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ACCULTURATIVE FAMILY DISTANCING: THEORY, RESEARCH, AND CLINICAL PRACTICE

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Despite the rapidly growing immigrant population settling in the United States, our knowledge of acculturative processes and their impact on immigrant families remains quite limited. This article describes a theoretical construct called Acculturative Family Distancing (AFD), the distancing that occurs between immigrant parents and children that is a result of immigration, cultural differences, and differing rates of acculturation. AFD occurs along two dimensions: communication and cultural values. Breakdowns in communication and incongruent cultural values between immigrant parents and children are hypothesized to increase over time and place families at risk for mental illness and family dysfunction. Clinical illustrations of AFD's impact on immigrant Asian families are provided and recommendations for dealing with AFD are presented.

Keywords: family, psychotherapy, culture, acculturation, Asian American

For generations, people have been coming to the United States from countries all around the world. According to the 2000 Census, foreign-born immigrants currently make up 11.1% (31 million) of the U.S. population and increased more than 57% between the years of 1990–2000 (Larsen, 2004). Despite our rapidly diversifying population, relatively few resources have been put forth to address the specific needs of America's immigrant population. Central to addressing immigrant needs is an accurate understanding of how acculturative forces can shape the health of immigrant families and subsequent generations.

Acculturation was defined by Redfield, Linton, and Herskovits (1936, p.149) as the ". . .phenomena which result when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the original culture patterns of either or both groups." In practicality, greater cultural changes tend to occur in the acculturating group than the majority group (Berry & Sam, 1997), and immigrant children tend to acculturate faster than their parents (Szapocznik & Kurtines, 1993). The discrepancy in acculturative status between immigrant parents and youth, known as the acculturation gap, has been hypothesized to impact normal parent–child generational differences and increase problem development for immigrant families (Szapocznik, Santisteban, Kurtines, Perez-Vidal, & Hervis, 1984).

Acculturation gaps have been hypothesized to increase intergenerational family conflict, defined as the conflict resulting from the typical generation gap across families compounded by acculturative differences between immigrant parents and youth (Sluzki, 1979; Ying, 1999). Intergenerational family conflict, in turn, leads to greater distress for children and parents. These hypotheses make intuitive sense and are supported by clinical observations by experts in the field as well as anecdotal experiences reported by immigrants (Fang & Wark, 1998; Lee, Choe, Kim, & Ngo, 2000; Szapocznik et al., 1984; Ying, Coombs, & Lee, 1999). However, more empirical research needs to be conducted to validate these reports and to determine how prevalent such acculturation gaps are in immigrant communities. Most of the research to date has focused on establishing the relationship between culturally influenced intergenerational family dysfunction

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and poor mental health (Greenberger & Chen, 1996; Lee & Liu, 2001; Lee, Su, & Yoshida, 2005; Su, Lee, & Vang, 2005) and on developing measures that assess culturally related intergenerational family conflict (Chung, 2001; Lee et al., 2000; Ying, Lee, & Tsai, 2004). There is also some evidence to suggest that Chinese children who immigrated to the United States at an early age evidenced greater family conflict than U.S.-born Chinese Americans, possibly because of a greater parent–child acculturation gap (Ying, Lee, Tsai, Lee, & Tsang, 2001).

Despite this growing body of literature, direct tests of the acculturation gap hypothesis are lacking. Recently, Crane, Ngai, Larson, and Hafen (2005) found that both the parent–child acculturation gap and poor family functioning were independently associated with depressive symptoms among North American Chinese adolescents. However, a small sample size that was split across Canada and two locations in the United States limit the rigor of the findings. Another study that directly tested this hypothesis among Mexican American youth at risk for conduct disorders did not find evidence to confirm this hypothesis, but unexpectedly found that greater youth conduct problems were associated with youth who were more aligned with the culture of origin than their parent (Lau, McCabe, Yeh, Garland, Wood, & Hough, 2005), a seemingly atypical combination.

It is important to note that the acculturation gap relationship may vary for different ethnic groups or type of outcomes. This area of study also suffers from many of the same challenges that the general acculturation literature faces. Specifically, the term acculturation is a proxy term that has been conceived of and generalizes to a large number of complex and overlapping issues involving demographic (e.g., country of origin, place of birth, and years in the United States), sociocultural (e.g., values, attitudes, beliefs, behaviors, social relations, and individualistic and collectivistic orientation), and psychological change (e.g., personality, identity, and ethnic identity) (Berry, 2003; Trimble, 2003). Historically, acculturation has also been viewed of and researched as both a unidimensional and bidimensional construct (e.g., the relationship between the maintenance of the heritage culture and the acceptance of the newer culture) (Berry, 2003; Trimble, 2003). Because there is not an unequivocal conceptualization, operationalization, or method of measuring acculturation, understanding and researching the impact of the acculturative gap, or parent–child discrepancies in acculturative status has been incredibly difficult. Moreover, as a distal construct, the acculturation gap may not be the mechanism that directly increases intergenerational family conflict among immigrants. Specifically, acculturation gaps may be likely to occur among immigrant families, but not all immigrant families develop problems. Therefore, the acculturation gap seems to serve as a proxy that sets the stage for problem development.

In this article, I present a theory and construct that I term Acculturative Family Distancing (AFD), a more proximal acculturation gap mechanism that increases risk for intergenerational family conflict among many immigrant families who evidence an acculturation gap. AFD is defined as the problematic distancing that occurs between immigrant parents and children that is a consequence of differences in acculturative processes and cultural changes that become more salient over time. AFD consists of two dimensions, a breakdown in communication and incongruent cultural values that develop as a consequence of different rates of acculturation and the formation of an acculturation gap. These two dimensions of AFD act as proximal mechanisms (e.g., problematic cultural incongruence and problematic linguistic barriers) of the more distal construct of the acculturation gap (e.g., cultural difference and change) and directly increase risk for problem development through emotional, cognitive, and behavioral distancing. Greater acculturation gaps increase the risk for developing the more proximal AFD, which in turn, acts as a mechanism that increases risk for misunderstanding. As AFD increases, immigrants experience greater risk for family conflict, which mediates the relationship between AFD and individual and family psychopathology and dysfunction. Following, the construct and theory behind AFD is presented, and its impact is illustrated by clinical case materials. In addition, recommendations for addressing AFD in research and clinical practice are provided. Although the illustrations provided address AFD in Asian immigrants, AFD processes and the recommendations presented to attenuate its impact may also serve as a point of departure for addressing acculturation-related family problems in other immigrant groups. Throughout the article, the terms parent and child

are used as descriptors of family positioning, not as an indicator of developmental periods.

Dimensions of Acculturative Family Distancing

The two clinical cases below are used to illustrate how AFD increases risk for family conflict and problem development among Asian American immigrant families.

Case Illustration 1

Sarah is a 17-year-old Cambodian American girl who immigrated to the United States when she was 6-years-old. Her parents came to the United States after staying in refugee camps in Thailand and the Philippines. Sarah was referred to the student-counseling center after she tried to commit suicide by swallowing a bottle of Tylenol. She did not know why she tried to hurt herself and spent the first two months of psychotherapy denying any problems. Her affect and demeanor supported her presentation, but it seemed like she was unconsciously repressing some of her feelings. Later in psychotherapy when talking about the sacrifices of the immigrant generation, Sarah burst into tears, and suddenly realized that she was holding deep feelings of resentment toward her parents and guilt for not being a good enough child. Sarah's parents both worked two jobs trying to support their family, and she felt that she couldn't be a "normal teen" because she had to take care of her younger siblings and do the housework.

Case Illustration 2

Mona is a 42-year-old Taiwanese American mother who came to the United States 17 years ago in search of better opportunities for her two sons, now 15 and 17 years old. She initially sought treatment from her primary care physician for difficulties sleeping, fatigue, worry, somatic pains, and tension headaches. After a thorough physical examination revealed no physical illness, she was referred to a community mental health center and began psychotherapy for depression. Much of her psychotherapy was focused on improving self-care. She and her husband both seemed to be in a perpetual immigrant "survival mode" even after her family seemed to reach an adequate level of financial success. She worked 70 hours per week while her husband worked two full-time jobs. In addition, Mona was expected to care for the children. Her life worries centered on making sure her children were successful.

Communication

One primary dimension of AFD is the loss or breakdown of communication between parents and children (both minor children as well as adult children). Effective communication between parents and children seems to be essential for proper growth and development across cultures (Lee & Chen, 2000; Rhee, Chang, & Rhee, 2003; Usita & Blieszner, 2002). There is some evidence to suggest that Asian American youth experience difficulties communicating effectively with their parents, and that these difficulties lead to a breakdown in family cohesion (Tseng & Fuligni, 2000) and greater individual and family dysfunction (Lee & Chen, 2000; Rhee et al., 2003; Usita & Blieszner, 2002).

Verbal communication. A primary acculturative stressor is the inability to speak English fluently (Vega, Khoury, Zimmerman, Gil, & Warheit, 1995). Because many immigrant children have greater exposure and access to mainstream American culture through schooling, they are likely to acculturate and become proficient in English faster than immigrant parents (Uba, 1994). However, many immigrant children do not undergo any formal schooling in their native languages, resulting in some children never gaining age-appropriate linguistic ability and others losing fluency because of lack of use (Lee & Chen, 2000; Rhee et al., 2003; Usita & Blieszner, 2002). As children acculturate, a language shift occurs and children eventually become more proficient and prefer to speak English because they are more likely to use it in social and work settings (this can vary depending on the child's age of immigration, with those immigrating after adolescence sometimes preferring to use their native languages) (Veltman, 1983).

This occurred with Sarah (case illustration 1) who was able to communicate effectively in English and preferred to do so because of previous experiences of people making fun of her for speaking a "chinky" language. She also began losing her ability to speak Cambodian because her parents were always at work. Although she could speak "fluent Cambodian" in terms of ex-

pressing instrumental needs and concrete activities, she was unable to communicate emotional and affective needs, nor discuss issues in greater complexity. After a breakthrough in psychotherapy, she was able to discuss her family problems and the difficulty she had communicating with her parents, which was mediated by the circumstances of their adaptation and changes in their family structure (e.g., her adultified role as a linguistic broker and caretaker for her younger siblings because her parents were always at work). Great care was taken to help her understand the impact of acculturative stressors on her family and normalize her experiences.

Unless immigrant parents come from higher socioeconomic or educational backgrounds, they are likely to acculturate slower than their children and have more difficulties learning and expressing themselves in English (Uba, 1994). This was the case with Mona (case illustration 2), who felt confident when speaking Mandarin or Taiwanese, but had limited English proficiency. Similar to many immigrant parents, she tried to pass on her family's culture and language to her children by speaking it with them at home. Because of the growth of ethnic minorities in the United States, many immigrants have the choice of whether to move into high-density ethnic communities that previous generations did not have. She felt that her sons should be able to fluently speak their language if they were to be successful in their community. However, her younger son disagreed and refused to speak Mandarin and would also often disobey her and hang out late at night with his friends. She was less worried about her oldest son who spoke Mandarin well and was quite filial, but did have concerns that he was isolative and did not have many friends.

Much of psychotherapy focused on helping her understand the natural but destructive process that acculturative forces can have on immigrant families. Specifically, immigrant families sometimes lose the ability to communicate in a common language (Tseng & Fuligni, 2000). Time was spent affirming her for trying to teach her children Mandarin even though they eventually began speaking English. She was also affirmed for trying to learn English, which is an incredibly difficult language to learn without formal schooling and many opportunities to practice. Loss of common language pits family members against each other because it increases the chance of misunderstandings and decreases family cohesion (Tseng & Fuligni, 2000), which in turn, could increase the likelihood of conflict and limits their ability to develop a positive emotional bond. This was evidenced by dinnertime experiences in Mona's family that shifted from initial periods of overt conflict, to fewer dinners eaten together, and then to long silences during meals that are taken together. This is what I call the "Asian American Silence Syndrome"—broken down communication between family members that is a direct consequence of AFD. Great care was made to acknowledge the acculturation-related reasons that compound problem development and shift the blame away from children and parents who can both be victims and unaware of these processes. In treating immigrant families, it is important to systematically address and evaluate whether problems developed as a consequence of culture-related factors, nonculture related reasons (e.g., bad parenting, individual differences in child temperament), or a synergism of the two.

Nonverbal communication. There are many different types of nonverbal communication. For example, Sue (1990) noted that nonverbal communication styles include proxemics (the use and perception of interpersonal space), kinesics (bodily movements and facial expressions), paralanguage (vocal cues such as pauses, silences, and inflections), and high–low context communication (the degree to which explicit language is used vs. implied). Many immigrants come from cultures that place a greater emphasis on high-context communication (communication that is implied through nonverbal means) than low-context communication (communication that is more direct and explicit) (Hall, 1976). Because children and parents often acculturate at different rates, their acquisition and preference for using different communication styles (whether these decisions are made consciously or unconsciously) can differ and impede communication and lead to conflict. More acculturated children often learn more liberal communication styles than their less acculturated traditional parents (Uba, 1994).

Using the principles of proxemics and kinesics as examples, we know that people from different cultures tend to have different norms and comfort zones for use of interpersonal space, as well as different levels of body and facial animation (Hall, 1976). When parents are less physically affectionate, use more interpersonal space, and

have more reserved or controlled facial and physical expressions, children may misinterpret this as their parents being emotionally cold or distant (Lee, 1997; Uba, 1994). This was the case with Sarah who assumed that her parents did not love her as much as her friend's parents, who were more verbally and physically affectionate. Some time was dedicated to helping Sarah understand that her parent's behaviors were culturally normative, as was her need to have her parents be more physically affectionate, which derived from American culture. Children who are unable to make these cultural perspective shifts and accept such differences are susceptible to family conflict and emotional distancing (Fang & Wark, 1998; Uba, 1994).

Parents are also at risk for making similar interpretive errors. They may perceive their children's more liberal expressions as being too boisterous, lacking emotional control, being too needy or affectionate, or being sexually promiscuous. For example, Mona often criticized her youngest son for being too "wild" when he was rambunctious and physically and emotionally expressive toward his friends. In both of these examples, it is not that either the parent or child are wrong in their interpretations, rather, different cultural perspectives lead to different value-based interpretations of the same behavior.

Differences in communication styles (i.e., high- vs. low-context communication) can also lead to similar misunderstandings (Hall, 1976). Americans are known to be more verbally direct and expressive; whereas, Asians are said to be more verbally indirect and restrained (Lee, 1997). However, what seems to be a culturally direct and appropriate method of communication to the parents may be viewed as indirect and confusing by more acculturated children. This can be exacerbated by the fact that American-raised children like Sarah may not have proficiently learned cultural communication styles, forgotten what they did learn over time, or made conscious decisions to surrender cultural values as they become more acculturated. Sarah's parents verbally told her that she could stay out late at night with friends, but communicated indirectly (i.e., by looking away and becoming more emotionally distanced) that she should come home by 9:00 p.m. Sarah took them literally and was surprised when they became upset and blamed her for making them lose sleep. Sarah did not consciously register her parents' indirect signals and assumed that saying yes meant yes, when in many Asian cultures, yes can have several meanings depending on how it is said (Uba, 1994). It could mean yes, no, I'm listening, or it could also be spoken in deference to authority.

Given all the sacrifices that they made to give her a better life, her parents felt that she was acting selfishly. They also interpreted Sarah's attempt at explaining as talking back and being disrespectful because traditional Cambodian family relationships, which her parents valued, are more hierarchical than American families which tend to be more egalitarian. Sarah became even more frustrated because she was not trying to be disrespectful and felt like she was only trying to explain herself and her feelings. As misunderstandings and conflicts increased over time, her mother repeatedly blamed Sarah for her health problems (e.g., headaches, aches and pains, difficulties sleeping), and her aunt often came over and told her to be a better daughter by not making her parents worry so much—an apparently socially indirect guilt-inducing strategy, but a culturally direct method of communication that is used to promote behavioral change from her parents' perspective.

Disruptions in communication can also be exacerbated by differences in paralanguage, or differences in tempo, use of silence, and inflections in speech (Sue, 1990). For example, a pause in speech in American culture could mean that it is the other person's turn to talk, while the same pause in Asian culture could suggest that one should not interrupt because the person is accentuating a point or formulating their thoughts before they continue. Mona tended to have longer pauses in between thoughts, and had more periods of silence in both the therapeutic and home setting than typical American clients. Part of this was culturally mediated by discomfort in expressing herself in a clinical setting, the other part by differences in paralanguage. It has been reported that Westerners think as they speak, whereas Asians formulate their thoughts first and then speak (Kim, 2002). The psychotherapist was cognizant of this difference and was careful not to interrupt Mona during periods of silence when she was trying to formulate her thoughts.

Being more acculturated, her children were cued to begin speaking during those pauses which exacerbated feelings that her children were cutting her off, speaking out of turn, and talking back to her. Greater emotional expression typical

of American communication styles in her children's voices also reinforced her feelings of being challenged and disrespected. In contrast, her sons felt like she did not care about them and did not value what they had to say. This was partially mediated by cultural differences in receptivity to unidirectional communication typical of Asian parents and less emotional expressions, which led them to believe that they were not being affirmed and loved. In the end, both Mona and her children became frustrated and emotionally withdrew because they felt that they were not being heard.

The psychotherapist worked with Mona and helped her understand how cultural differences in communication styles can lead to misunderstanding. Although Mona was able to understand these cultural differences, she had difficulty putting them into practice. The psychotherapist commended the sacrifices and effort she made to improve the lives of her children, noting that it takes a lot of strength and courage to improve family dynamics. Role-playing exercises helped her learn "American" parenting skills, and solution-focused techniques, such as projecting into the future helped her visualize the behavioral changes that would have to take place in order for relations to improve. Had her children attended therapy, it would have also been appropriate to teach them to respect and understand "Chinese" parenting skills.

Cultural Values

The second dimension of acculturative family distancing is the distancing that occurs between parents and children that is a consequence of incongruent cultural value systems that increase over time as both parties acculturate. Value discrepancies can occur along several value domains, including work, school, family, parenting, interpersonal relationships, romantic relationships, religion, and moral character. The salience of these differences and the rapidity of value changes that occur in the individual are likely to be influenced by a number of factors, including country of origin, age of immigration, ethnic density of surrounding neighborhoods, and the degree to which family and community push for preservation, surrender, or change.

Although children may be less likely to resist parental teachings when they are young, continued exposure to mainstream American values and traditions can lead to ethnic identity changes that shift them away from their culture of origin (Phinney, 1990; Phinney, Horenczyk, Liebkind, & Vedder, 2001). Interrupted cultural transmissions and the active and passive choices that children make in retaining, changing, or surrendering cultural values can place children at risk for developing relationship difficulties with their parents, especially if they choose to give up all native cultural values and become completely "American" at the distress of their parents (Ying et al., 1999). At the same time, how flexible parents are in adapting their parenting styles and value systems for their children may also influence parent–child relations.

It is important to note that the process of cultural transmission, retention, and change can be influenced by the first dimension of AFD, which is communication. Specifically, if the ability to communicate deteriorates over time, the parents' ability to pass on cultural values and traditions also diminishes. Because much of culture is transmitted through oral traditions, those who are not able to communicate in their native languages may be at a distinct disadvantage when it comes to preserving cultural values (Lee & Chen, 2000; Rhee et al., 2003; Usita & Blieszner, 2002). In the end, there is a natural shift for those raised in the United States to acculturate and take on the characteristics of the majority culture at a faster rate than parents who are raised in their native countries (Phinney, Ong, & Madden, 2000; Ying et al., 1999).

Individualism and collectivism. In describing cultural differences, Triandis (1989) distinguished between cultures that have individualistic versus collectivistic orientations. Each cultural orientation is associated with overlapping but qualitatively distinct differences. For instance, although all societies value family (this is a cultural universal phenomenon or an Etic), the relative importance assigned to family relationships and expectations, the quality of interactions, and behaviors associated with family dynamics may be different (culture specific phenomenon or Emic) (Berry, 1989). Those from collectivistic backgrounds are typically expected to sacrifice individual needs for family needs (Triandis, 1989). Those who deviate from this norm and place individual needs first provoke culturally normative disciplining strategies, such as guilt induction and scolding aimed at correcting what are perceived to be problematic selfish behaviors. Although individualistic cultures also value fam-

ily, the pursuit of individual needs is more normative and acceptable. Children pursuing their own interests and engaging in behaviors to benefit themselves are not reprimanded to the same extent.

Mona was determined to help her sons excel academically. However, they reacted differently to this value-driven pressure. Her oldest son received good grades but did not develop the social skills needed to make friends and develop a healthy social life. He became socially isolated and depressed. Her youngest son had the opposite reaction and reacted adversely to what he interpreted to be constant pressure to work harder and criticism for not being smart enough. He wanted to pursue a career in art, but his mother pressured him to pursue a career in medicine and could not understand why he wanted to pursue what she believed to be a nonpractical career. Even though he decided to pursue his interests, he continued to carry a heavy burden of guilt for disappointing his mother. He tried to distance himself from her criticism by hanging out with his friends more. Unfortunately, they often got in trouble for engaging in delinquent activities. Part of psychotherapy focused on helping them work through cultural differences and understanding each other's different culturally influenced perspectives.

Notions of self. Different cultural orientations are also likely to be associated with different cultural self-concepts (Markus & Kitayama, 1991, 1999). People from different cultural orientations (e.g., individualistic or collectivistic) can possess surprisingly different views and experiences of self, others, and self-other relations (Markus & Kitayama, 1991, 1999). These differences in self-concept, also known as self-construals, govern and shape our worlds, influencing the way we perceive, think, communicate, and express ourselves. They can play a large role in parenting behaviors and influence how parents assert authority, demand obedience, expect conformity, and utilize parenting strategies.

People from individualistic cultural orientations are said to have an independent self-construal, whereas those who come from collectivistic backgrounds are said to have an interdependent self-construal (Markus & Kitayama, 1991, 1999). Immigrant Asian parents who were raised in collectivistic cultural environments are more likely than their children to retain an interdependent self-construal than their children who are raised in mixed individualistic and collectivistic environments. This difference sets the stage for incongruent values and misunderstandings. In addition, immigrant children often undergo a more complicated individuation process than other American children or their parents who grow up in one cultural environment. They are raised in two cultural environments that can often have different or opposing value systems (e.g., being pulled toward collectivism at home and toward individualism in their public lives). These cultural differences can lead to ethnic identity confusion (Phinney, 1990; Phinney et al., 2001) as was evidenced by Sarah who had difficulty resolving differences between her ethnic and mainstream American self. When working with Asian American youth in educational and clinical settings, it is important to teach them about different models of ethnic identity formation and normalize their feelings and experiences.

It is also important to help immigrant families reinterpret behaviors through biculturally adaptive perspectives to avoid attribution errors, improper blaming, and misunderstandings (Szapocznik et al., 1984; Ying, 1999). For example, it is important to help children understand that it is culturally normative and even effective for Asian parents to use guilt-inducing strategies and social comparison to manage child behaviors. That is, their parents are not bad people who are purposefully trying to hurt them. At the same time, it is also important to help parents understand that their children are growing up in a cultural context that does not necessarily value or accept traditional parenting strategies. Specifically, culturally normative parenting behaviors that may have been effective in Asia may be ineffective and counterproductive when used with more acculturated Asian American youth. Adjustments in parenting styles may need to be made.

For example, Sarah felt like she made a lot of personal sacrifices by taking care of her two siblings and being in charge of many household responsibilities. Because she grew up in the United States, it was culturally normative for her to study what she was interested in (i.e., creative writing), go on dates like her other teenage peers, stay out past 9 p.m. on the weekends, and apply for colleges in other cities so that she could be more independent. Her parents had difficulty understanding and valuing her requests. According to their traditional Cambodian value system, children should try to stay as close to the family as possible, acquire practical skills so that they would be more marketable for marriage, and not

date during their teenage years or stay out late at night. Sarah had difficulty understanding why her parents acted this way and felt like they were unreasonable, controlling, and uncaring.

Her parents felt that she was being selfish, and although they understood why she might want to do these things, they did not agree and wanted their child to act more "Cambodian" than "American." They used typical Asian parenting strategies by asking Sarah why she could not be more like her cousin Lisa who was studying nursing at a nearby school and did not cause her parents to stay up late at night worrying about whether she would come home safe. This only made Sarah feel worse—she was angry at her parents and felt they were controlling, did not care about her needs, and also felt guilty for not being the child her parents wanted. Sarah became emotionally detached and was determined to move out for college. Her parents stood their ground and felt like she was being disrespectful, rebellious, and selfish.

Sarah and her parents were both in a double-bind. Sarah could give up her individualistic pursuits and be the filial child that her parents wanted, or she could pursue her goals and have her parents blame her for being selfish and disrespectful. Neither option seemed like a desirable outcome. Her parents could give up their collectivistic cultural values and allow Sarah to pursue her interests but they would continue to feel resentment toward Sarah for being selfish, or they could continue using traditional parenting strategies and risk her rebelling and becoming even more distant. Differences in cultural orientation and value systems created a natural schism and put Sarah and her parents at odds with each other. Both sides were reinforced for their stance and both had already made sacrifices above and beyond what is typical of nonimmigrant families. Sarah's parents worked long hours and saved all of their money for the children. Sarah sacrificed much of her social life and took on extra family responsibilities that her peers did not. Because of these extra sacrifices, both sides felt underappreciated. Helping immigrant parents and children understand each other's perspectives is the first step to reducing AFD and developing empathy for each other's struggles. The second step is to learn bicultural communication and social skills that will help each party meet the other's needs.

After several weeks of psychotherapy, Mona gained a better understanding of why her youngest son felt resentful and unloved. At first she was reluctant to change her parenting style and felt like her son should be more respectful and be the one to change. The psychotherapist affirmed her feelings, but pointed out that this strategy did not work in the past, and had her project what would happen if her family continued on this course. After visualizing what steps and changes would have to take place in order to achieve the future she desired, Mona decided that she was willing to make the adaptations necessary to improve their family relations. She and the psychotherapist role-played several situations and practiced more affirming dialogue that her son would be more receptive to. Surprised by the changes that her mother had made, her son became less defensive and was also better able to empathize with her mother's experience.

AFD Over the Life Course: How AFD Plays out Differently for Children and Parents

The clinical case materials provided thus far illustrate an immigrant parent–child life stage match, where parents grew up in their native countries and children spent critical stages of development in the United States. AFD is less likely to have any obvious consequences during the child's formative years, because they are often culturally insulated by the family and have had fewer opportunities to acquire the characteristics and traits of the majority culture (Kwak, 2003). Family values and traditions remain intact, and communication pathways remain strong because common language has not deteriorated or lagged developmentally.

As children enter adolescence, they begin the process of individuation and separation from their parents. Peer groups begin to have a stronger and more influential impact on their identity and development. At this time, immigrant adolescents begin making conscious and unconscious choices concerning cultural retention, ethnic identity, and social group affiliations (Phinney, 1990; Phinney et al., 2001). These choices may be mediated by the ethnic density of the neighborhoods they live in (e.g., whether they are growing up in predominantly White or ethnic neighborhoods). For example, Chinese American youth who live in ethnically dense parts of the East or West coast are more likely to form a strong ethnic identity because of the surrounding ethnic community and socialization with same-

ethnic peers. Those who grow up in the Midwest often make the choice to assimilate into the larger White community or to separate and retain ethnic identity (Berry, 2001). Some immigrant youth find a middle ground and develop a healthy bicultural identity. The degree to which ethnic youth affiliate with their culture of origin, along with how adamantly parents retain and pass on cultural traditions, ultimately determines the extent to which AFD influences family relations.

By the time adolescents reach young adulthood, their cultural identities become more fixed and they begin making many important life choices (Phinney, 1990; Phinney et al., 2001). Some enter the workforce, some move away for college, and others attend local universities to stay close to home. During this time, AFD has the potential for further interacting with normal individuation processes, and demographic relocation to lead to greater separation and distancing from parents. For many ethnic youth, college is a time for further self-exploration in an environment that is more culturally accepting. They have the opportunity to bond with other same-ethnic peers through ethnic student associations, ethnic studies classes, foreign language classes, and study abroad experiences. There is some evidence that these resources can serve to strengthen ethnic affiliations for those who are already strongly identified, but weaken cultural ties among those with weaker ties (Ethier & Deaux, 1994).

If left unaddressed, AFD can begin to have a cumulative negative effect for immigrant families. There is some evidence to suggest that Asian American college students experience more intergenerational family conflict than Hispanic and European students (Lee & Liu, 2001). In addition, there are a growing number of studies that indicate that Asian American youth have higher levels of depressive symptoms than Caucasian youth (Abe & Zane, 1990; Greenberger & Chen, 1996; Okazaki, 1997). As children enter adulthood, many do not internalize traditional values to take care of their aging parents. This can be culturally incongruent to parental expectations and parents can feel abandoned, underappreciated, and become isolated. Older Asian Americans, particularly women, have also been found to have the highest rates of suicide compared with all other groups (Diego, Yamamoto, Nguyen, & Hifumi, 1994).

It is important to note that the effect of AFD across the life span for both parents and youth is influenced by a number of factors. These include age at immigration, country of origin, pre and post migration factors, voluntary versus forced immigration, socioeconomic status, educational attainment, ethnic density of neighborhoods, immigration cohort, and so forth. It is also important to note that AFD can have a qualitatively different impact on immigrant families depending on the developmental stage at which children and parents come to the United States (e.g., whether they are born in the United States, immigrate during childhood, adolescence, early adulthood, middle adulthood, and late adulthood). For example, immigrant children who come during their late teens or adulthood with parents who are in their middle to late adulthood are less likely to experience distancing in terms of communication or cultural values because they have acquired greater language and cultural proficiency and are likely to acculturate at a slower rate than those who came to the United States during early childhood.

Conclusions and Recommendations for Addressing AFD

This article presented a construct called AFD and illustrated how it can potentially undermine family relationships as immigrants acculturate to life in the United States. Because many immigrants are unaware how acculturative forces can disrupt family communication lines and lead to the development of conflicting family values, educating immigrants about the larger sociocultural forces that set the stage for problems before their development will be necessary if we are to ensure healthy adaptation. Moreover, mental health practitioners need to be responsive to cultural issues that may impact family functioning if they are to provide competent care to immigrant families. AFD interventions are best conducted with the entire family but can be used effectively when working with individual family members.

Clinical Recommendations

1. Psychoeducation and AFD. Many immigrants experience AFD but do not learn about AFD or its effects until it is too late. Providing psychoeducation to the community through workshops and talks, in school through classes, and to individuals and groups in psychotherapy can help improve understanding and reduce the

impact of potentially harmful acculturative processes (Hwang, 2006; Hwang, Wood, Lin, & Cheung, 2006). In working with immigrant families, psychotherapists should reiterate that improving family relations takes time. They should understand that most problems do not change overnight, and they should also be affirmed for the progressive steps they take toward improving family relations.

2. Developing empathy and understanding the sacrifices of the immigrant generation. To help parents and children develop empathy for each other, it is important to increase mutual understanding of sacrifices made. This can be done by helping immigrants understand how the acculturative process potentially sets the stage for problem development. The clinician may have to spend additional time engaging clients, framing their experiences within a cultural context, and helping them develop improved listening skills. Szapocznik et al. (1984) recommend using therapeutic techniques such as "detouring" and "reframing" to alleviate blame on family members identified as having the problem and shifting the blame to the cultural conflict caused by cultural differences. They believe that this strategy is helpful because it helps loosen existing rigid generational–cultural alliances. In addition, they recommend using a technique called "establishing crossed alliances" to help parents and youth become more aware, comfortable with, and accepting of the positive aspects of each other's cultural affiliations. Their bicultural effectiveness training program has been found to improve family relations among Hispanic adolescents (Szapocznik et al., 1989).

3. Responsibility taking. Psychotherapists can help parents and children take responsibility for improving family relationships by helping them realize that they share similar goals (e.g., improving family relationships), and that they experience parallel processes (e.g., feelings of being undervalued, unloved, and misunderstood). Although each party may have different secondary goals (e.g., parents may want more filial children and children may want more independence and freedom), these goals are not mutually exclusive and a compromise that helps facilitate family relationships can be reached.

4. Acquiring skills. Understanding of AFD and its deleterious effects needs to be accompanied by skills development (LaFromboise, Coleman, & Gerton, 1993). These skills should address both dimensions of AFD (i.e., improving communication skills and learning how to negotiate cultural differences) and the mediating mechanisms (i.e., family conflict and emotional distancing) that lead to poor mental health and family functioning. In doing so, clinicians need to be aware that the culture of psychotherapy may be more likely to align with the cultural values of the more acculturated youth, which can potentially undermine parental authority in the family. Psychotherapy should be adapted so that cultural values and parenting styles are respected (e.g., paying careful attention to maintaining social hierarchies and not devaluing more traditional and authoritarian parenting styles). A practical skill's acquisition approach that utilizes role-playing and solution-focused exercises should be emphasized (Ying, 1999).

5. Making informed decisions. Immigrant parents and children will both have to make important decisions after they are educated about AFD and its effects. Improving lines of communication and learning how to negotiate cultural differences can be incredibly difficult (LaFromboise et al., 1993). Psychotherapists may need to have clients imagine how the future will look if problematic issues are not addressed and also use solution-focused techniques to help clients visualize what needs to be done if problems down the line are to be prevented. For example, psychotherapists may need to educate parents and children about differences in how love and caring is communicated in mainstream American culture compared with their native cultures (Hwang 2006; Hwang et al., 2006). Parents will need to decide whether they are willing to adapt their parenting style to meet the more acculturated mainstream needs of their children, not willing to change their parenting styles but willing to educate their children about cross-cultural differences in parenting and family values, or not willing to make any adjustments at all. The potential consequences of each decision should be clearly laid out (e.g., by not making any adjustments or by not taking the extra effort to let your children know how your culture expresses love, you place your children in a difficult situation where they may not fully be able to appreciate you as parents or balance social demands with family needs).

6. Develop cultural competence and multicultural understanding. Part of helping immigrant families negotiate AFD is to help them interpret behaviors through multicultural lenses and de-

velop novel ways of reexamining their lives. This process is not geared to help parents acculturate faster nor slow down the acculturation process for children. The goal is to help both parties make well-informed decisions by pointing out the advantages and disadvantages of each choice they make, and to help family members develop bicultural competence (Szapocznik et al., 1984). LaFromboise et al. (1993) note that it is important for the psychological well-being of minorities to develop and maintain competence in both cultures. Although a person may not follow the cultural beliefs of the other, a culturally competent individual is one who understands, appreciates, and accepts the value orientation of others. Parents and children can have successful family relations without compromising their cultural beliefs, as long as they respond to problematic situations with cultural understanding.

7. Adapting psychotherapy. AFD provides rich contextual information on how problems may have developed and were reinforced. Psychotherapists should remain open-minded to adapting or modifying their treatments to include culturally relevant information (Hwang, 2006; Hwang et al., 2006; Sue, 1998), and they should be able to integrate AFD into clinical practice regardless of their theoretical orientation. Psychodynamic psychotherapists might approach AFD by talking about the historical, developmental, and cultural aspects of individual and family development, reiterating how both dimensions of AFD can interrupt normal growth patterns. Psychotherapists could illustrate how unaddressed AFD creates stressful situations, affects cognitions and perceptions, influences relationships, and leads to psychiatric problems over the life course. Cognitive–behavioral psychotherapists could focus on how a person's current and past thoughts, feelings, and behaviors have been influenced by AFD.

8. Beware of cultural stereotyping. Sue (1998) warned that when learning about cultural phenomena, there is a tendency to develop rigid stereotypes of ethnic minority groups. To counter this tendency for cultural reductionism, he recommended that practitioners keep the principle of dynamic sizing in mind. Specifically, practitioners need to know when to culturally generalize versus individualize treatments. Practitioners need to be cognizant not to stereotype families and assume that their problems stem from cultural underpinnings, but also understand that acculturative issues can set the stage for problem development and use this knowledge to inform treatment.

Research Recommendations

9. Basic research. Although many believe that acculturation gaps are commonplace, there is an insufficient basic research base to estimate the prevalence of parent–child acculturative problems in different immigrant communities. More research needs to be conducted to understand how prevalent acculturative discrepancies are, during what life stage parent–child pairings they are most likely to have a negative affect, whether there is a clinical size of gap threshold that increases likelihood of problem development, and what individual, family, and community variables serve as risk or protective factors.

10. AFD research. It is unclear how the more distal construct of the acculturation gap leads to problem development. To advance our understanding of this important issue, we need develop a research base to empirically validate more proximal acculturative mechanisms, such as AFD that negatively impact immigrant families. This can be best accomplished by studying these issues longitudinally and across immigrant generations. I am currently pilot-testing an instrument that I have developed to measure AFD and empirically test its relation to family problems. Initial findings suggest that family conflict mediates the relationship between AFD and distress among Asian American college students (Hwang, manuscript in progress).

11. Intervention studies. More treatment and prevention research needs to be conducted to facilitate better immigrant adaptation and reduce intergenerational family conflict (Szapocznik et al., 1989; Ying, 1999). Treatment programs should target the mechanisms identified by basic research that increase risk for family conflict, AFD, and individual psychopathology. Moreover, the efficacy and creation of prevention programs that educate immigrants about the types of acculturation-related problems their families might encounter before they occur and provide skills for addressing them are sorely needed.

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