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Depression and Utilization of Mental Health Services Among BIPOC (Black Indigenous People
of Color) Communities in the United States

Briana DiMartino

SENIOR PROJECT

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Abstract

Members of BIPOC (Black Indigenous People of Color) communities living in the United States, whether American born or immigrants, are subjected to various stressors that can impact their mental health, including but not limited to: acculturative stress, discrimination and microaggressions. These factors substantially increase the prevalence of depressive symptoms within this community. In addition to the unique group of stressors that minoritized populations face, oftentimes, these individuals encounter barriers when accessing care and do not receive the same quality of care as a Caucasian American does, especially for mental health care. The aim of this thesis is to review relevant literature on stressors that minoritized populations encounter on a daily basis and explore the relationship between these stressors and the prevalence of depression in this population. In addition, experiential learning information on this topic was collected from few mental health professionals of color. This paper will highlight challenges/barriers to access care, experience of racism and utilization of services (traditional/alternative) to address their mental health issues including depression and other stresses. Finally, this paper will explore emerging themes across literature and practitioners' perspectives to understand various challenges, strengths and needs of these communities at large.

Keywords: depression, coping, BIPOC, minoritized communities

Depression and Utilization of Mental Health Services Among BIPOC Communities in the United States

As one of the most prevalent mood disorders in the United States and around the world, depression is a debilitating disorder that is increasing at a drastic rate and “is projected to become the second leading cause of disability within the next 20 years” (Mereish et al., 2016). Being characterized by “continuous sadness, loss of interest, insomnia, lack of appetite, feelings of guilt, and sometimes suicidal ideation” (Harman, 2017), depression greatly impacts one’s ability to function at their normal capacity in their daily activities, such as at school, work or during personal events. Although depression exists among all ethnicities, members of ethnically minoritized communities pose a much higher risk of developing depression due to the unique stressors they encounter living in the United States, as well as stressors they may have endured during the immigration process if they were foreign born.

Theoretical Perspectives

In this section, relevant psychological theories will be briefly discussed to help us understand the existing challenges and barriers among BIPOC communities. These perspectives will also address important psychosocial determinants of mental health risks among these groups.

Minority stress theory: Mental health issues among minoritized groups are related to their experience of ongoing social stressors, stigmas and discrimination compared to their non-minority counterparts (Everett et al., 2016).

Cultural Assimilation theory: Increased stressors and loss of personal identity that can occur when an immigrant experiences the contact between their new culture and their

native culture. Immigrants tend to adopt this process while relocating to a new country (Jagers & MacNeil, 2015).

Silencing the self: Mostly prevalent in women, this theory suggests that social inequality and societal gender norms can directly affect one's thoughts and behaviors and increase risk in developing depression and other mental health disorders as the individual is expected to put others before themselves and conform to oppressive behavior, which can "reinforce negative self-perception, lower self-esteem and result in feelings of a loss of self" (Grant et al., 2011). This theory can be seen in cultures in which women strictly hold traditional roles, such as caring for the kids and household, while the men are the providers for the family.

Multidimensional conceptualization of racism-related stress: The accumulated stress that results from everyday racially discriminatory interactions between an individual and their environment that threatens the individual's well-being (Hoggard et al., 2019).

Biopsychosocial model of racism: The exaggerated physiological and psychological responses that result from experiencing frequent racial discrimination that can limit "access to resources, opportunities for growth, and social mobility which, in turn, can further contribute to poorer mental health and well-being" (Hoggard et al., 2019).

Immigrant paradox: Despite that foreign born individuals typically experience higher levels of stressors that would predispose them to mental health issues, such as poverty and lower social status, it has been found that immigrants have lower rates of mental health disorders than BIPOC individuals that are US born (Lau et al., 2013). This

approach has acknowledged the resilience and strength in adaptation of challenges across various immigrants' groups.

As priorly mentioned, these theories will facilitate our insight into mental health risks and coping styles across immigrants and individuals of BIPOC backgrounds. The following section will cover a review of recent research studies to expand our understanding of various correlates of specific mental health issues among these minoritized groups.

Rationale

As a Caucasian woman, I was inclined to do this research as I have witnessed a lack of diversity throughout my studies in psychology. I have read numerous academic articles that tend to be white-washed and do not take into consideration the unique triumphs and challenges of working with BIPOC communities. As someone who has spent years working and studying in ethnically diverse communities, and hearing the stories of individuals of color, I understand that these individuals have unique needs that cannot be addressed using the “one size fits all” methods that have been developed for Caucasians in both psychology and primary care settings. As an experiential learning opportunity, I asked members of my personal social network about their experiences as a member of an ethnically minoritized community and how their ethnicity has had an impact on their experiences. Based on my prior research, I had expected that individuals who did not identify as Caucasian would report that they experienced more challenges in their school settings, workplace settings and personal life. My experiences from my social network solidified my interest to further evaluate existing literature in this topic in healthcare settings. The recently modified term “minoritized” will be used interchangeably as in past literature the term “minority” was mostly used.

Background

In general, minoritized communities experience increased amounts of stressors that predispose them to developing depressive disorders. Although different ethnicities encounter different stressors, which will be discussed at a later point in the literature review section, there are many common stressors that mostly all BIPOC individuals deal with, such as adaptive and acculturative stressors, the influence of their native culture, historical impacts, discrimination and access to effective, quality healthcare.

Adaptive and acculturative stressors are very common among individuals who have immigrated to the United States and must learn and adapt to aspects of American culture, which may be quite different from their own culture. Acculturation, which can be defined as the “continuous firsthand contact between different cultures, resulting in changes in the cultural patterns in one or both groups” (Jagers & MacNeil, 2015) can impact an individual's use of their native language, their support system, their family structure and more, which can directly cause an impact and loss of one's identity and increase their stress levels and discomfort. In general, immigrants also tend to live at lower socioeconomic statuses (SES) possibly due to their inability to speak fluent English and/or the expense endured during the immigration process, which can cause additional stress as their living situation is uncertain. Furthermore, the age of immigration can greatly affect one's ability to adapt to a new culture. For instance, while those who immigrate as adults experience great amounts of stress due to the factors listed above, they do also have an established identity rooted in their native culture that can act as a protective factor against some of the stressors they encounter. On the other hand, those who immigrate as children are disadvantaged because they do not yet have an established identity and instead “the transition into a different country is negotiating the two cultural systems that are each imposing

themselves on them” (Jaggers & MacNeil, 2015) and therefore shaping the child’s values, beliefs and culture, resulting in less innate protective factors. A child growing up between two cultures, that of the United States and of their native country, may develop traits of American culture that are much different than the traits of their parents, which in turn can cause familial tension and lead to parental disapproval and additional stress. In addition to children who migrate to the United States at a young age, these specific stressors are also applicable to the first-generation, U.S. born children of immigrants who once again are stuck between two cultures. Surprisingly, although immigration is generally associated with increased stress levels and lower SES status, “epidemiologic data indicate that immigrants have lower prevalence levels of psychiatric disorders relative to their U.S.-born counterparts” (Lau et al., 2013), which is known as the Immigrant Paradox Theory and supports the unique risk of first-generation, U.S. born children of immigrants.

The cultural beliefs of one’s native culture may also be a source of stress if their cultural beliefs do not align with those of Americans. One common example of this is the concept of collectivist societies versus individualistic societies. The United States is well-known as an individualistic culture, in which everyone works towards furthering their own personal interests. Many other cultures, such as Latin American and Asian cultures, are collectivist in nature and tend to prioritize the community over an individual. Due to the large waves of immigration to the United States over the past few decades, many cultural communities have formed, such as “China Town” or “Little Havana”, in which many immigrants of the same culture have settled together, which has counteracted the effects of the clash of collectivist and individualistic mannerisms. While this is true for some immigrants, not all immigrants have the ability to move to an area that is populated with other immigrants of their culture and must face losing their

family and friends, which functioned as their support systems, and adapt to fending for themselves instead of being able to rely on their communities in times of need. Being apart from one's cultural community can also impact their ability to participate in cultural events and traditions, which can have detrimental impacts on their identity and increase depressive symptoms (Harman, 2017). Another aspect of culture that can cause a major clash in adapting to the American culture is the individual culture's interpretation of gender roles. For instance, some Latin American cultures are known for *machismo*, in which the men are expected to provide for their families and appear strong and masculine, while the women have more traditional roles, such as caring for the home and the children. Living in the United States, women of these cultures may be expected to perform roles that are much different from those of their native cultures which could present a problem as the women may “defer to the needs of others, censor self-expression, repress anger, judge the self against an ideal, and inhibit self-directed action” (Grant et al., 2011), known as the self-silencing theory. The expectation to conform to American culture poses unique risks and challenges for immigrants, increasing their stress levels and therefore their potential of developing a depressive disorder.

When considering the challenges that immigrants face when coming to the United States, it is essential to take into consideration the impact of the history between America and the native country of the immigrant. For example, many African Americans “largely trace their original ancestry in the United States to antebellum slavery” (Mereish et al., 2016). Needless to say, the history of African slavery in the United States is deplorable and by no means justifiable, yet it has unfortunately shaped the beliefs of some Americans by creating an idea of white superiority and in turn, black inferiority. While many Americans do support and fight for their African American counterparts, there is still a large number of Americans who have not learned from our

history and are racist against African Americans, both in conscious and subconscious ways.

According to Mereish et al. (2016), “African American men have a longer history in the United States and exposure to racism; thus, discrimination may be internalized and consequently more deleterious to their self-esteem”. While African Americans are just one community with a complex history in the United States, many other cultures also have complex histories with the United States. The elevated levels of exposure to racism in the United States for these cultures dramatically increases stress levels and negatively impacts the individual's overall health, which can directly cause an increase in depressive symptoms.

In the United States, one of the major challenges that individuals of BIPOC communities encounter are the disproportionately high levels of racism and discrimination. Discrimination is harmful to one's overall health in many ways; in addition to feeling unsafe and unwelcome in their country, individuals who are frequently discriminated against may not be able to cope effectively which “may lead to negative self-evaluations, with future implications for compromised social development or well-being” (Everett et al., 2016). Ethnic and racial discrimination can take many forms, such as racist remarks, exclusion from certain activities or positions based on the way one identifies, or one of the most common forms, microaggressions. Microaggressions, known as “brief and commonplace daily verbal, behavioral or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults towards people of color” (Sue et al., 2007 as cited in Nadal et al., 2013), can be especially harmful as they occur very frequently and oftentimes the person initiating the microaggression is unaware of the harm of their statements or actions that are rooted in stereotypes or assumptions, which in turn can cause serious emotional distress to the recipient of the microaggression. Common examples of microaggressions, some of which might

occur completely subconsciously to the enactor, include crossing the street if an individual sees an African American man walking towards them despite the man acting completely ordinary or complementing a person of Asian descent on their ability to speak English, even though the enactor does not know the person's origins. It is having been supported in literature that “perceived racial discrimination negatively affects one’s mental health” and that specifically, “people of color experience a great amount of psychological distress in reaction to the accumulation of microaggressions in their lives” (Nadal et al., 2013). Frequent discrimination, regardless of the form it takes, acts as a catalyst for people of color in developing poorer health, reduced self-worth and self-esteem, and depressive symptomology.

As mentioned, individuals of ethnically minoritized BIPOC communities face unique stressors, such as the acculturation process, maintaining and expanding their cultural identity, the impacts of history, and multiple forms of discrimination, all which act to collectively increase their predisposition and risk of developing depressive disorders. Further complicating this situation, ethnically minoritized individuals have far less access to care, especially specialty mental health services, and of those who do receive care, “there are statistically significant racial/ethnic differences in the quality of care as a whole” (Alegría et al., 2008), which is especially prevalent for African Americans versus non-Latino whites. BIPOC individuals face both logistical and cultural barriers when it comes to finding care for their conditions. Previous research finds that many immigrants and people of color tend to have lower SES when compared to Caucasians, which in turn creates logistical barriers to accessing care such as the inability to take time off from work to visit a provider, possible lack of insurance coverage, inability to pay for a copay and much more. While these logistical concerns are a barrier to finding care, for those who actually receive care, many report dissatisfactions in the quality of their care due to

the lack of cultural sensitivity of their providers. Oftentimes, patients may have difficulty relating to providers that are from a different racial/ethnic background than they are due to potential language barriers and also because many cultures have different views on healthcare, especially in terms of mental health. Many “immigrant and non-English proficient patients in primary care do not tend to access or use specialty mental health services” (Fortuna et al., 2010) due to cultural stigmatization of mental health conditions and their cultural preference to use nontraditional forms of treatment, which opposes the standard U.S. practices of mental health treatment that may include medication and/or therapy. It is also important to note that some American providers may have difficulty diagnosing BIPOC individuals as symptomology can vary greatly across cultures, which can further delay the patient's ability to feel better and increase their distrust in not only the provider, but also the U.S. healthcare system in general.

Review of Literature

This paper will present brief summaries of research articles to provide information about mental health risks, challenges, adaption and triumph of immigrants and ethnic minoritized U.S. born individuals such as Latinx, Asian, Black (African & Caribbean descent), Indigenous or Native American groups and those with multiracial/multiethnic backgrounds.

In the article “Disparity in depression treatment among racial and ethnic minority populations in the United States” (Alegría et al., 2008), authors examined the relationship between ethnicity/race and the type and quality of care received for treatment of depression. The study used a representative sample recruited from nationally-represented surveys such as NLAAS, NSAL and NCS-R, and included participants from the Latinx, Asian American, African American and Black (Caribbean descent) communities. The results of the surveys were later assessed using the World Health Organization Composite International Diagnostic

Interview (WMH-CIDI) in order to evaluate if the participants had been diagnosed with any psychiatric disorder or subthreshold depressive disorder (known as minor depressive disorder), which resulted in the categorization of participants into five specific groups: “ [1] currently depressed respondents, who meet criteria for last year diagnosis of major depression or dysthymia (n = 1,082); [2] current sub-threshold respondents, but who do not meet criteria for last year diagnosis of major depression or dysthymia (n = 158); [3] lifetime depressed respondents, who meet criteria for lifetime major depression or dysthymia, but who do not meet criteria for last year depression or dysthymia (n = 1,230); [4] respondents meeting last year criteria for disorders other than depression (n = 919); and [5] the no-need group, which consists of respondents who did not meet last year criteria for any of psychiatric or substance abuse disorder assessed (n = 7,680)” (Alegría et al., 2008). Regardless of the categorization of the participant, the participant was asked to complete a survey regarding the mental health treatments that they had received in the past year and any medications they had been prescribed for emotional or cognitive impairments or for substance abuse. After statistically adjusting the minority individuals to have the same non-Latino white distributions for factors such as social class, poverty, education, and insurance coverage, shocking and significant findings were revealed. Starting with rates of depression, racial/ethnic minorities were found to have lower rates of depression when compared with non-Latino whites. Despite this finding, for individuals of ethnic or racial minorities who were diagnosed with a depressive disorder, many did not access any mental health treatment ($p < 0.001$) and they were also substantially less likely to receive quality care ($p < 0.001$). The results of this study highlight the disparities of mental health care that exist for ethnically minoritized BIPOC individuals. Some of these disparities might be explained by different depressive symptomatology among different ethnicities that may result in

misdiagnoses, delay or inability to seek services due to economic factors such as lack of insurance coverages or employment benefits and mistrust of providers from different ethnic backgrounds. Suggestions for future research include researching alternative, culturally sensitive, depression treatments and implementing policy changes to increase mental health resources.

Similarly, “Retention in depression treatment among ethnic and racial minority groups in the United States” (Fortuna et al., 2010) also addressed the access and quality of care of depression treatments for ethnically minoritized BIPOC groups. Past literature has described certain barriers that may prevent ethnically minoritized groups from staying in treatments for depression, such as “unfulfilled treatment expectations, less likelihood of obtaining specialty mental health care, lack of ethnic/racial matching between patient and provider, cultural mistrust of the mental health system, and inadequacy of services provided to ethnic minorities” (Fortuna et al., 2010). Pursuing an approach that addressed both patient and provider related factors that can affect treatment retention, this study collected data from the Collaborative Psychiatric Epidemiology Surveys (CPES) resulting in a sample of Latinx (n=2,554), Asian Americans (n=2,095), African Americans (n=3,570) and Black (Caribbean Descent) (n=1,621) participants. Eligibility criteria for this study included: “(1) having a past 12-months depressive disorders defined as meeting Diagnostic and Statistical Manual of Mental Disorders, Version 4 (DSM-IV) and (2) reporting at least one formal mental health visit during the previous year or the respondent reporting that they had dropped out of care in the last 12 months” (Fortuna et al., 2016). Participants were asked to complete sociodemographic surveys to provide information about their racial/ethnic identities, as well as information to other factors such as gender, age, education, marital status, poverty level and English language proficiency. Furthermore,

participants then were asked questions about the care they received in regards to their mental illness, such as the satisfaction of their care, if they were prescribed medication and which professionals they sought care from. The researchers then assessed for retention by seeing if the participants attended at least four formal mental health care appointments in the past year or at least one formal visit in the past year but is still seeking care. Results of this study highlighted various sociodemographic factors in racial/ethnic differences relating to treatment retention. The two characteristics that are significantly different were the sector of care treated and prescribed medication. Having seen a mental health specialist and having been prescribed medication in the past 12 months are both significant and positively associated. All groups who received care only from general healthcare providers resulted with least amount of depression treatment retention. While treatment from general providers was the biggest reason for premature treatment termination, other reasons participants did not stay engaged with their programs included believing the mental illness would heal itself, having different racial or ethnic backgrounds than providers, lack of English language proficiency and inadequate health insurance coverage. Further research should investigate ways to make culturally sensitive treatment programs for depression in both primary and specialty mental health care, with a particular focus for African-Americans, as they are the group that was found to be particularly at risk for the early termination of mental health care treatment services.

The next article, “Effects of minority status and perceived mental health” (Everett et al., 2016) explored the ways that one’s self-reported discriminatory experiences affected their mental health. Using the minority stress theory, which states that individuals pertaining to any minority group are exposed to more stressors which in turn has a negative impact on their mental health and well-being, the researchers identified impacts of perceived discrimination on perceived

stress, depressive symptoms and anxiety (Everett et al., 2016). This study also aimed to examine the impact of frequent discrimination and victimization, coping mechanisms and protective factors that helped reduce the negative effects of perceived discrimination on one's mental health. Using 92.5% of the original sample from the Waves I and IV of the National Longitudinal Study of Adolescent to Adult Health, the final sample for this study was composed of 14,609 individuals ranging in age from 24-34 years old. Participants were screened using questions that measured daily discriminatory interactions (opposed to one-time major events), the CES-D depression scale, a reverse coded questionnaire regarding stressful life situations that occurred over the past 30 days and administered an anxious personality scale. The findings showed that 24% of the participants who reported experiencing discrimination exhibited a greater level of depressive symptoms, perceived stress, and anxiety. Furthermore, Black (not specified between African American or Caribbean descent) and Latinx reported belonging to multiple minoritized groups, such as being both ethnically minoritized and having greater rates of obesity. These results support the detrimental effect of perceived discrimination on stress levels and depressive symptomatology regardless of minority status. However, those who reported more frequent discrimination were less impacted potentially due to the usage of adaptive coping strategies. Thus, more in-depth studies need to examine both within-group and between-group differences relating to variation in mental health issues and other correlates across minoritized groups.

In another study (Grant et al., 2009) on women from BIPOC communities, the close link between Depressive symptoms and self-silencing behavior was observed. As previously mentioned, self-silencing theory proposes that certain women may be more vulnerable to depression due to the normalization of their social inequalities and gender role expectations of

their culture. For this study, 223 ethnically diverse low-income women who abused substances during their pregnancies were recruited from the Parent-Child Assistance Program (PCAP). The eligibility criteria for the women in study included: “(1) were pregnant or up to 6 months postpartum; (2) self-reported heavy alcohol and/or illicit drug use during the index pregnancy; (3) were ineffectively or not at all engaged with community social services; and (4) lived in or near one of four cities served by PCAP in Washington State (Seattle, Tacoma, Yakima, or Spokane)” (Grant et al., 2009). Participants were administered the Addiction Severity Index (ASI) during intake interviews to collect information about their demographic factors and risk indications, the Depressive Distress Score (DDS) to assess depressive symptomatology over the previous 30 days, and the Silencing the Self Scale (STSS), a 31 item self-reported questionnaire to assess the participants level of self-silencing. The results of this study revealed a striking significant positive correlation between depressive distress and STSS scores; for every one-point increase in the participants STSS score, the researchers saw a 3% increase in the participants’ depressive distress. Moreover, statistical analyses revealed significant ethnic group differences regarding both depressive distress and self-silencing scores. The data collected from this study suggests that certain ethnic groups are at a higher risk of self-silencing and therefore, are more vulnerable to developing depressive disorders. Future research needs to examine self-silencing behavior as major risk factors for depression among specific minoritized groups.

Thus, ethnic minoritized groups are at higher risks for mental health disorders, such as depression due to many adverse social determinants including loss of status, poverty, challenges in terms of access to quality healthcare and discriminatory treatment across settings. The following section will cover literature on factors associated with depressive symptoms and care across specific ethnic communities.

Latinx/Latin American Community

When working with the Latinx community, there are unique cultural considerations that providers should be aware of when diagnosing and treating depression for these individuals. The article “Depression in Hispanic adults who immigrated as youth: Results from the National Latino and Asian American Study” (Jagers & MacNeil, 2015), dissects the impacts of the immigration process in the Latinx community in regards to the person's age of immigration. In general, there are various stressors associated with the immigration process, such as the acculturation process, the changes to one's social identity, familial impacts, social status, potential discrimination and more, all of which are stressors that can aggregate and lead to the development of depressive disorders. Previous literature has found that “although Hispanic immigrants are less likely to suffer from a mental illness than their U.S.-born Hispanic counterparts, longer residence in the United States increases the lifetime prevalence of mental illness” (Jagers & MacNeil, 2015), suggesting that Latinx immigrants who immigrated at a younger age are at higher risks of developing chronic depression or experiencing a major depressive episode (MDE). In this study, researchers conducted a secondary analysis of data that was originally collected from the National Latino and Asian American Study (NLAAS). The sample for the secondary analysis consisted of a total of 581 Latinx participants, all of whom migrated to the United States before age seventeen. Multiple measures were used to assess the impact of the immigration process on the participants including: a language proficiency scale for both English and Spanish, an eight-item acculturative stress scale, a five-item dissonant acculturation scale (cultural/intergenerational conflict between participants and their families), a three-item ethnic social identity measure, a ten-item family cohesion scale, a two-item subjective social status scale, a nine-item discrimination scale and a thirty-four item depressive symptom

checklist. According to the results of the data analysis, “variables found to be significantly different between younger migrants (those migrating by age twelve) and older migrants (those migrating between ages thirteen and seventeen) include acculturation, acculturative stress, perceived social status, and discrimination” (Jagers & MacNeil, 2015) and resulted in the emergence of two important themes when considering the impact of the immigration process for Latinx individuals: the importance of family and the stress of the acculturation process. Specifically, in regards to the individuals who migrated at younger ages, it was found that these individuals experienced higher levels of conflict with their family members in terms of their cultural values and beliefs. In most Latinx cultures, family is of utmost importance and oftentimes, the term family also includes the person's nuclear family, extended family, close friends, etc., therefore, conflict with family members can be extremely harmful and can appear as increased symptoms of depression. Furthermore, the more acculturative stress the participant experienced, the more dissonant acculturation and familial issues they encountered, which also acted as a catalyst for developing a depressive disorder or experiencing a MDE. The results of logistical regressions indicated that Latinx female immigrants were more likely to suffer from depression than the male Latinx immigrants. This may be due to multiple factors including cultural adaptation stress, gender role, access to resources and support, perceived discrimination and sociopolitical climate which contribute towards development of mental health disorders. It is necessary for clinicians, educators and family members to identify and address these health risks among latinx immigrants across generations to prevent and provide adequate services to address depression.

Asian/Asian American Community

The article “The immigrant paradox among Asian American women: are disparities in the burden of depression and anxiety paradoxical or explicable?” (Lau et al., 2013) examined lower levels of psychiatric disorders among foreign born immigrants compared to their U.S.-born counterparts. Using data extracted from the NLAAS, the sample for this study consisted of a total of 1,030 Asian American females, in which 18% (185) were U.S. born and 82% (845) were foreign-born and the largest ethnic groups represented were Chinese (28.80%), Filipino (24.70%) and Vietnamese (25.00%). During interviews administered in English, Mandarin, Cantonese, Tagalog or Vietnamese, participants were assessed using multiple measures, including the WMH-CIDI to assess prevalence of lifetime psychiatric disorders, a five-item cultural conflict survey, questionnaires about family cohesion, conflict and support, a nine-item discrimination scale, a single item social status measure and finally a demographic factors survey. The results of this study supported previous literature indicating that the time spent in the U.S. is positively correlated with developing mental health issues. The U.S. born Asian women had higher lifetime prevalence of depression and anxiety disorders (17.89% and 12.13%, respectively) compared to immigrant Asian women who immigrated before 25 years old (10.75% and 10.46%) as well as others who immigrated after 25 years old (5.53% and 7.02%). The possible explanations for the immigrant paradox include that “immigrant Asians have been described as hardy, exhibiting high internal locus of control, reporting mastery over previous stressors, and exhibiting lower reactivity to subsequent stressful experiences” (Lau et al., 2013). However, this theory was not supported as no nativity differences were reported in testing the reactivity of both the Asian immigrants and U.S.-born Asian women. However, the findings clearly indicated that U.S. born Asian women are exposed to a different set of stressors

throughout their lives, such as increased levels of discrimination, higher levels of family conflict and lower levels of family cohesion, all of which are factors that are associated with higher levels of depression and anxiety. Overall, this article provides insight as to how nativity differences in Asian American women may impact their risks for psychiatric disorders, such as depression, due to the different risk and protective factors that are prevalent among the U.S. born Asian women compared to immigrant Asian women. Thus, educators, providers and researchers must consider generation/culture-specific values and adaptation patterns across Asian immigrants and/or Asian Americans to identify both potential stressors and protective factors to facilitate effective preventative and treatment approaches for their wellbeing.

Black (African or Caribbean descent)/African American Community

In recent years, greater awareness and advocacy (Black Lives Matter and others) programs have called for serious attention towards addressing health risks and major mental illnesses among African Americans or Black individuals (e.g., African or Caribbean descent). The impact of generational trauma, victimization, criminalization and injustice towards Black people in the United States has been noticed through an increased rate of physical and psychiatric disorders. The article “Discrimination and depressive symptoms among Black American men: Moderated-mediation effects of ethnicity and self-esteem” (Mereish et al., 2016) examined the relationship between discrimination, self-esteem and depression among Black American men. This article highlights the lack of adequate treatment for depression and the detrimental consequences on their lives. Additionally, this article notes that “Although Black American men share similar experiences of anti-Black racism overall, ethnicity contributes to distinct differences in sociocultural socialization and practices, cultural histories, languages, and

values among these men" (Mereish et al., 2016). While it has been found that the Afro-Caribbean subgroup of Black Americans is the most at risk for developing mood disorders, risk for mood disorders for Black Americans is also directly related to time spent in the United States with greater exposure experience of discrimination. The data for this study was collected from the Inter-University Consortium for Political and Social Research and secondary analyses were collected from the National Survey of American Life (NSAL), resulting in an overall sample that included 1,271 African American males and 562 Afro-Caribbean American males. Using face-to-face interviews with providers of the same ethnic backgrounds, participants were assessed using a ten-item measure of everyday perceived discrimination, a ten-item Rosenberg Self-Esteem Scale, a twelve-item version of the Center for Epidemiological Studies Depression Scale and a one-item measure to assess for nativity status. The statistical analyses clearly showed the close link between everyday discrimination and depressive symptoms for all Black American men, regardless of their specific ethnicity. Additionally, self-esteem did function as a mediating factor between discrimination and depressive symptoms with poorer levels of self-esteem indicating greater depressive symptoms following experience of discrimination. For the Afro-Caribbean men, the membership to their ethnic group functioned as a protective factor against discrimination and therefore, their self-esteem was not impacted. It is also important to note that the majority of the Afro-Caribbean participants in this study were foreign born and had spent less than 11 years in the country, making it difficult to compare them to African American men sample who were majority (97.3%) U.S. born and have greater exposure to racial discrimination. Future research should examine both risks and protective factors to examine the impacts of discrimination/racism on self-esteem and mental health issues across immigrants and U.S. born African American men.

Another study, “Racial discrimination, personal growth initiative, and African American men’s depressive symptomatology: a moderate mediation model” (Hoggard et al., 2019) also investigated the relationship between racial discrimination and depressive symptoms for African American men. Using two theoretical frameworks previously mentioned, the multidimensional conceptualization of racism-related stress and the biopsychosocial model of racism, this study explored personal growth initiative (PGI), “defined as a set of cognitive and behavioral skills used to actively and intentionally improve one’s self across life domains and achieve life fulfillment” (Hoggard et al., 2019), as a mediating factor of discrimination and depressive symptoms opposed to self-esteem. In total 649 African American men were recruited from barber shops, academic institutions, and at a conference for African American male law enforcement professionals. Patients were administered a twelve-item version of the CES-D scale to assess depressive symptoms, an eighteen-item Daily Life Experience (DLS) scale to assess for racial discrimination or microaggressions, a nine-item PGI scale, and a sociodemographic questionnaire. Like the previous study, the results of this study found a positive association between racial discrimination and depressive symptoms after controlling for covariates. However, the study also found that “racial discrimination was inversely associated with PGI, which, in turn, was associated with greater depressive symptomatology” suggesting that “that racial discrimination may thwart African American men’s opportunities for social mobility and personal growth, regardless of their age, personal resources (i.e., income), and socioeconomic goal pursuits (i.e., education)” (Hoggard et al., 2019). Thus, these findings further elaborate the roles of clinicians, educators and researchers to understand the complex dynamics of depressive symptomatology and various social determinants such as discrimination and victimization as intergenerational/racial trauma that can create crippling devastation in all aspects of life among

Blacks in this country. Moreover, future studies need to explore culturally sensitive community-based approaches to develop prevention and intervention programs to foster growth and well-being among Black communities at large.

Native American/Indigenous Community

While ethnic minoritized communities are at higher risk for developing depressive disorders for various reasons, including having lower socioeconomic levels, increased discrimination and acculturative stressors, we need to identify cultural identities or traditions that serve as protective factors for their mental health and well-being. The article “The interaction of culture, self-perception, and depression in Native American youth” (Harman, 2017), analyzes the impact of group belonging and traditions on depressive symptoms for the Native American population. A total of 132 Native American students between ages 13-19 were recruited from their high school in Northern Michigan, which was located near a Native American reservation. During their homeroom classes, students were administered surveys that consisted of eighty-six questions divided into the following categories: depression, self-esteem, suicide attempt history, participation in cultural activities, perceived discrimination, cultural values, ethnic identity, cultural socialization, self-criticism, and demographic questions. The results of the study revealed that many of the Native American youth frequently encountered perceived discrimination, which was found to have a significant correlation with cultural socialization. Additionally, in comparison to Whites, Native Americans were significantly more likely to have attempted suicide and present with major depressive symptoms. Surprisingly, even though prior research has found that “belonging to a group helps individuals develop a sense of self, which can reduce depressive symptoms” (Harman, 2017), practicing cultural traditions, such as

attending, dancing at or playing drums at a Native American pow wow, did not have any protective effect on students, though the Native Americans did report higher levels of self-esteem when compared with Whites. It is important to note that a major limitation of this study is the small sample size. Further studies need to use a more representative sample to explore further protective factors against depression. Nevertheless, the information provided in this article seems extremely relevant for educators, clinicians and policy makers to support Native American groups for fostering health and well-being of their communities at large.

Multiethnic/Multiracial Community

Given the information obtained across above mentioned BIPOC groups, it is equally important to address mental health risks among individuals from multiethnic or multiracial backgrounds to explore the impact of microaggressions/discrimination relating to their multiracial heritage. The article “Microaggressions within families: experiences of multiracial people” (Nadal et al., 2013) explores the unique challenges that multiethnic and multiracial folks experience and the impact of these challenges on their well-being by specifically looking at microaggressions, which are defined as “brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color” (Nadal et al., 2013). Past literature has indicated the experience of microaggressions among multiracial in five major categories, including: exclusion or isolation, exoticization and objectification, assumption of monoracial or mistaken identity, denial of multiracial reality and pathologizing of identity and experiences. Additionally, many of these individuals reported that many microaggressions occurred within their own families, resulting in increased isolation from not only peers and community members, but also one's personal support system. For this study, a qualitative

secondary analysis was conducted using a data set from a previous study conducted by the main research investigators. A total of nine participants, eight of which were women and one man, who all identified as multiethnic or multiracial and ranged in age from 19 to 34 years old were arranged into three focus groups in which they each filled out demographic forms and then were asked: “(1) What types of microaggressions do multiracial individuals experience in their families?, (2) How do multiracial individuals react to the microaggressions that they experience within their families [note: in this context, families referred to both nuclear and extended families]” (Nadal et al., 2013). The findings of this study indicated that “racial microaggressions that occur within families may either (a) be more pervasive in the lives of multiracial people or (b) have more of a salient or significant influence on multiracial people's mental health and identity” (Nadal et al., 2013). Multiethnic and multiracial individuals have frequent experiences of microaggressions, face increased isolation, identity crisis and inadequate support systems which are detrimental towards their physical/psychological health. Moreover, they are exposed to various social challenges in terms of labelling, lack of acceptance and subsequent uncertainty or confusion surrounding their identity. Future studies are necessary to examine the experience of multiethnic or multiracial individuals to obtain better insight into prevalence of depression and other mental health issues. Furthermore, this information will certainly facilitate educators and clinicians to provide adequate services and support for individuals and families of multiethnic or multiracial descent.

Experiential Learning

To gain additional insight into this topic, three ethnically minoritized mental health providers were interviewed and asked to share their experiences and suggestions regarding

working with members of ethnically minoritized BIPOC community members. In addition, these providers gave information about specific service strategies, challenges and needs of these communities. Many common themes emerged from the providers' responses regarding working with individuals of ethnically minoritized communities. The following section describes ethnically diverse providers' (Latinx & Asian backgrounds) input concerning their knowledge and professional experience (see Appendix A for list of interview questions).

Starting off with the Latinx community, two Latinx providers who, respectively, work with mostly Latinx patients, shared their experiences. The first provider, who asked to remain anonymous, described herself as cisgender woman, bilingual (English/Spanish), mid-career clinician from Mexico. She is currently working as a full time out-patient clinician and in private practice a specialization in trauma/family work. She mostly works with adult Latinx women and teenagers. A theme that emerged multiple times from this interview is in regards to culturally sensitive care. Working with immigrants, as well as U.S. born Latinx people, this provider explains how being a Latina, having familiarity with the culture and the ability to speak Spanish has created a sense of comfort and understanding for her patients, resulting in an environment that they feel safe disclosing information about their mental health. This provider noted that during the previous presidential administration, she “noticed intense fear, victimization and PTSD... they [her patients] feel isolated, invalidated, targeted and dehumanized in our society.” To add, this provider explains that while treatment of course varies depending on the patient and their condition, generally she uses a supportive/relational therapy approach, which is a type of psychotherapy that considers social factors, such as one's culture, to examine the issue the patient is experiencing and the appropriate treatment. She finds that this approach works best especially for newer immigrants to the U.S. and sometimes for clients that are born and raised in

the U.S. as well, though the clients born in the U.S. also tend to be responsive to more traditional, evidence-based treatments as well. Overall, this provider emphasized that, “providers' respect, kindness and support are more important than their knowledge/status/skills. All providers must genuinely understand the racism experience of these groups whether they provide individual/group/family services.” The information shared by this provider further supports the literature review in saying that ethnically minoritized individuals, such as the Latinx population, experience unique and constantly changing factors that need to be considered to adequately treat these populations for mood disorders, such as depression.

Furthermore, information was gathered from another female bilingual Latinx provider (Spanish/English) Latina of Puerto Rican origin and a postdoctoral fellow specializing in trauma work at a community health center (Cambridge Health Alliance) the greater Boston area. While this provider has experience working with a diverse range of ages, she currently works mostly with adult Latinx patients, both immigrant and U.S.-born, and about 15% of her clients are non-Latino White U.S. born adults. In terms of providing treatment for these patients, this provider emphasized the need for a person-centered treatment approach that takes into account systematic factors that control the patient’s reality. The provider emphasized that immigrants must face both the logistical (e.g., legal status, resources, working multiple jobs, etc.) and socially dynamic factors (e.g., changes to one's identity, acculturation, have family in the U.S. and native country to provide for, etc.) which exacerbates their role as an immigrant and causes the need for provider flexibility to give the clients usable skills that guide them through their uncontrollable and unchangeable realities. Additionally, she noted that both immigrants and people who live in lower SES statuses usually have limited knowledge about therapy, so it is essential to explain theoretical frameworks and insight to what happens during therapy to create

a comfortable environment in which the client feels comfortable disclosing personal information. To add, due to the political climate and the rise of anti-immigrant hatred over the past few years, the provider has noted an intense shift in her clients who now present with immense fears and frequently experience being victims of discrimination and harassment in all realms of their lives. She also notes that currently, the disparities that exist for mental health treatments in the United States are already out of hand, yet are still getting worse as many people hold the assumption that BIPOC individuals do not deserve the long-term, dynamic dream work/fantasies/unconscious motives therapies as they need more direct solutions for their stressors and are only granted the limited resources they can afford through their insurance (e.g., 6 sessions for MassHealth). The experiences shared by this provider further highlight the points raised in the academic literature regarding disparities in health care and inadequate treatment among Latinx and minoritized/immigrant communities.

Finally, responses were collected from a cisgender female Asian provider who is working as a full-time clinician at the community health center along with her part-time teaching position in MA. She is a bilingual (English/Vietnamese) clinician works with clients of diverse Asian backgrounds including Vietnamese. She specializes in family therapy and like the Latinx providers, she indicated current challenges relating to pandemic which certainly have increased anxiety, depression and stress symptoms among her clients. Moreover, the Anti-Asian hate crimes, racial discrimination and targeting this group as carriers of the virus have added to their stresses and mental health issues. While this provider cited that her language skills are helpful for her Vietnamese patients, she shared her difficulties with clients of other Asian descent due to language barriers. Overall, like the Latinx providers, this provider cited the importance of engaging in culturally sensitive therapies for their patients opposed to the traditional U.S.

evidence-based therapies. For instance, this provider cites that “talking about religious practices, use of traditional herbs, healing practices etc.” is more important if that is what the patient shares with them and that “clinicians do not need to know everything as relationship matters the most”. She also emphasized that many Asian clients exhibit physical symptoms such as headaches, pain or issues with sleeping or eating, instead of the typical mental health symptomatology, which needs to be understood by non-Asian providers. In addition, some Asian clients are not comfortable disclosing their family issues as talk therapy and mental health issues are considered shameful in their culture. Especially when working with diverse communities, this provider highlights the need to not generalize patients and to consult with providers who are familiar with the clients’ cultural values for effective service. Thus, both Asian and Latinx providers have shared similar perspectives on culturally appropriate/quality care for immigrants of minoritized backgrounds. Moreover, it is important to refer to the response by the Asian provider here “it is not techniques rather building trust, respect and understanding Anti-Asian issues experienced by many Asians now.” Overall, the information provided by all these providers, further underscore the need for use of culturally sensitive treatments for clients and to address the impact of sociopolitical climate on their mental health issues including depression.

Barriers/Access to care

Most clients from BIPOC backgrounds have extremely disproportionate levels in access to health care services, especially for mental health services compared to their White counterparts. Many immigrants and ethnic minoritized individuals frequently have major barriers such as lack of language proficiency, lower socioeconomic statuses, long working hours, lack of insurance coverage, transportation, unfamiliarity with mental health services, less access to bilingual providers, childcare challenges and others (Alegría et al., 2008). In addition to

structural barriers, these individuals frequently do not receive satisfactory treatment for their conditions due to the other cultural barriers and lack of access to providers familiar with their cultural values, culturally sensitive treatment and/or providers from similar ethnic/racial backgrounds (Fortuna et al, 2010). Furthermore, providers have been trained to recognize depressive symptomatology/etiology as it appears in U.S. born Whites, which may distinctly differ across BIPOC communities. Furthermore, providers must also recognize culture-specific stigma, symptom presentation, discomfort in sharing openly issues concerning their mental health struggles, shame, family conflicts, racial marginalization experiences which pose added challenges to these groups. These issues were highlighted by providers in earlier sections. For instance, Asian patients present relatively more physical symptoms while suffering from mental health problems including major depression, leading to frequent misdiagnoses and ineffective treatments. This paper will briefly address the usage of traditional and non-traditional treatment approaches across BIPOC groups below.

Evidence Based Treatment

As can be seen through the experiential learning process interviews with providers, there are many cases in which evidence based-treatment (EBT) is not effective for patients that are members of BIPOC communities. As defined by the American Psychological Association (2005), the purpose of EBT “is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention.” As EBT has been supported by scientific evidence and has been proven to be successful through scientific research, it is the recommended and one of the most common treatments for psychological disorders, including major depression,

in the United States. Depending on the presenting condition of the client, oftentimes paired with EBT is the use of evidence-based medications (EBM) that similar to EBT, have been proven to be effective through scientific literature. While EBT may be functional to people who are born and raised in the United States, for immigrants and most ethnically minoritized individuals, regardless of nativity status, EBT is not beneficial to them as it fails to account for their cultural views and stigmas regarding mental health, as well as the unfamiliarity of talk therapy and use of medication as treatment. However, adoption of culturally appropriate evidence-based treatment is in progress to reduce barriers and facilitate care for BIPOC communities.

Non-traditional Culturally Responsive Treatment

In recent years, literature on healthcare across BIPOC consumers have indicated the effective use of indigenous/non-traditional intervention across various psychological disorders. This includes spiritual prayers, yoga, reiki, massage, culturally appropriate healing, chiropractic, acupuncture, herbal treatment meditation and others to address mental health issues. Moreover, mental health issues like depression could be addressed in a culturally sensitive manner using Culturally Responsive Therapy or Treatment. In addition to analyzing the client's cultural identity and preferences, "This approach seeks ways to explain and adapt techniques so that they make sense from the client's perspective. Such adaptation validates the client's experiences, which in turn can encourage the client to consider the need for change, resulting in overall greater therapeutic effectiveness" (American Psychological Association, 2016). This approach has been also suggested by our clinicians as mentioned in earlier sections as it builds trust in provider-client relationships, reduces unnecessary barriers, stigmas, and thus ensures effective treatment for these clients. Other examples of non-traditional, Culturally Responsive Treatments for members of BIPOC communities could include integration and encouragement for service

modality conducive to clients' cultures, such as religious practices, use of alternative treatments as mentioned earlier. Overall, the focus of this treatment is to create a comforting environment for the client and facilitate utilization of their cultural beliefs along with traditional intervention.

Discussion

Given the findings from research literature and providers' perspective, it is clear that ethnically minoritized BIPOC individuals experience disproportionate levels of stress in comparison to those of non-Latino White counterparts. Certain stressors that are apparent for ethnically minoritized individuals include acculturative stressors, family cohesion, discrimination and racism, to name a few, though many members of these communities also experience different stressors that are specific to their cultural and ethnic heritage. While some groups may have protective factors across psychological (e.g., self-esteem, PGI, resilience), sociocultural (e.g., social support, access to services, resources) contexts, many individuals from these minoritized groups are still predisposed to mental health risks including major depression along with other comorbid conditions. In essence, the current rise of the pandemic, unemployment, lack of resources has added more challenges and increased levels of health disparities across BIPOC communities. There is an urgent need for interprofessional collaboration, integrative service approach and innovative healthcare strategies to promote well-being of our communities at large.

Conclusions

Though there is a large amount of existing literature regarding immigrants and ethnically minoritized BIPOC individuals, their mental health, and treatment programs, there is still a lack of research regarding culturally sensitive treatments that can be utilized to better treat these

patients through understanding their cultural context and perspective. To add, it is important to note that not all ethnicities will respond to a single, culturally responsive treatment, so instead, future research should focus on designing a culturally sensitive treatment plan that can be easily adapted to fit all patients' diverse needs.

Another important topic that needs to be addressed is how to reduce the disparities in access to care for individuals of ethnically minoritized communities. As mentioned, prior, ethnically minoritized individuals are much less likely to see specialized mental healthcare providers, and do not receive adequate treatment from their primary care physicians. Possible ways to address this discrepancy would be to implicate policy changes and instituting wide-spread, low cost or free healthcare programs to all individuals living in the United States and to also increase the amount of bilingual health care and mental health care providers.

Overall, as the population of the United States has been becoming increasingly diverse, and we are enduring hardships such as the COVID-19 pandemic, the U.S.-Mexican border humanitarian crisis, and the attacks that caused the Black Lives Matter movement, now more than ever we need to support immigrants and members of ethnically minoritized communities and provide them with the mental health care support they need.

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Appendix A

Experiential learning Interview Questions for providers

In addition to providing information about their current positions and areas of specialization, all of the providers were asked the following questions:

1. Please describe your experience working with people of racial/ethnic groups in terms of needs and challenges? Can you share if BIPOC clients prefer any specific services (intervention modality) or strategies (medical care, community care etc.)? Have you noticed any differences among groups? Please give specific examples.
2. In your experience, working with clients concerning depressive symptoms, do you recommend specific services that are more useful for specific racial/ethnic groups? What are the challenges that you have noticed working with particular racial/ethnic groups and what suggestion would you like to provide for other providers? Provide examples.
3. Please provide any additional comments regarding working with BIPOC groups and their current needs/challenges.