A Review of Family-Based Mental Health Treatments That May Be Suitable for Children in Immigrant Families Involved in the Child Welfare System

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Children from immigrant families who are involved in the child welfare system face unique circumstances that can be harmful to their mental health. To date, there are no documented mental health treatment programs designed specifically for this population. However, there are family-based mental health treatments for immigrant families. Additionally, several evidence-based mental health treatments have been successfully applied to children in the child welfare system. A review of both types of treatments shows that these interventions have many positive aspects that may fit the needs of both maltreating and immigrant families. It is possible that these interventions could be successfully modified to aid children from immigrant families involved in the child welfare system.

KEYWORDS mental health, immigrant families, child maltreatment

Children who are victims of maltreatment often suffer from mental health problems. Estimates of the prevalence of emotional and behavioral disorders among children in the child welfare system (CWS) range from 40% to 80% (Burns, Phillips, Wagner, Barth, Kolko, et al., 2004; Clausen, Landsverk, Ganger, Chadwick, & Litonik, 1998; Garland, Landsverk, Hough, & Ellis-Macleod, 1996). While there are currently no estimates of the prevalence of mental health problems among children of immigrants in the CWS, these children face many obstacles that can be detrimental to their mental health.
Children in the CWS have frequently been exposed to poverty, domestic violence, parental mental illness and parental substance abuse, and any child exposed to these risk factors has an increased likelihood of developing mental health problems (Kerker & Dore, 2006). Children from immigrant families are often exposed to these risk factors as well. For example, in 2006, 51% of children of immigrants lived in families with incomes below the federal poverty level (Fortuny, Capps, Simms, & Chaudry, 2009). Additionally, some researchers have found high rates of intimate partner violence in Hispanic, South Asian, and Korean immigrant families (Raj & Sliverman, 2002). Furthermore, for some immigrant families, the experience of migrating to another country can be traumatic enough to cause the parents to develop symptoms of post-traumatic stress disorder (PTSD) (Dettlaff, Earner, & Phillips, 2009; Segal & Mayadas, 2005).

However, immigrant families that are involved in the CWS also face unique stressors that can be harmful to the children’s mental health. Chronic poverty is especially detrimental for children (Bolger, Patterson, Thompson, & Kupersmidt, 1995), but undocumented immigrant parents may have a harder time alleviating their poverty because they are not eligible for government assistance programs such as Temporary Aid for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP).

Also, acculturation can be a stressful process for many immigrant families, especially if the children acculturate at a faster rate than the parents. Due to the fact that children of immigrants must attend U.S. schools, they frequently learn English and American customs more quickly than their parents (Portes & Rumbaut, 2001; Sluzki, 1979). Conflict can arise if the children start to follow American customs that are in opposition with their parents' traditional views about how children should behave (Portes & Rumbaut, 2001; Sluzki, 1979). There is some evidence that family conflicts resulting from acculturation gaps can lead to depression in youth (Ying & Han, 2007).

Most immigrant families living in the United States are non-White (Fortuny et al., 2009). Both non-White immigrant youth and native-born youth from racial/ethnic minority backgrounds may encounter discrimination. However, for non-White immigrant youth who were part of the racial majority in their country of origin, the transition to minority status and subsequent encounters with racism may come as a shock. Furthermore, immigrant youth may face xenophobia and discriminatory attitudes towards immigrants in general.

In addition to possibly being victims of discrimination, youth in immigrant families who enter the CWS have been maltreated. Immigrant communities frequently have a culture of silence (Segal & Mayadas, 2005) and mistrust authorities (Chahine & Van Straaten, 2005). It is possible that cases of child abuse and neglect in these communities are not brought to the attention of authorities unless the cases are severe (Dettlaff, Earner, & Phillips, 2009). For example, Hispanic youth from immigrant families are more likely to enter
the CWS due to sexual abuse (Dettlaff et al., 2009) and to be removed from home due to sexual abuse (Vericker, Kuehn, & Capps, 2007) than Hispanic children who were born in the United States.

While being removed from home and placed into foster care can be traumatic for any youth (Kerker & Dore, 2006), it may be especially traumatic for children of immigrants. First of all, the removal may be the second time that these children are separated from their homes and family members. Children who are immigrants themselves will have already left their country of origin, and in the case of refugees, they may have been forced to leave against their will (Segal & Mayadas, 2005). Additionally, families sometimes immigrate in stages—one or both parents may immigrate first, and wait until they are financially secure before bringing all of the children to the United States (Garcia 2001 as cited in Dettlaff et al., 2009). Thus, children of immigrants who are placed in foster care may have been separated from their mothers or fathers one or more times before.

Secondly, immigrants may have no extended family in the United States (Segal & Mayadas, 2005), in which case it may be impossible to place a child from an immigrant family into kinship care. One study of 20,406 children in Texas’ foster care system found that Hispanic children from immigrant families were significantly less likely to be placed in kinship care than Hispanic children whose parents were born in the United States (Vericker, Kuehn, & Capps, 2007).

Furthermore, some immigrant families live in neighborhoods with large numbers of other immigrant families from the same country of origin, and if a child is placed in foster care outside of this type of neighborhood, the child will lose the social support that the child’s former community offered. Thus, when children from immigrant families are placed in out-of-home care, they may be forced to adjust to living with an unfamiliar family in an unfamiliar neighborhood where the culture is different from their own.

Finally, approximately one third of children of immigrants have parents who are not citizens (Fortuny et al., 2009), and some of these parents may be undocumented. Placement into foster care may be especially traumatic for children whose parents are undocumented, because they may fear that their parents will be deported before reunification can occur.

**PURPOSE**

Although children from immigrant families in the CWS face unique circumstances that can be harmful to their mental health, there have not been any documented mental health treatments designed specifically for this population. However, it is possible that existing mental health treatments could be adapted to meet the needs of these families. First, this article will review family-based mental health treatments for immigrants and evaluate their compatibility for families involved in CWS. Next, this article will review evidence-
based mental health treatments that are effective for maltreated children and their caregivers, and research on the application of these interventions with families in other countries as well as ethnic minority families living in the United States. This article will then discuss reasons the treatments may or may not be effective for immigrant families. The last treatment reviewed in this article will be an intervention that has been tested with both maltreating and immigrant families. Finally, this article will conclude with an analysis of how the reviewed treatments could be adapted for different types of immigrant families with CWS involvement and suggestions for future research.

The reviews in this article are not exhaustive. Rather they showcase interventions that either: a) have a well-developed parent component, b) have strong research support, or c) are specifically designed for groups that have not traditionally been the focus of mental health treatment programs (such as Asians or children living in foster care). More information on treatment programs for immigrant families is available from the National Child Traumatic Stress Network (2005) and is reported in Rousseau, Benoit, Gauthier, Lacroix, Alain, et al. (2007). Additional information on evidence-based mental health treatment for children in the CWS is reported in Shipman and Taussig (2009).

FAMILY-BASED MENTAL HEALTH TREATMENTS FOR IMMIGRANT FAMILIES

Entre Dos Mundos (Between Two Worlds)

The goal of Entre Dos Mundos is to help Hispanic immigrant families handle acculturative stress and prevent externalizing-behavior problems in adolescents ages 12 to 18 years. The program consists of eight lessons that are delivered weekly to a group of 810 families. At least one parent and one adolescent are expected to come to each meeting. The lessons all focus on aspects of acculturative stress such as balancing demands of two cultures, cultural conflict within the family, and discrimination (Smokowski & Bacallao, 2009).

Smokowski and Bacallao (2009) examined the effectiveness of this program when it was delivered to 88 primarily Mexican immigrant families living in North Carolina. The researchers found that, in families who attended more than four sessions, the adolescents had significant decreases in aggression, and symptoms of oppositional defiant and attention deficit disorders. Additionally, the families had significant improvements in adaptability and biculturalism.

Familias Unidas (Families United)

Similar to Entre Dos Mundos, Familias Unidas is designed to prevent extern-
alizing-behavior problems in adolescents from immigrant families. However, rather than focusing on acculturative stress, this intervention focuses on increasing parental involvement in children’s lives. Familias Unidas has been designed for youth in middle school and it also seeks to reduce drug use and risky sexual behaviors (Tapia, Schwartz, Lopez, & Pantin, 2006).

Familias Unidas is a 9-month intervention with several different stages. In the first stage, the facilitators work very hard to engage the families by calling them and conducting a home visit. During these interactions with the family, the facilitators address concerns about the intervention and explain how it can specifically help the family. When parents begin the treatment, they are taught that their adolescents live in three worlds: family, peers, and school, and that it is important for parents to be involved in each of the worlds. Next, the treatment focuses on the “family world” and parents are taught how to communicate in a non-judgmental style and how to use behavior management techniques to discipline their children. In the stage that addresses the “school world” a counselor from a middle school comes and teaches the parents about the United States school system. In the “peer world” stage, parents plan an outing with their adolescent and one of their adolescent’s friends and his or her parent/s. Finally, parents learn how to talk about substance abuse and sexual behavior with their adolescents in a supportive manner (Tapia, Schwartz, Lopez, & Pantin, 2006).

Preliminary research on this intervention has found that it has positive outcomes. In one randomized controlled trial with 167 Hispanic immigrant families from several different countries, families in the intervention group showed significant improvement in parental involvement and decreases in adolescent externalizing problems compared to families in the control group who did not receive any intervention. Additionally, parents who were the least involved with their adolescents prior to the intervention attended the most sessions and gained the most from treatment (Pantin, Coatsworth, Feaster, Newman, Briones, et al., 2003). In a second study with 266 Hispanic families randomly assigned to either Familias Unidas with PATH (an intervention designed to help parents and adolescents speak about HIV) or English for Speakers of Other Languages with PATH, or English for Speakers of Other Languages with HeartPower! (an intervention designed to promote physical health), the adolescent participants in Familias Unidas had the biggest decreases in drug use and risky sexual behavior (Pantin et al., 2005 as cited in Tapia et al., 2006).

Mental Health for Immigrants Program (MHIP)

Unlike Entre Dos Mundos and Familias Unidas, MHIP is delivered to children in schools with four optional sessions for parents. The goal of MHIP is to decrease symptoms of depression and PTSD among immigrant children in
grades 3 through 8 who have been exposed to violence. Children attend eight group therapy sessions that follow the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) model. The CBITS program teaches children methods from cognitive behavioral therapy that help individuals cope with upsetting memories and feelings of grief.

The group sessions for parents cover a variety of topics. Parents discuss the difficulties of the immigration process and are taught about how trauma can affect children. These sessions also provide psycho-education about the CBITS model and information on parenting practices. MHIP includes an in-service training session for teachers, which provides instructions about how children may react to trauma, and how to recognize possible symptoms of PTSD and depression (Kataoka, Stein, Jaycox, Wong, Escudero, et al., 2003).

MHIP was first implemented in the Los Angeles Unified School District and offered to Spanish, Armenian, Korean, and Russian immigrant children (Stein et al., 2003). However, the published research only reports results for the Hispanic immigrant participants in the intervention. The pilot study included 198 Hispanic immigrant students from 9 different elementary and middle schools. Forty-six of these students were assigned to the waitlist control condition. After adjusting for participants' initial symptom levels, students in the experimental group had significantly fewer symptoms of depression than students in the control group 3 months after the intervention ended. Furthermore, when the outcomes of the students who began the study with symptoms in the clinical range were compared, students who received the intervention had significantly greater decreases in both depression and PTSD (Kataoka et al., 2003).

Strengthening of Intergenerational/Intercultural Ties in Immigrant Chinese American Families (SITICAF)

SITICAF is an 8-week parent-training program for Chinese parents who have migrated to the United States. The 2-hour classes cover many topics: cross-cultural encounters, ethnic identity formation, cultural differences, child development, parenting practices such as active listening and limit setting, and handling stress. The classes are delivered in Mandarin, and the class format includes lectures, group exercises and homework (Ying, 1999).

This intervention has not been researched extensively, but a pilot study with 15 parents found that participation in SITICAF lead to increased sense of parenting responsibility, control of the child, and improvements in the parent-child relationship. While the intervention did not significantly affect children’s mental health, the quality of the parent-child relationship at the end of the program and at 3-months follow-up was significantly related to the child’s self esteem (Ying, 1999).
COMPATIBILITY OF FAMILY-BASED MENTAL HEALTH INTERVENTIONS FOR IMMIGRANTS WITH FAMILIES IN THE CHILD WELFARE SYSTEM

While none of the aforementioned programs have been tested with children from immigrant families in the CWS, there are many aspects of these interventions that indicate they may be effective for this unique population. For example, the main benefits of all of these programs are that they address acculturation stress, are delivered in the families’ native languages, and tackle intergenerational cultural conflicts. Mental health treatments provided to children and families in the CWS typically do not address these issues. If maltreatment in an immigrant family stems from difficulty coping with the children’s more rapid acculturation or with other aspects of the transition to life in the United States, then these programs may be superior to therapies that focus on other causes of maltreated children’s emotional and behavioral problems.

Another benefit of these programs is that they are all group-based. Participating in therapy groups gives both parents and children the chance to meet other people from immigrant families who are coping with similar problems. The opportunity to meet other people and possibly make new friends may also be especially beneficial to maltreating parents. Parents who are neglectful typically have smaller social networks and fewer friends or relatives who live nearby than parents who are not neglectful. Meanwhile parents who are physically abusive have fewer close relationships than non-maltreating parents (Coohey, 1996).

The fact that all of the programs involve the children’s biological parents is another sign that these programs may be helpful for families involved in the CWS. Most children who have contact with this system are not removed from home (Barth, Landsverk, Chamberlain, Reid, Rolls, et al., 2005) and most children who are placed in foster care are reunified with their biological parents within 2 years (American Academy of Child and Adolescent Psychiatry, 2005). Thus, it is very important to include parents in treatment when providing mental health services to children in child welfare.

Despite their potential effectiveness, these programs also have several potential limitations. For example, the children in the studies of these programs did not necessarily have mental health problems. Children in the CWS have high rates of psychological disorders (Burns et al., 2004; Clausen et al., 1998; Garland et al., 1996) and it is possible that these programs would not be able to effectively reduce their psychiatric distress.

Also, all of the families in the research studies volunteered to participate. Yet, families in the CWS may be mandated to attend treatment programs (Barth et al., 2005), and researchers have found that they are more likely than non-maltreating families to drop out of treatment prematurely (Lau & Weisz, 2003). The interventions designed for immigrant families could be less effective with families in which the parents were not participating out of
their own free will. However, it is also possible that the intensive engagement strategies used in Familias Unidas could significantly improve the retention of these families in treatment.

As reflected in the reviews, research on most of these programs is limited in number and methodological rigor to one or two observational studies with the exception of Familias Unidas which has been evaluated in two randomized controlled trials (Tapia et al., 2006). Before applying these treatments to immigrant families in the CWS it would be useful to conduct additional trials of their effectiveness.

Finally, all of these interventions are created for children living with their biological parents, and both Entre Dos Mundos and Familias Unidas are designed to address conflicts that occur between immigrant parents and their children when the children acculturate more quickly to the United States (Smokowski & Bacallao, 2009; Tapia et al., 2006). Yet if children from immigrant families are not brought to the attention of the CWS unless the incidents of abuse and neglect are severe, as has been hypothesized (Dettlaff et al., 2009), then it is likely that a high proportion will end up in foster care. Furthermore, these children may be placed in families of a different ethnicity. Or, they may be placed with caregivers who are of the same ethnicity, but the caregivers may have lived in the United States for longer than the child and may be more accustomed to United States culture. Thus, these foster families may need interventions that teach the caregivers about the child's culture and heritage, or that help them cope with conflicts between highly acculturated parents and less-acculturated children.

EVIDENCE-BASED MENTAL HEALTH TREATMENTS FOR FAMILIES IN THE CHILD WELFARE SYSTEM

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT is a treatment for sexually abused children ages 3 to 18 years that contains a mixture of cognitive behavior therapy and techniques used to treat PTSD. It is conducted in 12 to 16 sessions with both the child and the non-offending parent. The child and the parent are typically seen separately except for three joint sessions. The intervention covers parenting skills, common reactions to childhood trauma, relaxation and desensitization techniques, identifying relationships between thoughts, feelings, and behaviors, using positive self-talk, and problem solving. The child is asked to write a story about the trauma experienced, and the therapist helps the child identify and challenge the child’s cognitive distortions related to the experience. The child also reads the trauma narrative to the parent, and they work on improving their communication. They also generate ways to help keep the child safe in the future (Cohen, Mannarino, Murray, & Igelman, 2006).
At least six randomized controlled trials have examined the effectiveness of TF-CBT and have found that TF-CBT was superior to non-directive supportive therapies, and Rogerian style therapies, at reducing symptoms of PTSD and behavioral problems (Cohen, Mannarino, Murray, & Igelman, 2006). Additionally, TF-CBT is one of the primary treatments used in the Community Outreach Program-Esperanza offered by the National Crime Victims Research and Treatment Center at the Medical University of South Carolina (Charleston, SC). This program provides case management and mental health services to children who have been victims of crime. Many of the program recipients are immigrant families from Mexico (De Arellano, Waldrop, Deblinger, Cohen, & Mannarino, 2005; De Arellano, Ko, Danielson, & Sprague, 2008).

The experience of working with these families has lead to the development of a modified version of TF-CBT for Hispanics. Some of the modifications include providing a more thorough explanation of therapy in the psycho-education component, and reframing the discipline techniques as ways to increase respect because Hispanic parents may expect their children to be more respectful of adult authority than do White American parents (De Arellano, 2009). TF-CBT has also been modified for African refugees (Murray, Cohen, Ellis, & Mannarino, 2008) and for use in the Netherlands, Germany, Norway, Russia, Pakistan, Palestine/Israel, Sri Lanka, Indonesia and Thailand (De Arellano et al., 2008). The outcomes of these modified versions have not yet been published.

Parent–Child Interaction Therapy (PCIT)

In contrast to TF-CBT, which addresses internalizing problems, PCIT is a treatment for children age 2 to 6 years with behavioral disorders. PCIT has two phases: child-directed interaction (CDI) and parent-directed interaction (PDI), and it is implemented in 14 1-hour sessions. During each session the child is in a playroom with one of the parents (usually the mother), and the parent has an electronic ear “bug” through which the parent receives instructions from a therapist who is watching the activities in the playroom through a one-way mirror. The goal of the CDI phase is to teach the parent and child how to interact in a positive manner. The parent learns to let the child control the play session and to praise the child effectively. In the PDI phase, the parent learns how to give clear instructions to the child and how to apply appropriate consequences for misbehavior (Chaffin, Silovsky, Funderburk, Valle, Brestan, et al., 2004; Herschell, Calzada, Eyberg, & McNeil, 2002; Timmer, Urquiza, Zebell, & McGrath, 2005).

Research on PCIT has found that it improves maltreating parents’ interactions with their children, reduces children’s symptoms of externalizing disorders, and lowers the risk of re-abuse (Chaffin et al., 2004; Timmer et al., 2005). Besides being successful with maltreating families, it has also been
found to be an effective treatment for foster families in which the caregivers are having difficulties coping with children with behavior problems (Timmer, Urquiza, Herschell, McGrath, Zebell, et al., 2006; Timmer, Urquiza, & Zebell, 2006).

PCIT has also been successfully adapted and applied to children living in other countries. For example, Leung and colleagues (2009) studied the effectiveness of PCIT with Chinese families living in Hong Kong. The assessment measurements were translated into Chinese and the therapists spoke Cantonese, but no other modifications were made to the program. The researchers found that the 48 families in the intervention group had significantly greater improvements in parenting practices, parenting stress, and child behavior than the 62 families in the comparison group who did not receive treatment.

When PCIT was implemented in Puerto Rico the treatment received more modifications. In addition to translating the assessment measures and providing the treatment in Spanish, treatment providers modified the program for Puerto Rican children by working to establish a warm personal relationship with the mothers, using idiomatic expressions, and helping mothers figure out how to involve the extended families in treatment. The modified version was only tested with nine Puerto Rican families, but it led to improvements in the children’s behavior problems and the parents’ use of discipline techniques (Matos, Torres, Santiago, Jurado, & Rodriguez, 2006).

PCIT has also been modified for Mexican American families. The adapted version—Guiando a Niños Activos (GANA [Guiding Active Children])—has a more extensive engagement protocol than typical PCIT. The protocol was changed because research suggests that even if Mexican American mothers are interested in the treatment, they may not participate if the child’s father and grandparents are opposed to it. The more extensive engagement protocol includes contact with the fathers and extended family members in order to discuss any reservations they have about the treatment. Because having a child with mental health problems can be seen as shameful in the Mexican American community, the GANA program is advertised as an “educational” treatment and the therapists are called maestros (teachers). Additionally, the handouts for the GANA program have been translated into Spanish and rewritten in simpler language for parents with lower education levels (McCabe, Yeh, Garland, Lau, & Chavez, 2005).

A pilot study of GANA was conducted with 58 Mexican American families with children with externalizing disorders. The families were randomly assigned to GANA, regular PCIT, or usual care. Families who participated in GANA had significantly better outcomes than families who were given usual care. However, in general, the outcomes for the families who received GANA were not significantly different from those who received PCIT (McCabe & Yeh, 2009).
Multidimensional Treatment Foster Care (MTFC)

MTFC, which was designed by Chamberlain and colleagues at the Oregon Social Learning Center, is a milieu treatment that employs foster parents as agents of change (Fisher & Chamberlain, 2000). Foster parents who participate in MTFC are extensively trained in behavior management. They use a point system that rewards the foster child for engaging in activities that he would normally be expected to do, such as attending classes, and takes away points for breaking the household rules. The foster parent and the child are assisted by a clinical team which includes a Parent Daily Report (PDR) caller, case manager/clinical supervisor, behavior support specialist, youth therapist, family therapist, and consulting psychiatrist. The PDR caller contacts the foster parent daily and they complete a checklist of the problematic behaviors the child engaged in each day. This checklist is given to the clinical supervisor/case manager who coordinates the activities of the rest of the treatment team (Fisher & Chamberlain, 2000).

When conducted with maltreated children, MTFC has proven to be superior to regular foster care at reducing behavior problems and placement breakdown, and improving parenting skills (Chamberlain, 2003; Chamberlain, Price, Leve, Laurent, Landsverk, et al., 2008; Fisher & Chamberlain, 2000; Price, Chamberlain, Landsverk, Reid, Leve, et al., 2008). MTFC has also been implemented in Sweden, the United Kingdom, and Canada, and it is currently being implemented in Norway, Denmark, the Netherlands, and Ireland (TFC Consultants Inc., 2009). Yet effectiveness studies of these MTFC programs have not yet been published. Additionally, while the samples in studies of MTFC programs in the United States have contained minority youth including children who spoke primarily Spanish (Chamberlain et al., 2008), the outcomes of minority youth in comparison to White youth have not been the main focus of the research.

COMPATIBILITY OF TF-CBT, PCIT, AND MTFC WITH CHILDREN FROM IMMIGRANT FAMILIES INVOLVED IN THE CHILD WELFARE SYSTEM

Although TF-CBT, PCIT, and MTFC were not designed for immigrant families, there are many aspects of these treatments that indicate that they could potentially be beneficial for immigrant families in the CWS. For example, not only do these programs have extensive research supporting their efficacy, in contrast with many mental health interventions for immigrant families, these treatments have all been tested with children who have been maltreated and who exhibited symptoms of mental health problems. Additionally, both PCIT and MTFC have been applied to children in foster care. Furthermore, researchers frequently study the application of these interventions with new populations. The results from studies of the implementation of all three
programs in other countries may suggest ways in which these programs can be modified for immigrants.

TF-CBT may be especially applicable to immigrant families in the CWS, because children in these families may experience multiple forms of trauma. For example, Hispanic children who immigrate to the United States may witness acts of violence while crossing the border (De Arellano et al., 2005). TF-CBT therapists could help immigrant parents understand the impact these experiences may have on their children, and help the children cope with negative thoughts and feelings related to these events.

Although MTFC has a very different treatment philosophy and style than TF-CBT, it may also be easily adapted to suit the needs of immigrant families with children who have been placed in foster care. Some of the benefits of MTFC are that it has a large treatment team, and that the treatment is provided in a variety of settings: the child's school, community, foster home and biological home. This wrap-around style approach may be valuable for two reasons: First of all, one member of the treatment team could devote his or her time to helping the child deal with acculturative stress while the other members continue to focus on the child's behavior problems. Secondly, if the child is facing discrimination at school and having culturally-related conflicts with both his foster parents and his biological parents, MTFC could address all of these issues.

Finally, while MTFC and TF-CBT have the potential to help immigrant families, there is already some evidence that PCIT is successful with people from non-western cultures. Although GANA was not more successful than regular PCIT, it still led to positive outcomes and was more effective than a no treatment condition.

However, before assuming that these interventions will be successful with immigrant families, additional research, especially on the effectiveness of MTFC with families from non-western cultures, is needed. Additional studies of TF-CBT with children who have been physically abused or neglected are also needed, because immigrant children who are placed in the CWS may be victims of these types of maltreatment. Finally, immigrant parents may be difficult to engage in these programs due to limited English proficiency, possible lack of insurance coverage, and concern about the stigma of mental health treatment (Gudino, Lau, & Hough, 2008).

TREATMENTS THAT HAVE BEEN TESTED WITH BOTH CHILDREN FROM IMMIGRANT FAMILIES AND CHILDREN IN THE CHILD WELFARE SYSTEM

The Incredible Years

The Incredible Years is actually a series of treatment programs. One of
the parent-training programs, BASIC, is designed to help parents of infants and children age up to 12 years become more effective disciplinarians and address child behavior problems (Incredible Years, 2008). In 12–14 week sessions, parents watch and discuss videotapes of parent-child interactions. They learn how to play with and praise their children, set limits, and respond to inappropriate behavior (Linares, Montalto, Li, & Oza, 2006; Incredible Years, 2008).

Linares and colleagues (2006) studied the effectiveness of the BASIC program combined with a co-parenting intervention for 128 foster and biological parents of children who were currently in foster care. The co-parenting intervention consisted of one session in which the biological parents met with their child’s foster parents and attempted to resolve conflicts about parenting issues. The researchers found that compared to the control group, parents in the intervention group used significantly more positive parenting practices and were significantly better at providing clear expectations after completing treatment.

The effectiveness of the BASIC program has also been studied with a small sample of Korean American mothers and their children. All of the 29 mothers in the study were first-generation immigrants. The program was tested with this population because traditional Korean parenting practices include using harsh discipline and fewer positive interactions with children than standard American parenting practices. The mothers’ level of acculturation was measured and included in the analysis.

Following the training, the mothers in the intervention group were more likely to use positive discipline than the mothers in the control group who did not receive any kind of treatment. Furthermore, the researchers found that highly acculturated mothers increased their use of appropriate discipline techniques (time-outs, withdrawal of privileges) while less acculturated mothers decreased their use of harsh discipline (Kim, Cain, & Webster-Stratton, 2008). Although this study had a small sample size and most of the children did not have behavior problems, the results suggest that The Incredible Years may be successfully adapted for immigrant families.

CONCLUSION

The reviews of both evidence-based mental health treatments that have been tested with maltreating families, and family-based mental health treatments for immigrants suggest that the ideal treatment would:

- use engagement strategies to recruit immigrant families;
- address acculturative stress and acculturation conflicts;
- teach parenting techniques;
address trauma caused by maltreatment and or the immigration experience;
help parents with their own mental health problems;
be delivered in immigrant families’ native languages; and
have research support indicating effectiveness with both immigrant families and children who have been maltreated.

As shown in Table 1, none of the treatments in this review have all of the ideal components. Yet, both the interventions for immigrant families and those for maltreated children may be adapted to suit the needs of immigrant families in the CWS. The Incredible Years, MHIP, and TF-CBT may have the most research to support their application to this unique population. The Incredible Years is the only program that has been tested with both families with CWS involvement and immigrants. Also, the treatment used in MHIP is very similar to TF-CBT, which suggests that these types of cognitive behavioral treatments could be effective for immigrant youth in the CWS suffering from depression and PTSD.

However, these youth may vary in the severity of the maltreatment that they have experienced, and in the severity of their psychological disorders. Given the fact that mental health interventions for immigrant families are mostly group-based programs, and are designed for children living with their biological parents, these interventions may be best adapted for families with more mild incidents of maltreatment and for children with less acute mental health problems. Meanwhile, adaptations of individualized treatments such as TF-CBT, PCIT, and MTFC may be better suited for immigrant children with severe psychological problems who have been placed in foster care.

Children from immigrant families in foster care may also need interventions that address cultural conflicts that arise between foster parents who are either uninformed about the child’s heritage, or who are at a different level of acculturation than the child. Furthermore, parents in immigrant families may benefit from interventions that, in addition to focusing on intergenerational cultural conflicts, address some of the issues the parents may face such as substance abuse, domestic violence, or difficulties arising from undocumented status. Studies of immigrants have found that they are at risk for developing psychiatric problems and can face many obstacles that prevent them from accessing treatment including concerns about stigma and language barriers (Pumariega, Rothe, & Pumariega, 2005). Researchers and treatment providers seeking to create or adapt mental health interventions for immigrant families should consider the unique needs of all of the family members.

However, researchers and treatment providers should also be aware that parents in immigrant families may face many obstacles to utilization of mental health services (Gudino, Lau, & Hough, 2008). Future research on adapting mental health treatments for immigrant families involved in CWS should focus on whether the intensive engagement strategies used in
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<tr>
<td>Incredible Years</td>
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<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Mental Health for Immigrants Program (MHIP)</td>
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<td>Multidimensional Treatment Foster Care (MTFC)</td>
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<tr>
<td>Parent–Child Interaction Therapy (PCIT)</td>
<td>X (GANA)</td>
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<td></td>
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<td>X (Cantonese &amp; Spanish)</td>
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<tr>
<td>Strengthening of Intergenerational/Intercultural Ties in Immigrant Chinese American Families (SITICAF)</td>
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<td>X</td>
<td>X</td>
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<td>X (Mandarin)</td>
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<td>Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)</td>
<td></td>
<td></td>
<td>X</td>
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<td>X (Spanish)</td>
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</table>
Familias Unidas and GANA actually improve parents’ treatment engagement and prevent attrition. Further research is needed on whether these strategies can be used with immigrants from non-Spanish speaking cultures. Most of the mental health interventions identified in these reviews were designed or adapted for Hispanics, and research is also needed on the adaptation of mental health treatments for immigrants coming from Asian, African, and European countries.

Children from immigrant families that are involved in the CWS face several risk factors that can be detrimental to their mental health. In order to assist these children and their families, existing mental health treatments designed for immigrant families and those designed for families in the CWS could be modified to address both acculturative stress and the sequelae of maltreatment.

REFERENCES


CONTRIBUTOR

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