Istituto Nazionale per la promozione della salute delle popolazioni Migranti e per il contrasto delle malattie della Povertà INMP

NIHMP National Institute for Health Migration and Poverty

Cultural adaptation, migration and mental health

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Migration and Mental Health

- When migrants leave their country of origin, it is inevitable that they will leave a number of **anchors behind**.
- One of the key factors in the process of migration is what the individuals carry with them (both in material and emotional terms) and what they leave behind.

D. Bhugra and S. Gupta, Migration and Mental Health , 2011

Migration and Mental Health

- These losses may include a cultural bereavement, which may be related to some **loss of culture, cultural values and norms, especially in the face of adjustment to the new culture.**
- Another response to the new culture has been described as **culture shock**, although, again, not every migrant will experience this.

D. Bhugra and S. Gupta, Migration and Mental Health , 2011

Cultural bereavement

- Eisenbruch (1990, 1991) described cultural bereavement as the experience of the uprooted person or the group related to loss of social structures, cultural values, identity and an almost unnatural attachment to the past.
- Eisenbruch (1991) noted that such individuals have 'odd' experiences (e.g. *being visited by supernatural forces from the past*), feeling guilty (*for abandoning others and their culture, and perhaps because of their own survival*), intrusive images and thoughts of the past with an urge to complete obligations to the dead and feeling preoccupied with anxiety, morbid thoughts and anger (PTSD?).

Cultural bereavement

- The sense of loss may be more acute in the short term, whereas niggling feelings of abandoning social value and cultural support systems may **become more evident later on in the post-migration phase.**
- Kübler-Ross (1969) described five stages of grief: **denial and isolation, followed by anger, bargaining, depression and acceptance.**

Cultural bereavement

- Bowlby (1980) described a **four-stage model of loss**. These stages include **numbness or protest; yearning and searching, disorganisation and despair and, finally, reorganisation** (eg. refugees and asylum seekers).
- Loss of such a significant **attachment 'figure'** is bound to lead to loss and anger at separation. Fear expressed as a result of this loss will lead to anxiety, which may also be influenced by **separation anxiety.** Although Bowlby argues that parents are crucial attachment figures, our contention is that they cannot be seen in isolation from the culture in which they are born and live.

Cultural bereavement

- Freud (1953) described the role of loss in the development of melancholia, but attributed it to unconscious motives and desires. Depressive symptoms related to loss are well described. Internalisation of such feelings leads to depression and externalisation to violence, anger or aggression.
- Clinicians therefore need to be aware of 'normal' feelings of loss and grief before diagnosing these symptoms as abnormal. It is also possible that an individual's self-confidence and self-esteem will change with the stages of adjustment.

Culture shock

- Oberg (1960) used culture shock as a term to describe ‘shock’ experienced by migrants as moving to another culture. Culture shock is said to examine aspects which include stress of moving to a new culture, a sense of loss, confusion in role expectations and self-identity, a sense/feeling of rejection by the new culture, and resulting anxiety and sense of impotence in not being accepted as part of the new culture (Taft, 1977).

Culture conflict

- The concept of culture conflict emerges from an interaction of cultural factors between an individual and their within culture and across two cultures (Bhugra, 2004).
- A component of such conflict is related to cultural identity (Bhugra, 2004). It is inevitable that in some cases cultural and ethnic identity becomes more rigid and problematic. Individuals may choose to cling to their original identity, which may cause tensions with the larger new society but acceptance within their own. These tensions are also related to levels of acculturation.

Berry, J.W. (1990 e 1997). Psychology of acculturation

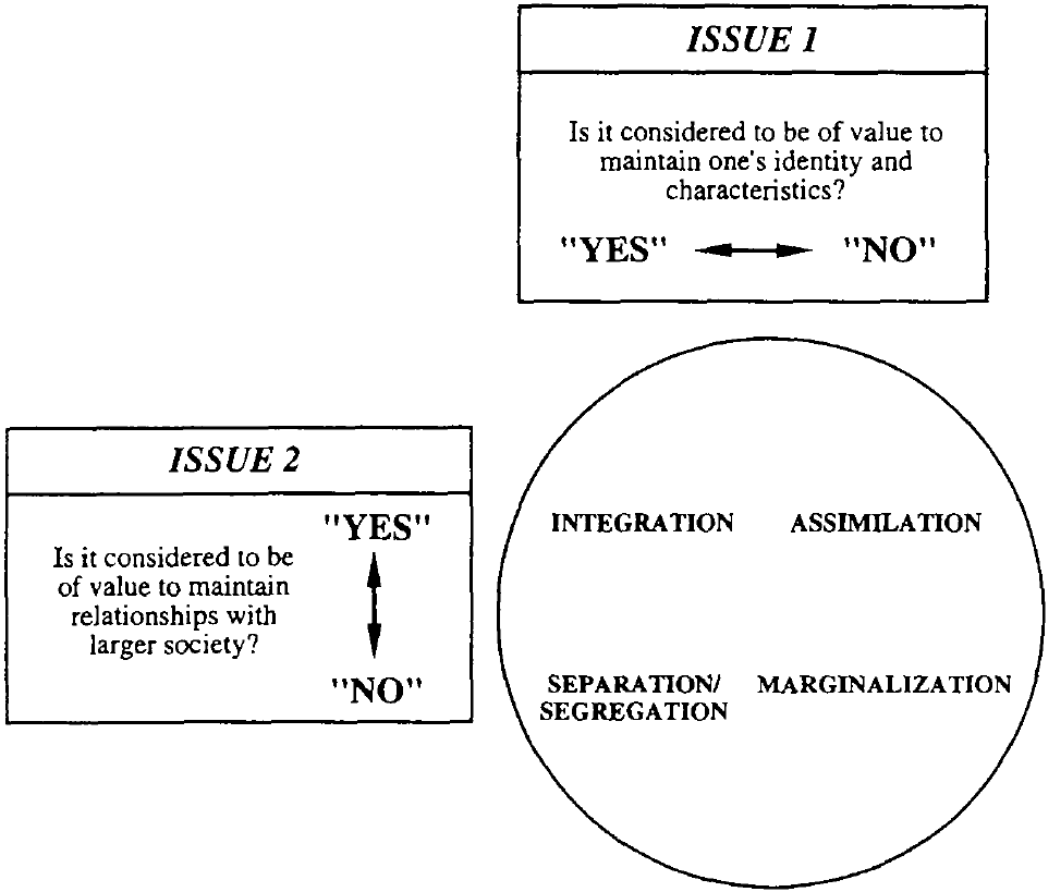

FIG. 1. Acculturation strategies.

Berry, J.W. (1990 e 1997). Psychology of acculturation

….. From the point of view of non-dominant groups, when individuals do not wish to maintain their cultural identity and seek daily interaction with other cultures, the ***Assimilation*** *strategy is defined. In contrast, when individuals place a value on holding on to their original culture, and at the same time wish to avoid interaction with others, then the* ***Separation*** *alternative is defined. When there is an interest in both maintaining one's original culture, while in daily interactions with other groups,* ***Integration*** *is the option; here, there is some degree of cultural integrity maintained, while at the same time seeking to participate as an integral part of the larger social network. Finally, when there is little possibility or interest in cultural maintenance (often for reasons of enforced cultural loss), and little interest in having relations with others (often for reasons of exclusion or discrimination) then* ***Marginalisation*** *is defined……*

Cultural congruity

- It has been argued that cultures can be divided into sociocentric and egocentric, as with individuals (Hofstede, 1980/2001; 1984).
- In **egocentric** societies, ties between individuals are relatively loose and each individual is supposed to look after themselves or the immediate nuclear family.
- In **collectivist** societies, individuals from their birth integrate into kinship-based structures and have very strong in-groups.

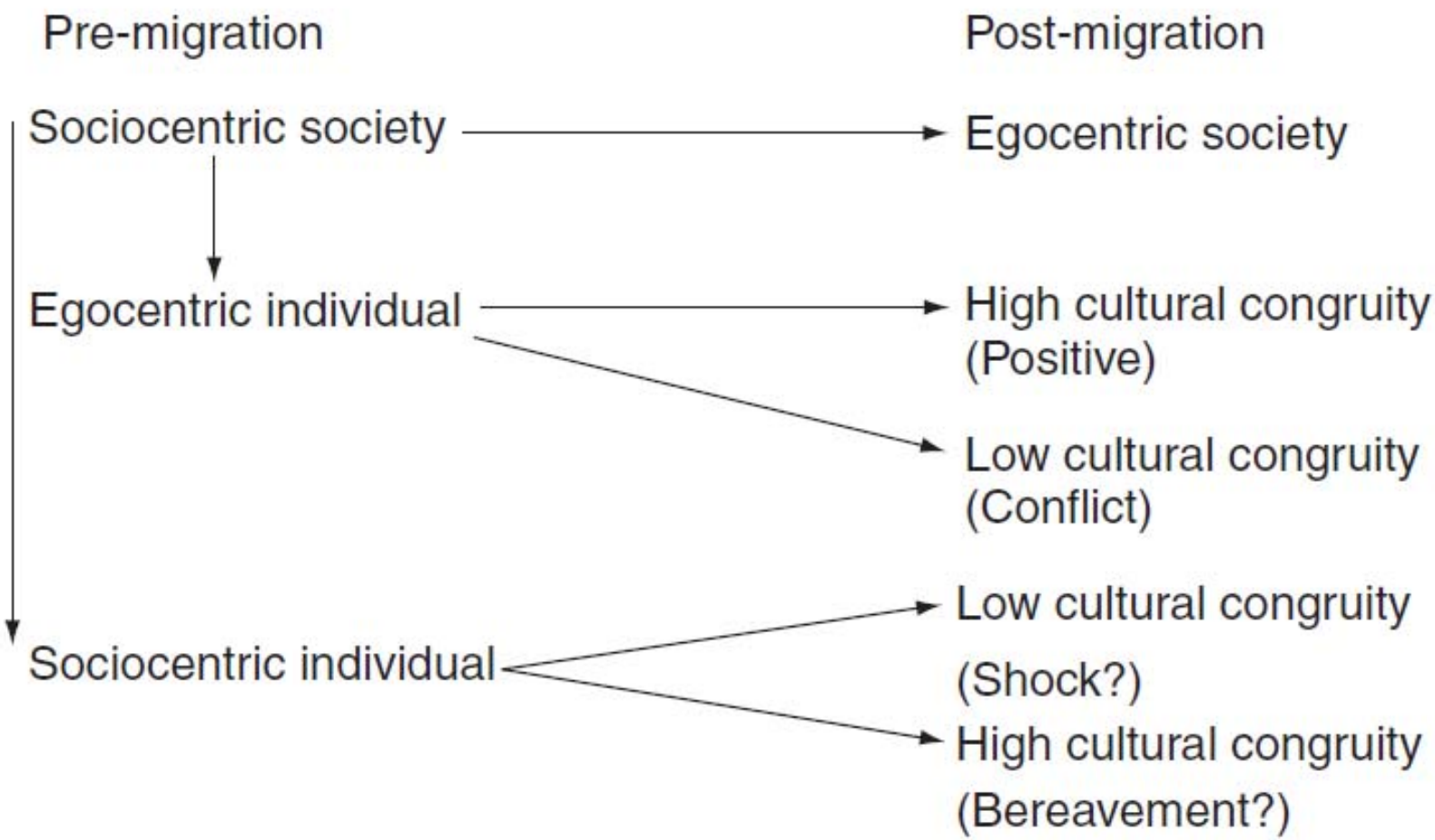

Figure 11.1 Theoretical model linking migration patterns.

Acculturation, violent radicalisation, and religious fundamentalism

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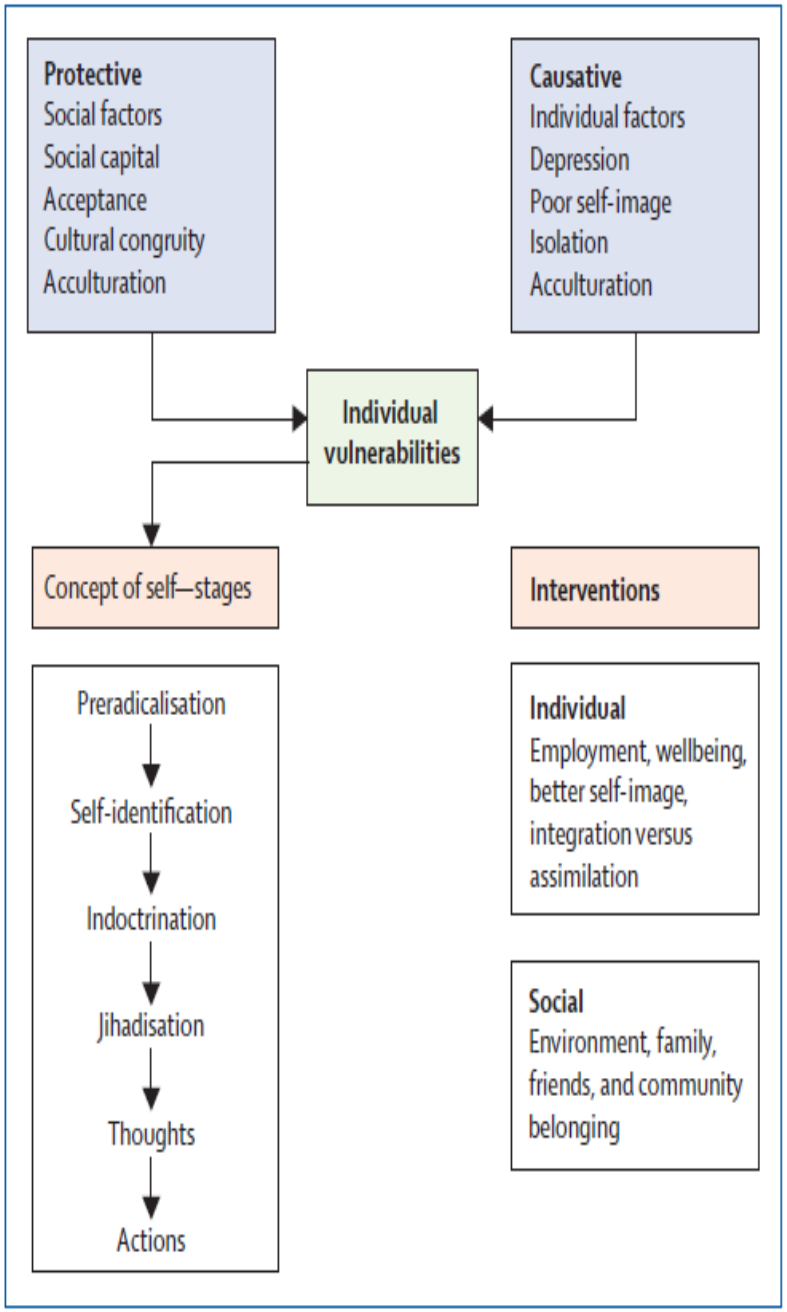
At times of uncertainty, identity confusion, and fear due to a perceived assault on their social group, vulnerable people might take up fundamental ideologies to validate their own identity, as is seen among adolescents. Religion is a key part of cultural identity, and acculturation after migration might affect religious values. Acculturation is defined as a change in culture that occurs as a consequence of contact between two distinct cultural groups.

Acculturation, violent radicalisation, and religious fundamentalism

we follow this convention. Erroneously, many researchers assume that acculturation has been completed by the second generation, so the third generation is not studied. Berry and colleagues[10] showed that acculturative stress is very common and might affect psychological, somatic, and social aspects of individuals' functioning; it varies across groups and generations, although acculturation in third-generation immigrants has not been studied.

Protective and causative factors toward acculturative stress vary widely: Bhui and colleagues[2] suggest that some of the risk factors for radicalisation (causative) may be modified by managing depression, improving wellbeing, and increasing social capital. Combining this with the stages in violent radicalisation described by Silber and Bhatt,[11] a picture of the causative and preventive factors in radicalistion starts to emerge (figure).



Language as a barrier

Since mental health treatment relies heavily on verbal communication, language skills are particularly important.

In general, lack of language fluency has been associated with low satisfaction with medical services and poor adherence to recommended treatments (Bhugra & Gupta, 2011).

Benefits of working with an interpreter

- Farooq et al. (1997) found that the use of an experienced interpreter provided reliable data for psychiatric diagnosis.
- Hillier et al. (1994) and Kaufert and Koolage (1984) argue that interpreters can usefully assist in establishing rapport and negotiating complex terminology and different explanatory models of health, and clients have reported a host of benefits, including feeling better understood and heard (Hillier et al., 1994; Kline et al., 1980; Mudarikri; 2003).
- It was also noted that patients using an interpreter had a higher return rate following assessment, and believed they had received better professional attention (Faust and Drickey, 1986).
- An interpreter can also function as a safe attachment figure (Alexander et al., 2004).

Models of interpretation

1. **The linguistic mode**, where the interpreter tries to interpret as far as possible word-for word and adopts a neutral and distanced position (Cushing, 2003; Tribe, 1998).
2. **The psychotherapeutic or constructionist mode**, where the meaning/feeling of the words is most important, and the interpreter is primarily concerned with the meaning to be conveyed and contextual variables rather than word-for-word interpretation (Raval, 2003; Tribe, 1998, 1999).
3. **The advocate or community interpreter**, where the interpreter takes the role of advocate for the client (sometimes called a link worker or health advocate in the UK), either at the individual or wider group or community level, and represents their interests within a health setting beyond interpreting language for them (Baylav, 2003; Drennan and Swartz, 1999; Razban, 2003).
4. **Cultural broker/bicultural worker**, where he interprets not only the spoken word but also relevant cultural and contextual variables (Drennan and Swartz, 1999; Tribe, 1998). In some European countries, for example Belgium and Spain, this is known as an intercultural mediator (Qureshi et al., 2010; Verrept and Louckx, 1997).

Relationship between a mother tongue and emotion

- Research shows that languages are not directly interchangeable; meanings may be coded, emotionally processed and internalised in one language and not always be directly accessible in another (Keefe, 2008).
- It is clear that the relationship between a mother tongue, second language and emotions is complex, and clinicians need to consider how they work with this and the availability of emotions or clinical features in a first and second language. Further research needs to be conducted.

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The Role of Language in Shaping International Migration*

Fluency in (or ease to quickly learn) the language of the destination country plays a key role in the transfer of human capital from the source country to another country and boosts the immigrant's rate of success at the destination's labor market. This suggests that the ability to learn and speak a foreign language might be an important factor in the migration decision. We use a novel dataset on immigration flows and stocks of foreigners in 30 OECD destination countries from 223 source countries for the years 1980–2009 and a wide range of linguistic indicators to study the role of language in shaping international migration. Specifically, we investigate how both linguistic distance and linguistic diversity, as a proxy for the "potential" ease to learn a new language and to adapt to a new context, affect migration. We find that migration rates increase with linguistic proximity and the result is robust to the inclusion of genetic distance as a proxy for cultural proximity and to the use of multiple measures of linguistic distance. Interestingly, linguistic proximity matters more for migrants moving into non-English speaking destinations than to English-speaking countries. The likely higher proficiency of the average migrant in English rather than in other languages may diminish the relevance of the linguistic proximity indicators to English speaking destinations. Finally, destinations that are linguistically more diverse and polarized attract fewer migrants than those with a single language; whereas more linguistic polarization at origin seems to act as a push factor.

Language and migration

- *Linguistic distance:* a measure that captures the linguistic proximity between two languages, ranges from 0 to 1 depending on how many levels of the linguistic family tree the languages of both the destination and the source country share.
- *Linguistic diversity:* measured with fractionalization and polarization indices from Desmet et al. (2011). The linguistic fractionalization index computes the probability that two individuals chosen at random will belong to different linguistic groups and the index is maximized when each individual belongs to a different group.

Kerswill, Paul (2006). Migration and language. In Klaus Mattheier, Ulrich Ammon & Peter Trudgill (eds.) *Sociolinguistics/Soziolinguistik. An international handbook of the science of language and society*, 2nd edn., Vol 3. Berlin: De Gruyter.

Koineisation: through koineisation, new varieties of a language are brought about as a result of contact between speakers of mutually intelligible varieties of that language. Koineisation is composed of the mixing of elements from different dialects, followed by levelling, which refers to "a process whereby, in a dialect mixture situation, those elements disappear which are marked either universally or in terms of the particular language undergoing koineization" (Trudgill 1986, 143).

Article

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Language proficiency among hospitalized immigrant psychiatric patients in Italy

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Methods

LP was considered inadequate when index clinical examinations had been conducted in a language other than Italian, when a patient needed translation for the majority of verbal interactions, or when they required the service of an interpreter.

Average Italian-LP (comprehension and spoken) was rated good or moderate in 62.4% of patients, and low or inadequate (needing an interpreter) in 37.6%.

We reviewed medical and pharmacy records of all 85 immigrant psychiatric patients hospitalized at the University of Foggia Medical Centre in 2004 (*n = 19), 2005 (n = 8), 2006 (n = 14), 2007 (n = 16), 2008 (n = 9) and 2009 (n = 19), and tested associations of demographic and clinical factors between those considered to have adequate versus inadequate proficiency in the Italian language*

We recorded age, sex, social and demographic information, DSM-IV-TR consensus, discharge diagnoses, as well as clinical presentation at hospitalization, including suicide attempts within 90 days, and days in hospital. We also gathered data on the presence of co-morbid clinical conditions, treatments given (and doses), as well as adverse events associated with prescribed treatments.

In addition, functional (*Global Assessment of Functioning [GAF]), clinical (Clinical Global Impression [CGI]) and psychopathological (Brief Psychiatric Rating Scale [BPRS]) ratings were extracted from medical records and scored by investigator consensus, with estimated percentage change in these ratings between hospital admission and discharge.*

Results

Subjects (44 men, 41 women; aged 35.7±10.0 years) were immigrant psychiatric patients hospitalized at the study site for an average of 10.0±6.79 days; they represented 3.62±0.94% of all admissions over the six years considered (2004–09), without significant differences in rates by year. Patients had emigrated from: other European countries (60.0%) > Africa (22.3%) > Latin America (9.42%) > Asia (8.23%); ***69.4% (n = 59/85) had entered Italy illegally and were undocumented, but information regarding status as an 'asylum seeker' was available for only for 8/85 patients.***

DSM-IV diagnoses ranked: **unspecified (NOS) psychoses (40%) > adjustment (18.8%) > substance use (14.1%) > mood (9.41%) > anxiety (7.05%) > somatoform (5.94%) > personality disorder (4.70%); 45.9% represented first-lifetime episodes.**

Initial bivariate comparisons identified factors preliminarily associated with LP status (Table 1). Factors significantly associated ($p \leq .05$) *with* ***inadequate LP were: (1) sex (men > women); (2) having entered Italy illegally (being undocumented); (3) fewer psychotropic drugs/person prescribed at hospitalization; (4) younger age; (5) first-lifetime episode; (6) unemployed; and (7) non-EU country of origin.***

Table 1. Bivariate comparison of factors in 85 hospitalized immigrant patients with adequate or inadequate Italian language proficiency.

Factor	Language proficiency (LP)		F or χ^2	p
	Adequate	Inadequate		
Women (%)	82.9	17.1	22.6	< .0001
Illegal entry	47.5	52.5	6.37	.012
Psychotropics at admission	2.02±0.96	1.53±0.81	6.22	.015
Age (years)	37.8±9.06	33.0±10.7	5.04	.027
First episode (%)	43.6	56.4	4.86	.027
Employed (%)	70.3	29.7	4.32	.038
European home country (%)	61.4	38.6	3.97	.046

Of the factors preliminarily associated with *inadequate LP, those significantly and independently remaining associated in subsequent logistic multivariate modeling were (in descending order of statistical significance):* ***(1) men > women; (2) non-EU country of origin; (3) fewer psychotropic drugs at hospitalization; and (4) having entered Italy illegally (Table 2).***

Table 2. Multivariate logistic regression model of factors associated with proficiency in Italian by 85 hospitalized immigrant psychiatric patients.

Factors	OR (95 % CI)	χ^2	*p*
Women > men	5.21 (1.23–22.0)	5.04	.025
European country of origin	29.5 (1.16–749)	4.21	.040
More psychotropics at hospitalization	2.44 (1.02–5.83)	4.03	.045
Legal entry	10.3 (0.97–109)	3.75	.053

Factors are in descending order of significance of independent contribution to greater LP.

Discussion

- Our preliminary bivariate analyses suggest that men had lower LP in Italian than women, perhaps reflecting gender differences in acquisition rates for new languages (Wallentin, 2009).
- Inadequate LP also was associated with being an undocumented immigrant or having entered Italy illegally. This association is not surprising, since illegal immigration is frequently associated with socially disadvantaged conditions and limited access to foreign cultural environments (Carta et al., 2005).

- Patients with poor or inadequate LP were also more likely to be unemployed and to have come from a non-EU country, possibly in part reflecting lack of benefits of efforts at social, cultural and economic exchanges between EU countries (Carta et al., 2005).
- The only clinical factors associated with poorer LP were greater incidence of first-episode disorders, and prescription of fewer psychotropic drugs at hospitalization. **Lack of LP can lead to higher distress levels and poorer cultural adaptation among immigrant patients, and these factors may contribute to risk of first-episode psychiatric disorders** severe enough to require hospitalization (Carta et al., 2001; Carta et al., 2005).

- In addition, given that mental health treatment relies greatly on verbal communication, LP may be especially important in psychiatric care settings, and patients with poorer language skills are probably under-diagnosed or at least less accurately diagnosed. This conclusion is suggested by the high observed prevalence of unspecified (NOS), adjustment disorder and anxiety disorder diagnoses in the present cohort.
- the greater number of psychotropic drugs received at hospitalization by patients with good LP suggests that better communication skills increased access to treatment.

Limitations

- Limitations of this study include moderate numbers of subjects, sampling from one institution, as well as lack of comparisons of hospitalized and ambulatory patients – all of which may limit generalization.
- In addition, reliable data about total time in Italy and of exposure to the Italian language were not available in most cases, nor were detailed reasons for immigration, perhaps reflecting the high proportion (69.4%) of undocumented immigrants, with a lack of medical information and availability of family members.

Many Thanks for your attention!