enforcement and other officials to rule individuals as inadmissible to the United States, thus initiating deportation without judicial oversight or review…(therefore) enforcement of deportation regulations varies by states, city, and even neighborhood (Yoshikawa, 2011, p. 293).

The H-2A Agricultural Guest Worker or Temporary Agricultural Program was included as part of the IRCA. This program allows agricultural employers "who anticipate a shortage of domestic workers to bring nonimmigrant foreign workers to the U.S. to perform agricultural labor or services of a temporary or seasonal nature" (United States Department of Labor, 2012). Even though the program is designed in a manner that requires workers to return to Mexico between the harvesting cycles, workers develop relationships with their host community that fosters future, and more permanent settlement (Fuligni & Perreria, 2009).

The government did not effectively monitor many of the measures associated with the IRCA and as a result, the bill failed to reform immigration.

President George Bush passed the Immigration Act of 1990, which increased legal immigration. It also included provisions to deport undocumented individuals with criminal backgrounds and to further increase the Border Patrol. President Clinton continued to support the Border Patrol and continued to increase funding in order to hire hundreds of agents. At this time, some states began to pass legislation to curtail undocumented immigration. In 1994, California passed Proposition 187, the "Save Our State" initiative. The law prevented undocumented immigrants from receiving public services including health care and public education.

Proposition 187 was ultimately deemed unconstitutional by a federal court, but continues to serve as an example of the power of anti-undocumented immigrant sentiment enacted in policy.

The Illegal Immigration Responsibility Act was passed in 1996 and provided for thousands more Border Patrol Agents, as well as legal action against immigrant smugglers and fencing along the southwest border to deter undocumented immigrants. These policies have not effectively prevented undocumented immigration, and by 2000, there were approximately 6 million undocumented immigrants in the nation. The U.S. Immigration and Naturalization Service is the government agency charged with collecting data on the number of undocumented immigrants that are apprehended by U.S. Border Patrol Agents and this number serves as a proxy for the total number of undocumented border crossings (White, Bean, & Espenshade, 1990). It is impossible to determine how many Mexicans enter the U.S. without appropriate visas, because available calculations only document the number of unauthorized immigrants who fail to enter the United States as opposed to those whose attempts are successful (Briggs, 1984). Due to the caps in visas available to immigrants from Latin America, Mexicans might be expected to wait up to 15 years to be issued a family-based visa to enter the United States (Fuligni & Perreira, 2009). According to the U.S. General Accounting Office, there are thousands of undocumented workers than journey across the 2,000-mile stretch of border between the United States and Mexico every day. In order to avoid detection by the Border Patrol, undocumented immigrants have needed to choose more dangerous and isolated geographic areas to cross, have incurred greater financial costs during the immigration process, and have remained in the United States for longer periods with fewer trips back to Mexico (Fuligni & Perreira, 2009).

Characteristics of the U.S.-Mexico Border

Mexican American performance artist Guillermo Gómez-Peña (1991) evocatively

described the U.S.-Mexico border as,

> [A]n infected wound on the body of the continent, its contradictions more painful than ever; its supremacist groups still hunting migrant workers as sport; its vigilantes pointing their car lights south; its helicopters and police dogs terrorizing Mexican and Central American peasants who come to feed this country (p. 9).

Similarly, Mendoza (1994) likened it to a "desert, a scar, a scab, a wasteland, a laboratory of the human condition, a war zone, a tortilla curtain, and a geo-political wound" and as "either a place of pain, a site of violence, neglect and waste, or an uncontrolled 'free' zone of capitalist activity, poverty, and vice, and as a gateway for human traffic into the 'land of opportunity'" (p. 120). More literally, the U.S.-Mexico border is defined through a network of geographical, political, economic, cultural, and linguistic realities. For those who live along the border or simply travel through, it can be all of these things at different moments: the experience shifts like a sudden dust storm and for the undocumented migrant, it can be both obscuring and abrasive. Understanding the factors impacting the attitudes of U.S. citizens toward undocumented immigration can be useful in developing a greater understanding of the psycho-socio-cultural-political environment encountered by undocumented immigrants from Mexico as they reside in or journey through the border region of the United States.

Alvarez (1995) claimed "the defining characteristic of border conflict and paradox is the abutment of the U.S., *the* world's dominant economic-political nation-state, with Mexico, a 'third world' economy" (italics in the original; p. 451). On the whole, Mexico's border region can be categorized as more prosperous than other regions of the nation. This relative prosperity stands in contrast to the U.S. border region which comprises a portion of the most poverty stricken regions in the country -- even though the per capita income for residents north of the border is typically three times greater than those living in Mexico (Mendoza, 1994). In fact, the unique characteristics of the U.S.-Mexico border have lead researchers to call it the "model of

border studies," because "no other border in the world exhibits the inequality of power, economics, and the human condition as this one" (Alvarez, 1995, p. 451).

Due to the unique character of the region, Americans who live in the proximity of the U.S.-Mexico border may develop distinct attitudes towards Mexican immigration to the United States. Mexican immigrants (both legal and undocumented) tend to settle in high concentrations in only a few U.S. states, namely, the border states of Texas, New Mexico, Arizona, and California (Burns & Gimpel, 2000; Center for Immigration Studies, 2010). For example, the American southwest has large communities of Mexican Americans and, due to their proximity to Mexico, there is "a strong cultural base from which to reinforce their cultural identity" (Guarnaccia & Martinez, 2002).

One of the most urgent aspects of U.S.-Mexico border issues concerns the trafficking of people and goods between both nations. This system "includes the everyday crossings of both documented and undocumented Mexicans who work in the United States, tourists and shoppers from both countries, the export-import business, and the illegal drug trade" (Jamail & Gutierrez, 1992, p.3). Alvarez (1995) stated, "the massive exchange of commodities, both human and material, dramatically affects life and behavior, as does the continuous shifting and reconfiguration of people, ethnicity, sexual orientation and identity, and economic hierarchy and subordination" (1995, p. 451). The border can also be seen as a "site of negotiation, subversion, and violence" (Mendoza, 1994, p. 120) and those who are most vulnerable to exploitation, incarceration, abuse, injury, and even death are the undocumented immigrants whose primary tool for survival is their inexpensive and unprotected labor.

Traditional settlement states for Mexican immigrants. The four U.S. states bordering Mexico have the largest percentage of Latinos, specifically Mexicans, of their total population

than any other state: New Mexico (44%), Texas (35.7%), California (35.9%), and Arizona (29.2%) (U.S. Census Bureau, 2006). Due to their location along the U.S.-Mexico border, these states have served as traditional settlement sites for documented and undocumented immigrants from Mexico (Burns & Gimpel, 2000; Center for Immigration Studies, 2010). The histories of these states have been defined by a nuanced relationship with Mexico, as large geographic areas of these states were once part of and governed by, Mexico and therefore share a transnational connection. It follows that mental health practitioners in these border-states have a greater exposure to and experience with the providing services to undocumented immigrants from Mexico that can serve as promising practices for professionals in other areas of the United States.

In 2006 the Pew Hispanic Center published a survey of unauthorized migrant populations in the United States. They found that California and Texas continue to have the largest percentage of undocumented immigrants at 2,500,000-2,750,000 and 1,400,000-1,600,000 respectively. The non-border states of Florida and New York, however, had the third and fourth highest migrant populations at 800,000-950,000 and 550,000-650,000 immigrants respectively. These shifts in the settlement of undocumented immigrants are consistent with other recent findings that have demonstrated a greater geographic dispersal of undocumented immigrants (Passel & Cohn, 2009). Since the institution of the H-2A guest worker program, Mexican workers have been encouraged to travel into the South and Midwest regions of the United States for employment. North Carolina, for example, has the largest H-2A program and had the fastest growing Latino population in the United States between 1990-2000 (Fuligni & Perreira, 2009).

Given that 11.9 million undocumented immigrants are currently living in the United States, accounting for 4% of the total population (Passel & Cohn, 2009), it seems appropriate for professionals nationwide to increase their cultural competence in working with undocumented

immigrants from Mexico. Mental health practitioners in new settlement states would benefit from learning about the experiences of border professionals and finding ways to incorporate these best practices into their work with undocumented Mexican immigrants.

Case study: The CYFD Protective Services Division in New Mexico. There is a wealth of knowledge that can be gained by gathering the experiences of mental health practitioners in the border region for clinicians working in other areas of the nation and this knowledge can begin to address the gaps in the current multicultural and social justice literature. The state of New Mexico is a prime example of how international, federal, state, and local forces impact how services are provided to undocumented immigrants from Mexico. With the largest population of Latinos in the United States, New Mexico has traditionally been a state that has had to negotiate transnational cultural exchange. Undocumented immigrants account for 4% of New Mexico's total population and 90% percent of New Mexico's undocumented immigrant population is originally from Mexico (Passel & Cohn, 2009). The Annie E. Casey Foundation (2010) found that 34% of children in immigrant families live in a home where no English is spoken. In addition, the group discovered that 71% of children of immigrant families in New Mexico live in low-income households. Overall, 22% of children in New Mexico live in immigrant families, both documented and undocumented (Annie E. Casey Foundation, 2010).

Historically New Mexico's immigrants have traveled back and forth between the U.S. and Mexico for education, medical care, shopping, and to stay connected with family, friends, and community (Finno & Bearzi, 2010). As a result of its strong ties to Mexico and concern for immigrant health and safety, New Mexico has initiated some liberal immigration policies and procedures to address the rights of undocumented immigrants. For example, New Mexico banned racial profiling in 1990 and the state capital, Santa Fe, is a "sanctuary city," meaning city

employees do not inform the federal government of the presence of undocumented immigrants in their community (Adams, 2010). Even so, New Mexico mental health practitioners have had to navigate and negotiate complex systems that can potentially compromise the effectiveness of mental health services to undocumented immigrants from Mexico.

The Children, Youth, and Families Department Protective Services Division (PSD), a New Mexican public welfare agency, has demonstrated the ability to address some of the competing factors impacting mental health practitioners and their work with undocumented immigrants from Mexico. PSD has a mandate to serve members of the community irrespective of their immigration status and therefore, ethical issues such as client confidentiality can compete with anti-undocumented immigration policies and laws (Finno & Bearzi, 2010). In order to serve families with undocumented status members, the agency benefits from not being required to disclose the immigration status of its clients to federal immigration authorities. In addressing legal status with clients, agency employees have been trained to "frame questions about legal status delicately" and to clearly inform families that their status will not be revealed to law enforcement (Finno & Bearzi, 2010, p. 312). In addition, agents refer families to legal assistance and federally funded benefits programs and services. The agency has also created a centralized immigration liaison position and whose role is to train, coach, and serve as a resource for agents in all matters associated with immigration policy and immigrant rights. In addition, the agency acknowledges the role language plays as a barrier to effective interventions. Documents are translated into Spanish, qualified translators are available, and many employees are bilingual.

Although many of the components of PSD's approach to working with undocumented immigrants from Mexico may be present in agencies across the United States, PSD can serve as a model for effective ways to coordinate international, federal, state, and local stakeholders in a

concerted effort to serve undocumented immigrants. Finno and Bearzi (2010) report the agency has experience providing services to families when a parent may be located in another country. Agents have been successful in obtaining Customs and Border Patrol permission and day passes so that Mexican parents can appear in court. Another barrier to serving families that PSD has demonstrated effectiveness with is securing birth certificates for children, especially since many Mexican hospitals do not issue these documents. A lack of a birth record not only complicates citizenship status, but also makes it difficult for Mexican adults to demonstrate parentage. The agency has also helped families obtain DNA tests to be able to prove citizenship.

When parents and children are separated due to workplace raids or other deportation events, PSD has had some success in coordinating visitations at border crossings even though there is no existing protocol for such meetings according to Homeland Security policies (Finno & Bearzi, 2010). The agency has also worked to navigate the complexities of familial reunification and has even advocated against reunification if it meant the moving the child "to a country and culture unknown to them, separating them from all known sources of strength and support" (Finno & Bearzi, 2010). The agency is currently advocating local and state agencies to be informed of immigration enforcement operations in an effort to assist the relatives, friends, and communities when children are left behind. Although there are many components of work with undocumented immigrants from Mexico that PSD and other border state social agencies are still attempting to effectively address, there is a wealth of knowledge that can be gained by collecting the experiences of practitioners in this region for other mental health professionals across the nation.

Factors Impacting the Mental Health of Undocumented Immigrants from Mexico

The case study highlights some of the complex issues impacting the mental health of

undocumented immigrants from Mexico. The sources of damage to the mental health of this population are multifaceted and can occur prior to migration, during the border crossing, and after settling in the United States. For this reason, it is essential that practitioners develop an understanding of the factors associated with the client's pre-migratory, migratory, and post-migratory experience.

Premigratory factors. The primary reasons why individuals and families choose to immigrate to the United States is due to financial necessity and to flee dangerous political events in their homeland (Partida, 1996). There is a scarcity of economic and employment opportunities among poor Mexicans in agricultural communities and many migrants first travel to larger Mexican cities in search of employment (Guarnaccia et al., 2005; Zuniga, 2004). Interest rates in Mexico preclude many from receiving loans to purchase land, homes, or businesses (Massey & Espinosa, 1997). As a result, some undocumented workers enter the United States in order to earn enough money to be able to return to Mexico and finance homes and businesses, due to the earning differential between the two nations (Guarnaccia et al., 2005; Taylor at al., 1996). Other undocumented immigrants attempt to make the United States a more permanent home in the hopes that they will be able to provide greater economic security for their families.

Violence and murder associated with the drug war in Mexico has also had a profound impact on Mexicans. According to the Mexican government's official tally, 47,515 people had been murdered in drug-related violence from 2006-2011 (Cave, 2012). Some researchers claim the number of homicides is nearly double what the government has reported and may be closer to 67,050 homicides between 2007 and 2010 (Cave, 2012). The war and the atrocities being committed against Mexican citizens by drug cartels and government forces have caused a new

wave of undocumented immigrants into the U.S. border region, refugees (Aguilar, 2012).

Juárez, Mexico, a border city that has long been known for criminal activity, has been particularly ravaged by bloodshed associated with the government war on the drug cartels. Rice (2011) reported of numerous murders: “beheaded bodies are left on busy streets, hit men open fire into crowds in broad daylight”. Over the past 4 years and assisted by U.S. military and law-enforcement, President Felipe Calderón has sent thousands of soldiers into Juárez, inciting a bloody power struggle with the cartels (Rice, 2011). Rice (2011) reported that there has been a tenfold increase Juárez’s murder rate; in 2010 there were 3,000 homicides, while neighboring El Paso, Texas had only 5 murders. Few residents of El Paso make the brief trip across the bridge into Juárez anymore and much of Juárez’s middle and upper class community has moved into the U.S. “taking their money, businesses, even their private schools with them, forming an affluent community in exile” (Rice, 2011). Many poor Mexicans have also fled to El Paso and since 2009, the Texas city’s population has increased by 50,000 with a significant percentage of them coming from Juárez. Some refugees in El Paso have formed *Mexicanos en Exilio* (Mexicans in Exile), to disseminate information about the war and to advocate for the rights of the victims. Unfortunately, the experiences of Mexicans living in Juárez are not unique and are repeated in communities across the nation. Citizens of Cadereyta Jiménez in the state of Nuevo León have witnessed: “mangled corpses turning up on street corners and inside restaurants, hung from bridges, and buried in mass graves” (Archibald & Cave, 2012). In light of this violence a resident commented, “We are coming to terms with the idea that we may leave our houses and not come back” (Archibold & Cave, 2012). Given the murder and chaos associated with the war, many more immigrants, who may be better characterized as refugees, can be expected to make the perilous journey into the U.S.

Migratory factors. There is significant danger, both physical and psychological, associated with immigration and specifically undocumented immigration by Mexicans. Studies have demonstrated that theft, violence, and sexual assault are common experiences during the migratory process (Falcon, 2001; Martinez, 1998; Ugarte, Zarate, & Farley, 2003). There is also evidence of abuse of undocumented immigrants from Mexico by U.S. Border Patrol agents. Although statistics on rape along with the U.S.-Mexico are "nonexistent" (Falcon, 2001), there have been several indictments of Border Patrol agents associated with the sexual assault of undocumented women from Mexico. Oftentimes, the assailants use the fear associated with possible incarceration and deportation as a weapon to secure women's silence. Women have reported "being raped was the price exacted of them to cross the border without being apprehended or deported, or to receive their confiscated documents" (Falcon, 2001). Martinez (1998) reported that Mexican women preparing to cross into the U.S. sometimes begin taking birth control pills, because they anticipate the potential for "violent rape and the demand for sex as the price of safe passage to *el norte*" (p. 58).

The militarization of the U.S. Mexico border in the name of homeland security and the War on Drugs has made border crossings even more treacherous (Falcon, 2001; Zuniga, 2004). The investment in new technologies to track and apprehend individuals attempting to enter the United States and the construction of a more impenetrable border fence has resulted in immigrants taking more dangerous routes. For example, the crossing of contaminated rivers polluted with raw human sewage and farm runoff has made immigrants vulnerable to contagious disease (Gross, 2000). Mexican immigrants also risk freezing in winter temperatures as they navigate rocky mountainous terrain or the danger of death associated with dehydration, exposure, and heat stroke while walking across desert expanses (Zuniga, 2004).

Many benefitted from a lucrative business associated with services associated with unauthorized border crossings. Known as *polleros, coyotes*, or *pateros*, they coordinate the smuggling of Mexican immigrants into the United States (Dwyer, 2010). The fee associated with hiring a coyote can be several thousands of U.S. dollars, a hefty sum that generates hardship among members of families. Ugarte and colleagues (2003) reported that coyotes and other traffickers have also been known to prey on undocumented Mexicans, committing abduction, rape, and murder. Sometimes immigrants are left to the elements by coyotes or are held for ransom, in both cases, assured the crimes will most likely never be reported by their victims (Ugarte et al., 2003). The researchers also report that coyotes may work in concert with pimps, where women and children may be entered into lives of commercial sexual exploitation as payment for their passage or might be sold outright into the sex trade, never reaching their intended destination. Encountering bandits who roam the border corridor is also a threat and can result in assault, rape, and robbery (Zuniga, 2004). Overall the threat and reality of death, assault, and injury associated with border crossings can lead to PTSD and other mental health vulnerabilities (Zuniga, 2004). The Diagnostic and Statistical Manual – Fourth Edition (2000) specifically addressed the vulnerability of PTSD among recent immigrants, highlighting factors common among undocumented immigrants from Mexico,

> Individuals who have recently emigrated from areas of considerable social unrest and civil conflict may have elevated rates of Posttraumatic Stress Disorder. Such individuals may be especially reluctant to divulge experiences of torture and trauma due to their vulnerable political immigrant status (p. 465).

Postmigratory factors. As demonstrated earlier, undocumented immigrants from Mexico face many factors associated with mental health indicators before entering the United States. But once families have begun the process of settlement in their new land, another system of forces can come into play that may negatively impact their mental health outcomes.

Undocumented immigrants from Mexico in the United States experience an atmosphere of economic exploitation, racism and persecution, fear of deportation, and forced separation from family, in addition to the already challenging stressors associated with acculturation that most immigrants encounter including language differences, absence of support systems, and encountering unfamiliar customs (Smart & Smart, 1995; Hancock, 2005).

Acculturation. As Mexican immigrants begin to live and work in the U.S., they may begin to experience negative mental health outcomes associated with acculturation. The process of acculturation is multidimensional as it "strengthens some aspects (i.e., ethnicity) and/or potential erodes other aspects (e.g., family cohesion) of the native culture as one begins integrated with the host culture" (Alegria & Woo, 2009, p. 17). There are many stressors associated with acculturation, including stress related to language, perceived discrimination, and perceived cultural incompatibilities (Alegria & Woo, 2009; Suárez-Orozco & Suárez-Orozco, 2001). Acculturative stress has been linked to depression, anxiety, substance abuse, decline in physical health, and reduction in coping skills and the risks for mental health problems due to acculturation appear to increase over time (Alegria & Woo, 2009; Thoman & Suris, 2004).

In addition, changes in values and norms through the process of acculturation can disrupt relationships as gender roles shift in Mexican immigrant families, leading to stress and the increased potential for domestic violence (Coltrane et al., 2004). The process of acculturation has been shown to lead to a lack of commitment to some culturally embedded values and behaviors that can negatively impact family relationships. Parental control may also be threated as children identify more closely with American values and less with Mexican cultural norms (Fontes, 2002). As parents work to maintain the family dynamic, traditional childrearing and disciplinary practices may become suspect and may also lead to involvement with child protective agencies

(Fontes, 2002; Olayo Mendez, 2006). It is necessary that clinicians assess the acculturation level of their Mexican immigrant clients and develop treatment interventions that include strategies for coping with stress associated with this process.

Prejudice and discrimination. Undocumented immigrants suffer hardships due to their exclusion from mainstream society. Moral exclusion exempts marginalized groups from fair treatment and their vilification can be used as a political tool of oppression (Deutsch, 2006). Deutsch (2006) writes that this can arise especially in times when there is economic hardship, war, social upheaval, and civil strife, such as today's climate. Once living in the United States, undocumented immigrants are often exposed to a climate of discrimination and prejudice (Guarnaccia et al., 2005; Zuniga, 2004). The experience of racial/ethnic discrimination by Latinos is associated with higher incidence of PTSD symptoms (Flores et al., 2010).

Due to their undocumented status, many Mexican immigrants experience housing, police, and job discrimination. Workplace exploitation is common, with workers experiencing dangerous and unhealthy conditions with substandard pay. Landlords have been known to charge excessive rental fees and provide hazardous living conditions, because they know their tenants will be fearful to contact authorities (Zuniga, 2004). Finally, there have been substantial cases of police harassment and the abuse of undocumented immigrants from Mexico. For example, Arizona sheriff Joseph Arpaio is facing indictment for abuses of authority by the Justice Department of anti-Latino bias (Nagourney, 2012).

Occupational exploitation and poverty. Chomsky (2007) asserted that,

> Noncitizens work, pay taxes, go to school, and raise families; they live in our cities and towns; they participate in religious, sports, and community events; they serve (in disproportionately large numbers) in the military... [yet] both the law and popular opinion deem them somehow different from the rest of us, and not eligible for the rights and privilege that 90 percent of the population enjoys (p. xiii).

One form of marginalization that oppresses undocumented migrants and privileges U.S. citizens is poverty. According to Nathan (1992), our nation's sociopolitical status quo is a factor in this marginalization,

> Capitalism everywhere is basing its survival and growth on making people work for long hours at rock bottom wages without unions or occupational safety or decent housing or environmental controls – in other words violating tenets of human decency and dignity whose enactment into reality and statute was part of the historical project of the past century (p. 12).

The availability of jobs, even those that are low paying, has led to over-population of Mexican border towns and the large pool of workers "has functioned well as a reserve labor force for the U.S." (Mendoza, 1994, p. 125). The resulting oversupply of labor creates a situation that favors owners and employers, who can offer increasingly low wages and still expect to find workers who must accept them; moreover, ordinary middle-class Americans who hire undocumented housekeepers and yard workers can often be counted among these employers (Mendoza, 1994).

Discrimination and prejudice also impacts families' financial resources, as government restrictions and hostility toward undocumented immigrants provides for typically undesirable job opportunities (Ugarte et al., 2003). The vast majority of farmworkers are immigrants (81%) and 95% of these immigrants were born in Mexico (National Agricultural Workers Survey, 2000). Mexican American farmworkers are often required to work long hours in back breaking work while being exposed to dangerous toxins. According to the General Accounting Office (2000) approximately 950 million pounds of pesticides are utilized in the U.S. agricultural system, exposure to which has been shown to cause cancer, cognitive impairments, and neuropathy. There is also an increase in risk for substance use to deal with the untenable working and living conditions. Researchers have also reported that the experience of "ethnic discrimination, job

mobility, economic decline in the southwest, and frustrated social and material aspirations lead to a rise in psychological distress and disorder" (Guarnaccia et al., 2005, p. 24).

Given the socio-cultural factors mentioned earlier, it follows that a large percentage of undocumented families are living in poverty. Studies have shown that 20% of undocumented adults and 33% of children of undocumented parents are living in poverty (Passel & Cohn, 2009). Undocumented immigrants from Mexico have less formal education and are more likely to have fewer financial resources including lower incomes than other undocumented groups (Passel & Cohn, 2009). The absence of health insurance and economic capital can lead to lack of health care and mental health care (Finch, Frank & Vega, 2004; Marin & Escobar, 2002). Many Mexican families rely on the money sent home from undocumented immigrants living in the U.S. and immigrants may not be able to provide for their own meager sustenance as a result (Zuniga, 2004). The physical and psychological health of undocumented immigrants is also very vulnerable to economic downturns and associated unemployment trends.

Living in poverty has been associated with increased psychological symptoms of depression and anxiety among individuals regardless of gender, age, and ethnicity (Belle & Doucet, 2003; Wadsworth & Santiago, 2008). The association between living in poverty and decreased social and community supports may also increase psychological stressors (Belle, 1990; Samaan, 2000). There is also a connection between poverty and poorer physical health including "elevated rates of threatening and uncontrollable life events, noxious life conditions, marital dissolution, infant mortality, many diseases, violent crime, homicide, accidents, and deaths from all causes" (Belle, Doucet, Harris, Miller, & Tan, 2000, p. 1160). In addition, the health of poor families in the United States is negatively impacted by access to fewer health-promoting resources, lower-quality treatment, and the exposure to classist attitudes among health care

professionals (Lott, 2002).

Fear of deportation and familial separation. There has been an increase in the criminalization of working in the United States without legal immigration status, resulting in mass incarcerations and deportations. As a result of this crackdown, there has been a rise in workplace raids from 850 arrests in 2004 to 4,940 arrests in 2007 (Bacon, 2008). These raids and the accompanying arrests have contributed to the fear and anxiety experienced by many Latinos. Lopez and Minushkin (2008) found that 40% of Latinos they surveyed worried "a lot" that a member of their family, a close friend, or they themselves might be deported from the United States due to undocumented status. While working with undocumented immigrants, Carbonell (2005) found that many clients experienced insomnia, recurrent nightmares and sleep disruption, and symptoms of paranoia and post-traumatic stress disorder.

Parker and Ballve chronicled the fear and anxiety experienced by the workers at a rural slaughterhouse in Postville, Iowa after a terrifying immigration raid in 2008. The employees of the plant were primarily Mexican and Guatemalan and most were not authorized for employment in the U.S. They worked six days a week and only earned $8 an hour during arduous 13-hour shifts packing chicken parts. The authors collected first-hand accounts of the trauma and community distress associated with the raid. According to eyewitness reports, "the workers hid in meat-lockers, freezers, bathroom stalls or under stacks of cardboard boxes. One worker hid within a mound of chicken feathers, another in a tub of blood and guts" (Parker & Ballve, 2008). In one interview, an undocumented mother from Mexico stated, "At night I can't sleep, because I am afraid someone is going to come and grab me." Another worker reported, "I'm just still afraid, because when they came after us, people were crying, others screamed, others ran; it was like a war in there. One still feels very sad, and very afraid."

In addition to inciting lasting fear and anxiety among those affected by immigration raids, the result of the associated incarcerations and deportations has also contributed to a rise in the experiences of separation from family among undocumented immigrants from Mexico. Immigrant families from Mexico can have diverse immigration statuses and according to Passel and Cohn (2009), 5.5 million children in the United States have at least one parent who is not a U.S. citizen while 75% of children in these families are citizens themselves. Due to the potential for a single family to have members who have documented and undocumented statuses, the possibility for forced familial separations due to deportation is a very real threat.

A recent study reported that for every three adults deported from the United States to Mexico, one child is abandoned in the United States (Trevino, 2008). Furthermore, Trevino (2008) reported that in the beginning of 2007, 90,000 children were deported by the United States to Mexico without a parent or caregiver. Also, children of undocumented Mexican immigrants have been found to have more parent-reported developmental-risk than children of U.S. citizens or documented immigrants (Ortega, Horwitz, Fang, Kuo, Wallace, & Inkelas, 2009). Cavazos-Rehg, Zayas, and Spitznagel (2007) found that fears surrounding possible deportation created in an increased risk for stress, decreased emotional wellbeing, and a limited use of health services. Children who experience parent-child separations are more prone to experience depression and additional stressors than children who have not been separated from their parents (Suarez-Orozco, Todorova, & Louie, 2002) and these effects may be life-long (Partida, 1996).

Financial factors also necessitate that Mexican families may need to immigrate in stages, sending some members ahead and leaving others behind (Partida, 1996). Similar to forced separations, even separations without incarceration and deportation can cause anxiety,

depression, and PTSD in family members (Smart & Smart, 1995). Overall, more studies are needed to identify how Mexican families are fairing in this climate of immigration-related stress due to forced separations and separations required by financial factors and the trauma associated with the fear and lived reality of incarcerations and deportations.

Factors Impacting Undocumented Mexican Immigrant Use of Health Care in U.S.

Many nativist politicians and groups have made the claim that access to benefits, such as health care and welfare, draws undocumented immigrants into the United States. As mentioned earlier, Republican Governor of California from 1990-1998, Pete Wilson, championed Proposition 187, a law that prevented undocumented immigrants in California from accessing health care, public education, and other services. Although the law was deemed unconstitutional and was never put into effect, it highlighted the controversial nature of providing aid to undocumented immigrants from Mexico. Anti-immigration activists have asserted that the burden of caring for undocumented immigrants siphons necessary resources from U.S. citizens. As a result, the availability of publicly funded health services declined in the mid-1990s after the introduction of legislation restricting access to undocumented immigrants (Kullgren, 2003). In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which constricted benefits at both the state and federal level to immigrants who were legal permanent residents of the United States, but not yet citizens. By creating extensive limitations to the services available to documented immigrants, it served to further restrict access to these benefits to undocumented immigrants.

Studies have demonstrated, however, that access to health care and other benefits programs are not the driving force behind undocumented immigration from Mexico. In a 2000 study of 972 undocumented Latino immigrants (90 percent of whom were Mexican) living in El

Paso and Houston, Texas and Fresno and Los Angeles, California, most of the respondents cited occupational opportunities as their main reason for entering the United States (Berk et al., 2000). Another major impetus for immigration was the chance to reunite with family members and friends. The results of this study demonstrated that less than 1 percent of all respondents stated that the most important reason for entering the United States was to secure social services.

There are few studies that explore the patterns of mental health service utilization among undocumented immigrants from Mexico. There are several factors that may impede the ability for researchers to gather information on this population. One obstacle is that U.S. hospitals rarely, if ever, collect information about their patients' immigration status (Okie, 2007). Studies have also cited the "hidden" nature of the undocumented immigrant population and the reluctance to report immigration status as contributing to sampling challenges when attempting to include them in research (Perez-Escamilla, Garcia, & Song, 2010). Although there is little knowledge regarding undocumented immigrants from Mexico and their use of U.S.- based health care services, some researchers have attempted to begin to fill in some of our gaps in understanding.

As highlighted earlier, undocumented Mexican immigrants face significant obstacles to obtaining health care and other services that promote positive health outcomes once in the United States (Okie, 2007). Many state and federal benefits programs including Medicaid, Social Security, Supplemental Security Income, Aid to Families with Dependent Children, subsidized housing, and food stamps are not available to undocumented immigrants. It is extremely difficult to assess, however, the health services that are actually being utilized by undocumented immigrants from Mexico. Studies have shown that the overall Mexican American community tends to underutilize mental health services (Vega & Alegria, 2001; Vega et al., 2001).

According to the Mexican American Prevalence and Services Study (MAPPS), approximately a quarter of Mexican Americans who met criteria for a DSM diagnosis interviewed mental health services actually sought psychological treatment (Vega, Kolody, Aguilar-Gaxiola, Alderate, Catalano, & Carveo-Anduaga, 1998). The researchers also found that Mexican immigrants only utilized 40% of the mental health services that U.S.-born Mexican Americans accessed. Furthermore, when Mexican Americans do seek assistance for psychological distress, they often reach out to general medical practitioners as opposed to contacting mental health providers.

Undocumented immigrants from Mexico, however, utilize medical services at even lower rates than their Mexican American or documented counterparts. The Hispanic Immigrant Health Care Access Survey, Project HOPE, reported that undocumented immigrants have fewer ambulatory physician visits and fewer hospital admissions, with the exception of those associated with childbirth, than the U.S. population as a whole. Furthermore, undocumented immigrants had much fewer physician visits, from 27% to 50% versus the national average of 75% (Berk et al., 2000). Overall, undocumented immigrants from Mexico rarely utilize social services designed for adults.

Although not specifically designed to explore the treatment patterns of undocumented immigrants solely from Mexico, Perez and Fortuna (2005) conducted a psychiatric chart review at a New York City-based hospital in order to explore the rates of mental health service use among undocumented, documented, and U.S.-born Latinos. The researchers found that the 29 undocumented Latino immigrant patients (primarily from Mexico and South America) studied were much less likely to have received previous inpatient and outpatient mental health services than their documented or U.S.-born Latino counterparts. The undocumented patients also had fewer appointments associated with psychological treatment, although they attended these

sessions at a rate comparable with the other two groups. Overall, despite the increase stressors experienced by the undocumented Latino immigrant patients the hospital served, these patients had less frequent clinical appointments and received shorter treatment courses than the other two groups studied.

Undocumented immigrants from Mexico utilize some services, specifically those available to the children, more regularly. For example, almost half of the undocumented immigrants and their family members in El Paso surveyed participated in the Women, Infants, and Children (WIC) program which provides supplemental food to women and their children up to age 5 who are deemed at nutritional risk (Berk et al., 2000). Many undocumented immigrants and their children also utilize public education and related free-lunch programs. In 1997, 67% of undocumented immigrants in El Paso, 50% in Fresno, and 40% in Los Angeles had at least one child in the area's public school system and 90% of those children received free or reduced fee lunches at school (Berk et al., 2000). It is important to remember, that although parents may have undocumented status, many of their children are legal citizens and are eligible for state and federal services available to all U.S. citizens. Despite the challenge made by anti-immigration advocates, the possibility of obtaining social services does not appear to be a significant incentive among undocumented immigrants from Mexicans, nor does further restriction of services seem to be an effective way to reduce unauthorized border crossings.

Many studies have shown that there is significant fear associated with accessing medical services due to undocumented status. Legal status is often a barrier to access to health services leading to mistrust and fears of deportation (Smart & Smart, 1995). Berk and Schur (2001) found that 39% of the 756 undocumented Latino immigrants they surveyed in Texas and California reported they were afraid of not getting medical aid due to their immigration status.

The researchers found that this fear was associated with unmet requirements for prescription drugs, dental care, and eyeglasses. The 2005 Deficit Reduction Act requires citizenship verification that may increase this fear, because the bill requires individuals to present of their passport or birth certificate in order to determine eligibility for Medicaid coverage (Escamilla et al., 2010). For these reasons and those discussed earlier, serious health issues may also be ignored by undocumented immigrants from Mexico, due to fear of discovery of immigration status (Hargrove, 2006).

Although there have been studies that demonstrate that legal status is a barrier to access to health services, there has been little research about the interplay of demographic factors that influence the access to and use of health related services by undocumented immigrants. One study that addresses this gap in the literature surveyed 431 undocumented immigrants from Mexico living in New York City. Nandi and colleagues (2008) found that social and family networks are important keys to greater access to and use of health services among undocumented immigrants from Mexico. The researchers also found that social resources contributed to a greater likelihood of health insurance coverage and access to a primary care provider. Level of education also plays an important role, as participants who had completed at least some college were more apt to have received emergency health services in the past six months than those with less than a high school education. Gender differences among undocumented immigrants from Mexico also appear to impact their use of health services. In a study conducted by Nandi and colleagues (2008), women were almost 3 times more likely than men to endorse access to a "regular health care provider" (p. 2015). The researchers reported that this disparity might be a result of the women's needs for gynecological care and obstetric services. The study further found that undocumented immigrants' access to a regular health care provide increases as their

duration living in the U.S. increases, perhaps due to a greater level of integration within their host community and more familiarity with the U.S. health care system. Interestingly, increased levels of parental acculturation have been associated with greater health care access among Latinos (Escamilla et al., 2010).

The researchers also found that economic resources contributed to a greater likelihood of health insurance coverage and access to a primary care provider, which represent more positive health. The results of the study suggested that immigrants who sent remittances back to loved-ones in Mexico and those with less formal sources of income were less likely to have health insurance and access to primary care. In addition, the results of the study suggested that a significant barrier faced by undocumented immigrants who require health care may be the fear of their immigration status being identified to government officials and agencies. Given these anxieties, the researchers found that social support structures that can provide these individuals with information about the actual risk associated with accessing health care services helped to mitigate the fear experienced by the participants. Finally, the experience of discrimination reduced attempts to access services. Overall, the results of the study suggested that an increase in social resources, formal employment, and ability to negotiate the U.S. health care system were all associated with greater access to health care for undocumented immigrants from Mexico.

Research has also shown that many Mexican immigrants choose to return to Mexico to seek health care services instead of using U.S.-based doctors and hospitals. In a study of current Mexican immigrants, former immigrants who returned to Mexico, and Mexican physicians, Bergmark and colleagues (2010) highlighted some of the reasons Mexican immigrants travel back to Mexico to meet their health care needs. Study participants reported that one factor that influenced their decision to leave the U.S. health care system was due to unsuccessful treatment.

They attributed the potential for better communication with their physician and greater social support from family as contributing to the success of Mexican-based care. Participants in the study also expressed concern about discrimination in U.S. hospitals and doctors' offices. Many respondents stated the cost of care in United States health care institutions also influenced their decision to seek services in Mexico. They reported that they received a much better standard of care at a Mexican hospital for significantly less cost. Finally, respondents expressed a conflict between their expectations for effective treatment and their American physician's. Participants cited American doctors' emphasis on diagnostic exploration as counterproductive to their need for effective pain management and their wish to avoid extensive follow-up appointments. One respondent commented,

> We need relief [from illness] to be able to continue working. I cannot work, I go to the doctor and he told me I cannot… I have another appointment I have another appointment, many times we need the relief rapidly because we have to work for our families, right? (p. 123).

The timely and practical treatments offered by Mexican physicians were viewed as necessary, given the economic struggles faced by the patients.

For undocumented immigrants, making the crossing back into Mexico can seriously compromise their ability to return to the homes, jobs, and families in the United States. It is essential that practitioners working in the United States understand the factors that might influence an undocumented immigrant to leave their new home for health care in Mexico in order to either advocate for their admittance back into the United States once treatment has concluded and/or to make the necessary adjustments to our health care system to address the unique needs of this undocumented population.

The Mexican immigrant community experiences substantial stressors associated with discrimination, poverty, legal status, and acculturation that can lead to the development of

psychological problems that were not present before immigration. There is, however, a significant stigma associated with mental illness and the utilization of mental health services among Mexican immigrants. Many Mexican immigrant communities rely on religious and extended family to address mental health symptoms (Guarnaccia et al., 2005). As a result, there are significant barriers to seeking mental health services once in the United States. Many Mexican immigrants choose to seek support from the Catholic or Protestant churches they attend or to employ the services of *curanderos*, native healers (Guarnaccia et al., 2005). This does not mean that Mexican immigrants will not turn to U.S. medical services. Studies have demonstrated that the use of more indigenous forms of healing does not deter immigrants from seeking psychological support services in the U.S. health system simultaneously or later in the course of the illness (Guarnaccia et al., 2005). Mental health professionals can help undocumented immigrants from Mexico overcome barriers to seeking treatment, through collaborating with faith-based leaders and organizations while supporting indigenous forms of healing concurrently with psychotherapy (Sue & Sue, 2008).

Attitudes Towards Undocumented Immigrants from Mexico

Despite immigration being an important national debate in the United States and although there have been studies on attitudes toward immigration among U.S. citizens, little empirical research exists regarding the attitudes of mental health practitioners toward undocumented immigration and how these attitudes may impact the effectiveness of their interventions. Psychologists are not immune to the internalization of societal messages about undocumented immigrants from Mexico that may emerge in the form of prejudicial and discriminatory attitudes and behaviors – attitudes that the 2002 APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change directs them to address. Specifically, this

document encourages psychologists to commit to “developing a cultural awareness and knowledge of self and others” and charges psychologists to “strive to apply culturally–appropriate skills in clinical and other applied psychological practices” (APA, 2002).

In keeping with the goals expressed by the APA Multicultural Guidelines, it is essential that psychologists give “explicit attention to the unique experiences of immigrant populations, including the negative attitudes towards the group held by the host community” (Yakushko, 2008, p. 37). As mentioned, psychologists are already and will continue to provide services to immigrant communities (Yakushko, 2008), and a better-developed understanding of attitudes held by Americans towards undocumented immigrants from Mexico can enable these clinicians to acknowledge the sociocultural factors that may be negatively impacting the mental health of their clients in both traditional and emerging settlement states. Not only can attention to these attitudes help educate mental health practitioners about immigrants’ needs, it can also contribute to the establishment of more accepting attitudes toward Mexican immigrants now living in American communities.

Group identification and attitude development. The examination of attitudes toward Mexican immigrants begins with an understanding of group identification. Group identification can be understood as how an individual aligns him or herself with the common experiences, values, attitudes, and beliefs of others. Group membership can be based on geographic location, race, ethnicity, gender, political affiliation, religion, education, and many other factors. Studies have shown that Americans living in the proximity of the U.S.-Mexico border may actually be more tolerant towards undocumented immigrants. For example, increased contact with a group has been shown to increase favorable responses with group versus contact with members of competing group generate negative orientation towards group. A study conducted by Hood and

Morris (1997) demonstrated that Intergroup Contact Theory might explain favorable Anglo attitudes towards Latinos. Hood and Morris (1997) found that Anglos living among communities of Latinos have a more positive view of the group and as a result, favor more lenient legal immigration policies. This finding supports the *contact hypothesis* that suggests antagonistic groups create negative expectations of each other and will also attempt to avoid contact (Rothbart & John, 1993, p. 42). As contact occurs, however, the "unrealistically negative perceptions of the group members are modified by experience" and "hostility is reduced as a result of increasingly favorable attitudes towards individual group members, which then generalize to the group as a whole" (Rothbart & John, 1993, p. 42).

Accordingly, group identification is thought to influence attitude development (Conover & Feldman, 1984). As outlined below, the results of previous research have suggested that several components of group identification may influence attitude development, including race, ethnicity, social class, political affiliation, and religious identification. Knowledge of the cultural composition of the host community, vis-à-vis group memberships, can assist a clinician in understanding factors that may contribute to a tendency toward positive or negative attitudes and therefore a more accepting or more marginalizing climate toward undocumented immigrants from Mexico who settle in these communities. An understanding of how the values and assumptions associated with group memberships may enable clinicians in developing a better sense of their own hidden biases and prejudice in working with this population.

Race and ethnicity. Biases regarding race and ethnicity may also operate with regard to attitudes toward Mexican immigrants. Race has been defined as "a characterization of a group of people believed to share physical characteristics such as skin color, facial features, and other hereditary traits" and these racial designations can include White, Black, Asian and Pacific

Islander, Native American, and Latino (Cokley, 2007, p. 225). Ethnicity, on the other hand, refers to "a characterization of a group of people who see themselves and are seen by others as having a common ancestry, shared history, shared traditions, and shared cultural traits such as language, beliefs, values, music, dress, and food" (Cokley, 2007, p. 225). Ethnicity can therefore be considered more mutable and subject to individual selection in that it is not as closely tied to phenotypic distinctions (Cokley, 2007). Racism can take many forms and can include an individual's feelings, attitudes, and beliefs that their racial group is superior to others (Jones, 1972).

Racist attitudes among Anglos have been shown to increase opposition to affirmative action, welfare allocations, tax increases, and busing students. Hood and Morris (1998) demonstrated that Anglos showed an increase in positive attitudes towards immigration as the relative percentage of legal immigrants increased in the local area. When the relative numbers of undocumented immigrants grew in the community, however, Anglo support of increased immigration waned. In a study conducted by Ayers and colleagues (2009), data from 549 Anglos was gathered using a telephone survey in San Diego County, California. The researchers found that although reported contact with Latino populations had little impact on Anglo attitudes towards legal immigration, contact did increase support for amnesty for undocumented immigrants already living in the U.S. Furthermore, aversion to Latinos and racism was shown to negatively influence attitudes toward immigration among Anglos.

Other research has shown that Latinos, and Mexican-Americans specifically, are more likely to support liberal immigration policies than are Black or Anglo U.S. citizens (Cain & Kiewiet, 1986; Espenshade & Calhoun, 1993; Harwood, 1983; Miller, Polinard, & Winkle, 1984). De la Garza and colleagues (1991) demonstrated that Mexican-American attitudes

towards employment and amnesty for undocumented immigrants might be impacted by individuals' experience of cultural affinity with recent immigrants. Strong ethnic salience may influence Latino attitudes towards immigration more than indicators of SES. The impact of racial and ethnic identification may also lead to more lenient attitudes towards undocumented immigration in the border region as it contains the highest concentration of Mexican-Americans in the United States (U.S. Census Bureau, 2010).

Social class membership. Studies have demonstrated social class position influences an individual's views on immigration and certain social class memberships are associated with experiencing greater perceived threat from immigrants. Social class can be understood as describing the extent to which an individual has access to socioeconomic power and privilege (Smith, 2010). Leondar-Wright (2005) developed working definitions of social class that can be used to highlight the various components that construct these strata including an individual's income, accumulated wealth, access to power, and position in society.

Leondar-Wright characterized poverty as a chronic state of insufficient income to meet basic needs. Those living in poverty may be homeless or live in substandard housing, may be dependent on public benefits, may experience a consistent lack of food and health care, and may experience persistent disruptions in their life such as involuntary moves and other disruptions. Those who occupy a working class position often have little or no college education, a low or even negative net worth, low income, typically live in rental housing or may own a modest home, and work in jobs that offer little personal control or involve physical labor. Individuals belonging to the middle class typically have college degrees and often work as salaried professionals.

The middle class has been described by Leondar-Wright as typified by secure home

ownership, a greater level of control in the workplace, more financial security than members of the working class. In addition, the middle class benefits from social status and connections that enable their children to remain middle class. Finally, individuals whose investments provide sufficient income such that work is not necessary to maintain their quality of life constitute the owning or upper class. Owning or upper class membership can be defined by an elite education achieved without the burden of student debt, extensive inheritances and familial wealth, access to luxuries, multiple home ownership, and extensive socioeconomic power. The owning or upper class also is able to provide their children with the connections and information necessary to ensure their future position in this class membership.

As mentioned earlier, social class membership can affect whether an individual feels that their livelihood may be threatened by undocumented immigration. This perception that one group's loss is another group's gain leads to prejudice, stereotyping, intolerance, and discriminatory behavior (Sidanius & Pratto, 1999, Chomsky, 2007). Hood and Morris (1998) asserted that individuals might develop restrictive immigration policy attitudes because they believe continued or a larger population of immigrants who are low-skilled and less-educated may be economically draining and lead to higher taxes and an increased demand on social services. Competition for scarce resources, whether economic, social, or cultural, has also been shown to lead to conflict among groups and "proximity among competing groups will accentuate such conflict" (Hood & Morris, 1998, p. 3).

Individuals who are economically disadvantaged, coming from a low income, employment status, education, or occupational category, may feel a greater threat from migrants and therefore are also likely to be supportive of restrictive immigration policies (Espenshade & Calhoun, 1993). This may be due to the lack of personal financial threat posed by the perceived

low-wage and low-skilled jobs held by undocumented workers (Hoskin & Mishler, 1983; Espenshade & Calhoun, 1993). Miller and colleagues' (1984) findings demonstrated that among middle- and upper-class Mexican Americans, increased immigration was perceived as a threat to their socioeconomic status. Conversely, in a study focused solely on Mexican-Americans, however, De la Garza and colleagues (1991) discovered no relationship between SES and immigration attitudes.

Level of education has also been shown to impact attitudes towards immigration. Burns and Gimpel (2000) found that decreases in education level among White participants were associated with increased racial prejudice toward Latinos and support for decreased immigration. Hoskin and Mishler (1983) demonstrated that an increase in education is related to more positive perceptions of immigrants and support for more liberal immigration policies. The authors conducted a multi-nation study of attitudes toward immigration, utilizing 1,843 respondents in Great Britain, 2,955 respondents in Germany, and 2,819 respondents in the United States. Among their American respondents, those with minimal education levels (grade school and high school) reported much more hostility toward immigrants than those with college degrees. Those in the German and British data set with higher education levels were also more likely to be more receptive and less hostile to immigrants. These results illustrate a trend whereby higher social class memberships are associated with more receptivity and less hostility toward undocumented immigrants. Based on their results, the authors assert that education level may actually be a stronger indicator of attitudes toward immigration than social class.

Political identification. Political identification refers to an individual's identification with the economic, social, and other policies associated with political party membership. Political ideology plays an important role in the conceptualization of public opinion and is likely

to play a part in the development of immigration attitudes (Burns & Gimpel, 2000; Citrin, Reingold, & Green, 1990). In response to issues of immigration, the Republican Party endorses the completion of the fence along the U.S.-Mexico border and increased border security (Republican National Convention, 2008). The party's platform opposes amnesty and prohibits undocumented immigrants from receiving driver's licenses, in-state tuition at U.S. universities, and public benefits. Furthermore, the Republican Party supports English as the official language of the nation and opposes bilingual education.

Although the U.S. Democratic Party's political platform also supports securing the nation's border, it differs significantly in its views towards immigration. The Democratic Party supports increasing immigration visas and supporting undocumented immigrants currently living in the U.S. to become citizens (Democratic National Convention, 2008). The party backs the DREAM Act, which would provide undocumented youth living in the U.S. the ability to gain citizenship through education or serving in the armed forces. Finally, the Democratic platform includes the support of bilingual education.

Understanding individuals' political party affiliation can be used to predict their views on certain social and economic issues, as voters tend to support the policies of their party. In addition, an individual's demographics can influence his or her political party membership. Among U.S. counties that typically vote Republican, an average of 93% of the population is comprised of native-born Americans (Doherty, 2006). Democratic counties and swing districts (districts that alternate support between Democratic and Republican candidates) often have a different makeup and tend to have twice as many foreign-born residents. Approximately half of the residents of Republican-and swing counties believe that "immigrants threaten American customs and values" and the majority believe that "immigrants living in the U.S. illegally should

be required to go home" compared to 44% of Democratic counties (Doherty, 2006). Simply stated, research has shown that in counties with dominant Democrat support, immigrants are more populous and more welcomed by their host community (Doherty, 2006)

In a study conduced by Neiman, Johnson, and Bowler (2006), the authors found that both Democrats and Republicans in Southern California express misgivings about immigration. The researchers gathered survey data from 559 individuals living in Riverside County, a community east of Los Angeles County and north of San Diego and Imperial Counties. Southern Riverside County is located approximately one and a half hours drive from Mexico. Overall, the authors concluded that Republicans demonstrate more negative attitudes toward immigrants and the impact of immigrants. The Republicans in their sample also expressed a preference for a decrease in immigration to the United States than their Democrat counterparts. Democrats, however, perceived fewer benefits and more harm associated with immigrants.

Although the Democratic Party platform demonstrates a greater tolerance for undocumented immigrants, the results of a study conducted by Branton, Dillingham, Dunaway, and Miller (2007) belied the assumption that Democratic voters closer to the U.S.-Mexico border would be less supportive of nativist policies. Using field poll data, the authors conducted research on the relationship between proximity to the U.S.-Mexico border and White Democratic support of Propositions 187 and 227. The results of their study indicated that proximity to the border actually increased nativist initiative support and decreased liberal immigration policy support by these Democrat voters, while support of the bill did not change as proximity to the border increased. The researchers concluded that even though Democrats in general are more likely to support less restrictive immigration policies, their support of nativist initiatives increases as their proximity to the border decreases.

Religious affiliation. Religion is a powerful component of cultural identity and impacts worldview and values (Fukuyama, Hernandez, & Robinson, 2007). Religious identification refers to the organized and prescribed system of faith, worship, traditions, and rituals associated with an individual's particular belief system (Worthington, 1989). Religious identification has been shown to influence views on undocumented immigration.

The Catholic Church has a history of supporting the rights of undocumented immigrants and supporting immigration reform policies (Keogan, 2002; Knoll, 2009). For example, the Pope and other church leaders vehemently and vocally opposed California's nativist bill, Proposition 187 (Mehan, 1997). The values of a religious body can impact the views of its parishioners. Knoll's (2009) study of religion and immigration policy attitudes surveyed 3,511 individuals and found that Catholics who attended religious services more frequently were more likely to endorse liberal attitudes towards immigration policy than those who never attended worship services. This supports Welch and Leege's (1988) assertion that the devotional style of Catholics or the frequency of attending religious services can be seen as a significant predictor of political policy attitudes. These respondents also agreed that undocumented migrants should be granted a form of legal status that would permit them to remain in the United States versus being deported.

The border region of the United States has a large percentage of Catholics as compared to most areas of the nation. The region along the U.S.-Mexico border is at least 25-50% Catholic, with some counties reporting even greater numbers (The Kennedy Directory, 2000). According to the Mexican government's 2000 census, 88% of Mexican respondents self-identified as Catholic (United States Department of State Bureau of Democracy, Human Rights, and Labor, 2006). It follows that differences in worldview may not stoke intergroup conflict between

Catholic residents and undocumented immigrants entering the United States because a major part of their worldview would be shared. In fact, the religious homogeneity could potentially create a sense of solidarity as opposed to animosity.

Implications for Mental Health Practice with Undocumented Mexican Immigrants

In 2005, more than 35 million people living in the U.S. were foreign-born (Chomsky, 2007). About one third of foreign-born people living in the U.S. are from Mexico and one third of all foreign-born individuals do not have legal status to reside in the country (Chomsky, 2007). The findings of the proposed study have practical implications for mental health professionals who are engaged in social justice advocacy and who work with immigrant communities, specifically those without legal immigration statuses. Undocumented immigrants from Mexico are vulnerable to many oppressive forces including racism and classism. Their immigration status leaves them open to unfair labor practices and additional stressors associated with the fear of imprisonment and deportation. Furthermore, as the result of their undocumented status, undocumented immigrants from Mexico may have little access to community-based supports or public agencies. Eighty percent of Mexican immigrants are likely to never receive treatment for psychiatric difficulties that may emerge from biological or circumstantial causes (Vega, Kolody, & Aguilar-Gaxiola, 2011). Overall, undocumented immigrants from Mexico are less likely to have group memberships that are associated with connecting to help-seeking services such as higher socio-economic status, extended social support systems, and knowledge of public mental health agencies (Keefe, 1982). Many undocumented immigrants experience trauma associated with the immigration experience and require the development of new coping skills and strategies in order to navigate a new land. The attitudes of the host community can lead to a more accepting or marginalizing experience for undocumented individuals and families.

Due to differences in socioeconomic status, established local support systems, acculturation levels, religious affiliation, and languages spoken, undocumented Mexican immigrants may furthermore be subject to increased stress combined with a more limited support network once in the United States (Ruiz-Beltran & Kamau, 2001). Undocumented immigrants often experience economic instability as result of sometimes having to pay a large amount of money for their passage into the United States in addition to the stress associated with elevated risk of incarceration, deportation, and potential for inhumane treatment by law enforcement (Chung et al., 2008). Yet, the economy of the United States continues to depend on immigrant labor, ingenuity, and sacrifice and there is no evidence that undocumented immigration is waning.

For psychologists working with undocumented immigrants from Mexico, knowledge of the unique experiences of their clients -- including an understanding of the issues surrounding the migratory process, the factors contributing to immigration attitudes held by the host community and mental health practitioners, and ways to navigate immigration policies – is essential to developing culturally-appropriate treatment strategies that are reflective of the needs and challenges faced by this population. A small body of literature advises therapists to accommodate the unique circumstances experienced by undocumented immigrants within a comprehensive approach to their clinical work with this population; for example, researchers have recommended that clinicians dedicate a substantial amount of time to gathering pertinent information about a client's immigration experience in order to assess for related trauma (Chung et al., 2008; Zuniga, 2004). Trauma associated with separation from family and community, possible negative interactions with police and border patrol, and the potential of fleeing regional instability can underlie the client's current presenting concerns (Negi & Furman, 2009;

Cervantes, Mejia, & Guerrero Mena, 2010). Given the distrust and fear associated with service agencies and the potential for deportation or detainment, counselors may find it challenging to create a safe and confidential space for undocumented immigrants to disclose their immigration status and to seek aid in securing necessary legal, health, employment, and educational services. This clinical picture becomes more even more complex in that, in addition to the stigmatization and procedural complexities associated with immigration status, undocumented immigrants from Mexico may also encounter discrimination based on having limited English proficiency, a marginalized ethnic identity, and a social class status marked by poverty and exploitation in the workplace.

The clinicians' challenge, therefore, is to knowledgeably address the breadth of sociocultural and political forces affecting the mental health of undocumented immigrant clients as they work to incorporate the nontraditional therapeutic functions suggested by Sue and colleagues (1998). For therapists working with undocumented immigrants from Mexico, this clinical work might also need to expand to include participating in community discussions, lobbying politicians, interfacing with school administrators, and otherwise challenging the status quo in order to contribute to the systemic change necessary to ensure that immigration policies reflect a concern for the physical, economic, and emotional health of their clients and their families. The results of the proposed study hold promise in illuminating the methods by which border practitioners navigate local and federal immigration laws and policies in their work with undocumented immigrants. When counselors have an understanding of the legal issues being encountered by their clients, they can not only contribute to their clients' emotional well-being, they can potentially advocate for and aid their clients in receiving educational, health, and employment support (Sue & Sue, 2008).

Summary

The Latino population in the United States is increasing at a rapid rate and Mexico continues to contribute the largest percentage of new immigrants (Chomsky, 2007). In addition, one third of all foreign-born individuals do not have legal status to reside in the United States (Chomsky, 2007). The economy of the United States continues to depend on immigrant labor, ingenuity, and sacrifice and there is no evidence that undocumented immigration is waning. The APA (2002) Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists encourages mental health practitioners to develop their own cultural awareness as well as to create culturally-appropriate interventions and practice when working with clients.

During the last 20 years, immigration from Mexico and Latin America has shifted from the traditional settlement states along the U.S.-Mexico border to new settlement states (Pew Hispanic Center, 2005). For example, Tennessee, Virginia, North Carolina and South Carolina have seen an influx in Mexican immigrants who travel to these states for work (Zuniga, 2004). These emerging settlement states have little experience with addressing the needs of these populations. Mental health practitioners outside of the border region have the invaluable opportunity to learn from the best practices among professionals in the states of New Mexico and Texas. Through exposure to the successes and challenges of border mental health practitioners, professionals across the U.S. can adapt and augment the interventions and services provided by their southwest neighbors. Furthermore, these practices can serve to inform the training of the next generation of counselors, psychologists, and social workers to meet the needs of our changing communities.

With the goal of addressing the gap in the psychological literature surrounding

psychological practice in the context of undocumented immigration, the proposed research study will address the following research questions:

- What are the challenges faced by mental health practitioners who provide services to undocumented immigrants from Mexico in the U.S.-Mexico border region?
- What are the ways in which immigration laws and policies affect this work?
- What is the impact of mental health practitioners' values and attitudes, vis-à-vis the intersection of their multiple cultural identities, on their work with undocumented immigrants from Mexico?
- What can the field of counseling psychology learn from the successes and failures of these mental health practitioners and how can these lessons translate into best practices for working with this population in other regions of the United States?
- What are the implications for training mental health practitioners who provide services to undocumented immigrants from Mexico?

Chapter 3

Method

The following section begins with a rationale for using a qualitative method, specifically consensual qualitative research, to collect and analyze the data gathered in the study. Next, the author will discuss the research sample. The study procedure including recruitment strategies, efforts to ensure participant confidentiality, the informed consent process, and the method of data collection will then be highlighted. There will also be an introduction to the instruments utilized in the study: the demographic questionnaire and interview protocol. The author will also review the potential ethical considerations raised by the study. The procedure for the data analysis will be described with special attention paid to the methodology and coding of the data. Finally, the structure of the research team will be outlined.

Rationale for Qualitative Research Design

The aim of this study is to discover the experiences of mental health practitioners who work with undocumented immigrants from Mexico and to make recommendations about what constitutes culturally responsive interventions for this population. Accordingly, due to the limited research done on the effect of values and attitudes associated with the intersections of border practitioners' identity, their perceived successes and challenges in working effectively, and the perceived impact of their training on their multicultural competency, a qualitative methodology is proposed for the study. According to Michelle Fine (2007), qualitative methods are "a way to humanize social experience, to place individuals in rich historic and social contexts, and to understand human behavior in all of its complexity" (p. 460). Counseling psychologists have often employed qualitative research designs to create studies that are at "complex and rigorous, grounded in the lives and words of participants, and methodologically

valid" (Fine, 2007, p. 460).

Consensual qualitative research (CQR) was developed by Clara E. Hill to address the limitations many counseling psychologists experienced when attempting to use traditional quantitative approaches to studying complex phenomena (Hill, Thompson, & Williams, 1997). CQR shares several characteristics of many qualitative methods (Hill et al., 1997). For example, data is gathered in natural settings and the researcher focuses on describing and not manipulating phenomena. In CQR as well as other qualitative methods, both process and outcome are examined. In addition, the conclusions are drawn from the data, instead of first developing hypotheses to be tested. Finally, there is a strong emphasis on understanding the studied phenomena from the position of the participant's experience and perspective. In this way, CQR can be considered constructivist, meaning, "people construct their reality and that there are multiple, equally valid, socially constructed versions of 'the truth'" (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005).

Although the development of CQR was influenced by existing qualitative methods, especially grounded theory, it departs from these methods in several ways (Hill et al., 1997). First, the researchers begin by determining their sample and then use the same interview protocol to gather the data from all participants before beginning an analysis of the data. Next, a team is convened to analyze the data using a process of consensus and an independent auditor is employed to verify the judgments made by the team. The data is coded into topic areas and these domains are later distilled into more abstract core ideas. Then the CQR team tabulates the frequency of cases within each category. Lastly, unlike grounded theory, CQR does not present findings using a hierarchical theory with subcategories and instead describes the findings across all of the domains in a non-sequential manner.

In CQR, researchers gather data using an interview protocol consisting of open-ended questions. The interview is semi-structured in nature, to ensure that the protocol does not inhibit spontaneous reflection by participants and supports participants in addressing experiences that they find to be most salient to their clinical work. Once the interviews have been transcribed, the dialogue between the interviewer and interviewee is analyzed. Unlike quantitative methods, CQR uses descriptive words as opposed to numbers to describe the studied phenomena (Hill et al., 1997). The researchers use labels such as *typical* or *variant* to convey the frequency of certain experiences described by the practitioners. CQR uses a smaller sample than most quantitative studies, because the data derived from these interviews are analyzed in an intensive and nuanced manner. The expectation is that CQR will provide the researcher with an in-depth understanding of the phenomenon. It is for all of the above reasons that this study proposes to utilize a CQR framework.

The CQR process is often described as inductive, meaning the conclusions of the research emerge from the data, instead of beginning the research process with the creation of hypotheses to be tested (Hill et al., 1997). The research team typically includes three to five individuals who work together to analyze the data. The use of a research team, as opposed to an individual researcher, ensures that a wealth of differing opinions is explored and limits researcher bias. Once judgments have been developed through consensus by the team, an auditor conducts a "stability check" to determine whether important aspects of the data have been omitted. Through the entire analysis process, the team returns to the raw data contained in the interview transcripts to confirm that the findings are grounded in the participants' words.

The CQR method is aligned with many aspects of feminist research theories (Hill et al., 1997). For example, CQR utilizes a team approach to analyze data, where members work

together to reach consensus through a process of collaboration and open dialogue. The team members also work diligently to develop an environment where all ideas generated during this process are valued and explored in order to create a shared understanding of the studied phenomenon. Furthermore, there is a particular emphasis placed on the awareness of emergent power dynamics and issues of equity among team members. Finally, the CQR process underscores the need to develop a respectful relationship with participants as well as among team members. As Hill and colleagues stated, "participants are experts on their inner experiences and researchers learn about the phenomenon from the participants" (1997, p. 522). Participant and researcher are understood to have an effect on one another, as the participant shares their experiences and thereby teaches the researcher about the phenomenon, the researcher also influences the participant's reflection through the use of clarifying questions (Hill et al., 2005). In this way, the researchers approach their participants with great respect and appreciation.

In most quantitative methods, a premium is placed on a large sample size in order to have valid, reliable, and generalizable results. In contrast, Patton (2002) noted, "the validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information richness of the cases selected and the observational/analytical capabilities of the researcher than with the sample size" (p. 245). Hill and colleagues (1997) recommend collecting data from 8 to fifteen participants when using a consensual qualitative research approach. A sample of 8 to fifteen participants enables the researcher to develop a vivid and refined understanding of the cases. Therefore, I recruited 12 participants for this study, which is consistent with these guidelines.

As previously mentioned, CQR does not utilize the same quantitative concepts to assess the level of rigor of the study. Instead, CQR addresses the level of *trustworthiness* or the "the

degree to which the results of the study can be trusted" (Hill et al., 1997, p. 556). Because of the inherent tendency toward subjectivity within qualitative research, CQR teams work hard to monitor both the process of data collection and analysis (Hill et al., 1997). Components of the CQR process designed to establish trustworthiness include the use of consensus, auditing, and the maintenance of all transcripts and raw data.

Throughout this process, there was a concerted effort to adhere to the consensual qualitative research method outlined by Clara Hill and colleagues (1997). Given the subjectivity inherent in CQR and the inability to control every aspect of the interview, the author ensured that every prompt in the protocol was delivered to each participant who participated in the study. Once transcribed, the principal investigator reviewed each transcript document while listening to the interview recordings to identify and correct any additions, omissions, or errors made during the transcription. The research team also closely followed the guidelines made by Hill and colleagues during the analysis of the transcripts. In addition, the team sought the feedback from the auditor at each critical juncture and carefully considered every recommendation. Finally, the team maintained a spirit of dedication to remaining truthful to the experiences of the study participants; each member approached the work of the CQR process with respect for the interviewees' narratives.

Research Sample

In order to gather information that captures the experiences of diverse practitioners, eligible participants for this study included licensed or license-eligible mental health professionals and practitioners currently in graduate training. Eligible participants therefore included psychologists, psychiatrists, mental health counselors, and social workers who have provided or currently provide individual or group psychotherapy with undocumented immigrants

from Mexico within the U.S.-Mexico border region. Specifically, for the purpose of this study, practitioners were recruited from the border states of New Mexico and Texas.

The sample was comprised of 1 male and 11 female participants who had worked with undocumented immigrants from Mexico in New Mexico (*n*=7), Texas (*n*=4), or in both New Mexico and Texas (*n*=1). Participants ranged in age from 26 to 44 (M=39.09, SD=5.34). One participant declined to report their age. Half of the participants identified as Latino/a (*n*=6) and half identified as White/European American (*n*=6). Most of the participants identified as middle class (*n*=9), while three participants identified as either upper middle class (*n*=1), lower middle class (*n*=1), or working class (*n*=1). Participants reported Christian (*n*=5), Catholic (*n*=3), and unaffiliated religious affiliations (*n*=4). In regards to political affiliation, the majority of participants identified as Democrat (*n*=6) or Independent (*n*=4), only one participant identified as Republican (*n*=1) and another declined to self-identify (*n*=1).

Participant level of education included having attained a Masters in Social Work (*n*=6), having attained a MA in Psychology and currently pursuing a PhD (*n*=3), having attained a PhD in Psychology (*n*=2), and working toward a Masters in Social Work (*n*=1). In addition, one participant had also attained a PhD in a field other than mental health. In terms of years working in the mental health field, participant experience ranged from 1 to 21 years (M=7.13, SD=5.42). Participant experience working with undocumented immigrants from Mexico ranged from 1 to 21 years (M=6.92, SD=6.17). All participants were either licensed or working under a licensed supervisor, licenses included Licensed Psychologist (*n*=3), Licensed Independent Social Worker (*n*=3), Licensed Professional Clinical Counselor (*n*=3), Licensed Mental Health Counselor (*n*=2), and Licensed Master Social Worker (*n*=1)

Procedure

Recruitment. I contacted southwestern universities, community-based agencies, and social justice organizations in the border-states of New Mexico and Texas to recruit mental health practitioners for the study. In addition to conducting outreach to these institutions, I also contacted practitioners in professional networks in the border-states for possible participant referrals and spoke to potential participants at professional conferences. The recruitment strategy incorporated telephone calls, emails, and snowball sampling. Recruitment materials included flyers and electronic PDFs that contained a brief description of the study and my contact information. Practitioners who were interested in participating in the study were advised to contact me via telephone or email to receive more information about the study and to schedule an interview time.

Confidentiality and Informed Consent. Study participants were informed of the purpose of the study, any potential risks and benefits of participation, my contact information if they have additional questions after the interview, and information regarding the audio recording of the interviews both verbally and through a written informed consent document. Participants were also informed that the data collected during the study would be de-identified and stored in a securely locked file cabinet in the author's office. Study participants were provided with ample opportunity to ask questions about the study and the author stopped the informed consent process several times to check that the participants understood the process and to elicit any issues needing clarification or to address potential concerns. Once the participants were informed of the volunteer nature of the study and their right to withdraw from the research at any time, they were invited to sign the document to demonstrate their consent to participate in the study. Participants were compensated for their time with a $25 visa gift card.

Data Collection. The semi-structured interviews were an average of 38 minutes in

duration and the author offered to conduct the interviews in person or via telephone. All of the participants elected to be interviewed via telephone. Although telephone interviews have been openly criticized by some scholars due to the belief that they create more distance between the researcher and participant than face-to-face interviews, Hill and colleagues (2005) reported that "telephone interviews are sometimes preferable in situations in which interviewees may potentially feel vulnerable or embarrassed, because the telephone format allows for more privacy and confidentiality than do face-to-face interviews" (p. 205). The participants were instructed to sit in a quiet and private room at his or her preferred location during the course of the interview for confidentiality purposes. I was also seated in a quiet and private room during the course of the interviews to ensure confidentiality. The interviews were conducted between the months of December 2012 and March 2013. Once each interview had been completed, the audio recording was transcribed verbatim and after all 12 interviews have been completed, the transcripts were analyzed.

Instruments

Demographic Questionnaire. The study began with the completion of a demographic questionnaire (see Appendix A). Participants were asked to identify their age, gender, ethnicity, social class status, level of education, political affiliation, and religious identification. Participants were also asked to provide their current professional status and any licenses they may hold to provide mental health services (e.g., graduate student or unlicensed professional under the supervision of a licensed practitioner, licensed psychologist or psychiatrist, and licensed social worker or mental health counselor). They were also asked to report their years of experience working in the mental health field and years of experience working with undocumented immigrants from Mexico. Participants were asked to report the highest degree

received and the type of license they provided these services under. If participants were not licensed, they were asked to identify the type of license held by their supervisor.

Interview Protocol. Participants then participated in a semi-structured interview containing questions derived from the literature and multicultural theory (see Appendix B). These interviews included items that elicited information about the clinician's experiences working with undocumented immigrants from Mexico within the border region, the role their multiple identities have on their values and attitudes towards undocumented immigrants and mental health services aimed at this population, their perceived successes and failures in their work, the ways in which their professional training may or may not have prepared them for this work, and their recommendations for best practices in providing these services in an effective and multiculturally competent manner. The protocol questions were written in an open-ended structure to offer participants the opportunity to respond in a spontaneous manner that emphasizes what they find to be salient issues and experiences in their work.

Ethical Considerations. Undocumented immigrants may face severe consequences if their immigration status is known, including harassment, termination of employment, arrest, and/or deportation. As a result, practitioners may be apprehensive to offer their experiences out of concern for their clients and patients. Given the vulnerability of this population, study participants were reminded that they were not required to provide identifying information about themselves or about the organizations they work with or any other information that may undermine the confidentiality and safety of their clients in the interview or in the demographic questionnaire. When practitioners did identify the organization that they work for by name or other potentially revealing information during the course of the interview that may lead to jeopardizing their clients' anonymity, this information was stricken from the transcriptions and

was not reported in the analysis of the data.

Data Analysis

Methodology. As mentioned earlier, the CQR method incorporates several stages of analysis of qualitative data. The data are collected through the use of a semi-structured interview protocol that is comprised of a series of open-ended questions. Once the interviews are transcribed, the analysis of the data is conducted by a team of individuals with unique perspectives that seek to reach consensus about the meaning of the data. This process includes several activities such as the creation of domains, core ideas, and categories that describe the data contained in the interviews. The CQR process also employs an auditor, who is recruited to challenge potential blind spots and bias in the team's work. Overall, the CQR process aims to guide the research team through the analysis process in a way that maximizes trustworthiness.

The following section discusses the process of data analysis using CQR. First, the development of domains will be introduced. Next, the ways in which the team constructs core ideas and the role of the auditor will be highlighted. A description of the process of cross-analysis will be followed by the utilization of frequency labels. Finally, the issues warranting consideration when creating the CQR research team will be identified and addressed.

Domain Development. Once the 12 interviews were completed and the audio-recordings had been transcribed, our CQR team initiated the process of domain development. A domain can be understood as a topical description that can be used to group relevant data (Hill et al., 2005). The process of developing domains began with the creation of a list of relevant domains based on the review of the literature and the interview protocol (Hill et al., 1997). These domains were designed to organize or cluster the data into unifying topics. For example, domains for the proposed study included "impact of clinician's identity within work with undocumented

immigrants from Mexico."

Once the team had developed the initial domains, each individual member worked independently to code the first interview transcript or first "case." After the team members completed coding the data contained in the transcript, the team reconvened as a group and discussed the results of their coding. During this discussion, the team worked to develop a consensus version of the transcript incorporating the most accurate domain titles as possible. This version included each domain and all of the raw data from the transcript that fit into each domain. Once the team developed a clear strategy for coding the data using the domains, subsequent transcripts were coded. Most, but not all, of the transcripts were analyzed. In the proposed study, 11 of the 12 transcripts were analyzed from the start and one was put aside to be used as a stability check towards the end of the analysis process. The stability check will be discussed later in this section.

It is important to note that domains may change as the researchers move from a theoretical understanding of the phenomenon to an understanding grounded in the specific experiences of the study participants (Hill et al., 1997). Therefore, the initial domains were amended once they were applied to the raw data and as the researchers worked to develop more refined ways segment the information in the transcripts. In addition, some domains were eliminated when there was no data that appropriately fit the domain. Furthermore, domains were combined when the researchers discover that similar components of the transcripts are being "double coded" and are routinely being assigned to more than one domain.

Core Ideas Construction. The next step of the CQR process was the construction of core ideas. The generation of core ideas is akin to a process of abstraction, where each team member returns to the raw data contained in each domain and attempts to distill the participant's

description of the experience contained within the whole domain using a few select words (Hill et al., 1997). For example, a core idea of this study was "believes it is much more difficult for undocumented immigrants from Mexico in Texas than New Mexico." The researchers attempted to remain as close to the experience described by the interviewee and refrained from making inferences, focusing on the explicit meaning and limiting interpretation (Hill et al., 2005).

Once each member had constructed the core ideas found in each domain on their own, the team assembled to share their coding. The team worked together to reach consensus, which involved refining a core idea until everyone agreed it best represented the participant's actual words. In addition, the team discovered that some data needed to be assigned to another domain. Team members' subjective reactions were valuable components of the process and were recorded in a "notes" section of their working document. This section served to highlight potential areas of bias and to differentiate their impressions from the perspective of the participant (Hill et al., 1997).

At this juncture, the team presented their current consensus document, which included the core ideas and domains for each case, to the auditor. The auditor is often more experienced in the process of CQR than the team members and assists the team by providing a critical lens to view their work up to this point (Hill et al., 1997). The auditor reviewed the raw data assigned to each domain and the core ideas that the team developed. Next, the auditor checked to ensure that the raw data are correctly assigned to each domain, determined whether the core ideas had been adequately abstracted all of the information contained in that domain, and decided whether the core ideas are concise and reflect the raw data appropriately (Hill et al., 1997). Overall, the auditor's role "is one of questioning and critiquing: Does the organization of the categories make logical and conceptual sense? Is there another way of organizing the categories that better

explicates the essence of the data?" (Hill et al., 2005, p. 113).

The feedback provided by the auditor was considered and discussed in detail by the team and each recommendation made by the auditor was then either accepted or rejected. The team completed this component of the process by returning the original comments made by the auditor with the new consensus document, so that the auditor could review how the team addressed each comment. If the auditor believed that the new consensus document still had unresolved issues, she could return the document to the team for further consideration.

Cross-Analysis. During the cross-analysis phase, the team began to compare the different cases to determine whether similarities occur across participants' experiences. The team transferred the core ideas for each domain and within each case to a new document. Then the team worked to cluster these core ideas into descriptive categories. These categories were designed to "capture the essence of the phenomenon in words" (Hill et al., 1997, p. 550). The categories function to make connections between individual participants' experiences. The process of developing categories also shed light onto core ideas that required further refinement or clarification. As the team continued to compare the different cases, some categories were combined, divided, or discarded. Once again, the auditor reviewed the categories and made recommendations that were then considered by the team.

Frequency Labels. The researchers used frequency labels to describe how often the categories represent the experiences of the entire research sample. Frequency labels also served to identify and describe variations in experience across all participants. If a category can be used to describe the experience of all participants, it was labeled *general*. A category was defined as *typical* if it can be used to describe the experience of at least half of the interviewees. When a category only applies to a less than half of the participants, for example, two or three, it was

labeled *variant*. Categories that are representation of only one of the cases were discarded, because they were not representative of the sample (Hill et al., 1997). The team also attempted to reintegrate these categories by developing another broader category (Hill et al., 1997).

Stability Check. A stability check provided the team with the opportunity to determine whether their categories were stable and descriptive enough so that new data did not alter the results. At this point the transcript that was put aside at the beginning of the analysis was coded. If the coding of the raw data contained in this transcript easily integrated into the structure established by the analysis of the previous 11 cases, the researchers could surmise that they had a *stability of findings*, meaning "the results generally explain the phenomenon for a defined group" (Hill et al., 1997, p. 552). If new domains, core ideas, or categories emerged as a result of the analysis of the final case, the findings of the study were not yet stable and the team would have needed to add additional cases one by one until no more major changes in the general, typical, or variant categories develop (Hill et al., 1997). At the introduction of the final transcript, the team determined that the findings were stable, and the author began the process of writing up the results of the study.

Research Team. Due to the collaborative nature of the CQR process, attention to team composition and dynamics was essential. The author, a White, Italian-American, married, heterosexual, middle-class doctoral student in counseling psychology, was the primary researcher and conducted the recruitment of participants and data collection. As I sought additional members for the research team, I intentionally attempted to recruit students who were interested in my research topic and who occupied different group memberships. I also looked to recruit team members with qualities suggested by Hill and colleagues (1997), such as individuals who "get along, respect each other, (are) able to resolve inherent power differences, feel free to

challenge each other, and have the ability to negotiate and resolve differences" (p. 528). In addition, potential team members needed to be able to commit to a long and intense process of data analysis. Finally, all team members were required to read several of Hill and colleagues' books and journal articles in preparation for the data analysis process.

To limit the bias associated with group memberships, theoretical orientation, and to ensure that assumptions were challenged, I invited one masters-level graduate student in counseling psychology and one masters-level graduate student in clinical psychology to join my CQR team. Both students identified as Latino/a and as children of immigrants with diverse ethnic heritages (one team member identified as being of Puerto Rican and Chinese descent and another identified as being of Cuban, Nicaraguan, and Dominican descent). Hill and colleagues (2007) also underscore the importance of selecting a strong auditor. Because the auditor reviews the work of the team and makes recommendations to improve the analysis, it is recommended that he or she be detail-oriented and experienced in CQR. In this study, the auditor was the dissertation sponsor who had already taken on this role within the context of many published CQR studies addressing similar research topics in the field of counseling psychology.

Biases and Expectations. As recommended by Vivino, Thompson, and Hill (2012), the team discussed how power differences may manifest during the CQR process before the data analysis began. Together we agreed to discuss our process and any emerging group dynamics during our meetings. We also agreed upon shared responsibilities for our CQR sessions including the expectation that we contribute equally, be mindful of nonverbal communication, and to support and respect each other.

Our CQR team also explored our individual and shared goals and visions as recommended by Vivino and colleagues (2012). We facilitated a conversation about what we

each wanted to gain as a result out of this process. Team member goals included wanting to learn more about the data analysis method, to see the study data through the eyes of our fellow team members, to gain perspective on the issues border practitioners are facing, and to enjoy our time together. The team also explored expectations around professional development opportunities such as the possibility of future presentations and publications.

Furthermore, the team processed possible biases, our personal issues that might create obstacles in responding objectively to the research data. We discussed our political affiliations, our beliefs about immigration policy, and our values surrounding mental health service provision. Our team also spoke about our own cultural identifications, including the unearned privileges and experiences with oppressive forces that stem from our multiple identities. We took the time to share our families' immigration stories and how these generational experiences might impact our ability to challenge our assumptions. Lastly, we explored how our clinical and training experiences have shaped our worldview regarding the role of psychologists in working toward social justice.

Chapter 4

Results

This chapter highlights the results of the study data, analyzed using the CQR process. The study data was organized using the structure recommended by Hill and colleagues (2012), first into domains, then into sub-domains, and finally into categories and sub-categories. The categories and subcategories were then assigned frequency labels that designated how common the experiences were among the 12 research participants. Categories that represented the experiences of 11 to 12 of the participants were labeled *general*, categories that applied to seven to ten participants were labeled *typical*, categories that applied to two to six participants were labeled *variant*, and categories that only applied to one of the participants were labeled as *rare*. The categories that were designated as *rare* were discarded are not discussed in the results of the study, because they are considered unrepresentative of the experiences of the study sample. When possible, the author has followed the recommendation of Hill and colleagues (1997) and has included verbatim quotes from the study participants. In addition to assisting the researcher in remaining close to the data, it is hoped that these quotes will bring the participants' perspectives and experiences to life for the reader.

Typical Case Narrative

Clara Hill (2012) recommends the results of a consensual qualitative research study begin with a "typical case narrative," that is, a narrative constructed of the experiences shared by the majority of the participants. The typical clinician in this study sample currently works with undocumented immigrants from Mexico in a community-based setting. Their agency provides a variety of services including case management, individual therapy, group therapy, and family therapy, all in their clients' native language. The practitioner believes that their undocumented

clients have entered the United States for reasons of survival, for example to escape dangerous situations back in Mexico and to provide a better life for their children. Once in the United States, their clients experience significant systemic barriers and a multitude of stressors, especially fear of deportation and separation from family, financial problems, and discrimination. Their clients also encounter obstacles to accessing medical, psychological, and/or social services. Furthermore, the clinician perceives public attitudes, especially those emerging from misinformation about undocumented immigrants from Mexico and U.S. policy, as detrimental to their clients. The clinician recognizes that their own experience with immigration profoundly impacts their work with undocumented immigrants from Mexico, most have either immigrated to the United States themselves or have family members who emigrated from other countries. This experience is seen as an important strength, providing them with an understanding of the difficulties their clients face. The practitioner also views their ability to speak Spanish and the development of a strong therapeutic alliance with their undocumented immigrant clients as essential assets to their work. Although the mental health provider reported that they experience challenges in providing mental health services to undocumented immigrants from Mexico, they also find their work to be enjoyable and rewarding. Finally, the clinician's commitment to participating in systemic change and working towards social justice was considered to be a guiding value in their work with undocumented immigrants from Mexico.

Domains

The team's CQR analysis yielded a total of 11 domains, or discrete topics, that provided a basic format for understanding and organizing the participants' experiences. Within the domains, the data were assigned to categories and subcategories, which describe the interview content in more nuanced detail. Category and subcategory names are noted below in italics.

Domain 1: Clinician's Current Agency/Affiliation Context. The first domain captured participant responses that included information about the agencies and institutions where they provided mental health services to undocumented immigrants from Mexico (UIFM). These responses fell into six typical and ten variant categories. It was typical for participants to *work with UIFM in community-based settings*. It was also typical for these sites to provide (a) *case management* and (b) *linguistically-appropriate services*. Most sites also provided (c) *individual therapy*, (d) *group therapy*, and (e) *family/couples therapy*. The first variant category included responses that clinicians *work with UIFM in hospital settings*. Additional variant categories included clinician responses that their agency provided (a) *low-cost/pro-bono services*, (b) *legal services*, (c) *housing services*, (d) *outreach, community education training, task forces, and prevention services*, and (e) *behavior management*. Furthermore, there were variant categories that discussed how their agency (f) *advocated for UIFM*, (g) *collaborated with other agencies/professionals/indigenous healing systems*, and (h) *provided services using a specific theoretical modality*. The final variant category for this domain contained responses regarding clinician perceptions that their (i) *agency struggled with needing resources*.

Domain 2: Perceptions of Undocumented Immigrants from Mexico Clients and Their Situations. Clinicians' perceptions of their undocumented clients from Mexico, the personal situations they faced, and the feelings and struggles that resulted were included in this domain. Of the 20 categories that were created, four were typical, and 13 were variant. In one typical category, clinicians reported they believed that undocumented immigrants from Mexico *enter the U.S. for reasons of survival.* As one participant stated:

> Just considering the sense that many of them are like refugees. If you think about it, you know, they're encountering a really high-risk situation in their home countries. And they flee from that country to escape a violent situation and at the risk of being murdered.

Other participants reported that their clients experience *experienced significant stressors.* It was also typical for clinicians to report that their clients experience specific *stressors associated with medical and mental health treatment*. One stressor that clinicians typically cited as particularly detrimental to their clients was the *fear of family separation*. One clinician commented:

> You know, on the other hand, I've had a lot of families that come in because a child or parent has been deported. And the ruptures that that causes in families is not insignificant. It's a major stress that's on their backs every day. And living with that kind of stress, and that kind of worry, it's really a huge burden for people. We started a support group. We're putting it together for families, many of the families that have mixed status. The children or maybe a parent are citizens, but some of the members are undocumented in the family. And that has had an impact on their family by deportation. And, you know, it's a very isolating experience. People don't know whom to trust. They kind of withdraw from the community and keep their experience silent. And I feel like one of the things that I've learned is that isolation and silence is really one of the biggest determinants of somebody's mental health. If you have an experience that you feel like you can't share, that it's dangerous for you to share, it can be very difficult to cope.

A variant number of participants responded that undocumented immigrants (a) *do not take advantage of the U.S.* and instead enter this country to (b) *earn a livelihood* and (c) *to escape danger*. Along these lines, one clinician stated, "I would say nobody is coming here to try to take advantage of the U.S. system. But that it's more about trying to have a livelihood and it's an issue of survival for many people."

Other variant categories included responses that clinicians perceived their clients as (d) *living in fear*, (e) having *issues with safety*, and (f) *feeling isolated*. Clinicians also stated that their clients encounter problems associated with (g) *acculturation challenges* and are (h) *impacted by discrimination and scapegoating*. Clinicians also mentioned that their undocumented clients experience (i) *financial and occupational stressors*. Several clinicians remarked that (j) *UIFM children experience stressors* as well. One participant explained, "They don't even know that they weren't born here. They don't even know that they're not citizens until

say, they apply for college. Then they realize their social security number is fake or something like that." An additional variant category described the perception that (k) *undocumented immigrants from Mexico respond better to treatment when clinicians are responsive to their needs*. As one clinician stated, "I think support groups would be really great because, you know, I'm generalizing here, but as Latinos, we tend to be more of a collectivist culture."

Although a few participants endorsed some (l) *negative perceptions*, many clinicians reported (m) *positive perceptions* of UIFM clients. One clinician remarked:

> I love working with immigrants, because for me, they're very easy to work with. They want the help. They feel like they have something to gain from it. They're very appreciative of the support that they feel when they come into our agency. So it's a very, for me on a very personal level, a very uplifting experience working with immigrants.

Domain 3: Impact of Clinician's Identity within Work with Undocumented Immigrants from Mexico. In this domain, the study participants described the impact of their multiple identities on their clinical work with undocumented immigrants from Mexico. Their responses fell into one general category and 8 variant categories. Almost all of the participants expressed that the belief that their own experience with immigration contributed positively to their work with their undocumented clients. As one clinician explained:

> So I went through it, you know. That time when I came to this country illegally, it wasn't the same way like it is right now. Right now it is more difficult and more dangerous to cross the border and come over here. You have to take the risk. And they still leave everybody behind or their life, basically. So I have a lot of respect even though sometimes I experience, like I said, anger or frustration. I have a lot of respect for them because it takes a lot of courage.

Another participant commented:

> I enjoy working with this population especially because I was an immigrant. I didn't witness domestic violence personally or any of that, but from being an immigrant and having limited resources, the language barriers and all those things, I know what it feels like to be in that situation. So I feel that I can, I can connect with them in that way.

Variant responses included clinician perceptions that their *political affiliation* impacted their

work. A clinician stated that as a “leftist liberal. I think my worldview--. I feel politically aligned with immigrants from the southern frontier.” *Religion* was also seen as an important component of providing mental health services to this population, as one participant noted:

> “I think all of the people that I've worked with so far have also been Catholic and have strongly identified with their religion or with their faith or using prayer as a coping skill. And so being able to understand that religion personally has been a help--, has been helpful for me to use as like an intervention or kind of build it up as strength.

Another variant response identified *social class* as a potential barrier between the clinician and client, summed up by one participant who reported:

> I wouldn't say I'm upper class, but you know, educated class. Meaning my parents are professors. So even though, even though maybe economically we're not too high up status-wise, you know, there is--, there's a certain background and culture coming from a highly educated family. So, you know, there was that. I guess that kind of might have put a barrier between me and being able to relate to them culturally.

Additional variant responses addressed the role that a *White or Anglo identity has on therapeutic efficacy*, as one clinician stated, “You know, just being a white middle-class woman, White, Anglo, middle-class woman. I think sometimes I don't represent a safe person to a client right off the bat.” A smaller number of clinicians reported that they *didn’t experience their White or Anglo identity as a particularly salient factor*, as one participant explained:

> You know, when I talked at first about opening the program, the idea of--, I mean, a lot of people said to me: Mexican immigrants, you know, talk therapy is not part of their culture or part of their traditions. They're not going to want to come. They're not going to want to see a *gringo* therapist. And I said: Well, we'll see.
>
> And you know, and I don’t think that is their assessment. I think there's some people that won't. But I think a lot of people confuse access with cultural difference and cultural traditions and they use the idea of cultural difference and cultural traditions as a reason to say: Well, this is why they won't go to therapy.
>
> And my attitude is that there's just not enough services for people to begin with. And once you provide enough services and evaluate that there are services that are linguistically and culturally appropriate, then you can start to question whether or not it's the cultural difference between the therapist and patient that is why people aren't coming.

> Or whether it's just because they can't afford it and there aren't enough services in the first place.

Variant responses also highlighted the belief that *among clinicians with Hispanic or Latino identity, race and ethnicity impacts therapeutic efficacy*. One participant noted, “I have a great appreciation for my roots and my culture. And I think that it plays a role in my ability to understand their culture, to definitely, you know, communicate with them proficiently.” Furthermore, although some *Hispanic and Latino clinicians reported it was (a) challenging to work with their own community*, they also reported they felt (b) *motivated to give back*:

> Believe it or not, that was really hard for me, especially (when I worked) in the prison. I came to this country illegally. So I could totally relate with the inmates, because that was one of my fears: what if I get caught and put in a detention center? I'm not going to be able to contact my family. So that was kind of a little bit difficult I would say for me, you know, kind of like mixed emotions. I wanted to do a lot of stuff to help them.

Another clinician stated:

> It's frustrating. Because, especially for me, because I speak Spanish. I'm from Puerto Rico, which of course is, I'm an American citizen. So, I came in with having the expectation that I would have more in common with these people than I really did. Because we speak Spanish and we share the same culture. But, it's very difficult to get information sometimes from, from people who are undocumented. And I understand the reason behind it. But, you know, you try and explain to them: don't worry, you know, this is safe. We're not going to contact anybody and still – especially when I'm advocating for the child -- the parents would be very guarded with information.

Domain 4: Clinician’s Perceived Strengths and Assets in Working with Undocumented Immigrants from Mexico. When asked to identify their strengths in delivering mental health services to undocumented immigrants from Mexico, one general, two typical, and three variant categories emerged. Almost all of the clinicians cited their *own experiences with the immigration process as integral to their work*. One participant summed up this general category:

> Well, like I said, one of my strengths would be the fact that I kind of--, I relate to some of my clients because I've been in part of, some of what they have experienced, which is identifying myself as Mexican. First language being Spanish, of being an immigrant, of

> being raised in Mexico compared to being raised here.

A typical response among clinicians identified the *ability to provide services in Spanish as a strength*, as one practitioner stated, “To be proficient in the language definitely is necessary, I think, in order to develop a good rapport.” Another typical response highlighted the clinicians’ strengths in *developing a strong therapeutic alliance*, as one participant noted, “Just to not be judgmental, because that has been one of the main things that they have, a lot of my clients have said to me, you know: I feel comfortable with you because you don't judge me.” Variant categories included strengths found in (a) *sharing aspects of identity with clients* and (b) *clinician’s theoretical orientation.* One clinician commented:

> I think as far as my strengths, I think the theory that we work from is a strength within itself, because it gives us the opportunity to not focus on pathology or deficits. So if someone comes in with like a diagnosis of bipolar disorder, we're not going to focus on the diagnosis as much as we focus on the problems that they're having because of the diagnosis. And I think that saves us a lot of time. We don't really talk about the problems in terms of like the pathology behind it. So I think that that's a strength, especially for this population who have maybe never had exposure to that kind of--, like working within that kind of framework, where we look at what they're doing well and how to do more of it.

The final variant category included clinician beliefs that the (c) *ability to advocate for their clients* was an important asset, as one participant stated, “I felt like it was my responsibility to be an advocate for the child.”

Domain 5: Clinician’s Perceived Limitations, Challenges, and Obstacles in Working with Undocumented Immigrants from Mexico. Clinician’s descriptions of the limitations, challenges, and obstacles they encounter in their work with undocumented immigrants from Mexico were organized into this domain, which contained one typical category and five variant categories. It was typical for the participants to identify *challenges associated with providing linguistically-competent services* for their clients, even for native speakers of Spanish. As one

participant explained:

> As a Spanish speaker, you know, having to, to excel in the English language and the skills and then having to go back to speaking the Spanish language-- So that's been a challenge for me. To be able to speak fluently in Spanish and to provide services and effective services to these clients in their language, in the Spanish speaking language. So that's, that's been one of the biggest challenges for me.

A variant category captured the *challenges clinicians encounter due to cultural and identity difference*s. As one clinician stated:

> There is the, like the microaggressions or the discrimination that happens. You know those things happen and--. You know, that's white privilege, I don't experience that as regularly as someone who is not white or who is an immigrant. And whether it is language or the way they look or how they do things that sets them apart from mainstream American culture. You know, I don't have that experience to empathize with fully.

Another variant category described *limitations due to clinical training*, as one practitioner reported:

> Well, I didn't get much preparation, I guess, in family counseling around systems. And I guess, I wish I would have gotten some training and some preparation in systems theory. And systems therapy because I think that's what I really, I really needed that would have been helpful for me. Because, you know, lots of times, in clinical and counseling psych, they train you really well to deal with the individual. And not with the family and the individual.

Clinicians also reported *challenges associated with a lack of resources*. One participant asserted, “It's very hard to find resources for them. And most of my clients, they have basic needs. They are lacking the basics like maybe shelter or maybe a place to live or food.” Some clinicians reported limitations when *recognizing and addressing intragroup differences within undocumented immigrant communities.* The final variant category contained responses that described *difficulties building rapport and a therapeutic alliance*. As one participant explained:

> Many times, they would invite me to their church for their festivities or whatever the traditions that they have in their pueblos and their towns in Mexico, which I couldn't attend because basically I cannot get involved with my clients outside of the work environment. Many of them also they feel kind of rejected or disrespected, I guess. Or

> humiliated, if you want to call it that way. When I would go to their houses, for example, and they would offer me: "Oh. Do you want something to eat? Do you want to take this? Here, take that." And I couldn’t take it. And they felt offended, you know. One time one family told me, if I was thinking I was better than them, that I have the same color. That I have the same color and would speak the same language. And I had to explain to them that it was unethical thing to follow.

Domain 6: Emotional Reactions/Responses Regarding Undocumented Immigrants from Mexico Clients and Service Provision. Throughout the interviews, clinicians discussed their emotional reactions and responses to their clients and service provision for undocumented immigrants from Mexico. Two typical and two variant categories emerged within this domain. It was typical for practitioners to *experience their work with undocumented immigrants from Mexico as challenging*, as one participant commented, “And not being able to help the source of the bigger problems. You know? I mean, doing CBT to help a child cope, but not being able to forget (that her mother is being deported).” Another clinician commented on feeling marginalized as a clinician when working with undocumented immigrants from Mexico and stated, “Sometimes you feel like you're like kind of alone. I think especially like working in a place like Texas that is really conservative. Like you feel really unsupported.” A second typical response centered on clinicians’ *experience of work with undocumented immigrants from Mexico as positive*. As one participant explained:

> I would say it's been an absolute privilege and an honor to work with the community. There has been an opportunity to raise awareness of a lot of the issues that the population faces. It's also, as I mentioned earlier, an opportunity to be able to help the community understand that there are many basic rights that every human being is entitled to. And many have not been previously aware they're available.

Variant responses included clinician descriptions of frustrations associated with the *lack of resources to help their undocumented clients*, as one practitioner stated, “Just frustration at the limitations of our government and our society in being able to help, really good citizens who are in our neighborhoods. Another participant commented:

> But maybe one thing is that, especially the therapies that we work with, this kind of population, we don't find resources in Spanish. So we, I usually have to translate the things that I find for my clients. Or I need to be very careful with written or books or some references that I can give to my clients in Spanish.

The second set of variant responses included emotional reactions associated with the *discrimination and oppression undocumented immigrants from Mexico face in the U.S.* As one clinician reported, “Oftentimes it's like a sense of disbelief when they've encountered, like blatant racism.”

Domain 7: Systemic Factors impacting Undocumented Immigrants from Mexico. As mentioned earlier, many of the clinicians interviewed discussed the systemic factors that impact their undocumented clients. This category highlights the multitude of obstacles these clients experience and include one general, five typical, and four variant categories. Almost every clinician who participated in this study mentioned that undocumented immigrants from Mexico experience *problems with access to services and culturally competent services*. As one practitioner stated:

> I think it's terrible. I mean, it's terrible. If we could look at access statistics, I think it's very clear that undocumented immigrants particularly have very hard times getting primary care visits. And that they are forced to use the emergency rooms for their primary care. And the cost of that to society is, and of the taxpayers – I should be careful when I say because many immigrants are taxpayers -- it's one of the benefits of paying your taxes. But um--. You know, that the, the cost of using emergency care vs. primary care is ridiculous. And I think that we need to incorporate a lot of changes that aren't based on somebody's legal status but are based on true public health principles of trying to focus on prevention. And prevention means that we, first of all, have access and that it's affordable and that it's culturally and linguistically appropriate.

Another clinician reported:

> They can't even qualify for Medicaid; they would have a really hard time being seen by any provider. Because they won't give them therapy for free. So the fact that we're a nonprofit it's a huge resource for them. But thinking about outside of this agency, I really don't know how they go about it, because where can they go to get mental health services?

> Or I know that the school sometimes they have like funding for kids who need therapy. But I don't know. I don't know how good or how they treat them or how--. I don't know that someone is doing something to access services for them. Because I'll tell you what, when our clients who don't qualify for our services because it's not related to domestic violence, we have a hard time referring them out. Because where do we refer? They don't have the money to pay for therapy. So we'll send them to some places, but they have to pay. Nothing is free.

As mentioned earlier, it was typical for clinicians to identify the fear of deportation and family separation as a significant issue associated with systemic factors. One participant discussed the relationship between *threat of deportation* and the experience of geographic isolation:

> So as you know, we have border checkpoints basically on every exit out of Las Cruces whether going to Alamogordo, going south toward El Paso, going towards Deming, there's border checkpoints. Or up north, going to Albuquerque. So they're living sort of in this like lonely cave, I can imagine where they are in this country, yet they have serious limitations leaving Las Cruces.

Another clinician commented on how the threat of deportation and family separation may dissuade women who are undocumented from seeking help when they experience domestic violence:

> When the victim decides to make a report and they're being advised to make a report, because of this person abused them or whatever, they also need to tell them what the consequences are. You know? That like the dad is going to be most likely deported. That these kids are not going to be able to see their parents anymore. And that this mom will not be able to get that child support that a regular mom would get, because the husband will no longer, there is no way that we can enforce that.

Furthermore, women without documentation are at increased risk for violence, as one clinician explained, "Which means many of the abusers are married to these undocumented women and they threaten them: If you saying something or if you leave, I'm going to get you deported. And I'm going to keep the kids."

It was typical for practitioners to discuss the *legal problems* encountered by undocumented immigrants from Mexico. One clinician discussed how financial pressures may lead to the inability of undocumented parents to fulfill court-mandated treatment requirements

for their children who have had legal problems:

> And then there's also kind of a trend that those with less socioeconomic status, those with parents that did have jobs, ended up in a detention center from what we could see was likely kind of a perspective or view that they--. Like the parents weren't able to take care of them or watch them or, you know. Kind of that sense. But it may also have contributed to why they were, why there was violation of probation, because if they couldn't attend outpatient services, be it traveling to a counseling center or the site of services, then they were violating probation. And just kind of like that whole system and that there's no--. They may, I think they were provided with bus passes, but then again, there's more to it.
>
> So and then there's parents that were in the outpatient, where they have a parent group, and so once a month there was a parent group and the parents are supposed to attend that. And you're talking about starting at 5 o'clock. And then having a parent group that starts around 6:30-ish or so. And so it's right after work. Some parents have two jobs so there's kind of this, this discrimination pretty much of those parents who didn't have just one job, those with one job would attend. There's a possibility of violating probation in that way too, because they aren't participating.

Another typical response captured in this domain highlighted the *financial barriers undocumented immigrants from Mexico encounter*. One clinician described how the experience of financial stressors impact mental health functioning:

> And a lot of our immigrant families have both, you know, psychotherapy needs, emotional/psychological needs, and case management needs. And a lot of those go hand-in-hand because of the coincidence between, the correlation between, poverty and mental illness. And so we try to not only address the individual psychological/emotional needs of individuals and their families, but also some of the case management needs, some of the other social needs. And, you know, meeting their basic needs.

Many of these financial barriers exist as a function of workplace exploitation, as one practitioner commented, "Many people who are contributing to our community in so many different ways and if an employer knows that they're undocumented, they will absolutely take advantage of them." Another clinician similarly stated:

> They could get fired for a lot of reasons that if they weren't immigrants they wouldn't be fired for. Misinformation. It can be from, you know, the kind of discrimination that a lot of immigrants feel when they're--, even when their status is just fine, they're residents or citizens, but because they have an accent or because they look a certain way, they don't move up in the work force. And, you know, then it becomes harder to say: I'm in a place that I can call my home. It's harder to say: I'm in a place where I feel safe.

Another typical response from clinicians described the *discrimination and the dehumanizing language their clients experience*. One participant asserted, “They continue to be scapegoated for a lot of the problems in society.” A fourth typical response by interviewees captured the impact of *stigmatization* on undocumented clients from Mexico, as one participant stated, “I've heard a lot of negative comments about immigrants: They come here just to steal jobs.”

There were five variant categories within this domain, the first category centered on *housing problems* experienced by their clients. As one practitioner stated:

> Recently, we were having a lot of barriers getting clients into housing programs because there were stipulations stating that they needed to have official employment, which of course didn't account for our clients because many of them don't have official employment. They can't verify that they have official employment.

Clinician responses also clustered within another variant category, the *difficulty attaining identification, work, and social security documents*. The final variant category in this domain captured clinician responses regarding issues associated with *cultural differences and acculturation stress*. As one participant stated, “I'm just thinking about some of my clients that come from other countries, or Mexican population, too, that they have their own values, their own beliefs. And it doesn't match to the beliefs that we have here. And it's so hard for them to raise their children in that way.” Clinicians also spoke about how cultural differences between U.S. clinicians and their undocumented Mexican clients can lead to misunderstandings and the potential for pathologizing culturally appropriate behavior:

> How they perceive you as an authority, you know, because whether or not, you have some kind of power, and we need to understand that. We need to just not jump to conclusions and: So yeah, they're acting this way because they are hiding something or because they are guilty for something. And, in Mexico, there are a lot of different groups that can work this way; you don't look to the eyes of somebody that is older than you when they're talking to you. You just have to look down.
>
> And for example, like when I was (providing mental health services) in the prison, a lot

> of the other workers they would take it like they were hiding something. Or something is going on with their mental health. So, they would take them as kind of an avoidant personality, like they're avoiding people. Then I just have to tell them, these people, they have been raised that way. You have some authority; they're not allowed to look to you in the eye when you're talking to them. They have to look down. And it doesn't have to do anything with being guilty for anything. Or having any mental health issues.

Domain 8: Perceptions of Public Attitudes Regarding Undocumented Immigrants from Mexico. In addition to the aforementioned systematic barriers and stressors clinicians identified as impacting their clients, interviewees discussed the particular effect of public attitudes on undocumented immigrants from Mexico. One general and three variant categories were constructed from their responses. Almost all of the clinicians reported that the *public is ignorant and misinformed about undocumented immigrants from Mexico and U.S. policy* as it applies to this group. Some of the responses focused on the public's lack of awareness of the complex and exploitative economic relationship between the U.S. and Mexico. For example, one participant stated:

> I remember talking to a couple of people who would say, you know: Why do they have all these problems at the border? And, it's kind of-- even explaining that there's, well, there's a dependency and there's a whole issue of money and greed involved in this, you know. That's not common knowledge in the general public…
>
> Well, I think it's kind of what I was saying, about like just publicly admitting that our relationship, the dependency that the U.S. has with at least Mexico. Just like an open the discussion that: OK. We have this. We, our corporations, function by this. Our cheap Wal-Mart products are the result of cheap labor in other countries. In our, you know, backyard as far as we know.

Other practitioners reported that the U.S. public lacks information about what services and benefits are actually available to undocumented immigrants from Mexico. As one clinician stated:

> So there's a lot of misinformation, I would think, out there, which is not the reality. But people hear that and they believe that. Or they think that: Oh, these people get all these benefits, blah-blah-blah. And the reality is no, they don't qualify for those benefits. They cannot get food stamps. They cannot get any benefits, or a lot of the benefits that they

think they do, they cannot.

A variant category that emerged discussed *public attitudes that are influenced by media and political rhetoric*. As one clinician explained:

> I'd like to see an end to all rhetoric about building a wall and deportation. Because of, I mean, like you don't need to be very populist to realize that immigrants, especially from our southern frontier, bring so much to our country. That they strengthen our country and fill a lot of roles right now in our country. And that we need to need to recognize all of those benefits, in our laws and our policies.

Clinicians also commented upon oppressive terms used to denigrate undocumented immigrants, for example:

> Well, I think, simple things like eliminating the word *illegal*, *anchor babies*, all of these very deprecating and hurtful language that people use to discuss immigrants. And return to an understanding of what our identity is as a country, it's founded in that, aside from Native Americans, the first Americans that were here, we are a country of immigrants.

A second variant category included within this domain described practitioner experiences that the *public responds to undocumented immigrants with racism, discrimination, and scapegoating*, as one clinician stated. The final variant category concerned the problems associated with *clinicians making their own problematic assumptions about undocumented immigrants from Mexico*, as one interviewee commented, "I didn't at first, and I can imagine I'm not unique in that sense. I was, you know, blinded by their status."

Domain 9: Recommendations for Training and/or Service Provision. This domain captured the recommendations interviewees made for training and service provision. This domain included one general category. Every mental health practitioner interviewed underscored the need for a *focus on cultural competency as applies to undocumented immigrants from Mexico*. These recommendations fell into eight variant categories. A variant number of clinicians *provided recommendations for professional organizations*. For example, one participant commented:

> I guess if we're thinking about who are already psychologists, thinking about planning and organizing, whether it's CE workshops or experiential practice, workshops or opportunities for people to actually start wrapping their mind around what it's like to work with some of these undocumented--. Instead of going to the generic, you know, CE workshops. Or really take an initiative and opening themselves and seeing that kind of information and training.
>
> But I think also like there's, you know, a call and a mission for psychologists to continue growing, you know, through the years in their work. And you know, there's always the option of taking supervision for someone and working in a new environment. And really exploring that. In order for someone to see that there's that need, there has to be, whether it's through APA seminars or APA conferences. You know, journals, paperwork, or publications that really call psychologists to do that. And then follow by providing opportunities to be trained or to have that training.

Practitioner responses also included categories that discussed the need to (a) *include experiential training* and (b) *gain experience working with UIFM in a socially-just/culturally competent way.* Another variant category included responses that *encouraged non-traditional service provision*. As one clinician commented, "I think there's issues of people taking the risk to go into communities and work from a participatory action framework that meets the people who are influential in that community." Clinician also encouraged their peers to (c) *learn about policy/laws and engage in advocacy* and (d) support *immigration reform*. A participant stated, "I think a lot of people don't know how to use their professional power to advocate… Cause there's a lot of power behind a PhD or a lot of power as a therapist in a community. If we know what to do with it." A variant number of clinicians also made specific recommendations for developing cultural competency, for example, to *provide culturally-informed community-based services for UIFM*. As one participant stated:

> I think it needs to be on more of a community level, so in schools and community organizations. I think support groups would be really great because--. You know, I'm generalizing here, but as Latinos, we tend to be more of a collectivist culture. Some people might benefit from individual therapy, but I think that maybe group therapy or, you know, groups, support groups, might be more effective, or more helpful for some people.

Another variant category included participant responses that *encouraged bilingualism.* For example, one clinician noted:

> I think one of the biggest things in psychology; we just don't have enough linguistically competent providers. And Spanish is--. I mean, there are other languages that would be very important, too. But Spanish is a big issue. And we see that in our hospital here. We can't even hire Spanish-speaking psychologists. There's not enough of them available--to fill positions. And so positions go unfilled. But that would be one thing that I would love to see training programs emphasize are recruitment of trainees who speak second languages or strong emphasis on trainees learning a second language to the point of competency.

Domain 10: Values and Commitments. Clinicians' descriptions of how their values and commitments impacted their work fell into one typical and three variant categories. Many participants discussed their *commitment to systemic change and social justice*. One interviewee commented, "I grew up being the one that would argue with prejudiced kids in high school who would make comments that were overtly racist." The first variant category included responses highlighting a *commitment to working with UIFM*. As one clinician stated, "I just wanted like to work with the immigrant community because me, myself, I'm an immigrant. I'm from Mexico. So I always felt the need to help my people." The second variant category encapsulated responses that addressed a commitment to *continuing to develop competence with UIFM*. For example, a participant noted:

> I am informed. And because of being informed and because I have experiences with people who have emigrated from different countries, it--, I mean, it opens my framework, I guess. It's not just something I read in a book. You know, it's something that's real.

The third variant category included responses that expressed the *belief that immigration status should not impact service provision/confidentiality*. As one clinician asserted:

> I definitely think that it's essential that if you are in the U.S. that you receive mental health services if you need it. That it's regardless if you're legal, illegal, if you're a permanent resident or citizen, or if you're here on a student visa or working towards another type of visa. I think it's essential component of any health is mental health. Therefore, we shouldn't restrict individuals to a certain type of legal status to provide

services or to receive services.

Domain 11: Reactions to Research Study. Lastly, participants' responses that commented specifically on the process of participating in the study were organized into two typical and two variant categories. Almost all of the clinicians disclosed that the *interview was a positive experience*. The second typical category included responses from clinicians that the *interview allowed them to reflect on work/experiences with UIFM*. As one participant stated:

> I also think it gave me the opportunity--. Like I was just saying, of thinking about it more I guess globally or looking at the bigger picture than just the work that I've been doing. And so it kind of makes me start to think about what really does need to change at a federal level or a state level. Kind of looking at it more, I guess, comprehensively. Because I've just been kind of doing my work, and not really--. I haven't really been given the opportunity or haven't taken the time to really think about like what else needs to change.

Participant responses that *questioned whether they had enough experience to contribute to the study* fell into the first variant category. The final variant category in this domain included responses that *expressed gratitude that the study is bringing awareness of service provision for UIFM*. As one interviewee commented:

> You know, it's good talking about it because not many people get to ask about what we do and the work we do and how we impact my people. And just being able to think about it, what we do makes me feel really good and makes me realize that we're doing a good job, and that there's a lot to do. For the communities or the providers of their mental health or anybody. So there's a lot to do, but I think we're working towards it. And of course, it's not something that we can do by our--, just on our own. We need the support of the bigger community. It brings awareness. Definitely, it brings awareness and gratitude and happiness just to know that we're doing something good for our community.

The Subjective Experience of the Principal Investigator

Feminist multicultural counseling psychology encourages critical thinking throughout the research process (Fischer & DeBord, 2013). Given that the "personal is political" and the authority attributed to the results scientific inquiry in the field of psychology, it was essential that

I acknowledge my subjective experience in conducting this study. Throughout this process, I considered how my multiple identities and social locations influenced my research and how my experiences with this study impacted me. Early on, I became aware of how my association with Columbia University served as an impediment to accessing my research participants. I wondered whether this experience was a function of the history of social science research and its tendency to "do research" on culturally-different others, without consideration of the impact of the study on its "subjects" and whether the results would be useful to the participants and their community. As I reached out to universities, community-based mental health clinics, and hospitals in New Mexico and Texas, I found that when I identified myself with this elite institution, I was often met with suspicion and distrust. Although I did not keep a count of the organizations and practitioners who declined to participate in my study, I know that the vast majority chose to not speak with me, and I suspect much of their reservation grew from a powerful sense of protectiveness for their clients' experience.

It was not until I shared my experience as "a local kid," who grew up in Las Cruces, New Mexico, who attended my hometown university, and whose motivation to conduct this research stemmed from a commitment to lend my voice in the fight against the oppression faced by undocumented immigrants from Mexico, that my participants welcomed me into their experience. I discovered that when my motives were clarified, that the purpose of my research was not simply to fill a gap in the literature or to meet the final requirement for my doctoral degree, but was instead inspired by the stories of my friends and their migrant families growing up in an agricultural community along the U.S./Mexico border, stories of exploitation, fear, and incredible resolve and resilience, that I was begun to be trusted.

I feel extraordinarily fortunate to have been given a small window into the life-changing

work being conducted by the mental health practitioners I interviewed. The experiences they shared never left me unmoved or unchanged. So often, as an interview ended, I realized I was trembling or that my eyes had filled with tears. The generosity of spirit exhibited my the professionals I spoke with manifested in their willingness to share both their successes and failures, to disclose moments of cultural insensitivity and lack of competence, and to lead me into a greater understanding of the impact this work has on their own lives. The frequent, "you know, because you are from here" comments by my interviewees made me feel like a proud collaborator and insider, and yet too often I had to admit to myself that I did not know and that even though I was from "there," my multiple privileges had kept me blind and ignorant to the experiences of so many living in my community. It is with this awareness that I rededicated myself again and again to this study, my growth as a practitioner, my development of multicultural competency, and my commitment to social justice.

Chapter 5

Discussion

Even though the largest group of new immigrants to the United States are Mexican (Chomsky, 2007) and one half of these immigrants are undocumented (Passel & Cohn, 2009), researchers have dedicated few studies to understanding mental health service provision to undocumented immigrants from Mexico. The purpose of the current study was to augment the multicultural psychology literature through the gathering of practitioners' clinical experiences with undocumented Mexican immigrants in New Mexico and Texas. The following research questions were employed to guide this study:

- What are the challenges faced by mental health practitioners who provide services to undocumented immigrants from Mexico in the U.S.-Mexico border region?
- What is the impact of mental health practitioners' values and attitudes, vis-à-vis the intersection of their multiple cultural identities, on their work with undocumented immigrants from Mexico?
- What are the ways in which immigration policies affect this work?
- What are the implications for training mental health practitioners who provide services to undocumented immigrants from Mexico?
- What can the field of counseling psychology learn from the successes and failures of these mental health practitioners and how can these lessons translate into best practices for working with this population in other regions of the United States?

The following chapter is structured according to these research questions, so that the discussion addresses each of them sequentially. It begins, therefore, with a discussion of the challenges faced by clinicians who provide mental health services to undocumented immigrants

from Mexico. Secondly, the impact of clinicians' multiple identities on their clinical effectiveness will then be outlined. Next, the role of immigration policies on the mental health functioning of undocumented immigrants will be highlighted. The implications of this study's results on clinical practice and training will follow, along with a summary of best practices for providing mental health services to undocumented immigrants from Mexico. Finally, the limitations of the study and potential future directions for research are presented. Under each of these headings, attention is given to how the results of this study confirm, contradict, or contribute to filling gaps in the current multicultural psychology literature in regards to the understanding of undocumented immigrant from Mexico clients and their unique needs.

Challenges Associated with Service Provision to Undocumented Mexican Immigrants

The results of this study suggest that clinicians face significant challenges associated with providing mental health services to undocumented immigrants from Mexico. Clinicians who participated in this study remarked that they believed they experienced barriers in their work due to limitations in the scope of their clinical training. Practitioners also cited the difficulties in providing linguistically-competent mental health interventions to their undocumented Mexican clients. Lastly, these professionals identified obstacles associated with cultural and identity differences between themselves and their clients that contributed to problems with the therapeutic alliance and responsive treatment.

Limitations in Training. The participants in this study often cited the traditional role of psychologist as significantly limiting their ability to provide responsive mental health services to undocumented immigrants from Mexico. These clinicians reported that their training programs, which typically emphasized diagnosis and theory, did not prepare them to adequately address the

multiple socio-cultural-political factors that impact their clients' functioning. For example, interviewees reported that their education did not prepare students to address legal barriers experienced by their clients, and as a result, young practitioners struggled with understanding the implications of local and national policy on their clients' clinical presentations. Participants also stated that ethical considerations specific to undocumented immigrants were not fully explored in their graduate programs and they reported experiencing early confusion about whether they were mandated to report their client's undocumented status to authorities. The results of this study point to the fact that traditional psychology programs do not teach students how to refer clients to social services and strategies they might employ in assisting their clients in accessing these resources. Finally, mental health practitioners who participated in this study reported that their graduate programs did not prepare them to work with clients who experienced pre-migratory and post-migratory trauma, leaving them unprepared to effectively treat clients with complex presenting concerns.

Sue and Sue (2008) have criticized mental health training programs for providing only a cursory presentation of the psychological issues impacting ethnic minority groups. They assert that when a discussion of identity is included in the classroom, the focus typically centers on perceived lifestyle deviance and the preservation of cultural stereotypes. Furthermore, they find that the field of psychotherapy itself is *culturally-encapsulated*, meaning that there is an emphasis on a universalistic approach to understanding experience, a disregard for cultural variations, and a staunch reliance on understanding the therapy process from a technique-oriented viewpoint. As a result, clinicians-in-training are taught to equate normalcy and ideal mental health with behaviors of the majority group, the culturally-appropriate behaviors of minority groups are often pathologized. Rarely do traditional training programs explore the

impact of systemic oppression on the mental health functioning of clients and traditional approaches to psychotherapy do not include interventions aimed at addressing or ameliorating these barriers. Atkinson and colleagues (1993) have emphasized the need for clinicians to expand their role beyond psychotherapist in order to truly provide culturally-competent treatment that addresses forces of systemic oppression. They encourage training programs to broaden their students' professional roles to include consultant, advocate, adviser, change agent, and facilitator of indigenous healing systems. In conclusion, as highlighted by the participants in this study, traditional psychological training and practice has the capacity to be culturally-destructive and without an emphasis on multicultural-competence and the willingness for educators to expose their students to non-traditional roles, mental health practitioners will be unable to provide responsive and effective treatment for undocumented immigrants from Mexico.

Linguistically-Competent Services. The clinicians who participated in this study shared that providing linguistically-competent services to their undocumented Mexican clients was a major challenge in their work. Practitioners who did not speak Spanish when they began treatment with their clients believed they were clinically ineffective until they learned the language. Researchers have asserted that language barriers negatively impact the use of mental health services (Guarnaccia et al., 2005). Guarnaccia and colleagues (2005) reported that even though there are specialty programs that have been developed to serve Latinos in the Southwest and Northeast U.S., overall there is a paucity of bilingual and bicultural mental health practitioners. Furthermore, they stated that there are even fewer bilingual and bicultural professionals operating with masters and doctorate degrees. Researchers have demonstrated that the absence of linguistically-appropriate services can have serious implications for diagnosis. Marcos (1976) found that bilingual Latino clients appear more symptomatic when clinical

interviews are conducted in English instead of Spanish.

In addition, clinicians who participated in this study reported that a major obstacle in their work with undocumented immigrants from Mexico is the lack of Spanish-language resources. They stated that they struggle to find text-based materials that their clients can read and share with members of their community and, as a result, often attempt to either create or translate English-language brochures, worksheets, and other mental health-related documents into Spanish. Anderson and colleagues (2003) highlighted the importance of the presence and utilization of linguistically appropriate instructional literature as essential to cultural competence in any health care setting. Without an institutional commitment to providing Spanish-language resources for their clients, bilingual clinicians find themselves taxed with the burden of hastily translating text-based materials in the moment or dedicating substantial time outside of their work hours to developing these resources themselves.

Cultural Differences. Clinicians who participated in this study cited cultural differences between client and clinician as leading to significant challenges in providing services to undocumented immigrants from Mexico. The mental health practitioners interviewed stated that they believed that their limited exposure to racism, poverty, and immigration-related stressors led to cultural misperceptions and difficulties relating to the issues brought into treatment by their clients. Again and again, the participants in this study highlighted their relative privilege as a potentially divisive influence in their work with their clients. They often stated that ethnic differences, at least during the onset of therapy, led to feelings of mistrust by their clients and in turn sometimes resulted in limited disclosure and problems with engaging in treatment. Furthermore, clinicians reported that even among Latino practitioners, there was a danger of not acknowledging intragroup differences. Clinicians who identified as Bolivian or Puerto Rican

reported the expectation by their colleagues, and at times themselves, that their Latino identity would bridge all cultural divides between themselves and their undocumented Mexican immigrant clients. The participants in this study cautioned that racial and ethnic identity alone cannot guarantee rapport and understanding between client and clinician.

Researchers have found, however, that ethnic matching between client and therapist might positively impact the therapeutic alliance. Lopez and colleagues (2002) reported that Latino clients who are paired with Latino service providers tend to report greater satisfaction with their treatment, are more likely to continue to attend follow-up appointments, and tend to remain in treatment longer. One possible reason for this increase in treatment adherence and satisfaction among Latino clients who work with Latino clinicians may be the expression of cultural values such as *respeto* and *personalismo*, culturally-appropriate expressions of respect and warmth by the therapist toward the client. This therapeutic stance has been seen to increase the working alliance and protect against premature termination. Practitioners who agreed to be interviewed in this study spoke at length about the role of cultural identity on their ability to deliver successful mental health treatment to undocumented immigrants from Mexico, which will be discussed further in the next section.

Clinician Identity and Impact on Clinical Effectiveness

Participants in this study often discussed how their own multiple identities influence their worldview and their interactions with their undocumented clients. The clinicians spoke about their racial, ethnic, political, social class, and religious backgrounds, in addition to their exposure to immigration-related experiences have shaped their understanding of their clients. These findings are consistent with the values of multicultural psychology, which assert that without an awareness of one's cultural assumptions, psychologists may continue to pathologize

marginalized clients through the enactment of their conscious and unconscious biases (Constantine, Capodilupo, & Kindaichi, 2007). The mental health practitioners interviewed agreed that their identity impacts therapeutic effectiveness with their culturally similar or different undocumented immigrant clients. Consistent with the APA's Multicultural Guidelines, participants in this study highlight reported the need for clinicians to develop an awareness of their culture-bound assumptions, beliefs, values, prejudices, experience of privilege, and their adherence to stereotypes (Chung & Bemak, 2007).

Race and Ethnicity. Many of the participants who identified as Hispanic or Latino reported that they believed that their identity impacts their ability to provide effective mental health services. Clinicians reported shared racial or ethnic identity with clients eased rapport building, in addition to giving these mental health practitioners insight to some of the oppression their clients experienced as Mexican immigrants. The professionals who participated in this study were quick to note, however, that intragroup differences should not be ignored. These practitioners asserted that simply being Latino was not sufficient to understand their clients fully and other master statuses, especially their social class, limited their personal exposure to their clients' hardships.

Some Latino clinicians interviewed stated that although they were inspired to "give back," there were significant challenges associated with working within their own community. Clinicians spoke of the difficulties they experienced when the norms of psychotherapy ran counter to their cultural values. These mental health professionals stated that their clients became confused and distressed when they had to enforce boundaries to prevent dual relationships, for example declining invitations to their clients' celebrations. They also reported feeling internal conflict when faced with invitations to share a meal with their clients, due to the

professional expectation to maintain the frame of therapy, when it meant that they would be failing to abide by cultural norms of *personalismo*. Those interviewed also spoke of their ability to advocate for their clients with culturally-different professional peers. They reported they often normalized their clients' responses for their non-Latino peers and attempted to ensure that culturally-appropriate reactions were not pathologized. This could be especially important in the case of spiritual and religious experiences, where Latinos may report having visions or other perceptual experiences. Without the knowledge of the culturally-appropriateness of these experiences in Latino communities, practitioners might confuse these experiences with symptoms of psychosis (Guarnaccia et al., 1992).

Non-Latino clinicians also reflected on their race and ethnicity and how it impacts their work with their undocumented Mexican clients. Those interviewed stated that they realized that they had significant shortcomings in working with this population due to their racial and ethnic backgrounds. They cited White privilege as creating significant blind spots in their understanding of their undocumented clients and the commented on their growing awareness of the biases they have internalized. Mental health practitioners who identified as non-Latino also discussed how they have been protected from the daily microaggressions their clients experience and their belief that they often do not represent, for their clients, a safe and trustworthy person given their clients' experiences of oppression.

Political Affiliation. Clinicians also cited their political affiliation as impacting their work with undocumented immigrants from Mexico, contributing to their values and worldview. Mental health practitioners who identified as liberal reported that their progressive politics were closely aligned to their commitment to social justice work and advocacy. Chung (2005) stressed the importance of understanding the role "political countertransference," which may emerge

when working with populations who are linked to sociopolitical issues. Political countertransference may trigger negative personal reactions within the mental health practitioner during their work with undocumented immigrants from Mexico, due to the influence of media coverage, political debate, and community concerns about migrants (Chung, 2005).

Religious Identification. Mental health practitioners who participated in this study also spoke of their religious orientation, specifically when they identified as Catholic, and how that may serve as common ground with their clients. Studies have demonstrated that among Latino Catholic immigrant families, participation in church helps establish support networks, develops a powerful, and serves to strengthen social ties (Kuperminc, Wilkins, Roche, & Alvarez-Jimenez, 2009). In addition, researchers recommend that clinicians consider their clients' involvement in religious and spiritual communities and practices as an important protective factor against the impact of stressors on mental health functioning (Alegria & Woo, 2009).

Social Class. The intersection of immigration status, race, and social class is another aspect of identity these clinicians reported as impacting their work with their clients. Most undocumented immigrants from Mexico live in poverty and those interviewed commented on how poverty negatively impacts the mental health functioning of their clients. These practitioners cited racial and class-based oppression manifesting in economic exploitation, limited education, and discrimination as factors that prevented their clients from attaining financial stability, leading to a host of stressors. In addition, the clinicians also reflected on their own social class identifications and reported that they believe that their social class positions sometimes interfere with their clinical effectiveness, particularly when it came to building rapport. The professionals who participated in this study commented that their social class privilege contributes to the creation of blind spots in understanding their clients' experiences. They also stated that their

clients may feel less safe with a clinician who occupies a higher social class position. These findings are consistent with the research of many psychologists who posit that social class impacts the therapeutic relationship in profound ways, even though it is often ignored by practitioners (Smith, 2010; Lott, 2002).

Impact of Immigration Policies on Work with Undocumented Immigrants from Mexico

The mental health professionals who participated in this study provided insight into how immigration policy affects their undocumented Mexican immigrant clients. The results of this study confirm the existing literature that states that these clients typically experience problems with access to culturally competent services. The clinicians interviewed also identified a series of systemic factors that negatively impact the mental health functioning of their clients. These barriers included legal problems, financial pressures, housing issues, and the challenges associated with attaining identification, work, and social security documents, along with some that have been less frequently studied by researchers, such as separation and isolation, stressors experienced by children, and the impact of public opinion.

Separation and Isolation. Study participants spoke about the various stressors encountered by their clients. Many clinicians discussed the fear and isolation experienced by undocumented immigrants due to the constant threat of deportation. Deportation also makes undocumented immigrants from Mexico vulnerable to painful familial separation. Although many immigrant groups experience dislocation from their family of origin as they immigrate in stages or leave family members behind in their country of origin, undocumented immigrants face the uncertainty of whether they might experience forced separation from family members with different immigration statuses who are at risk of being detained, incarcerated, or deported.

These reports by interviewees coincide with the findings of previous studies, where

results have also indicated that immigrants experience physical isolation associated with transportation issues. Some of the factors that have been found to limit immigrants' abilities to travel to and from work, school, and medical services include not being able to afford a vehicle, difficulties obtaining drivers' licenses, and a lack of or limited public transit systems in their communities (Robert Wood Johnson Foundation, 2006). As a result, immigrants have to rely on piecing together carpool networks and walking extensive distances at night or in dangerous environs. For migrant workers, whose agricultural communities are often located in underpopulated and remote rural areas, individuals and families may find themselves "tied to their farms" (Robert Wood Johnson Foundation, 2006, p. 15).

Although it has been known that transportation issues impact immigrants both in work and education, a unique contribution of this study may be the specific identification of geographic isolation as a prominent experience of undocumented immigrants from Mexico in the U.S. border region due to the presence of Border Patrol checkpoints. These situations combine the fear of deportation and familial separation combined with the limited transportation systems available; as a consequence, undocumented clients may find themselves trapped in U.S. border towns, unable to seek opportunities in other regions of this nation. Given the presence of border patrol stations positioned outside of the immediate border area, many undocumented immigrants may be forced to remain in geographically-confined areas once in the U.S., in order to avoid these checkpoints, preventing them from moving across counties and states.

Stressors Experienced by Undocumented Children. The clinicians interviewed for this study also reported that undocumented immigrant children experience significant stressors as well. One interviewee spoke of the surprise that these young people often encounter when they discover that their educational opportunities have been foreclosed by their immigration status.

For some aspiring college students, college entry may be the first time they become cognizant of the fact that they are undocumented. Suárez-Orozco and Suárez-Orozco (2001) wrote of the demoralization experienced when “highly motivated and school-oriented undocumented students are shattered to realize that their legal status will prevent them from pursuing their dream of a college education” (p. 35). The authors reported that these students experience a range of emotions related to their inability to continue their educations, starting with feelings of injustice and anger, oftentimes falling into depression and hopelessness.

Suárez-Orozco and Suárez-Orozco (2001) also found that undocumented status impacts the educational experiences of children in additional ways. For example, undocumented parents may become extremely guarded with school officials in the hopes that their status will not be discovered. As a result, they may provide inaccurate contact information for their families, making it impossible to reach them if there is an emergency involving their child. Furthermore, when children within the same family have mixed statuses, children without legal permission to reside in this country may “unconsciously become the family’s scapegoat while the documented child may occupy the role of the ‘golden child,’” resulting in feelings of shame and guilt among the young people (p. 35). Finally, the authors relayed that undocumented children often feel “hunted” and their parents may curtail their activities in an effort to protect them from being apprehended by immigration officials. Similar to the statements made by this study’s participants, the authors found that both children and parents expressed fear that they would be detained or deported, especially terrified that reunification with their loved ones would be impossible.

Unaccompanied undocumented immigrant children who travel to the U.S. without family face even greater stressors. Kennedy (2013) found that in addition to the suffering experienced

by undocumented children who migrate with their families, many unaccompanied children are also very likely to have experienced significant pre-immigration trauma. The same routes many of these children follow as they travel from Mexico to the U.S. are controlled by drug cartels that may forcibly recruit unaccompanied immigrant youth. Members of organized crime have also been known to "beat, drown, maim, murder, rob, molest, and starve" undocumented immigrants they encounter (Kennedy, 2013, p. 319). Furthermore, unaccompanied immigrant children may begin to use drugs or alcohol while in the company of coyotes to ameliorate their hunger and thirst during the journey. Coyotes have also coerced unaccompanied immigrant children into engaging in "hard labor" or even propositioning the youth for sex in exchange for survival. Navigating such a migration without the protection and support of caring adults can result in the some of the most debilitating levels of mental illness found in children living in this nation (Kennedy, 2013).

If detained at the border, unaccompanied immigrant minors are typically handed over to the Office of Refugee Resettlement (ORR), where they may receive some medical care. However, youth presenting with psychiatric symptoms and disorders such as addiction, suicidality, and PTSD are very unlikely to receive treatment in the ORR facilities. If released, to family members residing in the U.S., these children's access to ORR services ends. Furthermore, these youth are more prone to experiencing "greater stigmatization of mental illness, inadequate insurance coverage, and linguistic barriers" and lack of psychiatric treatment that can lead to "higher co-occurring substance abuse disorders, lower educational attainment, unemployment, homelessness, and imprisonment" (Kennedy, 2006, p. 320).

Given the impact that migratory trauma and systemic oppression combined with problems accessing appropriate care once in the U.S., it is essential that resources be allocated to

support the mental health needs of both unaccompanied immigrant youth and undocumented children who enter the U.S. with family members. In a policy brief produced by the National Collaboration for Youth and The National Juvenile Justice Network, Building Bridges to Benefit Youth (2006) has made a series of recommendations for advocates and service providers who work with undocumented immigrant youth. Some of these recommendations include urging the Department of Homeland Security to develop and enforce national standards for care for youth housed in their facilities. This agency was also encouraged to collaborate closely with community-based organizations in order to provide both linguistically and culturally competent child and family-friendly shelter and care. Law enforcement agencies were encouraged to ensure that undocumented youth and their families were provided with legal representation during their detention. Finally, the brief recommended that professionals protect immigrant youth through gaining knowledge about whether the law officials in their area routinely report undocumented children to immigration officials and then advocating for the youth they serve by discouraging the disclosure of the status of these children.

Public Perceptions of Undocumented Immigrants from Mexico

Participants in this study stated that public attitudes regarding undocumented immigrants from Mexico negatively impacted their clients. For example, they reported that they believed that the public is ignorant and misinformed about undocumented immigrants from Mexico and U.S. policy aimed at immigration. This atmosphere, exacerbated by media and political rhetoric, makes their clients the targets of racism, discrimination, derogatory language, scapegoating, and exploitation. Time and again, interviewees emphasized that their undocumented clients from Mexico did not enter the U.S. to take advantage of our system, and that they contribute to the economic vitality of our nation and work hard to earn an honest living.

In order to provide services that are responsive to their clients' needs, clinicians who work with undocumented immigrants from Mexico can make use of feminist psychotherapeutic frameworks that encourage conversations about the discrimination and victim-blaming that many oppressed groups experience (Remer & Oh, 2013). Feminist multicultural counseling psychology is perfectly suited to address the multiple psycho-social-political stressors undocumented immigrants from Mexico experience during their pre-migratory, migratory, and resettlement processes. As Enns and colleagues (2013) have stated, feminist multicultural counseling psychology emphasizes the impact of sociocultural environments on clients' goals, challenges, and their life trajectories. This perspective also illuminates power structures at the individual, social, and institutional levels, in addition to examining their connection to systems of privilege and oppression. Furthermore, feminist multicultural counseling psychology focuses on the role of consciousness-raising in the empowerment of clients and communities. Finally, this orientation highlights the need for both individual and social change in the service of supporting optimal mental health.

Clinical Implications

Mexico's New Immigrants: Refugees From Drug Violence. Researchers have begun to identify best practices for providing services for "Latinos," including acknowledging the role racism, classism, and acculturation stresses have on mental health functioning. Such generalizations do not, of course, apply equally well to all members of an ethnic group; as highlighted already, undocumented immigrants from Mexico experience all of these stressors, as well as the impact of exploitation associated with their immigration status, the fear of deportation, and the potential for trauma experienced during the migratory process. In the wake of Mexico's drug war and the violence it has inflicted on Mexican communities, it may be

appropriate to re-conceptualize those who enter the U.S. in an effort to flee this chaos as refugees.

Such a reconceptualization is supported by the results of this study, in which many of the mental health practitioners interviewed stated that undocumented immigrants from Mexico often enter the U.S. for reasons of survival and sometimes to escape danger. Their experiences echo the findings of a study conducted by Rios (2011), who found that the recent Mexican immigrants are more akin to refugees from violence than more traditional undocumented immigrants from Mexico that have come to the U.S. in the past. Now, more and more Mexicans are immigrating to the U.S. not for economic and educational opportunities, but for safety concerns. Even though our nation overall is receiving fewer immigrants from Mexico, U.S. border cities are seeing an increase in individuals and families who are escaping violence. Since 2008, Mexico has witnessed an increase in extortion, kidnapping, and homicide associated with drug-related organized crime. As organized crime syndicates battle for territorial claims and access to the U.S., border cities, the operation centers of many cartels, have been devastated by a concentration of homicides. In Juárez, the most dangerous city in Mexico, there were 216.06 victims of drug-related homicides per 100,000 residents in 2010 alone, a rate similar to those found in war zones. As a result of the violence, it is believed that 243,693 Mexicans have moved their residence in order to flee drug-related murders (Rios, 2011).

Refugees are differentiated from traditional immigrants, sojourners, and guest workers due to the “forced” nature of their migration (Bemak, Chung, Pedersen, 2003). As Bemak and colleagues (2003) assert, refugees immigrate involuntarily, usually to escape political turmoil and war that disrupts their established ways of living and prevents them from continuing to reside in their home countries. Confronted with “uncertainty, chaos, and personal danger” the

individual or family uproot their lives rapidly and relocate to another nation where the "loss of reference groups such as family and community, culture and country may mean, for the individual, loss and disruption of occupation, status, identity, and role definition" (Bemak et al., 2003, p. 9). As suggested by many clinicians who participated in this study undocumented immigrants who flee the bloodshed associated with Mexico's drug war appear to fit the criteria for designation as refugees.

Multi-Level Model (MLM). The Multi-Level Model (MLM) encourages clinicians to develop an "understanding and sensitivity to the history, sociopolitical, cultural, psychological realities, deeply rooted trauma, and loss associated with forced migration" (Bemak et al., 2003). Created by Bemak and Chung to address the unique needs of refugees, the MLM is comprised of four levels of intervention that incorporate "affective, behavioral, and cognitive intervention and prevention strategies that are rooted in cultural foundations and relate to social and community processes" (Bemak et al., 2003, p. 51). The first level focuses on psychoeducation about the mental health system and practices. The next phase of the model includes participation in individual, group, and family therapy. The third stage centers on supporting cultural empowerment and the fourth level incorporates indigenous healing methods. Although these four components of MLM are presented in a chronological manner, it should be noted that they are not sequential in nature and clinicians can shuttle between the phases as needed.

Taking into account that most refugees have very little experience or knowledge about the U.S. mental health care system, the MLM begins with educating clients about therapy. In addition to establishing rapport and a strong working alliance, clinicians may need to discuss what clients can expect from psychotherapy. Confidentiality and other issues around disclosure may warrant special attention, as refugees may be fearful of the potential for government

officials' involvement in treatment. Clinicians may need to explicitly describe the role of the clinician and professional boundaries. At this stage of the MLM, it is appropriate to explore the client's understanding of their presenting concerns and their beliefs about mental illness. The authors of this model also consider the role that trauma might play in client mistrust and work to avoid succumbing to the field of psychology's tendency to view the "suspicion, reluctance, confusion, and skepticism displayed by refugee clients as pathological resistance" (Bemak et al., 2003).

The second stage of MLM involves using culturally appropriate individual, group, and family interventions. At this phase many theoretical orientations may be applied, so long as they are compatible with the cultural norms of the clients. Studies have demonstrated the effectiveness of multiple modalities including cognitive-behavioral therapy, systems approaches, narrative therapy, dreamwork, and Gestalt therapy when working with refugees, but only when they are well matched with the clients' cultural traits. As the clinician gains a greater understanding of the client's exposure to trauma, the ability to competently address the symptoms of PTSD may be necessary. Group therapy may also be indicated, as it offers refugees with an opportunity to share their experiences of trauma while encouraging an environment of support and interdependence. MLM also recommends family therapy as a cornerstone intervention. When working with refugees from collectivist cultures like undocumented immigrants from Mexico, clinicians should work with clients to understand who might participate in family therapy sessions, due to the potential closeness of the extended family unit.

Cultural empowerment, leading to cultural and environmental mastery, constitutes the third stage of the MLM process. This phase is characterized by the coordination of a variety of agencies and community supports to address financial, occupational, educational, and housing

challenges. Clinicians are also encouraged to lend their efforts to advocating for their refugee clients. This may take the form of participating in anti-discrimination and social-justice initiatives, addressing institutional racism, and other forms of systemic oppression. Bemak and colleagues strongly recommend that these endeavors occur during session time, meaning that mental health professionals and clients dedicate some of the time allotted for psychotherapy to making phone calls to politicians and writing letters. They caution, however, that psychotherapists not attempt to serve as their clients' case manager and instead take on the mantle of "cultural systems information guide and advocate" as they provide necessary information about how systems function, possible ways to problem-solve, and the development of new skills and coping strategies to cope with these systems (Bemak et al., 2003, p. 57).

The final phase of MLM involves the integration of indigenous healing systems. In all cross-cultural therapy, it is essential that psychologists be prepared to collaborate and partner with traditional healers. Mental health professionals should become familiar with their clients' community and spiritual leaders, in addition to their cultural perspectives regarding optimal mental health. This might ultimately require the clinician to accept that their clients may prefer indigenous methods and interventions to ameliorate their psychological distress. Even though mental health practitioners are encouraged to develop respectful alliances with indigenous healers, Bemak and colleagues caution that clinicians also "fully explore and investigate the validity, reliability, and effectiveness of traditional healing as an effective intervention as well as the credibility of the traditional healer" (2003, p. 59).

Feminist Multicultural Counseling Psychology as Best Practice. Feminist multicultural counseling psychology is uniquely positioned to incorporate the recommendations made by the clinicians interviewed in this study, while also providing ample opportunity to

reflect upon current service provision and address necessary change. In addition, many of the values and commitments endorsed by this study's participants closely reflect the tenets of feminist multicultural counseling psychology. Many of the clinicians interviewed reported that they have dedicated themselves to working towards social justice and contributing to systemic change. These values included the belief that access to mental health services was a human right and should not be limited by immigration status. Others agreed that their commitment to working with this population included the responsibility to continue to develop competency in developing and delivering services to this population.

Participants in this study shared that they believed that cultural differences between clinicians and their undocumented Mexican clients have contributed to the potential for pathologizing culturally-appropriate behavior. For example, avoidant eye-contact in a client which can be attributed by clinicians as a marker of suspiciousness, might be better accounted for by cultural norms of deference toward those in positions of authority. Participants also spoke of acculturation stress that emerges when familial values and parenting styles are also seen through the lens of ethnocentric monoculturalism. In order to identify the socio-political-cultural forces that might be impacting their clients, feminist multicultural counseling psychology encourages an "environmental assessment." This assessment is essential, because unlike traditional models of psychology that have focused on an intra-psychic understanding of mental health, feminist models assert that the society, not the individual, is the source of the pathology (Remer & Oh, 2013; Brown, 2000). This process allows for an understanding of how behaviors and expressions of distress may not be symptoms of a psychiatric disorder, but may in fact be natural responses or coping strategies to the stressors in their current environment and possibly even signs of resisting a system that is oppressive (Remer & Oh, 2013).

It is here that a stringent adherence to theoretical models of psychotherapy might be particularly ill-advised, as they locate the pathology within the client as opposed to the larger socio-political structure. As one clinician commented, a hospital environment where Cognitive-Behavioral Therapy is usually privileged for its insurance-friendly short-term nature and measurable outcomes may not be appropriate when the client's problems stem from systemic forces. Solely addressing client cognitions, labeling them as maladaptive, and engaging in cognitive restructuring will most likely not ameliorate the suffering that the process of parental deportation has on a child's functioning.

Participants in this study agreed that they believed that undocumented immigrants from Mexico respond better to treatment when clinicians are responsive to their needs. As clinicians investigate the impact of the sociopolitical environment on their clients' presenting symptoms and concerns, the inclusion of nontraditional roles into their professional identity may be necessary. Atkinson, Thompson, and Grant (1993) described these additional roles as potentially including adviser, consultant, advocate, change agent, and facilitator of indigenous healing systems. Given the multitude of systemic factors impacting the mental health of undocumented immigrants from Mexico, it is not surprising to find that many of the participants of this study discussed how they integrate nontraditional service provision into their work with this population.

For feminist multicultural counseling psychologists, explicitly expressing their emotional reactions to systemic oppression as it impacts their clients may foster a therapeutic environment where opportunities for social justice actions may be recognized and supported. Remer and Oh (2013) assert that by "helping clients identify what should be changed in the environment, therapists help reduce self-blame and guilt, allowing more room for acceptance and healing" (p.

315). Once again, these interventions aimed at advising clients in addressing systemic issues are the antithesis of the objective, blank screens psychotherapists are encouraged to be by more traditional and analytic theoretical models.

Clinician Self-Care and the Provision of Services to Undocumented Immigrants from Mexico. The psychological impact of providing mental health services to undocumented immigrants from Mexico is evident in the participants' reports of their emotional reactions to their work. Although many participants highlighted the positive aspects of engaging in this work, for example, the privilege of contributing their voices to raising awareness of the issues facing undocumented clients and the pride they feel when they are able to give back to their communities, it was also the case that many of the clinicians interviewed in this study reported that they often experience their work with undocumented immigrants from Mexico as extremely challenging and frustrating. These emotions often emerged as a result of feeling helpless and hopeless in response to the limited resources they had to address their clients' multiple and at times, disparate needs. Others reported that they felt marginalized and unsupported in their work. Additionally, clinicians spoke of feeling disbelief along with other emotional reactions when exposed to the discrimination and oppression their clients encounter.

Studies have long warned clinicians who work with difficult populations of the threat of burnout, a constellation of physical, emotional, and behavioral symptoms that result when a professional feels overloaded and emotionally exhausted (Figley, 2002; Trippany, White Kress, & Wilcoxon, 2004). Figley (2002) wrote specifically of the impact of "compassion fatigue," a unique form of burnout experienced by clinicians who work with traumatized clients that leads to a diminished capacity to "bear the suffering of others" (p. 1434). Treatment is recommended for therapists who are experiencing compassion fatigue, including psychoeducation, desensitization

to traumatic stressors, exposure and relaxation, and finally the assessment and enhancement of the clinician's social supports (Figley, 2002).

More recently, researchers have begun to explore incidences of "secondary trauma" or "vicarious trauma" in these helping professionals. Although clinician burnout is viewed as a cumulative process, vicarious trauma is seen as "the emotional residue of exposure that counselors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured" (American Counseling Association, n.d.). Vicarious trauma has been associated with a host of deleterious effects on mental health practitioners' intrapsychic, interpersonal, and clinical effectiveness. The American Counseling Association published a series of "signs and symptoms" of vicarious trauma in counselors and these symptoms may erode the clinician's ability to provide ethical service provision to their clients, as "low motivation," "increased errors," "decreased quality," "avoidance of job responsibilities," "over-involvement in details/perfectionism," and "lack of flexibility" may all negatively impact job performance.

In addition, many of the symptoms of vicarious trauma mimic the criteria for posttraumatic stress disorder or PTSD (American Psychiatric Association, 2000). Several of the symptoms of vicarious trauma echo the DSM-IV TR diagnostic criteria for "re-experiencing," for example, having intrusive thoughts of their clients and dreaming about their clients and their trauma experiences. Other symptoms reflect criteria for "persistent avoidance" and "numbing" such as efforts to avoid talking or thinking about the trauma experienced by their clients, anhedonia, and withdrawal from others. Furthermore, signs of vicarious trauma can include symptoms that mirror "increased arousal" including difficulties falling and staying asleep, feelings of anger and irritation, and an exaggerated startle response.

The consequences of vicarious trauma on mental health practitioners are significant. Saakvitne and Pearlman (1996) underscored the impact that vicarious trauma has on the psychological health, interpersonal relationships, and ethical practice of clinicians. Practitioners who are experiencing vicarious trauma have a heightened awareness of the prevalence of trauma, which may lead to an increased feeling of helplessness and lack of control. They may be less capable of being emotionally accessible to loved ones and may have problems maintaining intimacy. Feelings of grief and guilt related to their clients' trauma may contribute to feelings of alienation, and the lowering of self-esteem and empathy (Herman, 1992; Saakvitne & Pearlman, 1996).

There are steps that can be taken to decrease the probability that mental health practitioners will experience vicarious trauma. Agencies can support their clinicians by limiting the number of clients with trauma histories in each practitioner's caseload, increasing opportunities for supervision and peer supervision, and continuing to provide training and professional development opportunities (Catherall, 1995; Pearlman & Saakvitne 1995). In addition, practitioners are less like to experience vicarious trauma if they maintain a work life balance, typified by ample time to socialize, be physically active, and engage in creative projects (Pearlman, 1995). Furthermore, the meaning and connection with others that many find in having a spiritual practice has been seen as a protective factor against vicarious trauma and can be a powerful coping mechanism for dealing with the stressors associated with providing services to traumatized clients (Pearlman & Saakvitne, 1995). Given the trauma experienced by undocumented immigrants from Mexico and the toll that working with traumatized clients can have on practitioners, it is imperative that clinicians who work with these clients receive appropriate support from their agencies and engage in sufficient self-care in order to limit the

effects of vicarious trauma on their personal and professional functioning.

Implications for Training

The strengths and limitations in service provision to undocumented immigrants from Mexico as discussed by the participants in this study point to several important training implications. When discussing the training of clinicians to effectively work with undocumented immigrants from Mexico, a diverse population experiencing multiple socio-political-cultural oppressive forces, participants in this study often cited the relevance of a social justice framework. This focus would better prepare mental health practitioners with the skills necessary to address the larger social context, as well as the individual client. Given the experiences of the professionals who participated in this study, the mental health of their undocumented clients is significantly impacted by the political policies, cultural norms, and social practices. A social justice emphasis would accurately identify the genesis of these clients' difficulties as occurring in the environment, as opposed to locating the source of their distress within intrapsychic factors.

As a field, counseling psychology has not adequately trained students to work systemically and researchers are encouraging practitioners to incorporate feminist and multicultural approaches to guide the development of the next generation of counseling psychologists (Goodman, Liang, Helms, Latta, Sparks, & Weintraub, 2004). Goodman and colleagues (2004) identified six principles that can be incorporated into the training of counseling psychologists that would increase practitioners' abilities to provide mental health services in a socially just way. These principles include (a) ongoing self-examination, (b) sharing power, (c) giving voice, (d) facilitating consciousness raising, (e) building on strengths, and (f) leaving clients with tools for social change.

Ongoing Self-Examination. Clinicians in this study shared their belief that clinicians

must constantly strive for an understanding of their own biases and assumptions, as some of those interviewed shared that they became aware of how they had unintentionally internalized negative messages about undocumented immigrants from Mexico and wondered how these biases may have unknowingly impacted their clients. Sue and Sue (2008) have stressed the importance of critical self-exploration in counselor training in order to uncover their preconceptions when engaging in cross-cultural counseling. Professionals interviewed in this study identified values and assumptions associated with their own multiple identities that translated into blind spots when providing services to undocumented immigrants from Mexico. They urged training programs to include discussions of identity, privilege, and power in coursework and supervision of clinicians who are engaging in direct service to undocumented immigrants from Mexico.

Goodman and colleagues (2004) asserted that effective self-examination requires dialogue and should not be left to the student to do in isolation. They recommended establishing an environment of safety in academic environments, enabling students to engage in exploration and vulnerable self-disclosure of their biases, values, assumptions, and experiences of oppression and unearned privileges. Furthermore, they encouraged professors and other educators to share their own growth resulting from critical self-examination, as it normalizes the discomfort of this process and also creates an atmosphere that encourages vulnerability and support among students. Burnes and Singh (2010) shared one strategy they employ in their programs to assist students in engaging in self-examination. They recommend that training programs institute journal exercises in addition to corresponding discussions in the classroom that provide students with the opportunity to reflect upon and respond to course content which leads to a greater personal involvement with theory and praxis. The authors assert that through written responses to

text and course discussion, students can also assess their own growing social justice competence by reflecting on the development of their knowledge, attitudes, and skills throughout their education.

Sharing Power. Essential to the training of socially-just mental health practitioners is the knowledge of how power-differentials between client and clinician might lead to the re-enactment of oppressive dynamics if the clinician does not remain vigilant in their pursuit of developing a non-hierarchical therapeutic relationship. Participants in this study discussed the importance of honoring their clients' expertise and engaging in collaboration in and out of therapy sessions. Clinicians in this study also identified various ways in which they wield their own power and privilege in the service of their clients. Many described their experience of the authority conferred upon them by having an advanced degree or doctorate. Practitioners interviewed spoke of the responsibility they believe they have to use that power to advocate and access resources for their undocumented Mexican immigrant clients.

Goodman and colleagues (2004) also referred to the importance of training clinicians to not abuse the inherent power differential within the therapeutic relationship and instead to help students learn how to capitalize on their authority as professionals to serve as change agents in their community. Toporek and Vaughn (2010) recommended that faculty model power-sharing for their students in the very structure of training programs. They stated professors can teach their students how to engage in power-sharing with their clients by engaging in a parallel process where "issues of privilege are important to acknowledge whether it results from one's earned position, such as faculty, or unearned identity statuses, such as race, gender, sexual orientation, disability, or other statuses" (Toporek & Vaughn, 2010, p. 179). Burnes and Vaughn (2010) agree and assert that through faculty modeling, students may learn how to effectively explore

differences in a “helpful, productive, and meaningful manner so they may vicariously learn how psychologists may address social justice in the real world and in real time” (p. 159). In addition, Toporek and Vaughn (2010) also strongly suggest that training programs model the practice of sharing power for their trainees by including students in programmatic decision-making and in the creation of departmental policy.

Training programs can also emphasize the importance of power sharing while teaching their students how to question their role as expert and engage in collaborative needs assessments, identification of appropriate interventions, and evaluation of services with diverse community stakeholders. One possible manifestation of power sharing suggested by this study’s participants is participatory action research, where researchers and community members partner to initiate and conduct studies based on the needs and interests of the community members themselves. In any power-sharing intervention, not only are social justice principles of empowerment and consensual decision making present, but also opportunities for increased mastery and ownership for clients in their own growth (Goodman et al., 2004). Training programs should teach their students about the benefits of engaging in power-sharing interventions for developing community empowerment and minimizing the power differentials present in traditional approaches to mental health service provision.

Giving Voice. Clinicians who participated in this study underscored the necessity for clinicians to be aware of the myriad ways that the cultural norms of undocumented immigrants from Mexico can be pathologized when viewed through the lens of traditional psychological practices and diagnoses. They stressed that training programs need to assist their students in understanding the cultural values and experiences of these clients. Study participants reported the multiple ways in which the values of their clients are denigrated and seen as symptomatic by

poorly trained practitioners. Goodman and colleagues (2004) suggested that programs train their students to work with their clients to conceptualize their difficulties, strengths, and therapeutic goals within their cultural context. Ali and colleagues (2008) recommend that clinicians learn to use narrative methods to psychotherapy to give voice to the existing knowledge within the community. Similar to a strengths-based approach, narrative interventions encourage clients to tell stories about the ways members of their community have approached their presenting concerns and build upon existing strategies while increasing community and individual self-efficacy.

It cannot be overstated that an essential component of understanding undocumented Mexican immigrant clients and providing a clinical environment where they can give voice to their experiences is being able to fluently speak Spanish. All participants in this study emphatically stated that recruiting Spanish-speaking trainees and encouraging students to become bilingual is crucial to providing responsive service provision. It is essential, however, that trainees and their supervisors not make assumptions that simply speaking Spanish implies that communication breakdowns will not occur, as many participants spoke about challenges associated with navigating the nuances found in differing regional dialects.

Facilitating Consciousness-Raising. Clinicians who were interviewed for this study discussed moments in treatment with undocumented immigrant clients when they engaged in consciousness-raising. They spoke of openly discussing systemic factors that might impact the mental health functioning of their clients, for example highlighting differences in U.S. parenting norms with undocumented clients to minimize cross-cultural misunderstandings associated with discipline styles. Other clinicians spoke about educating clients on laws associated with domestic violence and employment rights.

Training programs need to prepare their students to engage in consciousness-raising in the context of mental health treatment, both with clients and colleagues. A key component of training students to include consciousness-raising in their professional responsibilities is also acknowledging the need for psychologists to raise awareness of the deleterious effects of power differentials on marginalized groups among those with privilege (Goodman et al., 2004). Participants in this study reported that they often find it necessary to challenge peers and members of their own community when erroneous assumptions are made about undocumented immigrants from Mexico.

Programs should work to empower their students to initiate difficult conversations about the status quo and to speak up about the social justice implications of prejudice and ethnocentric monoculturalism on their clients both in mental health settings and in the larger community. Lewis (2010) discussed one possible training method programs may utilize to prepare their students for becoming change agents. He recommended that programs include student participation in a public policy initiative designed to decrease systemic obstacles their clients encounter as part of their practicum experience. For example, medical disparities may be an appropriate policy issue for students receiving training to provide services to undocumented immigrants to address. They might be encouraged to work with advocacy organizations and lobby for universal health care services. As Lewis (2010) stated, such a project would expose students to the process of combatting a system wide issue that pertains to the larger institutional structure of our nation's health care system. In working towards solution, trainees would learn how they might effect fundamental change in this system and success would require a series of skills related to the development of advanced social justice competencies, including an understanding of both public policy and legislative process, the ability to engage in

consultation, practice in lobbying politicians, and an increase in advocacy abilities.

Jones, Sander, and Booker (2013) teach their students to utilize a problem solving approach to engaging in advocacy work. Using their method, trainees learn to define the "problem," caused by an inequality experienced by their clients. Next, the students are directed to determine the frequency and intensity of this problem, for example the degree to which this inequality is occurring for the client and their community. Then the students are instructed to create a measurable goal that would demonstrate that the inequality was being ameliorated. At this point, the trainees develop an action plan to achieve their goal and then work to implement their plan. Finally, their students evaluate the outcomes associated with their plan, assessing the effectiveness of their attempts at advocacy and systems change.

Building on Strengths. In this study, participants spoke of working with their undocumented immigrant clients from a strengths-based approach. It is all too common for even well-meaning clinicians to selectively attend to the multiple stressors and obstacles their clients experience, forgetting the resilience, effective copings strategies, and assets their undocumented Mexican immigrant clients already possess. Instead of concentrating on deficits, socially-just service provision includes an active exploration and identification of the clients' strengths, abilities, and assets. Many coping strategies typically viewed as problematic in the context of traditional psychotherapy could be reframed as adaptive responses when they are consistent with a client's cultural values and norms (Goodman et al., 2004). When clinicians modify their conceptualization of their clients' behaviors to include a strengths-based approach, not only will they minimize the likelihood that they will pathologize culturally-appropriate coping strategies, but they will also engage in interventions that may empower their clients.

Training programs can support their students in developing a strengths-based approach to

service provision by encouraging an exploration of clients' beliefs, values, and cultural practices (Goodman et al., 2004). When students are taught to attend to their clients' existing resources instead of directing all of their energy toward enumerating their vulnerabilities, it is possible to identify strategies already proven to ameliorate their clients' distress. It should be noted that strengths-based modalities require a paradigm shift away from the medical model of conceptualizing psychological problems; students may require support in modifying their understanding of their clients from a deficit-centered to a resource-oriented model. Furthermore, aptitudes and behaviors seen as strengths are culture-bound, therefore training programs should encourage students to engage in a collaborative exploration of client assets, the clinician must not become the sole arbiter of what the client is doing effectively to manage their stressors.

Miville (2013) wrote that a multicultural feminist strengths-based training approach should also encourage students to reframe client behaviors that might be seen through the lens of the medical model as "problematic" instead as an adaptive response in light of the exposure to oppressive forces. In the case of immigrants, she stated that bilingualism could be seen as a deficit when emphasis is placed on test-taking difficulties associated with English language acquisition. Instead the author encourages clinicians to acknowledge that bilingualism is instead a valuable asset and strength for children and their families.

Vera and Speight (2003) heighted that when assessing a student's multicultural competence and social justice skills, programs must evaluate the extent by which the trainee's strengths-based approach extends beyond simply identifying the strengths inherent within the individual. They wrote that an integral part of this approach is the training of clinicians to gather information about the strengths found within the community as well. When the community's strengths are assessed and supported, empowerment follows as the solutions are found within the

community itself. The community is also empowered as a result of not requiring outsider influence in the amelioration of their problems. The student's role is not one of expert, but is instead defined by helping to organize and advocate with the community, requiring adequate training in the assessment of community needs, the facilitation of group process, and effective evaluation of programs and interventions.

Leaving Clients with Tools for Social Change. Finally, clinicians who operate from a social justice position work to foster client self-determination, autonomy, effectiveness, and self-fulfillment (Goodman et al., 2004). Contrary to traditional methods that emphasize the primacy of psychotherapy to address psychological distress, social justice approaches work to avoid the creation of "permanent patients" who rely exclusively on the mental health system for amelioration of their symptoms. One component of socially-just psychological practice mentioned by interviewees was their work towards integrating community-based and indigenous healing systems into their work with clients.

When training programs expose students to the existing support systems in their undocumented Mexican immigrant clients' communities and assist them in developing collaborative treatment strategies, students are less likely to foster a hierarchical dependency of clients on their services (Goodman et al., 2004). Instead, students are encouraged to facilitate engagement with these community resources in order to co-create more sustainable strategies for meeting their clients' needs. Participants in this study shared structures their clinics have in place to increase client autonomy and access to community supports. For example, several interviewees discussed agency programs that prepare clients to take on the role of educator in their own communities, serving as peer advocates. Finally, clinicians in this study remarked that one way they believe they leave clients with the tools for social change is to become

knowledgeable themselves about policies that impact their undocumented immigrant clients from Mexico and to model methods of enacting positive change at the local, state, and national level.

Lewis (2010) provided an example of how programs may train their students to provide their clients with the tools for social change is to begin with an emphasis on interactional justice in the therapeutic relationship. He wrote that students must learn to attend to the client's experience of injustice in society. During training in assessment students should be taught to elicit information regarding their client's experience of inequity across the distribution of rights, opportunities, and resources, as well as to gather information about how their client has responded to these oppressive forces. As their client completes treatment, this exploration of the impact of injustice on their life course and a greater understanding of the ways that their responses may have supported their mental health functioning might better prepare clients to meet these obstacles in the future. Such an intervention could lead to client empowerment and increase their potential for self-advocacy.

Summary: Promising Practices in Providing Mental Health Services to Undocumented Immigrants from Mexico

The following recommendations for best practices in providing mental health services to undocumented immigrants from Mexico are made based on the results of this study:

1. Continue to work towards your own multicultural competency. As recommended by Sue and Sue (2008), psychologists are encouraged to develop an awareness of their own biases, values, and assumptions. Secondly, clinicians are also expected to work towards gaining an understanding of the worldview of their clients. Lastly, therapists must identify and deliver culturally-appropriate treatment. Mental health practitioners who work with undocumented immigrants from Mexico should make a lifelong commitment

to their professional development as they seek out necessary training, supervision, and clinical experiences that lead to multicultural competency with this population.

2. Provide linguistically-appropriate services and materials. Given the results of this study, it is impossible to provide ethical and competent mental health services to undocumented immigrants from Mexico without the inclusion of linguistically-appropriate interventions. Clinics and agencies need to ensure that upon first contact, these clients are met with fluent Spanish-speaking staff and therapists. In addition, informed consent documents, psychoeducational handouts, and other text-based materials should be translated into Spanish and appropriate to the reading-level of the clients. When translators are employed to assist in sessions, care should be taken to discuss issues of confidentiality. Furthermore, mental health practitioners are encouraged to support our field in recruiting and mentoring more bilingual clinicians.
3. Be prepared to address client's pre-migratory, migratory, and post-migratory trauma. Undocumented immigrants from Mexico have often experienced trauma in their home country, during their journey to the U.S., and during resettlement in this country. Furthermore, scholars are asserting that current Mexican immigrants should now be understood as refugees, given the forced nature of their migration in the wake of violence and instability in their home country. In addition to assessing the experiences of trauma clients may have encountered and the possibility of Posttraumatic Stress Disorder, therapists should consider refugee-oriented treatment models such as the Multi-Level Model (MLM) which considers the client's presenting concerns in the context of their community's history, their past and current sociopolitical environment, their cultural identity, and the extensive series of losses associated with the process of forced migration

(Bemak et al., 2003). Clinicians should also consider the unique vulnerabilities experienced by undocumented immigrant children that may lead to even greater levels of trauma than their adult counterparts.

4. Be aware of and address the significant systemic forces that undocumented Mexican immigrants face once in the U.S. In addition to racism, sexism, and classism, undocumented immigrants experience legal problems, language barriers, financial pressures, housing issues, and the challenges associated with attaining identification, work, and social security documents. Clinicians should be aware of and include an understanding of how these systems may be impacting their clients' psychological functioning. Mental health practitioners are encouraged to tap into the values and interventions found in feminist multicultural counseling psychology to integrate discussions of these systemic issues in therapy and to support the empowerment of their clients.
5. Choose your theoretical models and interventions carefully. The field of psychology and its methods are culture-bound, creating the potential for practitioners to inflict damage if their theories, strategies, and interventions do not reflect the values and worldviews of their undocumented immigrant clients (Chung & Bemak, 2007). Consistent with APA's Multicultural Guidelines, mental health practitioners must provide culturally-appropriate services. Given the collectivistic nature of Mexican culture, family, group therapy, and community-based interventions such as participatory action research should be offered in addition to, or as an alternative to, individual treatment methods. As Bemak and colleagues (2003) assert, this also means that therapists acknowledge and respect that their clients may have a preference for indigenous healing practices and community-

sanctioned treatment methods over traditional psychotherapy. Therefore, clinicians should develop partnerships with credible healers within their clients' communities in order to help facilitate appropriate referrals and effective collaborations. Furthermore, there is the danger of cross-cultural misdiagnosis and the over-pathologizing of culturally-appropriate behavior when working with undocumented immigrants from Mexico. Practitioners are urged to explore whether a particular DSM-V diagnosis is warranted, given cultural variances in symptom manifestation and coping strategies.

6. Extend your professional role to include advocacy and social justice work. In order to provide effective services for undocumented immigrants from Mexico, therapists must expand their professional identity to challenge the oppressive systemic forces experienced by their clients (Enns, Nutt Williams, & Fassinger, 2013). Clinicians need to lend their collective influence to fight inequities and commit to anti-oppression work. The field of psychology has the ability to influence policies that impact undocumented immigrants from Mexico and clinicians are encouraged to lobby politicians, engage in organizing, and support agencies that work towards protecting the rights of this population. Graduate programs should emphasize a social justice approach to mental health service provision through encouraging going self-examination, sharing power with clients, giving voice to the experience of marginalized groups, facilitating consciousness raising in and outside of clinical settings, building on client strengths, and leaving clients with tools for social change (Goodman et al., 2004).
7. Engage in appropriate self-care. There is a profound psychological impact on clinicians when they engage in service provision to undocumented immigrants from Mexico and the presence of burnout and vicarious trauma should be assessed. Mental health practitioners

who are providing services to these clients can benefit from additional agency support to combat compassion fatigue and vicarious trauma, in addition to maintaining a healthy work life balance (Figley, 2002).

Study Limitations

Throughout this study, special care was taken to ensure that the method and analyses followed the recommendations made by experts in the field of counseling psychology and qualitative research. Nonetheless, there are several limitations to this study that merit discussion. As noted by Knox, Schlosser, and Hill (2012), qualitative research always requires consideration of the particular sample and its composition. Of this study's twelve participants, only one was male. It is unclear how the homogeneity of the sex of the participants may have impacted the findings. In addition, the sample was also drawn from only two states, New Mexico and Texas. In light of the recent political events in Arizona around immigration policy, it cannot be overstated how sampling from this state might have yielded additional and perhaps contradictory experiences of the clinicians.

Given the small samples typically employed in qualitative research, it is necessary to caution against attempting to generalize the results to a larger population (Knox, Schlosser, and Hill, 2012). Finally, the majority of the clinicians interviewed identified themselves as politically liberal or independent. Studies have demonstrated that individuals who align themselves with progressive political ideologies are more likely to be supportive of undocumented immigrants (Burns & Gimpel, 2000; Citrin, Reingold, & Green, 1990; Doherty, 2006). It is unclear whether the sample of clinicians interviewed in this study was unintentionally skewed towards more politically progressive practitioners, which may have potentially privileged a liberal viewpoint or whether practitioners who provide mental health services to undocumented immigrants overall

tend to align themselves with liberal ideology.

In regards to the research team, all three members attend an elite, progressive, urban, east-coast university. The values of their institution, as well as the social-justice emphasis of their training program, might have impacted the analysis of the data. It is possible that another research team, comprised of members who occupy different social locations and with different characteristics might have come to slightly different conclusions in regards to the study's findings.

Whereas questions of generalizability and validity are raised in association with quantitative studies, qualitative researchers must consider the *trustworthiness* of their data. Trustworthiness refers to the "researchers' claim to have used appropriate, adequate, and replicable methods and to have correctly reported the findings" (Nutt Williams & Hill, 2012, p. 175). As mentioned in the method section, this study followed the recommendations of Nutt Williams and Hill (2012) in that the author described the composition of the research team and their biases and expectations in detail. The author also provided evidence in regards to the adequacy of the research sample, a discussion of the recruitment strategy, the process of the interview, and has provided a copy of the interview protocol in the appendix. Furthermore, the author presented a discussion of the transcription process, the steps in the data analysis, including the stability check, and other information needed in the event that other researchers choose to replicate this study's procedures.

Future Directions for Research

As the field of psychology continues to expand its understanding of the factors that impact the mental health functioning of undocumented immigrants from Mexico and the ways in which service provision can be responsive to the needs of these clients, the results of this study

point to several areas of research that should be initiated or further developed. One potential direction for future research concerns the lack of empirically-supported treatments to address the specific needs of undocumented immigrants from Mexico. Our field would benefit from studies that attempt to determine the efficacy of different Spanish-language therapeutic modalities in ameliorating psychiatric symptoms associated with the multi-faceted stressors faced by undocumented immigrants from Mexico.

Every interview conducted in this study concluded with an invitation to the participants to provide feedback about their experience participating in this research protocol. The clinicians who contributed to this study reported that they found the interview to be a positive experience. Furthermore, the practitioners stated that participating in study provided them with a welcome opportunity to reflect on their work with undocumented immigrants from Mexico. Many of these clinicians expressed appreciation that the study is highlighting the challenges found in service provision to this population, as they often experience the field of psychology as overlooking the needs of their clients. In addition, the mental health practitioners spoke about the pride they felt when sharing their experiences with the interviewer. Given the wealth of knowledge these professionals have gained in their work with their clients and the paucity of research on effective service provision with this population, future studies should continue to explore the experiences of these practitioners in identifying best practices with undocumented immigrants from Mexico.

Finally, this study focused solely on the experiences of clinicians who provide services to undocumented immigrants from Mexico. It is essential that future research gather the experiences of the clients themselves in order to include their voices and experiences with mental health service provision and providers in the U.S. in the discussion of promising practices. Even the most attuned and informed of clinicians have blind spots that obscure aspects of their

understanding of their therapeutic efficacy. Only when undocumented immigrants from Mexico are viewed as the experts in identifying appropriate service provision, will our field be able to make the changes necessary to create responsive interventions.

Conclusions

It is essential to share the knowledge and experience acquired by the mental health professionals of the U.S./Mexico borderlands in their work with undocumented immigrants from Mexico. These lessons are not only relevant for professionals who provide services in the border states, but are also useful for practitioners who work with undocumented immigrants outside of this region. Furthermore, the best practices highlighted by this study's participants may illuminate culturally-responsive service provision for any clinician who needs to address the impact of sociopolitical factors and systemic oppression on the mental health functioning of their clients.

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APPENDIX A

Demographic Questionnaire

Participant Number: _________

1. Sex: __________ Male _________ Female

2. Age: _________

3. Race or ethnicity (please check all that apply)

__________ Asian/Asian American/Pacific Islander

__________ Black/African/African American

__________ Latino/a

__________ Native American/Native Alaskan

__________ White/European American

__________ Biracial/Multiracial

__________ Other (Please specify if not mentioned above) ____________________

4. Which of the following best describes your social class membership?

__________ Low income/poverty

__________ Working class

__________ Lower middle class

__________ Middle class

__________ Upper middle class

__________ Upper class/wealthy

5. Which of the following best describes your religious affiliation?

__________ Catholic

__________ Christian (Protestant denomination, Church of Latter Day Saints,

Jehovah's Witness, etc.)

__________ Jewish

__________ Buddhist

__________ Muslim

__________ Hindu

__________ Other faith (Please specify if not mentioned above) _________________

__________ Unaffiliated

6. Which of the following best describes your political identification?

__________ Democrat

__________ Republican

__________ Independent

7. Years of experience working in the mental health field: ___________________________

8. Years of experience working with undocumented immigrants from Mexico: ____________

9. Highest degree received: ____

10. License (or if not licensed, type of license your supervisor holds): __________________

11. Have you or do you currently work with undocumented immigrants from Mexico within the border states of New Mexico and/or Texas? _____ Yes _____ No

APPENDIX B

Interview Protocol

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1. How did you come to work with undocumented immigrants from Mexico along the U.S./Mexico border?

2. Please tell me about the work that you do with these clients. What is the nature of the agencies, hospitals, or organizations in which you work and/or collaborate with?

3. What has it been like for you to work with these clients?

   Possible prompts: What reactions have you had to the work and to your clients? What thoughts have you had about their narratives or situations?

4. Do you think that your own your multiple identities (race/ethnicity, religious affiliation, social class, political identification) have played a part in this work?

   If yes: How so? Do you think that they have any impact on your relationships with your clients and their response to you?

5. What do you view as your strengths and limitations in providing mental health services to undocumented immigrants from Mexico?

6. How did your training prepare you (or not prepare you) for this work?

7. What would you recommend training programs do in order to better prepare mental health practitioners to work with undocumented immigrants from Mexico?

8. What is your general view regarding the provision of mental health services to undocumented clients from Mexico? Do you think that some of your own values/assumptions are reflected in those views? Have your values/assumptions changed since you began your work and if so, how?

9. Do you have ideas about changes to U.S. immigration policy as it impacts undocumented

immigrants from Mexico? What are they? How do you envision these changes might be achieved?

10. What could be done to better serve these clients? What changes would need to take place to make that happen?

Possible prompts: What changes would you like to see in attitudes (among clinicians, the general public, etc.) towards undocumented immigrants from Mexico? How do you envision these changes might be achieved?

11. You have professional experience in working with a client population whose life situations and psychological needs are complex – and the numbers of these clients presenting for treatment is increasing. At the same time, many clinicians are without your experience and perspective. What message or advice do you have for them, or for the field of psychology in general?

12. Is there anything you would like to add?

13. What was this interview like for you?

APPENDIX C

Recruitment Email Message

My name is Kim Baranowski and I am a doctoral student in the Counseling Psychology program at Teachers College, Columbia University. I am looking for individuals who would like to participate in my research study exploring the experiences of clinicians who work with undocumented immigrants from Mexico in the states of New Mexico and Texas. You are invited to share your experiences in a one-on-one, confidential face-to-face or telephone interview that will last approximately 45 minutes. Participants will receive a $25.00 Visa gift card as compensation for participation.

If you are willing and eligible to participate, please contact me via phone (XXX-XXX-XXXX) or email (XXXXXXX@tc.columbia.edu) for more information and to schedule an interview. Thank you for your consideration! Also, if you could forward this message to colleagues who might be interested in participating, I would greatly appreciate it!

Eligibility Criteria:

* Must be a psychologist, psychiatrist, social worker, or graduate student in any of these fields.
* Must have provided mental health services to undocumented immigrants from Mexico in the states of New Mexico or Texas.

This study has been approved by the Teachers College, Columbia University Institutional Review Board, protocol XXXXXXXX. If you have any questions, concerns, or would like to know the results of the study, please contact me via e-mail at XXXXXXX@tc.columbia.edu.

APPENDIX D

Description of the Research / Participant's Rights

TITLE OF STUDY: The Experiences of Mental Health Practitioners Working With Undocumented Immigrants from Mexico Along the U.S./Mexico Border

PRINCIPLE INVESTIGATOR: Kim Baranowski, EdM

DESCRIPTION OF THE RESEARCH: You are invited to participate in a study researching the experiences of mental health professionals who provide services to undocumented immigrants from Mexico in the border states of New Mexico and Texas. The knowledge created by the study will provide recommendations for best practices for serving this population and recommendations for training mental health professionals who work with undocumented immigrants from Mexico. You will be asked several questions about your experiences working with this population during a 45-minute interview conducted by Kim Baranowski. This interview will be audiotaped and transcribed so that themes can be analyzed. The resulting themes will be used to describe the responses across the entire group of interviewees. All recordings and transcripts will remain confidential.

POTENTIAL RISKS AND BENEFITS: The risks associated with the present study are thought to be similar to those involved in a classroom or workshop discussion of social issues and topics related to mental health service provision. If any questions or concerns arise for you during the course of the interview or afterwards, you are invited to contact the principle investigator, Kim

Baranowski (XXXXXXX@tc.columbia.edu or XXX-XXX-XXXX). There are no direct benefits to participation in this study, but your contribution may provide needed insight into issues associated with service provision to undocumented immigrants from Mexico and may assist in the development of training that best prepares students for work with this population.

RIGHT OF REFUSAL TO PARTICIPATE AND WITHDRAWAL: Your participation in the present study in completely voluntary. If, at any point, you wish to withdraw from participation, you are free to do so immediately and without penalty.

CONFIDENTIALITY: The results from this study will be confidential. No individual identities will be used in association with any reports or publications resulting from this study. All audiotapes and transcripts of the interviews will be assigned an ID number and will be stored separately from any names or other direct identification information of participants. Research information collected will be kept in locked files at all times. Only research personnel will have access to the files and audiotapes. After the study is completed, the audiotapes will be destroyed.

PAYMENTS: You will receive a $25 Visa gift card as payment for your participation.

DATA STORAGE TO PROTECT CONFIDENTIALITY: All audiotapes and transcripts will be identified solely through ID number. Your name or the name of your organization will never be associated with any of the data. Audio recordings will remain in a locked cabinet and transcripts will only be viewed by the researcher and the research team.

TIME INVOLVEMENT: Your participation in this study will take approximately 45 minutes.

HOW RESULTS WILL BE USED: The results of this study will be used for research and educational purposes only. The information collected will remain confidential and may be used in future publications, i.e., journals, articles, and/or presentations. Such publications may be created with the intent of contributing to the field of psychology knowledge about the experiences of professions who work with undocumented immigrants from Mexico.

APPENDIX E

Informed Consent

<u>TITLE OF STUDY:</u> The Experiences of Mental Health Practitioners Working With Undocumented Immigrants from Mexico Along the U.S./Mexico Border

<u>PRINCIPLE INVESTIGATOR:</u> Kim Baranowski, EdM

- I have read and discussed the description of the research with the researcher. I have had the opportunity to ask questions about the purposes and procedures regarding this study.
- My participation in this research is voluntary. I may refuse to participate or withdraw from participation at any time without penalty.
- The researcher may withdraw me from the research at her professional discretion.
- If, during the course of the study, significant new information that has been developed becomes available which may relate to my willingness to continue to participate, the investigator will provide this information to me.
- Any information derived from the research project that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- If at any time I have any questions regarding the research or my participation, I can contact the investigator, who will answer my questions. The investigator's phone number is XXX-XXX-XXXX.
- If at any time I have comments, or concerns regarding the conduct of the research or questions about my rights as a research subject, I should contact the Teachers College,

Columbia University Institutional Review Board/IRB. The phone number for the IRB is XXX-XXX-XXXX. Or, I can write to the IRB at Teachers College, Columbia University, 525 West 120th Street, New York, NY 10027, Box 151.

- I should receive a copy of the Research Description/Participant's Rights and Informed Consent document.
- Audiotaped materials will be viewed only by the principle investigator and members of the research team:

  ( ) I consent to be audiotaped

  ( ) I do NOT consent to be audiotaped

- My signature indicated that I agree to participate in this study.

Participant's Signature: ______________________________________ Date: __/__/__

Table 1.

Domains, Sub-Domains Categories, and Frequencies*

Domains	*Categories*	*Label*
1. Clinician's Current Agency /Affiliation Context		
	Currently works with UIFM in community-based setting	Typical
	Provides case management	Typical
	Provides linguistically appropriate services	Typical
	Provides individual therapy	Typical
	Provides group therapy	Typical
	Provides family therapy/couples/family interventions	Typical
	Currently works with UIFM in hospital setting	Variant
	Provides behavior management	Variant
	Provides legal services	Variant
	Provides housing services	Variant
	Provides outreach, community education, training, task forces, prevention	Variant
	Provides services using a specific theoretical modality	Variant
	Provides low-cost/pro-bono services	Variant
	Agency advocates for UIFM	Variant
	Agency collaborates with other agencies/professionals/indigenous healing systems	Variant
	Agency struggles with needing resources	Variant
2. Perceptions of UIFM Clients and Their Situations		
	UIFM experience significant stressors	General
	UIFM enter US for reasons of survival	Typical
	UIFM experience fear of family separation	Typical
	Reported positive perceptions of UIFM	Variant
	Reported negative perceptions of UIFM	Variant
	Reported UIFM respond better to treatment when clinicians are responsive to their needs	Variant
	Earn a livelihood/better life/education for children	Variant
	UIFM escape danger	Variant
	UIFM do not to take advantage of U.S.	Variant
	UIFM experience safety issues	Variant
	UIFM experience acculturation issues	Variant

Table 1 (cont.)

Domains	*Categories*	*Label*
2. Perceptions of UIFM Clients and Their Situations (cont.)		
	UIFM express stressors associated with mental health and medical treatment	Typical
	UIFM are impacted by discrimination/scapegoating	Variant
	UIFM experience isolation	Variant
	UIFM experience financial and occupational stressors	Variant
	UIFM live in fear	Variant
	UIFM children experience stressors	Variant
3. Impact of Clinician's Identity within Work with UIFM		
	Own experience with immigration impacts work	General
	Social class differences create a barrier between clinician and UIFM	Variant
	Political affiliation impacts work with UIFM	Variant
	Religion plays a role in therapeutic alliance	Variant
3a. Is White/Anglo		
	Acknowledges race/ethnicity impacts therapeutic efficacy	Variant
	Doesn't believe race/ethnicity impacts therapeutic efficacy	Variant
3b. Is Latino/Hispanic		
	Acknowledges race/ethnicity impacts therapeutic efficacy	Variant
	Wants to give back to own community	Variant
	Challenging to work with own community	Variant
4. Clinician's Perceived Strengths and Assets in Working with UIFM		
	Own experience with immigration	General
	Builds strong therapeutic alliance	Typical
	Spanish speaking	Typical
	Shared race/ethnicity/religion	Variant
	Theoretical orientation	Variant
	Advocates for UIFM	Variant
5. Clinician's Perceived Limitations, Challenges, and Obstacles Working with UIFM		
	Challenges with providing linguistically-competent services	Typical
	Challenges due to cultural/identity differences	Variant

Table 1 (cont.)

Domains	*Categories*	*Label*
5. Clinician's Perceived Limitations, Challenges, and Obstacles Working with UIFM (cont.)		
	Limitations due to clinical training	Variant
	Challenges with recognizing/addressing intragroup differences within UIFM	Variant
	Difficulty building rapport/therapeutic alliance	Variant
	Limitations due to lack of resources	Variant
6. Emotional Reactions/Responses Regarding UIFM Clients and Service Provision		
	Experienced work with UIFM as challenging	Typical
	Experienced work with UIFM as positive	Typical
	Clinician perceived a lack of resources to help their UIFM clients	Variant
	UIFM experience discrimination/oppression	Variant
7. Systemic Factors impacting UIFM		
	Problems with access to services/culturally competent services	General
	Stigmatization	Typical
	Threat of deportation/separation from family	Typical
	Legal problems	Typical
	Financial barriers	Typical
	Housing issues	Variant
	Difficulty getting identification documents/social security documents/work documents	Variant
	Cultural differences/acculturation stress	Variant
8. Perceptions of Public Attitudes Regarding UIFM		
	Public is ignorant/misinformed about UIFM and policy as applies to UIFM	General
	Attitudes influenced by media and political rhetoric: "border wall", "anchor babies", "illegal alien"	Variant
	Public responds to UIFM with racism/discrimination/scapegoating	Variant
	Clinicians make own problematic assumptions about UIFM	Variant

Table 1 (cont.)

Domains	*Categories*	*Label*
9. Recommendations for Training and/or Service Provision		
	Focus in cultural competency as applies to UIFM	General
	Provided recommendations for professional organizations	Variant
	Encourage bilingualism	Variant
	Include experiential training	Variant
	Encourage non-traditional service provision/research	Variant
	Learn about policy/laws and engage in advocacy	Variant
	Gain experience working with UIFM in a socially-just/culturally-competent way	Variant
	Provide culturally-informed community-based services for UIFM	Variant
	Immigration reform	Variant
10. Values and Commitments		
	Committed to systemic change/social justice	Typical
	Committed to working with UIFM	Variant
	Continuing to develop competence with UIFM	Variant
	Belief that immigration status should not impact service provision/confidentiality	Variant
11. Reactions to Research Study		
	Interview was positive experience	Typical
	Interview allowed participant to reflect on work/experiences with UIFM	Typical
	Participant questioned whether had enough experience to contribute to study	Variant
	Expressed gratitude that study is bring awareness to service provision for UIFM	Variant

* General (11-12 cases), Typical (7-10 cases), Variant (2-6 cases)