

PSYCHOLOGICAL IMPACT OF MIGRATION ON LATINAS

Implications for Psychotherapeutic Practice

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This paper examines the psychological implications of the migratory process on Latin American women in the United States, addressing issues of gender roles, acculturation, language, loss, and grief that are frequently presented by immigrant Latinas in psychotherapy. The paper interprets these issues as reflective of the stresses created by the migratory process rather than as issues of individual psychopathology, and suggests ways to respond to them through psychotherapy.

The unique stresses created by the process of immigration into another country and the need for grieving the loss of the home country and loved ones are important psychological processes confronted by all immigrants and refugees. Frequently, the psychological effects of migration and its specific impact on women will manifest themselves in issues brought to the attention of psychotherapists working with Latinas. There is evidence that the impact of migration on women and their roles is different from the impact of the same process for men (Andizian et al., 1983), and more research is needed in this area.

For both immigrants and refugees, the process of migration implies a certain degree of culture-shock that entails mourning the loss of the old country and of love objects, coupled with the need to confront new situations and interpersonal encounters (Garza-Guerrero, 1973; Grinberg & Grinberg, 1984). Factors such as perceived or real freedom to migrate, relative ease or difficulty of this process, sense of responsibility for those

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left behind, and conditions in both the home and host countries, interact in specific ways with culture-shock for each individual migrant. For example, leaving the home country through illegal means that can be life threatening has a different psychological impact than does arrival in a new country via legal entry.

Some intrapsychic factors such as ego strength, decisionmaking skills, resolution of feelings of loss, and the ability to tolerate ambiguities, including gender-role ambiguities also influence migrants' adaptation processes. Shirley (1981) found that these factors actively interact with the joy and hope created by the opening of new doors and opportunities and, in some cases, with the escape from real or perceived life-threatening conditions. Other factors pertaining to the new country such as language proficiency, ability to find a job, losses or gains in status or social class, educational level, degree of similarity between the two cultures, and reception by citizens of the host country also determine and influence the experience of migration and subsequent adaptation (Stade, Doran, & Satterfield, in press; Taft, 1977).

These factors vary substantially for males and females. Thus, the unique interplay of issues pertaining to the psychological make-up of the individual Latina, specifics of the home subculture and social class, and the characteristics of North American culture can facilitate or interfere with the adaptation process.

The purpose of this article is to review and analyze clinical material relating to the psychological correlates of the process of migration in Latina women and girls and to suggest implications for the psychotherapeutic process. Most of the clinical evidence and examples presented in the paper are garnered from my own practice.

THE PSYCHOLOGY OF MIGRATION AND ACCULTURATION

An understanding of the psychological processes involved in adaptation to another culture is essential for the understanding of the psychological implications of migration. Acculturation can be distinguished from assimilation in that acculturation does not imply the disappearance of all values, customs, and behaviors originating in the home culture as implied in the "melting pot" ideology of assimilation. While acculturation is inevitable to some degree for all migrants, it does not need to be disruptive in a negative sense. Healthy acculturation may resolve itself into healthy biculturalism (Szapocznik & Kurtines, 1980).

Regardless of gender and cultural background, the process of immigration involves important psychological changes that take place before and after arrival in the new country. These changes continue to take place throughout the life of the immigrant and include the development of a new identity (Garza-Guerrero, 1973).

Psychological Stages of the Migratory Process

Clinical observations have led me to think of the process of migration as having three stages: (a) the initial decision concerning relocation, (b) the actual geographical move into another country, and (c) the adaptation to a new society and way of life. At each step of the way, men and women will experience the process differently. For instance, at the decisionmaking stage, women may not be consulted about their preference to leave or stay, whereas most men participate in the family decision to leave or make the decision themselves. At the relocation stage, particularly in situations of escaping dangerous political conditions, women's physical endurance may be questioned and they might not be provided the same opportunities to escape. At the third stage, when acculturation and adaptation are taking place, modifications of women's gender roles may be more dramatic than those experienced by men.

Acculturation and adaptation to a new culture may also follow several stages (Arredondo-Dowd, 1981). These include initial joy and relief, followed by disillusionment with the new country. Finally, if the process is successfully completed, the migrant moves into acceptance of the good and the bad in the host country, and thus into adjustment and reorganization coupled with adaptation to a new situation (Garza-Guerrero, 1973; Grinberg & Grinberg, 1984).

The process of adaptation, however, is not linear. The multiple intrapsychic and behavioral changes required for successful acculturation occur at many levels and may proceed at a different pace at each one of them.

If rejection and distance of the host culture becomes the preferred mode of coping with the new society and way of life, the adaptation process may never be successfully completed. The traditional expectations for the role of women in Latin culture may even foster the isolation of some women from the mainstream culture. These Latinas will seldom seek psychotherapy on their own either because they may be reluctant to do so, unable to afford it, or likely to encounter opposition from family, friends, or husbands who may view psychotherapy as an invasion of family privacy. When traditional Latinas consult a psychotherapist, they may have come into therapy following referral by a medical doctor, as a result of repeated somatic complaints. The high incidence of somatic complaints presented by Latinas with a traditional cultural orientation might be an expression of actual frequency of somatization of conflicts that is prevalent in traditional cultures (Kleinman, 1980).

On the other hand, somatic complaints might be the symptoms of a masked depression or of one of the many types of emotional disorders that frequently are presented with a cluster of somatic complaints. It is possible that traditional Latinas have few other ways to seek help, or that generally they are only aware of "feeling bad" without being able to pinpoint the source of those feelings. Perhaps some of the women simply do not know

what else to talk about with a "doctor," or do not want to talk with a stranger about their more intimate feelings about themselves and their families, and find it easier to continue to discuss physical symptoms instead. The fact that mental health professionals and physicians frequently prescribe tranquilizers and other medication for these patients rather than psychotherapy may also serve to reinforce the belief that they have some kind of physical illness.

Whatever the reason for the high incidence of somatic complaints, the fact is that those complaints are constantly presented by Latino clients (Abad, Ramos, & Boyce, 1974), especially by women. If the therapist does not show in some way that these somatic complaints are being addressed, the woman client who comes from a traditional cultural orientation is likely to see the treatment as irrelevant and may terminate the therapy.

Although some Latinas may choose the traditional role expectations, most Latina immigrants find that these are neither functional nor satisfying. Culturally-based conflicts may develop when newly encountered patterns of gender roles combined with greater access to paid employment for women open new economic, social, and emotional options which create an imbalance in the traditional power structure of the family (Torres-Matullo, 1980). These women may consult a therapist at their own initiative and they may or may not be very explicit about the interrelationship between the migratory process and their feelings of distress.

Gender Role Conflicts

Women and girls from a Latin background are presently acculturating into North American society at a time when the role of women in this culture is in flux. Sometimes they may come from countries where official government policies or other forces are also fostering a transformation of the role of women, or from urban professional environments which have also been affected by the global feminist movement. But in other instances, they may come from very traditional rural environments where adherence to traditional gender roles is considered of primary importance. These factors combine to create some confusion as to what is appropriate behavior for women in the newly-found North American culture. Frequently, the contradictions between home and host cultures are stronger for women than for men in terms of what constitutes appropriate gender-role behavior.

Role conflicts in migrant families tend to occur mostly along lines that coincide with age and gender differences (Szapocznik & Kurtines, 1980). It is a common clinical observation that parents tend to be distressed by their children's more rapid pace of acculturation and that husbands tend to become resentful of their wives' apparent new independence and challenge of their patriarchal authority. Research shows that even though the pace of acculturation tends to be slower for females in all other aspects, they tend

to acculturate faster than males when it comes to gender roles (Ginorio, 1979). Immigrant families may become entrenched in traditional social and sex-role norms as a defense against the strong pressures to acculturate. The home culture may become idealized and its values, characteristics, and customs may become a symbol of the stable parts of personal identity and probably the strongest defense against any sense of identity loss that might be engendered by acculturation. This attempt to preserve "old ways" tends to increase intergenerational and gender-role conflicts in the family.

In addition to gender, other factors such as age, class, and race affect the process of acculturation and adaptation for migrants. Light-skinned, young, and educated migrants usually encounter a more favorable reception in the United States than dark-skinned, older, and uneducated newcomers. These differences in reception may or may not parallel the migrant's experiences in the home culture. For example, when a migrant comes from a country where she belongs to the racial majority or where, as in Latin countries, racial mixtures are the norm, the experience of turning into a minority in the United States and encountering overt racial discrimination becomes a disorienting experience. In addition, economic need combined with lack of fluency in the new language frequently add to the experience of downward mobility in employment, particularly for refugees. This loss of status creates frustration and tensions in the family. Because of the increased employability of women and the loss of status and authority of the father in the family, further conflict related to gender norms often develops.

PSYCHOTHERAPY WITH MIGRANT LATINA WOMEN

Seldom will a Latina woman present herself for therapy stating that she has "acculturation problems" or "psychological problems due to immigration." Most typically, an immigrant Latina seeks therapy because of personal problems similar to those presented in therapy by other women: Because she is depressed, has trouble in developing relationships, feels disoriented, or has a specific situational problem such as conflicts with her husband, partner, children, parents, or co-workers. However, as does every individual who comes to therapy, she has a unique history that modulates and defines the parameters of her specific problem or problems. In the case of immigrant women, their individual histories are influenced by the experience of migration and by the circumstances surrounding that experience as well as by the vicissitudes of their own personal and family histories.

The specific socio-political, economic, and historical circumstances that motivated the migration affect the individual psychological development and the process of therapy. The impact of these circumstances may appear more clearly in Latina women who are refugees than in those women who

are voluntary migrants because of the danger surrounding the departure of most refugees and the impossibility of returning regularly to the country of origin. In addition, the problems presented in therapy by women who migrate alone may have different characteristics than those presented by women who migrate with their families.

Latina women who migrate alone have to struggle not only with loneliness, but also with feelings of shame and guilt and with the sociocultural expectations about the role of women that present themselves both externally and intrapsychically. On the one hand they feel freer of family control and have more flexibility in looking for new patterns of behavior in response to acculturation than those who migrate with other family members. On the other hand, they may continue to have traditional expectations for their own roles and behaviors that may not be realistic in the new context. In addition, they may have to contend with criticism from other immigrants from the same country for not conforming to traditional roles. Because they are alone, they may in fact need to acculturate faster.

These women, even if they constitute a numerical minority among immigrants, present unique challenges for therapeutic work. For example, an adolescent girl or a young woman who left her country without her family may find herself affected by a premature and traumatic separation from her parents that can stall or delay the process of healthy psychological separation in adulthood (Rodriguez-Nogues, 1983). Paris (1978) likens the forced individuation from the parent caused by leaving their country to the effect of the impossibility of completing the rapprochement period in the life of a child. In order for a child to successfully complete their individuation and reconciliation with the parents in adulthood, periodic return to parents is essential for refueling, and yet is impossible for young refugee women. When the rapprochement is interrupted as it is in the case of these refugee women, guilt, frustration, restlessness, and lowered self-esteem could develop.

The impossibility of contacting parents during the course of therapy may prevent the woman from working out conflicts that may have originated before the separation took place. Although some similarities may be encountered when parents are deceased, major differences are present in the case of migrant women: Dead parents cannot be affected by the woman's present anger or resentment. Living and geographically inaccessible parents, on the other hand, can be affected by anger. The migrant woman, particularly if she does not have regular contact with them, frequently feels guilty about her anger toward parents who are geographically distant and perceived to be in a situation of more or less danger in the country of origin. A monthly long-distance phone call to an absent mother does not provide the time to address any problematic issues.

Another example of women strongly affected by the inability to work out problematic feelings may be a mother who, at migration time, was forced by her relatives, ex-husband or situational factors to leave her chil-

dren behind. This woman's feelings of guilt and loss were exacerbated by the lack of contact with her growing children.

The feelings of guilt and loss usually associated with migration become heightened by this inaccessibility. Even when, the refugee may be allowed to return to her country of origin for brief visits, the time needed for working through issues will not be available in a week or two of family re-encounter after many years. And, even if they can have extended visits home, the family does not witness the change experienced by the woman in the new country, so they can dismiss or deny the importance of those changes in her life.

Thus, therapy proceeds in a void for migrant women. They have to learn to understand, express, and experience feelings concerning distant family members without ever fully testing those feelings in the interpersonal context where they originated.

When the migration has been preceded by situations of political persecution that may include experiences of torture or the disappearance of family members, other unique factors may be part of the therapy. Moreover, some of the traumatic events experienced by women refugees are directly associated with their gender. For example, repeated rape or other forms of sexual abuse or harassment may have been used as a means of torture. Or they may have been subjected to rape and harassment at the hands of their "protectors" or "saviors" during their escape from their country of origin.

Persons who have been subjected to these experiences may suffer from post-traumatic stress reactions that may vary in intensity for each individual (Figley, 1985; Molesky, 1986). Post-traumatic stress reactions may manifest themselves through nightmares, numbing of feelings, and overwhelming feelings of guilt. Empirical evidence seems to indicate that sadness, depression, and more serious pathology may recur or develop many years after the actual migration took place. This phenomenon seems to be particularly true of immigrant and refugee women who have suffered traumatic experiences in the process of migration, have lost their networks of female relatives and childhood friends through migration, or did not participate in the decision to migrate (Rumbaut, 1977; Telles, 1980). For the woman suffering from post-traumatic stress, therapy can provide a needed outlet. Because some of the experiences of torture and abuse suffered by refugees are so inconceivable to people who have lived in the United States all their lives, the woman refugee from a Latin American country sometimes has difficulty expressing what she has undergone without feeling she is seen as a liar. Mental health professionals have observed that just the telling of the experiences, the opportunity to speak about what was sometimes felt as unspeakable may in itself be therapeutic for these women (Cienfuegos & Monelli, 1983; Figley, 1985). To be able to talk about these experiences and be believed provides an enormous relief for the woman who has experienced torture and political persecution before migration.

Young women or adolescent girls who migrate with their families although accompanied and protected, confront the question of how to "become American" without losing completely their own cultural heritage. Role models of successful bicultural Latinas are scarce. A bicultural Latina therapist can thus provide an invaluable service just by being available to the young woman as a role model.

Girls frequently express their adolescent rebellion against the parental culture by refusing to speak Spanish at home, rejecting cultural customs, and generally reacting negatively toward their parents and native culture. Since American society at large encourages immigrants to deny their cultural heritage, the adolescent Latina finds plenty of support from adults in positions of authority to challenge her parents' values. Often conflicts over authority are played out around issues of appropriate sexual behavior such that dating and other behavior related to sexuality become the focus of conflict between parents and daughters (Espin, 1984). One of the most prevalent myths encountered by Latina immigrants is that all American women are "free" with sex. For the parents and the young woman alike, "to be Americanized" may be equated with becoming sexually promiscuous.

The question of loyalties to the home culture may manifest itself in other ways. For example, the parents of an adolescent Cuban girl became outraged and reacted with apparent unjustified violence to her interest in the new Cuban music, a popular form of song that developed in Cuba after the Revolution. Since she had come to this country when she was 2 years old, her interest in the music was simply an innocent way of familiarizing herself with something Cuban or simply just listening to music, while for her parents her interest was a political statement that had negative connotations.

AFFECTIVE AND COGNITIVE IMPLICATIONS OF LANGUAGE USE

Language is an important variable in psychodynamic psychotherapy with Latinas. Extensive discussion of the affective and cognitive implications of bilingualism and language use in therapy is beyond the scope of the paper. However, it is important to address this issue because even for those Latinas who are fluent in English, or who have lost fluency in the use of their first language, Spanish remains the language of emotions because it was in Spanish that affective meanings were originally encoded (Espin, 1982). To try to decode those affective meanings through the use of another language may be problematic at best. Psychotherapy relies too heavily on language to ignore its psychological implications for the therapeutic process, especially for persons who may constantly be changing between two languages or who are participating in a therapeutic process that is carried on in their second language.

Several authors have commented on the importance of language choice in therapy with bilinguals (Espin, 1982; Krapf, 1955; Marcos, 1976a, 1976b; Rosensky & Gomez, 1983). According to Marcos (1976a), bilinguals may appear to be withdrawn in their second language when they are not fully proficient in it. In this case, the attention paid to how things are said in therapy may distract attention from what is being said, thus impairing the therapeutic process. Conversely, proficient bilinguals may use independence between their two languages as a mechanism for compartmentalizing feelings (Marcos & Alpert, 1976). These mechanisms may render unavailable certain areas of the bilingual's intrapsychic world. Marcos and Urcuyo (1979) also describe the subjective experience of some language-independent bilinguals who experience a dual sense of self as a consequence of using different languages. According to De la Cancela,

The implications for psychotherapy of these difficulties may be that affects are blocked, hence, the client has difficulty in benefiting from catharsis and abreaction. As such, verbalization of feelings may turn out to be an arduous intellectual task which brings little relief to the client. Additionally both positive and negative transferences may be unsatisfactorily expressed leading to displacement or acting-out in the therapeutic relationship (1985, p. 430).

In my own clinical practice I have encountered instances in which the importance of language is expressed directly and those in which it is expressed indirectly. Manifestations of the impact of language in therapy with Latina clients are not clearly understood because the use of language in therapy has always been studied and described from a monolingual point of view (e.g., Havens, 1986). An example of an intuitive sense of the importance of the first language in therapy was provided by a college-age Puerto Rican woman who sought me out for therapy specifically because I could speak Spanish. She was fluently bilingual and did not need Spanish to communicate her feelings with a relative degree of sophistication. However, it was important to be in therapy with a Spanish-speaking therapist because, in her own words, "My problems are with my family and my family speaks Spanish, so my problems are in Spanish." Other clients have approached me as a therapist presenting variations of the same idea.

An indirect example suggesting the importance of the first language in therapy was provided by a professional woman who, having immigrated to the United States at a very young age, preferred to use English for her therapy even though she wanted a therapist who was "culturally sensitive." After two years in therapy conducted in English with minimal interspersed use of some common Spanish words, she came to a session in which she spoke only Spanish. At the end of the session, I pointed out that I had noticed we had used Spanish uninterrupted during the hour. She stated that there was nothing special in her language change in that particular session, that she just wanted to practice her Spanish more frequently. The

content of the session, in fact, had not been particularly deep or cathartic, so I went along with her expressed perception that there was nothing to her change in language. She never came back after that session. I must confess that her abrupt and unanticipated departure from therapy baffles me. But what is clear is that her change to Spanish on that particular day was not innocuous. Perhaps she was developing a negative maternal transference that became suddenly intensified by speaking to me in the only language her mother spoke or perhaps the use of Spanish brought up some other intense feelings that remained unacknowledged while she used English. Needless to say, I have never again treated lightly any shifts in language during therapy with bilingual women.

On the other hand, bilinguals conversing with each other habitually switch from one language to another without any significant psychological pattern being apparent. Speakers may choose expressions in the native or second language depending on the relative applicability of the expression to the context. As a bilingual therapist working with bilingual women, I try to remain alert to their language choice and switches as any therapist would remain alert to a client's choice of words. But, very specifically, I try to remain alert to possible areas of conflict that are being avoided or expressed by sudden shifts in language.

But while the use of English in therapy may act as a barrier and a resistance in dealing with certain components of the psyche, the second language can act as a facilitator for the emergence and discussion of certain topics. Some of these may be taboo topics or words in Spanish while others may refer to the new components of the self acquired through the process of acculturation after English became the primary or most used language. Gonzalez-Reigosa (1976), has demonstrated that taboo words in the language of origin elicit more anxiety than either taboo words in the second language or indifferent words in the first language.

The facilitative features of the second language become most evident when the topic discussed is sexuality. Latino culture has fairly traditional views of female sexuality (Espin, 1984, 1985a). For Latinas, English provides a vehicle for discussing sexual issues in therapy that may be too embarrassing to initiate with the use of forbidden Spanish words. In my practice I find this is particularly significant for Latina lesbians, who will describe their life situation and choices most frequently using terminology in English and will tend to avoid equivalent words in Spanish.

In addition to the emotional value associated with either the first or second language, an important aspect of language usage for bilinguals is its connection with self-esteem. In the United States, Spanish bilingualism is frequently associated with an inferior social status. Bilingual skills in Latinos are frequently devalued and rejection of bilingual parents as "ignorant" people who are contrasted with "educated" monolingual teachers may be encouraged in schools. The use of Spanish in therapy may be difficult because of these negative connotations, but may become an im-

portant instrument for reclaiming parts of the self that may have been rejected as negative through the process of acculturation.

ISSUES OF LOSS AND GRIEF IN THERAPY WITH IMMIGRANT WOMEN

Loss, grief and mourning are issues of primary importance when working in therapy with immigrants and refugees. Attempts to understand the psychological distress experienced by immigrants and refugees have generally focused on factors in the new environment and the need to cope with them or acculturative stress (Berry & Annis, 1974). However, the loss of home country and loved ones plays a significant role in the immigrant's adjustment. These feelings of loss must be resolved through a grieving process that can be facilitated by the therapy. In its normal form the grieving process involves a moderate level of emotional disorganization which may be manifested by apathy, insomnia, loss of appetite, irritability, angry outbursts, psychosomatic symptoms, and other signs of distress. When grief is delayed or inhibited because the loss is denied or otherwise defended against, the normal signs can take pathological forms by becoming prolonged or exaggerated (Lindemann, 1944). Parkes (1975) suggested several features by which to identify unresolved grief: a gradual process of realization from denial of the grief to recognition and acceptance of it; alarm reactions such as anxiety and other related physiological symptoms; an urge to search and find the lost object; anger and guilt; feelings of internal loss of self; identification with the lost object; and, pathological variants of grief. Telles (1980) has observed the effects of delayed grief on Cuban women who experienced a reactivation of this grieving process at the time of retirement from their jobs after many years of residing in the United States. The depression and emotional distress manifested by these women could be traced directly to the lack of successful mourning for the losses created by the migration in earlier years.

While the grief of the bereaved can be traced to the nature of the relationship to a specific person, in migration the lost object is vague and the loss pervasive. Migrants have lost country, culture and loved ones; in other words, what Ticho (1971) refers to as the "average expectable environment," which includes everyday patterns of relationships, obligations, networks, familiar food, places and people, and the behaviors that are considered "normal" in the home culture. When all those habitual patterns are disrupted at the same time and new patterns have to be learned, the amount of distress experienced by the migrant can be considerable. The magnitude of this loss is seldom understood by the immigrant or by others. Sometimes it may require returning to the homeland for the immigrant to realize what his loss had entailed (Espin, 1985b). Even supportive friends and social service agencies are more interested in the woman's adaptation

to her new life than in her feelings about who or what was left behind in the home country.

Latina immigrants struggle to maintain contact with the home country, either through physical proximity or through food, music, and other immigrants from the home country. In therapy, the effort to recover the lost objects (e.g., mother, country) may be expressed through strong transference reactions, particularly when the therapist comes from the same country or culture.

Preoccupation with "what could have been" if the woman had not left her country is a central theme in therapy with migrants. This preoccupation is expressed both through concern with what could have happened in her life had she stayed in her country of origin and concern with what has been gained by the migration. Not infrequently, the immigrant experiences feelings of guilt in relation to people and relationships left behind. New loyalties to individuals and relationships developed in the host country, including the therapeutic relationship, are frequently experienced as betrayal of the parents or the home country. In other words, "invisible loyalties" may interfere with the course of the therapy and with the process of adaptation to the new country. Boszormenyi-Nagy and Spark (1973) have discussed extensively the impact of "invisible loyalties" in personality development and relationships. "Invisible loyalties" can create powerful paralyzing and compulsive behavioral and emotional effects in individuals and families. They constitute an important aspect of the conflicts presented by immigrant Latinas in psychotherapy.

CONCLUSIONS

Because this article is about the stressors created by migration and their implications for psychotherapy with immigrant Latinas, emphasis has been placed on conflictual situations. However, it is important to understand that many of the reactions discussed in this paper are not pathological. It is important that the therapist interpret these reactions as natural consequences of a disturbing process and not as signs of individual pathology. This is not to deny that some Latinas will in fact present pathological manifestations whose sources existed prior to migration.

The therapist working with immigrant Latinas should acquire knowledge and information about each woman's reasons for migration, including the political and economic conditions in her country of origin and the specific circumstances in the woman's life that motivated her migration (Espin, 1985a, 1985b). Because some of the events described by Latinas in therapy are so extreme, it is important for the therapist to be aware of her own countertransference reactions to the client (Ticho, 1971).

Therapy should provide assistance in the grieving process and with the resolution of "invisible loyalties" that may be hindering adjustment. At the

same time, therapy should assist the client in maintaining loyalties and emotional proximity to those people and places that constitute the sources of her identity. Therapy can provide support in managing conflicts in the woman's relationships that might occur as a consequence of changes in her traditional roles and in newly acquired behaviors.

Bilingual/bicultural therapists can be especially helpful in assisting Latinas to resolve some of those concerns and to adapt successfully to their new lives. But the fact that there is a dearth of Latina psychotherapists poses additional problems in the treatment of this population. Anglo therapists who are sensitive and competent in integrating cultural variables in their treatment plan may provide the necessary support and skills needed to assist immigrant Latinas in their process of adaptation. However, the question remains of how cultural sensitivity can be identified or achieved. Lack of research data and information do not allow for clear identification of what requisite experience, background, and communication skills are necessary for competence in the conduct of psychotherapy with immigrant Latinas or with any other ethnic minority population, for that matter.

Until further information from research and clinical practice is available, some of the ideas discussed in this paper can serve to identify stressors present in the lives of immigrant Latinas, as well as issues to be addressed in therapy with this population and initial questions for further exploration.

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