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## Mental health of migrants

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### INTRODUCTION

Migration has been a constant element influencing human societies across the course of history. Migration is the process during which a person moves from one cultural setting to another to settle, either for a longer period or permanently. According to the IOM-OIM,<sup>[1]</sup> current estimates are that there are 244 million international migrants globally (or 3.3% of the world's population). While the vast majority of people in the world continue to live in the country, in which they were born, an increasing number of people are migrating to other countries, especially those within their region. Many others are migrating to high-income countries that are further afield. In this context, work is the major reason that people migrate internationally, and hence that migrant workers constitute a large majority of the world's international migrants, with most living in high-income countries and many engaged in the service sector.<sup>[1]</sup> Another reason for migration is global displacement, which is at a record high, with >70.8 million globally, the number of internally displaced at over 41.3 million, and the number of refugees >25.9 million.<sup>[2]</sup> Due to a global increase in social and political instability as well as socioeconomic and armed conflicts, the number of refugees, asylum seeker, and migrants over the globe is growing dramatically, and industrialized countries are likely to receive increasing numbers of people belonging to ethnic minorities in the form of refugees and asylum seekers. In addition, people migrate due to poverty, or climate crises in their country of origin, such as drought. Refugees and asylum seekers are a heterogeneous group, with many different reasons for migration, many different experiences during the migration, and differing legal status.<sup>[3]</sup> Most of them experience stress-related risk factors during the stages of premigration, migration, and postmigration.

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In this editorial, we would like to draw attention to the mental health of migrants and underline an enormous need for action.

### MIGRATION AND MENTAL HEALTH

Because migration is such a complex process, it often brings with it stress, strain, and risk factors such as poor medical care, separation of family and children as well as other relatives. It can also include homelessness, lack of food and water, xenophobic attacks, poor education, perceived and experienced discrimination, and a high risk of death and injury.<sup>[4,5]</sup> Furthermore, social factors, including cultural bereavement, culture shock, social defeat, as well as a discrepancy between expectations and achievement, and acceptance by the new nation can all affect adjustment.<sup>[3,6]</sup> Further risk factors in new communities can include social exclusion, stigma, and discrimination.

#### Migration and psychosis

According to Cantor-Graae and Selten,<sup>[7]</sup> chronic experience of social defeat was related to poor mental health and risk of psychosis in migrants. In a systematic review and meta-analysis, Henssler *et al.*<sup>[5]</sup> suggested that there are increased rates of schizophrenia and related psychoses in first- and second-generation migrants and refugees. The meta-analysis was on the incidence of nonaffective psychotic disorders among first- and second-generation migrants. Furthermore, the authors found substantial evidence for an increased relative risk of incidence among first- and second-generation migrants compared to the native population. The findings were interpreted in the context of social exclusion and isolation stress and provide an explanatory framework that links cultural differences in verbal communication and experienced discrimination with the emergence of psychotic experiences and their neurobiological correlates. In addition, the authors suggested that experienced discrimination and social exclusion are core factors underlying increased rates of psychotic experiences in subjects with a migration background. In another systematic review and meta-analysis, Brandt *et al.*<sup>[8]</sup> found that the risk of the manifestation of schizophrenia and associated nonaffective psychoses is statistically significantly increased in refugees compared

with the native population as well as compared with nonrefugee migrants.

### Migration and dementia

Most countries have an aging population with an increasing number of elderly migrants, and many of these elderly migrants will develop dementia in a country other than that of their origin. Thus, it can be assumed that dementia will also increase among migrants in the coming decades. Data on the prevalence of dementia among those with a migrant background are currently lacking, and it is not yet possible to estimate the size of the approaching burden on the health system. Aggarwal and Hinton addressed this subject in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Handbook on the Cultural Formulation Interview, which was edited by Lewis-Fernández *et al.* (2016)<sup>[9]</sup> in the chapter on “the Cultural Formulation Interview (CFI) supplementary module for older adults.”

In a few studies, it was reported that the risk of developing dementia among certain groups of migrants is higher in comparison to people who grew up in the host country. Pettit *et al.*<sup>[10]</sup> found a prevalence rate of 17.3% among Caribbean migrants in the UK, which was higher than among other groups of the population. The authors discussed that cardiovascular comorbidity may be responsible for the higher rate of dementia. According to a Danish study, a prevalence rate of 13.3% was found among people with a Turkish migration background in comparison to the prevalence rate of 7% in the indigenous population.<sup>[11]</sup> Nielsen and Waldemar<sup>[12]</sup> highlighted that in the diagnosis of dementia, in particular, the interpretation of cognitive tests continues to present a challenge. The existing screening tools have been demonstrated to require modification for use among those from an educationally disadvantaged background, those lacking knowledge of the health system, and first-generation migrants.<sup>[11]</sup> Neuropsychological dementia assessment of migrants is limited regarding the testing of cognitive abilities as well as the recording of everyday activities (Activities of Daily Living). Linguistic, educational, lifestyle, and cultural-religious factors have not been taken into account in psychometric instruments.<sup>[13]</sup> In addition, culturally and linguistically diverse elderly people with dementia face many unique challenges and have particular needs owing to the impairment of verbal and nonverbal language, which worsens with the degenerative process of dementia. Bilingual people with dementia also tend to mix languages and have problems with language separation.<sup>[14]</sup> The authors emphasized that communication is essential for social life, regardless of cognitive function, and for avoiding isolation, strengthening patients' identity, and decreasing depression and anxiety. With a growing aging population and increased global migration, language reversion is an upcoming and challenging topic that has received little research attention.<sup>[14]</sup> Therefore, the

assessment of elderly migrants is necessary for adapting health-care services and interventions. Dissemination of accumulated knowledge from studies about elderly migrants and language is urgently needed.

### Migration and posttraumatic stress disorder

In a systematic review, Morina *et al.*<sup>[15]</sup> reported that the highest prevalence of psychiatric disorders was registered for post-traumatic stress disorder from 3% to 88%, depression from 5% to 80%, and anxiety disorders from 1% to 81% in refugees and internally displaced persons after forced displacement. The authors pointed out that there is an urgent need for large-scale interventions that address psychiatric disorders in refugees and internally displaced persons after displacement. Lindert *et al.*<sup>[16]</sup> reported prevalence rates for posttraumatic stress disorder (PTSD), which varied from 5% to 71% (mean prevalence rate: 32%) rates for depression varied from 11% to 54% (mean prevalence rate: 35%) in the refugee population, whereas Bogic *et al.*<sup>[17]</sup> published significant prevalence rates of depression with the range of 2.3%–80%, PTSD from 4.4% to 86%, and unspecified anxiety disorder from 20.3% to 88%. In this systematic literature review, the authors found that greater exposure to premigration traumatic experiences and postmigration stress were the most consistent factors associated with all three disorders, whilst a poor postmigration socio-economic status was particularly associated with depression. In all studies, a wide range of prevalence rates were reported, which were attributable to the diversity of the study samples. Therefore, there is a need for more methodologically consistent and rigorous research on the mental health of long-settled war refugees.<sup>[17]</sup> The increased risk may not only be a consequence of exposure to wartime trauma but may also be influenced by postmigration socio-economic factors. According to Giacco *et al.*,<sup>[18]</sup> prevalence studies show that, in the first years of resettlement, only PTSD rates are clearly higher in refugees than in host countries' populations. The authors further reported that five years after resettlement, rates of depressive and anxiety disorders were also elevated. Exposure to traumatic events before or during migration may explain high rates of PTSD. Evidence suggests that poor social integration and difficulties in accessing care contribute to higher rates of mental disorders in the long term.<sup>[18]</sup> Chen *et al.*<sup>[19]</sup> also highlighted that postmigration resettlement-related stressors were the most important correlates of mental health in migrants fleeing for humanitarian reasons. Postmigration resettlement-related stressors accounted were both directly associated with mental health issues and also mediated indirect associations. Thus, targeting resettlement-related stressors through augmenting psychosocial care programs and social integration would be a key approach to improve humanitarian migrants' mental health. Winkler *et al.*<sup>[20]</sup> found significant correlations between insecure residency status and the symptoms of mental disorders in refugees and asylum seekers. In this study, respondents with

higher symptom load took less advantage of the support, participated less in measures designed to assist integration, and described more difficulties in their hearing. Only 11.6% of asylum seekers with mental disorders indicating symptoms were in psychiatric treatment.<sup>[20]</sup>

### MENTAL HEALTH CARE SERVICES: BARRIERS TO ACCESS

According to Park *et al.*,<sup>[21]</sup> migrant, refugee, and asylum seeker patients have an elevated need for mental health care, but simultaneously have less access to it. Reasons for this gap include stigma and shame regarding mental illness,<sup>[3]</sup> cultural beliefs, lack of language proficiency as well as financial constraints. Furthermore, real economic barriers and perceived social consequences could impede service seeking because migrants, refugees, and asylum seekers often lack health insurance.<sup>[22]</sup> Bridges *et al.*<sup>[23]</sup> pointed out that the highest barriers to service utilization were economic, because migrant, refugee, and asylum seeker patients generally have limited financial resources. Other barriers are linguistic because in many countries there are no legal regulations for the financing of interpreters. Interestingly, the authors emphasized that economic barriers were more salient for women than men, and for participants with a psychiatric disorder in comparison to those without. It is possible that certain cultures prioritize treatment for the breadwinner in the family. In addition, Bridges *et al.*<sup>[23]</sup> reported that the combination of lack of ability to speak the native language and service providers' lack of ability to translate into a first language significantly impeded help-seeking. Furthermore, the general lack of knowledge about help services was reported to be significantly exacerbated in men as compared to women.

### CULTURAL COMPETENCE

According to Bhugra *et al.*,<sup>[3]</sup> every psychiatrist should see his/her patients in the context of his/her culture as well as taking into account their own cultural values and prejudices.<sup>[3]</sup> In these intercultural settings, the psychiatrists are experts in biomedicine and psycho-social factors, while patients are experts in their own experience of distress. According to Schouler-Ocak *et al.*,<sup>[22]</sup> therefore, cultural competence is a central aspect of the daily work of the psychiatrists. Concepts such as cultural competence, cultural-sensitivity, humility, and responsiveness are necessary to help practitioners work with culture and context in clinical care. In this context, psychiatrists should be aware of their own cultural biases, and be able to productively engage with interpreters or culture brokers, as well as understand culturally different family structures, the effects of discrimination, exclusion, unemployment, intergenerational differences in acculturation, different explanations of illness, symptom presentations and treatment expectations, and idioms of distress.<sup>[24]</sup> Furthermore, they should be aware of the complications that can arise in

working with family members or relatives as well as training in intercultural psychotherapy, including issues of transference and counter-transference, and somatization.<sup>[24]</sup> According to Sue *et al.*,<sup>[25]</sup> cultural competence requires knowledge, skills, and attitudes that can improve the effectiveness of psychiatric treatment. It represents a comprehensive response to the mental health care needs of refugees, asylum seekers, and migrant patients, and it is important to be mindful of the risks of stereotyping.<sup>[22,26]</sup> The main skills of cultural competence are intercultural communication, the capacity to develop a therapeutic relationship with a culturally different patient, and the ability to adapt diagnosis and treatment in response to cultural differences between the psychiatrist and the patient.<sup>[22,26]</sup> Furthermore, intercultural work requires psychiatrists to challenge their own perceptions of "reality," explore their own cultural identity, prejudices, and biases, and to be willing to adapt to distinct cultural practices.<sup>[22]</sup> In this context, it should be highlighted that cultural competence is not the end of a process, technical expertise that confers on the individual a resolved accreditation which will enable them to work with patients from all cultures. It is an ongoing process of learning by training. Recommendations to policymakers, service providers, and clinicians are set out in the WPA guidance on mental health and mental healthcare in migrants,<sup>[6]</sup> the EPA guidance on mental health care of migrants<sup>[3]</sup> and the EPA guidance on cultural competence.<sup>[22]</sup>

### INTERCULTURAL COMMUNICATION

Language is the main working tool in psychiatry and psychotherapy. To avoid misdiagnosis, inappropriate treatment, and frustration, not only do we need good verbal communication, but we also need to consider different explanatory models regarding the cause, course, and cure of certain health problems.<sup>[27]</sup> In this context, a description of the respective diseases can have a thoroughly different meaning in a specific cultural context. Since a psychiatrist neither expected to be knowledgeable about all culture-related issues, nor master the languages of all his/her migrant, refugee, and asylum seeker patients, the involvement of professionally trained interpreters is inevitable.<sup>[22,26]</sup> Intercultural psychiatry is hindered not only by language barriers but also by more complex communication problems, based on different explanations of the causes, characteristics, and treatment options for various illnesses. However, migrant, refugee, and asylum seeker patients deserve access to the same professional psychiatric treatment as native patients. Therefore, costs for interpreters should be covered by the country's health-care system.

### ETHNOPHARMACOLOGY

Pharmacological treatment is the therapy of choice for almost all psychiatric illnesses. Nevertheless, undesirable side effects, lack of response to medication, and discontinuation of therapy by patients are common. The right choice of preparation and dosage can help to avoid or

reduce failed therapy attempts. Research findings in recent years have increasingly demonstrated the importance of individual circumstances when selecting pharmacological therapy.<sup>[28]</sup> Ethnicity, membership of a minority, and experience of migration play a central role alongside other demographic factors such as age, gender, duration of illness, and others, but are not sufficiently considered in everyday clinical practice when planning therapy.<sup>[28]</sup> A decline in access to health services for ethnic minorities, a more negative attitude toward psychiatric treatment, and a lack of consideration of cultural factors by psychiatrists play a role, as do biological factors that influence the metabolism and effects of drugs. There is good evidence of ethnic differences both in genes for cytochrome enzymes and different transporters and receptors. Even though the clinical relevance of all these genetic factors is not conclusively clarified at this point, initial recommendations, such as testing for the presence of the HLA-B\*1502 allele in risk populations, have already become established in psychiatric practice. The greater consideration of cultural and other clinical factors are also increasingly reflected in practice recommendations.<sup>[28,29]</sup> Thus, it is important to assess attitudes towards medication, use of traditional medicine, and the use of tobacco and alcohol.<sup>[6]</sup>

### Recommendations

Worldwide, it is expected that the number of migrants, refugees, and asylum seekers will continue to rise over the coming decades. Health-care services have to be prepared for this very heterogeneous population with different concepts of health and disease as well as expectations about treatment procedures. Health-care services, health-care professionals, stakeholders, and policymakers should be given the resources to meet the needs of migrant, asylum seekers, and refugee patients. Using the CFI can help to provide more information about the impact of culture on key aspects of a patient's clinical presentation and care. Furthermore, the cultural competence of all professional staff and the regular use of language and culture mediators could be very useful to access health care services and reduce the key barriers to service access and use. Improving the institutional, cultural competence could increase the quality of care at a systemic, organizational, and institutional level. Therefore, cultural competence training for all professional staff and initiatives to facilitate institutional, cultural competence should be implemented to increase the utilization of mental health services.

The recommendations to policymakers, service providers and clinicians that are set out in the WPA guidance on mental health and mental health care in migrants,<sup>[6]</sup> the EPA guidance on mental health care of migrants,<sup>[3]</sup> and the EPA guidance on cultural competence<sup>[22]</sup> should be realized.

According to WHO,<sup>[30]</sup> "Health is a state of complete physical, mental and social well-being and not merely the absence

of disease or infirmity ... Health is a resource for everyday life, not the object of living ... and is a fundamental human right, recognized in the Universal Declaration of Human Rights." It is incumbent on all mental health professionals to remember that the right to health is a human right and we should respect it for all of our patients.

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