Cultural Straddling: Counseling and Advocating for Immigrant and Refugee Clients

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Abstract

The ever-increasing number of immigrants and refugees entering the United States poses myriad challenges to human service professionals. While over 75% of immigrants in America in the 1960s were from European countries, the trend has since changed. Presently, over 80% of immigrants, including refugees, come from Latin America, Asia, Africa, the Middle East, and the Caribbean. This shift heralds unique psychological, acculturation, and adaption needs that dominant culture American professionals (DCHPs) may be ill-equipped to provide. As a result, the inability of these DCHPs to assess, conceptualize, and treat immigrant clients, especially vulnerable children and families, could result in severe psychological stress and coping problems. This article explores the many challenges and barriers for DCHPs working with immigrant and refugee populations (IRPs). This review discusses cultural straddling and presents strategies helpers can utilize when working as counselors, advocates, and resource persons for these populations.

Keywords: cultural straddling, immigrants, refugees, advocacy

Cultural straddling: Advocating for immigrant and refugee clients

For decades, the immigrant and refugee population (IRP) in America has not only grown exponentially, but has also become more diverse (Schwartz et al., 2013). For example, Jaeger (2007) noted that over 25 million immigrants have made their way legally to the United States since 1971, while Grieco and Trevelyan (2010) observed that immigrant populations, including refugees, as a sub-group, increased by 24% between 2000 and 2009. Likewise, Hernandez et al. (2007) observed that immigrant populations were becoming much more diverse, representing far more global countries than the first waves of European immigration to America. In their investigation, Grieco and Trevelyan (2010) found that 75% of foreign-born persons in America in 1960 were from European countries. In contrast, by 2009, there had been a shift with over 80% of immigrants coming from countries in Latin America, Asia, and Africa, with more recent immigrants coming from the Middle East and the Caribbean. By 2013, forty-one million immigrants had arrived in America from these diverse places (Camarota & Zeigler, 2014). Commenting on this trend, Kuo (2014) advised that such a shift brings with it special needs in coping, acculturation, and psychological adaption for IRPs, especially for vulnerable children and families, which, if not addressed by a culturally responsive and flexible process, could result in problems of severe psychological stress and coping.

Immigration to America, despite current national debates, is not likely to stop. For example, Jackson (2013) predicted that ethnic minorities were likely to make-up approximately half of the

United States population by 2050 and would likely rise to 60% by 2100. Perhaps, precisely because of ongoing national and global debates centering on immigration, now is the time to explore helping professionals' perspectives and approaches to treating the growing influx of diverse IRPs.

Although the IRP population has exponentially increased in recent decades, there are significant limitations in the ability (i.e., skills and knowledge) of the dominant culture helping professionals (DCHPs) to offer assessment, conceptualization, and treatment for these clients. Brown et al. (2010) noted gaps, if not a complete absence, of skills-oriented, experiential, and multicultural training interventions in DCHPs' preparation programs in this regard. Yet, there is a growing need for DCHPs to provide therapeutic services for the increasingly diverse IPRs. DCHPs include various professionals, such as human services professionals, school counselors, mental health counselors, case managers, social workers, psychiatrists, and related helping professionals working with IRPs in various settings. The purpose of this article is to review the literature on DCHPs multicultural competences and their usage of cultural straddling in addressing the unique mental health issues of IRPs, especially vulnerable children, and their families. Furthermore, it seeks to highlight some best practices of working with this population.

Cultural straddling

According to Sue et al. (2016), culture has been defined as the totality of life of all things people have learned to do, to believe in, value, and enjoy, as well as the unique ideas, beliefs, skills, tools, customs, and institutions into which each person is born. Broadly speaking, culture can be classified as either collectivist or individualist. Collectivist cultures are based on valuing the needs of a group or a community over the individual whereas individualist cultures value the individual over group needs. In contrast to the US and other Western cultures, most immigrant cultures are collectivist. Thus, immigrants who move between these cultural orientations must straddle them (Yazykova & McLeigh, 2015).

Cultural straddling is the concept of placing one foot on either side of a cultural divide. As individuals straddle cultures, they inevitably grapple with the indecision of which side is better and often end up trying to live on both sides (Carter, 2006). Additionally, referred to as bicultural straddling or bicultural orientation, cultural straddling includes the ongoing process that enables adaptation to a new culture through efficient pivoting of oneself within two or more different cultures (Kao & Huang, 2015; Yazykova & McLeigh, 2015). Just as IRPs face cultural straddling when they arrive in a new land, so do DCHPs. For example, DCHPs have to place themselves in both worlds (collectivist and host individualist) as they try to pick the tools that will help them address the mental health issues of IRP children and families in America.

According to Kao and Huang (2015), cultural straddling is an active and complementary adaptation process involving two different cultures. It is vital for DCHPs working with children, adolescents, and their families to understand both cultures by embracing the skills and knowledge relevant to addressing IRP mental health issues. Kao and Huang posited that these clients find themselves in active perceptual, developmental, adaptive, and coping struggles from living in two different worlds: the familial one of their parents at home and the outside environment. Hsiao (1992) also affirmed this view noting that the first-generation children's primary challenge is balancing between these two cultures (at home and within their local community). Thus, DCHPs must endeavor to provide an adequate climate, through need-based programs, for these high-risk first-generation children to succeed. According to Kao and Huang, the concept of cultural straddling recognizes four attributes: (a) cultural distance between family and society; (b) an

ongoing, active, or passive process within the context over time; (c) an individual balancing act (negotiation); and (d) outcomes related to identity integration.

Measurement of cultural distance between family and society is typically based on differences in the cultural values, expectations, and roles flanked by the home and social milieu (Kao & Huang, 2015). The client is exposed to three worlds: family, local community, and the larger society. From this context, cultural straddling is inevitable, as clients strive to balance varied values, attitudes, roles, and expectations. Cultural straddling is also considered to be an ongoing, active, and passive process, therefore, as clients acculturate, the host society becomes welcoming or marginalizing to them (Kao & Huang, 2015). Irrespective of the direction or ease of this process (i.e., the adolescents' ease versus the parents' lagging adaptation), the host society culture creates conflicts between parents and children. Additionally, the degree of ease with which IRP clients gain and perceive acceptance, support, or rejection from the society could impact their health behaviors and practices.

The individual's balancing act gives IRPs the autonomy to determine the level of involvement and contextual influence that the family and society may have on their health-related practices. Such negotiation may be influenced by IRPs' degree of acculturation, especially assimilation, considered the highest form of acculturation (Kao & Huang, 2015). Significantly, it is not unusual for immigrants to assimilate based on acculturation stress in adapting to the new culture. This could also include relational stress based on family dynamics, social status and contact, reconstruction of social networks, and oppression due to discrimination and other forms of prejudices (Berry, 2006; Berry et al., 1987). Therefore, cultural straddling may impact the clients' behavior based on length of interaction and stay. Notable, too, is how well clients embrace the host country's values and practices given their personal experience, autonomy, and response to varying stress levels.

Consequently, the manifestation of IRP clients' behaviors may stem from their level of integration (Kao & Huang, 2015). Since identity and self-esteem are connected, those who experience a positive identity affirmation from their peers, family, and society often respond positively. Conversely, those who receive a negative identity affirmation may have a negative or low self-esteem. Thus, IRPs are likely to associate and identify more with the cultural norms at home than those of the host culture. DCHPs must understand the struggles faced by IRP children and their families. A better knowledge and understanding of both cultures might guide DCHPs to choose, utilize, and apply the most appropriate intervention(s) for IRP clients (Kao & Huang, 2015). Consequently, DCHPs would be better positioned to understand, serve, and advocate for IRPs and their communities.

DCHPs responses to cultural straddling

As the presence of IRPs in the United States continues to grow, the issue of adaptation and acculturation as it impacts their overall well-being needs to be a primary focus for helping professionals and policymakers (Schwartz et al., 2013). DCHPs' application of mainstream approaches of assisting IRPs with unfamiliar cultural heritages can be challenging for their therapeutic needs. Thus, the main questions DCHPs need to address are twofold: (a) What could they do to overcome their biases and beliefs toward IRP clients; and (b) What can they do to develop the knowledge and skills needed to link and address IRP clients' psychological, emotional, physical, adjustment, and overall wellness issues?

To achieve this, there is need for DCHPs providers to be aware of and sensitive to their own biases, knowledge, skills, attitudes, and ethical concerns. Similarly, they need to address different acculturation and psychological well-being issues of their IRP clients (Qureshi & Collazos, 2005). IRP clients also bear equal responsibility in being aware of their own biases, attitudes, and lack of knowledge of the host society. In addition to direct clinical work with IRPs, DCHPs can play a pivotal role in helping these clients embrace a collaborative effort with the majority culture in addressing issues that affect them. This can be done by exploring IRPs' social support networks, goal-oriented meetings, and making referrals to community agencies that may offer acculturation or transition support and training (Su'arez-Orozco et al., 2010).

Challenges to IRPs' help-seeking

The most significant challenge IRPs face in seeking help relates to their status of being "on the margin of two cultures" (London, 1992). As immigrants and refugees make their cross-cultural journey to their new host country, they awaken to a complex psychological process of lifelong impacts on their individual identity and acculturation. The cross-cultural transition may consist of experiences of grief and loss, lack of social supports and skills, war traumas, refugee camp experiences, poverty, and health concerns. These transition stressors can lead to unique issues, such as IRP children acting out, sense of isolation, self-esteem, problems attracting and keeping friendships, academic deficits, somatic complaints, and truancy (Goh et al., 2007). These are further complicated by the challenge of assimilating into the new environment and the pressures adults may place on their children in an attempt to keep them true to their cultural ideals (Shariff, 2008). Adults may experience similar challenges in their daily settings. In addition, IRPs' help-seeking behaviors and needs may contrast with those of the host culture (Holcomb-McCoy, 2004). For example, their illegal immigration status could cause IRP families to avoid DCHPs out of the fear of being deported. IRP clients may also exhibit a lack of trust in authorities, including DCHPs and other helpers (e.g., schoolteachers), thereby complicating their ability to get help (Shariff, 2008).

IRPs also face numerous other barriers to seeking treatment. Communication difficulties often exacerbate IRPs' poor access to social and mental health services. Sue et al. (2016), estimate that over 50% of mental health service providers identify language as a significant source of difficulty in their service delivery. Language and other cultural barriers also negatively impact accurate assessment of their mental health issues and the utilization of test results. Similarly, IRPs' lack of knowledge of mainstream service delivery, cultural barriers, and inadequate resources compound the matter. Thus, it is not uncommon to find IRP clients suffering from recurring stress, depression, and anxiety, all of which are also commonly misdiagnosed (Sue et al., 2016).

The Western individualistic approach, in contrast to the cultural beliefs and practices of a collectivist frame of reference, could be challenging to IRPs (Sue et al., 2016). According to Du et al. (2015), individuals embracing collectivist cultural views in an individualistic society could end up with damaging rather than positive mental health outcomes. Similarly, DCHPs in a consultant role may negatively impact treatment if they are oblivious to prejudicial attitudes, stereotypical beliefs, or biases from their individualistic frame of reference (Holcomb-McCoy, 2004). If this happens, DCHPs could unwittingly impose their Western cultural values and mental health approaches on their IRP clients, leading them to experience identity crises, isolation, and rejection that may, in turn, lead to feelings of depression, inferiority, anxiety, and subsequent deficit behavior such as anger outbursts in IRP children.

Assessment of IRP client needs

Testing and assessment instruments are typically culture-specific; however, normed and standardized instruments applied on a population cannot alleviate all its potential bias. Thus, DCHPs must be cognizant of using appropriate formal tests and assessments for diverse IRP clients (Sue et al., 2016). Although test instruments are one of the main sources of essential data, DCHPs working with diverse IRP clients need to use many sources of information, including interviews, non-verbal content, and direct observations, possibly in the home. Relying only on a single source can cloud the true picture of clients' mental health (Sue et al., 2016).

One possible helpful assessment method for collectivist cultures involves the use of a three-generational genogram, which could enable the DCHP to assess a client concerning self/family, intellect, emotions, and capture a snapshot of a client's life journey (Gladding, 2014). This would enable DCHPs to understand IRP clients' family of origin, generational changes, and life journey in relation to historical and contemporary events. Both parties could also explore how these relationships relate to the deeper understanding of how IRP clients see and relate to the self, their perceptions, interpretations, and reactions to the new environment within their cultural contexts. This is especially important since most IRP clients have escaped war, left behind family members, lived in refugee camps for years, and faced many other challenges before settling.

Embracing multicultural understanding

According to Kao and Huang (2015), IRPs are impacted at various levels as they respond to acculturation and assimilation stresses. An adolescent IRP client's health practices, for instance, can be influenced by family, school, and community (Kao & Huang, 2015). With the inevitable cultural straddling of the adolescent, based on expectations from family, school, and society, the DCHP would need to work through a client's cultural lens to address their mental health issues. Understanding and balancing mainstream and multicultural therapeutic approaches on a case-by-case basis would enable DCHPs to select the most culturally appropriate treatment for their IRP clients (Roger-Sirin et al., 2015).

DCHPs must also strive to familiarize themselves with IRP cultures through cultural immersion activities and language acquisition, if they hope to be effective. Cultural immersion activities (e.g., cultural tours, attending cultural events, eating cultural dishes, watching foreign-language films or TV programs, and participating in service work) and reflective processing of these experiences can be essential components in familiarizing oneself with different cultures (Villalba, 2009). While language acquisition is an added advantage for DCHPs, as Villalba noted, it does not equate to cultural fluency, therefore, DCHPs should develop regular habits and plans to immerse themselves in their clients' culture to broaden their understanding and acceptance of diversity.

Developmental model of intercultural sensitivity

Intercultural sensitivity is the attitudinal forerunner to cultural competence (Barden et al., 2015). DCHPs, within this context, can be challenged to gain the ability to understand and experience cultural differences from a more diverse perspective. To demonstrate this, Bennett (1986) developed the developmental model of intercultural sensitivity (DMIS), based on cognitive psychology and constructivism, which primarily operates on the assumption that individuals are directed along a predictable path in gaining experience with different cultures (Barden et al., 2015). The DMIS, which uses a developmental framework, focuses on change at the individual

level (Barden et al., 2015). There are six progressive stages in DMIS, which are broken down into two groups of three ethnocentric stages (denial, polarization, and minimization), and three ethno-relative stages (acceptance, adaptation, and integration). Individuals displaying characteristics in the ethnocentric stage tend to avoid other cultures because they consider their own culture to be central to the truth (Pacino, 2015). On the other hand, individuals showing characteristics in the ethno-relative orientation tend to have more regard for other cultures and experiences within the framework of their own. To be culturally balanced, an integrative approach towards ethnocentric and ethno-relative perspectives is required, and DCHPs can use this model to guide their efforts toward cultural competence (Barden et al., 2015; Pacino, 2015).

Thinking in applied terms

According to Lewis and Arnold (1998), people, in general, are cultural beings exposed to cultural influences impacting life situations and worldviews. In this regard, DCHPs are encouraged to shift their focus from theories and attitudes to concrete applications (Lee & Richardson, 1991). Application by DCHPs, such as going through specific need-based training suitable for working with IRP clients, interpreters, and society, can be necessary and practical. In addition, IRP clients' sociopolitical realities are an essential consideration in the intervention process (Horenczyk & Tatar, 2011). In working with IRP clients' acculturation stressors and emotional and psychological challenges, DCHPs should demonstrate knowledge of community-based resources geared towards helping the counselor-client relationship to solve any problems in therapy. This includes DCHP's sensitivity regarding clients' beliefs and use of traditional folk healers, religious persons or entities, and the impact of the immediate and extended family in the family structure (Fuertes, 2004). It is also not uncommon among immigrant and refugee families to have a child direct and make decisions for the parents, especially if the parents do not speak or understand English proficiently. The DCHP, therefore, must demonstrate adequate knowledge of who the decision-maker is, who has power, and who makes informed decisions within the family by "joining" the family and understanding its structure.

Collaborative approach

DCHPs often view IRP clients as the "problem" rather than perceiving their challenges as manageable assimilation pathways into a new world (Tatar, 2012). In cases where IRP clients are experiencing language difficulties, some DCHPs might utilize a one-size-fits-all approach and risk viewing their clients as profit sources rather than human beings needing help (Tatar, 2012). DCHPs must show much patience and willingness to render assistance while IRP clients go through various stages of adaptation.

As a positive alternative, DCHPs should consider the presence of IRP clients as a "blessing" because they offer opportunities for collaboration, especially on relevant resources from their culture, such as from faith leaders, extended family members, cultural centers, and translators (Tatar, 2012). IRP clients could bring a diverse cultural perspective to enhance and promote a dual knowledge base in the arts, science, theatre, and music that could enrich rather than detract counseling sessions. With this approach, through awareness and gaining adequate knowledge and skills, DCHPs are encouraged to fully explore than assume IRP worldviews. In cases where religious and cultural biases contradict IRP worldviews, DCHPs are expected to "bracket" personal biases, beliefs, and values that stand in the way of objective conceptualization of immigrants (Sue et al., 2016). As an additional resource, DCHP could utilize professionals who are also immigrants

to enlighten and demonstrate the value of IRP clients as a rich asset to their work setting and society in general and learn how to provide competent care (Tatar, 2012).

Transitional theories

According to Scholossberg and Leibowitz (1980), transitional theory refers to experiences people go through requiring alterations in their behavioral patterns, thinking and the necessity for new coping strategies. Unique stressors typically characterize the different transitional stages. The pre-migration stage, for instance, is mainly associated with grief and loss, while the post-migration stage is associated with loss of self-esteem and fatigue.

Understandably, IRPs acquire higher resilience and "toughness" as they go through the two stages. Being resilient could nurture coping responses as follows: (a) modification of the situation; (b) controlling the problem meaning; and (c) helping in managing transitional stressors (Scholossberg & Leibowitz, 1980). According to Schlossberg (1981), applying this theory would provide the treatment framework for IRP clients who usually have accessibility only to a few mental health resources. The theory can be applied to social and institutional needs. While social needs address intimate, familial, and peer issues, institutional needs address community, organized services, and academic issues.

Counselors in "Fictive Kin" role

One final strategy that DCHPs may carefully consider is the fictive kin role with clients. A fictive kin relationship is not based on blood lineage or marriage, but on social connections that recreate many rights and obligations usually associated with formal family relationships (Ebaugh & Curry, 2000). In playing the role of fictive kin, DCHPs are expected to step into nurturing, guiding, coaching, role modeling, and overall imitation of the parental role with some clients. DCHPs could act as "godparents" to IRP children to validate, support, and reinforce cultural continuity, while considering the importance of balancing professional boundaries regarding managing multiple relationships (Ebaugh & Curry, 2000). DCHPs may need to be creative and flexible, to a degree, depending on the specific culture of their IRP clients. They may also be expected to step into these roles and engage in their clients' social world more so than with Western clients. DCHPs are encouraged to consult their specific ethical codes relative to utilizing aspects of this fictive kin approach.

Application to African IRPs in the US

By 2018, slightly more than 2 million Sub-Saharan African immigrants and refugees lived in the US (Echeverria-Estrada & Batalova, 2019). Like many immigrants and refugees from other continents in the US, African IRPs grapple with multiple identity changes. Besides the immediate and obvious culture shock, they confront various challenges, including loneliness, loss, racism, family adjustment, language, and traumas (Gitonga, 2021), for which they require mental health services mainly provided by DCHPs. To better serve African IRPs in the US, DCHPs need to utilize culturally relevant assessments, embrace multicultural understanding, demonstrate cultural sensitivity, and assume a 'Fictive Kin' role.

Since appropriate client assessment leads to effective treatment (Gitonga, 2021), and many available mental health assessment instruments are not normed for African immigrants and could be potentially biased, DCHPs ought to include non-traditional assessment methods. Aware that counseling is a new concept to many African IRPs (Gitonga, 2021) and relying on traditional

mental health assessment instruments could yield inaccurate outcomes (Sue et al., 2016), DCHPs need to employ less intrusive assessment methods (Gitonga, 2021). These methods include, but are not limited to client and family interviews, indirect and direct observations, home visits, and embracing a multicultural understanding.

For DCHPs to effectively work with African IRPs, they must embrace a multicultural understanding and purpose to acquire more knowledge about diverse African cultures. DCHPs can attain this through cultural activities, such as attending weddings, baby naming ceremonies, experimenting with the taste and flavor of cultural dishes, wearing traditional dresses, engaging in international travel to African countries, attending spiritual and religious ceremonies, and, to the extent if possible, language acquisition (Villalba, 2009). DCHPs exposure to and interaction with diverse African cultures would increase their cultural sensitivity to provide better mental health services to African IRPs.

To develop a robust cultural sensitivity, DCHPs must confront their biases, beliefs, and stereotypes about African IRPs (Gitonga, 2021) and explore their own sensitivity, awareness, knowledge, and skills for multicultural competence (Sue et al., 2016). Besides, they should also work to eliminate biases from the lens enshrined in mainstream individualistic and institutional racism (Carter, 2006) as they refrain from imposing their culture on African IRPs (Gitonga, 2021). As DCHPs advocate for African IRPs and commit to appreciating their social and immigration barriers and outcomes, they create a routing involvement to better understand their clients' worldviews (Woodgate & Busolo, 2021). To help African IRPs share their stories, including separation and acculturation challenges, DCHPs could utilize techniques such as motivational interviewing and Socratic questioning that promote guided discovery.

Finally, DCHPs need to understand and fit the fictive kin role with African IRPs. Close association and interaction with kin and non-kin members are essential in African cultures. In addition to immediate family, extended family and friendships are necessary for personal and communal development and support. The fictive kin practice is commonly practiced by African IRPs in the US, as evidenced by many social immigrant groups, including worship centers and welfare organizations. The fictive kin role is like a resource center that pulls immigrants to utilize these kin and fictive kin roles to rally community members to fulfill different functions such as parental, social, emotional, and spiritual coaches and mentors. By fitting into the kin and fictive kin role, DCHPs could enhance their professional alliance with IRPs (Ebaugh & Curry, 2000), and improve their effectiveness with African IRP clients. Such a therapeutic approach by the DCHP could promote trust with IRPs and alleviate some of the underlying emotional and psychological barriers to mental health interventions.

Conclusion

As the number of IRP clients continues to grow in America, there is a need for DCHPs to work more adeptly with these populations in finding a balance of cultural adjustment. Given the interplay between the IRP clients' race, ethnicity, culture, and identity, DCHPs can play a significant role in addressing IRP well-being (Barden et al., 2015). DCHPs must embrace new approaches throughout their work, adopt a collaborative approach in their helping settings when working with IRP clients, and explore some of the suggestions in this article, which could assist in promoting positive relationships between them. DCHPs could use the DMIS model to integrate ethnocentric and ethno-relative perspectives to enhance cultural competence and achieve cultural balance. Furthermore, DCHPs working with African IRPs need to consider culturally relevant

assessments, embrace multicultural understanding, demonstrate appropriate cultural sensitivity and competence, and practice from a 'Fictive Kin' role.

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