

“When Can I See You Again?": The Immigration Experience, Insecure Attachment and Psychotherapy

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Abstract: Adolescent immigrants need to navigate typical adolescent challenges while also struggling with the impact of immigration. Mastering the developmental tasks of adolescence is even more daunting for those teenagers who have underlying psychopathology. Intensive psychotherapy with these troubled teens provides a rich opportunity to better understand their struggles and to examine how best to provide necessary support for them. In this paper we explore how the task of engaging adolescents and their families warrants an approach that provides a space that is both flexible and responsive, addressing the underlying loss and behavior secondary to insecure or disorganized attachments. A case study of an immigrant teen in long-term treatment at a school-based health center (SBHC) highlights the importance of utilizing an attachment based model when intervening with this rewarding and highly vulnerable population. The case example illustrates the long term, therapeutic work which is reflective of the complicated patients in our caseloads, and also illuminates how the attachment framework shapes the therapeutic work. The advantages of the SBHC for utilizing this model are discussed.

Keywords: Adolescents, attachment, adolescent development, psychotherapy, immigrant adolescents, Asian adolescents, female adolescents, case report.

Attachment theory holds that emotional development occurs within an intersubjective dyad. That is, from infancy we grow with, are defined by, yearn for, or struggle with another. Bowlby's work on mother-infant bonds highlights the contribution of the environment – the mother – to shaping the parent-child bond. That is, the baby becomes the dependent, albeit active, partner in a dyadic dance. Ainsworth (1985) elaborated on Bowlby's work, denoting the “secure base” concept specifically to denote the mother-infant tie. Bowlby argued that “no parent is going to provide a secure base for his growing child unless he has an intuitive understanding and respect for his child's attachment behavior and treats it as the intrinsic and valuable part of human nature I believe it to be” (Bowlby, 1988, p. 12). It follows that if a parent cannot recognize these overtures in her child, there is the risk that the child's strategies may be ignored. This can lead to disorganized attachment, which can be displayed by the child being overwhelmed by negative emotions, mood lability in the face of anticipated loss, and disorganized behaviors in the child's frustrated attempts to establish proximity and comfort. The dyadic therapeutic relationship can become central for these teens to have a corrective experience and to learn to successfully handle stressful situations.

ATTACHMENT IN ADOLESCENCE

Teenagers normally seek other secure holding-environments outside their families, while continuing their essential attachments to their parents. This behavior is

termed “secure base seeking.” Secure base seeking behaviors constitute a repertoire of attachment strategies that help children navigate attachment and also establish proximity to alternative, safe, ‘non-parent’ adult attachments. Waters and Cummings (2000) stress that there needs to be a secure base from which the teen can safely explore newer attachment relationships.

PARENTAL EXPERIENCES AND ATTACHMENT

As Selma Fraiberg pointed out, ‘ghosts in the nursery’ haunt parents who have struggled with their own painful pasts to such a degree that they cannot hear their own baby's cries (Fraiberg, Adelson, & Shapiro, 1975). Researchers have analyzed the impact of parents' own experience on how they provide for their babies and growing children (Lyons-Ruth & Spielman, 2004; Lyons-Ruth, Wolfe, & Lyubchik, 2000; Lyons-Ruth, Yellin, Melnick, & Atwood, 2003; Main, Hesse, Greenberg, Cicchetti, & Cummings, 1990; Stern, 1985). There has been relatively less focus on how parents' experiences affect their relationships with their adolescent children, especially how they affect the evolution of the repertoire of attachment behaviors. Sroufe and Rutter (1984), Rosenstein and Horowitz (1996), and Waters and Cummings (2000) advocate for exploring the development of psychopathology in adolescence in the context of understanding how attachment trajectories are navigated throughout life. Many have stressed the importance of expanding the attachment paradigm throughout adolescence (Allen & Manning, 2007; Scharf & Mayseless, 2007), even asking how starting not with the study of infants but of adolescents might modify attachment theory, research and treatment.

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CULTURE AND ATTACHMENT

Western Culture vs. Interdependency

Western culture expects adolescents to progress towards autonomy and separation/individuation. In contrast, the cultures from which immigrants come may be termed “collectivist.” In such cultures, interdependence is prized and separation and individuation are not indicative of normative evolution, growth or resilience.

Brown, Rogers, and Kapadia (2008), when examining multicultural applications of attachment theory, state: “Attachment goals from a Western perspective move the individual from reliance on a safe base to personal exploration encompassing a wider and wider periphery, with the goal of autonomy...[while] in collectivist cultures, for example, the goal of the caretaker would be more apt to encourage mutual effort rather than self-reliance” (p358). That is, there may be an existing norm of “let’s do it together” rather than championing autonomy.

THE EXPERIENCE OF IMMIGRATION

Parental Trauma

The capacity of immigrant parents to nurture their children can be thwarted by their own traumas of immigration, deprivation and loss (Suarez-Orozco and Suarez-Orozco, 2001). In times of heightened stress the already compromised parent is unable to be attuned, empathic or at the very least, “good enough”. Immigration is one of the most stressful experiences an adult can go through. It involves separation and loss, and removes family members from many of the relationships and predictable contexts – community ties, customs, and (often) language. Immigrants are stripped of their significant relationships. They also lose the social roles that provided them with culturally scripted notions of how they fit into the world. These changes are highly disorienting and almost inevitably lead to a keen sense of loss (Ainslie, 1998). After arrival in the host country, there can be a reversal of roles, with the adolescent navigating the host culture and the parent perhaps perceiving loss of control, which may in turn reenact the parent’s disorganized attachment strategies. This is particularly the case when the adolescent is able to learn English swiftly while the parent’s acquisition is more labored.

Multiple Challenges Faced by Immigrant Teens

Being a teenager is inherently complicated. It is remarkable then that this already difficult developmental juncture, negotiated at best through a fragile normative alliance (Meeks, 2001), is broached at all by adolescents who may face stressful changes, assaults to their identity, and/or parental misattunements and losses. With the additional stressors that immigrant teens who struggle with psychopathology face, the transition can be amplified with major threats to their identity and relationships.

The Adolescent Immigrant Patient

Uprooting at any time during developmental point can be traumatic; when adolescents immigrate there can be sudden rupture with their previous attachment figures, loss of their

peers, and also loss of a previous sense of competence for both the parent and child. This can precipitate a period of silence, ‘frozenness’, or culture shock that can prevent immigrant teens from initiating peer relationships and developing trust in close friendships, engaging academically, or seeking out a role model (ego ideal) who can be a critical attachment figure in their new country (Igoa, 1995; Blos, 1967).

Age of migration for the child is also important, although regardless of the child’s age, the transition may be disruptive. Just as there are striking differences related to the reason for migration, i.e. having to flee one’s homeland as a refugee versus voluntarily leaving one’s home in the hope for a better future, there are also developmentally driven considerations. In childhood, immigration is often shocking, particularly when there is separation from one of the parents or from the extended family. Igoa (1995) speaks of a period of silence which she has observed in young children exhibit upon arrival to a foreign land. Schools and teachers often view the youngster as delayed, oppositional or uncooperative, when in actuality, the child is struggling from ‘culture shock’ and deeply longing to communicate. Igoa sees this stage as “a period of incubation during which the child must be provided with a warm and nurturing environment that makes it safe for him or her eventually to break out of a shell.” (ibid., p38).

James argues that this silence is a “universal characteristic of the uprooting experience...and can last up to one or two years” in immigrant children. Having an overwhelmed parent may further extend this period and complicate this transition.

Immigrant teens are not a homogenous group. Factors such as pre-migration socioeconomic status, anticipation of extended networks within the host culture, whether an intact family migrated together, whether the adolescent’s journey is one of flight as in the case of refugee minors – all have significant impact on the trajectories of adjustment. Teenagers are at great risk for poor outcomes if there is pre-migration lower socio-economic status, significant family psychiatric history, or limited resources. Most critically, adolescents with insecure attachments and a parent with disorganized attachment have an even more difficult time adapting to the host country. Their families bring with them very little financial, emotional or social “capital” (Suarez-Orozco, 2000). Tailored therapeutic intervention, soon after arrival in the host culture, maybe vital for this particular subset of teens.

One might assume that these teenagers, for whom day to day life is a struggle, would be difficult to engage in therapy. Yet in our work in a school-based health center (SBHC) and on an adolescent inpatient unit, we consistently see teens are willing to engage in care when the care is tailored to their unique needs. Describing how to do such work in a sensitive way that neither betrays the clinician’s therapeutic frame nor minimizes the fragile teenager’s needs is the purpose of our discussion here. A map for ‘how to’ engage these teens is delineated within the case studies and also outlined in Table 1.

Table 1. Attachment Informed Interventions

Child/Adolescent	Parent
<ul style="list-style-type: none"> ◆ Allowing for a flexible frame throughout treatment, especially in the initial phases ◆ Multi-systems treatment if possible ◆ Psychopharmacological intervention within an attachment frame ◆ Coordinate care with pediatrician – it takes ‘a village’/ system ◆ Ensuring safety through social services agency involvement as needed ◆ Reinterpret ‘behavior’ through an attachment framework ◆ Having clear boundaries and limits when necessary ◆ Allowing, witnessing and holding grief in adolescence ◆ Bridging to the ‘lost’ or more functional parent when appropriate within therapy ◆ School community building and mobilization of school leaders/staff ◆ Strengths-focused interactions to help with future orientation/ future goals ◆ Serving appropriately in multiple roles ◆ Appropriate self-disclosure in nurturing the alliance (i.e. “how did the therapist get to college?” calls for some level of transparency not neutrality) ◆ Allowing for ongoing proximity seeking and initiating outreach as needed ◆ Having clear boundaries/ limits when necessary ◆ Academic programs to support 1st generation college bound students ◆ Therapeutic support during school breaks as needed ◆ Bridging to ongoing counseling in the university setting 	<ul style="list-style-type: none"> ◆ Helping to develop a secure base for the parent as well ◆ Individual sessions with the parent and interpreter as needed ◆ Parent coaching and support ◆ Connecting the parent to ESL classes when ready or appropriate ◆ Teaching parents how to translate teen attachment behaviors ◆ Teaching perspective taking of their teen’s viewpoint when possible ◆ Helping with skill acquisition and reinforcing that entry into the host culture, may not mean letting go of their homeland, memories or traditions ◆ Connecting the parent to medical and mental health care ◆ Connecting the parent to social work to help secure employment as appropriate ◆ Teaching parents how to translate teen attachment behaviors ◆ Home based intervention and Family Stabilization Teams as available ◆ Connecting the parent to their own extended family supports as appropriate

CASE EXAMPLE

I¹ (AR) was introduced to Sue L., a 17 year-old Chinese-American adolescent, when the psychiatric emergency service dispatched me on an outreach call to evaluate a sophomore at her local, urban public high school. Sue told the school nurse that she had experienced thoughts of harming herself after an argument with her mother. She had a fairly good command of English after two years of English as a Second Language (ESL) classes, but seemed reticent and averted her gaze. Respecting her reserve, I gently invited her to share her story.

She and her mother had migrated to the United States together, leaving behind Sue’s father and their extended family in China. Sue tearfully described worsening depression and hopelessness. She was referred by the school to a Mandarin-speaking therapist a few miles from school, but had missed appointments for several months. She told me that as school became more demanding, she could no longer keep her appointments. She later reported that she was troubled that her therapist often spoke with her mother,

and also that the Mandarin-speaking therapist reminded Sue of her mother, whom she described as “old and traditional.” These worries troubled her and Sue was wary of disclosing her concerns to her culturally ‘matched’ therapist because of the perception that her therapist was allied with her mother.

Sue was willing to seek help even though she felt hopeless about her highly conflicted relationship with her disapproving mother. Soon after, when I transitioned to a staff position in her outpatient school-based health clinic, I began to see her in therapy. She recalled our first meeting and commented that she felt she could “say anything” without fear of rejection. She seemed to value easy access, reassurance that her treatment was confidential, and our therapeutic connection that was established during her previous crisis.

Sue described an immensely stressful migration from rural China, where she had left behind a supportive father and his extended family. She arrived by herself and was met by her mother, who had migrated a few months before. Sue was sad that she could not speak easily with her father and wanted to find work in order to earn enough money for a cell phone. (I would soon learn that for many immigrant teens the cell phone can provide a lifeline to a functional parent, a

¹I has been substituted for ease of the reader but indicates a collaborative effort in service delivery and supervision of these patients.

lost culture, and access to extended family with whom they can speak effortlessly in their native language).

Sue described a troubled relationship with her mother when she was younger, whom she experienced as consistently withholding and emotionally abusive. Sue said that Ms. L “has nothing but me [Sue]”, and that Sue’s mother was raised in poverty, with minimal education, and suffered from untreated chronic depression and anxiety. After separating from Sue’s father, Ms. L was involved with several abusive men. She told Sue that she came to the US so that she could provide Sue with academic opportunities to make her family proud. Sue wanted to become a physician and worked hard in her ESL classes and science classes, devoting twice as much time to studying as many of her classmates.

Sue described feeling depressed and anxious after arriving in the US. She confronted stressors that the average teenager does not encounter, such as acculturative stress, the pressure of adapting to her new host country to access basic needs, her separation from her supportive father, and the burden of fulfilling the ambitions of her extended family in China. Her main preoccupation in therapy, however, was her standoff with her mother, who she described as sadistic at worst and withholding at best. For example, Sue reported that Ms. L often would not give her food and even at one point placed a lock on her fridge door. Her mother had the expectation that Sue should financially support both of them while she attended high school. At times, this meant that Sue worked two jobs to support both of them. (Social Services dismissed the case, despite my concerns as well as those of the school that this constituted neglect and warranted the involvement of child protective services).

Our treatment lasted three years and began as a therapeutic relationship that did not fit the traditional frame. Sue often checked in with me, attempted to find me on days that I was not at the clinic, left notes for me, and frequently tried to extend our sessions. She let me know through her seeking behaviors, that the traditional 45-50 minute appointment did not meet her needs. The key was not to debate whether to ‘bend’ the frame or to indulge this testing, but to understand it within the context of attachment and help her be curious about it as well. Sue often ended our sessions in tears, wanting to know “When can I see you again?” Working with the school staff, we arranged for her guidance counselor to check on her regularly and for the school’s international office to continue to help her with her ESL goals.

With Sue’s permission, I met with her mother with an interpreter. I listened to Ms. L’s litany of complaints about Sue, and worked hard to validate her feelings in the hope that empowering the mother might help Sue to be able to further depend upon her. I tried to understand Ms. L’s sense of isolation, hostility and helplessness in the context of her own traumatic migration, and assessed her capacity to provide for Sue. I saw that Ms. L’s ‘ghosts’ were tormenting her and that she had even fewer supports than Sue did. I helped her to enroll in an ESL class, recommended treatment for her depression, and identified a primary care provider. She initially refused therapeutic support but eventually agreed to

see a social worker in the community. She also consented to Sue’s having an evaluation for medication and later agreed to an anti-depressant trial for her daughter.

During her junior year in high school, Sue’s second year of therapy, I worked hard to help her normalize her longing for maternal support, alongside her grief that her mother, although physically present, could not provide what she wanted. The constant craving alongside stark emotional vulnerabilities was immense. Although there was no physical violence at home, there were verbal altercations and isolation, with each of them absorbed in their own internal thoughts as they stared at the television, or sat alone in their rooms. There was heightened conflict at home about whether Ms. L should share her food with Sue. On the rare occasion when she did share food, there was an emotional cost. Sue was hurt that she needed to get even her most basic needs met outside of her relationship with her mother.

We helped Sue to begin to secure nurturing attachments outside of her home, and often this meant taking the risk of reaching out to others, expanding her social world. She was a very charismatic young woman whose story was quite compelling to adults. Sue was able to make strong connections with her teachers, guidance counselors and her mentors. She did, at times seem to overwhelm her school and peer supports as her needs seemed insatiable. At the same time, Mrs. L became more dependent on Sue as she perceived Sue as privileged and successfully able to access resources in their new culture.

During Sue’s junior and senior years in high school, I helped her to not feel ashamed of what would be conceptualized through a Western framework as clinginess or dependency. Sue also tested her psychiatrist’s availability in crisis. In addition to her psychopharmacology appointments, Sue often attended two psychotherapy appointments per week and seemed to fully utilize both meetings. At first glance, this could seem excessive and her demands unrealistic, given that she was clinically stable. However, I saw her ‘need’ as related to our access and her immense need for support, reality testing, and containment while she prepared for a major transition in her life.

One day Sue proudly announced that she was accepted to a small private college and would be moving some distance away. Although excited, she hesitantly stated that she was also overwhelmed. The prospect of going away unmasked her fear that all attachments rupture, and also elucidated her struggle to internalize our support as she faced potentially losing our connection. Sue asked me questions which indicated how important it was to her that I had internalized her, could hold onto who she was, just as she would need to evoke me while away at college. In our last session before Sue left for college, she asked “Will you be here when I come home?”, “How will you know what I’m doing?”, and “Can you call me?” and, her usual refrain, “When can I see you again?”

I prepared her for this transition, referring her to the counseling center at her college for ongoing care, and helping her to know how to access me and ‘hold on’ as needed through her adjustment. We arranged one bridging

phone call to ensure she had connected with her new therapist on-site at college and she often sent me email updates about her first semester. She frequently mentioned finally enjoying the freedom to openly stay in touch with her father in China. But she also was upset that her mother did not call her at college unless she (the mother) needed something, and had not visited her at school. Sue became increasingly despondent. She wrote about her affluent roommate whose intact family frequently called, sent care packages and visited her. She commented "there is already so much food and they just send her more." Additionally, her emails reflected her difficulty with navigating separation from her secure bases (therapy and high school). She wrote to me, "How are you doing? I miss you so much! ...everything is fine but a bit scary here...Now I actually miss you, and all the other people who care for me. I am thinking of going back sooner." The last comment signals some doubt about continuing in college. It may also have alluded to her upcoming trip to China to see her father. During her school breaks, Sue wanted to, and would need to, return to China as she did not feel welcome to return home to her mother.

Her freshman summer, Sue returned to China, but soon after her arrival she heard that her mother was ill and that she would need to return to the US sooner than planned. This was quite devastating as Sue felt that she had very little time with her father. Her secure base- and attachment-seeking behaviors are poignantly highlighted in the following e-mail excerpt:

...so this is my biggest concern now, that I don't know how I can have a weekly session with you. Again this is very important. And I know it may be too much of a favor to ask you for. But under special circumstances, would you consider one of the following methods (or come up with a better one if you can) to have a weekly or bi-weekly session with me? By 1) going on-line with a computer microphone, 2) I will try to get you a phone card to call China, so it will pay for the phone cost (it's cheaper to call back to China than from China to US, 3) other methods. Please HELP!!!
Love, Sue.

We did arrange to have one phone call when she scheduled a time to phone from China, and she revealed that she feared she was a burden to both her parents. After she returned to the US, she took a leave of absence secondary to her academic difficulties and her mother's ailing health, and she returned home and to our treatment. I encouraged her to prioritize her therapy for support during this crisis and took care to reframe what she described as a failure (her leave of absence). I took care to validate her sadness, but also to remind Sue of her bravery and the risks she had taken. I reminded her that she was welcome to return to treatment if needed, referenced her resiliency in the face of a myriad of other serious challenges or 'bumps in the road' and she seemed relieved. She returned to therapy, was grudgingly accepted back into Ms. L's home, and enrolled in a few classes at a local university. Facing her mother's disappointment was very difficult for her. Although Ms. L

had not supported her daughter's success, her disappointment indicated to Sue that Ms. L was counting on Sue's advancement. Although Ms. L's prognosis was stable (despite the earlier health scare), Sue became more depressed and engaged in high-risk sexual behaviors. She started to date a young man, also of Chinese descent. Sue announced proudly to me in one of our sessions that she was pregnant and wanted to become a mother and had decided to keep her child. Ms. L, when informed, was verbally hostile and disapproving, often calling Sue a failure. She retreated from Sue and at times would lock Sue out of their home.

I too struggled with the news of Sue's pregnancy, particularly after working so hard with her to help her achieve her dream of attending college. My initial reaction ranged from surprise, to countertransference disappointment, to relief for Sue, whose young life had been grossly deprived of loving connections. Sue also waited until she came home to engage in more high-risk behaviors (which she could have easily engaged in at her university), perhaps as an angry response to her mother's hostility. Suddenly, the treatment shifted to helping Sue manage her pregnancy. She continued to seek out our therapeutic 'secure base', as well as that of her primary care doctor for ongoing support until her delivery. As Sue's due date grew closer, she often worried that she would not be a good mother, and that she did not know how to be a mother, as she was painfully aware that she had never had adequate care.

With school- and hospital-based pre-natal support, Sue gave birth to a healthy baby boy. Her biological father supported his grandson's arrival from a distance and reassured Sue that her child was more than welcome in the family – indeed he would be valued and adored. She worked two jobs to pay her half of the rent at her mother's apartment, and attempted to stay connected to her former college and show her motivation to return to study. She stayed in treatment throughout her pregnancy, often seeking pragmatic advice and working to find housing that would be safe for her and her baby. As this housing was difficult to obtain and Sue did not want to stay at a family shelter, she continued to live with her mother. Sadly, Sue's mother could not find compassion even for her grandchild and resented his cries which kept her awake when she needed to sleep. Sue thought that Ms. L "hated" her grandson and saw him as an extension of Sue and an additional burden. Sue confided that she felt that Ms. L was angry with her for producing what she herself could not (an adored male), and for jeopardizing her housing provided by the State because of an additional child in their home. Sue did not trust Ms. L to care for her son, and thus Sue did not have reliable, affordable childcare.

On the few occasions when I saw Sue with her baby, she was for the most part loving and attuned, responsive when he cried and still struggling to manage her anxieties as a new mother with "no help from my mom." At times, however, she would hold her child rocking him gently, while speaking through her tears and ignoring his cries. At these times, we would help her notice what was happening with her son, and she would suddenly stop, gaze at her son and start to soothe him stating "you don't like when mommy cries." Finally someone in her life, even if it was an infant, was there to notice her sadness. Sue could now appreciate that her son

could sense and empathize with her feelings, perhaps from having experienced this reciprocity in her own therapeutic work.

Soon, Sue dreamt about returning to college. Her father told her that she was welcome in his home, as was her child, and encouraged her to prioritize her education. From his perspective, Sue was a heroine even though she had not married: she had given birth to a son who was not only the first grandchild, but was also an American citizen. Sue was determined to return to her college if she could know that her son was safe in her extended family's care in China. She was in frequent contact with her father to coordinate this transition. As she requested, I did speak with her father with a Mandarin phone interpreter and assessed that he was a reasonable care provider. After a year, Sue returned to China to leave her son with her father's family, then returned to college, and began to utilize treatment once again at her college counseling center. Despite knowing her son was well cared for, she described this rupture as the hardest separation she had endured.

DISCUSSION

Sue's case illustrates a stressful migration narrative and highlights many of the interventions outlined in the table above. One can clearly focus on the losses, traumas, and attachment ruptures that Sue confronted. However, most pertinent to our discussion here is how an attachment-specific treatment frame allowed this teenager to stay invested in a psychotherapeutic process. This frame cultivates security, provides consistency, and reinforces boundaries as needed, but then also makes room for secure base-seeking behaviors, even when those behaviors are moderately disorganized.

As our treatment progressed with Sue it was clear how essential her surrogate attachments were in helping her to navigate separation and bolstering her own identity and sense of autonomy. Her therapy and school supports were instrumental with regard to her goal of going to college. When she left for college, Sue had every intention of capitalizing on an opportunity that she felt that neither of her parents had ever been afforded. College and the distance from her mother were also essential.

I expected that Sue's internal turmoil and confusion would come to the forefront as she too anticipated becoming a mother and struggled with which aspects of her mother she would personify. In the few visits Sue brought her son to therapy, it was evident that she had capacities her mother did not. Sue would gaze lovingly at her son, wondering what he was trying to communicate, and heed to his cries almost vigilantly. He rarely appeared distressed, and notably, she fed him without his having to insist on being fed. Despite some understandable impairment, Sue was a markedly different kind of mother than her own mother. Additionally, she did much of this by rallying support from her church, food banks, and generous adults in her life. Although Sue believed she was protecting her baby son from her mother by sending him to live in China, I also wondered if she unconsciously feared at times that she was also capable of inflicting pain. Overtly, Sue was rescuing her child from her

mother, not abandoning him or protecting him from herself. However, to interpret her behavior as related to her fear of harming her child would have been very threatening. On another level, she at times related to her son as an extension of herself - the part of herself through which she finally gained admiration, value, and respect.

Although Sue was committed to her schooling, without a flexible therapeutic frame which left the door open to her returning to treatment, she may have never reattempted school, or found adequate parenting support. Although navigating motherhood is at times challenging for even the most securely attached, Sue struggled with defining her identity as a mother, student and individual, all while attempting to secure a future for herself and her child. Although not the most adaptive solution by Western standards, Sue attempted to solve a portion of her attachment struggles by creating her own family and thus providing constant access to adoration, mirroring and cultural restoration of her status in her family's eyes.

Disorganized Attachment and Psychopathology

For Sue, the parent with whom she migrated and on whom she was dependent was at once the source of potential support and the source of intense fear, the hallmark of a disorganized attachment style. This style is revealed most when, the parent who is supposed to be the child's source of comfort is also the child's source of fear (Zeanah, Keyes & Settles, 2003).

There is an extensive literature about the serious implications of disorganized attachment in both children and young adults, who may exhibit dissociative, borderline, and conduct symptoms (Lyons-Ruth, Alpern & Repacholi, 1993; Lyons-Ruth, Bronfman, and Atwood, 1999; Lyons-Ruth, 2008; Madigan, Moran, Shuenguel, Pederson, Otten, 2007). The initial groundwork for understanding this classification was laid by Main and Hesse, (1990) who noted that the approach/avoidance conflict lies at the origins of disorganized attachment. That is, when the mother's behavior is 'strange, unpredictable, or potentially threatening' (DeOliveira, Neufield-Bailey, Moran, & Pederson, 2004, p. 440), seeds may be sown with regard to the development of severe pathology in the child.

Defects in Mentalization

Sue's mother lacked the strengths that ensure symbolization, mentalization, and a construction of identity based on parental references such as is observed within securely attached dyads (Fonagy, Gergely & Target, 2007). Sue's mother's capacity to mentalize her infant child was probably critically lacking, and Sue was unlikely to have been exposed to many "mirroring" moments. Later on, Ms. L displayed profound post-emigration narcissistic vulnerability which may have limited her capacity to 'take on' what Sue was feeling in adjusting to her new world.

As Fonagy *et al.* (2007) state, "...the mother's secure attachment history permits and enhances her capacity to explore her own mind and promotes a similar enquiring stance towards the mental state of the new human being who has joined her social world. The mother's stance of open,

respectful enquiry makes use of her awareness of her own mental state to understand her infant, but not to a point where her understanding would obscure a genuine awareness of her child as an independent being” (p. 302). This inquisitive stance, where the mother is able to reflect and wonder about herself, ensures a certain mirroring which when shared with her infant, may aid in the construction of his or her reality. When this attentive capacity is missing in the parent-child interaction, a cornerstone of the therapeutic work with this vulnerable population is for the clinician to contain and mirror to the patient her internal states.

Mentalization and its relevance to self-representation are especially significant within adolescence - the chapter of life that promotes identity building. As Fonagy and colleagues attest, the infant focuses on the primary attachment figure, most often the mother, “as a source of reliable information about the world.” It is through the other that we come to know and ‘construct’ ourselves. Children who have suffered maltreatment show profound deficits in mentalization and secure attachment, and demonstrate well-documented emotional, behavioral, and psychiatric effects. One study in particular found serious impairments, especially in social recognition, in 23 preschoolers from ‘maltreating families’ (Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002). They elaborate that the impact within adolescence of delays in social cognition is profound and the impact within a bilingual, immigrant population who may need to rely on their ‘social IQ’, can be devastating. Such impairment might account for the teenagers’ need for concrete displays of connection and attachment, such as the therapist’s gratitude when they express how they feel.

Effects on Identity Development

Identity development is complicated in the face of disorganized attachment. Liotti (in DeOliveira, 2004) suggests that infants of abusive parents often do not have the required ‘scaffolding’ to develop ‘coherent attachment strategies.’ DeOliveira cites Liotti, noting that, “...a parent may act angry and punitive towards a child, and then respond with guilt or helplessness, provide nurturance to the child, and possibly also seek comfort from the child. In this case, the child is faced with the challenge of integrating multiple representations of the self as ‘victim’, ‘persecutor’, and ‘rescuer’ (De Oliveira, p. 441). For example, Sue’s mother often portrayed herself as the dependent victim one minute, at times seeking out Sue for financial and emotional support, even asking Sue for help with her own ESL homework. She would then act as an emotionally abusive, sadistic and withholding perpetrator the next. Finally, Ms. L would cast herself as the rescuing parent when Sue needed housing for herself and her child. The adolescent, who is in the process of identity definition, becomes exceedingly confused about who to be and how to integrate these multiple identities and their concurrent affective states. Sue’s mother’s inconsistent responses and unpredictable roles made developing the capacity to regulate affect a very difficult skill for Sue to master. In this paradigm, Sue is required to be a helper, a victim, and even a perpetrator as her mother’s needs dictated.

Immigrant parents often have intense ambivalence about tolerating their adolescents’ testing behaviors or identity differentiation. The therapeutic holding environment may in fact be the only space in which the teen’s ambivalence as related to her dependency needs along with her wish to gain autonomy can be safely explored, nurtured and understood. Here, the struggling adolescent may engage in and experiment with the full range of attachment behaviors in the quest to arrive at healthy interdependence. Such behaviors as testing and autonomy-seeking behaviors may not be condoned at home by immigrant parents who are dependent on their adolescents and require them to remain close. Optimal distance for the teen is not the same distance that is optimal for the dependent parent (Akhtar, 1999). The pressure to assimilate can force these teenagers to blend into the host culture to the point where “they usually act as if the past never existed” (James, 1997, p. 23). The parents may perceive this striving to belong as rejecting them. An accepting, therapeutic relationship can facilitate integration over time as these adolescents come to understand their simultaneous need to be both dependent and separate from their parents.

TREATMENT APPROACHES

The Importance of Early Intervention

Sue’s entry into treatment occurred within a year after arrival in the U.S. This is a critical period during which the teenager and the family are often in shock, and most vulnerable to further exacerbation of symptomology. Depending on the setting where help is offered, the adolescent may be especially receptive to services that are preventive and supportive of their acculturation and adjustment to the host country. Although Sue’s case is multi-layered and illustrative of the juncture of culture, psychopathology, development and attachment – there are many such youngsters and families in our school-based clinics. If early intervention is critical, then the interventions we are implementing with this unique population warrant a closer look. A more flexible frame may be exactly what the newly emigrated adolescent requires in order to ‘settle in’ to any therapeutic model.

The Advantages of the SBHC

For Sue and other teens like her it is critical to encourage seeking secure attachments within peer, academic, and therapeutic circles. Easy accessibility to the therapist and other support in a crisis is important. The school-based health center, which cultivates a teen friendly culture, promotes such a therapeutic model. The SBHC is a primary care clinic, housed within a school, which offers confidential treatment and same-day access. Urgent care walk-in appointments as needed are important in a population that can be impulsive and unlikely to follow through with medical care if they have to wait to be seen.

Families are often most willing to accept counseling within schools as the least stigmatized context for their children (James, 1997). The school-based clinician may be on the front lines of witnessing attachment driven behaviors play out in this population. Adolescents are also searching for reliable, ‘non-parent adults’ on whom they can

consistently depend. The school based clinician is poised to play this role and has a first line opportunity to assess, appropriately nurture, identify and facilitate attachment behaviors. This is particularly important because these behaviors may be dismissed as they do not initially appear to be adaptive from a classically Western perspective.

The importance of tailoring the therapeutic frame for this population is important even in these times when mental health services are unfortunately being drastically cut. That is, alternatives to traditional treatment models is essential even when there is no access to interpreters, family stabilization teams, psychiatric outreach models, or provision of twice a week treatment. For example, when there are limited resources, the therapist must ally quickly with the patient and empower the parent, identify a supportive teacher or guidance counselor as part of the therapeutic team, and allow for phone check-ins between visits as needed. It is critical that clinicians work within a flexible frame that seeks to bolster the parents' strengths, reinforce the teen's seeking of other safe holding environments, reconceptualize what these behaviors are indicative of, and elevate them to the realm of adaptive behavior.

Utilizing the Collectivist Framework

Clinicians who work with immigrant teens should cultivate an appreciation for how a teen from a collectivist framework navigates 'growing up.' The clinical material we have presented reveals that adolescent dependency can be potentially adaptive. Behaviors that appear regressive may reflect resiliency rather than regression when one understands that immigrant teens are often working hard to build, test and establish secure environments for themselves on which they can rely. Concomitantly, immigrant parents may need support with defining their children's behaviors as adaptive and serving multiple purposes rather than as rejecting or a threat to their relationship. Just as importantly, therapists need to understand the role that interdependency plays in other cultures.

Clinician awareness of multicultural differences within attachment behaviors is also central to working with this subset of teens as the therapist may be in a unique position to accept and encourage mutual effort of both parent and child, rather than leap to the misguided promotion of adolescent separation behaviors which appear closer to Western norms of autonomy. They may need their providers, in turn, to nurture the dependency that their Western host environment cannot comfortably manage. The clinician must at the same time tolerate the separation that the teen's parents may find so damaging.

The Use of Support and Reassurance

Sue's repeated question, "When can I see you again?" encapsulated her anxiety and need for reassurance. There may be many appropriate answers to this question. An interpretation of her question may have had the effect of shaming her because of her neediness. Instead, an answer that communicated reassurance and accommodation is what allowed Sue to remain in treatment throughout high school. Sue's case also illustrates how "termination" with this

population may resemble pausing their care rather than firmly ending treatment.

Sue initially seemed to warrant outreach to a degree that might overwhelm even a seasoned clinician. At times it appeared she believed that she was my only patient. Early in treatment, Sue required a tailored frame that delineated boundaries as needed, but also extended a first-line supportive stance that allowed her to locate me from near and far.

It is important to distinguish these interventions from those that undermine autonomy or foster regression. For example, explaining to a patient how to locate, call, or find you in crisis fosters healthy interdependence. In contrast, managing the problem for the patient may rob a young person of increased mastery. With the therapist as a surrogate secure base, Sue navigated her grief, began to define her identity, traversed the dangerous ground of seeking help from other adults, and began the difficult work of setting limits with her mother.

Boundaries and Limit-Setting

With these patients, we often work to establish how, when, and where they can access us, prior to setting firm boundaries. In our experience the struggling, compromised teen may interpret the reinforcement of firm boundaries as the clinician's ambivalence about the relationship, as it seems the therapist is at once extending an invitation to provide support and then retracting it in the same moment. We are stressing the dynamic that plays out with immigrant teens with quite compromised parental supports. Initially or concurrently setting limits consistent with Western models of care may be similar to the dynamic between the teenager and the compromised parent who cannot tolerate either the adolescent's level of need, or separation. The clinician may not intend to mimic this interaction, but may unwittingly invite the teen to engage, and then set a benign limit, which feels subjectively punitive to these teens, who then prematurely terminate treatment. This dynamic is highlighted when parents place multiple contingencies on their relationship with their children (as illustrated by the many examples in the case of Sue).

Work with Families

Involving the teenager's parents in the treatment, while sometimes difficult, is important. Sue's narrative illustrates the necessity of co-parenting with the family, creating a bridge to the lost functional parent. In Sue's case, the crisis of her pregnancy provided a catalyst for doing this. The parent who stays behind is often idealized, thus contact with Sue's father felt urgent. Regular contact can help foster a relationship that the adolescent has not yet been able to fully internalize and evoke, and ensure that the teenager and the compromised parent are *apart*, not dead to each other. Often there are financial barriers in the lives of young teens that prevent even phone calls, so developing a means of paying for calls is an important part of the treatment. Additionally, it communicates to the adolescent that while the therapist is often a critical attachment figure and bridge, she is certainly no substitute for the parent. The clinician's finesse with

regard to acting as a benign attachment figure is critical with these families.

Given the insular, vigilant and avoidant stances of parents who fear authority figures within the host culture, expansion of the adolescent's secure bases risks parental disapproval. In addition, psychological problems and traditional treatment settings are highly stigmatized in many cultures. Thus parents who are reluctant for treatment to occur at formal outpatient clinics or hospital-based psychiatric departments may more readily consent to treatment within the school health center. A setting that is also perceived as enhancing academic functioning may encourage a newly immigrated parent to say 'yes' to early intervention.

Clinicians need to see dependency as adaptive within some families. Separation can threaten the fragile homeostasis that the immigrant parent has worked hard to establish. Stressed, bi-cultural teenagers often confront profound challenges. They are navigating a complicated process, heightened because they are both grieving the loss of their homeland, and separation from family while also gaining competencies that can undermine parents' authority. These adolescents may already often behave in their host communities 'as if' Western norms are fully accepted and easily adopted (James, 1997; Igoa, 1995).

Some parents may have long-standing ambivalence in their care for their children because of their own neglect and may grow increasingly resentful and distant. The clinician may observe that when the struggling teen needs critical reassurance, he instead encounters ambivalence from his parents. The parents may undermine the teenager's attempt to separate as the immigrant parents reenact their own past dramas with their child where they may identify with their adolescent's bitter struggle and at the same time also fear that their adolescent will abandon them. As the parents struggle with their own isolation and marginalization, they may feel that they have no one else but their teen. The adolescent, may also feel she and her parents only have 'each other', even if the 'other' is the disorganized parent. Hence, the clinician's finesse with regard to being perceived as a helpful adult is critical with these families as they navigate this confusing response from their teen. The therapist is poised as both bridge and interpreter between the dyad during the teen's evocative transition to increased autonomy.

It is vital for effective work with this population for the therapist to explore the ways in which the parent is compromised, burdened by grief and stricken with poverty, and convey this shared reality to the teen. Such exploration may be central to empowering young girls such as Sue, to develop their own identities. Otherwise these immigrant girls may see their futures as limited, with their primary role to provide for their overburdened, and often mourning, parent who may solely depend upon them.

Sue's relationship with her mother speaks to the parental struggle with 'letting go' at transitional junctures. Without extensive support it can be difficult for immigrant parents to tolerate their teenagers' growth and separation, which represents further loss for these parents. Often, parents may

react by psychologically undermining or sabotaging the teen's strivings for separation. Parents may unconsciously raise the level of disorganization with concurrent crises of their own, or threaten disconnection and permanent separation from the immediate family. Sue's mother did seem to decompensate at transitional moments like graduation, departure to college, and when Sue was in China with her father. Ms. L's depression and medical concerns while legitimate, would worsen at times of anticipated separation.

Key meetings with Sue's mother were important at times to help her mother to focus on her present day life as she was so nostalgic for the past, preoccupied with it so fully, that supporting her daughter's growth and success were impossible. Volkan (1999) writes of lack of nostalgia, healthy nostalgia and 'poisoned' nostalgia in immigrant populations. He writes that with some adults, "remaining poorer was better than losing her original identity...[or] analogous to those immigrants who do not learn the language of their new country that receives them and live in a 'recreated' version of their old country" (p178). Nostalgia is poisoned when it maladaptively connects one to the old life, but "does not allow her to make a better adjustment to her new life" (p178). Awareness of this dynamic in this mother who was quite compromised psychiatrically with her own severe depression and trauma, allowed the therapist to utilize a dynamic attachment informed model when introducing interventions to help the mother move towards supporting Sue. For example, it was important for Sue's mother to begin to learn some English in order to engage in the most basic self-care such as primary care appointments. When given the opportunity, I stated to Sue's mother that ESL class would not necessarily mean losing her native language, or mean that she could no longer turn to Sue for help. That is, if needed, Sue reiterated that she would still accompany her mother to her doctors' appointments. To the clinician, this may seem to be a benign intervention, however, if there is no established alliance with the nostalgic parent, it could be perceived as threatening rather than supportive.

It is typical of the immigrant parents in our caseload to have intense ambivalence about tolerating their adolescents' testing behaviors or identity differentiation. It is important for the therapist not to personalize the parent's ambivalent reaction, or be overly identified with the teen. One's own countertransference reactions may signal times when the alliance with the teen's position may hinder one's ability to effectively empower the parent. The therapist's expression of respect for Sue's mother's history, along with genuine concern for Sue, helped Mrs. L to see academic and therapeutic support as adaptive for the entire family system rather than as an attempt to 'steal Sue away' or instigate more loss in her life. A key moment in treatment came when Sue revealed to me in tears that her mother had enrolled herself in an ESL class and was attending. Sue perceived this as a step forward for her mother and also saw that it allowed Sue to have some time alone with her baby at home and absolved Sue of her guilt.

Table 1 summarizes interventions useful in this population. While many adolescents benefit from flexibility

and outreach, the immigrant teen in therapy requires and relies on the therapist as secure base when acquiring cultural competency, and facing multiple stressors. These teens are independently navigating a new world, often with few financial, societal, or academic resources. They may find their acculturation and assimilation trajectories drastically misaligned with their families who are in a nostalgic or even fear-driven stance of cultural and self preservation. The therapist ideally becomes an essential liaison to navigating the host culture, a bridge to the teen for the parent, and a source of safety so that the teen can function, heal and practice autonomy while straddling two worlds. Most non-immigrant adolescents seen in clinical settings do not require this degree of wraparound or support. Perhaps every teen relies on cell phones, but they are not all using them as lifelines that prevent fragmentation and sustain a connection to a lost parent. With this population, the therapist is at once invited upon a rewarding journey during which the therapeutic treatment becomes a critical stepping-stone to growth, repair, identity building and more adaptive relationships in adulthood.

QUESTIONS FOR FUTURE CONSIDERATION AND RESEARCH

It should be clear from the case and discussion that the need for services that are tailored to the needs of immigrant adolescents is critical. Based on the 2000 U.S. census data, 1 of every 5 children in the United States is a child of immigrant parents. Their numbers are projected to rise. Suarez-Orozco & Suarez-Orozco (2001) argue that research with this population is essential, and estimate that perhaps a quarter of all children in the U.S. originate from immigrant families. Finally they cite another College Board study that notes that 1.5 million minors are 'illegal immigrants', and of those, 65,000 will graduate from our high schools (Passel, 2003).

While many teens go unserved in terms of mental health needs, minority adolescents are at considerably higher risk of not receiving any care. Latino and African American youth are far less likely to receive psychological or emotional counseling than white adolescents. It is clear that underserved minority youth receive less appropriate mental health treatment and are less likely to be included in evidenced based care (Alegria, 2004, p. 3). One key reason maybe related to parental recognition of the immigrant teens symptomology. Alegria (2004) cites parental assessment that the child needs mental health care has been shown to be a strong predictor of "receipt of care" (p. 3). Our discussion focuses on parents who may be far less likely to identify their child's struggles as related to a mental health problem, thus making the school based clinician a critical front line of early identification and referral to mental health care.

Parent coaching models, such as the Connect program (Moretti, 2008) where the parent is a collaborator rather than a passive recipient, may be the kind of program that plays an essential part in supporting the teen patient negotiating separation in the service of individual growth, and integration of ethnic identity. Efficacy of such collaborative models of care within SBHC's with this population will require closer study.

Attachment-based psychotherapeutic models when tailored to the immigrant teen population can allow for the exploration of attachment paradigms while facilitating resilience, provide space to resolve early attachment failings, empower the teen's family, and promote 'finding optimal distance' rather than solely supporting autonomy. Through repeated navigation of the adjunctive secure bases in these teenager's lives there is the possibility of mitigating psychopathology and restoring a sense of safety. Relationships with 'non-parent' adults within the academic and health care communities may be critical to facilitating adjustment, acculturation and interdependence in a bicultural adolescent clinical population. Future research with this clinical sample requires cross-disciplinary investigation, and the use of 'triangulated data' with multiple reporters, as well as 'outside and insider' approaches to collecting data (Suarez-Orozco, 2001, p. 31). The cases also speak to the need for additional research into specific factors which can help clinical samples of immigrant teens remain treatment adherent, and strive towards growth and healing. Without effective treatment they risk catapulting towards developmental arrest and exacerbation of psychopathology.

An e-mail Sue sent to me during her last year in treatment, illustrates her growth and healing. In it she paraphrased a story she found in a popular magazine about a relationship between a psychologist and her patient "who really wanted to end her life."

...the patient asked the psychologist to give her a reason to live, so the psychologist asked if she contract safety for a year, and work with her [the psychologist], then she will let her decide whether to live or die...after a year of intense psychological work, this girl getting a lot better, and....the psychologist look back and really think about what an extraordinary job they've both accomplished. Lastly, the psychologist notes that sometimes the present is not worth living, but the future you can never predict. [The patient asks]...can you give me a reason to live? You are living for the things that come around the corner, living for the person you could become." Then Sue added in her own words, "It could get good enough this time."

This communication reflects a deep sense of partnership, as well as revealing her sense of initial desperation related to trusting another adult. She alludes to a critical year in which things must have felt dire on some level, making her treatment, perhaps her first year in the country, a lifeline. With these distressed, but resilient patients, the therapist is at once co-parent, healer, and bridge to the future. Equally important, is that the therapist is a witness to immense loss and rupture, and at the same time, to a remarkable unfolding of potential.

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