AMERICAN PSYCHOLOGICAL ASSOCIATION

Psychological Science and Immigration Today

APA TASK FORCE ON IMMIGRATION AND HEALTH

AUGUST 2024

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AMERICAN PSYCHOLOGICAL ASSOCIATION

Psychological Science and Immigration Today

APPROVED BY APA COUNCIL OF REPRESENTATIVES, AUGUST 2024

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EXECUTIVE SUMMARY

This report updates the 2012 American Psychological Association (APA) report, *Crossroads: The Psychology of Immigration in the New Century*. Part 1 describes changes to the context of immigration in the United States since the seminal *Crossroads* report, reviewing trends in the foreign-born population in the United States, including countries of origin, legal statuses, and the social, political, and cultural context of their reception.

Part 2 begins with a brief historical review of the discriminatory immigration policies in the United States before segueing to address recent innovative advances in relevant psychological science and conceptual approaches since the *Crossroads* report. Authors pay particular attention to areas that have dominated the last decade of scholarship related to immigrant health in the United States, namely, the socioecological model, intersectionality, a population health framework, social and cultural determinants of health lenses, decolonial and liberation approaches, attachment theory, and trauma scholarship. They incorporate individual, communal, and societal factors, stressing how these intersecting levels of analysis impact immigrant health.

Part 3 applies this updated science to the current state of and future goals for psychological practice, research, training, and advocacy with immigrants, devoting significant attention to the importance of working directly with immigrant populations to ensure needs are accurately understood and collaboratively addressed. Service provision recommendations include developing a diverse, culturally competent workforce and providing wraparound care in convenient locations; research recommendations include emphasizing cultural humility and implementing innovative, decolonized research design; education recommendations include incentivizing immigrant-background psychologists and advancing culturally relevant knowledge in trainees; and advocacy recommendations include promoting immigrant-friendly policies and supporting funding for community-based participatory research.

Finally, Part 4 closes with broad, forward-looking conclusions to guide APA and our profession more broadly in the changing immigrant context.

POSITIONALITY STATEMENT

We offer a collective positionality statement to provide a picture of the composition of the Task Force in terms of representation and ethos. The Task Force consists of researchers, clinicians, educators, and advocates who, in diverse roles, have worked closely with immigrant communities. Notably, all twelve Task Force members have close personal experiences with immigration, as either children of immigrants or immigrants ourselves with diverse immigration statuses. Task Force members or their parents migrated to the United States via diverse pathways and mechanisms. Our origins come from across the globe, such that the Task Force includes Asian, Latin American, Caribbean, Middle Eastern, European, and other geographic, racial, and ethnic identities. Collectively, we represent first-generation college graduates and individuals from diverse socioeconomic, religious/spiritual, gender, and sexual identities. We currently reside across various geographic regions of the United States, particularly those where most immigrants live. The Task Force members also represent diverse professional backgrounds and include early, mid-career, and senior members, including a member of the Task Force that published the original 2012 American Psychological Association (APA) *Crossroads* report.

As immigrants, children of immigrants, parents, friends, and allies to immigrants, Task Force members also advocate for humane, science-based immigration policies. They represent the socio-political zeitgeist of immigrant-serving professionals working during the last three decades and recognize the inherent bias and privilege in their shared voice. The work of this Task Force involved writing and editing in small and large groups to ensure varied perspectives were represented in the report. We invited and valued one another's collective expertise based on decades of directly working with immigrant communities, all undergirded by a collaborative and culturally welcoming work environment in which members committed to critical self-reflection and cultural humility. We acknowledge that the Task Force does not and cannot represent the full range of diverse immigrant experiences.

Values Underlying the Work of the Task Force

For professionals and organizations engaged with immigrant communities, ethical considerations are critical. At the broadest level, the *APA Code of Ethics* (2017a) emphasizes the need to respect and protect civil and human rights and the importance of freedom of inquiry and expression (APA, 2017a). This report acknowledges that identity is shaped across different contexts and times by multiple cultural and contextual influences, including age, generation, sex, gender, sexual orientation, gender identity and expression, ethnicity, race, religion, spirituality, language, social class, education, employment, ability status, national origin, immigration status, and both historical and ongoing experiences of marginalization. The report follows the APA Multicultural Guidelines (APA, 2017b) and takes a social justice perspective within a human rights framework.

A social justice perspective involves recognizing and addressing inequalities, biases, and systemic barriers that impact marginalized or disadvantaged groups within society. It requires a commitment to fairness, equity, and the promotion of human rights for all individuals, irrespective of their intersectional identities. A social justice perspective seeks to dismantle harmful structures, policies, and practices perpetuating inequities, discrimination and oppression. It involves amplifying marginalized voices and advocating for change, interventions, and policies that rectify systemic injustices. Social justice goes beyond acknowledging disparities and entails active engagement toward systemic change to transform societal norms and structures to ensure equity and inclusion (Vasquez, 2012).

A human rights framework provides a set of principles, standards, and values that serve as a foundation for promoting and protecting the inherent dignity and rights of all individuals. Rooted in international law and treaties developed and agreed upon by the global community over decades, this framework asserts that every person is entitled to fundamental rights and freedoms without discrimination. It encompasses civil, political, economic, social, and cultural rights, recognizing that these rights are interdependent and indivisible. The framework emphasizes the universality, inalienability, and indivisibility of human rights, meaning they apply to all people universally, cannot be taken away, and are interconnected, requiring equal attention and protection. Human rights frameworks provide a normative basis for holding governments, institutions, and individuals accountable for respecting, protecting, and fulfilling the rights of individuals. They can serve as a guiding framework for advocacy, policymaking, and legal systems worldwide, aiming to create societies that uphold the dignity, equality, justice, and well-being of all individuals (APA, 2021a).

PSYCHOLOGICAL SCIENCE AND IMMIGRATION TODAY

Since the release of *Crossroads: The Psychology of Immigration in the New Century* report in 2012, the immigration landscape in the United States (U.S.) has undergone significant changes. These shifts have influenced scholarly research, which now explores immigrant health through innovative perspectives such as intersectionality, population health, social determinants of health (SDOH), attachment theory, decolonial and liberation psychology and trauma-informed approaches. Despite the ever-evolving nature of scientific knowledge in this field, psychological research is gradually converging on key conclusions about immigrant health, which carry substantial implications for the future.

The 2024 Presidential Task Force on Immigration and Health was appointed to focus on the U.S. immigration and health context, reflected in its membership, topics addressed, and literature reviewed. This scope was intended to facilitate coverage of the broad, heterogeneous immigration scholarship in the United States, resulting in recommendations targeted to the U.S. context. However, the Task Force believes that much of the information and many of the recommendations put forth may be transferable to varied global contexts. Additionally, though the report does not focus explicitly on refugees (see definition below in the Immigrant Legal Status section), many immigrants are also refugees and are therefore featured in much of the scholarship reviewed.

Intended Audience

The report is intended primarily for psychologists, including practitioners, scientists, educators, and advocates. However, other audiences may also find the report useful, including allied health professionals, students, educational institutions, policymakers, and community organizations, all of whom could benefit from the scientific information in the report.

Setting the Stage

The United States is home to more immigrants than any other country worldwide (Batalova, 2024). According to the International Organization for Migration, "immigrant" may be defined as "from the perspective of the country of arrival, a person who moves into a country other than that of his or her nationality or usual residence, so that the country of destination effectively becomes his or her new country of usual residence" (International Organization for Migration, n.d.). Global conditions have continued to drive growth in the number of people who have had to leave their countries of origin—the population of immigrants has reached 281 million globally (International Organization for Migration, 2023). By 2060, it is predicted that approximately one in five U.S. residents will be an immigrant (U.S. Census Bureau, 2020), reflecting rapid changes in the composition of the immigrant population

and the context in which immigration occurs. The children and grandchildren of immigrants often have deep connections to and unique impacts from their immigrant origins, further increasing the number of individuals impacted by immigration in the United States. Many immigrants today are also connected to their transnational and diasporic communities. This ongoing evolution of U.S. demographics introduces many opportunities for psychologists to support, engage with, and empower newcomers to meet their highest potential.

There is no single immigrant story, and highlighting the heterogeneity in immigrant experiences is critical. This report covers recent scholarship on immigrant health, focusing heavily on published work featuring health risks among immigrants who find themselves fleeing adversity in their home countries and facing continued difficulties like poverty, discrimination, and legal struggles after migration. This is not the experience of all migrants, however, as immigration patterns and experiences differ widely. Some immigrants arrive as refugees, with known refugee status prior to entry, whereas others enter on visas sponsored by large employers or educational institutions, and still others enter with no legal status in hopes of seeking asylum. Some immigrants migrate once and settle, long term, in the United States, whereas others migrate and settle briefly in multiple countries or return to their home country. For some, returning home is forced due to immigration laws; for others, it has always been their ultimate goal. Not all immigrants are exposed to traumatic events, and not all will experience ill health. Still, the published literature indicates that refugees, asylum seekers, and undocumented immigrants, among other groups, experience particular vulnerability to traumatic events and health risks. Their experiences are highlighted in Part III of this report.

Immigrants, as all people, deserve the highest attainable standard of physical and mental health (International Covenant on Economic, Social, and Cultural Rights, 1976). Moreover, it is in the national interest to support the health of immigrants as research shows that immigration is beneficial to host countries, including the United States, contributing to economic, cultural, and social growth. Economically, immigrants often drive innovation and productivity, as evidence from immigrant entrepreneurs suggests (Lee et al., 2023). Moreover, immigrants bring diverse skills, experiences, and perspectives, fostering a more dynamic workforce. Immigrants can bolster the economy by stimulating local economies, starting businesses, creating jobs, enhancing productivity, increasing consumer spending, and contributing to overall economic growth (Bansak et al., 2021). Culturally, immigration enriches the social fabric of a country by fostering diversity and multiculturalism. Immigrants bring their traditions, languages, cuisines, arts, and customs, contributing to the vibrant tapestry of a nation's cultural landscape. This cultural exchange promotes understanding, tolerance, and appreciation for different perspectives and backgrounds (Portes & Rumbaut, 2014). Cultural diversity resulting from immigration can enhance creativity, problem-solving abilities, and innovation within societies (Cooke & Kemeny, 2017). Exposure to diverse cultures can lead to increased cultural awareness and empathy among the population, enriching social interactions and promoting a more inclusive society. Socially, immigration often contributes to demographic revitalization and can help mitigate population aging and resulting problems in countries with declining birth rates as immigrants participate in the workforce, pay taxes, and contribute to social welfare systems (Parker et al., 2018; Lichter, 2012). They also infuse communities with new ideas and energy, revitalizing neighborhoods and supporting local services. Studies have highlighted that immigration can positively impact social cohesion by fostering cross-cultural connections and promoting social integration, ultimately contributing to stronger and more resilient communities (Portes & Rumbaut, 2014).

Immigration-Related Public Policies

Immigration policies shape the environments in which immigrants live and may sustain structural barriers that yield social, economic, educational, and health disparities and inequities. Immigration policies encompass multiple sectors, including law enforcement, health care, social welfare, education, employment, housing, and access to documentation needed for daily functioning (e.g., driver's licenses and identification cards), all of which influence social conditions that create differential access to resources and increase the risk for disparate outcomes (Garcini, Cadenas et al., 2022; Samari et al., 2021; Wallace et al., 2019).

Inclusive immigration policies protect and expand immigrant rights and facilitate access to resources and benefits (e.g., health care and education). Research shows that immigrants who live in U.S. states with more inclusive immigration policies (e.g., in-state tuition for undocumented immigrants, access to health care and health insurance, and driver's licenses regardless of immigration status) report better mental health outcomes than their

counterparts living elsewhere (Alberto et al., 2020; Hatzenbuehler et al., 2017; Vargas et al., 2017; Young & Wallace, 2019). Inclusive immigration policies foster environments where immigrants and their families can prosper by eliminating systemic barriers to health (e.g., education, housing, health care). In turn, breaking down systemic barriers facilitates opportunities for immigrant families to climb the social ladder and foster a sense of belongingness, which is crucial to their wellness (Garcini, Cadenas et al., 2022; Wallace et al., 2019; Young et al., 2019; Young & Wallace, 2019).

Anti-immigrant policies, in contrast, deny legal rights, deprive immigrants of eligible benefits, and support punitive enforcement. These policies create stressful environments for many immigrant groups; for example, international students being denied visas, and youth and families are particularly affected (Garcini, Domenech Rodríguez et al., 2023; Mercado et al., 2021; Mercado et al., 2022; Torres et al., 2018; Venta et al., 2022; Venta et al., 2023). Research shows that anti-immigrant policies are linked to racial/ethnic profiling, discrimination, distress, mistrust of health and government agencies, and diminished health outcomes among immigrants (Amuedo-Dorantes & Lopez, 2017; Armenta & Alvarez, 2017; Cruz Nichols et al., 2018; Galvan et al., 2022; Garcini, Domenech-Rodríguez et al., 2023; Hatzenbuehler et al., 2017; Lopez et al., 2017; Mercado et al., 2022; Vargas et al., 2017; Young et al., 2020). Avoidance of law enforcement due to discrimination and fear of deportation makes undocumented immigrants vulnerable to exploitation and crime, which in turn makes communities and society more dangerous (Evans & Hass, 2018). The consequences of expressed opposition or hostility to immigrants through real or perceived anti-immigrant policies and enforcement have a "spillover effect" that extends beyond immigrant populations and harms other community members of non-immigrant backgrounds (e.g., U.S.-born school peers, co-workers, neighbors, family members, friends; Aranda et al., 2014; Santos et al., 2021). Immigration policies also impact Indigenous Americans, as they are prevented from crossing externally created borders to participate in cultural events, visit religious sites, attend burials, or visit family (American Immigration Lawyers Association, 2023). Thus, immigration policies are a key driver of wellness and functioning among immigrants and nonimmigrants. The benefits that immigrants currently bring to the United States, including innovation and productive labor market participation, cultural enrichment, and social revitalization, are dependent on their health and well-being in this context of reception, so public policy that undermines their health and well-being ultimately hurts U.S. economic, cultural, and social growth.

Goals

The goals of the APA Immigrant Health Task Force are four-fold, each of which corresponds to a section of the report:

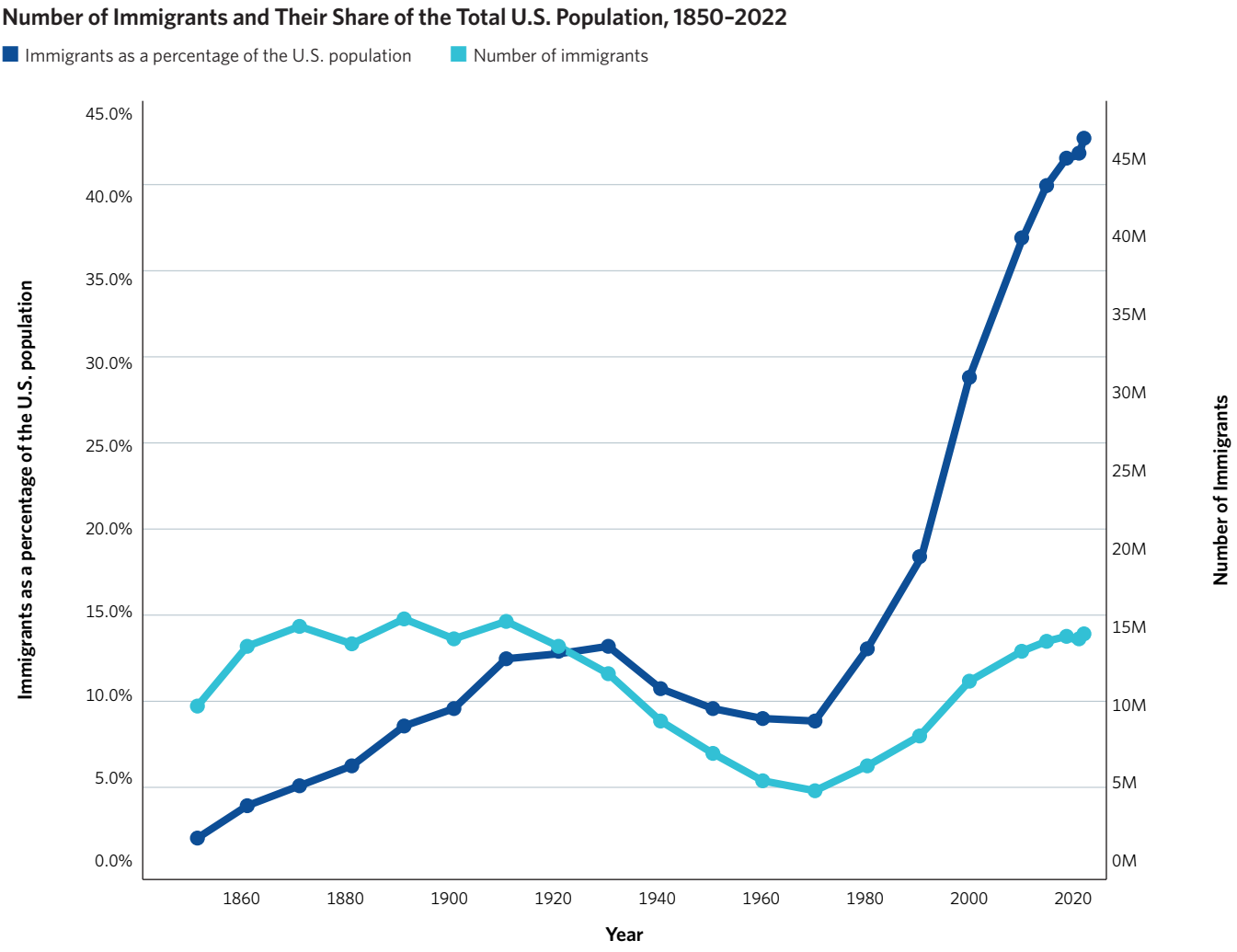
- First, the report describes changes to the context of immigration in the United States since the seminal 2012 *Crossroads* report (APA, 2012).
- Second, the report describes innovative advances in relevant psychological science and conceptual approaches since the *Crossroads* report.
- Third, the report describes the current state of and future goals for clinical practice, research, training, and advocacy with immigrants.
- Finally, the report closes with broad conclusions that will guide APA and our profession more broadly in the changing immigrant context.

PART I: CHANGE OF CONTEXT SINCE CROSSROADS: WHAT IS THE CURRENT CONTEXT OF IMMIGRATION IN THE UNITED STATES?

The U.S. foreign-born population consists of individuals living in the United States who were not U.S. citizens at birth (Congressional Research Service, 2023a). Today, the United States is home to approximately 46 million foreign-born people, representing about 14% of the total U.S. population and nearly a fifth of the world's immigrants (Congressional Research Service, 2023a). These estimates reflect a significant increase (see Figure 1) from the 40 million foreign-born individuals in the United States in 2012 at the time of the *Crossroads* report (Passel & Cohn, 2012, cited in APA, 2012). In 2021, more than one in seven U.S. households was headed by an immigrant (Cornelissen & Pack, 2023). The foreign-born population has increased across the United States (U.S. Census Bureau, 2019), with significant diversity in sociodemographic profiles, cultural backgrounds, and lived experiences (Congressional Budget Office, 2023).

FIGURE 1

Numbers and Percentages of Immigrants

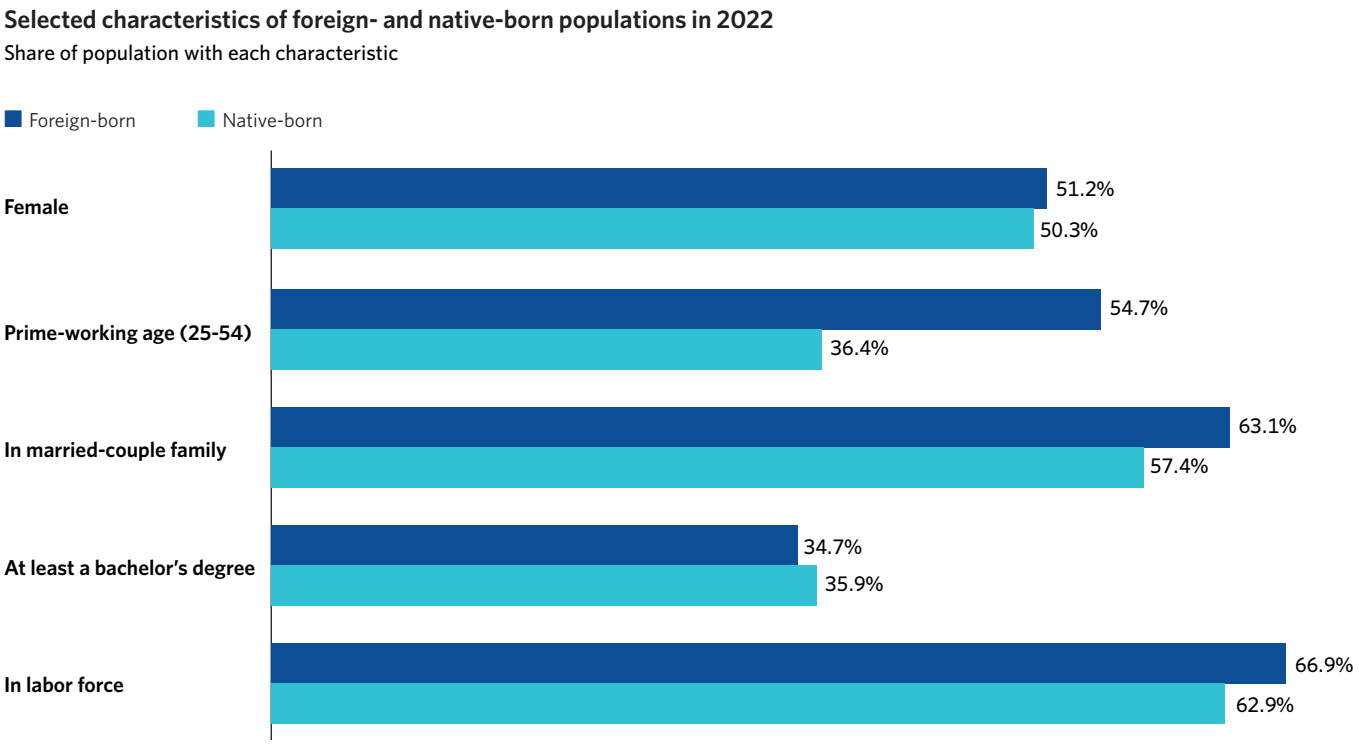


These statistics do not include second-generation immigrants born in the United States to foreign-born parents. One in four U.S.-born children currently have at least one immigrant parent (Batalova, 2024). If immigration decreases, the U.S. population is projected to decline by the next century (Schneider, 2023). Overall, the U.S. foreign-born population is relatively young compared to their U.S.-born counterparts (see Figure 2). More than half (55%) of foreign-born people in the United States are between ages 25 and 54; thus, immigrants in the United States are actively involved in the labor force and likely to marry and head families (USAFacts, 2023a).

Although immigrants of Mexican origin continue to represent the largest proportion of the U.S. foreign-born population (24.8%), changes in immigration policy are contributing to changes in migration flows that are diversifying the sociodemographic and cultural profiles of new arrivals (Statistica, 2023). U.S. immigrants have diverse cultural backgrounds, with the majority from Latin American countries (52.1%), followed by immigrants from Asia (31.1%), Europe (10.2%), Africa (6%), and Oceania (0.6%; Migration Policy Institute, 2023). Of the 4.5 million Black U.S. immigrants, 46% are from the Caribbean, with Jamaica (16%) and Haiti (15%) accounting for the most significant proportion of Black immigrants currently. However, African immigrants are the fastest-growing Black U.S. immigrant group (Migration Policy Institute, 2023).

FIGURE 2

Foreign-Born Demographic Characteristics



Data for those with at least a bachelor's degree count adults ages 25 and older. Data for those in the labor force counts people ages 16 and older.
Source: Census Bureau

New Immigrant Arrivals

Over the past decade, detrimental conditions in the sending countries (e.g., growing violence, crime, poverty), climate change, changes in U.S. immigration policy, and the COVID-19 pandemic have contributed to changes in the flow of new immigrants to the United States (USAFacts, 2023b). Although decreases in the number of immigrants coming to the United States were observed between 2016 and 2021, with arrivals reaching their lowest levels at the peak of the COVID-19 pandemic, this decline was followed by a rapid increase, with a new record high in 2022 (U.S. Census Bureau, 2022a).

Several trends are worth noting in the profiles of new immigrant arrivals. People from Asian countries made up the largest cohort of recent immigrants, closely followed by those from countries in North and Central America, as indicated in Figure 3. A rise in the number of immigrants from Cuba, Venezuela, Nicaragua, Colombia, Guatemala, Honduras, Peru, Ecuador, Haiti, El Salvador, Russia, India, Turkey, Brazil, China, and Romania, among others, is also observed (Isacson, 2022). Scholarship over the last five years has raised awareness of how these growing ethnic minority immigrant groups—like Iranian (Amini et al., 2022), Arab (Awad et al., 2020), Nigerian (Ekwemalor & Ezobele, 2020), Haitian (Fanfan et al., 2023), Ethiopian (Hall-Clifford et al., 2023), and Filipino (Sepulveda et al., 2021) immigrants have been excluded from the immigrant health literature, despite experiencing health disparities much like immigrants from the dominant sending countries.

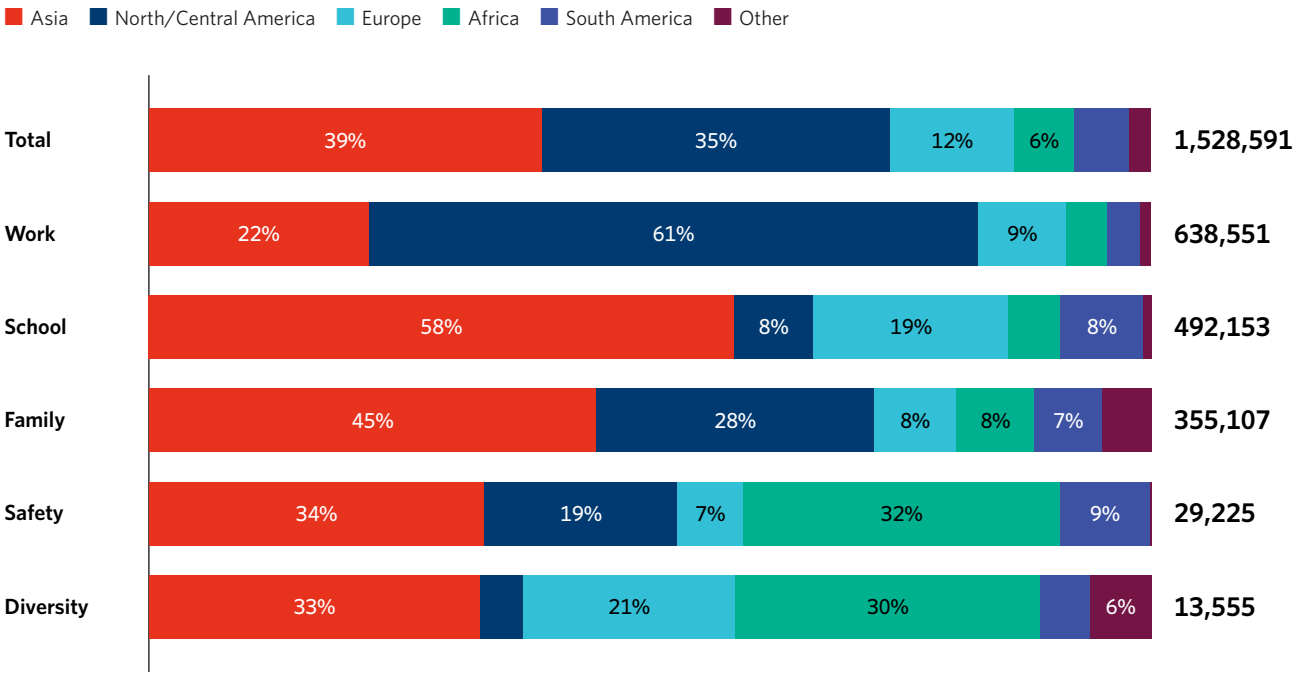
New immigrants increasingly arrive as families or unaccompanied youth rather than adult men traveling alone (Spagat, 2023). Migration of unaccompanied youth—people under the age of 18 who travel to the United States without a parent or adult family member—peaked in 2022 and has remained at record-high levels (Office of Refugee Resettlement, 2023). Since 2021, unaccompanied youth encounters at the U.S. border have consistently exceeded 8,500 per month (Congressional Research Service, 2023b). In many instances, unaccompanied youth are left in their home countries in early childhood by parents who migrate to the United States in search of safety or economic/employment opportunities. The youth, often in their late teens, then migrate, seeking to reunite with their parents (Silva et al., 2022). Reunited families face several stressors, including challenges navigating life together after long separations, trauma exposure among both parents and youth, ongoing immigration court proceedings, and serious mental health vulnerabilities (Cardoso et al., 2022). The empirical literature is also paying increased attention to the unique circumstances and vulnerabilities of immigrants fleeing their home countries and seeking asylum due to violence and discrimination associated with their sexual and gender identity (Shaw & Verghese, 2022). Recent scholarship has documented that LGBTQI+ immigrants face unique struggles that may include the absence of community and family support in their home countries and after migration, as well as negative mental health outcomes (Shaw & Verghese, 2022).

FIGURE 3

Country of Origin of Immigrants to the United States

People from Asia made up the largest cohort of newly arrived immigrants in 2021

New authorized immigrant arrivals by reason and region of origin, 2021



Data includes non-tourist visas, new arrival green cards, refugees, and asylees. Data for safety and diversity may sometimes be an underestimate as some countries' data is suppressed.

Source: US State Department

Immigration Legal Status

Immigrants arrive in the United States through varied pathways and with varied legal statuses (Garcini, Payan, & Cruz, 2023). As was the case at the time of the *Crossroads* report, immigration continues to be driven by family reunification, the search for work, and the need for humanitarian refuge (APA, 2012, p. 15), though the primary sending countries have changed over time (see Figure 3). The majority of foreign-born people in the United States (77%) are legal permanent residents (Budiman, 2020), and a little more than half (53%) are naturalized U.S. citizens. Refugees are a very small percentage of the U.S. foreign-born population; approximately 3.5 million have entered the United States since 1975 (USAFacts, 2023c). In the first eight months of 2023, a total of 31,800 refugees were resettled in the United States, and an additional 17,000 individuals were granted asylum while petitioning on U.S. soil (Migration Policy Institute, 2023). Recent refugee arrivals are diverse and come from countries on four continents, with the largest group coming from Africa (43%). This geographic trend represents a shift from 2012, when the largest groups were from the Middle East and South Asia (52%), with only 18% coming from Africa (Migration Policy Institute, 2023).[1] Figure 4 illustrates growth in the unauthorized immigrant population from Central and South America, Asia, Europe, the Middle East, Africa, and Canada from 2017 to 2021 and a decrease in that population from Mexico, indicating that many of the stereotyped views of unauthorized immigrant communities are outdated.

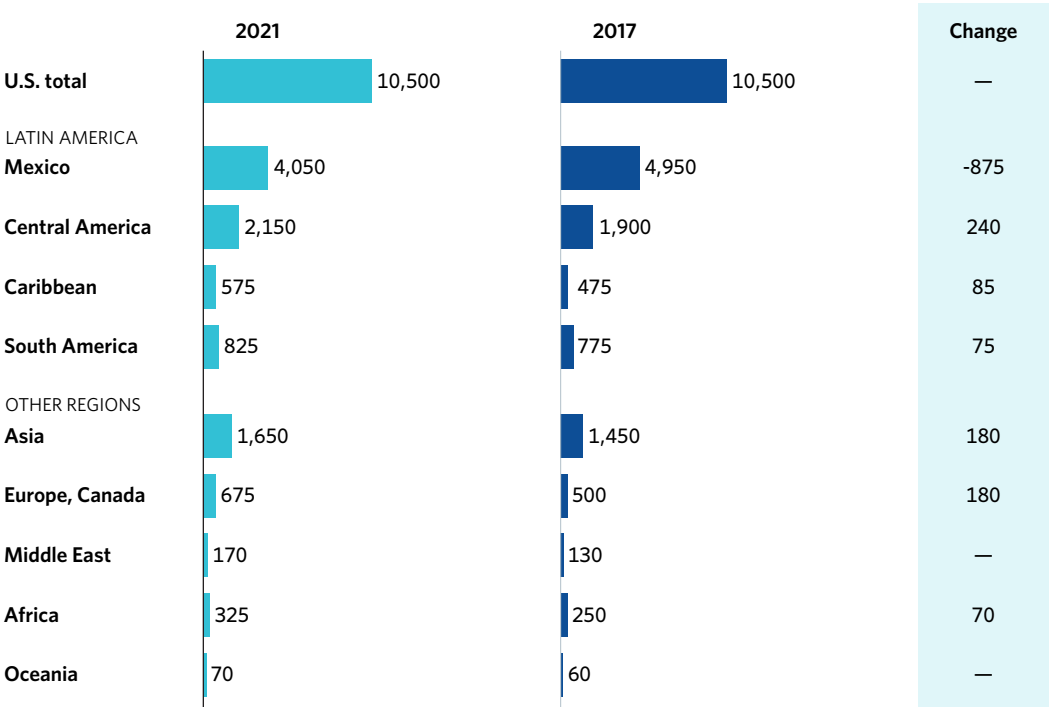
1 More detail on U.S. immigration categories is provided on the U.S. Department of Homeland Security website: https://www.dhs.gov/ohss/topics/immigration/lpr/classes-of-admission

FIGURE 4

Country of Origin of Unauthorized Immigrants to the United States

The U.S. unauthorized immigrant populations from most world regions grew from 2017 to 2021

U.S. unauthorized immigrant population by region of birth, in thousands



Note: All numbers are rounded. The change column is calculated from unrounded totals, giving a more accurate estimate than using rounded totals. Only statistically significant changes based on 90% confidence intervals are shown; other measured changes are not statistically different from zero. Asia consists of South and East Asia. All central Asian republics of the former Soviet Union are included in Europe. The Middle East consists of Southwest Asia and North Africa; Africa refers to sub-Saharan Africa. The U.S. total includes a residual (not shown) from other nations.
Source: Pew Research Center estimates based on augmented U.S. Census Bureau data.

The Refugee Act of 1980 considers the admission into the United States of people who are "pushed" out of their country of origin, having experienced persecution or a well-founded fear that forces them to seek protection in other countries (Office of Refugee Resettlement, 2012) and does not include immigrants fleeing due to economic necessity. Consistent with the United Nations High Commissioner for Refugees (1951) definition of a refugee, the persecution experienced by refugees is "for reasons of race, religion, nationality, membership of a particular social group or political opinion," which excludes migrants seeking refuge in the United States due to diffuse violence and instability in their countries of origin. Challenging economic, political, and humanitarian circumstances raise questions about this definition. For example, both economic "pull" and humanitarian "push" factors are at play in the plight of millions of people escaping extreme poverty and rampant violence in Central America, but most of these immigrants will not qualify as refugees. Immigrants who do not qualify for refugee status before arrival attempt to enter the United States without preauthorization. Some of these immigrants will seek asylum after entry, yet only approximately 9% will receive it (Congressional Research Service, 2024). Also, some immigrants who enter the United States legally will overstay their entry visa. Together, these groups comprise the large number of unauthorized migrants in the United States. Although data are inexact, recent estimates range between 10.3 to 11.4 million immigrants with unauthorized or undocumented status in the United States, approximately 23% to 26% of the U.S. foreign-born population (Congressional Research Service, 2023a). Importantly, many U.S. immigrant families are of mixed status, in which some family members are undocumented. The precarity of any family member's immigration legal status impacts all members of the family (Congressional Budget Office, 2023). As of 2019, approximately 6 million children, or roughly 7% of U.S. children, lived in a mixed-status family in which at least one parent has undocumented immigration status (Castaneda, 2019).

PART II: NEW PERSPECTIVES: THROUGH WHAT LENS TO VIEW PSYCHOLOGY AND IMMIGRATION TODAY?

Research and theory related to immigrant health have accelerated since *Crossroads* was published. A PubMed (comprehensive database on biomedical and life sciences literature) search shows exponential growth in articles indexed by "immigration" or "immigrant." At the time of *Crossroads, about 2,000 relevant articles per year were published on immigration, whereas in 2023,* there were nearly 3,000. This rapid growth in scholarly publication reflects expansions in theory and methodology related to immigration. While a scoping or systematic review is beyond the scope of this report, several frameworks and theoretical approaches to immigrant health research have dominated the last decade of scholarship, including the socioecological model, intersectionality, a population health framework, social and cultural determinants of health lenses, decolonial and liberation approaches, attachment theory, and trauma scholarship.

Historical Context: Hierarchy and Marginalization

As immigrant communities navigate U.S. immigration policies that shape their psychological experiences, they face a complex system of laws and processes. Policy scholars at the United Nations Research Institute for Social Development, among many others, point out that when the first U.S. immigration law was created in 1790, it led to inequitable practices, hierarchical systems, and conditions of disadvantage for immigrants, particularly people of color (Fredrickson, 2003). For instance, through quotas, preference categories, and immigration bans, U.S. policies have explicitly excluded immigrants from non-Western countries (e.g., China and countries in the Middle East, Africa, or Central and South America) for extended periods (Ngai, 2023). Furthermore, immigration enforcement to monitor and regulate immigrants within the United States has grown increasingly aggressive and stigmatizing (Goodman, 2020; Delgado, 2022; Santos et al., 2021).

Reflecting the historical context, over the past decade, historically marginalized U.S. immigrants have been portrayed as dangerous and a burden to the United States (Alamillo et al., 2019; Galindo Gómez, 2019). These stereotypes contribute to prejudice, discrimination, and marginalization, which are associated with diminished health, social, and economic outcomes for immigrant communities (Garcini et al., 2018). Indeed, research shows that discrimination fosters isolation, feelings of rejection and a sense of lack of belonging, even after years of living in the United States (Garcini et al., 2021). The harmful consequences of discrimination and marginalization are passed on to birth-right citizen children so that the experiences of hardship become a collective experience for immigrant families and communities over generations (Delgado, 2022).

However, despite a sharp rise of xenophobic rhetoric in the political arena (Samari et al., 2021), attitudes toward immigration remain relatively positive, with 68% of U.S. people perceiving immigration as "good" for the country (Saad, 2023). This aligns with global attitudes that view immigrants and their contributions as strengths (Pew Research Center, 2019). This positive view of immigration has remained constant since 2001, with pro-immigration attitudes peaking at 77% in 2020 (Gallup, 2023). Attitudes about immigration are also relevant for policy making. Although 70% of people in the United States are supportive of comprehensive policy reforms (Bernal, 2022), partisan polarization remains due to misinformation, disinformation, and demographic changes in the electorate (Abrajano et al., 2024; Willnat et al., 2023). Changing sentiment toward unauthorized migrants has affected how the overall population of immigrants is treated in society.

Against this backdrop, it becomes necessary to understand the psychological experiences of immigrants by using critical lenses to prevent harm and to protect the well-being of immigrant communities (Alvarez et al., 2016; APA, 2021b; Buchanan et al., 2021). The innovative lenses and conceptual frameworks we review in this section address to some extent the connection between immigrant health outcomes at the individual level with several systems (e.g., social, cultural, community, family) that intersect with and are impacted by the historical legacy and contemporary attitudes toward immigration.

Socioecological Model

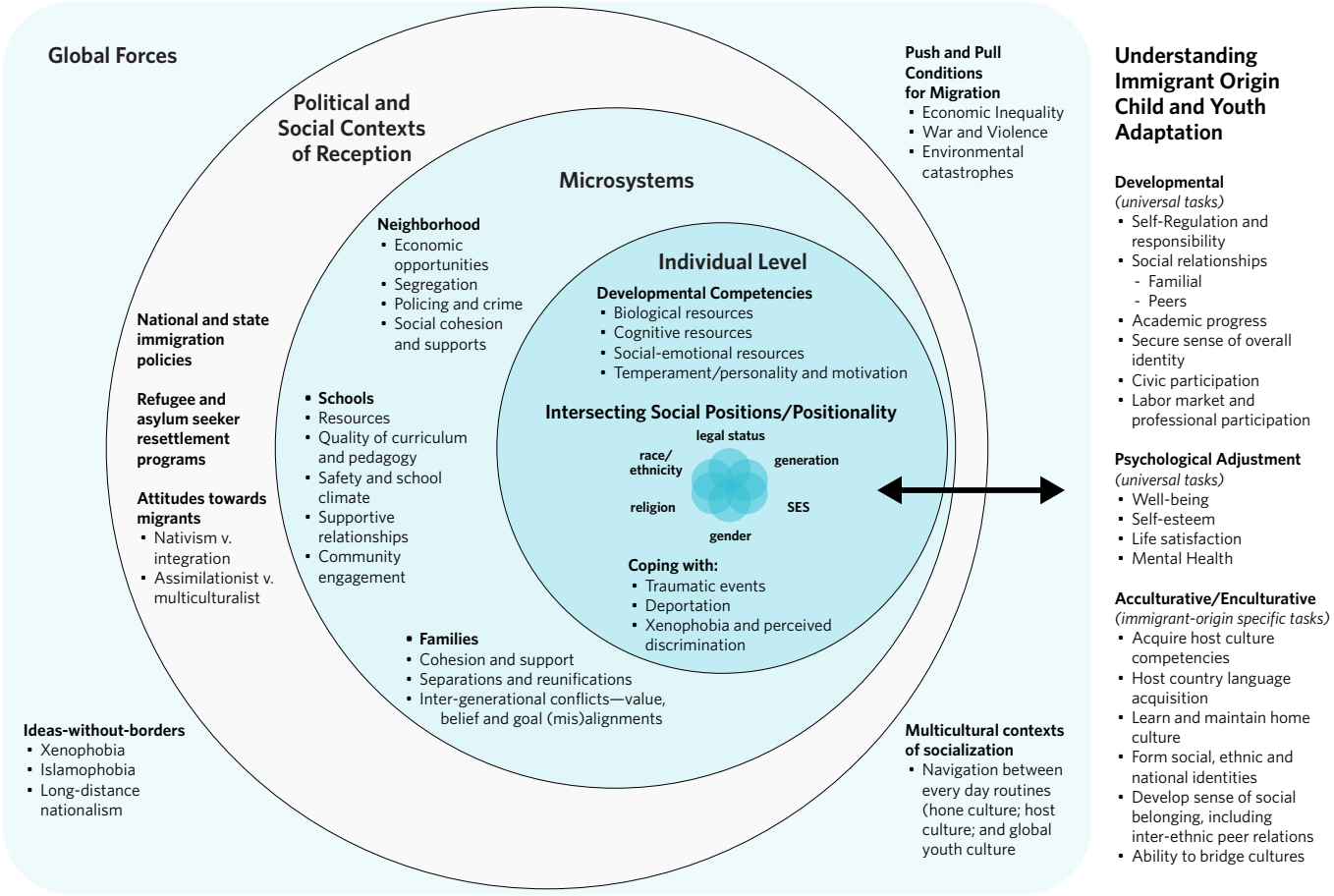
Bronfenbrenner's (1979) socioecological model framed the original *Crossroads* report. Socioecological models recognize that human behavior is influenced by the context within which it occurs, and people adapt to or resist the pressures of contexts that surround them. Bronfenbrenner's model conceptualizes nested levels of contextual influences from the immediate proximal environments in which the person participates, such as the family and the school/workplace, to the indirect influences of the local community, societal institutions, policies, cultural patterns, and attitudes. These contextual layers influence each other and change over time, following historical events and social change. Ecological models posit that individuals adapt to their environments.

Since *Crossroads*, socioecological models have been expanded to include considerations specific to the immigrant experience that reflect the complexities of immigrant lives. For immigrants, ecological models must be modified to include the influence of more than one culture because an immigrant's heritage is maintained in ethnic communities, organizations, and their families while they acculturate to the United States (Birman, 2011). Acculturation refers to how immigrants adopt and retain aspects of the host and heritage cultures (Berry, 2007; see Cultural Determinants of Health section for more details on acculturation). When considered from an ecological perspective, adaptation and acculturation unfold across different contexts or life domains of immigrant lives (e.g., family, work, school, peer group) that vary in whether they reflect the cultures of the host society, the heritage society, or both (Birman et al., 2014; Ward & Geeraert, 2016). As a result, acculturation to the heritage culture may be more adaptive in the more private sphere of family and coethnic peers. In contrast, in the more public sphere (work, school), it is often more adaptive to have the skills to engage with the culture of the host society (Arends-Toth & van de Vijver, 2006; Juang & Syed, 2019; Salo & Birman, 2015).

In this vein, Suárez-Orozco and colleagues (2018) have proposed a comprehensive ecological model specific to the immigrant experience. This integrative risk and resilience model (Figure 5) considers individual-level variables such as gender, ethnicity, and legal status; microsystems such as family and school; and national/political contexts of reception, including sociopolitical and cultural environments. In addition to incorporating influences of the host and the heritage cultures, the model attends to the global forces that drive migration and shape the experience of immigrants in resettlement countries.

FIGURE 5

Socioecological Model



As evident in Figure 5, socioecological approaches are complex, and no single study can attend to all layers of context. Ecological thinking directs attention to the different systems and environments shaping the immigrant experience, informing research and interventions. Social change can occur across different levels to cultivate environments that support immigrants and their health (Trickett, 2019).

An intersecting developmental perspective facilitates an understanding of the differential response of immigrants to acculturation and related stressors throughout their development. A developmental perspective is also important in socioecological frameworks, allowing for an understanding of human growth, change, and continuity across the entire lifespan. This approach emphasizes the dynamic interplay between biological, psychological, and sociocultural factors influencing development from conception to death. It recognizes that development is a lifelong process characterized by multiple stages and transitions, each with unique challenges and opportunities. Lifespan developmental perspectives highlight the significance of both continuity and change, acknowledging that individuals maintain a degree of stability in their traits and behaviors while also experiencing growth and adaptation in response to various influences. Moreover, this perspective emphasizes the importance of context, acknowledging that development occurs within a sociocultural environment that shapes and is shaped by the individual.

Intersectionality

Though a significant evidence base has examined how race/ethnicity, gender, socioeconomic status (SES), and legal immigration status relate to the health of immigrants since *Crossroads*, less work has taken an intersectional perspective. Intersectionality considers systems of oppression that render individuals vulnerable due to their possessing more than one socially devalued identity and, as a result, experiencing

greater oppression and discrimination (Cole, 2009; Crenshaw, 1989; Purdie-Vaughns & Eibach, 2008), with serious consequences for health. Race/ethnicity and immigration status are critical factors that shape the everyday experiences of immigrants of color (Alang et al., 2015; Misra et al., 2021) through institutional structures and discriminatory policies that impact their health and health care (Viruell-Fuentes et al., 2012). Indeed, immigrants from minoritized backgrounds in the United States are more likely to be exposed to experiences and systems that uphold racism, discrimination, stereotyping, and structural barriers to opportunities (e.g., economic mobility) as compared to immigrants from European backgrounds (Misra et al., 2021), reflecting the importance of recognizing that immigrants of color face greater vulnerability.

Society's gender norms also influence the immigrant experience. For example, reasons for leaving one's home country differ by gender (Castañeda et al., 2015). Historically, men are more likely to leave for economic reasons, such as seeking better employment and economic opportunities, whereas women's migration has been largely driven by family reunification. Women may also migrate to escape gender-based violence and are vulnerable to such violence during their migration trajectory (Menjívar & Walsh, 2019; Warren, 2017). Once in the destination country, men's and women's experiences are impacted by gender roles and expectations, access to care, and economic opportunities, which may not align with their countries of origin (Castañeda et al., 2015).

Further, socioeconomic conditions and social stratification in the sending and receiving countries significantly influence the immigrant experience. Immigrants with higher SES have greater access to resources for upward mobility, such as education, housing, and employment, in both their countries of destination and reception, while those of lower SES face multiple barriers within these domains (Clark & King, 2008; Ihara, 2011).

Immigration status is another important aspect of intersectionality (e.g., refugee, asylum seeker, undocumented, legal permanent resident), playing a critical role in the immigrant experience. Different statuses are associated with distinct challenges and privileges, influenced by public policies (Martinez et al., 2015; Prentice et al., 2005) that dictate access to education, housing, and employment. Most countries restrict immigrants without authorized status access to public housing (including government-subsidized housing), higher education and financial aid, employment opportunities, and access to social and health services (Martinez et al., 2015). Immigrant status often dictates available opportunities and upward mobility of immigrants, contributing to inequities and disparities in health and social outcomes.

It is also important to consider the intersection between immigration status and military service. Recent work has underscored the unique structural vulnerabilities faced by immigrant veterans in the United States (Horyniak et al., 2018; Tao et al., 2023). Though common public perception is that immigrants cannot serve in the armed forces due to not being U.S. citizens, immigrants with legal permanent residence who can speak English fluently and have a high school diploma can legally join the military (Mariscal, 2007). There is documented evidence that predatory military recruitment efforts target immigrants by enticing them with an expedited pathway to citizenship (Harsfield, 2011; Mariscal, 2007). However, upon completion of their service, veterans still face the same structural vulnerabilities as other immigrants. They are susceptible to being deported without any consideration of their honorable service or disabilities or mental health challenges resulting from their service (e.g., posttraumatic stress disorder [PTSD] and substance use). It is estimated that over 94,000 immigrant veterans have been deported from the United States since 1994 (Marrero, 2021).

Population Health Framework and Social Determinants of Health

Recognizing a shift since *Crossroads*, a recent call by APA (2022) advocates for psychologists to take a population health approach to promote health and reduce health inequities between populations, including immigrant communities (Olson et al., 2018). APA's four principles of population health include: (a) working across systems of influence to promote health and reduce disparities; (b) focusing on prevention and early intervention; (c) attending to health promotion and education; and (d) facilitating community engagement and partnerships to create systemic change effectively and efficiently (APA, 2022). A population health approach to immigrant health builds on the evidence put forth a decade ago by *Crossroads* while moving our field upstream to focus on prevention and systemic change in the health and well-being of immigrants.

In line with a population health approach, the SDOH lens is critical in addressing health disparities and inequalities among immigrant communities (Garcini, Cadenas et al., 2022; Thurston et al., 2023; World Health Organization,

2008). SDOH refers to the environments, conditions, and societal structures to which individuals are exposed and affect their health outcomes (Wilkinson & Marmot, 2003). According to Dahlgren and Whitehead (2006), social determinants of health may manifest on individual, social, and community levels, as well as general socioeconomic, cultural, and environmental levels. Five key SDOHs for immigrant families are health care access, economic mobility, education, housing, and social context (Figueroa et al., 2020). Immigration is often considered its own SDOH, with considerable implications for health, including behavioral health (Castañeda et al., 2015). However, structural and systemic barriers from the cultural, social, and political context lead to compounded stress that is detrimental to the health and well-being of immigrant communities.

HEALTH CARE ACCESS

Most immigrants are healthy and underutilize the U.S. health care system compared to their U.S.-born counterparts (Garcini, Nguyen et al., 2022; Vernice et al., 2020). However, many immigrants may delay the use of health services due to personal, interpersonal, and structural barriers, including lack of insurance, financial difficulties, linguistic and cultural barriers, fears of detention and deportation, and concerns of discrimination (Batalova, 2024; Garcini, Venta et al., 2022; Torres et al., 2018; Vargas et al., 2017). Variations in geographic regions also influence health care access among immigrant populations, with immigrants living in states that provide more expansive insurance coverage able to access care more readily (Pillae et al., 2023).

Barriers to health care access are more pronounced among immigrants who have a precarious immigration legal status (i.e., unauthorized), lower income, limited English proficiency, and multiple marginalized identities related to ethnicity/race, gender, and religion (Garcini, Venta et al., 2022). Older immigrants and those working in hazardous, unregulated environments unlikely to offer health insurance coverage (e.g., construction, agriculture, domestic workers) are also less likely to receive adequate health care. They are at greater health risk (Garcini, Domenech Rodríguez et al., 2023). The detrimental health consequences of lacking health care access, including greater risk for morbidity and mortality, are well documented (Guadamuz et al., 2022).

ECONOMIC MOBILITY

The active contribution of U.S. immigrants to the workforce is associated with strong upward mobility for foreign-born people over time and across generations, although newly arrived immigrants take longer to climb the social ladder (Garcini, Cadenas et al., 2022; Gelatt et al., 2022). For low-income immigrants, being employed does not always guarantee upward economic mobility. Many immigrants work in low-paying jobs that are exploitative and include practices hazardous to health—including lack of safety protections, violence by supervisors, payroll irregularities, and other forms of abuse—without legal protections (Garcini, Cadenas et al., 2022; Misra et al., 2021).

The U.S. economy is continually in need of people to fill jobs at both ends of the economic spectrum as there are not enough college graduates from science and technology programs to take the higher-status jobs nor manual laborers willing to take the lower-status jobs. Current U.S. labor immigration has been described as bifurcated (Portes, 2020), with the majority of new arrivals coming to fill jobs at either end of the "hourglass"—either highly educated "white collar" professionals or laborers coming to work in unregulated jobs. Temporary (nonimmigrant) visas that facilitate entry for employees rely on a sponsor (typically an employer) who has the power to extend or discontinue the visa status. As such, labor policies and employers hold significant power over immigrant workforce opportunities in the United States.

Despite their contributions to labor markets and the U.S. economy, immigrants often experience limited opportunities for economic mobility: Immigrants entering with low-status jobs are often unable to pass through the aforementioned "hourglass" into higher-status jobs (Portes, 2020). Indeed, approximately a third of U.S. immigrants live in poverty (Gelatt et al., 2022). A barrier to upward economic mobility for low-income immigrant families and families with unauthorized status is the lack of, or limited access to, mainstream financial services, such as bank account ownership or credit history (Rodríguez-Sánchez, 2021). Moreover, the need to provide remittances to assist families abroad can restrict economic upward mobility (Solheim et al., 2022). These financial challenges contribute to stress, strain family and interpersonal relationships, and increase vulnerability to disease due to the inability to access and pay for health services (Garcini, Ambriz et al., 2022; Garcini, Kanzler et al., 2022).

Immigrants with low-income or unauthorized status must weigh the competing demands of low-paying, work-intensive jobs that demand most of their time against a chance to pursue educational opportunities, including becoming English proficient (Valdivia et al., 2023). Limited

English proficiency is a significant stressor for many immigrant families, and it is associated with fewer opportunities for economic mobility, lower health literacy, and greater challenges accessing and navigating legal and health care systems (Garcini et al., 2021; Yeheskel & Rawal, 2019). Educational hurdles persist for low-income and unauthorized immigrants, which, in combination with economic struggles, can increase health risks.

EDUCATION

Approximately 25% of all youth in U.S. schools are immigrants or children of immigrants (Zong et al., 2019), in part because the landmark 1982 Supreme Court case decision, Plyler vs. Doe, asserted that P-12 schools in the United States must provide access to education for all children, including those with unauthorized status (Rabin, 2023; Radoff, 2011). Estimates suggest that nearly 100,000 unauthorized students graduate from high school each year (Zong & Batalova, 2019). Nevertheless, immigrant youth holding a range of different statuses encounter significant barriers in their educational journeys in the United States, and educational practice, research, and policy have been slow to implement effective strategies to foster educational equity (Crawford & Dorner, 2019; Suárez-Orozco et al., 2015). The degree to which educational policies and practices adapt to welcome immigrant youth and support their educational success varies tremendously (Gonzales, 2010; Jefferies & Dabach, 2014; Nienhusser, 2013), and the ability of immigrant youths to access behavioral health care support in the school system differs as a result.

Immigrants are increasingly forming part of the college-attending population in the United States, although there are significant disparities in educational attainment and related opportunities (Krogstad & Radford, 2018). For example, more than half of Asian immigrants are college-educated compared to less than a quarter of Latin American immigrants (Batalova & Fix, 2023), and immigrants with lower incomes and those with precarious or undocumented immigration status are falling behind educationally (Garcini, Nguyen et al., 2022). Attending college as an immigrant has health implications. Indeed, research based on large national samples has found that college students who hold precarious immigration statuses (e.g., undocumented, temporary protections) tend to report elevated anxiety, depression, and experiences of discrimination compared

to their peers who are U.S. citizens or international students (Cadenas & Nienhusser, 2021). A recent systematic review of the literature summarized how psychosocial well-being is impacted by immigration status, sociopolitical climate, public policies, institutional policies and practices, and challenges in the higher education mental health care system (Nienhusser & Romandia, 2022). Importantly, providing mental health services to immigrants in higher education and creating college environments that are responsive to the needs of immigrant students are critical for addressing immigration-related health disparities in college student mental health (Nienhusser et al., 2023).

HOUSING AND THE NEIGHBORHOOD ENVIRONMENT

The association between housing, neighborhood environment, and health is determined by physical and material structures and psychosocial attributes such as a sense of meaning, belonging, and security (Brake et al., 2023). Foreign-born families, particularly new arrivals, often face significant barriers to becoming homeowners, including financial instability, lack of credit history, discrimination, and difficulty accessing and navigating informational and banking systems (Garcini, Cadenas et al., 2022). Financial instability and limited access to loans lead many immigrant families to settle in low-income and segregated neighborhoods with high crime, low safety, low-quality housing, and limited access to public services and recreational facilities (Asad & Rosen, 2019). High housing costs often lead low-income immigrant families to reside in crowded homes, which may complicate family dynamics and compound stress (Olayo-Méndez et al., 2021). The aforementioned difficulties are more pronounced for immigrant families with unauthorized or mixed status, which may increase the risk of a diminished sense of security and belonging and lead to ill health (Garcini, Nguyen et al., 2022). Finally, issues related to the built environment where immigrants often reside are critical to consider. For example, recent studies have suggested that immigrant children were at higher risk of lead poisoning than their U.S. counterparts (e.g., Eisenberg et al., 2011; Tehranifar et al., 2008), associated with increased risk for learning, developmental, cognitive, and behavioral health concerns (Naranjo et al., 2020).

Cultural Determinants of Health

Research since *Crossroads* has built upon foundational theory and research on acculturation processes to highlight acculturation as an essential cultural determinant of health for immigrants (see Ferguson et al., 2023). Psychological acculturation—acculturation for short—involves cultural and psychological changes in an individual's observable behaviors such as language, dress, and preferences for food, media, and friendships, as well as changes in deeper psychological facets of values (e.g., around family relations, gender roles, nutrition, and health) and identity (e.g., cultural identification; see Sam & Berry, 2016). Contact between individuals and groups with differing cultures initiates the process of acculturation, which can be associated with health outcomes (Schwartz & Unger, 2017). Acculturation conditions include the typical health habits, illness and healing beliefs, and help-seeking norms of the heritage country juxtaposed against those of mainstream U.S. culture. Greater cultural distance between the two cultures, such as differences in values, religion, or language, can potentially strengthen acculturation's role as a cultural determinant of health for a given individual or cumulatively across immigrant generations. Cultural stress theory (Schwartz, 2021) posits that as immigrants engage in acculturation upon arriving in the United States, they experience structural conditions (i.e., discrimination, negative context of reception, and bicultural stressors) that may activate stress and negatively impact their psychological health.

Research since *Crossroads* has also highlighted the concept of remote acculturation (Ferguson & Bornstein, 2012a). The acculturation of immigrants and refugees in the United States often begins long before their arrival due to globalization: Technology, trade, tourism, and transnationalism readily transport U.S. culture across land and sea borders to many premigrants in their home and transit countries (Eales et al., 2020). This remote acculturation precedes the proximal acculturation many individuals experience upon arrival to the United States and has health implications (Ferguson et al., 2016). For example, research in Jamaica indicates that remotely acculturating island youth with a strong orientation toward European American culture tend to watch more U.S.-produced media and, in turn, eat more unhealthy foods relative to their peers (Ferguson et al., 2018). In contrast, second-generation Jamaican immigrant adolescents living in the United States have healthier eating habits as they make greater efforts to learn and connect to their heritage culture remotely (Gillespie et al., 2024).

ACCULTURATION ORIENTATIONS

Acculturation orientations have remained a focus of research attention since *Crossroads*, but dimensional frame-

works have progressed toward more complex models to account for multiple cultural orientations (Sam & Ward, 2021). Unidimensional (or unidirectional) acculturation frameworks, which hold that strengthening a new cultural affiliation requires distancing from a heritage culture, have long been unsupported empirically relative to bidimensional frameworks, which capture simultaneous orientations toward one heritage culture and one U.S. destination culture (Berry, 1980, 1997). However, tridimensional (Birman & Trickett, 2001; Ferguson et al., 2012b) and quad-dimensional acculturation frameworks (Yoon et al., 2022) have now been introduced to capture multiple simultaneous orientations toward more than one heritage and destination cultures, which is increasingly common among U.S. immigrants. Despite some remaining debate, meta-analytic evidence across multiple cross-sectional studies supports the "integration hypothesis," meaning that the acculturation strategy of integrating heritage and U.S. cultures in one's life is more strongly associated with positive psychological well-being and sociocultural competence than single-culture engagement (Grigoyev et al., 2023; Nguyen & Benet-Martínez, 2013). Acculturation theorists and researchers continue to argue for the importance of paying attention to both immigrants and nonimmigrants as both need to make cognitive, emotional, and behavioral adjustments for effective interactions with each other in super-diverse contexts like the United States (see Berry, 1997; van der Zee & van Oudenhoven, 2022). Overall, the current generation of acculturation research has increasingly focused on dynamic processes and mechanisms of acculturation (Ferguson et al., 2023), including explorations of how identity processes like hybridizing and alternating identity styles (Ward et al., 2021) or day-to-day cultural identity variability (Nguyen & Ferguson, 2019) can promote or protect positive mental health outcomes.

CULTURAL RESILIENCE

Several cultural factors and processes at the individual, interactional (e.g., family level), group, and national levels can promote and protect immigrant health in the face of acculturative stress and societal discrimination (Motti-Stefanidi & Masten, 2020). Individual-level skills such as language competence (see Suárez-Orozco et al., 2018) and culture-based media literacy (Ferguson et al., 2020) promote positive immigrant adaptation, as do family factors such as moderate levels of familism, family obligations, and familial, ethnic socialization (Diaz & Niño, 2019; Umana-Taylor et al., 2009). Cultural resilience at the societal level can result from cultural socialization into healthy heritage culture norms and practices such as slow-cooked meals using less processed ingredients (Gillespie et al., 2024). Cultural socialization can also propel ethnic-racial identity development, a powerful protective factor against discrimination for U.S. youth of color, including immigrant-origin youth (Umana-Taylor & Rivas-Drake, 2021). At the broadest societal levels, multicultural attitudes of nonimmigrant U.S. residents and equitable health care and educational policies also promote and protect immigrant health (Chen et al., 2016).

Cultural Adaptation of Interventions

The APA Multicultural Guidelines (APA, 2017b) indicate the need for culturally responsive interventions when working with diverse populations, including immigrant groups. Proponents of evidence-based interventions have argued the importance of adapting interventions to fit better the contextual and cultural needs of diverse groups, including immigrants (Barrera et al., 2011; Lau et al., 2023; Piña et al., 2019). However, accumulating evidence has suggested that most effective adaptations of evidence-based practices are more "surface-level" or cosmetic, for example, using culturally congruent examples, materials, and language, and do not necessarily change the active ingredients of the practice (Arundell et al., 2021; Gonzales et al., 2016; Piña et al., 2019). The tension between the need for fidelity to an evidence-based model and the need to adapt the model for immigrant groups has led to a strategy called "community-defined" or "practice-based" evidence, which develops programming from the "ground up" by community members who then evaluate their efforts, building an evidence base for programming that is developed by and for immigrant communities (Beehler et al., 2012; California Pan-Ethnic Health Network, 2021; Weis, 2019). Recent adaptation frameworks propose both "top-down" and "bottom-up" approaches to evaluating the efficacy and effectiveness of adaptations of interventions (e.g., Barrera et al., 2013). One new step-by-step blueprint for accomplishing cultural adaptation first isolates the universal "active ingredients" of the intervention, demarcates the culture-specific portions for replacement, and identifies a process that can work for face-to-face and digital immigrant interventions (Simenec et al., 2022).

Decolonial and Liberation Perspectives

Since the publishing of *Crossroads* (APA, 2012), critical

perspectives describing the connections between psychological distress, larger societal power dynamics, and sociopolitical events have become more prominent in psychological science (Garcini, Barrita et al., 2023). Moreover, the ways in which psychologists have participated in or aligned themselves with oppressive structures have received increasing empirical attention (Ali & Sichel, 2020). As immigrant communities navigate U.S. immigration policies that shape their psychological experiences, they face a complex system of laws and processes that affect their health and social outcomes (Spickard et al., 2022). Decolonial and liberation approaches provide insights as to how psychologists may function within complex social and political systems (Comas-Díaz & Rivera, 2020; Martín-Baró, 1996) by (a) promoting a critical awareness of the ways that power and privilege may influence psychological functioning and contribute to disparities and inequities (Montero & Sonn, 2009), and (b) highlighting the unique cultural values, social attitudes, and traditional healing practices that facilitate the resilience of marginalized communities. Liberation psychology, which was developed in the 1990s (Martín-Baró, 1996), emphasizes that for psychology to meet the needs of the global majority, it is important to elevate the voices and lived experiences of communities at the margins of mainstream society to facilitate systemic change and promote equity.

CRITICAL CONSCIOUSNESS

Critical consciousness is the process by which individuals who face marginalization become aware of oppressive conditions through critical reflection and analyses and how they become active in addressing such oppression (e.g., advocacy, civic engagement, and activism; Freire, 1973). Critical consciousness has been applied widely to many fields (e.g., education, sociology, legal studies, public health), and the psychological science examining this phenomenon has grown significantly since *Crossroads*. Two recently published volumes summarize much of the theory and science regarding this construct in psychological and social sciences (Godfrey & Rapa, 2023; Rapa & Luke, 2023).

As the study of critical consciousness expands rapidly, so does its application among immigrant communities. Novel research has started to uncover how critical consciousness is leveraged as a coping mechanism by immigrant youth

when experiencing ongoing discrimination and other forms of social oppression (Cadenas et al., 2023). Research suggests that engaging in critical consciousness can facilitate agency in political and social justice domains, which, in turn, plays a protective role in the mental health of immigrant communities (Cadenas et al., 2018; Cadenas et al., 2021). A recent review summarized the many ways in which civic engagement, advocacy, and activism serve as healthy outlets for immigrant youth, improving outcomes in their mental health, education, and workforce development (Cadenas, Campos et al., 2022). This early-stage research demonstrates that critical consciousness is a psychological strength immigrants develop in the context of resistance to policies that marginalize them.

The Family in the Immigration Context

All migrations involve changes in family and interpersonal networks, as they entail the physical separation of an individual from their home country and the people and relationships that made that place home. Given the importance of the mental health of the supportive relationships provided by both nuclear and extended family, it is important to consider that changes to the interpersonal context of migrants can represent both risk and resilience. Moreover, the changing immigrant context has meant that unaccompanied youth and asylum-seeking families comprise a larger proportion of new immigrants, justifying increased focus on how migration affects family relationships. An attachment theory lens is useful to conceptualize the experience of these groups pre-, during, and postmigration, and to organize sources of risk and resilience. Indeed, this lens has gained attention recently, with increasing scholarship since *Crossroads* measuring attachment in these groups and using attachment and relational perspectives to conceptualize immigrant risk and resilience (Juang et al., 2018).

Attachment theory, pioneered by John Bowlby (1969), posits that infants have an innate need to form an attachment bond with a caregiver and that separation from or loss of that caregiver has a lasting impact on the child's development. Bowlby described attachments between children and caregivers as either *secure*—where the child views themselves as worthy of care and others as reliable caregivers—or *insecure*—where the child views themselves as unworthy of care and others as unreliable. Recent scholarship has begun to characterize migration and related stressors as attachment injuries—events that threaten to rupture attachment bonds with consequences for a child's well-being across the lifespan (i.e., greater likelihood of insecure attachment style and mental health symptoms). This section will specifically describe recent research on three forms of attachment injuries affecting recent migrants: children left behind by parental migration, children separated from their families while migrating alone, and families being separated due to immigration policy and enforcement. Research highlights the tremendous resilience of immigrant youth and families, including immigrant youth who have experienced family separation (Muller et al., 2019), perhaps because secure attachment histories protected them.

CHILDREN "LEFT BEHIND" BY PARENTAL MIGRATION

The term "left behind" has appeared recently in scholarship, describing the experiences of children who remain in their home countries while their parents—sometimes one, sometimes both, and sometimes one followed by the other—migrate in search of economic opportunities or to seek safety or necessary health care. Though clinical observations of how this separation negatively affects parent-child attachment have existed for decades (e.g., Smith et al., 2004), when *Crossroads* was published, empirical research was just beginning to tie family separation to attachment insecurity (e.g., Santa-Maria & Cornille, 2007). The empirical research has grown since then, documenting links between parental migration, Romanian children's attachment figures (Brumariu et al., 2020) and Latin American teenagers' attachment security (Venta et al., 2020).

Mitigating and exacerbating factors have also emerged in recent scholarship. De Haene et al. (2013) reported that both secure and insecure attachment narratives exist among young refugee children, with family cohesion during times of separation emphasized in the narratives of children able to maintain attachment security. These findings were echoed by Venta et al. (2021) in a large sample of Latin American young adults who had been left behind by migrant parents. However, separation was associated with attachment insecurity; frequent phone and video contact dampened this relationship, particularly when the child was older at the time of migration. Taken together, these findings point to a significant relation between separation due to migration and attachment insecurity, though this relation can be altered by the family's ability to cultivate cohesion and connection during and after the separation. Though empirical research has not yet linked separation to mental health difficulties *through* the mechanism of attachment insecurity (e.g., mediational, prospective research), there are clear, foundational literature bases

linking parental separation (Freud & Burlingham, 1943) and attachment insecurity (Bowlby, 1969) with negative psychological outcomes for children. Moreover, a recent study by Wang and Liu (2019) suggesting increased risk for self-injury among Chinese adolescents left behind by migration—particularly those experiencing both separation and attachment insecurity—indicates that future research on attachment insecurity as a mechanism linking separation due to migration and youth mental health is warranted.

CHILDREN SEPARATED FROM THEIR FAMILIES WHILE MIGRATING ALONE

Unaccompanied immigrant migration increased precipitously at the start of the last decade and has remained at very high levels (Silva et al., 2022), with much of the relevant scholarship emerging after the publication of *Crossroads* (Garcia & Birman, 2022). This group of migrants tends to experience separation from caregivers in two ways. First and most commonly, they are left in their home country by parents who migrate in search of opportunity or safety. For instance, the child remains with his mother when the father migrates (Venta et al., 2020). Commonly, the mother also migrates a few years later, leaving the child with extended family (DeBrabander & Venta, 2022). These placements often erode due to additional migration, death of caregivers, or conflict. Then, the child makes the decision, sometimes with the permission and financial support of a parent and sometimes without, to travel to the United States to seek reunification with parents who previously migrated (Silva et al., 2022).

These children are exposed to the attachment injuries of parental separation described in the previous section but also face attachment-related hardships of separating from surrogate caregivers and extended family (Patel et al., 2016), as well as hardship in reunifying with parents. Indeed, separations of this kind can be quite long—more than a decade in some instances—and often begin at a very young age (Venta et al., 2020). The parent often describes guilt about their own migration and subsequent separation from their child. The parent can also experience challenges living with a teenager who may have been exposed to numerous traumatic events prior to and during migration and is now dealing with the reality of being new to the United States. and interacting with new siblings or caregivers for the first time (Cardoso et al., 2022). Difficulties in family reunions have been linked with unhealthy family functioning and mental health consequences (Rusch & Reyes, 2013).

Second, unaccompanied immigrant minors may be the first in their immediate family to migrate. This scenario may occur when an older adolescent needs to flee gang recruitment or is the family's best option for employment and economic opportunity in the United States. Most of these migrants are boys. Often, the decision to migrate alone is made by the family in the hopes of protecting the child (Garcia & Birman, 2022). Little is known about the experiences of this second group of unaccompanied minors in terms of attachment security. Still, unaccompanied immigrant minors have well-documented mental health vulnerabilities (Silva et al., 2022; von Werthern et al., 2019) that persist over time (Seglem et al., 2014). These vulnerabilities are thought to stem from trauma exposure and the need to cope with life in a new country at a vulnerable age while separated from their attachment figures and broader social and cultural support networks (Galvan et al., 2023). Exacerbation of these vulnerabilities was reported during and after the COVID-19 pandemic (Venta et al., 2023). Indeed, their experiences of separation from family, as well as emotional reactions to reunification, are distressing and have important developmental implications (Patel et al., 2021).

Conversely, emerging empirical research indicates that attachment security to parents and peers, as well as feelings of connection to school, are associated with reduced mental health problems and increased resilience among immigrant youth from Latin America (Venta et al., 2019). Moreover, attachment security to mothers may buffer the effects of trauma exposure, allowing a smoother process of acculturation during immigrant children's first year in the United States (Venta, 2020). These findings are mirrored in Somali adolescents resettled in the United States, for whom school belonging was associated with reduced depression and increased self-efficacy (Kia-Keating & Ellis, 2007).

Families Separated Due to Immigration Policy and Enforcement

Immigration policy can lead to family separation in several ways, as detailed earlier in this report, with much attention paid to migration-related family separation since *Crossroads*. Very little exists in the published literature regarding the attachment consequences of forced family separation that occurred in the United States during the Trump administration's zero-tolerance policy, though researchers have observed attachment disorganization (a severe form of

attachment insecurity), trauma reactions (Edyburn & Meek, 2021; Jordan et al., 2018), and pronounced emotional and interpersonal problems (MacLean et al., 2020) in separated children. Case reports and semistructured interviews with families separated via parental deportation highlight this event as an attachment injury (Brabeck et al., 2020; Rayburn et al., 2021), though more empirical research is needed. Needless to say, the forced separation of children from their caregivers due to immigration policy and its enforcement will affect their access to the secure base and safe haven that they need to flourish. Importantly, recent scholarship suggests that the effects of anti-immigrant laws may stretch beyond immigrants who might themselves be directly affected and "spill over" to other members of their schools and communities (e.g., Santos et al., 2018).

Broader Notions of Attachment in the Immigrant Context

While attachment theory takes a specific and precise approach to operationalizing attachment figures and measuring attachment security, its foundation is holistic in highlighting that individuals need safety and comfort during times of difficulty as well as a foundation from which to explore and take risks. In this broader context, it is important to note aspects of the local sociocultural context (Kinnvall, 2004) that provide security and safety (Ozer, 2020). Specifically, immigrants will differ in their degree of attachment to the host country—with time spent in the United States, plans to stay in the United States, and the likelihood of describing oneself as American all increasing with time (Pew Research Center, 2007). Recent scholarship has operationalized cultural integration as existing along two dimensions: "origin attachment" (i.e., links to the home country and culture) and "destination attachment" (i.e., links to the host country and culture; Kim et al., 2022), consistent with the acculturation literature (Sam & Berry, 2016). These dimensions vary according to the level of similarity (also known as cultural distance) between home and host countries in language, geography, and culture (Kim et al., 2022) as well as by immigrant generation (Huang et al., 2018). Moreover, a variety of interpersonal attachments can foster "local embeddedness" for immigrants, where they experience security because of participation and belonging in "relational, institutional, and cultural contexts" (Ozer, 2020). Recent scholarship has indicated the positive effects of felt belonging in these contexts on boosting immigrant mental health (e.g., Fisher et al., 2015; Venta et al., 2022) and buffering against violent extremism (Ozer, 2020).

Traumatic Stress in Immigrant Communities and Those Who Serve Them

During the decade since *Crossroads*, there has been increased attention paid to the trauma immigrants experience prior to, during, and after the migration journey (Cohodes et al., 2021; Doctors Without Borders, 2020). Conditions within migrant-sending countries can include war, political torture, physical and emotional abuse, community violence, family separation, poverty, discrimination, and natural disasters (Garcia & Birman, 2022). The migration journey itself varies greatly between individuals—some journeys are long and arduous, while others are brief and streamlined. Traumatic events during the migration journey include limited resources (e.g., food, water), violence, sexual assault, financial abuse, dangerous border crossings, separation of family members, kidnapping, and extortion. The process of applying for asylum can be equally distressing, as immigrants face demands to repeat their story of trauma, provide corroborating evidence, and navigate a lengthy and costly process to obtain a work permit or asylum (Evans & Hass, 2018).

Potential postmigration stressors include poor social integration, economic difficulties, worrying about friends and family in the country of origin, loneliness (Chen et al., 2016), disorientation (Urzua et al., 2019), difficult family reunifications, and structural barriers associated with health care, employment, education, and immigration legal status. Cumulative traumatic experiences are compounded by a harsh sociopolitical climate and anti-immigrant sentiments, leading to fear, distress, and an unwillingness to seek help (Barajas-Gonzalez et al., 2018; Costello, 2016; Rinaldi & Shah, 2017; Torres et al., 2018; Vargas et al., 2017; Yoshikawa et al., 2017). Immigrants who are detained often report harsh conditions, abuse, and discrimination, including family separation (Morales et al., 2023; Palacios et al., 2022). All these factors increase the risk of psychological distress and mental health problems, sometimes leading to posttraumatic stress symptomatology (Goninon et al., 2021; Grochtdreis et al., 2021), though responses to trauma vary greatly by individual and culture.

Indeed, traumatic distress worldwide manifests in complex and often culturally-rooted ways (Bryant-Davis, 2019; Ford et al., 2015). Traumatic distress can range from

formal psychological diagnoses like PTSD and depression (APA, 2022) to somatic and physical repercussions and comorbidities, including cardiovascular and immune disorders (Gupta, 2013). Unsurprisingly, a systematic review of global prevalence rates among immigrants concluded that several anxiety- and trauma-related disorders were more common among immigrant populations than nonimmigrant populations (Amiri, 2022). In one study of asylum-seeking children at the Texas-Mexico border, 60% of children met the cutoff for a likely PTSD diagnosis, compared to 3.9% of the general U.S. youth population (U.S. Department of Veterans Affairs, 2018). The severity of posttraumatic symptoms among children may be most significantly influenced by premigration trauma and the duration of parent-child separation (Sidamon-Eristoff et al., 2022).

WOMEN, GIRLS, AND SEXUAL AND GENDER MINORITIES

Since *Crossroads,* research has highlighted that certain migrant populations are particularly vulnerable to traumatic distress, including women, girls, and sexual and gender minority individuals (Maher & Segrave, 2018; Skinta & Nakamura, 2021). Migrating across borders can significantly strain immigrant families, leading to an increased likelihood of interpersonal partner violence for women survivors (Kim et al., 2017). Challenges such as economic uncertainty, language barriers, social isolation, and discrimination contribute to heightened susceptibility to interpersonal partner violence (Garnweidner-Holme et al., 2017; Raj & Silverman, 2022). Unaccompanied girls are twice as likely to report emotional distress during migration than boys (Potler et al., 2023). Moreover, sexual and gender minority migrants face additional stressors concerning their identities, including complex histories of childhood abuse, lifelong victimization, and mistreatment by immigration authorities and other state entities (Hermaszewska et al., 2022). These intersecting challenges underscore the urgent need for comprehensive and targeted interventions tailored to address the unique needs of vulnerable migrant populations and ensure their well-being throughout the migration process.

OLDER ADULTS AND PEOPLE WITH DISABILITIES

On average, foreign-born individuals tend to have more comorbidities and disability as they age (Nkimbeng et al., 2019). Health and disability trajectories become more complex after disaggregating racial/ethnic data and considering factors such as migrating later in life, low income, and cumulative stress (Bacong & Đoàn, 2022; Hawkins et al., 2022). The COVID-19 pandemic highlighted increased health disparities and stress among older immigrants due to structural inequities and discrimination (Ma et al., 2021). Older immigrants with complex trauma from their country of origin or the migration process may also experience retraumatization as they witness anti-immigrant sentiments and hate crimes in the media or first-hand. Fears for their safety, stigma, social isolation, and limited social services during the pandemic also affected health care access of older and younger immigrants with disabilities. Despite an international focus on the rights of migrants with disabilities (European Union Agency for Fundamental Rights, 2016), research is sparse in the United States (Echave & Gonzalez, 2022). Disabled immigrants often face barriers to appropriate legal, educational, vocational, and health accommodations (Echave & Gonzalez, 2023). Given how aging and disability intersect with immigration to influence health, focused research and interventions in these areas are crucial.

COMPLEX TRAUMA

Increased attention since *Crossroads* has shifted to the concept of complex trauma, which can result from prolonged exposure to severe and interpersonal traumatic events, often occurring in the formative years of an individual's life (Kliethermes et al., 2014; Courtois, 2020). Unlike single-event trauma, complex trauma involves repeated incidents, such as chronic abuse, neglect, or exposure to violence. This type of trauma can have profound and enduring effects on a person's mental, emotional, and physical well-being. Individuals who experience complex trauma may develop a range of symptoms, including difficulties with emotional regulation, disrupted attachment patterns, and challenges in forming healthy relationships (Ford, 2017). The cumulative impact of repeated traumatic experiences can alter the brain's neurobiology, affecting cognitive functions and emotional processing (McLaughlin et al., 2020). Complex trauma can also manifest in symptoms resembling PTSD but with additional complexities due to the ongoing nature and cultural differences in the manifestation of trauma (Cloitre, 2021). Several studies have identified complex PTSD symptomatology in migrant populations, particularly when exposed to interpersonal violence (de Silva et al., 2021; Rasmussen et al., 2007; Sabin et al., 2006; Spitzer et al., 2009).

Racial Trauma

Racial discrimination can also lead to racial trauma for immigrants of color. Racial trauma denotes the experiences of harm, shame, humiliation, and guilt that result from threats, prejudice, abuses, and microaggressions (Cénat, 2022). Complex racial trauma can result from the consistency of racist victimization beyond childhood, as well as internalized racism. Like complex trauma, it may have consequences for physical and mental health, behavior, cognition, relationships with others, self-concept, and social and economic outcomes. When identified, it is important to address race-based stress and trauma (Bhambhani & Gallo, 2022).

SECONDARY TRAUMATIC STRESS

People who support immigrants can also experience harm to their mental health. Secondary traumatic stress (STS) occurs when helping professionals are vicariously exposed to the traumatic experiences of those they work with (Figley, 1993). Symptoms of STS are similar to symptoms of PTSD and are associated with compassion fatigue or burnout (Maslach, 2003). Seminal and recent research has documented the prevalence of indirect exposure to trauma and STS symptoms among social workers (Bride, 2007), counselors (Sodeke-Gregson et al., 2013), medical professionals (Ogińska-Bulik et al., 2021), child protection workers (MacEachern et al., 2018), and, most recently, among professionals working with forced migrants (Mercado et al., under review; Roberts et al., 2021). Since *Crossroads*, empirical accounts of race-based STS have been published, citing secondary trauma resulting from listening to client reports of discrimination (Giordano et al., 2021). STS is more prevalent among women, those who have experienced trauma in their own lives, and those who have had greater exposure to vicarious trauma (Lynch, 2019). Importantly, STS is understood to occur in an ecological context (Ludick & Figley, 2017) and can be prevented by organizational-level factors such as trauma awareness in the workplace (Kulkarni et al., 2013; Sutton et al., 2022). A recent literature review (Kim et al., 2021) reported that most interventions for vicarious trauma were focused on self-care and wellness promotion and involved psychoeducation and mindfulness, concluding that such interventions showed positive outcomes, particularly when delivered over the longer term in a group setting. Further, the concept of "vicarious resilience" has been introduced to describe service provider resilience resulting from exposure to the resilience of clients (Hernández et al., 2007).

PART III: HOW SHOULD THEORETICAL PERSPECTIVES ON IMMIGRATION BE PUT INTO PRACTICE?

Drawing on the theoretical and empirical updates described earlier, this section outlines factors to consider in clinical work, research, education, training, and advocacy for professionals working on immigration-related issues.

What Factors Should be Considered in the Provision of Clinical Services to Immigrant Populations?

A wide range of protective and risk factors affect the psychosocial adjustment and mental health outcomes of immigrants (Fazel et al., 2012; Suárez-Orozco et al., 2018). Indeed, as described in Parts I and II of this report, immigrants possess strengths and vulnerabilities that must be considered when providing clinical services.

LOCATION AND INTEGRATION OF CARE

Immigrants experience health disparities due in part to limited access to health services in comparison to U.S.-born groups (Derr, 2016). Health disparities are exacerbated among immigrants residing in rural areas, of low SES, and in destinations with recently arrived migrants. Immigrant children and adolescents, especially those of racially minoritized backgrounds, also experience significant disparities in access to care. Many immigrants have a poor understanding of the U.S. behavioral health system and do not know how to access behavioral health care (Roche et al., 2018). Stigma and transportation costs may also be barriers. Additionally, anti-immigrant public policies are often associated with reduced access to health care services, especially for undocumented immigrants (Martinez et al., 2015).

Utilizing nontraditional settings and providers to deliver behavioral health programming can help address these barriers (Alegría et al., 2018). Behavioral health care services should be expanded by providing them in community-based and home settings. For example, services could be provided to immigrants who qualify for Medicaid and/or state health insurance programs by tying them to housing support services (Alegría et al., 2018; Centers for Medicare & Medicaid Services, 2021). Schools are an important setting for prevention and intervention in behavioral health programming as they are often one of the first U.S. institutions (outside of the immigration system) that immigrant children and their families encounter upon arriving in the United States (Suárez-Orozco et al., 2008). Additionally, places of worship could serve as another potential avenue for increasing services for immigrants, as data suggest that immigrant groups are more likely to participate in religious activities and endorse greater spirituality than their native-born counterparts (Derr, 2016).

Intensive care coordination (ICC) services, also known as wraparound and comprehensive services, should also be expanded. These individualized approaches aim to support individuals with mental health or behavioral challenges (Substance Abuse and Mental Health Services Administration, 2019). This multifaceted strategy involves coordinating various services and resources, such as counseling, therapy, medication management, case management, social support, educational assistance, and community-based programs, to address the diverse needs of individuals in a holistic manner, considering their unique circumstances, cultural backgrounds, and specific challenges. By providing a personalized support network, wraparound services strive to empower individuals, enhance their well-being, and promote integration into their communities while fostering resilience and recovery. Several studies point to the possible effectiveness of comprehensive mental health services for immigrant children (e.g., Beehler et al., 2012; Endale et al., 2022), though their actual efficacy has not been established. ICC services typically consist of seven components: assessment and service planning, referral and linkages to appropriate services, care coordination, crisis management, case management to meet basic living needs, advocacy, and monitoring. Research into the effectiveness of wraparound services for behavioral health has shown promising outcomes, particularly in child and adolescent populations (Olson et al., 2018). However, data on the impact of ICC on the behavioral health outcomes of immigrants is not yet available.

WORKFORCE DEVELOPMENT

It is important to diversify the workforce involved in providing services to immigrants in behavioral health systems. Integrating lay professionals into delivering behavioral health services represents a promising approach to expanding access and improving outcomes (Barnett et al.,

2018). These individuals, often referred to as peer support specialists, culture brokers, or community health workers, are typically recruited from the communities they serve and receive specialized training to provide culturally sensitive support and assistance (Balcazar, 2011; Substance Abuse and Mental Health Services Administration, 2023). Their roles vary widely, from conducting outreach and education, to providing basic counseling, to connecting individuals with appropriate resources. By leveraging their unique understanding of local contexts, languages, and social norms, professionals from immigrant communities can effectively bridge gaps in access to care, particularly in communities where low mental health literacy and increased stigma are potential barriers to entry. Evidence indicates that their involvement can lead to increased engagement in treatment, improved mental health literacy, and reduced disparities in access to behavioral health services, thereby contributing to more equitable and comprehensive care delivery (Barnett et al., 2018; Mutschler et al., 2022; Richard et al., 2022).

Contextual Approaches

Considering the context of the immigrant client is critical for health providers who can help cultivate immigrants' inner sense of security and promote interpersonal resilience, while recognizing and addressing sometimes unwelcoming and discriminatory contexts of reception. Immigrant children, youth, and young adults demonstrate great resilience (Garcini et al., 2021), drawn in many instances from interpersonal connections. This resilience helps manage the hardships and challenges faced during the migration process, and promotes more desirable developmental outcomes (Juang et al., 2018; Martin et al., 2022).

For children or youth of younger ages, family-focused interventions center on increasing caregiver sensitivity, attunement, and responsiveness to promote interpersonal resilience (Bernard et al., 2012; Kohlhoff et al., 2022). Additionally, because the immigration process can result in children and youth being separated from their attachment figures, health providers can help immigrant youth establish regular and positive interactions and emotional connections with their family members, peers, and cultural communities in the host country to foster new secure attachment relationships. Longitudinal research suggests that with adequate emotional support and nurturing from new attachment figures over time, even children with insecure attachment patterns can develop secure attachments (Sroufe, 2005). Researchers have recently developed attachment-based interventions that cultivate this strength-based awareness and utilize interpersonal resil-

ience to promote more optimal adaptation and developmental outcomes for immigrant youth and adolescents (Motti-Stefanidi, 2019).

Multiple layers of risk and resilience factors should be considered when developing interventions and assessments for immigrant populations (Suárez-Orozco et al., 2018). For instance, Silva, Paris, and Añez (2017) developed the CAMINO framework, which emphasizes integrating contextual variables in mental health assessments with immigrants. Likewise, effective interventions must move beyond the transitional one-on-one psychological service model and include community and structural interventions if they are to affect community-level outcomes (Wilcox et al., 2024). For instance, increasing the cognitive and behavioral engagement of immigrant students at the interpersonal and school levels is positively related to academic resilience (Martin et al., 2022). Immigrant youth and adolescents who report greater trust, more positive communication, and more support from peers tend to experience lower levels of anxiety and depression and report better social and school adjustments (Fazel et al., 2012; Gorrese, 2016; Venta et al., 2019). Therefore, programs that aim to enhance interpersonal support for immigrant youth, including community and school efforts that enhance positive social networks among peers, teachers, and/or community mentors, should be implemented (Garcini et al., 2021; Juang et al., 2018).

PREVENTIVE INTERVENTIONS AND HEALTH PROMOTION

Preventive mental health services and health promotion initiatives should play a pivotal role in addressing the unique mental health challenges faced by immigrants. In behavioral health, prevention primarily centers on averting the occurrence or progression of behavioral health conditions, emphasizing actions to eliminate or reduce risks (APA, 2014). There is consistent evidence demonstrating the positive impact of preventive interventions for behavioral health concerns in immigrants (e.g., Fazel & Betancourt, 2018; Martinez et al., in press). These services encompass a range of interventions aimed at mitigating stressors associated with migration, acculturation, and adjustment to a new environment. Tailoring mental health programs to the specific needs of immigrant populations involves culturally sensitive approaches that consider linguistic diversity, cultural norms, and SDOH. By offering culturally competent interventions such as counseling, support groups, and community outreach programs, preventive mental health services can foster resilience, reduce stigma, and enhance access to care among immigrant communities (Simenec et al., 2022). Behavioral health programs should partner with community-based organizations and paraprofessionals to promote behavioral health access, reduce stigma, eliminate barriers to care, and increase engagement in the mental health system of care (Rusch et al., 2015). Given emerging understanding of the role of premigration remote acculturation (acculturation of immigrants in the United States beginning before their arrival due to globalization) in immigrant health habits upon arrival (Horlicks-Romanovsky et al., 2021), preventive health interventions in sending countries, and transnational diasporic interventions, can also support immigrant health in the United States (e.g., "JUS Media? Programme" intervention; Ferguson et al., 2019; Simenec et al., 2022).

Health promotion, on the other hand, concentrates on enhancing behavioral health and quality of life by fostering positive behaviors and creating supportive environments (APA, 2014). It encompasses educational initiatives, empowerment strategies, and advocacy efforts to encourage healthy lifestyles, build resilience, and address SDOH. Health promotion initiatives focusing on psychoeducation, stress management, and social support networks can empower immigrants to navigate challenges proactively and improve their overall mental well-being. Problem management plus (PM+) is an example of an evidence-based health promotion program developed for immigrants (World Health Organization, 2018), currently being evaluated for its feasibility and effectiveness in a U.S. immigrant sample (Poudel-Tandukar et al., 2022). While prevention focuses on a specific concern, such as the risk associated with traumatic stress, health promotion takes a holistic approach, aiming to cultivate overall wellness and address the root causes of health disparities. Both prevention and health promotion are crucial components of effective public health strategies, working synergistically to improve individual and community health outcomes.

Trauma-Informed Interventions

When working with immigrant populations who have suffered traumatic experiences during their migration and upon their arrival in the United States, it is vital for clinicians to utilize trauma-informed interventions. Cultural modifications to existing interventions for immigrants appear to be efficacious (Lau, 2006; Miranda et al., 2005), and trauma-focused cognitive behavioral therapy seems particularly effective (Classen et al., 2011; Ford et al., 2018; Han et al., 2021; MacIntosh et al., 2018; Noroozi et al., 2018; Wieferink

et al., 2017). Two meta-analyses support the use of trauma-focused therapies and active interventions in refugees (Kip et al., 2020; Lambert & Alhassoon, 2015).

Clinicians should pay particular attention to racial trauma (Chioneso et al., 2020; Comas-Díaz, 2016). Therapists must identify victims of racial trauma, empower them, and incorporate trauma-focused interventions into treatment. In order to help clients navigate future racist incidents and assist those around them, it is important to consider therapeutic aspects, take into account cultural aspects in the expression of trauma and cultural systems of care, amplify clients' social support and connection to their communities, and integrate liberation psychology into the care and empowerment process (Comas-Díaz, 2020; Quiñones-Rosado, 2020). Comas-Díaz's (2016) method combines culturally relevant traditional therapies, liberation psychology, and systems of ethnic healing, incorporating social action, psychological decolonization, reprocessing, desensitization, evaluation, and stabilization. This method enables survivors to become more competent at expressing and changing their reality, addressing both racial trauma and race-based stress. The Healing Ethno-Racial Trauma (HEART) framework (Chavez-Dueñas et al., 2019) is a treatment for racial trauma among individuals of Latino descent residing in the United States. This model includes four phases: establishing sanctuary spaces; acknowledging, reprocessing, and coping with symptoms; strengthening and connecting individuals, families, and communities to survival strategies and cultural traditions that heal; and liberation.

Psychologists must consider cultural aspects of symptom presentation and complex trauma as they influence meaning-making processes that modulate pathways to resilience (Orang et al., 2023). Culturally sensitive psychological interventions do not stigmatize or pathologize mental health problems, instead focusing on the resilience and resources of the clients. (Goodkind et al., 2014; Marley & Mauki, 2019; Murray et al., 2010; Orang et al., 2023; Yellman & Murray, 2013). In their clinical work, psychologists must cultivate the inherent resilience and strength displayed by immigrants amidst traumatic experiences. Immigrants possess personal, familial, and community resources that support their confidence, self-efficacy, positive functioning, self-belief, agency, and ability to manage acute or chronic challenges (Aube et al., 2019; Poudel-Tandukar et al., 2019; Weine, 2011). Resilience is associated with self-esteem, self-awareness, optimism, self-efficacy, meaning-making, and quality of life (Armstrong et al., 2011; Grasser, 2022; Cowden & Meyer-Weitz, 2016; Goodkind et al., 2014; Lee et al., 2008; Marley & Mauki, 2019; Ryff, 2014; Siriwardhana et al., 2015). The resilience of migrant and refugee groups is a key factor against the development of mental health problems such as depression, anxiety, and PTSD (Siriwardhana et al., 2015; see also Aube et al., 2019; Gagnon et al., 2014).

Holistic, Community-Centered Approaches

Psychologists should incorporate holistically inclusive, antiracist practices that promote healing and thriving while centering and empowering immigrant communities. These approaches shift how mental health services are structured in typical institutions and settings. Elements can include taking a holistic view of the connections between mind, body, and spirit, centering collective and community well-being, and integrating intersectional and transnational identities (e.g., Bryant-Davis & Comas-Díaz, 2016). Critical perspectives have been applied to develop new assessment tools to measure the degree to which immigrants are perceived as threats by white majorities (Kiehne & Cadenas, 2021) and the impact of stigmatization and marginalization on their psychological well-being (Santos et al., 2021).

Emerging research suggests that practice and interventions that infuse critical consciousness and liberatory approaches should be mainstreamed. For instance, interventions targeting the educational and career development of Latinx immigrant youth in K-12 and higher education have produced promising effects (McWhirter et al., 2013, 2021). Educational intervention programs grounded in critical consciousness have also been helpful to immigrant communities in learning about community-based social entrepreneurship, internet technology, and workforce development while engaging in culturally affirming dialogues (Cadenas et al., 2020; Cadenas, Campos et al., 2022). A recent model developed by psychologists, allied health professionals, and immigrant rights activists provides an initial blueprint for liberatory practices that may be embedded into psychologists' many roles with immigrant communities (Cadenas, Campos et al., 2022). These practices include centering immigrant voices and wisdom, establishing relationships that promote democratic sharing power, infusing trauma-informed conversations, and collaborating in teams to develop action strategies that are responsive to regional contexts. Additionally, the HEART framework in immigrant commu-

nities provides an excellent guide for the integration of critical consciousness and resistance approaches within the provision of clinical and mental services to immigrants (Chavez-Dueñas et al., 2019). These intervention approaches inform psychological practice, guiding scholars and practitioners to develop interventions that are responsive to the lived realities of immigrants who experience varying degrees of oppression and marginalization.

LANGUAGE ACCESS

This report has repeatedly cited language and other structural barriers to accessing health care as contributing to some negative health implications for immigrants. Working with interpreters can mitigate these barriers and address psychologist own ethical duties. Indeed, psychologists working with immigrant populations must comply with Title VI of the 1964 Civil Rights Act, which requires all federally funded programming (e.g., Medicaid) to increase access to persons with limited English proficiency through reasonable means, whether through the provision of services in a client's native language or through the use of interpreters. Evidence generally suggests that there is no difference in behavioral health outcomes when interpreters are used during trauma-focused interventions versus when services are provided in the client's native language (Villalobos et al., 2021).

Predoctoral and postdoctoral graduate training in health psychology generally does not provide specific training on working with interpreters (e.g., Hernandez et al., 2022; Martin et al., 2020), and APA has yet to issue specific practice guidelines for psychologists on the use of interpreters. However, since *Crossroads*, significant progress has been made, including the publication of Professional Guidelines for Psychological Evaluations in Immigration Proceedings (Mercado et al., 2022), which provides extensive information on the use of interpreters in evaluations used in immigration court proceedings; recommendations for working with interpreters in psychotherapy and psychological and neuropsychological settings (e.g., Martin et al., 2020); suggestions for addressing training needs in the use of interpreters (Frandsen et al., 2019); and a number of national guidelines for psychologists working with interpreters (British Psychological Society, 2017; Australian Psychological Society, 2013). Psychologist training should include trauma-informed approaches to working with interpreters, especially with immigrant populations at high risk of having experienced traumatic stress, as interpreters are often ill-prepared for assessment and therapy sessions focused on trauma (Villalobos et al., 2021). Practice guidelines should be developed, and advocacy should be conducted to fund the use of interpreters, particularly in treatment settings that might not be bound by Title VI.

Integration With Immigration Courts

Since *Crossroads*, many psychologists have supported immigrants undergoing immigration court proceedings, leading to guidelines and publications. Assessment of social and psychological functioning and well-being can aid clinical care, inform immigration proceedings, and support government agencies to provide adequate care to immigrants seeking legal relief. Professionals performing such evaluations serve a vulnerable population, contributing to outcomes that inform important decisions for the lives of immigrants and their families. Recently published principles for psychologists and other mental health clinicians completing psychological evaluations intend to provide a framework and promote the quality and consistency of immigration-related evaluations (Mercado et al., 2022). They provide well-supported guidance for the practice of forensic psychological assessments (i.e., the evaluation answers a psycholegal question) and forensic-adjacent assessments (i.e., the evaluation is conducted on an individual in immigration court proceedings) conducted for the United States Citizenship and Immigration Services and other immigrant-serving entities. Psychologists and allied health professionals must conduct ethical evaluations and obtain adequate training on effective existing standards (See Appendix A), especially given emerging scholarship on the risk that immigration court proceedings pose to immigrant health (e.g., Bailey et al., 2021).

Future Directions for Service Provision

In the context of service provision in the new immigrant context, psychologists should:

1. Provide care in locations convenient to immigrant populations, ideally providing holistic, wraparound services incorporating counseling, therapy, medication management, case management, social support, educational assistance, and community-based programs;
2. Diversify the workforce involved in the provision of services to immigrants, including partnering with community health workers;
3. Increase interpersonal support to immigrants, particularly youth and families, in order to promote secure attachments, helping cultivate a sense of security and resilience;

4. Emphasize preventive interventions and health promotion, which are crucial components of effective public health strategies;
5. Ensure that interventions are trauma-informed, including cultural aspects of symptom presentation and race-based trauma;
6. Rely on best practices for working with interpreters and conducting assessments with immigrants seeking legal relief;
7. Receive training to include recent published frameworks and principles that promote quality and consistency on immigration evaluations;
8. Use expertise as scientists and practitioners beyond person-level interventions and treatments; target the dynamics between individuals and institutions and/or systems (i.e., structural approach).

What Considerations Should be Emphasized for Conducting Research With Immigrant Populations?

PARTICIPANT RECRUITMENT

Immigrant populations are underrepresented in research studies. Although immigrant populations are certainly interested in safeguarding and improving their health, they are often considered "hard-to-reach" in health research. Barriers such as language, cultural differences, fear of disclosing sensitive information (e.g., undocumented status), and mistrust of researchers prevent many immigrants from participating in health research. As such, the use of traditional probability sampling methods to recruit a representative immigrant sample is a significant obstacle.

To facilitate recruitment efforts, researchers should apply diverse sampling methods that are culturally and contextually informed. Partnering with trusted community organizations and entities such as places of worship, schools, family-oriented or community-based events (e.g., community fairs, soccer leagues) are effective recruitment strategies, as well as advertisements in culturally-appropriate media such as radio or newspapers (Mansfield et al., 2023; Martinez et al., 2012). Collaboration with cultural brokers from the immigrant community as members of the research team is also crucial (Hodges et al., 2024). Snowball sampling and respondent-driven sampling, which entail tapping into immigrant social networks to facilitate recruitment are also effective recruitment strategies (Garcini et al., 2020; Reichel & Morales, 2017)

Although nonprobabilistic sampling approaches can limit the generalizability of findings, various statistical approaches exist to make data more representative of the population being studied. These statistical approaches include, for example: using weighted sampling to compensate for under- or over-representation of certain immigrant populations; poststratification, which involves creating weights based on specific characteristics such as age, gender, ethnicity, education, etc., and can aid in reducing sampling biases and account for survey design effects, resulting in a more representative dataset. Calculating poststratification weights can be done using nationally representative data (e.g., U.S. census, the Current Population Survey, the American Community Survey), although finding good estimates for immigrant characteristics is challenging.

Inclusion of Acculturation in Immigrant Health Research

It is critical to consider the role of acculturation in immigrant health outcomes. Although the use of unidimensional models of acculturation has been abandoned by most researchers for theoretical and empirical reasons (Yoon et al., 2011), there remain challenges about the complexities involved in the assessment and measurement of multidimensional models of acculturation (see Ferguson et al., 2023). Regardless, it is critical for future research to utilize novel theoretical frameworks that can facilitate understanding of the complex interplay of factors that influence immigrant health and a healthy adaptation process. The remote acculturation framework can be used to examine premigrant acculturation and is compatible with proximal immigrant acculturation frameworks; therefore, researchers are encouraged to use both frameworks to uncover longitudinal and lifespan associations with immigrant health.

Research With Immigrant Families

While the decade since *Crossroads* has seen increased research on how migration can threaten attachment bonds, with long-term consequences for immigrant families, several important areas of research warrant additional attention. First, while cross-sectional research links the loss of social support associated with migration to deleterious health outcomes, and conversely, attachment security and interpersonal ties with positive health outcomes, more longitudinal research is sorely needed. The long-term impacts of family separation due to migration,

detention, and deportation on immigrant attachment security, interpersonal functioning, and health is currently unknown. Identifying the costs of family separation across multiple levels of analysis—including its possible biological and epigenetic effects—is essential to understanding health disparities faced by immigrant communities and endeavoring to remove the societal structures and policy approaches that create them.

Longitudinal research is needed to highlight putative causal mechanisms by which family separation exerts a negative influence on children, parents, and communities more broadly. Mediational research is needed to explore how family separation associated with migration, detention, and deportation may be linked to health outcomes through the mechanism of attachment insecurity or related constructs like emotion dysregulation or deficits in social cognition. Mediational research is also critical in identifying malleable treatment targets. That is, while the separation itself may be outside the scope of evidence-based clinical care, affecting change in mediational processes like those aforementioned is squarely within the bounds of many clinical interventions and can ameliorate the harm of ongoing family separations. Within this broader area for future research, several methodological recommendations should be noted. Attachment measures and those targeting other interpersonal processes must be subjected to psychometric evaluation in multiple languages and with immigrant groups specifically. Moreover, a broader perspective on attachment bonds—that moves beyond biological parents—will be needed to recognize the varied caregiving arrangements and large interpersonal networks many immigrants experience. Finally, documenting health outcomes associated with family separation necessitates reaching families who have experienced separation—meaning that recruitment efforts must focus on community partners and the sampling techniques mentioned earlier in this section.

Conducting Research Using Decolonial and Liberation Psychology Lenses

Research that conceptualizes scientific endeavors in the context of colonial and decolonial dynamics is needed to fill existing knowledge gaps in immigrant health research (Garcini, Barrita et al., 2023). Decolonial and liberation approaches to research intentionally undo colonial ways that have shaped our knowledge practices and cocreate scientific knowledge through collaborative work with immigrant communities (Garcini, Barrita et al., 2023). Awareness of language and policies that maintain the status quo require the unmasking of dominant beliefs and the development of critical consciousness. For example, immigration research has been problematic when framing questions around how well immigrants adapt to the majority culture, or when analyses revolve around comparisons between ethnic groups of immigrants and the majority group in the receiving country.

Valuable examples exist of decolonial and liberation theory and methodology that can shift the approach and conceptualization of research studies with immigrant populations. For instance, the liberation psychology approach to immigrant integration conceptualizes migration as a process of self-empowerment, self-construction, and transformation of internal processes (e.g., critical thinking; García-Ramírez et al., 2011). Interdisciplinary scholars offer a critical analysis of immigration and antiracism in relation to nationalism and settler colonialism (Chatterjee, 2019) that may serve as a guide to deepen and clarify the view of migration as a process. For applied research, undocumented critical theory (Aguilar, 2019) challenges mainstream immigrant narratives and proposes mechanisms of empowerment among immigrant communities. Decolonial and liberation frameworks are helpful in building a scientific understanding of immigrants that is culturally and contextually informed.

FUTURE DIRECTIONS FOR RESEARCH

In the context of research within new immigrant communities, researchers should:

1. Begin with deep cultural humility, including a willingness to invest in lifelong critical reflexivity and learning, to rethink long-standing beliefs and values, and to commit to action that enhances community well-being;
2. Recruit immigrant populations in health research, utilizing diverse sampling methods and statistical approaches as necessary;
3. Investigate the long-term impacts of family separation due to migration, detention, and deportation;
4. Examine positionality along various social systems and identities (e.g., race, ethnicity, social class, gender, sexuality, ability, immigration status) in relation to the immigrant groups and communities that they are seeking to learn about;
5. Critically question what constructs and questions are meaningful to immigrant communities themselves, rather than imposing Westernized concepts;

6. Engage in partnership, cocreation, and empowerment of immigrant voices and roles, and truly shared leadership in scientific practices, and outcomes;
7. Decolonize their methods by adopting a wider range of methodological and analytical approaches, including multiple forms of qualitative research and mixed-methodologies.

How Can Immigration-Related Issues Be Incorporated Into Education and Training?

APA's training guidelines for students indicate that "training programs strive to ensure that psychology trainees demonstrate acceptable levels of knowledge, skills, and awareness to work effectively with diverse individuals" (APA, n.d., Serving Diverse Public section). Given the changing immigrant context of the United States and globally, it is an ethical responsibility to train students to understand the immigrant context. The *APA Code of Ethics* (2017a) explicitly recognizes national origin as a cultural factor that must be considered in working with the public to reduce biases when working with immigrant populations. Therefore, APA's *Guidelines on Race and Ethnicity in Psychology* (APA, 2019) apply to the work of psychologists with individuals that have an immigrant background. These guidelines recommend training that promotes: inclusive curricula creation for ethnic-racial responsiveness, equity, and justice (guideline #5); ethnic-racial self-awareness and reflexivity in trainees (#6); community engagement skill development for work with ethnically diverse groups (#7); and, accountable educational systems that address the ongoing negative effects of ethnic-racial biases and instead foster well-being and justice (#8).

Many psychology departments, the institutions of higher education in which they are embedded, and relevant organizations in broader society have had ongoing diversity, equity, and inclusion (DEI) efforts since the 2020 racial reckoning, although some states are now adopting anti-EDI legislation (Hicks, 2024). Some institutional and organizational structures already exist to deliver training on the uniqueness of immigrants within broader DEI objectives, yet national origin, one of the 10 cultural dimensions critical to incorporate in work with diverse ethnocultural groups (ADDRESSING framework; Hays, 2008, 2016) is often insufficiently addressed by DEI efforts. Psychologists have both an ethical imperative and the materials (e.g., frameworks, empirical literature) to train students to competently serve immigrant-origin individuals, families, and communities.

Current State of Training

Given the number of immigrants and children of immigrants in the United States, it is crucial that training programs incorporate immigration and immigrant health, as should guiding documents for practitioners. To the Task Force's knowledge, there is no centralized listing of psychology programs with immigration-related training offerings (as there are for aging, couples and families, or addiction) nor centralized lists of relevant continuing education offerings. In addition, APA Guidelines on Race and Ethnicity in Psychology include immigration and immigrant status minimally, while APA's Multicultural Guidelines include only slightly more discussion of immigrant health (including acculturation, for instance). Within both the APA's Standards of Accreditation for Health Service Psychology: Master's Programs and the APA's Standards of Accreditation for Health Service Psychology, immigrant status is not mentioned, despite several standards relating to equity in terms of race, ethnicity, and other demographics. Regarding training emphases, the terms "specialties," "subspecialties," and "proficiencies" are specifically defined and listed on APA's website, and none include multiculturalism, broadly, or immigrant health, specifically.

A newer Ph.D. program in clinical psychology at the U.S.-Mexico border has an innovative Latinx mental health focus highlighting immigrant populations. Doctoral students in clinical psychology complete coursework on assessments and interventions with immigrant groups and complete field research and clinical practice at a Humanitarian Respite Center in the United States and at tent encampments in northern Mexico. To the knowledge of the Task Force, there is only one evidence-based training curriculum designed to enhance cultural competencies for providing psychological services to immigrant communities (Cadenas, Neimeyer et al., 2022). Research indicated that this brief training curriculum (three 90-minute educational sessions) was effective in promoting foundational competencies among psychologists across career and educational stages, including graduate students and seasoned providers. Programs like these can offer models for immigrant health training. APA offers some guidance regarding the taxonomy programs should use to refer to their specialties or subspecialties so that there is consistency across programs in what would be considered an "emphasis" versus an "experience." While no program could feature immigration or immigration health as a major area of study under this taxonomy, they could offer an emphasis, exposure, or experience related to immigrant

health. Indeed, existing psychology training programs and internship programs may be able to offer courses or didactics specific to the psychology of immigration, specialized training in immigration evaluations for a forensic context, or practicum experiences related specifically to immigrant communities. However, these offerings are frequently dependent upon the particular interests of faculty and may not be sustainable for the training program itself due to changes in faculty composition and interest. Several webinar series and continuing education programs in psychology focus on specific aspects of serving immigrant communities, such as unaccompanied immigrant minors. However, these are, by their nature, extracurricular for psychologists and do not aim to provide trainees with fundamental competency working with immigrants. Educational programs beyond psychology exist to provide specialized postgraduate training or certificates in migration, refugee studies, or global mental health.

The current state of training must also acknowledge that psychology is generally perceived by many immigrant communities as a Western-based, ethnocentric discipline (Wang & Çiftçi, 2019). Immigrant students face barriers to admission or academic success within training programs associated with family and personal stressors (e.g., legal troubles or financial strain). Structural barriers, including early exposure to colonial perspectives in psychology, difficulties gaining research experience during college years, and limited mentorship from immigrant origin faculty may all pose barriers for success among immigrant background students in psychology and the biomedical sciences. There are several domains in which the status quo could be improved.

Diversifying Training Programs. To encourage more immigrant-background youth to pursue psychology as their professional career, state and/or federal organizations could provide financial incentives to psychology graduate programs to reach out to younger students with immigrant backgrounds who are interested in psychology. Changes to the admissions process, either formally or informally, are needed to recognize the unique strengths of immigrant background students and to recognize that structural barriers and discrimination may affect their applications. For instance, an immigrant background student's application may show diverse language skills and unique wisdom and resilience stemming from their immigrant experience but may not reflect volunteer work in a research lab which may not be financially feasible. Moreover, immigrant-background students whose native language is not English may have lower standardized testing scores, but their multilingual fluency is a strength and necessity in our profession.

Training programs in the new immigrant context must also center immigrant students and attend to their unique strengths. This means recognizing that immigrant students possess a wealth of multicultural and international experience to share, often possess a strong personal and family commitment to education, and tend to have developed levels of perspective taking, flexibility, and resilience. Moreover, a sensitive training program will recognize that immigrants should not be asked to speak on behalf of their entire group nor be compelled to share when other students are not (see *APA Ethics Code* Section 7.04).

Coursework. Research has indicated that, beginning in secondary education and extending through higher and continuing education, educators can guide learners to examine their social positionality and practice reflexivity (Jacobson & Mustafa, 2019). This can help students develop cultural humility and understand the processes of acculturation and enculturation, both regarding their own identities and those of others (Lorenzo-Blanco et al., 2023). Much of the published empirical and training research in these domains features people of color and people from immigrant backgrounds. More specifically, psychology training programs lack training on immigrant strengths and needs and on the skills trainees will need to develop competence with new populations. Engaging learners in reflexivity can motivate their involvement in social justice activities, advocacy, and collaboration with immigrant communities.

Research Training. Immigrant-origin individuals and communities are vulnerable populations from an ethical standpoint, meriting higher standards for their protection as "human subjects" in psychological research. Immigrant research calls for nuance in applying the Belmont principles (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979) of respect for persons (e.g., ensuring that consent is truly "informed" and voluntary given differences in language, culture, and power between most researchers and immigrant participants); beneficence (e.g., collecting only necessary data to safeguard against confidentiality breaches that could harm immigrant-origin individuals, especially if undocumented); and justice (e.g., lowering barriers to participation and prioritizing rapid dissemina-

tion of results back to immigrant communities to decrease risks and increase benefits of research participation). For these reasons, Hernández et al. (2013) published ethical guidelines for in-person research with immigrant communities, and Hodges et al. (2024) published guidelines for ethical online research with immigrant communities.

Training researchers who will engage immigrant communities also involves careful consideration of immigration-specific variables (e.g., acculturation), theory, research design, and methodology. Bidimensional, tridimensional, and multidimensional acculturation models that capture multiple cultural affiliations should be utilized. Acculturation proxies such as age of immigration are not robust psychological variables and should no longer be used in isolation. Instead, acculturation orientations should be measured along with acculturation conditions (e.g., perceived discrimination) and processes of acculturation (e.g., parent-child communication, identity processes) to best predict individual differences in outcomes (see Figure 6; Ferguson et al., 2023). Moreover, approaches to acculturation that focus on the dynamics of intergroup interactions with a view to promoting multicultural effectiveness of both nonimmigrants and immigrants should be included in research as important contributors to immigrant health (van der Zee & van Oudenhoven, 2022).

Research designs grounded in strengths-based approaches avoid stereotyping. Community-based participatory research and mixed methods may be particularly appropriate for immigrant health research (Abdi et al., 2022; Vaughn et al., 2017). In sync with representational ethics, research teams intentionally assembled to include researchers who are cultural insiders and cultural outsiders to the immigrant communities are likely to produce high-quality immigrant research (Lorenzo-Blanco et al., 2023). Moreover, quantitative and mixed methods daily diary research can examine the health implications of daily fluctuations in the salience or integration of multiple cultural identities among immigrant-origin individuals in studies of mental and physical health (see Nguyen & Ferguson, 2019; Schwartz et al., 2020; Ward et al., 2021; Wen et al., 2023).

Clinical training. Heterogeneity among immigrant populations means that there is no single way to provide training for working with immigrant-background clients and that efforts to serve and avoid over-pathologizing immigrants are, by design, context specific. Still, current diagnostic systems for mental disorders and psychological issues do not adequately take into consideration cultural factors (Reynolds & Suzuki, 2013) and commonly used assessment tools have not been validated with immigrant populations. These realities pose ethical dilemmas for using the assessment tools to inform high-stakes decisions (e.g., placing a child in an individualized education program or determining custody cases). In contrast, culturally responsive approaches (e.g., cultural formulation interviews) that include initiating a discussion with immigrant clients/patients to gather information about their beliefs related to mental illness and culturally appropriate healing methods so they can take active steps to incorporate client preferences into the treatment planning and practice are related to positive treatment outcomes (Muralidharan et al., 2017). An example of culturally responsive clinical training is seen in the guide for psychological service providers seeking to develop competencies for working with immigrants protected by the Deferred Action for Childhood Arrivals (DACA) program (Cadenas et al., 2020). That guide contains 10 initial steps to consider when providing clinical services with immigrants, and it was published in collaboration with Informed Immigrant, a hub for resources for providers and the community that is maintained by immigrant-serving groups. While individual training guides may not be generalizable to all immigrants, a shift in perspective from an individual to a structural frame of reference can enhance the contextual and cultural relevance of clinical interventions among immigrant communities and affect community-level outcomes (Wilcox et al., 2024).

Given the increasing immigrant populations in the United States, clinical training programs at master's and doctoral levels, predoctoral internships, and postdoctoral programs struggle to recruit sufficient faculty and supervisors with bicultural, bilingual, multicultural, and multilingual backgrounds, and to establish practicum placements in collaboration with local immigrant serving organizations. Additionally, applied psychologists and health providers have been criticized for focusing too much on pathology (Marsella, 2012). A strengths-based approach can be utilized to engage in preventive interventions and/or educational/outreach activities that help immigrant communities fulfill their positive potentials. Instructors and supervisors can integrate curricula, practical training, community engagement, and field experiences into coursework and supervision to foster awareness and skills related to advocating for immigrant mental health.

Service Learning. Field training experiences allow students

first-hand exposure to the lived realities, complex disparities, and personal experiences of immigrants. This kind of "service learning" is particularly valuable in offering a systemic perspective, strengthening engagement, and building social commitment. Service learning has been found to promote students' social justice advocacy skills and engage their moral and ethical development. Service learning is critical in helping prepare students for work in community-based systems and creating social justice initiatives. In addition, students may be more deeply challenged to consider moral and ethical perspectives across community-based work. Psychology undergraduate students engaged in service learning tend to report a significantly higher level of satisfaction in courses than students who do not have the opportunity to participate in service learning (Arias-Sánchez et al., 2019). Students report a deeper absorption of course materials, which includes behavioral and personal changes (Long, 2011). Service learning in partnership with community-based organizations can help students feel more empowered, improve self-efficacy, and increase the likelihood that students will engage in future leadership and advocacy opportunities (Lee, 2019).

Advocacy Training. Experiential training in how to conduct policy advocacy is another form of service learning that can be integrated into classroom teaching. Central to this didactic approach is allowing students to use their voices as community members, voting constituents, mental health care providers-in-training, and professionals with firsthand knowledge of the concerns of migrants. Learners can engage in partnership with local organizations, investigate and select proposed legislation, and engage in direct face-to-face contact (or letter writing) with local legislators. This kind of work improves the self-efficacy of students and increases future engagement in health advocacy and leadership. Developing policy advocacy skills allows students who may otherwise be focused on individual impact (e.g., direct service) to promote mental health and migrant rights at a broader systemic level. Many students in health-related training programs engage in service learning through their clinical training; however, few students have opportunities to build skills for legislative impact. This is critical in helping students shift their perspective toward community-based work and can lead to better understanding and engagement in long-term advocacy work (Arias-Sánchez et al., 2019; Lee et al., 2019; Long et al., 2011).

Future Directions for Training

In the context of training students to serve the new immigrant context, psychologists should:

1. Increase the number of immigrant background psychologists by providing financial incentives to psychology graduate programs, changing the admissions process, and centering the immigrant student. It would be helpful for the state or federal government to provide more resources to encourage the establishment of training programs and faculty with expertise in training health providers to serve immigrant communities;
2. Advance cultural knowledge of psychology students at every stage of training by featuring scholarship from immigrants and recognizing the contributions of immigrants in every domain of scholarship;
3. Increase the ability of students to conduct research with immigrant populations in the domains of representational ethics; acculturation theory and methods; community-based participatory research; quantitative, qualitative, and mixed methods analytic approaches; and strengths-based frameworks; (for case studies of how psychologists can develop ethics in this domain please see Suarez-Balcazar et al., 2022; for frameworks to approach community-based research and advocacy, please see Cadenas, Campos et al., 2022 and Garcini, Barrita et al., 2023).
4. Avoid the one-model-fits-all fallacy and over-pathologizing immigrants;
5. Create more opportunities for trainees to engage in preventive interventions and educational/outreach activities that highlight the strengths or facilitate the fulfillment of the positive potentials of immigrants;
6. Incorporate professional guidelines into training curricula to effectively work with recent immigrants;
7. Increase service-learning opportunities for clinical and advocacy training.

How Can Psychologists Advocate in Support of Immigrants?

Professionals and organizations working with immigrant populations may engage in various forms of advocacy to promote immigrant well-being, such as client advocacy, student advocacy, consultation, action research, and policy advocacy. This can take place across contexts such as

schools; colleges and universities; hospitals; health agencies; and local, city, state, and national government. The Centers for Diseases Control (CDC) recognizes in its essential public health service framework the importance of promoting policies, systems, and community conditions to achieve health equity (CDC, 2023). In order to define advocacy and offer guidance on how to develop advocacy competencies and skills across ecological levels and settings, the Task Force draws upon three frameworks: (a) the APA Multicultural Guidelines (Clauss-Ehlers et al., 2019); (b) advocacy, multicultural, and social justice counseling competencies (Lewis et al., 2002; Ratts et al., 2016; Toporek & Daniels, 2018); and (c) the model of collaborative immigration advocacy (Cadenas, Morrissey et al., 2022).

APA MULTICULTURAL GUIDELINES

Initially published in 2002 and updated in 2019, the APA Multicultural Guidelines offer a helpful framework to conceptualize diversity and multicultural practice through the lens of intersectionality (Clauss-Ehlers et al., 2019). A set of 10 guidelines is presented in an ecological model to help professionals and organizations consider their practices in relation to larger contexts, time, cultural influences (e.g., country of origin, immigration status), and experiences of marginalization. Importantly, Guideline 6 states that, "psychologists seek to promote culturally adaptive interventions and advocacy within and across systems, including prevention, early intervention, and recovery." (p. 239). The model specifically encourages professionals and organizations to identify how they may serve as advocates for systems change, to engage in relationship-centered advocacy based on social justice frameworks that promote community cooperation, and to support advocacy efforts that aim to increase access to care and develop culturally affirming mental health infrastructures.

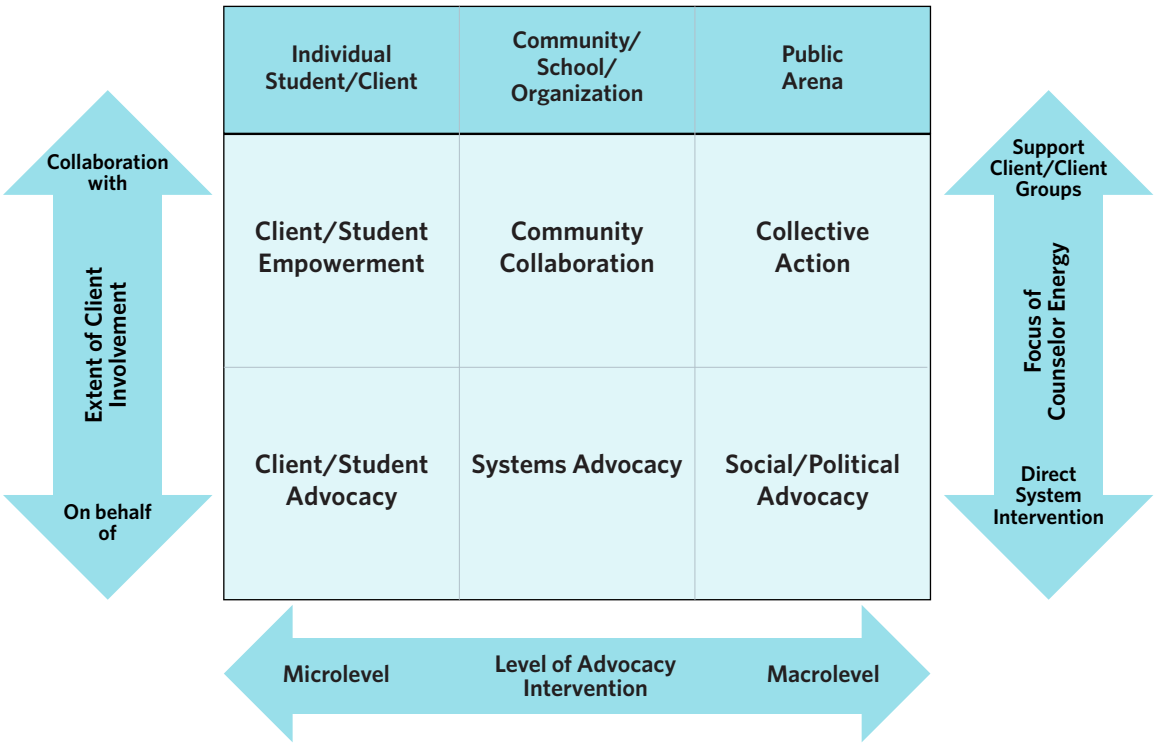
The multicultural guidelines emphasize that it is important for professionals to consider how resilience, trauma, and identity are shaped within ecological levels such as individual, family, community, school, neighborhood, and broader society, and in relational contexts such as between client and clinician, student and educator, or researcher and researcher. These considerations must also take into account human rights, influenced by power and privilege dynamics (Clauss-Ehlers et al., 2019). This model can be used as a guide to reflect upon the complexity of layers that shape the experiences of immigrant individuals and groups prior to and during advocacy efforts.

ADVOCACY, MULTICULTURAL, AND SOCIAL JUSTICE COMPETENCIES

A burgeoning body of conceptual work has delineated competencies for professionals to engage in advocacy and to infuse advocacy and empowerment strategies in services provided to individuals and groups (e.g., during clinical services or group interventions; Lewis et al., 2002; Ratts et al., 2016; Toporek & Daniels, 2018). In 2002, the American Counseling Association published a set of advocacy competencies that outline a microlevel to macrolevel ecology in which professionals and organizations can develop advocacy skills (Lewis et al., 2002). The model encourages professionals to consider whether their advocacy is focused on the individual, group, or public arena level. Furthermore, the advocate should consider whether their role is to advocate with individuals and communities or on their behalf, considering their role on a spectrum from direct support to direct system intervention. Considering this complex matrix (see Figure 6), professionals and organizations may develop competencies in empowerment, advocacy with and on behalf of individual cases, community collaboration, systems advocacy, collective action, and social/political advocacy. This expansive conceptualization of advocacy competencies is directly relevant to advocating with and on behalf of immigrant communities.

FIGURE 6

ACA Advocacy Competencies



*Counselor actions must be grounded in multicultural and ethical considerations

Building upon the ACA Advocacy Competencies, the field of counseling published a set of multicultural and social justice competencies (MSJCC; Ratts et al., 2016). These competencies guide practitioners and researchers to consider their positionality on a continuum from privilege to marginalization and in relation to the privilege and marginalization experienced by the individuals and communities that they serve. Specifically, the MSJCC framework encourages professionals to gain self-awareness, ensure an understanding of the worldview of the individuals and groups they serve, and attend to power dynamics in working relationships. This is necessary to develop and implement advocacy interventions aiming to reduce the negative influence of oppression on mental health and well-being. Applying this model to immigration advocacy, advocates should reflect upon their own positions of power and experiences of marginalization and seek to promote egalitarian relationships with immigrant individuals and communities.

MODEL OF COLLABORATIVE IMMIGRATION ADVOCACY

In recent years, leaders from several APA divisions developed an interdivisional immigration project that held critical dialogues with leaders of immigrant community organizations across five U.S. regions. This multi-year project led to the development of specific advocacy recommendations (Cadenas et al., 2021) and a model for collaborative immigration advocacy (Cadenas, Campos et al., 2022). The model provides guidance on how professionals and organizations may seek to prevent policy-based traumatization of immigrant communities by working alongside community leaders to reverse anti-immigrant policies and advance a humane immigration policy agenda. It offers guidance to establish trauma-informed advocacy partnerships that (a) are facilitated by shared leadership styles, (b) center the voices of immigrants, (c) address trauma from immigrant groups and professionals who serve them, (d) foster honest dialogue on the impact of anti-immigrant policies, (e) make use of localized team structures, and (f) develop advocacy strat-

egies led by immigrant groups that are based on mutual understanding and cooperation. Professionals and organizations who engage in immigration advocacy should apply this model to promote collaborative goals and tactics and prevent the imposition of advocacy agendas that are not guided by immigrants themselves.

As addressed in the aforementioned models and frameworks, engaging in immigration-related advocacy is complex, varying according to the ecological level, the advocacy competencies required, and the positionality and approach of the advocate. Advocates should attend to different levels of advocacy across a range of roles and settings: individual level (health professionals advocating on behalf of those they serve); community level (advocacy with community groups and organizations); policy level (advocacy for changes in local, state, and federal policies); and teaching level (training students and others with advocacy skills).

EXAMPLES OF ADVOCACY FOR IMMIGRANT HEALTH

Facilitating empowerment with clients, students, and community members	**Advocating on behalf of clients, students, and community members**
• Establish trust. • Express cultural humility. • Validate concerns. • Identify strengths and cultural values. • Connect with resources. • Recognize links between distress and social oppression. • Support developing a self-advocacy plan. • Conduct assessments that are culturally adapted and affirming.	• Acknowledge your power and privileges. • Inform decision makers about individual student needs. • Share student stories. • Serve as liaison. • Identify allies within your communities or institutions.
Community Collaboration	**Systems Advocacy**
• Contribute your skills (facilitation, research, teaching, career counseling). • Coordinate meetings with students, campus allies, community organizations, advocacy organizations. • Host a campus/community event about this issue. • Codevelop community-engaged research projects using appropriate methods (e.g., participatory action research).	• Encourage responsive policies, programs, and services. • Promote creation of formal committees. • Design and/or implement programs and services tailored to immigrant students.
Public Information Advocacy	**Social & Political Advocacy**
• Increase visibility of support for immigrant students. • Provide public information helpful to immigrant students (e.g., career development assessments, infographics, webinars). • Share knowledge and facts about this population. • Engage with media (e.g., op-eds).	• Encourage your institution to draft public statements to support humane immigration policies at the local, city/town, state, and national levels. • Connect with local, state, or national organizations advocating for policy changes. • Contact your institution, professional association with your elected officials at local, state, or national levels to advocate for change.

FUTURE DIRECTIONS FOR ADVOCACY

Based on the research summarized in this report, psychologists can use the mechanisms identified in this section to advocate for or against specific types of public policies. Psychologists should encourage policymakers to:

1. Enact policies and engage in public discourse that facilitates immigrant reception and minimizes xenophobic attitudes and actions that harm immigrant health;
2. Halt detention, separation, and deportation practices that separate families and traumatize immigrant communities;
3. Increase funding for community-based participatory research to accelerate discovery of health promotion and prevention strategies that enhance the health of immigrant communities;
4. Increase funding to federal grant programs that are focused on immigrant education, integration, and health;
5. Shift the immigration narrative to humanize and depoliticize the policy context, including acknowledging the contributions that immigrants make to health care and the U.S. workforce, economy, cultural diversity, and social revitalization.

How Should APA Engage in the New Immigrant Context?

Given the rapidly changing sociopolitical context around immigration, and the rapid growth of science and practice, the Task Force recommends that APA:

1. Ensure centralized coordination of immigration policy and activities;
2. Continue to summarize the theory and science regarding immigrant health, integration, and well-being;
3. Monitor and support the emergence of training programs and curricula focused on immigrant health, integration, and well-being;
4. Consolidate and make available resources that are essential for psychologists developing competencies to work with immigrant populations;
5. Support the development and codification of professional guidelines related to practicing within the new immigrant context (i.e., Psychological Evaluation Guidelines for Immigration Proceedings; see Appendix A);
6. Serve as a resource to community members, providers, and advocates of immigrant rights.

PART IV: CONCLUSIONS

Since the publication of *Crossroads*, the U.S. immigration landscape has changed. That changing landscape has informed scholarship conducted through novel lenses including decolonial and liberation psychology, intersectionality, population health, SDOH, cultural determinants of health, attachment theory, and trauma-informed perspectives. The state of the science regarding immigrant health is constantly evolving and will, to some extent, be outdated before the release of this report. Still, the science is converging on several conclusions about immigrant health with significant implications for the future. Specifically:

Immigrants are vulnerable to but not inherently prone to physical and mental health concerns. The global sociopolitical conditions that push individuals to leave their country of origin, the barriers and threats they encounter on their journey, and the often-challenging reception in their new country expose immigrants to health and mental health risks.

Immigrants have developed resilience-building strategies that can inform health care in the United States. Research is beginning to shed light on the many mechanisms that immigrants use to develop resilience in the context of disadvantageous conditions. This resilience has allowed immigrants to survive hardships and disadvantages. Further, health equity experts have started to learn these strategies and the science in this area is quickly growing. Indeed, migration waves accelerated the growth and refinement of distinct areas of psychology focusing on Black, Latinx, Indigenous, Asian, Arab, and Middle Eastern communities in the U.S.

Anti-immigrant policies are harmful to immigrants and to U.S. citizens. Extensive research has documented the psychological, social, and health consequences of restrictive policies, aggressive immigration enforcement that targets ethnic neighborhoods and communities of color, and discriminatory state-based policies that limit access to higher education and health services. Evidence of spillover indicates that anti-immigrant policies are detrimental to people who are not immigrants, including law enforcement on the frontlines.

Programs that help immigrants navigate the cultural and sociopolitical context in the United States are helpful to their health, supporting their economic and social contributions. Innovative research has documented that educational curricula and community-based health strategies can promote the well-being of immigrants by helping them develop an awareness of the cultural context in which they live and how to navigate obstacles. Proactive interventions are particularly effective when delivered in collaboration with immigrant communities and when aligned to the immigrant cultural and contextual lens.

Trainees and professionals interact with immigrants in every aspect of their professional lives. Training programs must prepare professionals to address the health needs of immigrant communities through research, practice, policy, and advocacy, and will be enriched by facilitating admission of and nurturing enrolled immigrant students.

Immigration is more unifying than commonly believed. Most Americans and people around the world agree that immigrants are a strength. Most people in the United States would like to see more humane immigration policies that provide a pathway to citizenship in order to decrease unauthorized entry.

As a Task Force, it is our hope that these conclusions can motivate research, clinical practice, education, and advocacy that is responsive to the new immigration landscape by capitalizing upon the strengths of immigrant communities and the strengths of our history, skills, and profession as psychologists.

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APPENDIX A: ETHICAL STANDARDS GUIDING IMMIGRATION EVALUATIONS

The National Latinx Psychological Association's Undocumented Collaborative Special Interest Group included subject-matter experts on immigration and mental health. Over the span of two years, a Task Force of the group worked together and published "Professional Guidelines for Psychological Evaluations Used in Immigration Proceedings" (Mercado & Venta, 2022). The Task Force consisted of a group of experts from the United States who have extensive experience conducting psychological evaluations; some of them have also been involved in other professional guidelines work for APA. Following is a summary of the nine principles that are included in the manuscript.

PRINCIPLE 1:

Psychologists who conduct psychological testing and assessment for immigration purposes strive to take reasonable steps to develop and maintain competence relevant to the immigration evaluation process. Psychologists conduct immigration evaluations only with populations and in content areas within the boundaries of their competence. Thus, psychologists obtain the education, training, experience, consultation, study, or supervision necessary to ensure the competence of their services or make appropriate referrals.

PRINCIPLE 2:

Evaluators must consider the influence of cultural factors on each aspect of the evaluation process, including the assessment, interpretation of data, conceptualization, and diagnosis, when making determinations regarding the examinee's mental health. Cultural factors must be included in every part of the evaluation process, from a selection of assessment measures to diagnostic conclusions (Achenbach & Rescorla, 2007; APA, 2017b; Mercado & Venta, 2022). Cultural factors are relevant during both the selection and administration of assessment measures. A cultural lens must also be used when interpreting all assessment data (Achenbach & Rescorla, 2007; APA, 2017b).

PRINCIPLE 3:

Evaluators must consider the influence of contextual factors on psychological functioning and psychopathology. Relevant contextual factors include the circumstances of immigration, past and current living environment, and community and family dynamics. Important contextual factors to consider include the possible detrimental effects of socioeconomic adversity (e.g., poverty, inadequate housing, hazardous living conditions, living in dangerous neighborhoods, food insecurity), lack of or limited job and educational opportunities, exposure to hazardous environments or natural disasters, and loss or changes in objective and subjective social status at different stages of the immigration process (including pre, during, and postmigration) on mental health, well-being, and functioning (Hass, 2018).

PRINCIPLE 4:

Evaluators must familiarize themselves with psychometric theory and scientific methods that allow them to evaluate standard assessment instruments according to their scientific merits and value as evidence in legal procedures. Mental health evaluators must be mindful of the ways that cultural and contextual adaptations, although sometimes necessary, affect the psychometric properties of a measure. Competency in psychological testing goes beyond academic training to include familiarity with studies that extend the applications of psychological tests and critically evaluate their functioning in different populations (APA Task Force on Psychological Assessment and Evaluation Guidelines, 2020; Mercado & Venta, 2022). Adaptations can be used to ensure that evidenced-based practices are culturally and contextually appropriate.

PRINCIPLE 5:

Examiners assess for and integrate consideration of the immigrant's intersecting identities when formulating opinions regarding the examinee's psychological functioning. While they share the identity of being immigrants, there is considerable variability in other identities. As such, the unique experiences of each immigrant must be considered in the context of how they shape their sense of self and how this impacts their overall functioning and psychological assessment results (APA, 2017b; Mercado & Venta, 2022).

PRINCIPLE 6:

Examiners should consider framing their evaluation and findings within a trauma-informed framework as appropriate to better capture the complexity of the examinee's psychological reality. Obtaining adequate timelines of symptom onset relative to traumatic events is critical when conducting trauma-informed assessments. Assessment measures that may capture migration-related distress and trauma symptoms more broadly can be useful in obtaining crucial information related to the psychological functioning of immigrant populations to aid in trauma-informed conceptualizations (Hobfoll & de Jong, 2014).

PRINCIPLE 7:

Examiners strive to assess the examinee's motivation, effort, and response style within the context of the evaluation to establish the validity of the evaluation. Examiners must tread available information carefully when assessing motivation and effort taking into account the appropriateness of measures used and available normative samples. Response bias (e.g., negative or positive impression management) could be detrimental to the validity of the assessment, and evaluators must make efforts to minimize these effects.

PRINCIPLE 8:

When evaluating minors, examiners should strive to utilize developmentally appropriate frameworks and appreciate that evaluations typically take place while a child is outside of a traditional caregiving environment. Examiners endeavor to follow best practices regarding assessing minors and simultaneously possess and utilize expertise in trauma-informed, culturally sensitive, and developmentally appropriate frameworks for assessment (APA, 2017a) to obtain accurate assessments and optimize information gathering.

PRINCIPLE 9

Examiners are responsible for ensuring that interpreters demonstrate competence, cultural sensitivity, and professionalism while providing a semantically accurate message converted from one language into another. It is equally recommended that psychologists take individual responsibility for making sure they are skilled at working effectively with interpreters.

Psychologists identify the examinee's first language and find an interpreter who speaks this language or dialect and is, ideally, from the same country. Psychologists should make sure the interpreter is qualified, professionally trained, and appropriate for the evaluation. When possible, psychologists should obtain formal training in working with interpreters.

CONCLUSION

Assessment of social and psychological functioning and well-being can add valuable information to immigration proceedings and support government agencies in providing adequate care to immigrants seeking relief. These guidelines for psychologists and other mental health clinicians completing psychological evaluations for the United States Citizenship and Immigration Services are aspirational, intending to promote quality and consistency in the delivery of psychological evaluations in immigration proceedings and to provide a framework for conducting immigration evaluations.

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