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Mental Health of Immigrants and Refugees

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ABSTRACT: The United States is a country of immigrants. With the exception of Native-Americans, every other American is, or descends from, an immigrant. First and second generation immigrant children are the most rapidly growing segment of the American population, with the great majority of this population being of non-European origin. This paper reviews the unique risk factors and mental health needs of our new immigrant populations, as well as treatment and services approaches to address their unique needs.

INTRODUCTION

In the last three decades, war, famine and political struggles have caused an increase of forced migrations worldwide. In 1970, there were approximately 2.5 million refugees. This number increased to 8.2 million a decade later. In 1990 the number doubled to 17 million and, with

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the wars in the Balkans and the collapse of the former Soviet Block, the number of refugees in the world approximated 40 million by the year 2000. This number does not take into account the number of "internal refugees", which migrate within a country. These are thought to add up to 15–20 million. It is considered that one out of every 135 people alive in the world today is a "refugee" (U.N. High Commission on Refugees, 2000). A number of these refugees arrive in the United States. This period of time has also witnessed a number of large refugee crises that have involved large populations of children, either accompanied by their families or at times separated from them or even orphaned. These have included (amongst many more) the post-Vietnam and Cambodia refugee exodus, the Cuban exodus across the Florida Straits, the Balkan refugee crisis, and the exodus of Central American refugees fleeing civil war and terrorism in their homelands. These do not include the multiple crises related to natural disasters and wars involving large culturally diverse populations.

The United States is a country of immigrants. With the exception of Native-Americans, every other American is, or descends from, an immigrant. First and second generation immigrant children are the most rapidly growing segment of the American population (Landale & Oropesa, 1995; U.S. Census, 2000). The future of American society is ultimately related to the adaptation of immigrants and their children, even with possible future efforts to reduce immigration.

Until the mid-twentieth century, the racial and cultural characteristics of European immigrants allowed them to assimilate readily into the American social fabric. In the past 40 years, immigration from Europe and Canada has declined dramatically while non-European immigration and non-European minority groups have grown dramatically, at a much faster rate than European-background populations. Americans will have a plurality of diverse ethnic and racial groups before the year 2050, and among those less than 18 years of age before the year 2030. Culturally diverse youth now constitute 30% of the population under age 18, and close to 40% by the year 2020. (U.S. Census, 2000).

These growing populations constitute a wide array of nationalities, ethnicities and races, many of which are overlapping. For example, there are numerous nationalities of Hispanics in the United States, comprising a wide variety of racial groups, different socioeconomic levels, and levels of education, as well as different patterns and motives of immigration, although they share Spanish as a common language. The same diversity is seen in the three other major ethnic/racial

groups. Although these populations are becoming the numerical majority in the United States, they unfortunately still suffer from inequities in socioeconomic status, education, political influence, and access to health and human services. This is reflected in significantly lower mean household incomes and levels of education, higher unemployment, and higher mortality rates (including infant mortality) and health morbidity rates (Pumariega, 2003; U.S. Office of the Surgeon General, 2001).

TRAUMA AND STRESSORS FACED BY IMMIGRANTS AND REFUGEES

The path to immigration to the United States is filled with risks and stressors that are unique to immigrants, both prior and after their arrival.

Pre-migration and Migration Stressors

Added stressors from the process of immigration itself can lead to increased risk for emotional disturbance in newer immigrants. These include previous traumatic exposure in their homelands (war, torture, terrorism, natural disasters, famine), many of which prompt the decision to emigrate in the first place. These are often compounded by the loss of extended family and kinship networks (and even separation from nuclear family members, such as children from their parents) as well as difficult and traumatic journeys to the United States (crossing rivers, capsizing in rafts, witnessing deaths). Detention in refugee camps for prolonged periods and illegal immigration also increases the risk of victimization through exposure to criminal activity and lawlessness.

Children often feel especially vulnerable in these situations given the fact that their parents or guardians are themselves often overwhelmed and unable to attend to their emotional needs. Latter psychological stressors can often re-activate the emotions and memories associated with these events, especially for children and adolescents. Different immigrant groups have different degrees of exposure to such traumas, with Central American, Cambodian/Khmer, Tamil, Bosnian, and Cuban immigrants and refugees having significant exposure to such traumatization (Hermansson, Timpka, & Thyberg, 2003; Holman,

Silver, & Waitzkin, 2000; Rothe, Castillo-Matos, & Busquets, 2002; Silove, Steel, McGorry, Miles, & Drobny, 2002).

Post-migration Stressors

The majority of immigrants arriving in America come to escape poverty in their countries of origin and, along with other populations of color, have low levels of education and job skills. They inhabit inner city neighborhoods where rents are low, but which are crime-infested. Families survive in overcrowded buildings with little space with little opportunity for privacy. The neighborhoods are unsafe and children live in an atmosphere of impending danger and risk of crime and violence, which undermines social cohesion (Beiser, Hou, Hyman, & Tousignant, 2002; Canino & Spurlock, 1994; Suarez-Orozco & Suarez-Orozco, 2001). Inner city schools are usually overcrowded and offer an inferior level of education, when compared to suburban schools. The cycle of poverty, coupled with inferior levels of education, threatens to create a downward spiral of declining financial opportunity that the immigrant may have difficulty escaping from (Orfield & Yun, 1999).

Discrimination and prejudice are other major stressors that come into prominence once the immigrant is better established and oriented to the mainstream culture. This is experienced not only as originating from mainstream culture Americans, but often from other earlier-arriving immigrants, even from their nation or culture of origin, who may feel threat of displacement as far as job security and access to resources and opportunity. Children and especially adolescents experience discrimination and prejudice from their peers in school and social settings, with more intense expression of what is more subtle amongst adult counterparts. Discrimination is increasingly recognized as an adverse mental health risk (Finch, Kolody, & Vega, 2000).

CULTURE AND ACCULTURATION IN IMMIGRANTS

Increasingly, the process of cultural transition is being recognized to be as much a psychological process as a sociological one, with significant implications for the mental health of immigrants.

Culture and Ethnic Identity

Hughes (1993) defines culture as "a socially transmitted system of ideas that shapes behavior, categorizes perceptions, and through language, gives names to selected aspects of experience". He adds that a culture is "widely shared by members of a given society or social group" and that it "functions as an orientational framework for behavior, and serves as a communication matrix to coordinate and sanction behavior." Hughes (1993) defines cultural process as a "mechanism for conveying values across the generations".

Children's awareness of ethnic identity and the awareness of ethnic and cultural differences appear, for the first time at the age of 3 or 4. Children also begin to notice differences of language utilization by this age. Between the ages of 4 and 8-years-old, children develop an ethnic orientation, they select one social group over another, they consolidate their sense of group concept and they develop curiosity about other groups. Also about his age, children become keenly aware of their reception by others (Porter, 1971).

Adults have solidified their ethnic identification as part of their identity consolidation by the end of their adolescence. Their subsequent experiences in gender and marital, parenting, and occupational roles help to solidify their ethnic identity orientation. By older adulthood, ethnic identity becomes intertwined with the individual's life history, and they become the keepers and transmitters of family and cultural lore and traditions for subsequent generations (Lin, 2004).

Acculturation and Acculturation Stress

Classic anthropology and social sciences proposed that the most effective and healthy way to adapt to a new culture was through assimilation. In this model, the individual renounces his culture of origin and identifies with the culture of the host country. However, American mainstream culture presents images that are untenable to most members of minority and immigrants groups. Even those who achieve competence in the dominant culture often experience a sense of loss that threatens their personal identity (Rogler, Cortes, & Malgady, 1991).

Margination is the opposite form of acculturation, with the immigrants embracing their culture of origin to the exclusion of the host culture, often including living in ethnic enclaves. Margination is common among older immigrants and exiles, given their more limited

developmental and cognitive flexibility and resultant limitations in assimilating major changes such as a new language, new customs, and new values and belief systems, and their security in their established cultural practices.

The adult immigrant adapts in different ways to this condition. They may resign themselves to their marginated existence by involving themselves in the community life and organizations of their ethnic enclave. They might focus on economic and material success to compensate for their sense of isolation and disconnection from the mainstream culture. Another alternative is to focus on the academic and economic success of their children, rationalizing their "sacrifice" for the success of the next generation in their adopted land. These reactions may at times be accompanied by over-identification with the mainstream culture's values and forsaking of traditional values.

However, margination is not an option for children and adolescents, who have to encounter and master the mainstream culture in school and social activities. However, they are also encouraged by families to remain loyal to the ethnic enclave, with departure regarded as familial and cultural betrayal. Szapocnik and collaborators (Szapocnik, Ladner, & Scopetta, 1979; Szapocnik, Kurtines, & Fernandez, 1980) studied "well acculturated" Cuban–American youth living with "poorly acculturated" Cuban parents, and found significant family conflict as well as a higher risk of conduct disorder and substance abuse, in adolescents growing up within this context.

Adolescents in these instances can either over-identify with their culture of origin, with the mainstream culture, or become alienated from both their families and mainstream peers, identifying with similarly marginalized adolescents. If an immigrant child or adolescent feels rejected or denigrated by the mainstream culture, he/she may identify with and internalize these negative perceptions, which may lead to "ethnic self hate" (Vega, Hough, & Romero, 1983). Immigrant youth may respond with passivity, which can lead to depression and substance abuse, or may develop an "adversarial identity", standing in defiance against the majority culture and often joining gangs. The gang may serve the adolescent as supportive structure helping them traverse the psychological developmental turmoil of this particular developmental stage, and offers belonging, solidarity, protection, discipline and warmth (Suarez-Orozco & Suarez-Orozco, 2001; Vigil, 1988). Some studies with immigrant youth have demonstrated an association between cultural adjustment difficulties and higher risk of mental health problems (Yeh, 2003).

Biculturalism, a new proposed model of acculturation, allows for the validation and reaffirmation of the person's identity by both cultures. It validates both their traditional values as well as their competencies in the new culture, and allows the young person to consolidate their sense of self. (Grenier & Perez, 1996; Suarez-Orozco & Suarez-Orozco, 2001; Szapocnik & Kurtines, 1980). For any culturally diverse child it is important to determine their degree of acculturation to the mainstream culture, and their culture of origin determines their relative influence in their world view and psychological adaptation. This adaptation is even more valued for the immigrant child born in their nation of origin and raised in the United States, whom the literary Perez-Firmat calls "generation 1.5" (between first and second generation). These individuals have frequently served as "bridge people" between the two cultures, both enhancing understanding as well as cross-pollinating them into a new hybrid (Perez-Firmat, 1994).

The cultural transition process for adult immigrants is fraught with difficulties given their relative cognitive inflexibility and their solidified ethnic identity. Migration immerses the individual into the host nation's socioeconomic system, and immigrants may experience significant strains relating to changes in their socioeconomic status and their interaction with their encounter with different customs and beliefs, major life events, and emotional and social resources (Rogler, Malgady, and Rodriguez, 1989). Lin, Masuda, & Tazuma (1982) proposed five alternative routes for coping with cultural changes and stress induced by immigration: neurotic marginality (anxiously trying to meet the demands of both cultures), deviant marginality (isolated as a result of ignoring the norms of both cultures), traditionalism (withdrawal into nostalgia for the old culture), over-acculturation (abandoning the culture of origin), or biculturality (integrating the best of both cultures).

Older adult immigrants face a greater challenge when they encounter a cultural transition. They not only face one of the most daunting challenges to their traditional values and lifestyle as a result of immigration, but are often isolated from their children and grandchildren as a result of their more rapid acculturation as well as linguistic barriers. This sense of isolation is mitigated by involvement in ethnic enclaves and traditional practices, and the lack of such supports renders them highly vulnerable to adverse cultural stresses (Lee, Crittenden, & Yu, 1996; Mui, 1996). Other factors such as years of residence in the U.S., level of involvement with mainstream culture, and level of contact with their country of origin also contribute to cultural adaptation (Casado & Laung, 2001; Pham & Harris, 2001).

MENTAL HEALTH NEEDS OF IMMIGRANTS AND REFUGEES

As a result of the many traumas and stressors faced by immigrants and refugees during their physical and psychological odyssey, they have been found to generally be at high risk for mental health problems (Keyes, 2000). Amongst adults, the main problems reported are those of depression and anxiety disorders, particularly post-traumatic stress disorders (Fox, Burns, Popovich, & Ilg, 2001; Hermansson, Timkpa, & Thyberg, 2002; Maddern, 2004; Mollica et al., 2001; Steel & Silove, 2001). These disorders have been correlated to exposure and proximity to pre-migration and post-migration traumatizing events (Fenta, Yman, & Noh, 2004). Other risk factors that affect the degree of symptomatology and impairment include poverty, education, subsequent unemployment, low self-esteem, and poor physical health (Hermansson et al., 2002; Hsu, Davies, & Hansen, 2004; Weine et al., 2000). Culture-bound illness expression, culture-bound syndromes, and cultural bereavement in response to the stresses encountered from the acculturation process also need to be considered as significant entities that can resemble but are distinct from Western-oriented psychiatric symptoms and disorders (Davis, 2000; Hsu, 1999). There are other dysfunctional behavioral consequences from the impact of traumas and losses suffered by immigrants and refugees, including domestic violence and pathological gambling (Petry, Armentano, Kuoch, Norinth, & Smith, 2003; Steele et al., 2002). However, some studies, like those of Mexican-born immigrants, have been found that they have better mental health profiles than subsequent generations despite significant socioeconomic disadvantages. Possible explanations include greater use of protective traditional family networks, a lower set of expectations for "success" in America, and lower substance abuse (Escobar, Nervi, & Gara, 2000).

Immigrant children and youth suffer from similar conditions as described for adults, including anxiety disorders, depression, and post-traumatic stress disorders (Fox, Burns, Popovich, Belknap, & Frank-Stromborg 2004; McKelvey et al., 2002). Such disorders can significantly impair functioning for these children, such as academic functioning (Fox et al., 2004). Factors such as parental emotional well-being and peer relationships can mitigate or aggravate the symptomatic and functional impact of such disorders (Almquist & Broberg, 1999). Second generation children (American-born offspring of immigrants) have been found to be at higher risk of more behavioral conditions, such as substance abuse, conduct disturbance, and eating disorders, than the first generation of immigrant youth (Szapocnik et al., 1979; Szapocnik & Kurtines, 1989;

Miller & Pumariega, 2001). Such higher risk may be a result of this group facing the chronic stresses created by poverty, margination and discrimination without the secure identity and traditional values of their parents, while not yet having a secure bicultural identity and skills. For example, Pumariega, Swanson, Holzer, Linskey, and Quintero-Salinas (1992) found that being second generation Mexican–American, who tended to hang out with friends, were more exposed to the media, and spent less time with their families and in religious activities, had a significantly higher risk of substance abuse and suicidality than more traditional Mexican-born youth. Various studies have shown greater risk for eating disorders in more acculturated immigrant youth both in the United States and in Europe (Miller & Pumariega, 2001).

Much of the literature on child and adolescent refugees has focused on victims of war and genocide. Arroyo and Eth (1985) studied Central American adolescent victims of war and found elevated rates of conduct disorder, aggressive and sexual acting out behaviors, and substance abuse among these youth. In turn, Mollica, Pool, and Son (1997) studied Cambodian adolescents in refugee camps. They found a dose–response relationship between exposure and psychiatric symptoms but not for traumatic exposure and social functioning. In terms of the long term effects of trauma, Kinzie et al. (1986) and Berthold (1999) followed Cambodian adolescents who had suffered severe trauma in Khmer concentration camps in two different studies, with 25–50% were diagnosed as having PTSD years after the trauma. Weine and colleagues (1995) studied Bosnian adolescent victims of "ethnic cleansing" who reunited with their families in the United States. They reported that only 25% met criteria for PTSD and even fewer met criteria for depressive disorders. Becker et al. (1999) found these rates had decreased even more a year later, and speculated that the cultural differences between the country of origin and the host country accounted for the better adaptation of Bosnian refugees to the United States. Rothe and colleagues (Rothe et al., 1998, 2002; Rothe et al., 2002) studied Cuban child and adolescent refugees who had left the island with their family members on rafts and had suffered prolonged confinement in refugee camps prior to arriving in the United States. They found that more than half of these children continued to suffer PTSD symptoms after arrival. However, these symptoms were experienced silently and subjectively, did not affect school functioning and were unnoticed by the teachers that cared for them.

Older adults face perhaps the greatest vulnerability for mental health problems amongst immigrants, perhaps with the exception of

victims of warfare and torture. This vulnerability results from an interaction of their traditionalism and cultural inflexibility, linguistic barriers, lack of family and social support, and physical infirmities. A number of studies involving multiple older adult immigrant groups (ranging from Korean, Chinese, Mexican, and Russian/Eastern European) point to high risks for depressive symptoms and disorders, somatization, and a variety of traditional culture-bound syndromes (Black, Markides, & Miller, 1998; Mui, Kang, Chen, & Domanski, 2003; Stokes, Thompson, Murphy, & Gallager-Thompson, 2001; Tran, Khatutsky, Aroian, Balsam, & Conway, 2000). The expression of distress in older immigrants is also more consistent with more traditional symptomatic patterns than the usual Western-oriented psychiatric syndromes and disorders (Pang, 2000). Older immigrants also access formal services at an even lower rate than the already low rate seen in immigrant populations in general, and rely much more on traditional healers and remedies (Pang, 1996).

In summary, the findings of studies on the mental health of immigrant and refugee populations can be summarized as follows:

1. Proximity to the traumatic events, duration of exposure and intensity of the traumatic experience may affect psychological response.
2. Children and adolescents are influenced by the response of others to such trauma-family, peer, community, and cultural environment-during and after the traumatic experience.
3. Immigrant adolescents are less symptomatic and demonstrate better social functioning than their adult counterparts. This finding may point to a relative resilience conferred by this particular developmental stage (Rothe et al., 2002).
4. There may be increased risks for second-generation children and youth (the children of immigrants), who may face more chronic stressors.
5. Mental health factors, most of which go unrecognized and untreated, can adversely affect the immigrant's successful adaptation and functioning after immigration.
6. Older adults have the highest risk for mental health problems resulting from immigration, with the possible exception of traumatized immigrants. Lack of cultural flexibility, isolation from family members and the community, and health risk factors contribute to this increased risk.

MENTAL HEALTH SERVICES FOR IMMIGRANTS AND REFUGEES

The principles of culturally competent mental health services are most applicable to the development and delivery of mental health services for immigrant and refugees (see Pumariega, Rogers, and Rothe, this issue). This includes addressing differences in symptom expression that can bias diagnostic assessment, and factors that affect the accessibility and acceptability (such as location, stigma, linguistic barriers, documentation and legal status, and cultural healing modalities and practitioners). For example, Vietnamese immigrants with mental illness have been found to use local Vietnamese-speaking physicians, Asian naturalists, spiritual and folk healers as well as psychiatric facilities and community mental health services (Phan, 2000). Russian immigrants, on the other hand, tend to use individual outpatient services at voluntary non-profit agencies (Chow, Jafffee, & Choi, 1999). Mexican immigrants are unlikely to use formal mental health services and use primary care physicians instead (Pumariega, Glover, Holzer, & Nguyen, 1998; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). Cultural consultants with backgrounds in the immigrant and refugee communities have been found to be particularly effective in facilitating accurate assessment and improved services utilization and effectiveness (Kirkmayer, Groleau, Guzder, Blake, & Jarvis, 2003). Approaches that address the need for validation, mutual support, and processing of their common experiences have been found to be particularly effective (Dossa, 2002; Simich, Beiser, & Mawani, 2003).

Another critical function for mental health and social services is that of educating and assisting immigrants and refugees from diverse cultures in understanding different cultural norms and practices in their new environment, as well as educating mainstream providers about immigrants' traditional cultural practices. This includes the re-evaluation of practices from their culture of origin that are negatively valued in mainstream American and Western culture, which can range from the definition of what constitutes child abuse to practices such as female genital mutilation (Morris, 1999; Shor, 1999). However, it also includes the incorporation of traditional cultural practices into Western-oriented health and mental health services that can facilitate their acceptability by immigrants of diverse backgrounds (such as placental disposal amongst Hmong refugees; Hensel & Mochel, 2002).

In dealing with refugee crises, sometimes the receiving community may find itself besieged by a massive arrival of refugees, which may

overwhelm the available mental health infrastructure. To avoid this situation, it is advisable to compose teams of mental health professionals that take into account the particular circumstances of the refugee crisis and the particular cultural and language characteristics of the of the refugee group in question. Culturally competent professionals must compose the treatment groups and, if they are not proficient in the particular language of the members of the refugee group, translator services should then become indispensable. (Sack, 1998).

Treatment interventions with large refugee groups follow the similar parameters of those of victims of natural disasters and can be divided into three phases: triage, debriefing and emergency services. The first intervention involves triaging the most psychologically severely affected refugees (the "psychological casualties"), in order to provide the immediate necessary treatment interventions to the victims. Child refugees and their families often suffer cognitive disorganization as a result of the multiple stresses to which they have been subjected, and which result from the process of traumatic migrations. The process of debriefing aims to validate the traumatic and disorganizing quality of the experience, and to inform and orient the refugees about their new surrounding reality. The traumatic events and their associated emotional, behavioral, and physical reactions are revisited, analyzed and understood in the context of the surrounding circumstances. Activities are designed in order to provide structure, help organize time, and plan daily activities, including work activities, in an attempt to normalize routines. This prevents the child and the family's cognitive disorganization and its consequences. Supporting indigenous religious practices and culturally prescribed altruistic practices amongst refugees also supports resiliency and recovery (Guarnaccia & Lopez, 1998; Rothe et al., 2002; Rothe et al., 2002; Mollica, Cui, McIness, & Massangli, 2002).

Psychotherapy and process groups, provided to individuals or (better yet) in the context of the family, should be organized and provided by culturally competent clinicians. These therapeutic interventions are aimed at addressing feelings of impotence, emotional dyscontrol and regressive behaviors, helping the refugee slowly regain control of his surroundings. An open line of communication with members of the mental health teams is vital, so that the refugees feel cared for, as opposed to abandoned and helpless (Ying, 2001).

The second phase of the intervention includes providing appropriate housing, employment and schooling for the members of the refugee family, allowing for the beginning of their integration into the new

community. The third phase involves helping the refugee family maintain communication and liaison with the appropriate social services and mental health agencies that can help the refugee family, as problems continue to arise in the process of adaptation and acculturation into the new host community (Guarnaccia & Lopez, 1998). Latter therapeutic approaches should include a focus on the cultural divide between the child and their family, with such techniques already demonstrating effectiveness in addressing substance abuse and conduct disturbances (Szapocznik & Kurtines, 1989).

The use of community-based mental health services and a community systems of care approach is extremely valuable in addressing the mental health needs of refugee children, adults, and their families (Pumariega, Winters, & Huffine, 2003; Watters, 2001). Such an approach uses natural strengths and supports in the immigrant community along with community-based mental services to maintain the child living and functioning in that community and empowers their family in their overall adaptation and management of the child's behavioral needs. This approach includes the use of mental health services based in schools and community agencies (Fazel & Stein, 2002) as well as community screening and preventive programs (Kataoka et al., 2003; Kennedy, Seymour, & Hummel, 1999; Palinkas et al., 2003). A similar community-based and naturalistic approach may be necessary to met the challenges of providing mental health services for elder immigrants, especially in the context of traditions of family caregiving conflicting with changing family structure and cohesion (Strumpf, Glicksman, Goldberg-Glen, Fox, & Logue 2001).

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