

Multicultural Disparities in Legal and Mental Health Systems: Challenges and Potential Solutions

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Abstract

Psychologists recognize that experiences of oppression shape negative outcomes for people and consider their role in addressing disparities and disproportionalities in mental health systems as well as in criminal justice and legal systems. Using an ecological framework, psychologists can identify the ways by which marginalization hinders access to resources at the community level. There are interactions between larger cultural norms and societal laws resulting from privilege or oppression that limit an individual's access to community resources. Therefore, psychologists address disparities at both individual and systemic levels for low income, disability, racial and ethnic minority, immigrant, and refugee populations. To address disparities, potential applications in practice, research, and training/consultation are suggested. The recommendations for solutions to inequity are based on theories of intersectionality and structural stigma, as well as on implications of social justice action that brings the voice of psychology into public policy.

Keywords: multicultural disparities; accessibility; underutilization; stigma; advocacy; culturally informed

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Ecological psychology informs the current understanding of social contexts in human suffering. A primary example is the physical and mental health outcomes for populations who are living in environments that lack resources (Eggertson, 2011). Understanding about resources has been improved by the inclusion of objective information on socio-demographics in the 2000 United States (U.S.) Census and other regional databases, such as racial, ethnic, and immigrant/refugee status, income levels, home ownership, car ownership, public education, public transportation, location of clinics and hospitals, and availability of grocery stores. Such data are key to understanding the role of societal resources for the well-being of low income, disability, racial and ethnic minority, immigrant, and refugee populations. This paper illuminates disparities for these populations so that psychologists and policy makers can collaborate to make informed changes in the prevalence of disparities in the U.S. mental health and legal systems.

Theoretical Conceptualizations of Oppression

Intersectionality of Societal Oppressions at the Individual Level

Oppressions of race, ethnicity, class, gender, sexual orientation, and immigrant/refugee standing are different but often these are experienced simultaneously by a person in all five social locations, e.g., being poor, Black, a woman, a lesbian, and a Caribbean immigrant. Such categories of marginalization are experienced individually as well as at social group levels. However, these experiences are not a sum total of discrete oppressions. Clarifying further, oppression is not experienced as an aggregate of Poverty + Race + Gender + Sexual Orientation + Immigrant Status. What if a homeless African American male is incarcerated? How is this person treated in a jail? How is a child with disabilities from a poor family treated in an educational system? What are the systemic barriers for a Muslim immigrant woman seeking mental healthcare? Conceptualizing oppressions as arising from various social categorizations and looking for commonalities across these rather than looking at group-specific or single axial oppression differences are the current interest of feminist intersectional researchers (Cole, 2009). This latent conceptualization can be used by psychologists for coalition-building among marginalized people to bring about social change that benefits individuals as well as groups.

Inequalities of race, gender, class, sexual orientation, and immigrant or refugee standing are not simply demographic status descriptors but encapsulate historical marginalization across the ecological macro, exo, micro, and individual systems. Thus, psychologists view individuals as embedded in historical contexts and “take seriously the cultural and political history of groups, as well as the ways these socially constructed categories depend on one another for meaning and are jointly associated with outcomes” (Cole, 2009, p. 178) for individuals with multiple social identities. Clinicians learn how to pair culturally-informed practice in one identity domain (immigrant status) with culturally-informed practice in another (gay sexual orientation), thus maintaining an adaptive approach. On the other side of that argument, psychologists also have the opportunity to draw on the accumulated strengths or resilience competencies that an individual has developed as a result of several overlapping identities.

Structural Stigma

In the last decade, psychologists have argued for research that describes and evaluates broad, structural forms of stigma that impact the lives of stigmatized individuals. Expanding the stigma construct beyond individual and microsystemic levels (a family’s stigma) to macrosocial forms allows psychologists to establish larger models of societal dynamics and their social, emotional, and political impacts on groups and individuals. “Intentional” structural stigma is typically manifested as rules, policies, and procedures of entities or institutions in positions of power (Corrigan, Markowitz, & Watson, 2004). Examples of intentional structural stigma include executive orders on bathroom segregation for transgender individuals that cross through macrosocial (sex assigned in birth certificates, driver’s license), microsocial (lack of gynecological care or sex change surgeries), to individual levels, where oppressive cisgender attitudes are engendered in people and threaten transgender individuals and their integrity (Budge, Tebbe, & Howard, 2010). Other recent examples include the reversal of same-sex marriage law (cf. Eskridge & Spedale, 2006) and U.S. travel bans proposed for specific Muslim nations, immigrants, and refugees.

Recent research has begun to address the relationship between structural stigma and microsystemic and individual stigma processes. One particular cross-national study focused on the way the combination of national legislation (ban against homosexuality) and social attitudes (heterosexuality) were linked to specific stigmatization processes at community and individual levels for sexual minority individuals (Pachankis et al., 2015); this study showed that sexual minority men were more likely to conceal their sexual orientation and/or gender identity in countries that were determined to have high levels of structural stigma as compared to low stigma countries. Policy analysis is one form of newly developed research that focuses on the content of policies through city, state, and country-wide levels that informs the presence of structural stigma across institutions (Corrigan, Markowitz, & Watson, 2004). Another type of research that has expansively contributed to understanding stigma includes aggregated measures on social attitudes that incorporate individuals' attitudes towards members of stigmatized groups and combining these with individual-level negative outcomes among stigmatized groups (Hatzenbuehler, 2016).

Cultural Stigma of Immigrant Societies

Underutilization of mental health services results from stigmatization by (a) the dominant society about the mental health of marginalized groups (related to over-diagnosis or under-diagnosis), (b) cultural stigmatization by one's racial or ethnic group, and (c) an individual's internalization of both societies' stigmas (Breau & Ryujin, 1999; Chang & Yoon, 2011; Li & Seidman, 2010). For instance, although immigrants from countries with high rates of political violence have a strong likelihood of trauma symptomology, Latino/Hispanic/Latinx men were less likely to seek treatment after political violence than other immigrant groups (Fortuna, Porche, & Alegria, 2008). Asian Indians stigmatized mental illness within religious views of karmic punishment and negative supernatural associations, or they provided somatic medical explanations for their underlying psychopathology (Li & Seidman, 2010). These Asian Indians, thus, also utilized services in ways unrelated to their identified psychopathology (Kim et al., 2011). Similarly, Chinese immigrants practiced self-denial of services, fearing stigmatization by their Chinese immigrant society and self-stigmatization about loss of personal respect and Chinese identity (Kung, 2003). Older Korean immigrants between the ages of 60 and 74 were also likely to have stigmatized perceptions of mental illness and utilization of services (Park et al., 2014). Education is needed for both multicultural populations and therapists to reduce cultural stigma about mental health problems.

Disparities Owing to Macro Level Oppressions

Macro level oppressions (Essed, 2002), such as racism (Du Bois, 1903/1996), cultural imperialism (Speight, 2007), classism (Liu, 2012), ableism (Anderson, Olkin & Pledger, 2003), English only injunction (Lynch, 2006), cisgenderism (American Psychological Association, 2015), and stigma about marginalized status (Meyer, 2003), result in disparities in law enforcement, judicial processes, and mental health services. Thus, people from oppressed groups experience limited access, less utilization, and diminished quality of healthcare (Institute of Medicine, 2003; U.S. Department of Health and Human Services [HHS], 2011).

To determine whether a particular group is oppressed and treated disparately, Young (1990) delineated, among others, such categories as marginalization (i.e., excluding groups from

community life), powerlessness (i.e., lacking authority to be active agents of one's healthcare like having easy access to providers), cultural imperialism (i.e., privileging the dominant group's perspectives over that of others, such as about mental health), and violence (i.e., directing destructive law enforcement or judicial practices systemically at particular groups, such as, African Americans). Oppression-caused disparities can be experienced separately or in combination. Its combination results in traumas that can be transmitted collectively across generations, as in the case of American Indians/Alaska Natives and African Americans (cf. Brave Heart, Chase, Elkins, & Altschul, 2011; Gone, 2013; LaFramboise & Malik, 2016; Leary, 2005; Turner & Pope, 2009). Using Figure 1, psychologists can analyze systemic disparities in legal and healthcare contexts.

Disparities in the Legal System

Racial, Ethnic, and Language Minority People

There are significant disparities in the legal treatment of racial, ethnic, and language minority people, as well as for poor and homeless populations (Chan, 2011; Vernon & Leigh, 2007; Lunsky, Raina, & Jones, 2012). These disparities are given consideration. The need for psychologists to address disparities in legal systems and engage in advocacy work is discussed next.

Racial profiling by the police targets individuals for suspicion of crime based on an individual's race, ethnicity, religion, or national origin (Chan, 2011). Racial profiling means that people of color are disproportionately likely to be stopped, questioned, and ultimately arrested. Arizona's SB 1070 invites racial profiling against people presumed to be "foreign" based on how they look or sound. This law authorizes the police to demand papers proving citizenship or immigration status from anyone they stop and suspect of being in the country unlawfully. The U.S. Supreme Court upheld Arizona's anti-immigrant bill, further sanctioning injustice.

Following the publicized fatal police shootings of several African American males in 2014 and 2015, protest groups, such as Black Lives Matter, accused law enforcement officers of being too quick to use lethal force against African Americans. Overall in 2015, Black people were killed at twice the rate for White, Hispanic, and American Indians; about 25% of the African Americans killed were unarmed, compared with 17% of White people (Laughland, Lartey, & McCarthy, 2015). This disparity or disproportionality narrowed since the middle of 2015 at which point Black people killed were twice as likely not to have a weapon than have a weapon (Reese, 2015). There are disparities in incarceration rates, such that Black individuals are incarcerated at a rate 5.1 times greater than their White counterparts (The Sentencing Project, 2015). Scholars attribute these differences to disparate criminal justice policy, stereotypes, and implicit bias in decision-making among law enforcement and justice officials (Mauer, 2011).

Poor People

Poverty and homelessness, particularly in conjunction with mental illness, lead to heightened law enforcement intervention as individuals who lack housing are forced to live in public spaces and are vulnerable to arrest for trespassing, loitering, and disorderly conduct; in addition, they may be incarcerated for long periods of time for offenses that often receive no jail time for other people (Vernon & Leigh, 2007). Rates of incarceration are also related to lack of money for those who cannot afford private lawyers and bail; there are sentencing differences per policy, for example, with regard to possession of crack versus powder cocaine; and juror implicit bias also contributes to sentencing disparities (Cohn, Bucolo, Pride, & Sommers, 2009).

Access for homeless individuals to paramedics and police, can be limited due to the fear of the consequences of using local resources. Many homeless people interact with both police officers and paramedics. However, trust of the two professions varies in the homeless community. A study showed that 92% of a polled homeless population reported that they would be willing to call paramedics in comparison to 69% who would call the police in an emergency (Zakrison, Hamel, & Hwang, 2004). This disparity was seen to be the case even in individuals who had never been assaulted by the police and those who had no interaction with law enforcement in the past year. Unwillingness to call the police can be especially detrimental because of the relative inability of the homeless to escape or remove themselves from a dangerous situation.

For prison management, importance is placed on keeping the area safe, orderly, and escape-proof, while also making sure that appropriate programs are included to change offensive behavior and provide rehabilitation; but oftentimes, programs targeted at mental health receive less attention when striving to keep this balance (Jordan, 2011). This disparity is especially problematic because there is a significant link between a lack of adequate mental healthcare in prison and an increase in suicidality and psychiatric symptoms, decompensated medical conditions, and relapse to drug use and overdose (Ahmed, Angel, Martell, Pyne, & Keenan, 2016; Binswanger et al., 2011). Imprisonment without appropriate mental health care is seen to be related to recidivism (Visher & O'Connell, 2012).

What few mental health services may be available in a jail or prison setting are generally not accessible to people with speech and hearing disabilities as well as for immigrants with low English proficiency because of a lack of language interpreters (Vernon & Leigh, 2007). These marginalized people do not always receive the civil rights or healthcare they are entitled to under current Americans with Disability Act (ADA) laws.

Recommendations for Applications in Jails

One key way that psychologists can contribute to the well-being of incarcerated individuals is by providing high-quality and timely forensic evaluations; these may be used to make determinations about competency to stand trial. Such evaluations may expedite the appropriate mental healthcare for individuals without other resources.

Psychologists are also encouraged to advocate for alternatives to incarceration, such as immediate mental health and substance abuse treatment; improved access to appropriate mental healthcare; and transition homes upon release (e.g., work-release programs that involve treatment

as a requirement) (Collier, 2014). Both the offender and community may be better served when public policy includes advocacy for appropriate treatment. By engaging in advocacy for arrested and incarcerated poor and mentally ill people, psychologists can be involved in fostering a more socially just society. Psychologists have an opportunity to engage in the application of sound science in forensics psychology for the improvement of public policy for marginalized groups.

Disparities in Mental Healthcare

Disparities in mental healthcare are experienced by a number of groups who find themselves located outside privileged U.S. statuses. Marginalized groups may lack the required health insurance to afford quality services. Moreover, across marginalized groups there exists a stigma about seeking help for mental health concerns (discussed previously). They also mistrust the mental health system. Psychologists who advocate for these populations engage in cultural competent practice and policy-making that increase access and relevance of services.

Low Income People

Unemployment has been linked to poorer psychological well-being. American Indians/Alaska Natives (9.9%) and Black Americans (9.6%) were found to have the highest rates of unemployment, which far exceeded their White counterparts' (4.6%) (U.S. Bureau of Labor Statistics, 2015). Using data from two nationally representative samples, the National Comorbidity Survey Replication (NCS-R) and the National Latino and Asian American Study (NLAAS), researchers found that long-term unemployment predicted large, negative effects on mental health. These effects were larger for Black and Latino/Hispanic/Latinx Americans (Diette, Goldsmith, Hamilton, Darity, 2012). Similarly, income gap was a stronger indicator of health status than actual income for new immigrants and refugees, who also reported higher unemployment than non-immigrants (Mawani, 2014). Relatedly, 17.7 % of newly immigrated Asian Indian immigrants who were underemployed were found to have depression, but suitably employed Asian Indians were 90.9% less likely to do so (Leung, Cheung, & Tsui, 2011).

Researchers have identified acute and chronic stressors that result from poverty and the impact that such stressors have; for example, food insecurity may lead to anxiety, hopelessness, and social isolation (cf. Goodman, Pugach, Skolnik, & Smith, 2013; HHS, 2011). Economic instability may affect immune and endocrine systems (Golden, 2007), and as a stressor, supports such risky behaviors as smoking, drinking and driving, and obesity (Agnew, 2009).

Immigrants and Refugees

Barriers to the utilization of mental health services amongst immigrant populations can be characterized by the examination of two distinctly prevalent phenomena: that of dropping out of treatment and that of not seeking support or treatment until syndromes or related sequelae become dysfunctional enough to be significantly debilitating (Dow, 2011). Precipitants for these two phenomena are largely the same and include a cultural disconnect with Western medicine and treatment, language barriers, and misdiagnosis—the latter of which may be a particularly salient concern in the context of treatment (Dow, 2011).

When treatment is provided, it is too often disparate. For example, in a study on outpatient services, Latino/Hispanic/Latinx and Asian Pacific Islander immigrant youth with

externalizing problems (e.g., aggression, anger) were twice as likely to receive services when compared to Latino/Hispanic/Latinx children with internalizing problems (e.g., low self-esteem, depression). Another disparity noted was that internalizing problems were addressed more often in non-immigrant families (Gudiño, Lau, & Hough, 2008). Additionally, economic factors impact Latino/Hispanic/Latinx immigrants' access to Medicaid specialty services and lead to poor quality of mental healthcare, which results in Latino/Hispanic/Latinx resorting to seeking support from natural healers and social support systems (Alegria et al., 2002). The low income status of Latino/Hispanic/Latinx immigrants also makes costly treatments, expensive medications, and private insurance coverage inaccessible (Thomas, & Snowden, 2002). Among Chinese immigrants, 77% reported cost of treatment as expensive; 64% cited time and language as barriers to treatment; 25% questioned credibility of treatment; and most asserted logistical barriers (Kung, 2003). The mental health system's lack of response to the frequent and primary use of social as opposed to professional resources may contribute to the isolation of immigrant families and their systemic concealment of mental illness in family members (Dow, 2011). There are a number of other factors that may lead to the underrepresentation of multicultural populations in mental health services that are discussed in the next section.

Client Cultural Mistrust and Practitioner Misunderstandings

The under-representation of people of color in mental health services cannot be solely explained by low access. Even when economic factors are not a barrier to mental health service for people of color, differences in service utilization persist. For instance, clients from diverse racial and ethnic backgrounds with similar levels of health insurance still receive fewer services than their White counterparts (Smedley, Stith, & Nelson, 2003). Fear of institutions prevents utilization. For instance, about 1/3 of refugees and asylees reported that they had physical and/or mental health concerns, but many avoided public programs and assistance, despite eligibility because they feared that participation would affect their legal status (Edberg, Cleary, & Vyas, 2011).

Variables that have been proposed to explain service underutilization include: prior mistreatment in health settings resulting in cultural mistrust (Alegria et al., 2008; Whaley, 2001); linguistic difference between providers and clients (Kim et al., 2011); failure of clinicians to understand the needs of people of color (Breux & Ryujin, 1999); under-detection by both providers and families (Alegria et al., 2008); clients' perceptions of their therapists' understanding of race (Chang & Yoon, 2011); lack of psychoeducation for people of color on mental health as well as distrust of Western treatment (Li & Seidman, 2010); and lack of multicultural competence among clinicians (Daniel, Roysircar, Abeles, & Boyd, 2004; Hernandez et al., 2009).

When racial and ethnic minorities do receive treatment, they are more likely to drop out in comparison to their White counterparts (Owen, Imel, Adelson, & Rodolfa, 2012). Barriers of cultural disconnect range across therapist responses from body language to the pursuit of inappropriate or inapplicable interventions.

With regard to misdiagnosis, cases of abuse have been either overlooked or wrongly emphasized as a result of language barriers, child-rearing norms, nuanced cultural contexts, therapist bias, or lack of therapist cultural competence (Aday, 2002). Practitioners' lack of

awareness of or ability to attune to cultural characteristics has led to over-pathologizing of psychotic symptoms, which in the context of certain cultures may present as within an appropriate range of stress responses (Dow, 2011). The prevalence of disparity in diagnosis confirms the Surgeon General's report (2001-2002), which stated that, "...cultural misunderstanding or communication problems between clients and therapists may prevent minority group members from using services and receiving appropriate care" (p. 42).

Religious Minorities

When health disparities are discussed, oftentimes religion is neglected. The United States is a society that prides itself on freedom of religion. However, in the attempt to keep this freedom for all and not impinge upon the rights of others, individuals become uncomfortable speaking about religion (Mitchum, 2012). As a Western society, religion is generally not a part of current U.S. medical practices. However, for many culturally diverse individuals, health is not solely based on medical symptomatology but can be intersecting with a person's religious experiences. Religion gives rise to different values and practices that intersect with other social categories, such as, race, ethnicity, nationality, gender, or socioeconomic status. Furthermore, religion can often influence the way that individuals seek assistance for their illnesses (Herzig, Roysircar, Kosyluk, & Corrigan, 2013; Padela & Curlin, 2013). Many Muslims view illness as a "trial from God" (Mitchum, 2011; Roysircar, 2003). When conceptualized in this way, it is not appropriate to solely treat the underlying medical condition. While that alleviates the physical aspects of an ailment, spiritual healing is also needed.

Another important factor of the relationship between medical practice and religion is the fact that some religions prohibit certain medical interventions. Using Islam as an example again, Muslims are not allowed to consume pork, but some vaccines and medicines are derived from pig products (Mitchum, 2012). If a Muslim client presents with an illness, making sure that the agreed-upon medicine does not contain certain substances like pig products is needed.

There is a lack of training in the field of psychology on the role of religion and spirituality in treatment even though approximately 90% of the world's population has spiritual beliefs that are essential to their coping (Pargament, Smith, Koenig, & Perez, 1998; Richards & Bergin, 2014). Given the increased levels of anti-Islamic and anti-Semitic rhetoric, addressing knowledge, biases, and assumptions related to religious minorities is essential to providing culturally competent care. Table 1 summarizes disparities in law enforcement, justice system, and mental healthcare owing to differences in race, ethnicity, disability, immigrant/refugee status, class, and religion.

Recommendations for Applications in Mental Healthcare

Accessibility

Psychologists might engage in education and outreach efforts for immigrant and marginalized communities to help de-stigmatize help-seeking, reduce limitations on service utilization, and build collaborative relationships with the stakeholders of communities. Perhaps beginning wide, with open informal groups that offer a free and useful service would help initially to draw community members to a clinic. Play groups for young children that offer parenting support, education, and socializing might be useful as caregivers may be more likely to

later seek psychological support for their children and families. Such open community groups may serve as a way to normalize mental health services in neighborhoods where native knowledge and culture would not typically draw people to a mental health clinic. So far, much of the work in mental health service surrounds the treatment itself like multicultural competence or evidence-based practice and less so on issues of accessibility. One inherent challenge to accessing mental health care in low income and cultural minority communities is a lack of awareness of resources or how the resources could help. However, it is also likely that seeking psychological services is simply not within the realm of a difficult everyday life. On the other hand, learning about what therapy provides, what a therapist's role entails, what a client's role entails, how change occurs, and how one might benefit from a therapist's social-emotional support may be necessary for a community to access treatment. The responsibility, therefore, resides in clinicians to find ways and means to inform and educate localities where services are less likely to be accessed. Milburn and Lightfoot (2016) found that family-based interventions for behavior changes in adolescents were successful when Latino/Hispanic/Latinx families were involved at every level of the intervention, particularly in the enrollment, engagement, and retention processes. Higher retention among Latino/Hispanic/Latinx families was linked to higher educational level and income. Millburn and Lightfoot noted that there was an increased enrollment in a clinical research project for Latino/Hispanic/Latinx parents with less education when provided with an incentive, but reported that these parents were less willing to participate once the study started. It is, therefore, important to consider utilization barriers and develop strategies that might enable parents to increase their levels of motivation and retention.

Culturally Informed Practice

Psychoeducation for practitioners would encourage cultural attunement of services, for example, knowledge about what healthcare practices would go with or against a religious, racial, or ethnic identity is important. An evidence-based cultural practice was exemplified by Hwang (2016), who developed a "bottom-up" formative method of adapting psychotherapy with Chinese communities in San Francisco that are culturally segregated and insular. He recognized that Chinese-oriented ideologies would be invaluable for informing cognitive-behavioral therapy (CBT). For instance, he placed psychological symptoms in one column on a chart and corresponding physical symptoms in another column, helping to foster a sense of balance of psychological-somatization presentation. Then, metaphors and Chinese proverbs helped in communicating the relationship between symptoms and CBT. One *chengyu* or Chinese proverb was translated as, "If a mountain is obstructing your path, then find a way around it. If there is no road around it, then you need to find or make a path of your own. If you can't find a way around it or create a path, then you need to change the way you think and feel about the problem" (Hwang, 2016, p. 298).

When treating depression in African American women, Aguilera et al.'s (2016) cultural adaptations included limiting the participant group to only African American women, changing the language used to describe CBT, incorporating spirituality, addressing interdependence of African American families, and including experiences around racial identity. Results indicated that African American women in the culturally informed CBT group had a more significant decrease in depression compared to African American women who were not in the culturally informed CBT group. Data from the non-culturally informed CBT study could be inaccurately interpreted as CBT being ineffective in treating depression in African American women.

Table 1. *Disparities in Law and Order and Mental Healthcare for Marginalized Populations*

Marginalized Populations	Law and Order	Mental Healthcare
Racial and Ethnic Minorities Immigrants Refugees	Racial profiling, police violence; greater likelihood of being arrested, increased demand to prove citizenship; law enforcement is quicker to use lethal force; implicit bias in police officers	Fewer support-seeking behaviors; higher rates of dropout; misdiagnosis due to cultural and linguistic differences; limited access to Medicaid specialty services resulting in seeking support from natural healers and social support systems instead; mental health system's lack of response to infrequent use of professional resources may contribute to systemic concealment of mental illness
Homeless/ Economically Disadvantaged Individuals	Heightened law enforcement intervention; more vulnerable to arrest for petty criminal acts; more jail time; more imprisonment without appropriate mental health care; unwillingness to call the police when the individual is themselves in a dangerous situation; cannot afford private law representation and bail; juror implicit bias; without treatment, may experience more trauma while incarcerated	Poor accessibility; more limitations on providers due to finances; limited access to Medicaid specialty services resulting in seeking support from natural healers and social support systems instead; mental health system's lack of response to frequent use of professional resources may contribute to systemic concealment of mental illness
Individuals with Disabilities	More imprisonment without appropriate mental health care, end up in the justice system more frequently; translators may not be readily accessible for those with hearing disabilities	Fewer standardized assessments for individuals with special needs, fewer facilities accessible for people with mobility difficulties
Non-English Speaking Individuals	More imprisonment without appropriate mental health care; translators may not be readily accessible	Misdiagnosis due to cultural and linguistic differences; lack of multicultural competence among clinicians; cases of abuse are often overlooked or wrongly emphasized due to language barriers; over-pathologizing of psychotic symptoms

Rather, the implication could be CBT when adapted may be *as* or *more* effective for African American women in comparison to CBT with other women (Aguilera et al.).

Suicide has disproportionately impacted American Indian/Alaska Native (AI/AN) populations for over half a century. Despite their sufferings, AI/AN youth often avoid psychological services because they believe that practitioners cannot understand what they are going through (LaFromboise & Malik, 2016). There appears to be a disconnect between school suicide prevention programs and AI/AN communities because many interventions do not explicitly address cultural and colonization factors (LaFromboise & Malik, 2016). For instance, psychologists need education and training in AI/AN culture-specific historical trauma, or “trauma resulting from successive, compounding events perpetrated on a community over generations to eliminate the cultural practices and cultural identity of its members” (LaFromboise & Malik, 2016, p. 226). LaFromboise and Malik (2016) encourage discussions with AI/AN groups to validate their fears and build relationships characterized by trust and understanding. On the basis of cultural and familial factors of an American Indian community, LaFromboise created the Zuni Life Skills Development Curriculum as a suicide prevention intervention program in schools, which reduced suicide rates at significant levels across several AI/AN tribes and reservations in different geographic locations (LaFromboise & Malik). In this model, LaFromboise included factors that contribute to depression, demoralization, and trauma and raise AI/AN suicide rates; these factors were perceived discrimination and negative stereotypes, interpersonal/social issues of adolescence, historical trauma, acculturative stress, community violence, gang activity, substance use, and culturally oppressive policies.

Psychologists may wish to keep in mind economic disparity when addressing minority stress. Moreover, it is amiss to target behavioral health outcomes without first targeting the economic, sociopolitical, or environmental catalysts. Career and employment assessment and counseling can become a social justice intervention with low income or unemployed populations.

Immigrant and Refugee Care

With Asian Indians, symptomology may be reframed as reactions to family or interpersonal issues. Attention is needed for Latino/Hispanic/Latinx populations who would be utilizing resources if not for their limited English proficiency. Language assistance policies alone resulted in greater utilization in all Asian immigrant samples that were surveyed (Snowden et al., 2011). In addition to the words being used, correct methods of communication need to be sought. Norms of address or greetings could be extremely important factors in a group setting or in family therapy (Hudson, Adams, & Lauderdale, 2016).

Having an awareness of how mental health is discussed in a particular culture is vital for establishing good rapport with a client who comes from a diverse culture. If a client refuses to talk about something, it could reflect the nature of how traumatizing that event was. However, if the topic in question is a subject that is not spoken of in this individual’s culture (i.e., an issue of stigma), declining to talk about the subject might not be indicative of a severe trauma. Avoidance might be reflecting a certain society’s belief that speaking on a certain topic is inappropriate. On the other hand, this inability to address a topic might be a result of it being not culturally appropriate to discuss as well as being extremely traumatizing (e.g., rape). Here it is important not to impose the values of Western therapy, such as self-disclosure and trust in the therapist—a

stranger, in essence—on an immigrant client. In addition, being aware of the terminology that a particular culture uses (e.g. “fuku,” an intergenerational curse referred to by Dominicans; Roysircar & Pignatiello, 2015) can reduce potential confusion on the part of the therapist or the client. Including families and addressing family commitment to change and to continue treatment are both crucial to productive therapy (Li & Seidman, 2010). This is especially important in more collectivist cultures where well-being is tied to how well the family is functioning and how committed the family is to change in the health of a family member. Assessment includes pre-immigration vulnerabilities (Mawani, 2014; Roysircar, 2004), such as religious persecution, torture, rape, flight, relocation camps, and exacerbation by post-immigration stressors (Mawani, 2014; Roysircar, 2004), of underemployment, absence of network support, rejection by the host society, identity conflicts, and acculturative stress.

It is important to realize that refugees who have been re-settled are likely grieving for multiple losses. A few examples of a refugee’s losses could be the loss of community, loss of an established role in that community, loss of supports, and the inability to use certain coping mechanisms that may have been helpful in the past. A meta-analysis was conducted to see what themes were recurrent in delivering healthcare to refugees affected by intergenerational trauma (Hudson, Adams, & Lauderdale, 2016). Six recurrent themes were identified important to refugee healthcare delivery: silence, communication, adaptation, relationship, remembering, and national redress. The authors recommended that practitioners consider cultural influences of intergenerational trauma in processing grief related to loss and how artistic modes of expression are experienced both individually and communally in refugee health care delivery.

Increasing empowerment and social capital by providing specific resources of support groups, language classes, and vocational training is critical to immigrants in the process of adapting to their second culture (Agnew, 2009). It may be beneficial to learn about how immigrant individuals would have addressed their challenges “at home” (i.e., first culture) so that their own natural strengths and coping resources may be tapped. This may include either consultation with family members or it may involve imagining the advice of respected family members or elders who are not physically present but whose wisdom reflected on in therapy may be a significant support.

Cultural Mistrust and the Therapeutic Alliance

From treatment research, the implication is that a strong therapeutic alliance may ameliorate cultural mistrust and positively affect treatment outcomes. First, psychologists need to know Terrell and Terrell’s (1984) concept of cultural mistrust, which is the idea that targets of oppression bring a justifiable skepticism to medical, mental health, and research settings due to prior exploitation and continued discrimination. Second, validating clients’ cultural mistrust and demonstrating willingness and humility to engage in open discussion of racial issues could strengthen the therapeutic alliance and ultimately enhance treatment outcomes (Ward, 2002).

Likewise, self-disclosure that is considered an essential component of positive therapy outcomes is affected by cultural mistrust. However, the process of self-disclosure is minimally included in culturally adapted interventions. Future research needs to include the important aspects of self-disclosure and the therapeutic alliance when considering reasons why mental health services are not accessed and utilized widely within minority communities.

Recommendations for Research

With regard to research, there should be more attention to active inclusion of minority populations in mainstream research rather than simply under the umbrella of 'special issues.' Methodological diversity is also crucial. For example, investigators could complement quantitative methods with qualitative, discovery-oriented, and community-based participatory approaches. S. Sue (1999) raised a crucial point that psychological research has emphasized the internal validity of well-controlled studies over external validity (i.e., generalizable to populations and happenings in the outside world), which has had negative implications for marginalized communities that have been excluded from many research studies of empirically supported treatments (cf. Wampold & Bhati, 2004). It will become increasingly important for researchers to establish relationships with community partners to collect and analyze data with and from those communities (Hill, Pace, & Robbins, 2010; Huynh & Roysircar, 2006; Roysircar, Colvin, Afolayan, Thompson, & Robertson, 2017).

Scholars have conceptualized the phenomenon of lateral violence—an interpersonal consequence of internalized oppression—whereby targets who are unable to challenge oppressive systems displace destructive feelings and actions onto a member of his or her own or another marginalized social group (Maracle, 1996). Research is needed to better understand the precise links between internalized oppression and expressions of lateral violence. With regard to studies on refugee and immigrant mental health, most focus on specialist services like inpatient care and do not address the whole range of service sectors where mental healthcare is provided. There is also very limited information on the help-seeking and service utilization of refugee and immigrant children. Research is also needed on how refugees and immigrants can be impacted psychologically by the lack of recognition of their skill level (e.g., formerly they may have been doctors, educators, or executives in their first culture), and how unhealthy psychosocial and physical environments accompanying low-skill jobs negatively affect refugee well-being. Another area of research could be on how inequalities in exposure to environmental contaminants (e.g., lead, poor sanitation, air pollutants, crowded and unhygienic living conditions) can have long-term mental and health consequences for farm laborers, refugees, and immigrants. Exposure to environmental contaminants can even impact intergenerational lines.

Integrated Healthcare

Increased focus should be placed on the integrative aspects of healthcare, including the interface between mental and physical health services (Reiss-Brennan, Brunisholz, Dredge et al., 2016). Doing so may further serve to increase access to care and destigmatize seeking mental healthcare among racial and ethnic minority, refugee, immigrant, and less privileged populations. From a meta-analytic perspective, such research should be dynamically focused on the multiple arenas of healthcare and service delivery, including: access to and awareness of healthcare options, utilization of such options, responsiveness to cultural diversity with regard to healthcare missions, immigrant/refugee perceptions of the quality of obtainable healthcare options, and healthcare treatment outcomes for marginalized status individuals. Most studies have either exclusively focused on physical healthcare services (e.g., Calvo & Hawkins, 2015; Avila & Bramlett, 2013; Alang, McCreedy, & McAlpine, 2015; Kan, Choi, & Davis, 2016) or on mental healthcare services (e.g., Chong, Lee, & Victorino, 2014; Rousseau, Measham, & Nadeau,

2013), but not the integration of the two, as is becoming commonplace in a variety of community health centers, outpatient practices, and hospitals. Such a focus would help bridge the gap between physical health disparities and mental health disparities for immigrants, refugees, and working class people while also aiding in our consideration of stigma around mental health disorders.

Comparative Research

The majority of the existing literature on immigrant mental healthcare focuses exclusively on target minority groups and within-group differences (Li & Seidman, 2010; Huang, Calzada, Cheng, & Brotman, 2012; Roberts, Mann, & Montgomery, 2015; Tsai & Thompson, 2013). Comparative studies that include marginalized and dominant groups might be utilized to better understand the disparities in mental healthcare between non-mainstream and mainstream help-seeking individuals. Similar studies have been conducted in international settings (e.g., Hollander, Bruce, Burstrom, & Ekblad, 2011), and findings showed disparities by race or immigrant/refugee status as well as by gender, age, socioeconomic status, and community support.

Recommendations for Consultation and Training

Addressing stigma is central to increasing healthcare utilization by marginalized groups. Stigma can be addressed through public talks on mental health, community health fairs and screenings, and by films and discussions in community settings, including by individuals who have mental disorders and have benefited from treatment. Underutilization of treatment services warrants education and consultation with psychologists on language matching, affordability, and location. Matching refugees and immigrants with providers of the same race or cultural background is possibly an advantage, but such matching also limits accessibility. Therefore, psychologists receiving education and training in a particular mental health problem, such as, refugee trauma and on the treatment of refugee trauma, comprise cultural competence training.

Awareness of one's privilege is critical for providing culturally competent care. A psychologist consulting with a group that is having interpersonal difficulties can facilitate discussions about the effects of a structurally-imposed disparity, such as socio-economic status or social class. Similarly, such discussions can facilitate consciousness of how group dynamics may reflect power dynamics in the larger society (Roysircar, 2008). Psychologists can help minority individuals in work groups find their voice, create cross-group relationships, and gain equity in resource allocations, in addition to experiencing equality.

Additionally, issues relating to human rights such as torture are not generally addressed in graduate programs (<http://www.nepsy.com/articles/leading-stories/graduate-programs-fail-to-address-torture-issue>). Similarly, trainees need to take on the ethical issues of psychologists working in potentially coercive settings, such as places of incarceration. Conversations about fairness and justice need to commence during training and supervision.

Returning to the issue of accessibility, advances in technology have led to an increase in ways for individuals to receive consultation. For individuals who have mobility difficulties, distance help can be very beneficial. If these individuals cannot physically go to an office, it is

possible for them to talk with a telehealth professional via phone, email, videoconferencing, or mobile applications. Other benefits of this type of service include access to service in a native language, increased access to those unable to leave their homes (individuals with agoraphobia), and increased access to specialists for those who live in a remote geographic area (APA, 2016). Although this type of consultation lacks the personal element of face-to-face treatment, having telehealth as an option provides access to certain populations that might otherwise be unable to benefit from healthcare services. However, poverty can limit the ability to access technological resources that are costly.

Recommendations for Engagement in Social Justice

It is argued that necessary action of psychologists extends beyond in-session treatment to a balanced recognition of client presentations due to systemic disparities and unique individual characteristics of a client. Therefore, per the values and goals of social justice, when psychologists do not address structural disparities, the role and purpose of therapy cannot be described as wholly inclusive or beneficial. In regards to the current political and social climate in the United States, there is a re-emergence of particular conservative cultural trends in upholding self-sufficiency, 'gate-watching,' and exclusion of non-mainstream societies, which undermine psychologists' concerns for oppressions, marginalization, inequity, underutilization, inequality of care, and culturally informed practice. Likewise, it becomes a responsibility of psychologists to work in a preventative capacity as educators for the prevention of mental disorders, better treatment options and accessibility. Such work also demands continuous reassessment of current social and political climate and consideration of minority and immigrant mental healthcare, which this review seeks to address. In such a way, psychologists are able to better serve the populations under their care and pursue treatment with social responsibility.

Implications for Social Justice Psychologists' Involvement in Public Policy

All people, including racial, ethnic, linguistic, and LGBTQ+ minorities, prison inmates, immigrants and refugees, the poor, and people with disabilities have a right to equitable treatment, allocation of societal resources, and decision-making. Thus, "citizen psychologists" understand power differentials, power dynamics, and privilege lying at the core of U.S. culture and their impact on societal structures (laws, policies, government) and institutionalized forms of oppression (inaccessibility, inequity). Psychologists promote advocacy beyond the direct support of clients to include influencing public policy decisions, advancing human welfare services and public health, participating in systems of care, doing training/education/consultation and research, and getting funding to affect the well-being of the public at large. Utilizing advocacy's systems perspective creates a socially responsive voice for marginalized populations. Being involved in public policy strengthens the voice and presence of psychology in the public domain. Specific recommendations for psychologists role in applying research to shape public policy include: learning to be strategic, including identifying who the stakeholders and decision-makers are; identifying information gaps that exist and the best way to communicate what needs to be known; evaluating the effectiveness and costs of existing programs and also developing programs to address key public health issues; and developing relationships with policy-makers so that progress can be made (Maton, 2016). Additionally, it should be noted that shaping public policy on key issues related to disparity is a complex and multifaceted process and this requires commitment and resilience in psychologists.

Conclusion

Psychologists actively aspire to address structural inequalities. They resist the temptation to view symptom etiology only from an individualized stance, which might invalidate clients' experiences in their respective contexts, neglect to identify contextual data, and/or blame clients for their plight. By incorporating contextual factors, psychologists are likely to obtain a comprehensive understanding of clients' concerns. There are several constructs that shaped our understanding of disparities in the legal and mental healthcare systems. First, individuals experience privilege and oppression in their identity statuses in intersecting ways, which provide for both complex barriers to community resources as well as accumulated individual strengths that result from several overlapping identities. Second, psychologists are expected to provide culturally-informed interventions as well as advocate for policies that optimize access and equality of treatment in immigrant mental healthcare and reduce differential rates of incarceration by race, ethnicity, income, gender identity, disability, or language proficiency. Third, psychologists' advocacy through multicultural competence training, social justice engagement, and public-policy-making is essential for the removal of structural and cultural stigmas that impede accessibility, utilization, and equitable participation in systems of care. Stigmas about mental health can come from the dominant society's biased views of marginalized groups, from the cultures of racial and ethnic minority societies, and from an individual's internalization of both societies' stigmas. Disparities due to various systemic processes can be addressed with education/consultation for both providers and marginalized communities, legal advocacy, and culture-centered evidence-based practice.

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