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Clinical Encounters with Immigrants: What Matters for U.S. Psychiatrists

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Abstract

About 3.2 percent of the population across the globe are migrants. Today, unprecedented numbers of people are relocating in the U.S. and more than ever, psychiatrists find themselves caring for immigrant patients. International migration is a multilayered issue that often has implications for the mental health of migrants. Thus, there is an increasing interest in understanding how the different factors associated with migration processes affect the mental health outcomes of immigrants. We group these factors into three categories: immigrant process, clinical encounter, and mental health services. When possible, we incorporate a gendered and life span perspective and suggest avenues for including what we know into the care of children, adults, and elderly psychiatric patients with immigrant backgrounds. We pay special attention to the immigrant paradox literature, which explains why some immigrants are healthier when they start their journey, and why their mental health deteriorates as they live longer in the host societies. We aim at providing psychiatrists an understanding of what to ask, assess, and consider when caring for patients who are international migrants.

Keywords

Immigration; mental health; immigrant paradox; psychiatry

Since ancient times, mobility has been a marker of the human species. In 2013, 232 million people, or about 3.2 per cent of the world's population, were migrants (1).

We define migrants as individuals who relocate territorially across nation states, and for whom this relocation carries changes in social membership. The U.S. attracts approximately 20 per cent of the migrants across the globe, and in 2013, over 41 million immigrants lived in the country (2). Combined, immigrants and their children, represented about a quarter of the U.S. population (2). Immigrants to the U.S. are more diverse than ever. People of Mexican origin make up 28 per cent of the immigrant population in the U.S., followed by

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[1] We use undocumented and unauthorized interchangeably in this article.

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Chinese (5.6 per cent), and Indians (4.8 per cent) (3). Never before in the country's history have we witnessed such volume and diversity among its immigrants.

As described by Portes & Rumbaut (4), immigration is a bilateral process driven by the immigrants' needs (for instance, to pursue economic opportunities, to improve their children's access to education, to escape from totalitarian governments) on the one hand, and the changing needs of employers and governments benefiting from immigrant labor (e.g., cheap labor, skilled workers), on the other. On the individual level, migration processes can be understood as an investment in one's well-being (5), but sometimes this investment may not yield a good mental health return. For the host country, immigrants' labor resources and investments may be welcome, while at the same time their presence challenges established ideas about community and citizenship. Tensions between the individuals' and host society's needs and wishes have implications for the mental health of immigrants. Unrealistic expectations of support on the migrants' side or hostile conditions of reception may add stressors to the already challenging migration process, resulting in the diminished sense of well-being among newcomers. This in turn may exacerbate latent vulnerabilities for mental health disorders. For instance, a greater incidence of nonaffective and affective psychoses has been documented among dark-skinned migrant groups in the United Kingdom (6) and in Sweden (7).

We have begun to grasp the complexities and challenges involved in the process of immigration to the U.S. and how these impact people's mental health. However, disentangling this relationship is difficult in that the effects of immigration on mental health can only be understood taking into consideration the micro-, meso-, and macro-level factors associated with this process. Complicating matters, our understanding of the relationship between immigration and mental health is challenged by the fact that immigrants and immigration conditions are intrinsically heterogeneous and constantly changing. Their diversity makes comparisons across groups difficult, and pose challenges to the design, testing, and implementation of evidence-based practices to care for these patients. Amidst the heterogeneity of immigrants, however, there are common issues that most must face, including their need to adjust to a new environment, and their experience of loss of a shared sociocultural world.

This article offers some insights into what we know about the factors shaping the mental health outcomes of migrants, and how these issues should be included in the clinical encounter with immigrant patients. We start by discussing key concepts describing the experiences of migrants to the U.S., including those that capture their cultural incorporation. Then, we propose a model to understand immigration as a multilayered and complex phenomenon that has the potential for affecting mental health. When necessary, we incorporate a life span and gendered perspective to discuss the interactions among these factors. We address issues of how to include the patient's immigration experience in the clinical encounter, and suggest what psychiatrists should ask, assess, and consider when caring for immigrants. We finish by discussing the immigrant paradox literature, which explains why some immigrants are healthier when they start their journey, and why their mental health deteriorates as they live longer, or in subsequent generations in the host societies.

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The cultural integration of immigrants

There are two dominant theoretical approaches to the study of the cultural integration of immigrants: one sees it as a linear process that involves the shedding of the heritage culture and the increasing endorsement of the host culture, while the other theorizes that it is a bi-dimensional process involving adoption of the host culture as well as maintenance of the heritage culture. Researchers in the first camp often refer to this pattern of cultural integration as *assimilation*, and owe much of their approach to studies on the integration of 20th century European immigrants to the US (see, for instance, 8). Promoters of assimilation endorse cultural homogeneity, and often use metrics such as economic achievement or intermarriage rates to explain that immigrants who manage to assimilate have better outcomes. The second theoretical approach to the study of immigrants' cultural change refers to this process as *acculturation*. Acculturation has been widely studied by psychologists interested in the mental health of immigrants (see, for instance, 9, 10). Scholars who see acculturation as a bidirectional process embrace cultural heterogeneity, and promote practices that sustain the co-existence of people of different backgrounds. For them, the aim of the acculturative process is to reach biculturalism, which refers to the integration of cognitions, attitudes and behaviors from the culture of origin and the dominant culture (11). Although this position has weak empirical support, this camp endorses the notion that individuals of immigrant backgrounds who become bicultural have better mental health outcomes (12).

Implications for clinical practice

The conceptualizations of the process of cultural change among immigrants have implications for psychiatrists in that they call for alternative models of addressing the patients' culture in the delivery of clinical services. Promoters of assimilation stress the universality of Western understandings of mental health disorders and of U.S. treatment models. Little attention is paid to the patient's cultural models of symptom presentation, illness behaviors, treatment models, and help-seek behaviors. Translators may be included in the service delivery, but cultural differences between providers and patients are often ignored. Endorsers of acculturative theories call for multiculturalism and promote culturally-competency. Culturally-competent psychiatric services incorporate the patients' ethnocultural beliefs, values, attitudes, and conventions (13). Culturally-competent services seek to generate intercultural understanding between providers and consumers, avoid imposing the providers' values and practices on the patients, and allow patients to respond to their mental health needs through culturally meaningful ways (14). Part of the challenge in implementing culturally-competent services is that they place much of the cultural bridging responsibilities on the providers. Specifically, culturally-competent services demand that clinicians understand what culture is, the role it plays in mental health, and include it in every aspect of service delivery. For instance, psychiatrist assessing culturally diverse patients must inquire about their level of acculturation, particularly in reference to mental health. When serving children of immigrant backgrounds, the clinician would evaluate if there is an acculturation gap between the child and his or her caregivers, how it may impact treatment adherence, and plan treatment accordingly. More importantly, clinicians will stay away of stereotypical notions about culture, such as assuming that a similar background

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equals identical culture. Patients' culture will be assessed taking into consideration its dynamic nature, and considering for instance the interaction of age, gender, class, education, religion, etc. Although complex, the delivery of culturally-competent services is critical for immigrant patients. Meta-analyses have found that culturally-competent treatments are more effective than standard mental health services among ethnocultural minorities (see, for instance, 15, 16).

Immigration and mental health

The relationship between immigration processes and mental health outcomes have been explored by a number of researchers (see, for instance, 17-21). From that body of work we identified variables that mental health providers should consider when serving immigrant patients. We added variables we ascertained as important in our research with immigrants. For purposes of clarity, we organize these variables within three categories: *Clinical encounter, immigrant experience*, and *mental health services*. We close each section with suggestions about how clinicians can include these categories in their work.

Clinical work with immigrant patients

Immigrants' characteristics mold their migration trajectories, the type of stressors they face, and the resources they have to cope with these stressors. Among these variables are the immigrant's age, gender, sexual orientation and religion. Migration processes should be understood from a life span perspective, as *age* shapes the experience of immigrants. For instance, older adults may have a harder time adjusting to a new society, while children adapt faster than adults to changing cultural contexts. These different adjustment rates may impact immigrants' mental health in various ways. Older adults may feel disempowered and incompetent navigating their new social context. Children, on the contrary, because they learn new languages quickly, may become translators for their caregivers, feeling empowered. Early age of immigration, however, may not have positive effect on mental health for all groups. For instance, Vega and colleagues (22) found that among Latinos of Mexican descent, a younger age of entry and a longer residence in the United States are associated with higher prevalence of psychiatric disorders.

Gender—The effects of immigration stressors and contexts of reception on immigrants' mental health should be framed within gender categories (23). For instance, Takeuchi and colleagues (24) found that among Asian immigrants, lacking English proficiency had a greater negative impact on the employment opportunities of men compared to women, increasing men's risk for mental health problems.

The gender ideologies and practices of immigrants may be different from those of mainstream Americans. Female Genital Mutilations (FGM) provides a challenging example of the balancing act that psychiatrists must perform between the patients' cultural practices and their rights. In 2015, it was estimated that over half a million girls and women are at risk or have undergone FGM in the U.S. (25). FGM has been associated with adverse psychological effects (26). U.S. law prohibits the practice of FGM on minors, as well as taking a minor to another country to perform FGM. Although FGM has been studied more in the OB-GYN and anthropological literature (27-29), psychiatrists ought to include

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questions about it in the assessment of vulnerable clients and contact protective services if they are concerned about a girl's risk of being mutilated.

Sexual orientation—Many immigrants of the LGBT community experience chronic discrimination in their countries of origin, from homophobia to threats to their life. Perceived discrimination is consistently associated with negative mental health outcomes (30).

Marital status—Independently of immigration status, marital status and the health of marital relationships is often a focus of inquiry during psychiatric assessments and treatment. For many immigrants, marriage with a U.S. citizen offers the fastest and often only pathway for legal residency. Within the U.S., many undocumented immigrants and those with temporary work visas enter marriages for immigration purposes. Marriage is also a pathway for people in less develop nations to legally migrate to the U.S. Some become mail-order brides, which is considered a form of human trafficking. There are documented risks associated with these marital practices including domestic violence (see, for instance, 31).

Ethnicity and race—Several disparities in risk behaviors and mental health disorders have been identified across ethnic groups of immigrants in the U.S. (for instance, high rates of suicide attempts among Latina adolescents, 32). The interplay of race, as a social construct, and the mental health outcomes of immigrants is very complex. For instance, many immigrants have not been exposed to the U.S. binary white-black race ideologies prior to arriving to the country. Based on ascribed racial characteristics, for instance their skin color, they may find themselves labeled as racial minorities. For these immigrants, racial discrimination can be puzzling. Discrimination has been identified as a risk factor on the mental health of Asian and Latino immigrants (33). At the same time, Black immigrants of Caribbean and African origin may also struggle with their new acquired racial minority status in the US. Their increased exposure to discrimination because of their skin color puts them at risk for mental health disorders (34).

Religion—In general, religious participation is considered a protective factor for the mental health of individuals. Many religious organizations have important roles in keeping the culture of origin alive for immigrant communities, for instance, by hosting ethnic schools. Ethnic school attendance has been identified as a protective factor in the development of youth of immigrant backgrounds (35). The protective function of religion on mental health does not apply equally across groups of immigrants. For instance, Muslim immigrants face growing discrimination following the 9/11 events. Islamophobia has been associated with increased psychological distress, reduced levels of happiness, and worse health status among Arab Americans (36).

English proficiency—The mother tongue carries the immigrant's definition of their identity and a grounding of her or his understanding of the world, while the acquisition of English aids their cultural and social integration in the U.S. English proficiency may act as a protective factor for depression and stress among immigrants. Foreign-accented speakers often face accent discrimination. Kim and colleagues (37) found that among Asian and

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Latino immigrants, those with limited English proficiency were less likely to access psychiatric services to address they mental health needs.

Culture and mental health—Psychiatrists encounter a growing number of migrant patients (38), who sometimes present diverse modes of expression of emotional distress (see, for instance, the literature on "ataques de nervios," 39), understandings of mental health and its treatment (40), and about the relationship between providers and patients (41). These culturally-based dimensions shape the definitions and lived experience of mental illness and services. Culture shapes developmental and behavioral expectations, along with parenting practices. In cultures with greater emphasis on obedience, the threshold for disruptive behaviors is lower than in those that value individual expression (42). Thus, the same behavior may be assessed as disruptive in one cultural context, while in other it may be encouraged. It is important that clinicians serving children of immigrant backgrounds become familiar with the caregivers' parenting and developmental schemes. As in general child psychiatry practice, multiple informants need to be interviewed to gather a nuanced profile of the pediatric patient mental health. During the psychiatric assessment phase with immigrant children, the psychiatrist will interview informants from different cultural backgrounds. This practice helps to separate culturally-based parental complains about children behaviors from those that need to be addressed thought psychiatric intervention.

Stigma—Mental illness and treatment stigma is a cultural dimension that hinders immigrants' access to psychiatric services. Immigrants, who already confront discrimination because of their otherness, fear increased prejudice due to mental illness (43). Perceptions about psychiatric services vary across the globe, and immigrants carry their own cultural perspectives when they come to America. For example, immigrants from regions in which psychiatric services have been used to aid political oppression may be reluctant to seek treatment. In many places across the globe, psychiatric services are practically unknown to the general population or are exclusively for the severely mentally ill who are treated in asylums.

On the *provider side*, working with immigrant patients may pose challenges different from those elicited by native clients. Cultural-competency training mostly addresses what psychiatrists need to know about multicultural patients, but rarely address what these patients require from and elicit in the professionals caring for them. Practical challenges require adapting the clinical practice parameters to the immigrant patients' cultural and linguistic needs. For instance, these patients may need translation assistance, thus requiring psychiatrists to allocate more time per appointment. Others may need appointment schedules that do not interfere with praying times. Cultural differences with patients may generate a range of emotional responses among clinicians. A client endorsing patriarchal values may decline services from a female provider, making her upset. Others may seek the psychiatrist's help with issues that fall beyond the scope of mental health services, leaving providers overwhelmed or frustrated. Interactions with immigrant patients may also trigger a psychiatrist's cultural or religious biases.

The Cultural Formulation model aids practitioners in rendering accurate psychiatric diagnosis and treatment formulation across cultural boundaries (44). Lewis-Fernández and

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colleagues developed an interview combining five dimensions relevant to mental health services, including assessing cultural identity, cultural explanations of mental illness, cultural factors related to the psychosocial context and impairment level, cultural aspects of the doctor–patient relationship, and the overall impact of culture on psychiatric diagnosis and care. Cultural Formulations Interview is a standard component of culturally-competent psychiatric care.

Implications for clinical practice—The intersection of social and cultural characteristics shapes the immigrants' experiences and their mental health. To fully understand the migration experience, clinicians ought to include life span and gendered perspectives, and be attuned to the compounded vulnerabilities that different sub-groups face as they adjust to life in America. Cultural-competence is critical for psychiatrists serving this population. Culturally-competent services must include considerations about (a) the patients social and cultural characteristics, and how these frame their migrant experiences and mental health; and (b) the clinician's response to immigrant clients. Psychiatrists can improve the accuracy of their diagnosis and develop better treatments for immigrants by using the Cultural Formulation method.

Immigration process

. The *context of departure* shapes the decision, process and nature of the exit of the country of origin (19). Country of origin socio-political characteristics have a great impact on the reasons and conditions of exit and arrival of migrants. When the decision to emigrate is driven by life-threatening risks, immigrants may arrive to the U.S. or other host country with a more compromised mental health status. For instance, the prevalence of anxiety and depression rates among refugees is almost double that those of economic migrants (45). The cultural match between the immigrant's country of origin and the U.S. may hinder or facilitate their incorporation into American society.

Migrants move to the U.S. due to different reasons and under diverse conditions, and their migration decision is not always voluntary. Voluntary international migrants are those who relocate because of reasons under their control. These can include those who decide to pursue new career opportunities in a different country or move to relocate with family members. Forced international migrants are those need to relocate to a different country for decisions beyond their control. People may migrate to the U.S. because of war or because they belong to persecuted minorities, such as sexual or religious minorities. Coerced migrants, such as victims of human trafficking, constitute a third category of international migrants. Initially, these individuals may have sought to migrate, but the circumstances of their migration fall beyond their control. Lastly, children and the elderly are another group who migrate internationally, but their control over the decisions regarding migration may be limited. Although the majority of children migrate either with or to reunite with family members, increasing numbers do so on their own. This is the case of children who migrate to the U.S. alone to attend school (see, for instance, 46), or of the unaccompanied minors crossing international borders (47).

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The process by which immigrants move from one country to another may be direct or in stages. Today, the duration and strenuousness of the voyage is determined in part by the immigrant's level of education and economic resources. In general, poorer migrants with less education take longer to complete the trip from their country of origin to their destination, and sometimes their journey takes them through several countries prior to arriving to the U.S. One example are the Chinese immigrants who arrive to the U.S. by crossing the border with Mexico (48). Sometimes this process can take months and even years. As border crossings became more difficult because of increased surveillance, the risks unauthorized immigrants take and the price they pay have also increased. Unauthorized migrants often enter the country under extremely stressful circumstances, and are regularly victimized by traffickers. For instance, Amnesty International (49) reported that six out of 10 girls and women crossing the Mexican border are sexually assaulted or raped. In addition, many immigrants arrive to the U.S. owing large sums of money to the coyotes or snakeheads that helped them migrate, and the well-being of their families depends on their ability to honor these debts. Traumatic migration experiences are not unique to undocumented migrants, as some authorized immigrants often arrive to America after stressful periods in refugee camps, during civil wars, or endure traumatic separations from their loved ones prior to initiating their journey to the U.S.

Family members often migrate to the U.S. in stages, a process that has been referred to as “serial migration” (50). The separations of parents and children can be quite extended (51). The family configurations and dynamics must adjust to this trans-national experience in which members are physically absent but emotionally present. In these families, contact between biological parents and children may be regular or sporadic, but in general, parents lack the ability to provide supervision to the children left behind. Parents separated from their children and unable to reunite because of their immigration status may experience guilt, worry, sadness, and powerlessness. In many cases, children with migrant parents, who are left under the care of relatives or friends, endure emotional hardship as well as physical and sexual abuse. In others, the emotional ties that bind parents and children fade, and new ones are forged with the temporary caregivers. Whatever the case, family reunifications can be very challenging (52).

Immigrants from rural backgrounds encounter multiple barriers in their process of adaptation to the U.S. Some of these barriers are rooted in the country's immigration policy, which has prioritized the legal incorporation of educated and urban migrants, while neglecting agricultural and less educated workers and their families. Farm workers and their families face many stressors related to the physical environment (e.g., exposure to pesticides), and the economic difficulties and uncertainties associated with farming (e.g., lack of work during droughts). In addition, children of rural immigrant families are often recruited into farm work at an early age, and have limited access to educational opportunities. When immigrants from rural backgrounds chose to settle in post-industrial urban areas, they may encounter serious obstacles in their adaptation due to their lack of education and urban social capital. These stressors can pose detrimental effects on the mental health of this group of immigrants.

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Immigrants face different *contexts of incorporation* relevant to their mental health. While the importance of immigrants for the U.S. economy is never in doubt, the country's approach to the incorporation of immigrants has varied over time. These variations resulted from changing geopolitical, economic, and social factors that influenced domestic and foreign policies. Governmental policies are important in determining the incorporation patterns of arriving immigrants (53), because immigrants encountering exclusionary policies endure greater structural and economic restrictions, and general disadvantage. For instance, immigrants arriving to the U.S. from Muslim countries face greater discrimination than those from Western European countries, which may impact their sense of well-being and acculturation

Legal status is a common concern for immigrants in the U.S. The term “legal” or “documented” applies to individuals who have acquired legal rights and protections through birth in the United States (resulting in full citizenship), or through federally immigration (54). Authorized immigration to the U.S. happens though visa (e.g., employment, student, or work visas), refugee status, resident alien status, or naturalization. The terms “undocumented”[1] refers to immigrants who are in the United States without federal government authorization, also known as “illegal” (54). Immigrant families are often “mixed-status” family units in which some members, often children born in the country, are US citizens, while others are undocumented immigrants or have some legal status that could ultimately allow them to access US citizenship (i.e., refugee, legal resident) (55). About four in 10 second-generation Latino children have at least one undocumented immigrant parent and hence live in a mixed-status family (56). The growing number of deportations of unauthorized immigrants, many of them parents of U.S. citizen children who in many cases are left behind, requires that mental health professionals become prepared to work with this population (57). Research has shown that undocumented Latino immigrants fear of deportation heightens their risk for experiencing negative emotional states, particularly anger (58).

Once in the U.S., newly arrived immigrants must compete with others, including U.S. workers, for jobs. Legal immigrants, including those with professional visas or admitted for family reunification processes, may be able to access the formal wage-market. As part of the process of reception and placement, adult refugees are given employment assistance, thus easing their transition into the work force. Undocumented immigrants depend greatly on their social networks to obtain employment and often do so in the informal economy. Depending on their educational background and skills, command of the English language, professional credentials, and social capital, immigrants’ insertion in the market may be more or less challenging. Professional immigrants with work visas or those who lack legal authorization to work may be more vulnerable to exploitation and abuse by employers, as their opportunities to obtain employment are limited. Many immigrants must insert themselves into the labor economy by taking jobs that may-even with better pay- carry less social recognition than the jobs they performed in their country of origin. Medical doctors may start again as residents or even as health educators, and police officers may have to work as landscapers. This may pose special challenges for the well-being of immigrants whose sense of identity is closely tied to their professional role. Men used to being the sole

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providers for their families may learn that their low wage work is not be enough to support their spouses and children, threatening their self-esteem.

Because more often than not, immigrant families in the lower SES strata cannot survive on one low wage income, women may start to work to help support the family. Women may find it easier than men to get jobs in the service economy. Their entry in the workforce, especially among immigrants from countries with lesser opportunities for education and employment for women, can change family and gender dynamics (59), and bring about serious interpersonal and marital stressors. Furthermore, as with many American women who juggle work and families, immigrant women may struggle with caring for their children and spouses while working. In more traditional and less acculturated immigrant homes, men may not be expected to help with child rearing and homecare tasks, thus, further burdening females who work. Working, however, can also foster a sense of empowerment through building women's social and human capital, and facilitate their acculturation.

Just as adult immigrants need to insert themselves into the labor market, children have to negotiate the educational system. Supportive learning environments are not always available for immigrant children, and some face discrimination and lack of opportunities at school. The effect of the school experience on academic outcomes is well documented. For instance, perceived discrimination at school has been linked with poorer academic outcomes among Mexican immigrant children (60). In addition, psychiatrists should be attuned to the behavioral manifestations of the children's experience at school and beware of confusing it with pathology. For example, some young children entering a school environment with no knowledge of English often go through a non-verbal period in their second-language that should not be confused with selective mutism (61).

Elderly adults often immigrate to the U.S. as part of family reunification-authorized or unauthorized- processes. Sometimes they join the family to help care for younger children while the parents work outside the home. While some elderly migrants could feel isolated if they left behind family and friends, others could feel empowered by their caregiver roles. Older adults may have a harder time adjusting to the new environments, learning the new language, and building social networks. Sometimes, their acculturation issues can be confused with cognitive decline; for example the case of an older adult who may get lost navigating their new neighborhood and may not know the language to ask for help.

Another important aspect of the context of reception has to do with the proportion of coethnics among neighbors, co-workers, classmates, etc. Many low SES immigrants arrive to the country through personal networks, and initially settle with family members or co-ethnics. Their opportunities for work are also organized within networks of co-ethnics, which in turn build reciprocity and support. These networks are critical for the well-being of immigrants (62, 63); they not only provide support, but help newcomers in the process of adjusting to the U.S. As time goes by, some immigrants become successful and move to areas with less co-ethnics while others continue to struggle and face limited opportunities for social mobility. Research suggests that large numbers of immigrants downwardly assimilate, a phenomenon called segmented assimilation (64). This assimilation pattern exposes them to

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many risk factors for negative health and mental health outcomes, such as poverty, a dearth of educational and occupational opportunities, inadequate health care, and discrimination.

Implications for clinical practice

Clinicians shall collect a comprehensive narrative of the patient's migration trajectory, including reasons for migration, conditions of exit and entering, and exposure to stressful events prior to, during and post migration. Psychiatrists could explore not only what promoted the migration, but if the patient's expectations for the settlement in the U.S. were fulfilled. In addition, clinicians could ask how the process of migration affected the patient's emotional well-being, his or her social network, and the quality of his or her relationships. Disruptions in social networks, along with changes in family dynamics, should be the focus of attention during services.

Explore family immigration processes is important, as well as trans-national family experiences, and what meaning patients give to these experiences. Clinicians should explore the conditions of separation and-if it has occurred- reunification. Special attention must be given to parents separated from minors, and to children and teens reunited with their parents after period of extended separations. Supportive services and culturally competent family therapy could ease the conflicts emerging during family separations and reunification, and reduce the mood and behavioral symptoms resulting from these conflicts.

Mental health professionals cannot ignore immigration law. Psychiatrists ought to be sensitive to the patient's immigrant status, and how its impacts his or her mental health. In addition, some undocumented patients may fear that being diagnosed with a psychiatric disorder could carry negative effects on their future ability to secure legal immigrant status. Thus, psychiatrists need to stress issues of confidentiality in the delivery of mental health services. Clinicians serving this population could become aware of local non-profit groups that provide legal counsel when needed, and identify who may benefit from immigration assistance. For instance, undocumented women in abusive relationships may qualify for domestic violence asylum in the U.S., and many domestic violence service agencies have immigration lawyers on staff. Psychiatrists may explore the legal status of all members of an immigrant family, and when needed, assist families in the process of separation due to deportation. Mental health professionals are increasingly acting as expert witnesses in immigration courts on behalf of developmentally disabled or mentally ill US citizen children whose caregivers are in process of being deported. Their advocacy aims at curbing the deportation process and at securing that families can remain united so children can receive the services they need.

Mental health services—Cultural and contextual variables impact immigrants' help-seeking pathways. The choice of treatment provider is strongly influenced by culture, while the opportunities to meet those providers are shaped by contextual factors. For instance, some immigrants may approach ethnic healers, such as *curanderos*, or spiritual leaders, such as Imams, instead of seeking the assistance of a psychiatrist (see, for instance, 65). Others who may be engaged in psychiatric treatment, may complement those services with spiritual or folk practices (see, for instance, 66).

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On the contextual side, immigrants experience many barriers to accessing psychiatric services. Immigrants often have low levels of income and health literacy, and their work schedules preclude them from attending appointments. Compounded with these barriers, there is a shortage of mental health services and multicultural providers. Health insurance is not available for undocumented immigrants.

The age of immigrants may also impact their access and use of mental health services, as psychiatrists are more likely to see immigrant children than adults. This is because immigrant children attend school, and in this context they interact with teachers and others who are familiar with American ideologies of mental health. If the child is referred for services, the psychiatrists may meet caregivers who do not assess the child's behaviors as pathological or may not understand the nature of psychiatric services.

Implications for clinical practice

Practitioners must be aware of the challenges faced by immigrant patients to access services, and generate opportunities to reach them outside traditional mental health settings. For instance, psychiatrists could partner with ethnic community centers or religious organizations to educate immigrants about mental health. Accessing services despite challenging barriers is a marker of resilience and positive prognosis among immigrant patients.

The immigrant paradox

The *immigrant paradox* describes a phenomenon in which newly arrived immigrants are more successful at navigating life and healthier in their host societies than more assimilated individuals of immigrant backgrounds. This paradox has been described among Latinos (62), Black Caribbeans (67), Africans (68), and among Asian American women (24). The premise of the paradox is that newly-arrived immigrants show good adaptation in a number of outcomes, in spite of their poor socioeconomic profile and low education background (69). For instance, Vega and colleagues (70) found that Mexican immigrants have about half the prevalence rate of psychiatric disorders as people of Mexican descent born in the United States. The positive outcomes among newly-arrived immigrants have been detected in a myriad of mental health outcomes including psychosis, substance abuse, and depression (see, for instance, 6, 71, 72).

Implications for clinical practice

The immigrant paradox highlights that the effects of international migration processes spill over multiple generations. Psychiatrists should pay special attention to immigrants who belong to groups more likely to undergo downward mobility post-immigration, and thus face the combined effects of discrimination due to their race, immigrant backgrounds and their SES. Preventive psychiatric interventions for immigrants ought to incorporate protective elements of the patients' cultural background. Mental health professionals must explore the process of adaptation and mobility upon the immigrants' arrival to the new country, including opportunities for upward mobility, cultural integration, and exposure to discrimination. Along with these, psychiatrists could focus on disentangling if the presenting

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mental health problem is related to the immigration process or it is adaptive to the contexts of reception.

Summary

Immigrants in the U.S. are as diverse as their mental health needs. Their vulnerabilities for mental health disorders are compounded with diverse patterns of stressors related to the immigration process. Although much more still needs to be learned about the how differential risks relate to the immigrants' mental health outcomes, it is clear that these risks can be moderated by the contexts of reception. Psychiatrists delivering clinical services can make substantial contributions to the well-being of this group of vulnerable group as they and their children become part of America.

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References

1. United Nations Population Fund [Internet]. Migration: Overview; 2014. [Place unknown]Available from http://www.unfpa.org/migration [2015 May 1]
2. Batalova, J.; Terrazas, A.; [Internet]. Migration information source. Washington (DC): 2015. Frequently requested statistics on immigrants and immigration in the United States.. Available from http://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states [2015 May 1]
3. Migration Policy Institute [Internet]. Largest U.S. immigrant Groups over Time, 1960-Present; Washington (DC): 2013. Available from http://www.migrationpolicy.org/programs/data-hub/charts/largest-immigrant-groups-overtime [2015 May 1]
4. Portes, A.; Rumbaut, RG. Immigrant America: a portrait. 3rd ed.. University of California Press; Berkley and Los Angeles: 2006.
5. Bodvarsson, ÖB.; Van den Berg, H. The economics of international migration: Theory and ppolicy. Springer; New York: 2009.
6. Coid JW, Kirkbride JB, Barker D, Cowden F, Stamps R, Yang M, Jones PB. Raised incidence rates of all psychoses among migrant groups: findings from the East London first episode psychosis study. Arch Gen Psychiat. 2008; 65(11):1250–1258. [PubMed: 18981336]
7. Zolkowska K, Cantor-Graae E, McNeil TF. Increased rates of psychosis among immigrants to Sweden: is migration a risk factor for psychosis? Psychol Med. 2001; 31(04):669–678. [PubMed: 11352369]
8. Waters MC, Jiménez TR. Assessing immigrant assimilation: New empirical and theoretical challenges. Annual Review of Sociology. 2005; 31:105–125.
9. Berry JW. Acculturation: Living successfully in two cultures. International Journal of Intercultural Relations. 2005; 29(6):697–712.
10. Chun, KM.; Balls Organista, PE.; Marín, GE. Acculturation: Advances in theory, measurement, and applied research. American Psychological Association; Washington, DC: 2003.
11. Smokowski, PR.; Bacallao, M. Becoming bicultural: Risk, resilience, and Latino youth. NYU Press; New York: 2011.
12. Rudmin FW. Critical history of the acculturation psychology of assimilation, separation, integration, and marginalization. Review of General Psychology. 2003; 7(1):3–37.
13. Bhui K, Warfa N, Edonya P, McKenzie K, Bhugra D. Cultural competence in mental health care: a review of model evaluations. BMC Health Serv Res. 2007; 7(1):1–10. [PubMed: 17199886]
14. Guarnaccia PJ, Rodriguez O. Concepts of culture and their role in the development of culturally competent mental health services. Hispanic Journal of Behavioral Sciences. 1996; 18(4):419–443.

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15. Benish SG, Quintana S, Wampold BE. Culturally adapted psychotherapy and the legitimacy of myth: a direct-comparison meta-analysis. Journal of Counseling Psychology. 2011; 58(3):279–289. [PubMed: 21604860]
16. Griner D, Smith TB. Culturally adapted mental health intervention: A meta-analytic review. Psychotherapy: Theory, Research, Practice, Training. 2006; 43(4):531–248.
17. Bhugra D. Migration and mental health. Acta Psychiatr Scand. 2004; 109(4):243–258. [PubMed: 15008797]
18. Escobar JI, Vega WA. Mental health and immigration's AAAs: where are we and where do we go from here? J Nerv Ment Dis. 2000; 188(11):736–740. [PubMed: 11093375]
19. Guarnaccia, PJ. Social stress and psychological distress among Latinos in the United States.. In: Al-Issa, I.; Tousignant, M., editors. Ethnicity, immigration, and psychopathology. Plenun; New York: 1997. p. 71-94.
20. Kirmayer LJ, Narasiah L, Munoz M, Rashid M, Ryder A G, Guzder J, Hassan G, Rousseau C, Pottie K. Common mental health problems in immigrants and refugees: general approach in primary care. CMAJ. 2011; 183(12):959–967.
21. Portes A, Kyle D, Eaton WW. Mental illness and help-seeking behavior among Mariel Cuban and Haitian refugees in South Florida. Journal of Health and Social Behavior. 1992; 33(4):283–298. [PubMed: 1464715]
22. Vega WA, Sribney WM, Aguilar-Gaxiola S, Kolody B. 12-month prevalence of DSM-III-R psychiatric disorders among Mexican Americans: nativity, social assimilation, and age determinants. J Nerv Ment Dis. 2004; 192(8):532–541. [PubMed: 15387155]
23. Leu J, Walton E, Takeuchi D. Contextualizing acculturation: Gender, family, and community reception influences on Asian immigrant mental health. American Journal of Community Psychology. 2011; 48(3-4):168–180. [PubMed: 20882334]
24. Takeuchi DT, Zane N, Hong S, Chae DH, Gong F, Gee GC, Walton E, Sue S, Alegría M. Immigration-related factors and mental disorders among Asian Americans. Am J Public Health. 2007; 97(1):84–90. [PubMed: 17138908]
25. Equality Now [Internet]. [2015 May 1] New York City (NY) Female Genital Mutilation in the U.S. Factsheet. 2015. Available at http://www.equalitynow.org/FGM_in_US_FAQ
26. Mulongo P, Hollins Martin C, McAndrew S. The psychological impact of Female Genital Mutilation/Cutting (FGM/C) on girls/women's mental health: a narrative literature review. Journal of Reproductive and Infant Psychology. 2014; 32(5):469–485.
27. Abdelshahid A, Campbell C. 'Should I Circumcise My Daughter?' Exploring Diversity and Ambivalence in Egyptian Parents' Social Representations of Female Circumcision. Journal of Community & Applied Social Psychology. 2015; 25(1):49–65.
28. Johansen REB. Care for infibulated women giving birth in Norway: an anthropological analysis of health workers' management of a medically and culturally unfamiliar issue. Med Anthropol Q. 2006; 20(4):516–544. [PubMed: 17225657]
29. Berg RC, Denison E. A tradition in transition: factors perpetuating and hindering the continuance of female genital mutilation/cutting (FGM/C) summarized in a systematic review. Health care women int. 2013; 34(10):837–859. [PubMed: 23489149]
30. Pascoe EA, Smart Richman L. Perceived discrimination and health: a meta-analytic review. Psychol bull. 2009; 135(4):531–554. [PubMed: 19586161]
31. Wu, Y. Professionals' awareness of the unique needs of mail order brides who experience domestic violence. University of Minnesota Digital Conservancy; 2012. Minneapolis (MN): "They're the same as any woman. [Internet]Available from http://purl.umn.edu/123436 [2015 May 1]
32. Zayas LH, Lester RJ, Cabassa LJ, Fortuna LR. Why do so many Latina teens attempt suicide? A conceptual model for research. Am J Orthopsychiatry. 2005; 75(2):275–287. [PubMed: 15839764]
33. Leong F, Park YS, Kalibatseva Z. Disentangling immigrant status in mental health: Psychological protective and risk factors among Latino and Asian American immigrants. Am J Orthopsychiatry. 2013; 83(2pt3):361–371. [PubMed: 23889027]
34. Williams DR, Haile R, Gonzalez HM, Neighbors H, Baser R, Jackson JS. The mental health of Black Caribbean immigrants: results from the National Survey of American Life. Am J Public Health. 2007; 97(1):52–59. [PubMed: 17138909]

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35. Guarnaccia, P.; Giliberti, M.; Hausmann-Stabile, C.; Martinez, I. [2015 May 1] New Brunswick (NJ): What makes the process of acculturation successful?. An initial report of a study at Rutgers University. 2013. [Internet]Available from http://www.ihhcpar.rutgers.edu/downloads/Acc_Study_Report.pdf
36. Rousseau C, Hassan G, Moreau N, Thombs BD. Perceived discrimination and its association with psychological distress among newly arrived immigrants before and after September 11, 2001. Am J Public Health. 2011; 101(5):909–915. [PubMed: 20724695]
37. Kim G, Loi CXA, Chiriboga DA, Jang Y, Parmelee P, Allen RS. Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders. Psychiatry Res. 2011; 45(1):104–110.
38. Bhugra D, Gupta S, Bhui K, Craig T, Dogra N, Ingleby JD, Kirkbride J, Tribe R. WPA guidance on mental health and mental health care in migrants. World Psychiatry. 2011; 10(1):2–10. [PubMed: 21379345]
39. Guarnaccia PJ, Canino G, Rubio-Stipec M, Bravo M. The prevalence of ataques de nervios in the Puerto Rico Disaster Study: The role of culture in psychiatric epidemiology. J Nerv Ment Dis. 1993; 181(3):157–165. [PubMed: 8445374]
40. Kleinman, A. Rethinking psychiatry: From cultural category to personal experience. Free Press; New York: 1988.
41. Kleinman, A. Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry. University of California Press; Los Angeles: 1980.
42. Canino G, Guarnaccia P. Methodological challenges in the assessment of Hispanic children and adolescents. Applied Dev Sci. 1997; 1(3):124–134.
43. Gary FA. Stigma: Barrier to mental health care among ethnic minorities. Issues in Mental Health Nursing. 2005; 26(10):979–999. [PubMed: 16283995]
44. Lewis-Fernández R, Aggarwal NK, Bäärnhielm S, Rohlof H, Kirmayer LJ, Weiss MG, Jadhav S, Hinton L, Alarcón RD, Bhugra D, Groen S, van Dijk R, Qureshi A, Collazos F, Rousseau C, Caballero L, Ramos M, Lu F. Culture and psychiatric evaluation: Operationalizing cultural formulation for DSM-5. Psychiatry. 2014; 77(2):130–154. [PubMed: 24865197]
45. Lindert J, von Ehrenstein OS, Priebe S, Mielck A, Brähler E. Depression and anxiety in labor migrants and refugees–a systematic review and meta-analysis. Soc Sci Med. 2009; 69(2):246–257. [PubMed: 19539414]
46. Zhou M. "Parachute kids" in Southern California: The educational experience of Chinese children in transnational families. Educational Policy. 1998; 12(6):682–704.
47. Aitken, SC.; Swanson, K.; Kennedy, EG. Unaccompanied migrant children and youth: Navigating relational borderlands.. In: Spyrou, S.; Christou, M., editors. Children and Borders. Palgrave Macmillan; London: 2014. p. 214-240.
48. Cesar, S. New York City (NY): In Arizona, a Stream of Illegal Immigrants From China. The New York Times; Jan 22. 2010 [Internet]Available from http://www.nytimes.com/2010/01/23/us/23smuggle.html [2015 May 1]
49. Amnesty International [Internet]. New York City (NY): Widespread abuse of migrants in Mexico is 'human rights crisis.'. 2010. Available from http://www.amnesty.org/en/news-and-updates/report/widespread-abuse-migrants-mexico-human-rights-crisis-2010-04-27
50. Cervantes JM, Mejía OL, Mena AG. Serial migration and the assessment of extreme and unusual psychological hardship with undocumented Latina/o families. Hispanic Journal of Behavioral Sciences. 2010; 32(2):275–291.
51. Suárez-Orozco C, Bang HJ, Kim HY. I felt like my heart was staying behind: Psychological implications of family separations & reunifications for immigrant youth. Journal of Adolescent Research. 2010; 26(2):222–257.
52. Suárez-Orozco C, Kim HY, Bang HJ. Getting used to each other: Immigrant youth's family reunification experiences. Child Studies in Diverse Contexts. 2011; 1(1):1–23.
53. Portes, A.; Manning, RD. The immigrant enclave: Theory and empirical examples.. In: Olzak, S.; Nagel, J., editors. Competitive Ethnic Relations. Academic Press; Orlando, FL: 1986. p. 47-68.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

54. Taylor, P.; Lopez, MH.; Passel, JS.; Motel, S. Unauthorized Immigrants: Length of Residency, Patterns of Parenthood. PEW Hispanic Center; Washington (DC): 2011. [Internet]Available from http://www.pewhispanic.org/files/2011/12/Unauthorized-Characteristics.pdf [2015 May 1]
55. Zayas, L. Forgotten citizens: Deportation, children, and the making of American exiles and orphans. Oxford University Press; New York: 2015.
56. Fry, R.; Passel, JS. Latino children: A majority are U.S.-born offspring of immigrants. PEW Hispanic Center; Washington (DC): 2009. [Internet]Available from http://pewhispanic.org/files/reports/110.pdf [2015 May 1]
57. Lopez A, Boie I. Voices: Exploring the experiences of non-mental health professionals working with Mexican immigrants affected by deportation. Journal for Social Action in Counseling and Psychology. 2012; 4(1):40–52.
58. Cavazos-Rehg PA, Zayas LH, Spitznagel EL. Legal status, emotional well-being and subjective health status of Latino immigrants. J Natl Med Assoc. 2007; 99:1126–1131. [PubMed: 17987916]
59. Stock I. Immigrant women workers in the neoliberal age. Ethnic and Racial Studies. 2014; 37(10)
60. Stone S, Han M. Perceived school environments, perceived discrimination, and school performance among children of Mexican immigrants. Children and Youth Services Review. 2005; 27(1):51–66.
61. Toppelberg CO, Tabors P, Coggins A, Lum K, Burger C, Jellinek MS. Differential diagnosis of selective mutism in bilingual children. J Am Acad Child Adolesc Psychiatry. 2005; 44(6):592–595. [PubMed: 15908842]
62. Alegria M, Canino G, Shrout PE, Woo M, Duan N, Vila D, Torres M, Chen CN, Meng XL. Prevalence of mental illness in immigrant and non-immigrant US Latino groups. Am J Psychiatry. 2008; 165(3):359–369. [PubMed: 18245178]
63. Wright EM, Benson ML. Immigration and intimate partner violence: Exploring the immigrant paradox. Social Problems. 2010; 57(3):480–503.
64. Portes A, Zhou M. The New Second Generation: Segmented Assimilation and its Variants. The ANNALS of the American Academy of Political and Social Science. 1993; 530(1):74–96.
65. Abu-Ras W, Gheith A, Cournos F. The Imam's role in mental health promotion: A study at 22 mosques in New York City's Muslim community. Journal of Muslim Mental Health. 2008; 3(2):155–176.
66. Ma GX. Between two worlds: the use of traditional and Western health services by Chinese immigrants. Journal of Community Health. 1999; 24(6):421–437. [PubMed: 10593423]
67. Williams DR, Gonzalez HM, Neighbors H, Nesse R, Abelson JM, Sweetman J, Jackson JS. Prevalence and distribution of major depressive disorder in African Americans, Caribbean blacks, and non-Hispanic whites: results from the National Survey of American Life. Arch Gen Psychiat. 2007; 64(3):305–315. [PubMed: 17339519]
68. Venters H, Gany F. African immigrant health. J Immigr Minor Health. 2011; 13(2):333–344. [PubMed: 19347581]
69. Garcia Coll, C.; Kerivan Marks, A., editors. The Immigrant Paradox in Children and Adolescents: Is Becoming American a Developmental Risk?. American Psychological Association; Washington, DC: 2012.
70. Vega WA, Kolody B, Aguilar-Gaxiola S, Alderete E, Catalano R, Caraveo-Anduaga J. Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. Arch Gen Psychiat. 1998; 55(9):771–778. [PubMed: 9736002]
71. Grant BF, Stinson FS, Hasin DS, Dawson DA, Chou SP, Anderson K. Immigration and lifetime prevalence of DSM-IV psychiatric disorders among Mexican Americans and Non-Hispanic Whites in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. Arch Gen Psychiat. 2004; 61(12):1226–1233. [PubMed: 15583114]
72. Vega WA, Sribney WM, Miskimen TM, Escobar JI, Aguilar-Gaxiola S. Putative psychotic symptoms in the Mexican American population: prevalence and co-occurrence with psychiatric disorders. J Nerv Ment Dis. 2006; 194(7):471–477. [PubMed: 16840842]