Migrant and Refugee Mental Health

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Migration is a natural phenomenon that has occurred since the beginning of time. Migration—to flee harm, drought, or war or to pursue sustenance, fertile land, or trade routes—is a natural aspect of human life. What is not natural is *forced* displacement of people. By the mid-2020, forcibly displaced people worldwide surpassed an all-time high of 80 million. These numbers include 46 million internally displaced people, 26 million international refugees, and 4 million asylees (United Nations High Commission on Refugees 2020).

The United States celebrates its identity as a nation of immigrants with its welcoming poem by Emma Lazarus, *The New Colossus*, on the iconic Statue of Liberty. The nation's story is of pilgrims crossing the ocean to seek religious freedom. These cultural narratives often obscure the story of a different type of migration: forced displacement of native and African people. Slavery has been a foundational economic institution, backed by the state, robbing people of everything, including their wealth-producing labor and land. This institution remains in distinct though familiar modern-day iterations. While its players and context are different, the power dynamics and interdependent push and pull factors of migration today are not dissimilar to those throughout history.

Forced or involuntary migration may be attributed to human causes such as conflict or to so-called natural causes such as disasters. In practice, these are inter-connected, as conflict often arises over natural resources and human activity itself may trigger natural disasters such as long-term climate warming. The response (or lack of response) to a natural disaster can range from neglect to state violence, hence creating a political or humanitarian disaster. The drastic increase of forced displacement that has occurred in the decade of 2010–2020 is mainly due to conflicts in the Syrian region, sub-Saharan Africa, the inflow

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of Rohingya refugees to Bangladesh, and the displacement of Venezuelans (International Migration Law 2019).

This chapter begins with defining the various legal and social designations used for groups of migrant and refugee populations, as these legal and social definitions affect quality of life and mental health. Important sociocultural factors that influence mental health needs in immigrant and refugee populations are described along with a brief overview and examples of culturally tailored evidence-based treatments that have been found to be beneficial. The chapter concludes with an emphasis on the need for including affirmative and culturally responsive practices in clinical training and the importance of understanding and preventing vicarious trauma. Through the use of best practices, clinicians are able to optimize their clinical care of migrants and refugees while also maintaining their own wellness.

Defining the Populations: Migrant, Asylum Seeker, Refugee, and Other Important Populations

Not all displaced people can achieve the legal status of refugees. A refugee, as defined by the United Nations High Commissioner for Refugees, is a person who has a:

> …well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail themselves of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear is unwilling to return to it. (United Nations High Commissioner for Refugees 1951)

This status is granted internationally before entry to the United States or other receiving countries. When refugees remain in their host country, they often move steadily toward full citizenship in their established new home.

Seeking asylum is a human right. Individuals may seek asylum due to fear of persecution or other reasons, as described in the definition of refugee status. While refugees request protection while still overseas, before entry into the United States, a person who requests protection within the first year of arrival is called an asylum seeker. In the United States, asylees achieve legal permanent residency and, in theory, are able to naturalize, i.e., become citizens, within 3 years.

Other persons may be granted temporary protected status (TPS), a designation by the US Citizenship and Immigration Services to eligible nationals of certain countries (or parts of countries), who are already in the United States due to ongoing armed conflict, environmental disaster, epidemic or other extraordinary, and temporary conditions. During a designated period, TPS beneficiaries are not deportable, can obtain a work permit, and may be granted travel authorization (US Citizenship and Immigration Services 2021). While nationals of some countries receive TPS for 2 or 3 years before their designation ends, others, such as Sudanese, Nicaraguans, Hondurans, and Salvadorans, have held TPS for almost two decades. Salvadorans make up 60% of the 437,000 TPS recipients (Congressional Research Service 2020). This is a precarious and temporary status which creates uncertainty, physically and emotionally, for TPS beneficiaries and their 250,000 US citizen children.

Children who entered the United States without authorization, i.e., undocumented, are known as "Dreamers" and if they meet the criteria of the 2012 Deferred Action for Childhood Arrivals (DACA) program are also conferred a temporary protection from deportation. It should be noted that DACA only applies to those who arrived in the United States after June 15, 2007. Similarly, these young people face the stress of uncertainty, as the designation has been challenged by litigation and political rhetoric. Additionally, they often carry the emotional and financial burden of supporting their undocumented parents and mixed-status families.

Deferred Enforced Departure is a status similar to DACA, recently granted to Venezuelans, the largest displaced population in this hemisphere as of this writing. It confers protection from deportation but no opportunity for

permanency (unless an individual is otherwise qualified to adjust his or her status).

Documented migrants are foreign-born individuals who are legally admitted to the United States, as they were able to avail themselves of existing laws and to provide proper documentation. Unauthorized immigrants either entered without inspection or overstayed a visa such as a tourist, work, business, or student visa and were unable to extend or adjust their status.

Mixed-status families include family members with various immigration status. Typically, these families are made of parents who do not have legal status, while their children do, generally because they were born on US territory. A 2015 report found that approximately half a million US citizen children experienced apprehension, detention, and deportation of at least one parent in the course of about 2 years (Capps et al. 2015).

Hemispheric and Regional Migration: Central America's Northern Triangle

About 3.5 million immigrants in the United States come from Central America. In 2017, Central Americans were about 8% of the overall immigrant population in the United States, and people from the Central American Northern Triangle (Guatemala, Honduras, and El Salvador) represented 86% of Central Americans. They primarily cite insecurity and environmental challenges as the cause of their migration. For instance, civil wars in the Northern Triangle have led to a rise in the number of migrants since the 1980s. Hurricanes, such as Mitch in Honduras and Nicaragua in 1998, or earthquakes like the one that hit El Salvador in 2001 have been the sources of migration along with drought (Migration Policy Institute 2019). Overall, Hondurans and Guatemalans were estimated to be crossing in greater number as of 2018, even surpassing Mexicans that year (Restrepo et al. 2019).

While adult men are traditionally the majority of migrants, unaccompanied minors and families have been on the rise. In 2018, the Customs and Border Protection apprehended 38,000 minors and 104,000 traveling as families. People have been traveling in larger groups, including caravans of several hundreds or even several thousands of people. An estimated 30–34 million (38–43%) of the 80 million forcibly displaced persons globally are children below 18 years of age (United Nations High Commissioner for Refugees 2020). Conditions in the home country as well as the reception in the receiving country have lifelong and intergenerational impact on the psycho-social development of these children and their families.

Certain populations, in addition to unaccompanied children, face distinct circumstances in the migratory process. For indigenous populations, language and cultural adaptation may take longer as they adjust to new urban settings. Some LGBTQI migrants are able to successfully claim refugee or asylee status as members of a persecuted group. However, they may face specific challenges when engaging with the immigration administration, for example, regarding their gender marker on official documents. Structural stigma toward sexual minorities in receiving countries was associated with increased health risks, mitigated by time and language ability (Pachankis et al. 2017).

Sociocultural Factors Impacting the Mental Health of Immigrant Communities

Immigration and Sociopolitical Factors

Immigration in and of itself can be considered a social determinant of health. The intersection between immigration status and other factors, such as living and working conditions, detention, and deportation, and the association of different immigration classifications with eligibility for different types of benefits can affect the mental health of immigrants and their access to healthcare services. Structural factors such as racism and discrimination, financial difficulties, family and community separation, previous experiences

of civil conflict, war, and other types of violence and trauma have also been implicated in the increasing risk of mental illness among immigrants. The interplay of these factors can impact an individual's risk of mental illness (Rodriguez et al. 2020).

Sociocultural Factors

Identity and culture are key factors to consider when addressing the mental health needs of immigrant communities. The history of immigrant communities is as complex and rich as the story and trajectory of their members and their descendants. Appreciating these differences and eliciting and respecting the way individuals define their cultural identity is critical for inclusion, engagement, and equitable access to care. It is also important to recognize and address specific stressors during pre-migration (e.g., history of abuse or violence; loss of social, familial, and material resources), migration (e.g., forced vs. voluntary, documented vs. undocumented immigrant status, length of distance traveled, trauma during migration), and post-migration (e.g., language proficiency, lack of employment or housing, discrimination, separation from family or friends, work exploitation) stages (Walker and Barnett 2007; Watters 2001).

One must also consider the level of acculturation with the dominant or host culture (How et al. 2017). Acculturation is a process resulting in shifts in an individual's identity, behaviors, values, and opinions that occurs through the contact that an immigrant person has with the new culture(s) in the host country. This process is influenced by the degree to which an individual is affiliated with their own culture versus the degree of their affiliation with the host culture (Berry 1997).

Cultural assimilation happens when an individual rejects or exchanges certain aspects of their original culture for that of the majority culture. Assimilation is the process of adapting effectively to the host culture which historically has been found to be a protective factor for positive mental health outcomes. *Integration*, sometimes called biculturalism, occurs when immigrants maintain important parts of their original cultural values while also adapting positively to the host culture. If the host society supports cultural diversity, acculturation and/or the development of bicultural identity can happen more smoothly. On the other hand, psychological acculturative stress is more likely if the host culture has an attitude of rejection toward other cultures or tries to eliminate diversity through policies that marginalize cultural minorities or force assimilation (Berry 1997). Simultaneously, some immigrants experience marginalization when they either reject their own culture or do not adopt the host culture.

Research has also identified some sociocultural factors that can protect the mental health of immigrant communities. The collectivistic approach to life in which group cohesiveness and well-being are valued over individual well-being can be protective for many immigrant communities. Family relationships and peer networks with other immigrants can also provide a buffering effect (Kim et al. 2012). Other studies have identified protective factors for refugees such as English proficiency, social support, community inclusion, connection to the culture of the host country, valuing of and connection to one's native culture, valued social roles, and access to resources to be predictors of refugee mental health (Goodkind et al. 2020). Other potential strengthening qualities include centrality of family ties and extended kindship (Valdivieso-Mora et al. 2016), as well as faith, spirituality, and religious attendance (Moreno and Cardemil 2016; Shaw et al. 2019).

Mental Health Needs, Community Psychiatry, and Treatments That Work

The Mental Health Needs of Migrants and Refugees

Research shows that immigrants to the United States are often initially healthier upon the first arrival compared with other immigrants who

have remained in the host country for longer periods. In the literature, this has been referred to as the "healthy immigrant effect" or "the immigrant paradox." This phenomenon has been described in multiple immigrant groups, including Asian American, Africans, Afro-Caribbeans, and Latinx, and for a variety of mental health outcomes including psychosis, substance use, and depression (Alegria et al. 2008; Williams et al. 2007; Venters and Gany 2011; Takeuchi et al. 2007).

It is important to note that contradictory evidence exists to prevent the generalization of the immigrant paradox to all immigrants, particularly when discussing immigrant populations. For example, Alegria et al. (2008) found that this phenomenon cannot be generalized to all Latinx subgroups and all psychiatric disorders. Some evidence suggests that context and issues within the host society (racism, anti-immigrant sentiments, etc.) and their intersection account for this effect, rather than any intrinsic features regarding immigrants as individuals (Perez et al. 2008). As an example, migrating from an under-developed to a developed country has been found to be associated with higher rates of schizophrenia. This effect was more pronounced when the immigrants lived in an area where they were outnumbered by the majority group, likely resulting in worsening cultural isolation and marginalization (Zolokowska et al. 2001). Additionally, a systematic literature review of studies that assessed the prevalence and factors associated with depression and anxiety in adult war-refugees found that resettlement to the United States predicted higher rates of depression and anxiety (Bogic et al. 2015). Sociopolitical climate, especially anti-immigrant/refugee policies and xenophobia, can have a strong and negative impact on the mental health of resettled individuals.

Access to Care in Community Psychiatry

Immigrant populations utilize mental health services at lower rates than non-immigrants (Bauldry and Szaflarski 2017). The reasons for this can be understood at the levels of individual (health literacy, insight, socioeconomic reasons), interpersonal (stigma), institutional (racism, lack of cultural and linguistic competence in providers), and structural barriers (lack of insurance, transportation issues, clinic locations) explored below. These barriers reflect the existing inequality and oppression within a society, such as racism, sexism, and homophobia. This leads to worse health care for immigrants.

Mental health services are least utilized among people who are uninsured and undocumented. This highlights the intersection of structural and interpersonal barriers, spanning multiple levels of issues including economic, political, and cultural disenfranchisement that impact immigrants. Undocumented immigrants might not only have to address their own culture's stigma against mental illness and mental health treatment but also navigate a complex healthcare system without insurance and overcome the fear of being reported to immigration authorities and therefore face the possibility of deportation. For example, Derr (2016) reviewed studies describing the utilization of mental healthcare services by immigrant populations in the United States and found that limitations in healthcare system capabilities such as lack of linguistic and cultural competency by clinicians are important structural barriers to care. It also identified other significant barriers such as cultural stigma of mental health within immigrant communities, fear of deportation, unaffordable cost of services, lack of insurance, lack of knowledge about services, and communication challenges. Additional barriers to accessing care for immigrants included undocumented status, male gender, youth, and lack of insurance.

Clinical practice locations may negatively affect patient access. Clinical care provided through healthcare workers affiliated with places of worship, schools, and other public agencies can help mitigate the challenges posed by the inadequate placement of clinical practices. Enhancing telepsychiatry and teleservices capacity within community organizations and practices may provide a new model of care that may help address disparities in mental healthcare access

due to practice location and transportation challenges.

People who end up seeking mental health treatment will often find themselves seeking care from mental health professionals who are most likely white and American-born. According to a study that assessed the ethnicity of US psychiatrists, practicing psychiatrists from historically under-represented backgrounds (URMs) are 10.4% of all psychiatrists, compared to 32% of the US population (Wyse et al. 2020). Although the proportion of URM resident physicians training in psychiatry increases every year, the number of URM faculty increases at a rate disproportionately four times slower.

According to the American Psychiatric Association, 27% of all practicing psychiatrists in the United States are international medical graduates, suggesting that a significant proportion of psychiatrists are themselves immigrants. However, disproportionately fewer are in faculty positions, leadership, or management roles. Specialized training in mental health for immigrant populations is not standard among psychiatry residency programs, nor are all community clinics and hospitals integrating awareness of racial oppression, history of imperialism and colonialism, and cross-generational trauma in their operational policies and practices. People who seek mental health treatment might find themselves getting care from providers who belong to the majority group, who do not share the same background, and who may apply a western biomedical model to explain experiences and symptoms which may not fit neatly under a DSM-5 diagnosis. A grave concern is not simply misdiagnosing or misunderstanding patients but the fact that a western biomedical gaze can risk reinforcing the same institutional and systemic oppression that exists outside the mental health system during an individual's time of emotional need or vulnerability.

A concept described in the literature is that of mistrust of the medical system, especially when discussing marginalized populations. Although this attitude has been previously described as a barrier to care, focusing on individual characteristics may result in missed opportunities to better explain this phenomenon and reach the populations in need. Language matters when discussing these concerns. Instead of discussing distrust, which places the burden of remediation on the individual, healthcare workers striving to regain the community's trust must assess and openly discuss the trustworthiness of institutions and its practices. From coercive sterilizations to withholding of treatment, as in the infamous Tuskegee Study, medicine has a past of exploiting and experimenting on minority groups, which cannot be ignored (Nuriddin et al. 2020). To improve access to and quality of care for historically under-served groups and immigrants, mental health providers must demonstrate awareness of this history to patients who may bring it up while actively challenging its long-ranging impacts on an administrative level.

High Rates of Trauma and Variable Clinical Presentations: The Need for Cultural Humility

The mental health needs of immigrant patients depend on a variety of factors, including the context resulting in their migration, their migratory journey, legal status in the United States, level of acculturation, family, and other social support. Due to sociopolitical factors, nearly all immigrants in the United States will experience a certain level of discrimination and will be more likely to belong to a low socioeconomic household and to experience unemployment. Additionally, almost all immigrants will have experienced a certain level of family separation, as most have left extended family in their home countries. The concepts of acculturation, acculturative stress, and assimilation will also be felt to some extent by all immigrants, potentially affecting their mental health. Depending on the severity of factors such as financial stress, racism, and discrimination, the negative impact may be higher in some individuals than others.

Although all immigrants experience the above stressors in some form, there is a differentiation between immigrants whose journeys were not forced and those who migrated to the United

States fleeing violence or persecution. Asylum seekers, refugees, exiles, and unaccompanied immigrant children have high rates of traumatic experiences that span their pre-migratory, peri-migratory, and post-migratory process. Rates of PTSD, depression, and anxiety disorders are higher in recently resettled refugees compared to their non-war-affected counterparts. Estimates show that one in five refugees of war may experience psychiatric illness such as depression, anxiety, or posttraumatic stress disorder (PTSD), even 5 years or longer after displacement (Fazel et al. 2005). Exiles, or individuals barred from their country often due to political reasons, are a special population that has been under-studied. Matos et al. (2008) found that a quarter of adult Cuban exiles self-reported symptoms of trauma and depression, more than 60% reported frequent thoughts related to the family separation and emotional distress experienced during the process of becoming exile.

Unaccompanied children are an especially vulnerable group in the immigrant population. Minors tend to migrate unaccompanied by a caregiver due to home or community violence, threat of war, threat of recruitment as child soldiers or enslavement, or after the death of their guardian (Ehntholt and Yule 2006). These children have high rates of peri-migratory trauma, with studies documenting that up to one-third had a history of sexual trauma prior to their migration to the United States (Betancourt et al. 2012). They are also at higher risk of experiencing traumatic experiences during their migratory journey (Women's Refugee Commission 2012), during their stays in refugee camps (Rothe et al. 2002), and during the initial period of resettlement (National Immigrant Justice Center et al. 2014). This is a highly vulnerable immigrant population that has been found to present with higher levels of psychological distress when compared to accompanied immigrant children, with up to 30% of them experiencing PTSD (Betancourt et al. 2012).

Children who have been separated from their families, as was increasingly seen after the zero-tolerance policy went into place under the Trump administration, have been found to have high levels of anxiety and depression compared to immigrant children who did not experience family separation (Suarez-Orozco et al. 2011). Additionally, even if the child is reunified with their natural family, they may experience further traumatic experiences through reunification-related stress. Changes in family composition and dynamics, as well as the possibility that the caregivers may feel guilty or ashamed of allowing the child to migrate independently, could impact the caregivers' ability to validate the child's emotional distress upon reunification.

Factors such as age, gender, legal status, socioeconomic level, English proficiency, and migration history may impact the clinical presentation of immigrants. These factors not only affect the way patients express symptoms and their needs but also clinicians' ability to engage the patient, take a thorough history, display empathy, and address mental health needs as one would with non-immigrant patients.

Culturally Tailored Treatments

A concept in health care that can help clinicians to provide high-quality mental health care for immigrants and refugees is cultural humility, which guides clinical practice by encouraging learning about a person's identity in their own words (Tervalon and Murray-García 1998). The principle behind this concept is to understand that "culture" does not imply a fixed identity or body of discrete traits. Instead, cultural factors are perceived as an ever-changing system of notions and actions that persons can choose from, shaped by the specific social context in which it is generated. However, it is not possible to predict the beliefs and behaviors of individuals solely based on their cultural background (Hunt 2001). Knowing as much as possible about a person's background is highly valuable, but it is not necessarily useful without a simultaneous process of self-reflection and commitment to lifelong learning in which clinicians become comfortable letting go of the false sense of security that stereotyping brings. This process mediates enough flexibility and humbleness for clinicians

to recognize when they do not know or understand their patient's belief system. Understanding the cultural background of others using humility as an approach instead of as a mastered subject and searching for resources that might facilitate this understanding can make a significant difference in the rapport of clinicians with their immigrant patients and enhance the quality of the treatment they obtain (Cabán-Alemán 2017). For detailed discussion in this regard, please also see chapter "Cultural and Linguistic Competence".

Cultural adaptations of evidence-based psychotherapeutic treatments have been created and found to be helpful in addressing mental health needs of refugees and immigrants. Cognitive behavioral therapy interventions have been adapted to meet the cultural needs of immigrant populations with positive results in symptom reduction of certain conditions. The Integrated Intervention for Dual Problems and Early Action (IIDEA) is a ten-session intervention that incorporates cognitive therapy and mindfulness to address symptoms of depression, anxiety, post-traumatic stress, and co-occurring substance use problems. This intervention has been studied in Latinx immigrants with positive outcomes in mental health symptoms and significant improvements in mindful awareness, therapeutic alliance, and illness self-management (Fortuna et al. 2020; Alegria et al. 2019).

Multiphase model of psychotherapy (MMP) and counseling, social justice, and human rights are culturally responsive interventions that aim to address the unique challenges of refugees. It incorporates psychotherapeutic concepts to address trauma and the psychological responses seen with pre-migratory stress, displacement, acculturation, and the patient's cultural conceptualization of mental illness and recovery. Additionally, MMP engages the clinician in assessing their own personal biases and political countertransference, which makes this a unique intervention (Bemak and Chung 2015; Chung et al. 2011).

For children and their families, therapeutic modalities must be adept to assess family structure and functioning. Cognitive behavioral therapy (CBT) for traumatic stress has been studied as a school-based, multi-level CBT intervention that includes individual and group psychoeducational components addressing acculturation stress and cultural trauma. It is delivered by educators and mental health providers and has been found to reduce symptoms of PTSD and depression in immigrant youth (Kataoka et al. 2003). Narrative exposure therapy, studied in the Netherlands, is another intervention that has demonstrated positive effects in addressing symptoms of trauma in child immigrants (Schauer et al. 2011). It incorporates storytelling of the child's life, opening up the opportunity to narrate multiple traumas as these children oftentimes do not have one index trauma. This process promotes habituation of emotional responses when discussing trauma and improves insight into the relationship between past traumatic experiences and current psychological functioning. Child-parent psychotherapy has been found to be effective in addressing mother-child attachment (Lieberman and Van Horn 2008).

A psychotherapeutic model to address refugee child mental health needs in the context of humanitarian crises has been previously described by Rothe (2008). It includes three main aims: (1) to decrease hyperarousal symptoms and protect the patient's neuroendocrine system, (2) to help the patient construct a cohesive narrative of events during the peri-traumatic period, and (3) to enable the clinician to be an advocate for the refugee children and their families. Personal empowerment, connecting patients to community agencies, and psychoeducation are key components of this approach that aims to create a strong foundation as the patient and their families continue to navigate challenging situations requiring psychological agility and adaptation.

Predictors of treatment outcomes for refugees with PTSD have been identified, although data is limited. Factors associated with improvement in symptoms included higher baseline symptoms, high level of functioning, young age at arrival to host country, full-time employment, and reunified family status (Sonne et al. 2021). Prevention and treatment models that incorporate community members, a multidisciplinary team, and systems of care approach have been shown to be

effective in addressing the mental health needs of immigrants and refugee youth (Abdi 2011). Approaches that include validation, mutual support, and the processing of common migration and adaptation experiences have been found to be protective (Abdi et al. 2012).

Practical Applications in Community Mental Health Care

Addressing the Social Determinants of Health for Immigrants and Refugees

When developing and implementing community-focused interventions to address the mental health of persons that are or were refugees or immigrants, it is very helpful to have an ecological perspective that focuses on multiple levels of context. This includes the microsystem or immediate environment of the patient (e.g., living situation, family, school, work), the ecosystem around the microsystem (other formal and informal social structures), and the macrosystem (economic, political, legal, and other social systems) that together affect a patient's health and development, emphasizing improvement of fit between patients and their environments.

Poverty, racism, and migration-related stress are social determinants of the mental health of immigrants and refugees. Attention to these social determinants arguably eclipses even necessary primary and behavioral health care, as it critically affects basic survival and well-being. Interprofessional collaborations are crucial to provide effective mental health treatment and address the needs of immigrant communities (How et al. 2017). These collaborative services must include a very wide range of human services, usually led by community-based organizations, including those that are faith-based. Such services must include legal support, vocational development, nutritional or dietary services, housing assistance, English as second language resources, tutoring, and access to any public entitlements that could be available.

Clinical Applications and Advocacy

Cultural and structural humility assist mental health practitioners to become culturally and structurally competent, as they help recognize how social, cultural, and structural determinants result in inequities and shape health and illness before, during, and after the clinical encounter (Metzl and Hansen 2014). The clinical model of "affirmative practice" is a key approach for serving immigrant and refugee populations. Originating from work with LGBTQI communities, affirmative practice refers to a range of models that serve to create supportive healthcare environments in which individuals can safely express their identity, with the services they receive acknowledging and countering the oppressive contexts people often experience in more conventional care (Mendoza et al. 2020). Therefore, affirmative care with immigrant and refugee individuals includes practicing with cultural humility to understand beliefs, values, and strengths while also validating that social disparities, discrimination, and racism have an impact on well-being. Some examples of how to cultivate affirmative care practices include working collaboratively with communities in services planning; paying attention to the relevant and central aspects of cultural, social, and political narratives; honoring and facilitating an understanding of patients' expressed needs, priorities, and preferences; identifying sociocultural factors that influence care; and engaging supportive cultural networks (Mendoza et al. 2020). No matter how well-educated psychiatrists and other behavioral health clinicians are, one cannot expect clinicians to fully understand a patient's culture and experience of oppression or to have the ability to predict their social needs. Therefore, structural and cultural humility are imperative, further reducing clinician unconscious bias and facilitating affirmative practice.

Optimizing Clinical Skills: Sociopolitical Countertransference and Vicarious Trauma

Experiences of systemic oppression may result in distrust of the healthcare system. Patients who are mistrustful of a medical provider, system, or treatment options may present as disengaged or guarded and have challenges adhering to clinical recommendations. Structurally and culturally competent clinicians ought not to interpret these presentations as signs of patient disinterest or inability to engage with treatment. Instead, one must engage in trauma-informed care that incorporates a sociopolitical lens, enabling the patient to express their needs in their own way and to take their time in trusting and engaging with a recommended treatment plan. Struggling with this often arouses negative countertransference.

Simultaneously, mental health clinicians may find themselves having to comply with unrealistic clinical service expectations, particularly in settings where vulnerable populations such as asylum seekers, refugees, and immigrants are encountered. Overly full clinic days, limited resources to address the social determinants of health, and limited availability of support and supervision by peers can result in the moral injury associated with burnout. Specifically, in the clinical care of migrants and refugees, clinicians can be vulnerable to displacing frustrations with the system in which they work onto patients, creating emotional or cognitive barriers to fully engage in the care of patients with such complex presentations and circumstantially high need. Clearly, countertransference is a tool that cannot be ignored, and it offers potential opportunity to advocate for systemic change.

Another dimension of countertransference is the role of vicarious trauma: the experience of exposure to trauma through the narratives of the patients we treat. This must be taken into consideration when treating vulnerable populations such as migrants, asylum seekers, and refugees. Vicarious trauma has been associated with negative outcomes such as compassion fatigue and lack of intimacy, as well as positive outcomes such as vicarious posttraumatic growth (Rizkalla and Segal 2020). Adequate training and supervision can support a clinician's ability to maintain mental well-being while working with traumatized patient populations (Finklestein et al. 2015). Clinicians inspired to work with migrants, refugees, and asylum seekers can find unique opportunities to engage in meaningful work as they learn clinical skills and systems-based practices necessary to serve this population. Some opportunities include participation in national organizations within psychiatry, such as the American Psychiatric Association and its Council on Minority Mental Health and Health Disparities, and the minority caucuses. As medical trainees, one can also become involved with the national organization Physicians for Human Rights, which trains physicians to assess and document trauma and torture to support asylum seeker's claims in immigration court. A team approach can be helpful to prevent the negative outcomes from vicarious trauma, foster the use of sociocultural and political conceptualization, and make the best use of trauma-informed care practices. Supervision and debriefing opportunities can decrease the mental load carried by mental health providers. Group and individual supervision can improve accountability, which is a necessary tool for mental health providers to maintain the use of trauma-informed care practices and reduce the negative effects of countertransference reactions.

Conclusion

Provision of mental health treatment to migrants and refugees can be challenging within the current medical system. Clinicians looking for opportunities to gain clinical, research, advocacy, and administrative skills needed to establish unique mechanisms and provide quality mental health care often find creative ways to find and engage in health equity work by seeking collaborators and/or clinical models to learn from. Participation with community agencies serving this population and networking with mentors even outside our own institution are some ways one can acquire the knowledge and experience to serve this vulnerable population. However, all

mental health clinicians have an opportunity to optimize their clinical skills when working with migrant and refugee populations by practicing the skills and clinical approaches presented in this chapter. It is also important to understand how the sociocultural-political climate and resulting policies can negatively impact immigrant and refugee patients' mental health. It is within the purview of the mental health field to engage in a higher level of community and political engagement to advocate for policy changes and cultivate models of care that aim to reduce or extinguish the barriers to care that patients often face.

References

Abdi, S., Barrett, C., Blood, E.A., Betancourt, T.S., Ellis, B.H. Miller, A.B. (2012). Multi-tier mental health program for refugee youth. Journal of Consulting and Clinical Psychology, 81, 1, 129–140.

Abdi, S. (2011). New directions in refugee youth mental health services: overcoming barriers to engagement. J Child Adolesc Trauma, 4, 1, 69–85.

Alegría, M., Canino, G., Shrout, P.E., et al. (2008). Prevalence of mental illness in immigrant and non-immigrant U.S. Latino groups. *Am J Psychiatry*, 165, 359–369.

Alegría, M., Falgas-Bague, I., Collazos, F., et al. (2019). Evaluation of the integrated intervention for dual problems and early action among Latino immigrants with co-occurring mental health and substance misuse symptoms: a randomized clinical trial. JAMA Netw Open, 2, 1.

Bauldry, S. and Szaflarski, M. (2017). Immigrant-based disparities in mental health care utilization. *Socius: Sociological Research for a Dynamic World*, 3, 1–14.

Bemak, F. and Chung, R.C.-Y. (2015). Counseling refugees and migrants. In P.B. Pedersen, W.J. Lonner, J.G. Draguns, J.E. Trimble, and M.R. Scharron-del Rio (Eds.), *Counseling across cultures* (7th ed., pp 323–346). Thousand Oaks, CA: Sage.

Berry, J.W. (1997). Immigration, acculturation, and adaptation. *Applied Psychology,* 46(1), 5–34.

Betancourt, T.S., Newnham, E.A., Layne, C.M., Kim, S., Steinberg, A.M., Ellis, H., Birman, D. (2012). Trauma history and psychopathology in war-affected refugee children referred for trauma-related mental health services in the United States. *J Trauma Stress*, 25(6), 682–90.

Bogic, M., Njoku, A., Priebe, S. (2015). Long-term mental health of war-refugees: a systematic literature review. *BMC International Health and Human Rights*, 15, 1–41.

Cabán-Alemán, C. (2017). Cultural Humility. In J. Tse & S.Y. Volpp (Eds.), *A Case-based Approach to Public Psychiatry* (pp 29–36). Oxford University Press.

Capps, R., Koball, H., Campetella, A., Perreira, K., Hooker, S., Pedroza, J.M. (2015). Implications of immigration enforcement activities for the wellbeing of children in immigrant families. Urban Institute and Migration Policy Institute. Retrieved January 25, 2021, from https://www.urban.org/sites/default/files/alfresco/publication-exhibits/2000405/2000405-Implications-of-Immigration-Enforcement-Activities-for-the-Well-Being-of-Children-in-Immigrant-Families.pdf

Chung, R.C.-Y., Bemak, F., Kudo Grabosky, T. (2011). Multicultural-social justice leadership strategies: Counseling and advocacy with immigrants. *Journal of Social Action in Counseling and Psychology*, 3, 86–102.

Congressional Research Service. (2020). Temporary Protected Status: Overview and Current Issues. Retrieved January 26, 2021, from https://crsreports.congress.gov/product/pdf/RS/RS20844

Derr A.S. (2016). Mental health service use among immigrants in the United States: A systematic review. *Psychiatric Services*, 67(3), 265–274.

Ehntholt, K.A. and Yule, W. (2006). Practitioner review: assessment and treatment of refugee children and adolescents who have experienced war related trauma. *J Child Psychol Psychiatry* 47, 1197–1210.

Fazel, M., Wheeler, J., Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in Western countries: A systematic review. *Lancet*, 365, 1309–14.

Finklestein, M., Stein, E., Greene, T., Bronstein, I., Solomon, Z. (2015). Posttraumatic Stress Disorder and Vicarious Trauma in Mental Health Professionals. *Health & Social Work*, 40(2), 25–31.

Fortuna, L.R., Falgas-Bague, I., Ramos, Z., Porche, M.V., Alegría, M. (2020). Development of a cognitive behavioral therapy with integrated mindfulness for Latinx immigrants with co-occurring disorders: Analysis of intermediary outcomes. *Psychol Trauma*, 12(8), 825–835.

Goodkind, J.R., Bybee, D., Hess, J.M., et al. (2020). Randomized Controlled Trial of a Multilevel Intervention to Address Social Determinants of Refugee Mental Health. *American Journal of Community Psychology,* 65 (3–4), 272–289.

How, P.C., Lo, P., Westervelt, M., et al. (2017). Refugees and Immigrants. In J. Tse & S.Y. Volpp (Eds.), *A Case-based Approach to Public Psychiatry* (pp 179–186). Oxford University Press.

Hunt, L. (2001). *Beyond cultural competence: applying humility to clinical settings*. Park Ridge Center Bulletin, 24, 3e4.

International Migration Law. (2019). Glossary on Migration, No 34. Geneva, Switzerland. Retrieved January, 25, 2021 from https://publications.iom.int/system/files/pdf/iml_34_glossary.pdf

Kataoka, S.H., Stein, B.D., Haycox, L.H., Wong, M., Escudero, P., Tu, W., Zaragoza, C., Fink, A. (2003). A school-based mental health program for traumatized Latino immigrant children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43, 3, 311–318.

Kim, J., Suh, W., Kim, S., Gopalan, H. (2012). Coping strategies to manage acculturative stress: Meaningful activity participation, social support, and positive emotion among Korean immigrant adolescents in the USA. *International Journal of Qualitative Studies on Health and Well-Being*, 7, 1–10.

Lieberman, A. F. and Van Horn, P. (2008). *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment*. New York, NY: Guilford Press.

Matos, H.C., Rothe, E.M., Pumariega, A.J., Lewis, J.E. (2008). Trauma historico, perdidas y separaciones: un estudio piloto para evaluar los problemas especificos de la salud mental de los exiliados. Revista Latinoamericana de Psiquiatria, 9, 10–18.

Mendoza, N. S., Moreno, F. A., Hishaw, G. A., Gaw, A. C., Fortuna, L. R., Skubel, A., Porche, M. V., Roessel, M. H., Shore, J., Gallegos, A. (2020). Affirmative Care Across Cultures: Broadening Application. *Focus (American Psychiatric Publishing)*, *18*(1), 31–39.

Metzl, J. M. and Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine*, 103, 126–133.

Migration Policy Institute. (2019). Central American Immigrants in the United States. Retrieved January 20, 2021, from https://www.migrationpolicy.org/article/central-american-immigrants-united-states-2017

Moreno, O. and Cardemil, E. (2016). The role of religious attendance on mental health among Mexican populations: A contribution toward the discussion of the immigrant health paradox. Am J Orthopsychiatry, 88, 1, 10–15.

National Immigrant Justice Center, Esperanza Immigrant Rights Project, Americans for Immigrant Justice, Florence Immigrant and Refugee Rights Project, ACLU Border Litigation Project. (2014). Systemic abuse of unaccompanied immigrant children by U.S. Customs and Border Protection. Retrieved January 26, 2021, from, http://www.immigrantjustice.org/sites/immigrantjustice.

Nuriddin, A., Mooney, G., White, A.R. (2020). Reckoning with histories of medical racism and violence in the USA. *The Lancet*, 296: 949–951.

Pachankis, J., Hatzenbuehler, M., Berg, R., Fernandez-Davila, P., Mirandola, M., Marchus, U. et al. (2017). Anti-LGBT and anti-immigrant structural stigma: an intersectional analysis of sexual minority men's HIV risk when migrating to or within Europe. *Journal of Acquired Immuno Deficiency Syndromes*, 76, 4, 356–366.

Pérez, D. J., Fortuna, L., Alegria, M. (2008). Prevalence and correlates of everyday discrimination among US Latinos. *Journal of Community Psychology*, 36(4), 421–433.

Restrepo, D., Sutton, T., Martinez, J. (2019). Getting Migration in the Americas Rights: A National Interest-driven approach. Center for American Progress. Retrieved January 12, 2021, from https://www.americanprogress.org/issues/security/reports/2019/06/24/471322/getting-migration-americas-right/

Rizkalla, N. and Segal, S. (2020). Refugee trauma work: Effects on intimate relationships and vicarious post-traumatic growth. *Journal of Affective Disorders*, 276, 839–847.

Rodriguez, D.X., Hill, J., McDaniel, P. (2020). A scoping review of literature about mental health and well-being among immigrant communities in the United States. *Health Promotion Practice.* Advance online publication.

Rothe, E.M., Castillo-Matos, H., Busquets, R. (2002). Posttraumatic stress symptoms in Cuban adolescents refugees during camp confinement. *Adolesc Psychiatry*, 26, 97–124.

Rothe, E.M. (2008). Psychotherapy model for treating refugee children caught in the midst of catastrophic situations. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 36, 4, 625–642.

Schauer, M., Neuner, F., Elbert, T. (2011). Narrative exposure therapy: A short team treatment for traumatic stress disorders (2nd ed). Cambridge, MA: Hogrefe Publishing.

Shaw, S.A., Peacock, L., Ali, L.M., Pillai, V., Husain, A. (2019). Religious coping and challenges among displaced Muslim female refugees. Affilia, 34, 4, 518–534.

Sonne, C., Lykke, E., Silove, D., Palic, S., Carlsson, J. (2021). Predictors of treatment outcomes for trauma affected refugees: Results from two randomized trials. *Journal of Affective Disorders*, 282, 194–202.

Suarez-Orozco, C., Bang, H.J., Kim, H.Y. (2011). I felt like my heart was staying behind: Psychological implications of family separations & reunifications for immigrant youth. *Journal of Adolescent Research*, 26(2), 222–257.

Takeuchi DT, Zane N, Hong S, et al. (2007). Immigration-related factors and mental disorders among Asian Americans. *Am J Public Health*, 97:84–90.

Tervalon, M. and Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved, 9, 2, 117–125.

United Nations High Commissioner for Refugees. (1951). Convention and Protocol Relating to the Status of Refugees, Article 1, A(2).

United Nations High Commissioner for Refugees. (2020). Refugee Statistics. Retrieved January 25, 2021, from https://www.unhcr.org/refugee-statistics/

U.S. Citizenship and Immigration Services. (2021). Temporary Protected Status. Retrieved January 25, 2021, from https://www.uscis.gov/humanitarian/temporary-protected-status

Valdivieso-Mora, E., Peet, C.L., Garnier-Villarreal, M., Salazar-Villanea, M., Johnson, D.K. (2016). A systematic review of the relationship between familism and mental health outcomes in Latino population. Front Psychol, 7, 1632.

Walker, P.F. and Barnett, E.D. (2007). *Immigrant medicine*. St. Louis, MO. Saunders/Elsevier.

Watters, C. (2001). Emerging paradigms in the mental health care of refugees. *Social science & medicine*, 52(11), 1709–18.

Williams, D.R., Gonzalez, H.M., Neighbors, H., Nesse, R., Abelson, J.M., Sweetman, J., Jackson, J.S. (2007). Prevalence and distribution of major depressive disorder in African Americans, Caribbean blacks, and non-Hispanic whites: results from the National Survey of American Life. *Archives of General Psychiatry*, 64(3), 305–315.

Women's Refugee Commission. 2012. Forced from home: The lost boys and girls of Central America. Retrieved January 20, 2021, from www.womensrefugeecommission.org/component/zdocs/document?id=844-forced-from-home-the-lost-boys-and-girlsof-central-america.

Wyse, R., Hwang, W.-T., Ahmed, A.A., Richards, E., Deville C, (2020). Diversity by Race, Ethnicity, and Sex within the US Psychiatry Physician Workforce. *Acad Psychiatry*, 44(5), 523–530.

Venters, H. and Gany, F. (2011). African immigrant health. *J Immigr Minor Health*, 13(2), 333–344.

Zolokowska, K., Cantor-Graae, E., McNeil, T. (2001). Increased rates of psychosis among immigrants to Sweden: Is immigration a risk factor for psychosis? Psychological Medicine, 31, 669–678.