

MIGRANT AND MENTAL ILLNESS

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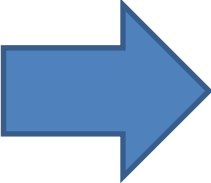

What is a migrant?

- Someone who changes their place of residence for any purpose or for any period of time
- Legal classification
- Characteristics of migration
- Motivation of migration

Occupational Migration

- Anthropology
- Diplomacy
- Higher Education
- Journalism
- Military Service
- Missionaries
- Sales People
- Seasonal Migratory Work

Patterns of Migration

- Across countries
- In country
- Rural  Urban
- Urban  Rural

Reasons for Migration

Political

- Exiles
- Refugees

Economic

- Single
- Business Transient
- Permanent
- Group

Social

- Students
- Film Stars ; Pop stars

Demographics of Migrants

- Age
- Gender
- Primary
- Education
- Voluntary or Forced?
- Duration of Location

Reactions to Migration

- Over accepting, enthusiastic
- Deny difficulties
- Actively critical
- Inhibited
- Hypo reactive: feel lost, perplexed, dissatisfied

Reactions to Migration

- Hyper reactive: labile; act out
- **Berry (1976)** Types of acculturation
 - Adjustment
 - Reaction
 - Withdrawal

Impact on Individuals

Acculturation

Language

Rituals

Behaviours

Attitudes

Deculturation

Assimilation

Acculturation Strategies

- Orientation towards one's own group
- Orientation towards the other's group

Relative preference for maintaining one's own culture and identity

VS

Relative preference for having contact with and participating in the larger society with others.

(Berry 2007)

Stages and Reactions




Reasons

Preparation → as life event → Adjustment

Generational → as event → Adjustment

Folk Explanations

- Supernatural
 - Natural
 - Somato – medical
 - Psychological
 - Mixture ><
 - Social
- 
- Does it reflect some kind of evolutionary process?

		Folk	Professional
Supernatural			
	Spirits	+++	-
	Breaking Taboo	++	-
	Evil Eye	++	-
	Soul Loss	+++	-
Natural			
	Disharmony	+++	<u>+</u>
	Fate	++	-
	Noxious Environment	+	+
	Karmic Law	+++	<u>+</u>

		Folk	Professional
Somatomedical Explanations			
Insufficient Vitality	+ +		<u>+</u>
Dysfunction		+ +	+++
Physiological Imbalance		+	+++
Heredity		+ +	+++
Psychological Explanations			
Fright		+ +	<u>+</u>
Excess Emotion		+ +	<u>+</u>
Slowness		+ +	-
Too Much Thinking		+ +	-

Changes associated with Migration

- Communication
 - Verbal
 - Non-verbal
- Social Support
- Vocational Change
- Social Roles
- Legal Implications

Factors Responsible for Distress

- Experiences before, during and after arrival
- Migrated alone or in a group
- Initial intentions and expectations
- Attitudes towards new country and culture
- Helpfulness of the new society in adjustment
- Previous similar experiences

Reactions to Migration

- Cultural Expansion
- Cultural Contraction

Culture

- Culture is broadly defined as a common heritage or set of beliefs, norms, and values (DHHS, 1999). It refers to the shared attributes of one group. Anthropologists often describe culture as a system of shared meanings.

Culture

- The term 'culture' is as applicable to whites as it is to racial and ethnic minorities. The dominant culture for much of the West is focused on the beliefs, norms, and values of Europeans. But today's UK is unmistakably multicultural.

Cultural Identities

- And because there are a variety of ways to define a cultural group (e.g., by ethnicity, religion, geographic region, age group, sexual orientation or profession), many people consider themselves as having multiple cultural identities.

Culture

- Culture is a concept not limited to patients. It also applies to the professionals who treat them.
- Every group of professionals embodies a 'culture' in the sense that they too have a shared set of beliefs, norms and values.

Culture

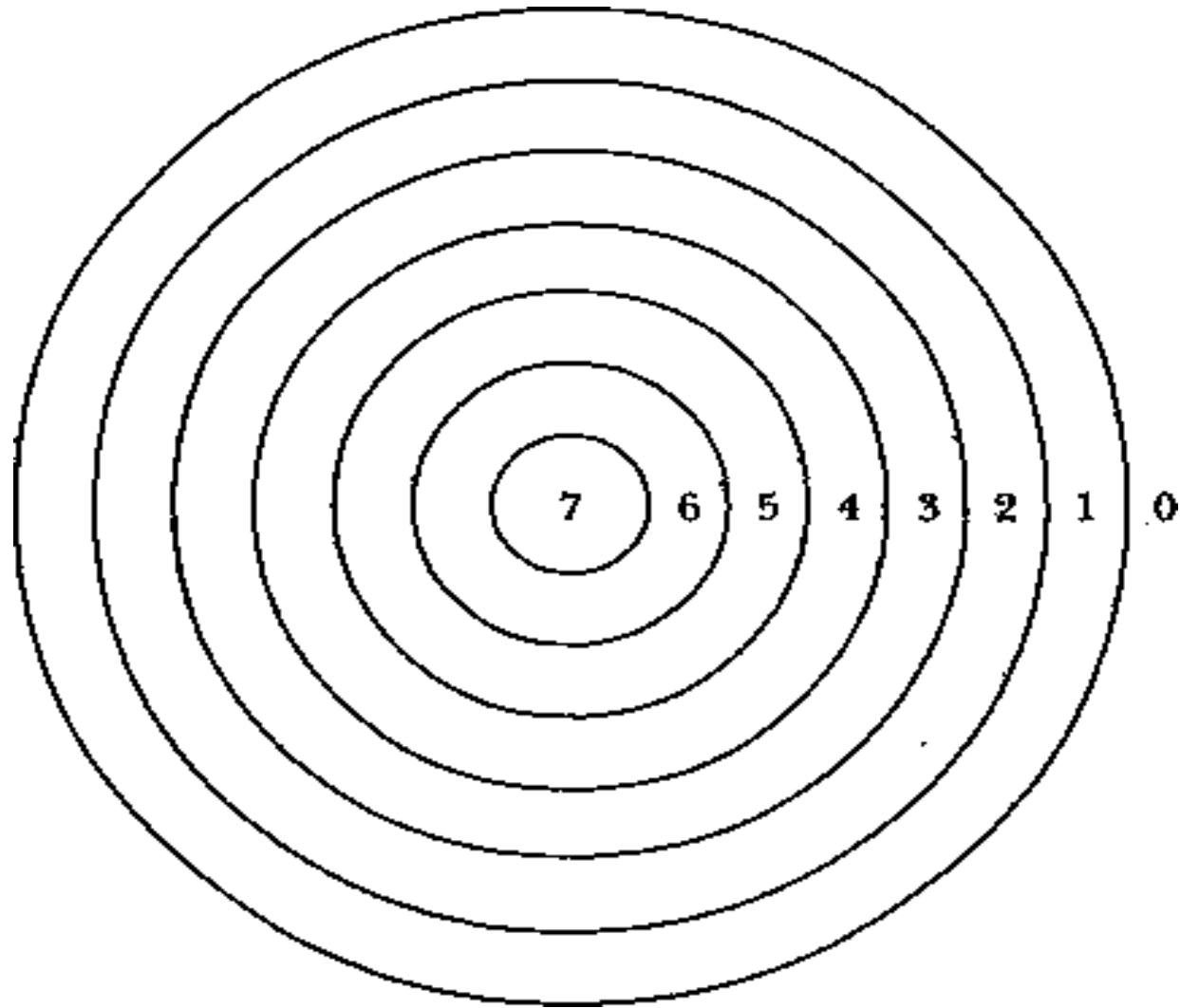
- Thus true for health professionals as it is for other professional groups such as engineers and teachers. Any professional group's culture can be gleaned from the jargon they use, the orientation and emphasis in their textbooks, and from their mindset or way of looking at the world 'world view'.

Culture

- Is dynamic
- Changes subtly over time
- Can change acutely
- Culture is integrated in people's lives
- People acquire culture - a number of ways
- Culture ensures generational continuity
- **Influences cognitive and social development**

Disease vs Illness

- Diseases are literally dis-ease and physicians diagnose and treat diseases (Eisenberg 1977)
- Patients suffer 'illnesses' which are *experiences* of disvalued changes in states of being and in social functioning (Eisenberg 1977)
- Sickness, on the other hand, is defined by the society



*Man, culture and society (Hsu, 1985):
7 unconscious; 6 pre-conscious; 5 unexpressible conscious; 4 expressible
conscious; 3 intimate society and culture; 2 operative society and culture
1 wider society and culture; 0 outer world*

Evidence of elevated rates continues



Available online at www.sciencedirect.com



Schizophrenia Research 87 (2006) 205–211

SCHIZOPHRENIA
RESEARCH

www.elsevier.com/locate/schres

The incidence of schizophrenia in European immigrants to Canada

G.N. Smith ^{a,*}, J. Boydell ^b, R.M. Murray ^b, S. Flynn ^a, K. McKay ^c,
M. Sherwood ^a, W.G. Honer ^a

- Evidence of raised rates of psychosis in immigrants to British Columbia in early 20th Century
- Analysed historical hospital records, made DSM-IV diagnoses
- RR in European immigrants: 1.54 (95% CI: 1.33, 1.78)
- Compared with Canadian-born
- *Adjusted for age, sex & time*

Evidence of elevated rates

- First reports of raised rates in black Caribbean immigrants in 1960s (Hemsi)
- Post-war immigration to UK & Europe to fill labour shortages
- Based on old Colonial ties
- Opportunity for employment & income
- But substantial discrimination, poverty, inner-city deprivation

Evidence of elevated rates

- Repeated finding for England & Wales, independent of age structure (Cochrane, 1977)
- Littlewood & Lipsedge find elevated rates in black Caribbean & West African migrants in West London

Refinement of incidence rates

- Studies improve methodologies to overcome difficulties
- E.g. Harrison et al (1988)
 - Incidence rates elevated in first & second generation Caribbean migrants in Nottingham (x8-10 white rate)
 - Prospective case-finding
 - Standardised diagnoses
 - Well-defined catchment area
- After 1991 inclusion of ethnicity data in UK Census allowed estimation of accurate denominator
- Raised rates persisted in further UK studies

Ödegaard (1932)

- Norwegians in USA n = 1067
in Norway n = 1995
- Norwegians in USA showed 30-50% higher incidence of psychiatric morbidity
- Admissions due to schizophrenia considerably higher
- 11% presented within two years of migration
- 50% *presented after 10 years or more*

UK African Caribbean Immigrants and UK Natives Rates per 1000 for Schizophrenia

Study	Location	Diagnosis	Age Std	UK Native ^s	UK African Caribbeans	Ratio
Hemsi 1967	Camberwell + Lambeth	Own from case notes	+	2.7	13.1	4.9
Cochrane 1977	England + Wales	Mental Health Enquiry	0	*M 8.7 *F 8.7	29.0 32.3	3.3 3.7
Cochrane + Bal 1987	England + Wales	Mental Health Enquiry	+	M 1.2 F 1.2	3.9 3.3	3.3 2.8
Carpenter + Brockington 1980	Manchester	Hospital	+	2.0	11.1	5.6
Dean et al. 1981	SE England	Own from assessment	+	M 1.1 F 1.0	5.5 5.3	5.0 5.3

*** Prevalence Rates**

UK African Caribbean Immigrants and UK Natives Incidence Rates per 1000 for Schizophrenia

Study	Location	Diagnosis	Age Std	UK Natives	UK African Caribbean	Ratio
Littlewood + Lipsedge 1981	Hackney	Own from case notes	+	1.9	4.5	2.4
McGovern + Cope 1987	Birmingham	Hospital	+	Age 16-29 1.4 30-64 1.1	11.7 4.7	8.4 4.3
Harrison et al 1988	Nottingham	Own from assessment	+	16-29 2.0 30-44 1.6	29.1 19.7	14.6 12.3
King et al 1994	North London	Own from assessment	+	2.0	8.9	4.4
Bhugra et al 1995	West and South London	Own from PSE assessment	+	2.96	6.88	2.2

UK African Caribbean Immigrants and UK Natives Incidence Rates per 1000 for Schizophrenia

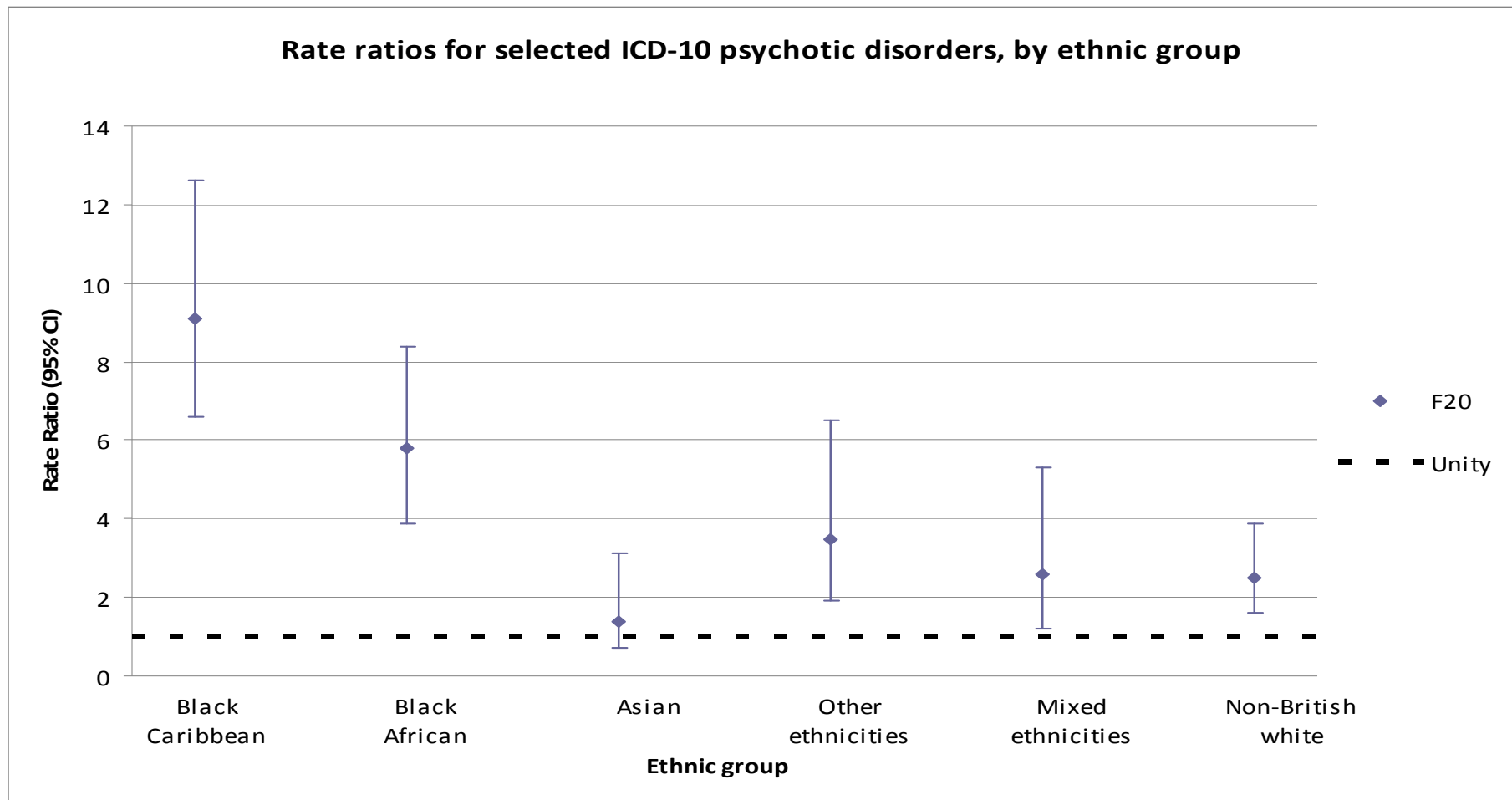
Study	Location	Diagnosis	Age Std	UK Natives	UK African Caribbean	Ratio
Castle et al 1991	London	Case Notes		1965-69 0.88 1970-74 0.98 1980-84 1.20	4.6 7.9 5.08	5.3 8.2 4.0
Thomas et al 1993	Manchester	Hospital	Yes	3.5	32.5	9.2
Harrison et al 1997	Nottingham	own	yes	6	6	10.0

Refinement of incidence rates

- AESOP & ELFEP studies
- Standardised consensus diagnoses, blind to ethnicity
- Prospective case-finding
- Well-defined catchment area
- Accurate denominator estimation 2001 Census
- Separated white British from non-British white
- Control for confounders – age, sex, socioeconomic status
- Found raised rates in several ethnic groups as reported previously

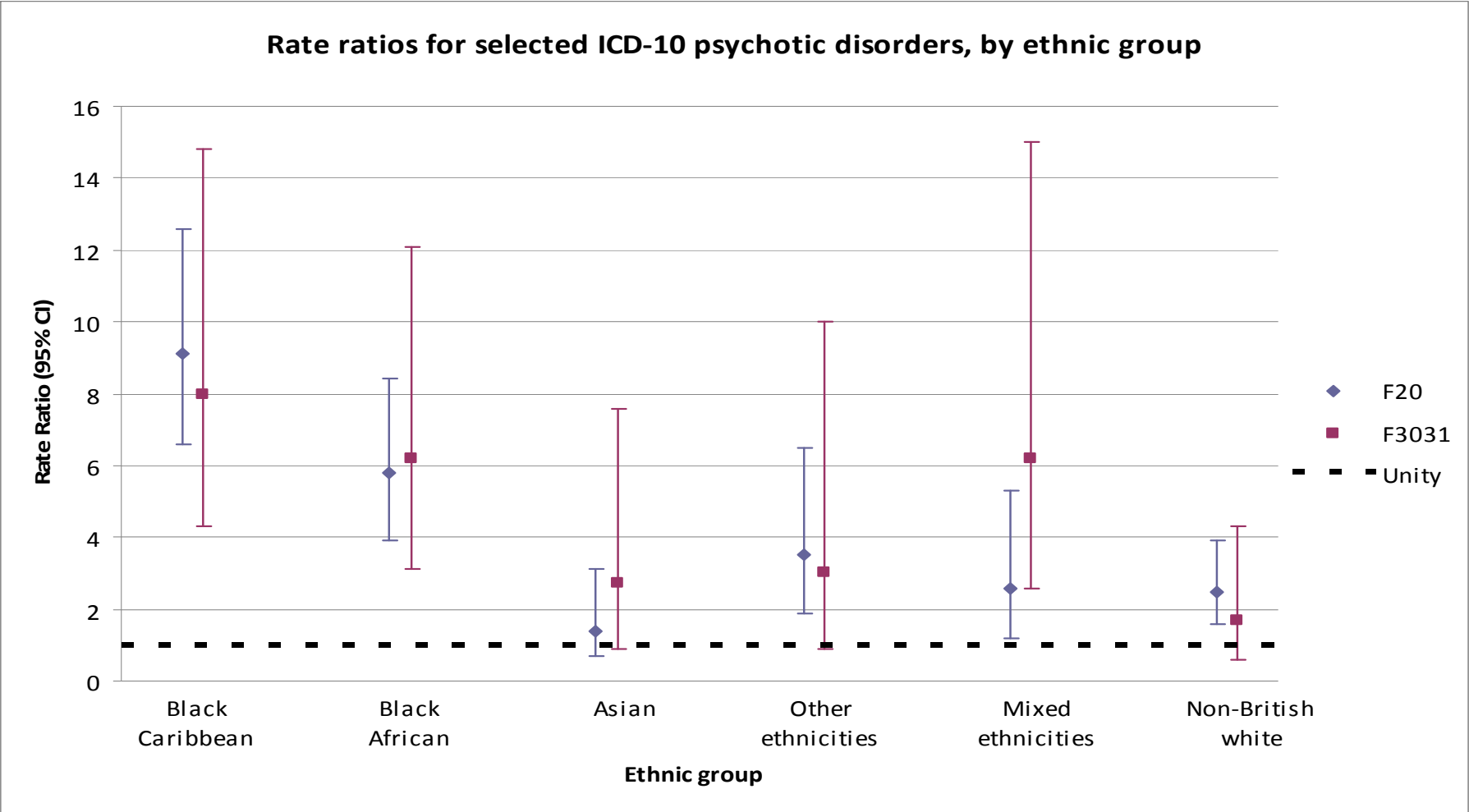
Refinement of incidence rates

- AESOP study (Fearon *et al*, 2006)



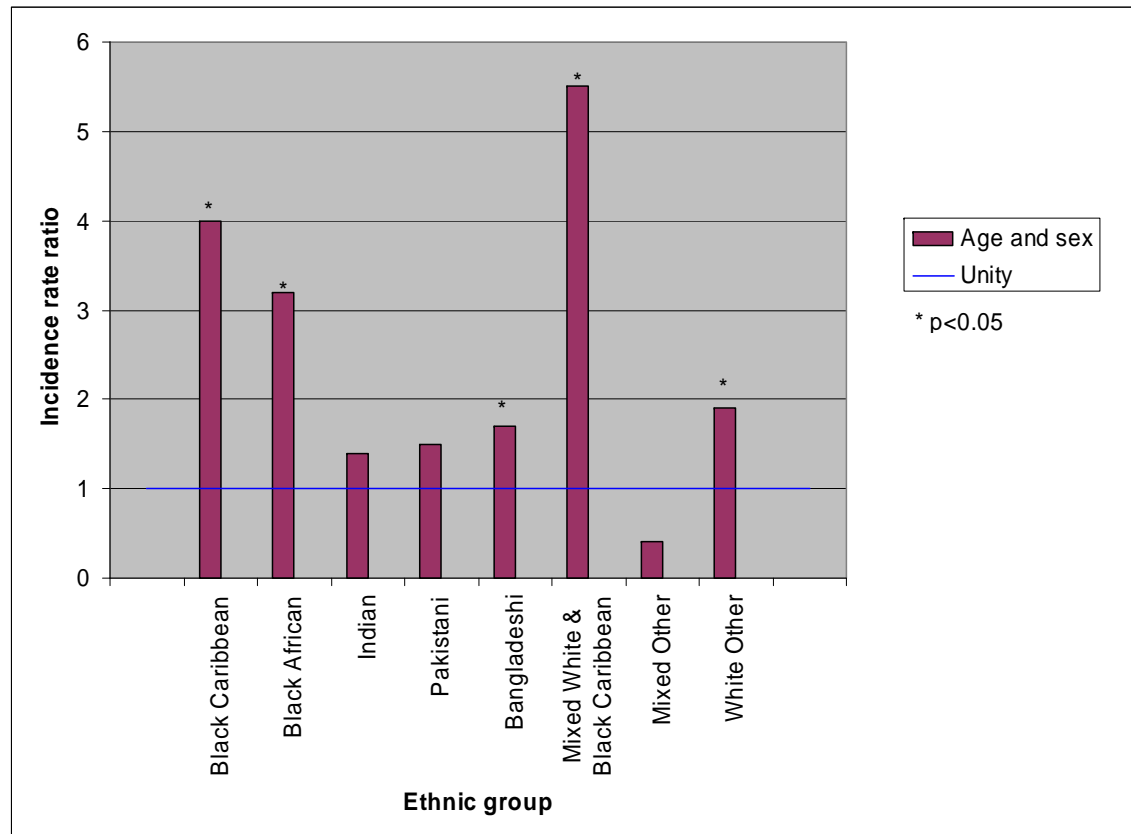
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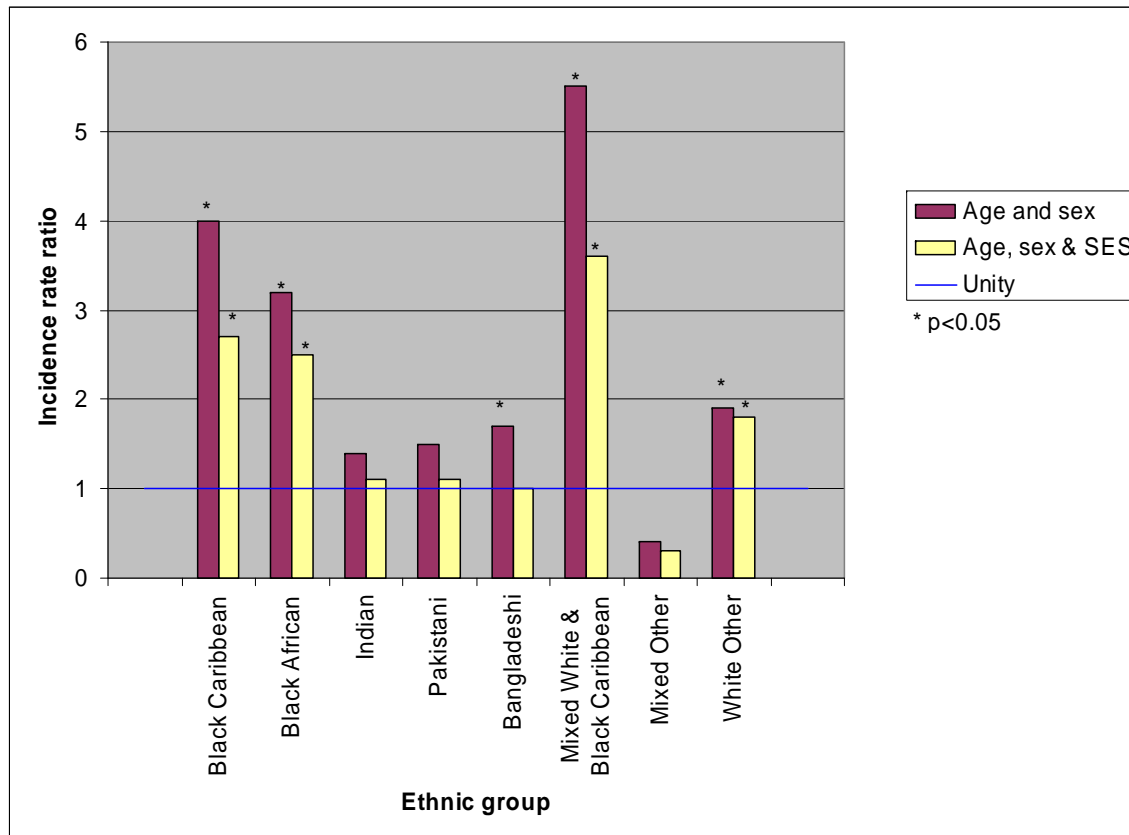
Refinement of incidence rates

- ELFEP study (Kirkbride *et al*, 2008, BJP)
- All clinically relevant psychoses (n=484):



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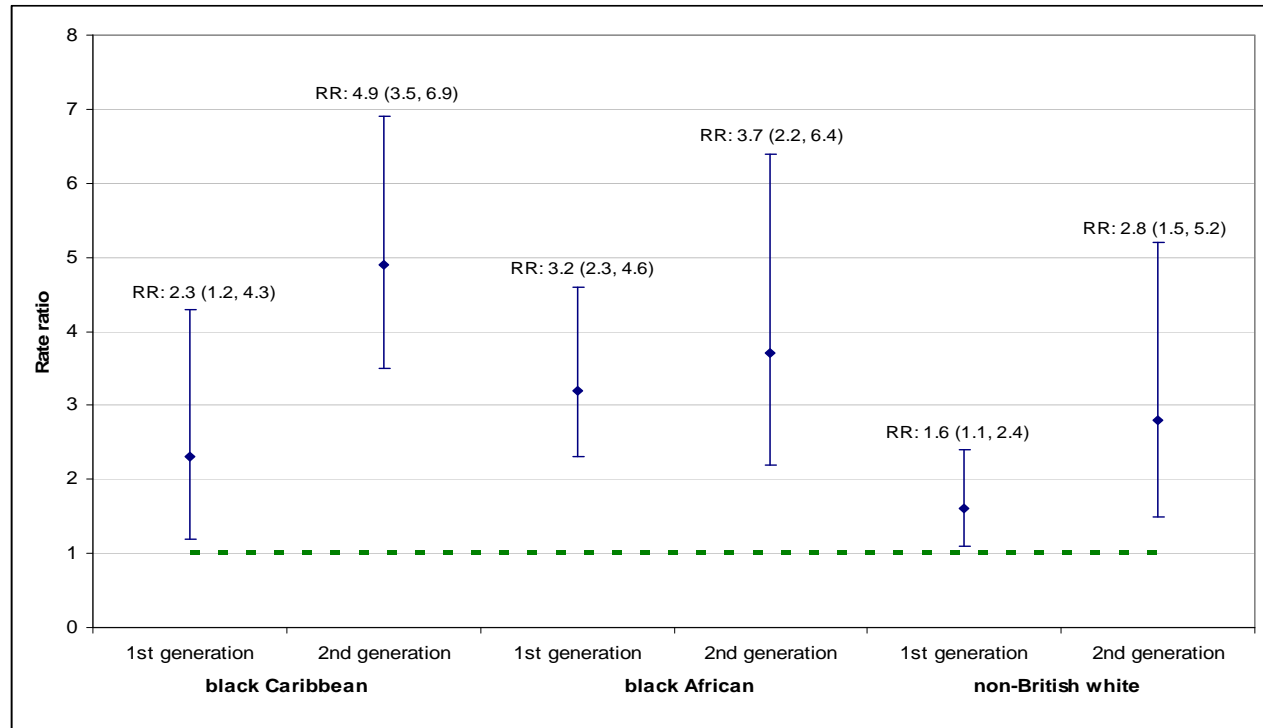
Refinement of incidence rates

- ELFEP study (Kirkbride *et al*, 2008, BJP)
- Raised rates of schizophrenia for Asian women:

IRR [95% CI]¹	Men	Women
Indian	0.8 [0.4, 1.7]	1.0 [0.3, 3.5]
Pakistani	0.8 [0.3, 1.9]	3.1 [1.2, 8.1]
Bangladeshi	0.8 [0.5, 1.3]	2.3 [1.1, 4.7]

¹Adjusted for age and SES

Refinement of incidence rates



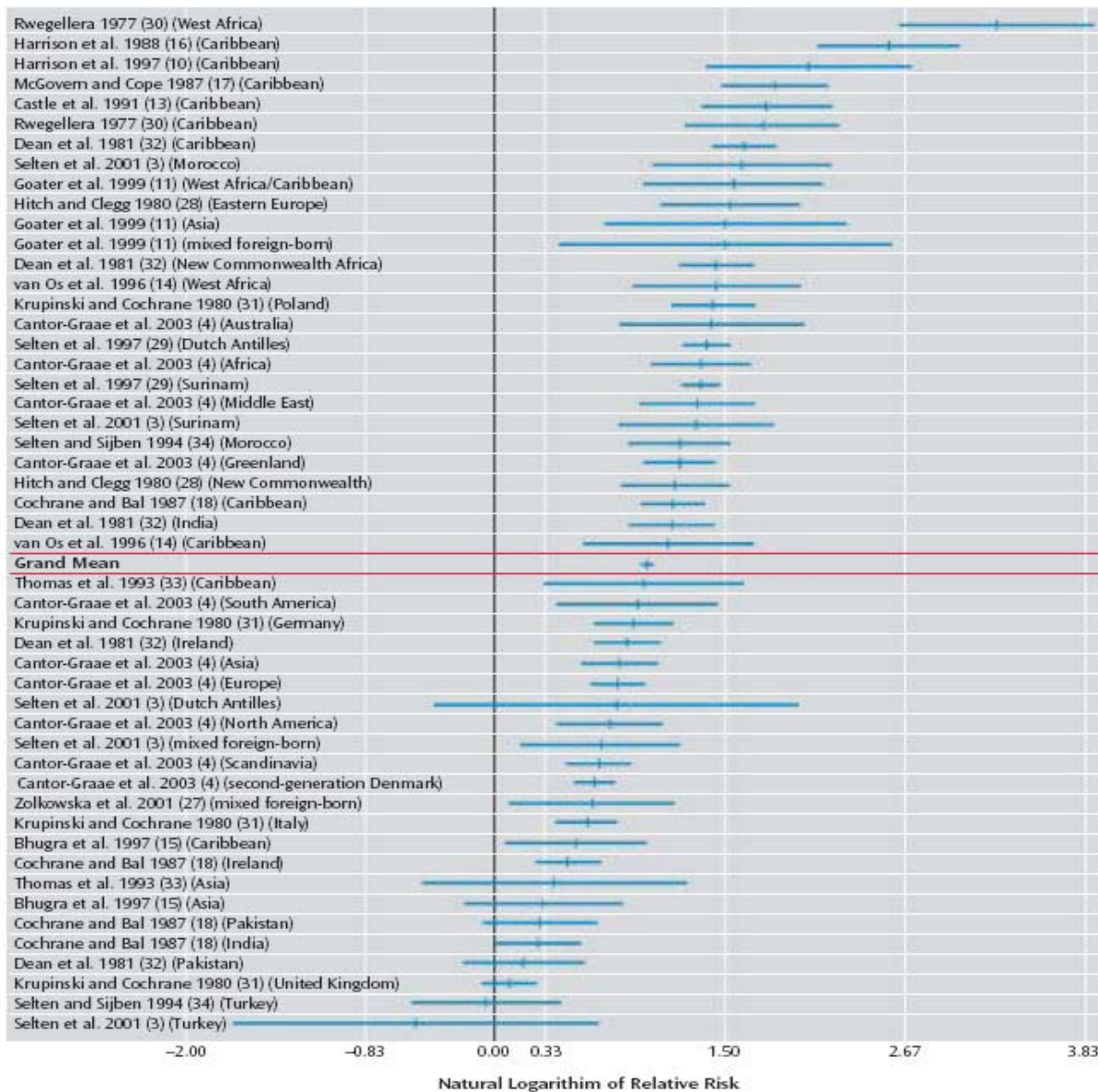
- ELFEP study also confirmed previous finding of elevated rates of psychosis in first & second generation migrants

Refinement of incidence rates

- Rates of psychosis elevated in migrants:
- Netherlands (Selten *et al*, 2001; Veling *et al*, 2006)
 - Surinamese 1st (RR~2.5) & 2nd generation (RR~3)
 - Moroccan 1st (RR~5) & 2nd generation (RR~7)
 - Turkish 2nd generation (RR~ 2)
 - Dutch Antilles 1st generation (RR~2)
- Denmark – Cantor-Graae *et al*. 2003
 - 1st generation from several parts of the world, including Scandinavia & Europe
 - 2nd generation as a whole (RR~2)
- USA – Bresnahan *et al*, 2006
 - African-American RR: 3.27; 95% CI: 1.71-6.27

Refinement of incidence rates

- Sweden – Leao *et al.* 2006; Zolkowska *et al.*, 2001; Hjern *et al.*, 2004; Cantor-Graae *et al.*, 2005
 - Finns (RR~2) (Leao *et al.*, 2006) of 1st & 2nd generation status (Hjern *et al.* 2004)
 - Migrants from Europe (1st & 2nd gen), Asia & Africa (Zolkowska *et al.*, 2001; Hjern *et al.*, 2004)
 - “Black” immigrant groups (RR~5) (Cantor-Graae *et al.*, 2005)
- Israel – Weiser *et al.* 2008;
 - One study found elevated rates in 1st & 2nd gen groups (both RR~1.5); specifically those of Ethiopian descent (RR~3) (Weiser *et al.*, 2008)
 - Another study did not find elevated rates in second generation (Corcoran *et al.*, 2009)



- Mean relative risk for schizophrenia associated with immigrant status: 2.9 (95% CI: 2.5-3.4)
- Cantor-Graae & Selten (2005) AJP

Hypotheses

- Misdiagnosis
- Ethnic liability
- Selective migration
- Obstetric complications
- The stress of migration
- Cannabis use
- Socio-economic disadvantage

Misdiagnosis

➤ **Social Control: Increased compulsory detention**

➤ **Wrong Diagnosis**

Schizophrenia

i. **difficult diagnosis**

ii. **diagnostic changes**

iii. **c.f. brief reactive psychosis**

Precipitated by crisis:

delusions of persecution

hallucinations/delusions

cultural factors

Comparison of Asians in London with WHO data

	Broad S	S+	Non-S
CHD-R	4.20	1.10	3.10
CHD-U	3.50	0.90	2.60
AS	3.46	2.02	0.80

Stress of Migration

- Immediate
- Short-term
- Long-term

Stress of Migration

- Long-Term
- Unemployment
- Achievement and Aspiration-discrepancy
- Ethnic density
- Cultural congruence

	W	AS	A-C	
MOTHER				
Yes	6 (17)	3 (14)	12 (34)	
No	29 (83)	18 (86)	23 (66)	$p = 0.152$
FATHER				
Yes	12 (34)	3 (14)	19 (53)	$\chi^2 = 8.61$
No	23 (66)	18 (86)	17 (47)	$df = 2$ $p = 0.013$

Rates of Attempted Suicide

Ethnic group	Population	Number	Rate	CI
South Asian women	17322	65	37.5	29.02-47.1
White women	63528	148	23.3	19.7-27.4
Black women	7089	17	23.9	13.9-38.4
Other	5641	17	30.1	17.6-48.2
South Asian men	17196	24	13.0	8.9-20.8
White men	61346	15.1	24.6	20.9-28.7
Black men	6191	7	11.3	4.6-23.2
Other	5741	5	8.7	2.8-20.3

Nazroo (1997)

Weekly Prevalence of Depressive Neurosis in the UK

White	Males 2.7%	Females 4.8%
African Caribbean	5.6%	6.4%
Irish	5.8%	6.8%
Indian	2.5%	3.2%
Pakistanis	3.8%	2.9%
Bangladeshi	1.6%	2.3%

CIS-R migrants' rates? Language??

EMPIRIC Study (2004)

- Irish males
- Indian females
- Pakistani females
- Higher rates among born in the UK or early migration

Furnham & Bochner (1986)

- Theoretical Constructs for Depression
- Loss
- Fatalism
- Selective migration
- Expectations
- Negative life events
- Social support
- Social skills deficit
- Clash of values

Under-detection of depression in primary care, in transcultural settings

<i>Explanation</i>	<i>Author</i>
Different explanatory models between the patient and the clinician	Jacob et al, Bhui et al, Ballenger et al, Bhugra
Unwillingness to disclose all symptoms to the GP – Focusing on somatic symptoms	Jacob et al, Bhui et al, Lecrubier, Weiss et al,
Variation of clinical features across cultures – Use of somatic metaphors	Patel, Manson, Bhugra et al Bebbington
Linguistic – cultural - racial barriers between doctor and patient	Brewin, Leo et al
Insufficient probing by the clinician	Weiss et al, Comino et al, Ballenger et al ⁵
Physicians' familiarity with depression and attitude towards depression	Leo et al, Borowsky et al, Robbins et al
Patient's age and co-existence of a somatic diagnosis	Lecrubier

Somatic idioms of distress

<i>Country / Culture</i>	<i>Somatic idiom</i>
India (Bhugra et al)	“Sinking heart” “Feeling hot” “Gas”
Nigeria (Ebigbo,1982)	“Heat in the head” “Biting sensation all over the body” “Heaviness sensation in the head”
Mexican Americans (Jenkins,1988)	“Nervios”= “brainache, brain exploding or uncontrollable
Chinese (Parker et al)	“Shenjing shuairuo” = “Neurasthenia”
Dubai (Sulaiman et al)	“Sadri dayeq alayya” = “My chest feels tight” “Tabana” = “I am tired, fatigued” Jesmi metkasser” = “Broken body”
United Arab Emirates (Hamdi et al)	“The heart is poisoning me” “As if there is hot water over my back” “Something is blocking my throat”

Somatic symptoms reported (n=75)

Bhugra et al 1997

Symptoms	Male		Female	
	N	%	N	%
Sinking heart	13	35	20	52
Headaches	11	30	19	50
Dizziness	3	8	7	18
Agitation	4	11	4	11

Bhugra et al (1997b)

Depression in Punjabi women

Focus Groups
Vignette

Findings
-Recognition
-Aetiology
-Management

Cognitive Schema

Beck's Triad

I am a failure

The future is bleak

The world is horrible

I-ness

We-ness

Gilbert and Adler (1998)

Cognitive factors for depression include:

- Social rank
- Defeat
- Sense of entrapment

Trapped

Learned helplessness

Entrapment

Arrested flight: suppression of explorative behaviour; submissive posture, cut-off

Locus of control: Internal vs External

Aspiration vs Achievement

1. What level did you think you would reach in the field of.....?
2. Have you done so?
3. If not, how far do you think you have to go?
4. Do you feel let down that you have not done so?
5. Do you feel content that you have done so?

Education, housing, employment, social status,
financial well-being

Assessing Depression

- Assess:
 - sadness
 - joylessness
 - hopelessness
 - lack of energy
 - poor concentration

Assess Biological Symptoms

- Loss of:
 - libido
 - sleep
 - appetite

Cultural variations likely

Assess Symptoms

- Assess reasons for:
 - migration
 - preparation
 - Achievements/expectations
 - Social support
 - Negative life events
- Feelings of
- loss
 - grief

Also Assess

- Self-esteem
- Self-confidence
- Cultural identity
- Any social skills deficit
- Culture shock
- Acculturation

Therapeutic Interventions

- Cultural competency is about skills that a clinician has which can be employed to understand the cultural values, attitudes and behaviours of patients especially those whose cultural background differs from that of the mental health professional.

Some general issues

- Cultural Skills
- Cultural Knowledge
- Cultural Attitudes
- Institutional Barriers

Cultural Values

- Cultural values of the immigrant patient should be incorporated into therapy.
- Ethnic Matching
- Mental health interventions should be easily accessible and targeted
- Support resources available within immigrant patients' community, extended family members, tradition should be incorporated into therapy interventions.

Culturally adapted Interventions

- Four times more effective than interventions provided to groups consisting of patients from a variety of cultural backgrounds.
- Interventions conducted in patients' native or primary language were twice as effective as interventions conducted in English.
- The format of intervention (individual therapy, group interventions), did not moderate the overall results .

Cultural Formulation

- Cultural identity of the individual and their beliefs and values
- Symptoms in cultural context
- Relationship with the environment
- Reinforcing factors
- Distress due to the problems and its explanations
- Shared understanding of the problems
- Shared plan for addressing the problems
- The nature of the interaction

Psychotherapy

- In addition, the outcome of psychotherapy can be influenced enormously by the diverse concepts of illness and health, traditional values and beliefs as well as by the specific cultural factors.
- Integrating two different cultures within the self is one of the most fundamental developmental tasks in the acculturative process.

Psychotherapy

- Psychotherapy in native languages cannot be realized everywhere because the number of qualified psychotherapists who speak a native language is limited.
- Ethnic matching does NOT affect long-term outcome

Psychotherapy

- Tribe describes four modes of interpreting as psychotherapeutic or constructionist; linguistic; as advocate or adversarial or community and cultural broker/bicultural.

Pharmacotherapy

- Pharmacokinetics---how biological organism affects the fate and distribution of drugs- absorption; distribution ; metabolism and excretion
- Pharmacodynamics ---how drug affects a person

Pharmacotherapy

- Demographic factors-age , gender and ethnicity
- Pharmacogenetic factors
- Pharmacokinetic factors-enzymatic factors
- Dietary factors-taboos, special foods
- Environmental factors-smoking,CAM

Pharmacotherapy

- Biological Factors-genetic variations---90%
Asian Americans developed side effects cf 60%
among blacks and 67% whites did so on
similar doses of haloperidol
- Specific colour choices for medication
- Non-biological factors---stress, prescription
patterns , treatment adherence and CAM

Planning Pharmacotherapy

- Prior: check diet, religious taboos, smoking, alcohol and drug use , attitudes to medication
- While: start at lower dose , low threshold for side effects, check compliance
- Afterwards: monitor side effects, check adherence, environmental factors

Psychological interventions

- Most Western psychotherapies – ego based
- Cognitive behaviour therapies: adaptable across cultures
- Ethnically matching therapists & patients
- Use of indigenous therapies and their adaptation

Culture Bound Syndromes

- “Cultural concepts of distress, cultural syndromes and cultural idioms of distress and cultural explanations are more relevant than previous notions of culture bound syndromes...CBS ignores clinical cultural differences and emphasises local explanations....all forms of distress are locally shaped including the DSM disorders ”

DSM 5 (American Psychiatric Association)

Culture Bound Syndromes

- Many well described syndromes eg, Koro, Pikbloto, Amok, Dhat syndrome

Increasing globalisation changes patterns

- Anorexia Nervosa: a CBS?

More research into illness characteristics than symptoms needed

Therapist qualities

- Aware of own likes, dislikes, beliefs stereotypes
- Aware of own identity
- Ability to be neutral and open-minded
- Ability to learn about other cultures
- Awareness that there are differences
- Tendency to idealise one or other cultures
- Strengths and weaknesses of own/other cultures

Some assumptions

- **Colour Blindness** Assumes minority patient is same.
- **Colour Consciousness** All problems are due to minority status.
- **Cultural Transference** Patients feelings to do with therapists race.
- **Cultural Counter-transference** Therapist feelings to do with patients race.
- **Cultural Identification** Minority therapists may over identify.
- **Identification with Oppressor** Minority therapists deny their status.

Self examination

- Do you know your ethnic heritage?
- Monocultural? Bicultural? Multicultural?
- What messages do you receive from each cultural group?
- How do these influence your therapeutic work?
- How well do you recognise your abilities, strengths and weaknesses?
- Are you aware of your worldview? discrepancy with the client?

Conclusions

- Rates of psychoses ; depression and deliberate self-harm higher among some migrant groups
- Acculturation continues across generations
- Psychotherapy needs to be tailored
- Medication needs to be introduced and monitored carefully