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A Literature Review: What mental health challenges are experienced by first-generation Latino immigrant and refugee families entering the U.S.?

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ABSTRACT

It is believed that people leave their homeland and come to America for better opportunities, freedom, safety, or second chances at life. As of 2021, Latino's account for Americas largest minority population however measures to support their communities medically and socially have fallen short. The downfalls of misunderstanding the traumas experienced in their homelands, accounting for premigration, during migration, and postmigration stressors, and systemic issues that fall short in providing culturally sensitive care creates room for mental health challenges to accumulate. Cases of traumas experienced in homelands, cultural implications, the controversies, and difficulties of being held in detention centers, challenges with cultural assimilation, social determinants of health (SDOH), anxiety and depression prevalence, plus alcohol and recreation drug use prevalence with be evaluated and discussed in this literary review. An interview of a member of the Latino community will also be conducted to gain firsthand insight to areas of focus in this paper. The findings discussed in this research paper are compiled and extracted from peer systematic literature reviews, peer-reviewed articles, multiyear longitudinal studies, multiple logistic regression analysis, and meta-analyses published between 2003 - 2021. This research paper examines the strengths and limitations of the reviewed articles. Research from these different disciplines will be presented to highlight the mental health challenges of first-generation Latino immigrants and refugees and urge for further support to limit and mitigate these challenges.

Keywords: Mental health, Latino, immigration, refugee, minority, social determinants of health, trauma, anxiety, depression, cultural sensitivity.

INTRODUCTION

Latinos are the largest and fastest-growing minority in the United States of America (USA) (21) accounting for 18.5% of the national population (40). From 1990 to 2019, legal and unauthorized immigrants grew by 276% and 325%, respectively (40). Despite the exponential and continuous growth of the Latino population in America, few studies have examined the mental health effects of trauma and stress prior to and after migration among refugees and immigrants in the U.S. (22). For those that have conducted research on these matters, short comings have been highlighted by failing to understand the contrasting factors amongst different Latino populations. Latinos are not a monolithic group. The history of each Latin American country entails complex historical, cultural, and social dynamics (21). Upon arrival, social determinants of health largely slowly creep into play and impact the transition of life in America making it difficult to settle in.

A comprehensive systemic literature review, evidence suggests that the mental health challenges first-generation Latino immigrant families entering the U.S. are intensified. Phases of the migration process, premigration, during migration, and postmigration, have specific risks and exposures that may differentially impact youth mental health outcomes that create mental health challenges and SDOH barriers for Latino immigrants (5). This literature review provide evidence demonstrating factors that play a role into these challenges and the subsequent effects these challenges play on their quality of life.

Latino is defined as a person or Latin American origin living in the U.S. or a native/inhabitant of Latin America (Merriam-webster). Mental health by the World Health Organization (WHO) is grouped into the definition of general health. The WHO states health is a

"state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (26). However, this definition fails to fully encompass the intricacies of mental health. Mental health should be thought of as a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium (25). Defining quality of life (QOL) has proven challenging because it includes subjective evaluation of positive and negative aspects of one's own life. Consequently, one proposed definition of quality of life is a conscious cognitive judgment of satisfaction with one's life (27). A second proposed definition is an individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns (27). SDOH defined by Healthy People 2020, organizes SDOH into 5 key domains: economic stability (eg, poverty and food insufficiency), education (eg, language barriers and high school graduation status), social and community context (eg, concerns about immigration status, cultural importance, and social support), health and health care (eg, mental health, QOL, and access to a health care provider), and neighborhood and built environment (eg, neighborhood crime and quality of housing) (28)

BACKGROUND

Cultural implications and mental health stigmas

Mental health has been an uphill battle globally because seeing is believing. One cannot see physical signs and symptoms or run a lab test for a mental health condition such as depression as you would for something such as strep pharyngitis. Although we have a way to go, cultural influence and awareness have opened the door for mental health in America. On the contrary, cultural influence plays an important role in the perception and stigma surrounding mental health in Latino culture. In a study consisting of 47 mental health service users in Mexico, participants reported the main sources of stigma towards them to be from friends, family, and mental health service providers (14). Participants were aware of possible mental health consequences, but they also experienced stigmatization for having a mental illness. The psychiatrists' negative attitudes towards their patients creates a barrier for optimal quality of care when the support you should rely on for help also holds negative attitudes towards your challenges (29). The source of the stigmatism from psychiatrists may arise from health care staff often having limited mental health knowledge (29). As a result, providers reject or make patients with certain diagnoses wait longer; give little information about diagnoses and treatments; dismiss and misattribute physical symptoms to patients' mental disorders leading to under-diagnosis and delay in accessing treatments; and have pessimistic outlooks on recovery (14). Asking participants how society reacts psychiatric patients and how they have been treated after receiving that label, responses consisted of terms such as discrimination, lack of empathy, labelling, judging, social distance, fear, and so on. Mexico is an area with a relatively high prevalence of mental disorders however a low proportion of people seek mental health care and even fewer receive care. This creates a foundation for mental health challenges in particular with

older generations immigrating to America. Being raised in an environment makes it difficult to give mental health the attention it requires.

Preimmigration trauma and stress seen in home country

Immigrants leave their countries of origin by choice in search of social and economic opportunity while refugees are forced to migrate in search of safety from conflict and persecution (22). Migration is a process that involves several stressors. Undocumented immigrants are particularly vulnerable since they face unique risks and exposure to traumatic experiences before, during, and after migrating that put them at high risk of mental health distress (21). Those from the Northern Triangle (Honduras, El Salvador, and Guatemala) face harsh adversities. The Northern Triangle was among the top five highest murder rates in the world in the previous decade and thousands have fled the increasing violence going north via Mexico which is a risky journey (30). A high proportion suffer unintentional injuries and various forms of violence, such as theft, extortion, mugging, kidnapping, trafficking, and sexual abuse perpetrated by Mexican gangs and federal officials who take advantage of their vulnerable status (22, 31).

War, famine, rape, kidnappings, and other forms of trauma post-traumatic stress disorder (PTSD) experienced at a young age predispose children for short-term as a youth and long-term challenges in adulthood. Early adversity is associated with leading causes of adult morbidity and mortality and effects on life opportunities (24). Surveying 104 Latino youth aged 12-17 years old who have been in the U.S. for three years or less, two-thirds of the participants experienced at least one traumatic event. Of those, 59% reported that the event occurred in their home country, 20% reported experiencing the event during migration, and 18% reported an event since arriving in the U.S. (5). Designed by Sangalang to further compare the challenges refugees compared to immigrant's face, 1629 Latinos (306 refugees and 1323 immigrants) were used to examine the

premigration and post migration stressors and subsequent mental health outcomes of the two groups (22).

In order from highest percentage to lowest percentage, the top five pre-migration traumatic events for refugees were being in a terror zone (30%), witnessing death or seeing a dead body (29%), being in a war zone (29%), unexpected death of someone close (20%), and natural disasters (14%). Comparatively, the same list for immigrants was natural disaster (13%), unexpected death of someone close (12%), witnessing death or seeing a dead body (12%), beaten up by parents (7%), and mugged/held up/threatened with a weapon (7%) (22). However, despite the fear residing in their native country, promise of asylum was not guaranteed in the U.S. In 2019, the Department of Justice has been asked to prosecute "all adult aliens apprehended crossing the border illegally, with no exception for asylum seekers or those with minor children." (21). Consequently, among Latinos, premigration trauma and stressors increased the risk of psychological distress for refugees and immigrants placing them at greater odds for psychiatric disorders (22).

Immigration process and Detention centers

A crisis of mass immigration detention exists in the U.S. which is home to the world's largest immigration detention system (32). The battle is not over upon arrival to American soil. The detention centers are commonly understaffed, small in space, and poorly trained in medical management. There is a need for assessment and trauma experienced during the immigration process, but detention centers must be added to this assessment. The immigration detention system is legally classified as civil, rather than criminal, and therefore non-punitive although there are increasing reports of civil and human rights abuses. It mimics the criminal incarceration system and holds detained individuals in punitive, prison-like conditions (32). Nonetheless,

being in a detention center is not a temporary hold until you can enter the country. Despite enduring the traumatic experiences, you may very well be deported and removed from the country. In 2019, under the Trump administration, immigration reached its peak in American history as daily populations across 200 detention centers in the country reached an average daily population of 55,000. In this time, at least one in four Latinos reported to personally know someone who has been detained or deported within the last 12 months (32).

Human rights violations in detention centers are widely ignored and downplayed. Rape and sexual assault are often underreported due to fears of retaliation, solitary confinement like isolation, language barriers, fear of minimizing chances of being accepted into the country, and the underlying understanding that allegations are not given proper investigation. For example, the Department of Homeland Security received 33,126 complaints of sexual and physical abuse from January 2010 to July 2016 but investigated only 570 (32). Furthermore, as daily populations grow, overcrowding is becoming a greater concern. State and local investigators plus the Centers for Disease Control (CDC) have identified outbreaks of mumps and measles, pneumonia, influenza, and other respiratory disease in several detention facilities (32, 34). Other concerns arising from the overcrowding are sleep deprivation, lack of privacy, sanitation deficiencies, restricted recreation time, dirty or inadequate clothing (particularly for weather changes), inadequate meals, and deprivation of autonomy and security (35). Amongst the issues of overcrowding may be separation of families and support systems. Children and their parents are sent to different facilities or different locations within the same facilities and may not see their loved ones for unpredictable periods of time. At times, even if your family knows of your location, they will not contact you or visit you due to fear of entering a detention center (32, 36).

Detention centers are not equipped to handle chronic medical issues or identify potentially problematic behavior that may be a result of a traumatic journey individuals just endured. Failing to recognize these signs will open the door for mental health challenged to grow. Many detention facilities use solitary confinement as punishment or to monitor individuals who experienced victimization or are mentally ill, despite its detrimental impact on physical and psychological well-being (33).

Post-migration stressors

Sangalang hypothesizes that both premigration and postmigration trauma are associated with greater risk of mental illness and increased psychological distress for immigrants and refugees. However, they emphasize that postmigration stressors will amplify risk for mental illness and elevate psychological distress (22). To name a few obstacles, immigrants face stressors related to their constant documentation status/fear of deportation, language and cultural barriers, fear of family separation, discrimination, and limited access to healthcare and public services. These adjustment stressors can adversely affect family relationships and lead to family conflict, which is strongly linked to psychological distress and mental health in migrant populations (22, 23).

The trauma you face as a child follows you into adulthood. Similar to premigration traumas, postmigration trauma increased the risk of psychological distress for refugees and immigrants placing them at greater odds for psychiatric disorders (22). From 2011 – 2014 in 23 states, 214,157 participants 18 years of age or older who faced Adverse Childhood Experiences (ACE) were surveyed (24). The ACE module consists of 11 questions collapsed into the following 8 categories: physical abuse, emotional abuse, sexual abuse, household mental illness, household substance use, household domestic violence, incarcerated household member, and

parental separation or divorce (24). Of the total respondents, 61.55% had at least 1 and 24.64% reported 3 or more ACEs. Significantly higher ACE exposures were reported by participants who identified as black, Hispanic, or multiracial, those with less than a high school education (e.g., language barriers), those with income of less than $15 000 per year (e.g., socioeconomic disadvantages), and those who were unemployed or unable to work (e.g., undocumented workers). Emotional abuse was the most prevalent ACE (34.42%), followed by parental separation or divorce (27.63%) and household substance abuse (27.56%) (24).

Social Determinants of Health

Immigrants face stressors unique to the experience of premigration and postmigration that may exacerbate preexisting mental health problems or trigger new ones and yet, they still access care at rates far below the general population, leaving them at risk of untreated mental health condition (4). Untreated mental health disorders can lead to substantial negative health and social consequences, including academic failures, self-injuries, substance abuse, violence, crime, chronic physical disorders, and suicidal behaviors (8). Structural health disparities that are at play include, but are not limited to, lack of insurance (with immigration concerns as well), lack of transportation, lack of mental health knowledge, high cost, accessibility, and language barriers thus sparking the discussion on eliminating health and mental health disparities in underrepresented communities (4).

Barriers to adolescents receiving care may further be broken into five different levels of adolescent, parent/family, service provider, contextual/structural, and social/cultural levels. Refer to appendix A for full descriptions of the different levels plus barriers and facilitators to each level.

Recovering from premigration trauma and PTSD is difficult when postmigration trauma, PTSD, and social determinants of health (SDOH) are overwhelmingly present. The SDOH variables that are consistently found to immigrants postmigration adjustment are income, employment, housing, language skills and interpretation, social support and social isolation, and discrimination (42). Furthermore, it is assumed that these obstacles are heightened in the conditions of refuges more so than voluntary immigrants.

No matter the age, gender, or immigrant status, having a lower socioeconomic status (SES) has been a strong predictor of PTSD, distress, depression, and other mental health challenges (42). Regardless of their SES in their home country, many immigrants leave behind most of their material possessions, businesses, and properties from which they derived livelihoods. In the cases of refuges who are not always afforded the opportunity to plan an escape, they leave behind savings and even documentation proving their qualifications for their profession to attain jobs in the U.S (42). The inability to provide documents from previous employment often leads to immigrants and refugees being overqualified for jobs in the U.S. which has effects on poor mental health. Frustration, lower self-esteem, and lower self-confidence may be a natural result of working an overqualified position.

Language barriers are an issue in employment but in also largely an issue in healthcare. Language barriers in healthcare lead to miscommunication between medical professionals and patients, reducing both parties' satisfaction and decreasing the quality of healthcare delivery and patient safety (6). Many healthcare institutions offer interpreter services to improve healthcare access, patient and provider satisfaction, and communication. However, these services increase the cost and length of treatment (6). In addition to language barriers, discrimination and poverty are strong factors in contributing to loneliness and isolation which are common concerns of

immigrants. With reference to detention centers, forced family separation is a common cause of isolation across all age groups (42).

Social difficulties

Immigrant status has been found to be associated with acculturative stressors which include adapting to a new environment, language barriers, severe economic hardship, occupational related exploitation, residential instability, legal status stressors, discrimination, and loss of social support (17). Biological age shapes social experiences, health behaviors, economic incorporation, and access to public assistance programs (37). For adolescent immigrants, adapting to a new school, friends, culture, and lifestyle can be overwhelming. Examining friendships and suicidality among female and male Mexican American adolescents is a focus since they are impressionable, attempting to adapt while possibly feeling like an outsider, and are at higher rates of suicidality than non-Latino youth (7). Relationships and social integration are important in suicidality although there is disagreement on whether they are protective or considered risk factors. Close relationships can provide support but can also limit individuality and even model self-destructive behavior (7). Adolescents are impressionable which leads to them holding others' opinions to a high degree. Preexisting social hurdles are now being overshadowed by social media influences. Identifying these stressors has posed challenges because of the numerous ways to access to the internet and social media platforms. Moreover, the adults, guardians, and school administration have difficulties monitoring forms of cyberbullying. Challenges parents face may be working to provide for their family so they cannot oversee their children's social media activity, not understanding social media culture, or not having the technological literacy/skills to block social media platforms or know how to navigate apps to avoid foreseeable issues.

A protective measure from suicidal behavior has been identified as strong ethnic identity. Higher levels of cultural identification have been positively correlated with self-esteem, family support, and school adjustment. Maintaining strong, healthy family relationships was evident in discovering that family conflict was associated with poorer mental health across all outcomes for refugees, and with anxiety disorders and psychological distress for immigrants (22). Regarding friendships, Latino adolescents report stronger friendship bonds, especially among girls and those who are less acculturated (7) suggesting that 1) cultural identity is a protective measure from psychological distress and 2) gravitate towards those that resemble similar beliefs and identity. Living amongst other Latinos is a protective measure against mental challenges as increasing residential segregation was associated with less mental distress (10). Research suggests an association between higher Latino ethnic density and lower levels of depression overall with those living in areas of moderate ethnic density having the most depressive symptoms (10).

Latino minorities make up majority of America's minority population, but many find themselves at the bottom of the economic totem pole. Mostly in low-paying jobs (particularly in the agricultural area), living below poverty levels in terms of housing, income, nutrition, and other parameters (20). Latino focused support groups have been created by Hispanic psychiatrists in the U.S. Groups and support outlets such as the American Society of Hispanic Psychiatry (ASHP), the Latino Behavioral Health Institute, the Hispanic Caucus of the American Psychiatric Association (APA), and specialized centers in academic and clinical facilities have been created because their importance has been recognized. SDOH have a focus on language barriers in the healthcare field however cultural assimilation and the ability to relate is a strong characteristic of a medical provider (20). Spanish speaking psychiatrists provide comfort,

reassurance, and validation because are coming from a country where medical providers, family, and friends who held negative stigmas and discriminations towards those facing mental health challenges (14). Furthermore, providing culturally centered patient care is important in formulating treatment plans.

Anxiety and depression

Mental health challenges are a product of biological and social factors. A leading cause of this anxiety may be fears of deportation or mistrust of health services, dissuading care-seeking behavior (32). Fear of deportation is also associated with increased cardiovascular risk factors, lower birth weights, and worsened mental health. In addition, these health behaviors, and outcomes ripple throughout the communities to which immigrants belong causing those who should have no cause for concern to begin fearing deportation. The historical pattern of deportation has not helped these concerns either. For example, the Bush administration deported two million immigrants, Obama administration three million immigrants, and Trump administrations urged a zero-tolerance policy with anti-immigrant rhetoric and threats to build a wall (21).

Using data from the Hispanic Established Populations for the Epidemiologic Study of the Elderly, the question arises whether life expectancy with depression and without depression varies by nativity, age of migration, and gender (17). Differential migratory experiences may contribute to complex gender patterns in mental health outcomes as acculturative stress, economic adversity, loss of social support, and the social position these immigrants occupy once in the United States vary between immigrant men and women. An extra obstacle that elders generation immigrants have is they have grown accustomed to the culture and lifestyle of their homeland more so than younger generations. The saying old habits die hard may be applicable

here as prior research shows immigrants who arrived as adolescent to be at lower risk for psychological distress compared to adult immigrants (17). Although they feel the burden of low SDOH, adolescents to a degree are not expected to overcome economic and social obstacles to provide for their families. Older immigrants have more difficulties adapting to U.S. society as they are less likely to speak English, have fewer socioeconomic resources, and have a higher likelihood of physical and cognitive decline, which increases social isolation and dependency on family members (38). With regards to acculturation, those who are more acculturated have poorer mental health compared to recent immigrants because of the increased interaction with mainstream society and the longer-term exposure to discrimination in the U.S. (9).

Difference in depression outcomes between genders reflect men being the active decision makers in the migratory process. Culturally speaking, men tend to make the decision for the family stripping women of autonomy. Men often make the decision for occupational and financial purposes which comes with participation in labor forces, accumulation of socioeconomic resources, and extension of social networks which is protective of their mental health (17). In contrast, women are follower immigrants and are still held to the same cultural standards and family obligations which increase the risk for psychological distress. Not being an active member in the decision-making process to leave your homeland and then being stripped of social ties from family, friends, and cultural attachment from their country of origin may lead to stress vulnerability and increased isolation in the U.S. (17). Mental health stressors are then increased for pregnant and postpartum women. Identifiable stressors included the quality of relationships with their family and significant other and difficulties in transitioning to motherhood in a country where they feel isolated (16). For those that are held in detention centers, recent studies indicate that Latina mothers have reported high rates of anxiety, stress,

and depressive symptoms caused by different stressors such as persecution, physical and sexual abuse, extortion, and separation from their children (21).

Recreation drug use and alcohol use

Hispanics are the largest ethnic minority in the U.S. and current population projections predict a doubling of the Hispanic population by 2060 to 119 million (40). Mexican Americans are the largest Hispanic subgroup today, constituting about 63% of the U.S. Hispanic population (41). Considering the current population and projected increase, focus should be shifted towards the simultaneously growing substance use and psychiatric morbidity amongst these demographics. Studies have focused on immigration status and age at entry into the U.S. as areas of focus to gauge for risk factors (11). The comorbidity of heroin and mental health exists, and heroin users have higher rates of depression, anxiety, suicide attempts, borderline personality disorder, and other disorders (9) however not all are a result of heroin use. One study found that more than 50% of participants have mental health disorders not related to substance use suggesting that people had turned towards drugs due to their mental health challenges (39). In the same argument, important factors such as higher levels of family and cultural stressors, acculturation, gang membership, and incarceration history also emerged as associated risk factors of negative mental health outcomes and substance use (9).

Ones age at immigration plays an important role in how impressionable they may be. From 2012-2013, face-to-face interviews were conducted consisting of 36,309 participants. Research found that Foreign-born Mexican Americans older than 18 years old at immigration were at greater risk of drug use, drug use disorders, and nicotine use disorder compared with foreign-born Mexican Americans 18 years old or younger at immigration (11). The younger an individual is, the more likely they are to fall victim to their surroundings and peer pressure. The

desire to fit in or the stress of being in a new environment may be too overwhelming to where younger, more impressionable individuals choose the path of recreational drug use and alcohol use (11).

Yadira interview

Yadira is a first-generation child in the U.S. who is currently in a masters Physician Assistant program. Her parents immigrated from Jalisco, Mexico to leave poverty and violence with the intentions of giving their daughters endless opportunities. Yadira has taken the time to answer the following questions in regard to a few of the topics discussed in this background section thus far. This interview took place on July 8th, 2021.

What are the cultural implications and stigmas surrounding mental health in your community?

> Many do not believe in mental illnesses. For example, I have an aunt who married a man who later was diagnosed with schizophrenia. All of the family members believe that he is faking his behavior to his convenience and is only episodic. Depression and anxiety occurring in our youth is belittled by adults to being weak minded and lazy. The typical parental solution to their child mentioning they are depressed or anything other than happy is giving them chores and a deadline because it is boredom and laziness that is the issue.

What are pre-immigration traumas and the stressors seen in your homeland that may predispose someone for mental health challenges down the road?

> Depending on the region you are from but most witness cartel violence for example, shootings, human remains on the street. Drug users and overdoses. Alcohol abuse is only

a problem if you can't keep a job. Extreme hunger and poverty. Violence and murder of women by men. Kidnapping of women by men. Rape or sexual abuse. Lack of affection in the home. Labor at a young age.

From a social aspect, what are obstacles that Latinos face?

As a first-generation child in the U.S., parents send their children to school to learn English; which puts them at a disadvantage to their peers. It was stressful attending Kindergarten because I was unable to communicate with those around me, making me feel unsafe. Those students who came at an older age were placed in "ESL" classes, English as a second language, to better teach the needed material. However, there was no good transitioning out of those classes and students were then segregated from the other students causing them to be easily racially targeted and not getting the same quality of education.

Focusing particularly on anxiety and depression, could you speak on their prevalence in your community and how living in America has played into exacerbating these issues?

Anxiety and depression is high in the Mexican communities living in the U.S. Children of the parents who immigrated to the U.S. for a better life have the constant pressure of succeeding or else facing the guilt of not being able to make their parents' sacrifices worth the struggle. The U.S. has more emotionally intelligent individuals in comparison to rural Mexico. Parents who fled to the U.S. for a better life often come from a loveless home in terms of affection. Love is more so seen as providing shelter, food and safety. If illegally in the U.S. you have to deal with the anxiety of being deported, obtaining a license or seeking help. If you are the child of illegal parents, you worry of going to

school and coming to an empty home. You are also given the responsibility of translating every English-speaking situation for your parents.

In your opinion, what must be done to support this community and limit/reduce mental health challenges in America for first generation Latino immigrants and refugees?

The solution and response to this question is very complex which makes it difficult to answer in a single sitting. Mental health needs to be explained as a physiological disorder rather than one solely controlled by the individual affected. For example, a Hispanic child in therapy may have advancing sessions but there will be no true improvement until the parents understand the issue and how to help. Generational trauma for behaviors and psychological issues is another factor that play a role into the community. Much advocacy needs to occur within the community to normalize mental health and make needed resources accessible. We must also teach soon to be parents about emotions and ways to express themselves and how those factors affect their future children could be part of courses offered. Exposure leads to expansion so "normalizing" mental health in the Latino community can open the door to open mindedness and acceptance that mental health is real.

METHODS

A comprehensive systemic literature review was conducted using PubMed and Google Scholar databases for peer reviewed research articles plus the United States Census Bureau for statistical data. Initial broad searches included a combination of the following key terms: "mental health Latino Americans", "anxiety and depression among Latino immigrants", "immigration stress factors", "migration trauma and PTSD", "access to health services", "health disparities and

SDOH for Latino immigrants". Next, to focus the topic, this next set of terms were added into the search: language barriers in medical care, deportation centers, effects on adulthood due to childhood PTSD, cultural influence on mental health, discrimination towards Latino immigrants.

New literature was discovered within articles while reading through these articles found by the process explained above. An intentional effort was made to find a diverse set of sample designs including but not limited to meta-analysis, systemic literature reviews, multiple logistic regression, longitudinal studies, and multivariable and decomposition regression analyses. A second intention was to find literature from different areas in the U.S. however that was not as easy as expected. Much of the literature relevant to the topic of focus was conducted in the South, Southwest, and West coast of the U.S. Inclusion criteria for all peer reviewed articles was 1) articles from 2000 and beyond, 2) articles focusing on the mental health aspect of premigration, during migration, and postmigration phases, and 3) articles on immigration from Latin America. Exclusion criteria for all per reviewed articles was 1) articles prior to 2000, 2) articles that do not discuss mental health, SDOH, or cultural implications, and 3) articles focusing solely on non-Latino countries. Figure 1 in appendix B illustrates the search strategy diagram used to narrow the literature into articles relevant to the research topic question

DISCUSSION

The purpose of this literary analysis is to provide support for the need to target first-generation Latino immigrant and refugee families entering the U.S. and the mental health challenges they face. Further analysis of the existing literature is essential to raising awareness to their daily obstacles. In doing so, a possible solution can be formulated if a foundation of issue can be identified. In addition to the systemic challenges and SDOH Latinos face, many feel

rejected by their peers as well. From 2004 to 2013, rates of perceived discrimination increased by more than 80 percent among immigrants from Latin America (19). When factoring in SDOH, the largest perceived rates of discrimination were observed among Latinos with less than high school education and residing in households earning $20,000 – 35,000. Consequentially, those who fell victim to identity-based discrimination were strongly linked with mental health problems (19). However, of interest, discrimination was linked to poorer mental health across all outcomes for immigrants, but less associated with mental health outcomes for refugees (22). Explanation for this difference is still unclear.

In 2009, Johns Hopkins Medicine established the Access Partnership (TAP) to provide specialty services to uninsured residents of the East Baltimore community surrounding Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (21). Between 2012 and 2015, a total of 1735 patients received outpatient medical care through the TAP program of which 870 identified as Hispanic or Latino. Females accounted for most mental health encounters (67%). The majority (78%) of mental health encounters was for mood disorders, with 530 encounters for major depression and depressive disorders. Anxiety disorders accounted 16% of mental health encounters, followed by adjustment, psychotic, and alcohol-related conditions (21). The data collected by the TAP program strongly supports and correlates with the findings discussed in the literature review thus far. Women are more at risk for mental health challenges because of the lack of autonomy in the decision-making process of coming to America and once here, they are not given the freedom that men have. Women are more often asked to remain home which strips them of social aspects that humans need. It puts them into isolation from as social aspect in the U.S but also isolates them from their community and family back home. With an understanding of possible traumas faced in their homelands or the trauma experienced in detention centers, one

can understand how isolation can trigger or exacerbate mental health conditions leading to poor outcomes. In fact, the neurological changes resulting from isolation transform into pain felt in a physical form which can lead to suicidal ideations (43). Likewise, isolation in detention centers can have similarly devastating impacts on their mental health and neurological development.

Disciplinary actions in detention centers are commonly met with isolation rather than the need for mental health testing. Combined with the stressors experienced in the pre-immigration process, isolation as a form of discipline can exacerbate one's mental health condition. Nonetheless, if detainees do not have pre-existing mental health conditions, it is likely that they will develop them based on the duration of their isolation. Common findings are the development or exacerbation of depression, anxiety, increased anger, hallucinations, loss of appetite or refusal to eat, self-harm in the form slashing or biting themselves, suicidal attempts, etc. (44). Furthermore, for adolescents, early life maternal separation or isolation has been discovered to affect one's brain development and strongly affect adult life. Strong correlations have been tied to psychiatric disorders such as anxiety, depression, and schizophrenia (45). With special consideration of the climate, we are living in today, isolation has become common practice. The COVID-19 cases surging in the year 2020 and poor sanitation in detention centers, outbreaks were common. However, this is not a unique situation. In 2016, there were measles outbreaks in detention facilities leading to further isolation and precautions (46).

Despite overcoming the difficulties immigrants and refugees face during the immigration process, they are left in a country with systemic flaws that strips them of mental health support. Conducting a sample survey with Latino high school students in San Diego, self-reported scores of depression (via Patient Health Questionnaire-2) and loneliness were collected as outcome variables with access to a primary care physician as the main independent variable (23). Results

showed multilevel logistic regression linking access to a physician and being at risk for major depression and feeling lonely resulted in an odds ratio of 0.316 and 0.371, respectively (23). Healthcare disparities continue to be a barrier to the quality of health for Latinos in America which raises the need for culturally informed care. If these issues are not addressed at a young age, data has shown for these individuals to be predisposed to new mental health conditions and worsening of their current states.

Analyzing the mental health effects of premigration, migration, and postmigration among refugees and immigrants in the U.S is essential to developing care specific to the Latino population. The mental health community must integrate trauma informed care and culturally sensitive care into their practices to enhanced public health, improved patient lives, and an enriched experience for psychiatrists themselves (47). One cannot exist without the other. Providing trauma informed care without cultural humility and understanding would be incomplete because your patients culture will dictate what is appropriate to do, say, prescribe, etc. Likewise, cultural implications may be the source of trauma. It is one's culture that people construct their values, priorities, identities, beliefs, and expectations put on themselves.

According to the Substance Abuse and Mental Health Services Administration, individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being (48). Trauma-informed care is a strength-based approach to caring for individuals mindfully, with compassion and clarity regarding boundaries and expectations, to avoid unintentionally triggering a trauma or stress response. It acknowledges that people have experienced potentially traumatic events and that the health consequences of such events are significant (47). Trauma-

informed care conforms to the standards of ethical practice recognized in the profession and thus, should not be regarded as a development that steers psychiatry away from its core mission. Consequentially, it should rather be perceived as a way that the profession can more readily achieve that mission (47). It recognizes everyone's unique history including ACE, physical trauma, social trauma, and cultural environments and how these influence the way people respond to potential stressors. Although trauma informed care is recognized, many healthcare professionals fall short in enforcing its underlying core values.

Trauma informed care must include empowerment, choice, collaboration, trustworthiness, transparency, respect, safety, and a person-centered care approach because those past traumatic events strip one of their power, autonomy, trust in others, and ability to become vulnerable (47). It should be a priority to make the patient feel as if they are back in control. Empowerment entails acknowledging and using patients' strengths early in the treatment process rather than overemphasizing diagnoses, weaknesses, or victim status. Trauma informed care practiced with an attitude of cultural humility is a means to serve mental health care patients more effectively (47). The prevalence of potentially traumatic events in the population and the diversity of Latino patient backgrounds demands that psychiatry simultaneously acknowledge their unique backgrounds and actively integrate them into healing experiences.

Culturally sensitive care is the ability to deliver care with the consideration of one's diverse values, beliefs, and feelings. An alternative to the title that has gained support is cultural humility. Providers must acknowledge that culture is something that can be learned, mastered, and neatly categorized. Cultural humility entails admitting that cultural experience is something one cannot fully analyze or understand but can seek to appreciate and respect (47). Cultural humility is characterized by principles of mutual learning and critical self-reflection, recognition

of power imbalances, and the existence of implicit biases. With reference to the importance of empowering patients, cultural humility can serve as a guiding concept for the practice of trauma-informed care in centering and empowering patients on their journey of healing, rather than making assumptions about the patient's experience or practicing an authoritative, power-over communication style (47). Examples of culturally humble approaches in the clinical setting are:

> Do not engage in propagating stereotypes about any gender, race, culture, religion, or other groups.
> Do not assume that someone from a given culture would be unsafe, troubled, or traumatized.
> Do not assume someone from a different culture speaks a certain language, practices a certain religion or tradition, or behaves in a certain way.
> Do not assume people of the same race, culture, or ethnicity know each other or are related.
> Get Safe Zone training to practice openness and inclusion regarding gender and sexual identities.
> Always offer all options for treatment without making presumptions about affordability based on socioeconomic status (47).

From the perspective of a healthcare provider, the willingness to accept that one's own culturally preferred approaches may not be the most beneficial to the patient is essential. There is no one size fits all in the field of medicine. Healthcare providers must abandon assumptions and enter each case with an open, humble approach. In doing so, self-reflection on the part of the psychiatrist can help ensure that responsibilities to the patient are effectively observed (47). Furthermore, the benefits that comes from culturally humble encounters with patients from different cultures is a form of ongoing growth that can benefit medical providers as well both personally and professionally.

CONCLUSION

Mental health challenges amongst first generation immigrant and refugee Latinos in America are an area that requires further research. Further research is needed on how to manage mental health in the Latino community and ways to mitigate these difficulties. Additional research may also be conducted on whether on mental health and its genetic correlation. For example, do children born to immigrants or refugees have the same or similar mental health challenges despite being born in the U.S. and thus not having to endure the stressors and trauma of migration or the marathon of experiencing social difficulties or obvious discrimination due to language barriers or lack of cultural assimilation.

In addition to educating the medical field and its employees, education should be provided to the general public that is not intertwined into a political debate. It is important to understand that the source of the Latino communities' mental illnesses may be a result of the challenges faced during premigration process. Upon entering the U.S., an immigrant or refugee is susceptible to exacerbation of their pre-existing mental health conditions or the development of new ones due to the systemic flaws currently in place. Although it is difficult to solve due to the never-ending political debate surround immigrants and refugees, the treatment, and conditions of those in detention centers should not be a partisanship issue. The environment of a detention center alone can be the source of mental illnesses let alone the SDOH that are down the road that will indeed impact one's mental health. Perhaps the solution is government funding. There are established groups targeting the Latino community such as the ASHP and APA who provide academic and clinical facilities, coordinate scientific and professional events, educate providers in multidisciplinary encounters, publish specialized literature, and create training events for young Hispanic clinicians and researchers (20). Nonetheless, future research is also

needed on how to fix the issues in detention centers, provide support for Latino communities to minimize SDOH and health disparities, and breakdown systemic barriers that makes adapting to American life more difficult for Latino minorities. Ultimately, the Latino population will continue to grow in America so there must be an effort put forward to develop trauma informed care and culturally sensitive care for these individuals. We must identify ways to support these communities and the obstacle they are facing whether that is through further research, political policy changes, or grassroot efforts.

CITATIONS

1. Bourque F, van der Ven E, Malla A. A meta-analysis of the risk for psychotic disorders among first- and second-generation immigrants. Psychol Med. 2011;41(5):897-910. doi:10.1017/S0033291710001406
2. Derr AS. Mental Health Service Use Among Immigrants in the United States: A Systematic Review. Psychiatr Serv. 2016;67(3):265-274. doi:10.1176/appi.ps.201500004
3. Cleary SD, Snead R, Dietz-Chavez D, Rivera I, Edberg MC. Immigrant Trauma and Mental Health Outcomes Among Latino Youth. J Immigr Minor Health. 2018;20(5):1053-1059. doi:10.1007/s10903-017-0673-6
4. Cleary SD, Snead R, Dietz-Chavez D, Rivera I, Edberg MC. Immigrant Trauma and Mental Health Outcomes Among Latino Youth. J Immigr Minor Health. 2018;20(5):1053-1059. doi:10.1007/s10903-017-0673-6
5. Al Shamsi H, Almutairi AG, Al Mashrafi S, Al Kalbani T. Implications of Language Barriers for Healthcare: A Systematic Review. Oman Med J. 2020;35(2):e122. Published 2020 Apr 30. doi:10.5001/omj.2020.40
6. Winterrowd E, Canetto SS, Chavez EL. Friendships and suicidality among Mexican American adolescent girls and boys. Death Stud. 2010;34(7):641-660. doi:10.1080/07481181003765527
7. Lu W, Todhunter-Reid A, Mitsdarffer ML, Muñoz-Laboy M, Yoon AS, Xu L. Barriers and Facilitators for Mental Health Service Use Among Racial/Ethnic Minority Adolescents: A Systematic Review of Literature. Front Public Health. 2021;9:641605. Published 2021 Mar 8. doi:10.3389/fpubh.2021.641605

8. Nowotny KM, Perdue T, Cepeda A, Valdez A. Mental health of heroin users with differing injection drug use histories: A non-treatment sample of Mexican American young adult men. Drug Alcohol Depend. 2017;181:124-131. doi:10.1016/j.drugalcdep.2017.08.041
9. Nowotny KM, Perdue T, Cepeda A, Valdez A. Mental health of heroin users with differing injection drug use histories: A non-treatment sample of Mexican American young adult men. Drug Alcohol Depend. 2017;181:124-131. doi:10.1016/j.drugalcdep.2017.08.041
10. Nobles CJ, Valentine SE, Zepeda ED, et al. Residential segregation and mental health among Latinos in a nationally representative survey. J Epidemiol Community Health. 2017;71(4):318-323. doi:10.1136/jech-2016-208034
11. Kerridge BT, Chou SP, Pickering RP. Substance Use and Psychiatric Disorders Among Mexican Americans and Non-Hispanic Whites by Immigration Status. Prim Care Companion CNS Disord. 2019;21(1):18m02359. Published 2019 Feb 28. doi:10.4088/PCC.18m02359
12. Cepeda A, Nowotny KM, Frankeberger J, et al. Examination of multilevel domains of minority stress: Implications for drug use and mental and physical health among Latina women who have sex with women and men. PLoS One. 2020;15(3):e0230437. Published 2020 Mar 26. doi:10.1371/journal.pone.0230437
13. Bustamante AV, McKenna RM, Viana J, Ortega AN, Chen J. Access-To-Care Differences Between Mexican-Heritage And Other Latinos In California After The Affordable Care Act. Health Aff (Millwood). 2018;37(9):1400-1408. doi:10.1377/hlthaff.2018.0416
14. Lagunes-Cordoba E, Davalos A, Fresan-Orellana A, et al. Mental Health Service Users' Perceptions of Stigma, From the General Population and From Mental Health Professionals in Mexico: A Qualitative Study. Community Ment Health J. 2021;57(5):985-993. doi:10.1007/s10597-020-00706-4

15. Donato KM, Caron L, Hamilton E. Migration and Mental Health in Mexico: Domestic Migrants, Return U.S. Migrants, and Non-Migrants. Front Psychiatry. 2020;10:970. Published 2020 Feb 3. doi:10.3389/fpsyt.2019.00970
16. Recto P, Dimmitt Champion J. Mexican-American adolescents' perceptions about causes of perinatal depression, self-help strategies, and how to obtain mental health information. J Child Adolesc Psychiatr Nurs. 2018;31(2-3):61-69. doi:10.1111/jcap.12210
17. García C, Garcia MA, Chiu CT, Rivera FI, Raji M. Life Expectancies With Depression by Age of Migration and Gender Among Older Mexican Americans. Gerontologist. 2019;59(5):877-885. doi:10.1093/geront/gny107
18. May FP, Yano EM, Provenzale D, Steers WN, Washington DL. Race, Poverty, and Mental Health Drive Colorectal Cancer Screening Disparities in the Veterans Health Administration. Med Care. 2019;57(10):773-780. doi:10.1097/MLR.0000000000001186
19. Alarcón RD, Lolas F, Mari JJ, Lázaro J, Baca-Baldomero E. Latin American and Spanish-speaking perspectives on the challenges of global psychiatry. Braz J Psychiatry. 2020;42(1):77-86. doi:10.1590/1516-4446-2018-0397
20. Bucay-Harari L, Page KR, Krawczyk N, Robles YP, Castillo-Salgado C. Mental Health Needs of an Emerging Latino Community. J Behav Health Serv Res. 2020;47(3):388-398. doi:10.1007/s11414-020-09688-3
21. Sangalang CC, Becerra D, Mitchell FM, Lechuga-Peña S, Lopez K, Kim I. Trauma, Post-Migration Stress, and Mental Health: A Comparative Analysis of Refugees and Immigrants in the United States. J Immigr Minor Health. 2019;21(5):909-919. doi:10.1007/s10903-018-0826-2

22. Gell-Redman M, Shi L, Zhang D, Mungaray AB. Access to Health Care and Mental Health Among Latino Students in San Diego. Health Equity. 2020;4(1):255-259. Published 2020 Jun 16. doi:10.1089/heq.2019.0115
23. Merrick MT, Ford DC, Ports KA, Guinn AS. Prevalence of Adverse Childhood Experiences From the 2011-2014 Behavioral Risk Factor Surveillance System in 23 States [published correction appears in JAMA Pediatr. 2018 Nov 1;172(11):1104]. JAMA Pediatr. 2018;172(11):1038-1044. doi:10.1001/jamapediatrics.2018.2537
24. Galderisi S, Heinz A, Kastrup M, Beezhold J, Sartorius N. A proposed new definition of mental health. Propozycja nowej definicji zdrowia psychicznego. Psychiatr Pol. 2017;51(3):407-411. doi:10.12740/PP/74145
25. WHO. 1948 Constitution of the World Health Organization, 2006.
26. Karimi M, Brazier J. Health, Health-Related Quality of Life, and Quality of Life: What is the Difference?. Pharmacoeconomics. 2016;34(7):645-649. doi:10.1007/s40273-016-0389-9
27. Sokol R, Austin A, Chandler C, et al. Screening Children for Social Determinants of Health: A Systematic Review. Pediatrics. 2019;144(4):e20191622. doi:10.1542/peds.2019-1622
28. Knaak S, Mantler E, Szeto A. Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. Healthc Manage Forum. 2017;30(2):111-116. doi:10.1177/0840470416679413
29. Stinchcomb D, Hershberg E. Unaccompanied Migrant Children from Central America: Context, Causes, and Responses.; 2014. doi:10.2139/ssrn.2524001.
30. Infante C, Idrovo AJ, Sánchez-Domínguez MS, Vinhas S, González-Vázquez T. Violence committed against migrants in transit: experiences on the Northern Mexican border. J Immigr Minor Health. 2012;14(3):449-459. doi:10.1007/s10903-011-9489-y

31. Saadi A, De Trinidad Young ME, Patler C, Estrada JL, Venters H. Understanding US Immigration Detention: Reaffirming Rights and Addressing Social-Structural Determinants of Health. Health Hum Rights. 2020;22(1):187-197.
32. Patler C., Sacha J. O., Branic N. "The black box within a black box: Solitary confinement practices in a subset of U.S. immigrant detention facilities," Journal of Population Research. 2018;35(4):435–465
33. Leung J, Elson D, Sanders K, et al. Notes from the Field: Mumps in Detention Facilities that House Detained Migrants - United States, September 2018-August 2019. MMWR Morb Mortal Wkly Rep. 2019;68(34):749-750. Published 2019 Aug 30. doi:10.15585/mmwr.mm6834a4
34. Wong, Tom K., Sebastian Bonilla, and Anna Colemana. 2019. Seeking Asylum: Part 1. La Jolla, CA: U.S. Immigration Policy Center (USIPC) at UC San Diego.
35. Patler C., Branic N. "Patterns of family visitation during immigration detention," RSF: The Russell Sage Foundation Journal of the Social Sciences. 2017;3(4):18–36.
36. Burr J., Gerst K., Kwan N., & Mutchler J (2008). Economic well-being and welfare program participation among older immigrants in the United States. Generations, 32, 53–60
37. Angel J. L., Rote S., & Markides K (2017). The Role of the latino family in late-life caregiving. In Wilmoth J. M. & Silverstein M. (Eds.), Later-life social support and service provision in diverse and vulnerable populations (pp. 58–73). New York: Routledge.
38. Kidorf M, Disney ER, King VL, Neufeld K, Beilenson PL, Brooner RK. Prevalence of psychiatric and substance use disorders in opioid abusers in a community syringe exchange program. Drug Alcohol Depend. 2004;74(2):115-122. doi:10.1016/j.drugalcdep.2003.11.014

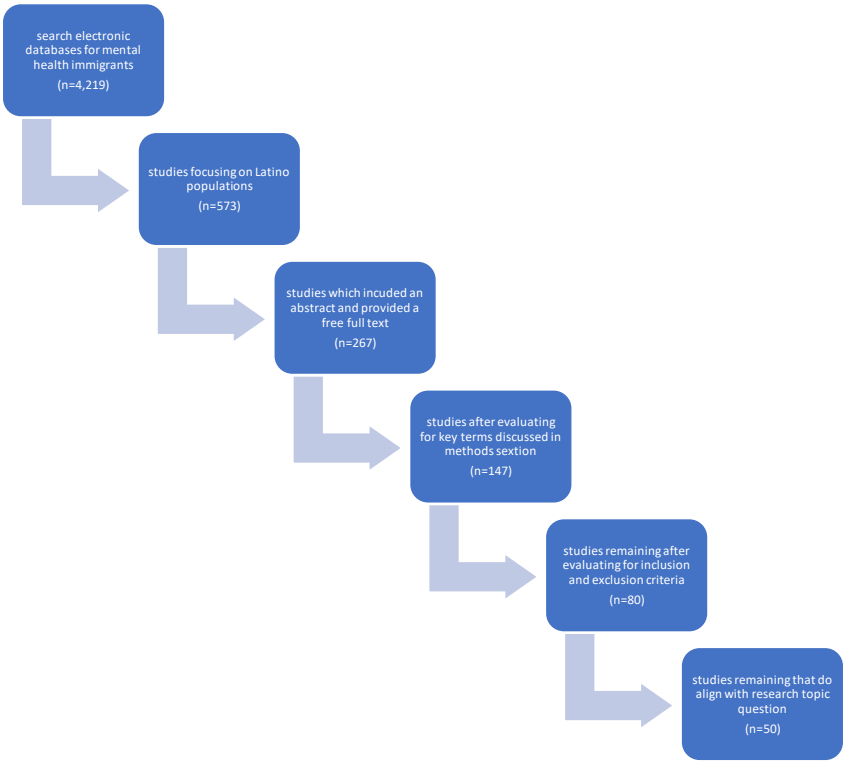
39. Bureau of the Census. Projections of the Size and Composition of the US Population: Population Estimates and Projections. Washington, DC: US Bureau of the Census; 2015.
40. Bureau of the Census. Hispanic Roots: Breakdown of US Hispanic Population, by Specific Origin: 2014. Washington, DC: US Bureau of the Census; 2016.
41. Hynie M. The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review. Can J Psychiatry. 2018;63(5):297-303. doi:10.1177/0706743717746666
42. Bandes SA, Pryor M, Kerrison EM, Goff PA. The mismeasure of Terry stops: Assessing the psychological and emotional harms of stop and frisk to individuals and communities. Behav Sci Law. 2019;37(2):176-194. doi:10.1002/bsl.2401
43. Reiter K, Ventura J, Lovell D, et al. Psychological Distress in Solitary Confinement: Symptoms, Severity, and Prevalence in the United States, 2017-2018. Am J Public Health. 2020;110(S1):S56-S62. doi:10.2105/AJPH.2019.305375
44. Siuda D, Wu Z, Chen Y, et al. Social isolation-induced epigenetic changes in midbrain of
45. adult mice. J Physiol Pharmacol. 2014;65(2):247-255.
46. Venkat H, Briggs G, Brady S, et al. Measles Outbreak at a Privately Operated Detention Facility: Arizona, 2016. Clin Infect Dis. 2019;68(12):2018-2025. doi:10.1093/cid/ciy819
47. Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014.

Appendix A

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7982679/table/T3/?report=objectonly

Appendix B

Search strategy diagram



Appendix C

Literature review table

https://docs.google.com/spreadsheets/d/1NgJ3XcA8m6Ue8fu83DCx9VvbMBldaBNOi1WoYme3eNY/edit?usp=sharing

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