Chapter 5
Best Practices and Research Perspectives with Immigrant Groups

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As a son of immigrant parents and a psychologist that provides psychological services to the immigrant population in a border community and conducts research at a Hispanic Serving Institution on Latin x and immigrant groups, I was honored to contribute a chapter on the best practices and research perspectives to be considered when working with this important population. I was elated to co-write this chapter with my dear colleagues, Dr. Amanda Venta, a Latina psychologist, and Dr. Ricardo Irizarry, a Latino psychiatrist, thus bringing together our wealth of knowledge and experience to further others' understanding on the best practices for working with this unique population, whether in a clinical setting or the research realm. As I write this chapter, I am teaching at the University Central De Ecuador, where I have a visiting professorship role in the Facultad de Ciencias Psicologicas. This cultural emergence experience continues to fuel my passion for psychology across international borders. I have collaborated with researchers from Universidad de Guadalajara, Universidad Autonoma De Nueveo Leon in Mexico, and Universidad Central de Ecuador, and have presented in international platforms on my work with Latinos in

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the US and the immigrant population. This chapter aims to highlight the importance of working with culturally diverse immigrant groups and lays out critical research and clinical perspectives that contribute to advances in mental health.

The Journey

Many individuals and families migrate to the USA for an array of reasons. Our continuous contact with this population in clinical and research settings has revealed reasons of trauma as many immigrant groups are escaping violence and poverty, while many others are reuniting with family members who have been living in the USA for a long time or seeking educational and economic opportunities. The USA is currently home to approximately 40.4 million immigrants (U.S. Census Bureau, 2011), of which one-third are from Mexico and 55% originate from Latin-America (U.S. Census Bureau, 2011). There has also been a more recent increase in immigrants and refugees from the Middle East, given the unrest in that part of the world (Kiely, Fairley, & Gore, 2015). One in five individuals living in the USA is a first- or second-generation immigrant, and almost a quarter of children under the age of 18 have an immigrant parent (Mather, 2009), while current estimates of undocumented individuals sit at 11.7 million (Passel, Cohn, & Gonzalez-Barrera, 2013).

Practicing in a border community, we have seen a rise in unaccompanied minors and immigrant mothers and their children crossing the Rio Grande River, which borders Northern Mexico and Texas. This is a distinct region in the USA, which is a predominantly Latino community and is where many immigrant groups and an array of cultures meet (Mercado et al., 2016). There has been an increase of 131% in the number of children and families crossing the Southwestern border of the USA between 2015 and 2016 (U.S. Border Patrol, Southwest Border Sectors, 2016). Approximately 52,000 minors aged five and up, most from Honduras, Guatemala, and El Salvador, crossed the border in 2015. The number of undocumented and unaccompanied youth entering the USA have significantly increased throughout the last 2 years, something that is evident in the border community where we practice and conduct research. Due to these diverse demographics, psychologists and mental health professionals are increasingly serving immigrant children and adults, both documented and undocumented, presenting with a multitude of problems across settings including schools, clinics, hospitals, and prisons (Casas, 2017). Thus, clinicians should be aware of this important population as practitioners and researchers in an ever-growing multicultural society.

APA's Crossroads Report

In 2013, the American Psychological Association's Presidential Task Force on Immigration published *Crossroads: The Psychology of Immigration in the New Century*, "an evidence-based report on the psychological factors related to the

immigration experience…. focusing on factors that impede and facilitate adjustment (APA's, 2013)." The report was also intended to facilitate decision-making in regard to immigration, which has become a societal, political, and legal issue in contemporary America.

The report outlines three guiding principles: (1) immigrants are resilient and resourceful, (2) immigrants are influenced by their social contexts and, thus, ecological circumstances should be considered when framing their experiences, and (3) it is essential to use cultural lenses with the diverse immigrant-origin population (APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists, 2013). The report indicates that first-generation immigrants often display greater physical and behavioral health than subsequent generations, despite having to face many challenges such as language barriers, racial discrimination, poverty, occupational disappointments, social isolation, and educational difficulties (APA, 2013). Racial discrimination is one of the most difficult stressors that newly arrived immigrants are faced with, and it is also one of the most researched. Discrimination is dealt with in the workplace, neighborhood, schools, and even service agencies. For many immigrants, immigration to the USA provides their first encounter with racial discrimination (APA, 2013). Even without the undue burden of racial discrimination, acculturation is not without its own challenges. Age is a factor in how well immigrants acculturate to their new environment, with younger immigrants generally acculturating faster and with greater ease than their older counterparts (APA, 2013). Although immigrants may come to adopt many of the values and behavioral practices of the new culture, the values and practices of the country of origin are rarely abandoned entirely (APA, 2013). The process of acculturation has the potential to strain the dynamics of the parent–child relationship, as children may begin to lose faith in their parent's ability to understand and help them cope with the challenges they face in the new culture as children (APA, 2013).

Immigrants are often disadvantaged and perform below their actual competencies when tested with clinical and educational assessments that may not be sufficiently attuned to their cultural background or frame of reference (APA, 2013). In the clinical realm, immigrants are particularly disadvantaged when administered ability, aptitude, and achievement testing. Although many first-generation immigrants are less adapted to the language of their new country, they often display certain advantages in educational contexts such as optimism, high aspirations, dedication to hard work, positive attitudes toward school, and family support (APA, 2013). However, they tend to perform poorly on "high-stakes testing," according to the report. The needs of immigrant students are often inadequately addressed within the educational system, and they are often at a significant disadvantage.

The report states that immigrants have not been shown to suffer from mental illnesses more frequently than non-immigrants, with the exception of refugees (APA, 2013). However, when such illnesses do occur within this population, they are frequently a product of the immigration process—"loss of and separation from [the] country of origin, family members, and familiar customs and traditions; changes in social class and/or socioeconomic status; exposure to a new physical environment;

and the need to navigate unfamiliar cultural contexts" (APA, 2013). The issues of immigrants can often be classified according to three categories: (1) acculturation-based problems, (2) trauma-based presenting problems, and (3) discrimination, racism, and xenophobia-based problems (APA, 2013). The report highlights that recognition and appropriate utilization of culture-specific coping should be promoted within the clinical context. The report identifies three kinds of barriers to culturally sensitive treatment with immigrants: (1) social-cultural barriers, such as differences in frame of reference regarding the causes and treatments of mental illness, (2) contextual-structural barriers, which includes lack of access or knowledge of culturally sensitive mental health services, and (3) clinical-procedural barriers, which may be described as "clinical bias" due to lack of cultural sensitivity, language barriers, misdiagnosis, and lack of recognition for culture-specific forms of coping and resiliency (APA, 2013).

Overall, the field of psychology and immigration was enhanced by this important report that former APA president, Dr. Melba Vasquez, initiated during her presidency at APA. Members of the task force compiled pertinent data and reviewed critical literature to set forth these important guiding principles and frameworks when working with immigrant groups.

Research Perspectives: Immigration and Mental Health/ Acculturation and Resiliency

The aim of this section is to review the existing data on three critical variables: immigration status, acculturation, and resiliency in relation to mental health.

Immigration

Existing literature regarding the relation between immigration and mental health has created a construct called the *Immigrant Paradox*, which suggests that first-generation immigrants are at a lower risk for a range of health problems and psychopathology than their native-born counterparts, despite sociological disadvantage (Acevedo-Garcia & Bates, 2008; Lui, 2015; MacDonald & Saunders, 2012; Vaughn, Salas-Wright, DeLisi, & Maynard, 2014; Wolff, Baglivio, Intravia, & Piquero, 2015). The effect has been documented in various psychological outcomes, as well as related outcomes such as the emotional and sexual abuse of children (Millett, 2016). Similarly, the *Hispanic Health Paradox* refers to an existing literature base showing that, despite exposure to many health risks like low socioeconomic status, limited access to health care and insurance, and reduced education and employment, Hispanics in the USA generally report greater health than non-Hispanic Whites (Ruiz, Hamann, Mehl, & O'Connor, 2016). The effect is even more

pronounced among Hispanic immigrants (i.e., foreign-born) (Singh, Rodriguez-Lainz, & Kogan, 2013).

However, some research focused on the mental health of immigrant populations actually suggests a *disadvantage*. For instance, in some studies, immigrants report a higher prevalence of conduct problems, phobias, and early substance use (Breslau et al., 2011); decreased mental health functioning than their native-born ethnic counterparts (Farley, Galves, Dickinson, & Perez, 2005); and psychiatric disorder rates comparable to non-Latino White subjects (Alegría et al., 2008). Overall, findings are inconsistent, and a review of the *Immigrant Paradox* and *Hispanic Health Paradox* literature bases suggests that it does not apply evenly across ethnic groups, age groups, or genders, with, for example, Mexican American mothers at an increased risk of adverse perinatal outcomes than immigrant Asian Indian mothers (Gould, Madan, Qin, & Chavez, 2003; Teruya & Bazargan-Hejazi, 2013). Teruya and Bazargan-Hejazi (Teruya & Bazargan-Hejazi, 2013), in conducting a review of extant literature, observe that immigrants who do not have health insurance are older at the time of migration, and who have spent more time in the USA (see Acculturation section, below) experience the worst outcomes. Moreover, they state that "immigrant adolescents in general appear to be the most vulnerable to psychosocial stressors, with Latino populations at greatest risk" (Teruya & Bazargan-Hejazi, 2013, p. 501).

The latter may be accounted for, at least in part, by unprecedented increases in the migration of adolescents to the USA from Central America—particularly El Salvador, Guatemala, and Honduras—where crime, death, and violence have reached record levels. This shift is recent, with Honduras reporting the highest homicide rate globally in 2011, 2013 marking the end of a truce between major gang powers in El Salvador, and crime victimization cited as a major reason for Central American migration in 2014 (Hiskey, Cordova, Orces, & Malone, 2016). As the socio-political climate of Central America has changed, so have patterns of Hispanic immigration to the USA. Indeed, between 2015 and 2016 alone, there was a 131% increase in the number of children and families crossing the Southwestern border of the USA, reflecting large numbers of families seeking "humanitarian protection" (U.S. Border Patrol, Southwest Border Sectors, 2016). The unprecedented danger in Central America has been cited as a "humanitarian emergency" by President Obama, with children and families being described as requiring "special attention" (Declaration by The Government Of The United States Of America and The Government Of The United Mexican States Concerning Twenty-First Century Border Management, 2010) and "particular focus" (Federal Strategic Action Plan on Services for Victims of Human Trafficking in the United States, 2014) by several government agencies. Dramatic increases in rates of crime, violence, and death in Central America have corresponded to increases in reports of trauma and posttraumatic symptoms among recent waves of Hispanic immigrants (U.S. Conference on Catholic Bishops, 2014).

Research with other immigrant groups has also demonstrated that individuals who are displaced due to violence in society, abuse in the home, persecution, or deprivation are at a higher risk for developing psychopathology (Ehntholt & Yule,

2006; Fazel, Reed, Panter-Brick, & Stein, 2012; Reed, Fazel, Jones, Panter-Brick, & Stein, 2012); this distinguishes many recent Hispanic immigrants from individuals who immigrated freely to the USA. Indeed, studies examining psychopathology in Hispanic adolescent immigrants in the USA confirm high rates of psychopathology (Locke, Southwick, McCloskey, & Fernández-Esquer, 1996; Perreira & Ornelas, 2013; Potochnick & Perreira, 2010) and suggest that the *Immigrant Paradox* or *Hispanic Paradox* may not apply. Likewise, a review of risk and protective factors for mental health in youth who are displaced from their home countries and resettled in high-income countries after immigration reveals high rates of adversity during migration and in their home country, with related increases in posttraumatic stress, internalizing problems, and social maladjustment (Fazel et al., 2012). Across the literature on this topic, exposure to pre-migration violence, being female, migrating without a guardian, perceived discrimination after migration, exposure to post-migration violence, changes of residence after migration, parental exposure to violence, limited financial means, single parent families, and parental psychopathology were identified as risk factors for immigrant youth mental health (Fazel et al., 2012). High parental/familial support, self-reported peer support, positive school experiences, and placement with a foster care family of the same ethnic background emerged as protective factors in this review (Fazel et al., 2012).

Across literatures related to Hispanics and non-Hispanic immigrants, as well as youth and adult immigrants, the relation between immigration and mental health is inconsistent. Relations identified in prior research appear to depend upon exposure to contextual risk factors as well as individual variables and pre-existing vulnerability (e.g., exposure to violence in home country). Across many aforementioned studies, the role of acculturation is modeled or theorized. A review of that literature occupies the next section.

Acculturation

Acculturation refers to a bi-dimensional process in which an individual will range from high to low on affiliation with their host (post-migration) culture and, on a separate axis, from high to low on affiliation with their culture of origin (Sam & Berry, 2010). Individuals high in affiliation with their host culture and low in affiliation with their culture of origin, for instance, are described as "assimilated," where as individuals high on both axes are referred to as "bicultural/integrated." Individuals low in both metrics are described as "marginalized" and individuals with high affiliation with their culture of origin only are referred to as "traditional/separated." Overall, acculturation among immigrants is conceptualized as a change in cultural identity, which includes shifts in various cultural dimensions including typical practices, values, and identifications (Schwartz, Unger, Zamboanga, & Szapocznik, 2010).

Literature regarding the link between acculturation and mental health is mixed, with some studies of the *Immigrant Paradox* reporting that lower acculturation with the host country accounts for health benefits (e.g., Kaplan & Marks, 1990) and others

showing that low acculturation among immigrants is risk factor for negative mental health outcomes (e.g., Hwang & Ting, 2008). Indeed, the aforementioned *Immigrant* and *Hispanic Paradox* literatures cite that individuals with lower acculturation to the USA experience greater benefits (Teruya & Bazargan-Hejazi, 2013), and some of the identified health benefits noted in the *Paradox* research erode with increasing time and generations in the USA as Hispanic acculturation to US culture increases and damaging health behaviors (e.g., smoking) increase (Kondo, Rossi, Schwartz, Zamboanga, & Scalf, 2016). Numerous explanations have been put forth to explain these inconsistent findings, including heterogeneity within and across immigrant groups, inconsistent measurement of acculturation, and lack of measurement of related variables regarding ethnic identity (Bulut & Gayman, 2016). In studies that have endeavored to address these limitations, acculturation emerges as a complex construct without simple relations to mental health. Indeed, findings do not link simple conceptualizations of high or low acculturation to mental health, but rather identify risk in specific interactions between both axes put forth by Sam and Berry (2010). Specifically, marginalization appears to be relatively associated with negative mental health outcomes, whereas integration is associated with positive mental health outcomes (Yoon et al., 2013). Support for this conclusion has been documented with regard to both Latino and Asian immigrants (Bulut & Gayman, 2016), and the worst outcomes have been noted among recently arrived immigrants.

Critiques of existing literature on acculturation in the context of mental health, however, have cited inconsistent measurement and definition of acculturation across studies (Bulut & Gayman, 2016; Teruya & Bazargan-Hejazi, 2013). Indeed, acculturation is often treated as though it is synonymous with acculturative stress—self-reported distress during the acculturation process (e.g., distress associated with speaking with an accent). Existing literature regarding acculturative stress is relatively consistent across immigrant groups, suggesting that distress while adjusting to acculturation has a negative impact on all ethnic groups' mental health (Caplan, 2007; Teruya & Bazargan-Hejazi, 2013; Turner, Lloyd, & Taylor, 2006), with particularly profound impacts on the substance use of Hispanics in the USA (Turner et al., 2006). Relatedly, perceived racism and discrimination have been linked to negative mental health and academic outcomes in immigrant youth in the USA (Smokowski & Bacallao, 2006; Suárez-Orozco, Rhodes, & Milburn, 2009). In studies that account for both acculturation level and acculturative stress, the latter emerges as the significant risk factor for psychopathology (Hwang & Ting, 2008), indicating that experiences of perceived discrimination and related distress are more relevant to mental health in immigrant groups than cultural identification alone.

Resiliency

One important characteristic that is apparent when working with immigrant groups in the clinical and research setting is the level of resiliency they exude. Many researchers have highlighted the Latino culture and how it affects health outcomes.

For example, Gallo, Penedo, de los Monteros, and Arguelles (2009) and colleagues conceptualize the Reserve Capacity Model, which helps explain how multiple types of psychosocial factors might contribute to the disparities related to SES. Individuals with less reserve capacity may have fewer social factors to help deal with stress. These factors can be interpersonal (support, relationships, social roles), intrapersonal (perception of control, future, optimistic views), and/or tangible (transportation, saving, day care). To be able to have a better chance of being resilient, the more reserve capacity an individual has, the higher chance they have at overcoming obstacles. This may represent a protective factor that enhances resiliency in individuals who maintain high levels of reserve capacity even in the context of adverse circumstances. Latino cultural values can play a significant role in resiliency. Some main values include allocentrism, familismo, and simpatia. Allocentrism and familismo focus on the idea that the group or family needs come before the individual. This allows for individuals to have greater social networks and support. Simpatia reflects a drive toward non-confrontational social interactions.

Another prominent model, The *Hispanic Health Paradox*, is one of the sociocultural resilience factors put forth by Ruiz et al. (2016). This model posits that the Hispanic health advantage is driven by sociocultural resilience factors that promote positive health—specifically, collectivist values including "family (*familismo*), interpersonal harmony (*simpatía*), and valuing of elder community members (*respeto*)" (Ruiz et al., 2016, p. 467). This model will be examined later in the future directions section, as there is a great need for research to be done on resilience factors and the health of immigrant groups in the USA.

Practice Perspectives

Assessments

The overwhelming majority of relevant empirical and position papers address the psychological assessment of ethnic minorities. While not specific to immigrant groups, this literature base has been central in identifying psychometric considerations that are critical in determining whether it is appropriate to extend assessment instruments developed in one cultural group to another. In this section, we review Pina, Gonzales, Holly, Zerr, and Wynne's (2013) approach to evidence-based assessment with ethnic minorities, focusing on the psychometric concepts of measurement equivalence and method bias. Overall, these topics go beyond calculation of basic psychometric properties like internal consistency or validity to examine whether psychometric properties are consistent across meaningful population subgroups (e.g., cultural groups or immigrant groups)—considerations cited in the *Standards for Educational and Psychological Testing* (AERA, APA, & NCME, 1999) and in the American Psychological Association's Handbook of Clinical Psychology (Norcross, VandenBos, Freedheim, & Domenech Rodríguez, 2016).

Psychometric Considerations

Measurement equivalence includes both item equivalence (which can include configural, metric, threshold, and item uniqueness invariance) and construct validity equivalence (which includes functional and scalar equivalence) (Hui & Triandis, 1985; Knight, Tein, Prost, & Gonzales, 2002; Pina et al., 2013). Broadly, configural invariance asks whether an assessment instrument demonstrates the same factor structure across groups (Ghorpade, Hattrup, & Lackritz, 1999; Millsap & Tein, 2004; Pina et al., 2013; Vandenberg & Lance, 2000). If the configural invariance of an instrument is low, some items from that instrument do not load onto their hypothesized and previously documented factor when the scale is completed in a different cultural group. Pina et al. (2013) are careful to note that evidence of configural invariance is insufficient to support the use of an instrument across groups, citing that metric invariance—the extent to which the meaning of individual assessment items differs across groups (Labouvie & Ruetsch, 1995; Pina et al., 2013; Raykov, 2004)—may be a more important clinical consideration. Indeed, Pina et al. (2013) note that culturally embedded terms like "nervios" in Spanish may be mistaken for less culturally laden terms, like the more general "nervous," thereby leading to different interpretations of an item across groups. Similarly, items intended to assess depression by probing feelings of "punishment" may not perform equivalently in cultural groups where religious notions of punishment are common (Azocar, Arean, Miranda, & Muñoz, 2001). Finally, threshold invariance (Pina et al., 2013; Widaman & Reise, 1997) asks how severely a construct must be experienced before the client endorses a given item, and item uniqueness invariance (Byrne, Shavelson, & Muthén, 1989; Pina et al., 2013) refers to the unexplained variance in item endorsement. Ideally, assessment instruments would be subjected to empirical analyses of configural, metric, threshold, and item uniqueness invariance in an effort to establish item equivalence between the group in which the measure was developed and the group to which the assessment client belongs.

In order to fully evaluate measurement equivalence, empirical work would also endeavor to examine construct validity equivalence—the notion that "the construct being assessed has similar precursors, consequences, and/or correlates across groups" (Pina et al., 2013). Specifically, functional equivalence would assess whether the slopes of construct validity relations are consistent across groups, whereas scalar equivalence would evaluate the intercepts of those relations (Knight et al., 2002; Knight & Hill, 1998). An assessment instrument should have demonstrated both construct validity equivalence and item equivalence with respect to the client's cultural, ethnic, or racial group before being included in an evidence-based assessment. The same standard could be applied to other meaningful subpopulations, like immigrant groups.

A final consideration noted by Pina et al. (2013) centers upon method bias—the notion that assessment methods like interviews or questionnaires produce non-equivalent data across groups (e.g., Van de Vijver & Leung, 2011). For instance, Asian American ratings of social anxiety are significantly higher than European

Americans on questionnaire-based measures but significantly lower on interview-based measures, suggesting method bias in the assessment of social anxiety (Matsumoto & Kupperbusch, 2001). Attention to method variance introduces a number of other assessment considerations related to the language of assessment.

Linguistic Considerations

A number of studies have cited concerns regarding how psychological assessment in one's non-native language (a common experience among immigrant groups) may affect the quality of clinical assessment. Existing data suggests that conducting psychodiagnostic interviews—both semi- and unstructured—in a second language may influence the emotional content described by the client and the affective states observed by the clinician, possibly biasing assessment data (Oquendo, 1996; Venta, Muñoz, & Bailey, 2017). It should be noted that determining the language in which to conduct a psychological assessment is a complex area of empirical research on its own (see the Multidimensional Assessment Model for Bilingual Individuals by Ortiz & Ochoa, 2005, for instance). Moreover, it is established within cognitive and achievement testing realms that linguistic dominance interacts with cultural loading in relation to test validity issues (e.g., Rhodes, Ochoa, & Ortiz, 2005).

The Culture-Language Test Classification system (Flanagan & Ortiz, 2001; Flanagan, Ortiz, & Alfonso, 2007; McGrew & Flanagan, 1998) was developed in order to address the question of whether low cognitive or achievement test scores reflect cultural/linguistic differences or disorder (i.e., "difference versus disorder") (Ortiz, Ochoa, & Dynda, 2012). Specifically, existing norm-referenced tests were categorized according to their hypothesized cultural loading (based on bilingual examinee performance) on the Culture-Language Test Classifications matrix and on its successor, the Culture-Language Interpretive Matrix. The current iteration of Flanagan and Ortiz's (2001) Culture-Language Interpretive Matrix arranges psychological assessments across axes representing linguistic demand and cultural loading. Client performance is hypothesized to be least affected when both cultural loading and linguistic demand are low and, conversely, most affected when both are high. Interested clinicians are referred to the Cross-Battery Assessment Software System (X-BASS v. 1.3), available for purchase, which includes interactive worksheets to determine the linguistic demand and cultural loading for specific, commonly used assessment instruments (Ortiz, Flanagan, & Alfonso, 2017).

Practical Solutions

Clinicians are encouraged to select instruments that have demonstrated measurement equivalence and consider the cultural loading and linguistic demands of instruments prior to inclusion in their evidence-based assessment batteries. Pina et al.

(2013) provide a comprehensive review of existing literature of cross-ethnic measurement equivalence studies of broad-band, internalizing, and externalizing rating scales as well as diagnostic interviews available for youth in their chapter "Toward Evidence-Based Clinical Assessment of Ethnic Minority Youth." Clinicians engaged in intellectual testing may benefit from Ortiz et al. (2012) chapter entitled "Testing with Culturally and Linguistically Diverse Populations: Moving beyond the Verbal-Performance Dichotomy into Evidence-Based Practice." A broad review of assessment instruments for adults and children is provided by Suzuki and Wilton (2015) in their chapter, "Assessment with Racial/Ethnic Minorities and Special Populations" within the American Psychological Association's Handbook of Clinical Psychology. Clinicians practicing within a special emphasis area, such as forensic clinical psychology, may have only a few articles providing guidance regarding assessments across cultural or ethnic groups (e.g., Canales, Kan, & Varela, 2016; Weiss & Rosenfeld, 2012).

Still, existing literature often assumes homogeneity across ethnic groups with little consideration for critical variables reviewed in this chapter like immigration status and acculturation. Moreover, measurement equivalence and method bias studies are limited, partly because they require substantial resources and pose unique methodological challenges (Fernandez, Boccaccini, & Noland, 2007). At this time, clinicians are encouraged to take the scientist-practitioner model to heart—reviewing available empirical support for the instruments they use and acknowledging limitations in the existing data when describing the validity of assessment instruments included in their chosen battery. Indeed, regardless of focus area, clinicians may find the four-step approach put forth by Fernandez et al. (2007) helpful. First, clinicians identify tests available in their language of interest; second, available research must be reviewed so that; third, research can be reviewed for its applicability to the specific client; and finally, the clinician can make an overall determination about the level of research support for using the selected test with the identified client. Though the four-step approach was originally devised for clinicians seeking to identify and select translated tests, it is based on the professional testing standards put forth by the *Standards for Educational and Psychological Testing* (AERA, APA, & NCME, 1999) which addresses "fairness in testing" more generally and may therefore be useful to clinicians working with immigrant populations.

Counseling Perspectives

In order to provide the most effective mental health interventions to immigrant groups, several guiding principles have been proposed by Casas (2017) and La Roche, Christopher, and West (2017). One important movement in psychotherapy has been cultural evidenced-based psychotherapies (CEBPs). CEBPs refer to evidenced-based counseling interventions that emphasize race and ethnicity, and also integrates cultural proximal variables, such as socioeconomic status,

neighborhood violence, and religion (La Roche et al. 2017). By integrating cultural and proximal factors, clinicians can have a better understanding of the psychotherapeutic process. One important consideration La Roche et al. (2017) highlight is the importance of operationally defining race, ethnicity, and culture, and examining the effects of cultural variables as each impacts the psychotherapeutic process. Doing so can further enhance the efficacy of cultural competency recommendations.

Casas (2017) also postulates imperative guiding principles for clinicians to work effectively with culturally diverse groups, yet specifically identifies the immigrant population. First, the author suggests using an ecological framework proposed by Bronfenbrenner and Morris (2006) to guide interventions. This perspective highlights the human experience as a result of reciprocal interactions between people and the environment, and how it varies from individuals, contexts, culture, and time (Casas, 2017). This allows clinicians to understand the immigrant experience and thus develop appropriate interventions. A second guiding principle includes the necessity of integrating evidenced-based practice with practice-based interventions (Casas, 2017; La Roche et al. 2017). The third guiding principle supports The APA's Presidential Task Force on Immigration (2012) report postulating the importance of cultural competency, which includes cultural knowledge, the therapist's attitudes and beliefs, as well as the skills needed for the effective delivery of culturally appropriate interventions. A fourth guiding principle involves the significance of utilizing comprehensive community-based interventions. This allows the clinician to collaborate with the various systems that are part of the client's life, such as primary care, mental health, social, legal, and educational branches. Collaborating with various social service entities allows the client to be validated and empowered (Casas, 2017). The fifth and final guiding principle used in effective delivery of clinical interventions with immigrant groups includes the importance of using a social justice perspective as a driving force for all services (Casas, 2017). We have found this to be a vital factor in the implementation of effective treatment delivery. The belief that all people have a right for equitable treatment and fair allocation of societal resources is critical and is a paradigm shift among mental health providers. There are obstacles that some may face, however, playing an active role in advocacy and policymaking for humane treatment of all persons including immigrant groups is of utmost importance. Advocacy in local, state, and national platforms is critical in order to advance social justice and mental health.

New Psychiatric Perspectives

Psychiatric disorders are brain disorders, and generally speaking most people have brains that are anatomically similar. The conversation about ethnicities and cultural competence in the field of psychiatry is essential to understanding these disorders. Although it can be said that most of us have brains composed of the same major anatomical areas such as Frontal, Temporal, Occipital Lobes, and subcortical areas like the Amygdala, Thalamus, and others, all of our brains are different. What makes

one brain different from another lies in the development of particular pathways, tracts, and connections contained within those structures. All of these trillions of connections are shaped through the developmental stages from birth to the mid-20s. Although the brain has an intrinsic ability to form these connections, the environment has been found to be crucial in how they are made. Culture is an essential aspect of the environmental factors affecting the millions of connections that are made during the life of a person. Culture not only affects brain development but also builds our perception of our self and our relationship with our environment.

According to the U.S. Census in 2017, there are approximately 57.5 million Latinos or Hispanics. It has been found in statistical data that about 15% of this population suffer from psychiatric disorders each year (NIMH Census Study, 2012). While some believe that Latinos have a negative attitude toward psychiatric disorders, there is very little evidence to support this perception. This belief is probably a remnant of previous generations and their attitudes. It is quite common to hear stories from patients describing how these attitudes have changed over time. It is possible to assume that those Latinos who have recently immigrated to the USA may experience more difficulties regarding treatment of psychiatric conditions. Psychiatric disorders in general are embedded with stigma, and this is in part related to the dualism of mental conditions—the belief that mental conditions originate somewhere other than the brain. The Latino culture has always attempted to explain abnormal behavior by blaming an outside entity, that being parents, friends, or via spirituality. It is common to meet Hispanic parents that present to the clinic suffering depression after their child has developed a mental disorder. Many Hispanics may decide to prolong the treatment of mental conditions, believing that their suffering is rooted in a spiritual or personal weakness.

What studies have shown is that, in the USA, the problem doesn't lie with negative attitudes toward mental disorders but rather that Hispanics have more positive attitudes toward mental disorders than non-Hispanic Whites. This suggests that the barriers to treatment are structural in nature, including socioeconomic factors as well as language. The lifetime prevalence of mental illness for Latino populations in the USA is lower than that of non-Latino Whites (30–40% vs. 50%). Latinos that have immigrated to the USA actually have a lower prevalence of mental illness than those who are US born. Many factors can be associated with these findings. This data is essential for clinicians when diagnosing and treating Latinos.

Another epidemiological factor of concern is related to the prevalence of suicide ideas and suicidal attempts within the Latino community. Centre for Disease Control (CDC) data reported in 2012 shows that Latino males in high school have the same prevalence of suicidal ideas as non-Latino Whites (10.7 vs. 10.5), but tend to have more suicidal attempts (6.9 vs. 4.6). This data is even more concerning when looking at females in the same age range. Latino females are twice as likely to think about suicide and to attempt suicide compared to their male counterparts (13.5%) (CDC Data on Adolescent Suicide, 2014). These rates are higher than those found in non-Latino individuals. When a clinician encounters a Latino, keeping these factors in consideration would allow for a more tailored approach to their treatment.

For example, recognizing that Latino females in high school have a high prevalence of suicide ideas should trigger a more focused interview for this population.

Interestingly, acculturation in the Latino population has been studied and the results were unexpected to a certain extent. Most Latinos that immigrate to the USA do so as part of an effort to better their socioeconomic status. Studies have shown that in the Latino population, the more acculturation achieved by the individual, the more prevalence of mental disorders (Lanouette, Folsom, Sciolla, & Jeste, 2009). Acculturation is defined by the process in which an individual acquires the attitudes, values, beliefs, and customs of another culture. It is unclear if this correlation shows a protective factor from the innate culture or a liability acquired with the new culture, or if it is just the result of stress related to being an immigrant and leaving home behind. More studies need to be done in this area.

Treatment adherence in the Latino population is also an area of concern. For example, it has been noted that an average of 50% of Latino patients return to see their psychologist, based on a report from the American Psychological Association. This compares to about a 70% rate of return by non-Latino Whites. The American Psychiatric Association reported in their Fact Sheet (2014) that only 36% of Hispanics with depression ever receive treatment, versus 60% of Whites. One of the concerns shared by the APA is a language barrier. Another concern was that Latinos are usually under-treated compared to Whites. Reasons for this under-treatment should be investigated further. It is a universal understanding in the field of mental health that social support, including family, is essential to the adherence of treatment and for achieving remission of symptoms. The US Latino population doesn't maintain, as a general rule, the same level of family interaction that is seen in Latino countries, which may be a factor that triggers worse outcomes in the USA compared to Latino countries.

A meta-analysis of treatment adherence in the Latino population demonstrated that there are various factors that were associated with better adherence. Some factors were, as expected, family support, being married, and having better finances. Other factors that were interesting included more severe cases of depression and use of Selective Serotonin Receptor Inhibitors (SSRI's) (Lanouette et al., 2009). Apparently in severe depression syndromes, Latinos experience an increase in adherence to treatment, showing more resilience. Also, Latino patients suffering with depression tend to be more adherent to SSRIs than to non-SSRI medications. It is possible that there is genetic predisposition to being more tolerant of this class of medications than to other antidepressants, as a general rule. Latinos that were involved in therapy by attending more than eight sessions in a year with a non-medical therapist would be more adherent to their psychotropics. In certain systems in the USA, access to psychologists and master-level counselors is very limited, and care is limited to the prescription of medications. Under these circumstances, the Latino patient will most likely experience a low adherence. It is important to always involve a therapist or psychologist in the treatment of mental illness. It seems the Latino patient benefits substantially from these interventions and increases in overall adherence to treatment.

Another study found that Latinos are less likely to have discussions regarding their medications with their physicians. This same study also found that Latinos are less likely to complain about side effects than non-Latino Whites (Alegría et al., 2008). In the Latino culture, physicians and health providers are still perceived as figures of authority. The Latino patient seems to be more self-conscious about this dynamic, which in turn impedes the delivery of necessary services. A Latino patient may be more concerned about upsetting his provider for not following treatment recommendations. It is important for the provider to develop a non-judgmental approach to the Latino patient, focusing on developing rapport and establishing a relationship of collaboration that is evident from the beginning. The patient should be empowered with participating in the decision-making process related to their treatment. There are no evidence-based guidelines for improving adherence in the Latino population, but some general recommendations can be made based on the literature review, such as reassessing adherence frequently during patient encounters and using pharmacy records in addition to family reports to detect non-adherence. The physician should make it a point to discuss medication adherence and side effects at each visit, and encourage the patient to participate in these discussions. Medication information should be provided in Spanish, including effects, side effects, and what to expect from the medications. Remember that including a therapist in the treatment plan also increases adherence in Latino patients.

The rate of Latino patients in the USA without insurance is about 35.7%, compared to non-Latino Whites at 12.6%. The physician and prescriber should be mindful about this factor when prescribing medications and always attempt to provide medications that would be more cost-effective for the patient, including using generics. Since this is a population which has problems accessing health care, a caring physician who maintains good rapport and allows the Latino patient to be an important member of the treatment team would improve compliance and consequently better prognosis. Even clinics with bilingual programs have been shown to have barriers to treatment. Language may not necessarily be a predominant barrier when the clinician takes into account the important factors in the delivery of services to a Latino patient.

When treating a Latino patient with behavioral health symptoms, one of the most important aspects to consider is the prevalence of Metabolic Syndrome (MetS). The clinician should be aware of the high prevalence of MetS in the Latino population, since this affects compliance as well as effectiveness in treatment. Psychiatric medications are well known for carrying an increased risk of MetS, specifically antipsychotics. This group of medications has been associated with an increase in weight, as well as increased lipid parameters and hyperglycemia. The combination of changes in these parameters can lead to MetS. Schizophrenia in particular has been associated with increased levels in these parameters, and treatment can ultimately multiply these risks. This problem is magnified in the Latino population. A study by Manuel Ortiz and colleagues from University of California showed that there is a particular increase for the predisposition of MetS in the Latino population (Psychosocial Predictors of Metabolic Syndrome Among Latino Group in the Multi-Ethnic Study of Atherosclerosis, Ortiz, Myers, Schetter, Rodriguez, & Seeman; PLOS ONE, April

Ortiz, Myers, Schetter, Rodriguez, & Seeman, 2015). Furthermore, they were able to demonstrate that even when not looking at medication-related risks, the presence of chronic stress as an isolated factor tends to increase the prevalence of MetS in Latinos, and predominantly in Mexican American and Puerto Rican Americans. When treating Latinos with antipsychotic medications, one must pay particular attention to monitoring weight, lipid profiles, and glucose levels. The best approach is to educate the person early on during the initiation of treatment. In our experience, best results are seen when these parameters are discussed at every session.

The integration of behavioral health and primary care has been one of the most interesting challenges of the last decade. The understanding that psychiatric patients have an increased mortality rate compared to the general population has led us to understand that integration of care is essential to the prevention of disease within this population. This is especially true when addressing MetS. In the medical integration model of Primary Care and Behavioral Health, the patient is seen in a holistic perspective and the members of the team pay particular attention to the interactions between general health and behavioral health interventions. A true integration effort should have both departments within the same building and sharing the same electronic medical record. Communication between providers is essential to diminish all risks associated with the psychiatric condition, as well as the medical interventions they require. Integration models have shown that they are effective in reducing morbidity related to medical interventions.

Smoking cessation is a one of the clinical challenges that is more effectively addressed within the integrative model of care. Smoking not only has harmful effects on the body—the main component, nicotine, has psychopharmacological properties and diminishes the effectiveness of psychiatric medications. Much has been said about the impact of smoking in the psychiatric patient. In Schizophrenia, the person finds nicotine to be anxiolytic and is able to reduce some of the internal restlessness that is the result of complex changes in neurotransmitters related to this condition. Interestingly enough, some studies have shown that smoking has a specific impact on the Latino patient, with an increased prevalence of depression (2014). This finding is significant and must be evaluated in the Latino patient that suffers from a psychiatric condition and simultaneously has a Nicotine Use Disorder. Since Schizophrenia is already associated with an increased incidence of smoking than the general population, it can be assumed that in the Latino population it may carry an increased loading of depressive symptoms as well. This may even explain the high prevalence of Schizoaffective Disorders, Depressed type found in the Latino population. The clinician should always inquire about the smoking status of the Latino person, and a positive response should lead to further investigating of depressive symptoms. PHQ-3 and PHQ-9 are screening tools that can be useful in persons with Schizophrenia and should frequently be screened due to the increased risk of depression and nicotine use.

Some observations based on clinical experience as well as various small studies suggest that Latinos, in general, believe that medications used in psychiatry are addictive (Vargas et al., 2015). The Latino patient is ambivalent about psychiatric treatment in general. This is seen quite frequently in our community mental health clinics with a predominantly Latino population. The perception that psychiatric

medications are addictive probably stems from the early use of benzodiazepines as main treatments for depression. The consequence of this perception is that Latino patients will have less adherence to treatment than other minorities or ethnicities. The Latino patient will generalize this perception to most medications in the treatment, leading to a resistance to such medications. The patient may refuse to start medications when they may be indicated, or may decide to stop the medications or take them only as needed to prevent a potential addiction. Since this is a predominant idea in the Latino population, it is important to provide as much education as possible regarding the fact that most antidepressants and other medications in psychiatry are not addictive or cause physiological dependence. Another false perception related to addiction is the belief that once they are started on a medication, they will need to take the medication for the rest of their lives. The clinician needs to be disciplined in maintaining the treatment until the risk of recurrence has diminished enough to attempt reducing or even tapering down the medication, especially with regard to antidepressants.

Future Directions

The vast majority of mental health research conducted on immigrant families assesses the functioning of children and parents who have been residing within the USA for a number of years, allowing time for a certain level of acculturation. There appears to be a large gap in the study of immigrant families at the point upon which immigrants of Latin-American origin have immediately arrived within the confines of the US border. An important future direction is to explore critical psychological factors in newly arrived immigrant groups. This is something that the authors of this chapter are currently exploring with immigrant groups on the Texas–Mexico border, where there has been a recent influx of immigrants of approximately 15,500 Latinos from Central and South America, in addition to a surge of Cubans and Haitians in the month of November 2016 alone, according to the U.S. Customs and Border Protection Office of Field Operations (The Monitor, 2017).

Another important future consideration is to further investigate The *Hispanic Health Paradox*. This model refers to an existing literature base showing that, despite exposure to many health risks like low socioeconomic status, limited access to health care and insurance, and reduced education and employment, Hispanics in the USA generally report greater health than non-Hispanic Whites (Ruiz et al., 2016). The Hispanic health advantage is evident in life expectancy (Heron, 2015), infant mortality (Collins, Soskolne, Rankin, & Bennett, 2013), cardiovascular disease (Mozaffarian et al., 2015), and cancer (Ruiz et al., 2016). The effect is even more pronounced among Hispanic immigrants (i.e., foreign-born) (Singh et al., 2013). Critically, the advantage erodes with increasing time and generations in the USA as Hispanic acculturation to US culture increases and damaging health behaviors (e.g., smoking) increase (Kondo et al., 2015).

The *Hispanic Health Paradox* is one of the sociocultural resilience factors put forth by Ruiz et al. (2016). This model posits that the Hispanic health advantage

(including both susceptibility to disease and survival) is driven by sociocultural resilience factors that promote positive health—specifically, collectivist values including "family (*familismo*), interpersonal harmony (*simpatía*), and valuing of elder community members (*respeto*)" (Ruiz et al., 2016, p. 467). The possible protective role of these sociocultural values has been largely speculated as an explanation for the *Hispanic Health Paradox*, and its erosion as acculturation to US culture increases. However, empirical support for this model is limited by a research base that rarely assesses these sociocultural values directly. Instead, studies have linked "proxies of Latino culture" (Ruiz, Campos, & Garcia, 2016, p. 64) such as higher neighborhood ethnic density (Shaw & Pickett, 2013), foreign nativity (Holmes, Driscoll, & Heron, 2015), and low US acculturation (Kondo et al., 2015) to positive health and *assumed* that increased endorsement of Hispanic cultural values drives the observed relations. Calls to directly assess relations between proposed sociocultural resilience factors and health have dominated recent commentaries on the Hispanic health advantage (e.g., Ruiz and colleagues).

To date, there is little research directly assessing the relation between Hispanic sociocultural factors and physical health in recent immigrants. Without that data, resilience models of the Hispanic Health Paradox fail to identify sociocultural values that may be targets for public health intervention in American-born Hispanics and other ethnic groups. One recent study exploring trauma and cultural values in the health of recent immigrants has identified mental health as the only crisis in the U.S. Southern border (Mercado, Venta, Henderson, & Pimentel, 2019) highlighting the alarming rates of trauma and need for culturally sensitive trauma measures (Venta & Mercado 2018). Moreover, previous studies and models describing sociocultural factors in relation to Hispanic immigrant health have failed to include psychological variables to date, despite tremendous increases in crime, violence, and death in much of Central America. Identifying factors that relate both positively and negatively to the physical health of Hispanic immigrant women and children is a critical variable in identifying vulnerabilities in need of future research and ultimate intervention studies, as well as protective factors warranting public health attention for health promotion in other communities. Research addressing this disparity has implications for a large number of Latinos currently living in the USA, as well as the large number of Latino immigrants that continue crossing its Southwestern border each day. Considering both cultural and psychological variables in a conceptual model of physical health may serve as a model for future research addressing the physical health of other immigrant groups, a pressing need in light of current global crises of unprecedented Middle Eastern and North African family migration.

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