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Introduction

Migrating can be a complex and challenging experience, this means that mental health practitioners may have service users/clients who are migrants accessing services. For example, in a meta-analysis, Cantor-Graee & Selton (2005) found that people who had migrated were two to five times more likely to have a diagnosis of psychosis than for people who are not migrants. Whilst the number of people who were detained under the Mental Health Act in the UK are skewed towards people from Black, Asian and Minority Ethnic (BAME) backgrounds, many of whom will have migratory histories. A similar finding was found in relation to the people who were reported as being in crisis and accessed services later than those without migratory backgrounds (Bhui et al, 2003 Fernando, 2014). Issues relating to institutional racism in mental health services has been discussed by a number of authors including Fernando, (2017). The prevalence of mental health issues in the country of migration has been found to be different to that found in the country of origin (Stuart et al, 1998). Therefore, mental health services need to be culturally and linguistically accessible and appropriate if they are to meet the requirements of all members of our communities including people who have migrated.

This chapter will examine different types of migration, detail the reasons people migrate and the potential psychological experiences relating to this. These will include issues relating to identity and well-being, belonging in a changing world with increasing issues of nationalism (Balibar, 1991; Mavroudi, 2010) and where post truth has currency. The issue of negotiating transitions as well as individual and community meaning-making will be reviewed in relation to the experience of mobility and change. Displacement from one country to another where voluntary or forced migrants may find

their representations and meanings of mental health and illness to be challenged and defined differently, can be a perplexing experience (Tribe, 2002). Issues relating to working with an interpreter or cross-culturally will also be discussed. Migration may happen in a context of racism and within an experience of dealing with a range of changes (Fernando, 2014; Tribe & Patel, 2007; Tribe, 2002).

Migration and the Socio-cultural-political Context

The term migrant is always developed and exists in a socio-cultural-political context where political power plays and the vagaries of the wider national and international politics are played out. The relationship between high, middle and low income countries is also ever present and may play a role in definitions and perceptions of migration, as will issues of colonialism and power (Fernando, 2014). Some politicians have used the term migrant in negative ways and have presented a problematized image of migrants and the need to stem immigration for their own agenda (Fernando, 2014; Geddes & Scholten, 2016). Many have linked it in a range of ways to the problems of/within what they define as 'their' country. (Examples of this can be found in most continents around the world at different historical periods.). Social identity theorists such as Tajfel & Turner, (1979) have written about the notion of in and out groups. By doing this they attempt to delineate in the loosest sense what and who are represented or designated as preferred citizens and who are not, thereby setting up in its loosest sense a notion of 'in' or 'out' groups. This can polarise opinion and has the potential to lead to what has been called outgroup derogation (Hewstone et al, 2002) in which a group who are labelled as an 'out' group are seen as threatening in some way to those who define themselves as the 'in' group. By doing this, politicians, media or other groups are trying to establish a discourse around migration, which frequently also problematizes issues of diversity, race, culture, religion, class and ethnicity in particular ways (Migration Observatory, 2016). McIntyre et al (2016) have noted that lack of social identification is linked with heightened risk of developing both depression and anxiety, but that interventions designed to assist people feeling they are part

of groups and not socially excluded may be able to play a role in ameliorating these negative effects. Therefore mental health practitioners need to be aware of the wider context and issues which migrants may face.

The language used in relation to migration in itself may tell us something about how diversity is viewed and issues of institutional racism (Patel, 2017), the positioning of race (Bell, 2013), nationalism (Mavroudi, 2010) and what has been labelled neo-colonialism (Tribe, 2014) are played out. The legal, psychological and political positioning may be different. The term 'alien' is used in several countries, including the UK, USA, whereas the term 'foreign national' is used in Canada to define someone who is not a national, and other countries use the term 'foreigner'. The connotations of this word appear to emphasize a discourse of difference and a lack of similarity with people defined as 'nationals'. Whilst politicians in some lower and middle income countries have defined their nationals who temporarily migrate to high income countries to seek work due to worldwide financial disparities as 'Heroes,' for example, in the Philippines (Nicolas, 2011). Many of these 'heroes', who are a sub-group of migrants will financially support their families in the country of origin, although family separation caused by international financial disparities may not be conducive to good family cohesion, continuity or well-being.

The structural inequalities lens focusses on the economic and social determinants of health and the cumulative disadvantages. For example many older Black and Minority Ethnic people (BME) are living with higher levels of poverty, inferior housing and their access to benefits and pensions are less than older people who are white (Joseph Rowntree Foundation 2004). Lack of access to health care and the cultural appropriateness and accessibility of services for a number of marginalised groups has been raised by a number of authors (Bhugra & Bhui, 2018). Racial discrimination and linguistic barriers (Tribe and Lane 2009) are major issues for some migrants. All of these factors can be negative indicators for optimal mental health.

Different Types of Migration

The different types of migration have been defined in various ways, but the major demarcation is between involuntary or forced migrants and voluntary migrants. Voluntary migrants make a positive decision to move to another country, within some constraints they can select which country they wish to move to and are usually able to arrange when they will migrate. They can take some time to prepare themselves psychologically, although this does not mean that the transition will not be enormous and may be stressful (Christodoulidi, 2010). The new country may bring about a series of challenges, some of which may not have been anticipated, for example racism; the different presentation of age, gender, family roles, sexuality and sexual orientation, disability, race, class, religion; and attitudes to and understanding of mental health. So-called voluntary migrants may have or choose to move due to work, family, economic, health, personal, geo-political reasons, disasters or for education or other reasons. This may sometimes be less of a choice than it would appear, for example if not migrating means unemployment, the inability to provide for children, or poverty. The latter has been referred to as voluntary but reluctant migration. Forced migrants are people who have been forced to flee from their home country due to war, international or national geopolitics or other reason, including asylum seekers, refugees, internally displaced people and people who have been trafficked (Patel, Tribe & Yule, 2018).

The term migrant covers a diverse range of people from the highly paid and supported worker moving for a multinational company to a refugee, to an older adult who migrates to be closer to their relatives. Their journeys and needs regarding mental health will be diverse. Their pre-migration, migration and post-migration experiences are likely to be very different. For example, the multinational employee may face a different psychological journey, receiving a formal briefing and ongoing financial and emotional support for the individual and their family before moving and whilst settling in a second country. This varies significantly from people migrating in older age who might not speak the language of the new country and may have restricted social capital and networks.

Family members may hold a range of views about the move and may find different issues challenging. Children often adapt more quickly than adults and may gain literacy in a different language or adapt to cultural mores more quickly. This can put children into the role of taking on

adult roles within the family prematurely and it can also lead to the infantilising of parents (Douglas, 2018) who may take longer to learn a new language or to adapt. This can perturbate or alter family dynamics in unexpected ways. Adults may find themselves dependent on their children to negotiate systems and translate, this is not conducive to containment for children and can upset the family dynamics and well-being in unexpected ways. It can also lead to adult migrants feeling socially excluded.

Social Exclusion and Mental Wellbeing of Immigrants

There is increasing evidence that social exclusion and adversity may result in an increased risk of mental health difficulties with migrants as well as an interactive relationship between the two phenomena (Hjern et al, 2004; McKenzie et al 2006). Although definitions of social exclusion within the mental health literature have been criticised for being loosely defined theoretically and methodologically, most emphasise lack of participation in social activities as the core characteristic (Morgan et al, 2007).

There is an intricate and complex interplay between culture and mental wellbeing or health. The positive contributions many migrants bring to a community are frequently conveniently forgotten, or the person becomes relabelled as belonging to the country when it is beneficial to the country or they win plaudits for the country or are seen as having the potential to do so. We need to avoid what Maldonado-Torres, (2016) and a number of other post-colonial theorists call a hierarchy of difference. Dustmann & Frattini (2014) estimated that between 1995 and 2011, European immigrants to Britain made a positive financial contribution of over \$ 6.4 billion. Many countries have actively sought out migrants with particular skills, for example people with computer skills. Countries to do this have included USA, Canada, Australia and Israel (Refugee Council, 2018). Migrants who possess desirable educational or professional qualifications and are geographically mobile have been found to draw upon transnational networks as a source of social capital and support, they are not limited to place and a sense of inclusion can refer to international networks (Kindler et al, 2015). This access to resources can be beneficial to their well-being and resiliency. These factors are likely

to impact upon issues of identity, belonging, stability and consistency at the individual, familial, community, national or international level.

The role of social support and good networks in promoting positive mental health and resilience and reducing or buffering stress was reviewed by Kessler et al, (1985). Loneliness and lack of support networks are documented to be detrimental to good mental health (Mental Health Foundation, 2006). Some migrants may be at an increased risk of being isolated due to racism and potential marginalization. Some migrants will have family members living in a range of countries and may not have access to a family support network, although this will vary across communities (Lane & Tribe, 2017). Social networks were found to play a useful role for migrants in the early settlement process, assisting with practical issues and giving support particularly to some degree buffering the negative effects of poor cultural and economic capital, as well as lack of a stable legal status (Kindler et al, 2015).

Migratory Transitions and Identity

The transition for any migrant is a complex practical and psychological process to be negotiated (Bhugra & Gupta, 2011). As stated earlier, many people with skills which are useful to another country are asked or chose to re locate to a country different to that of their birth. Although, often seen as a more privileged group, voluntary migration is always a multi-faceted process where issues of cultural and geopolitical displacement will be experienced. Voluntary migrants may in theory be free to return to their country of origin but this may not always be straight forward. Whilst it is often assumed that voluntary migrants will have fewer issues relating to the psychological experience of migration, it can be a very challenging transition with multiple differences to negotiate (Christodoulidi, 2010). In addition to differences in language, culture and practical differences, migration can lead to changes in perception of identity at the individual, familial, cultural and societal level (Bell, 2013). Migrants perceived as different owing to skin colour may be subject to racism and micro aggressions either overtly or covertly (Migration Observatory, 2016). The migratory

transition can perturbate or lead to changes for an individual, family system and their sense of community (Bhugra & Gupta, 2011; British Psychological Society Guidelines on Responding to Refugees and Asylum Seekers in the UK: Guidance for Psychologists 2018). Transitions and change can perturbate a sense of identity and adversely affect mental health and wellbeing. Therefore practitioners need to be cognisant of these issues. Migrants have been reported to have higher rates of mental ill health in some studies (Stuart et al, 1998). Inequalities, stigma and discriminatory attitudes and practices are frequently associated with having a mental health diagnosis (Mental Health Foundation, 2015; Corrigan, & Watson, 2002). When racism is also present, the different forms of discrimination may intersect and lead to negative health outcomes. Social exclusion and discrimination have been found to be related to poor mental wellbeing (McIntyre et al, 2016).

There are a range of theoretical models around transition, culture and migration. These have included the acculturation, alternation, assimilation, fusion and multicultural models (Lafromboise et al, 1993), as well as what has been labelled the blended model of biculturalism where migrants are seen to preserve a positive heritage and cultural identity whilst also developing a positive identity through membership of the majority culture (Phinney & Devich-Navarro, 1997). How an individual negotiates a transition between two (or more) countries or cultures is likely to be an individual experience which will be mediated by a wide range of factors. Breakwell, (1986, 2011) developed identity process theory (IPT) in relation to identity formation across the life-span, with an emphasis upon the underlying psychological and social processes. The latter may gain particular resonance when identity is felt to be challenged, for example when a significant life transition, is experienced, which questions their previous self-concept. Migration may be one such social transition that poses a threat to an individual's identity, sense of self and subsequent wellbeing and mental health.

Culture, migration and contextual factors

The way culture is considered in the literature has evolved in high income countries from the naïve (at best) view of culture being something that was related to migrants or people from 'other countries'

a form of ‘othering’ towards a more considered and refined understanding which has begun to recognize a variety of ways of being and views of the world (Tribe & Tunariu, 2018) and also encourages clinicians in high-income countries to question their own cultural constructions and the limits of their generalizability. The so called cultural norm within high income countries was frequently assumed to be the white western (Sashidharan, 2001; Fernando, 2014; Tribe 2007) usually male perspective (and often young and able –bodied) within the wider societal and mainstream mental health context (Condor, 1991).

It could be argued that all mental health work should foreground culture, as everyone is influenced knowingly or unknowingly by aspects of ‘their’ culture and cultural identity. Whilst the cultural identity an individual develops or selects is multi-layered and may be flexible and will be subject to influences throughout the life span. Culture can also be reified as something sacrosanct and unquestionable in ways that can be detrimental to people and their human rights and the principles of social justice and equity, for example in relation to prescribed gender roles, sexuality and how mental distress is managed. Lewis- Fernandez (2015) chair of the Culture Subgroup of the Gender and Culture Study Group of the DSM-5 writes;

“Culture is an interpretive framework for symptoms, signs, behaviors which are transmitted, revised, and recreated within families and society. They affect boundaries between normality and pathology, thresholds of tolerance, coping, and interpretations of need for help, awareness of the impact of culture may reduce misdiagnosis. Culture may help determine support and resilience, by contrast, it may contribute to vulnerability and stigma. It helps shape the clinical encounter and affects help-seeking choices, adherence, course, recovery.” (Lewis- Fernandez, 2015:136)

Discrimination on any grounds is likely to have an adverse effect on mental health, this may include, but not limited to racial discrimination (Chakraborty & McKenzie, 2002), gender discrimination (Bondi & Burman, 2001), discrimination on account of sexuality (Broadway-Horner, 2017), disability (Smith, 2016) or age discrimination (Lane & Tribe, 2017), and class (Williams et al, 1997). In addition intersectionality (Crenshaw, 1989) occurs when two forms of discrimination intersect, for

example a disabled older adult of Afro-Caribbean heritage may suffer discrimination on account of her age, disability, ethnicity and gender.

Intersectionality where different forms of discrimination intersect and which examines the macro (institutional or contextual) as well as the micro (the interpersonal) power relationships (Kelly 2009) may be at play and effect someone labelled as a migrant. At the macro level, intersectionality can illustrate some of the conjoined forms of structural oppression and how inequalities may be entrenched in socio-cultural-political systems. For example, it has been found that Black, Asian and Minority Ethnic (BAME) families use fewer health and social welfare services and are less aware of what support is available (Ahmad, 2000; Shah, 2008). At the micro level this may mean individuals not accessing services or finding them inappropriate to their needs.

Mental health, culture and social context

Mental health can never be viewed in a vacuum, and the importance of contextual factors are being increasingly recognised. Kindler et al, (2015) in a review of the European literature noted that in addition to racism, many migrants may initially suffer lack of income, poorer housing and lack of social capital, at least initially. These and other contextual factors that have been identified as detrimental to mental health include the following factors; approximately two-fifths of people in low income households come from migrant or BAME communities (The Poverty Site, 2017). Common mental disorders are twice as frequent among the poor as among the rich (WHO, 2001).

Requirements for mental health services are very varied, and pre-migratory health, reasons for migration, age, explanatory health beliefs, help-seeking behaviour, selected idioms of distress, health status and language may all play a part.

Stuart et al (1998) working in Australia found that the prevalence of bio medical mental disorders varied in different migrant groups, but these differences differed markedly to the rates reported in

their countries of origin, but instead appeared to be related to their migration journey and the hardships experienced in advance of migration. Having said that migrants are an extremely diverse group and no simple generalisations should be made. People who choose to migrate often possess flexibility of mind, optimism, flexible thinking and considerable resilience which may bode well for good mental health. As the Department of Health Mental health: Migrant Health Guide (2017; 1) notes “Most migrants do not have mental health problems, some may be at increased risk as a result of their experiences prior to, during, or after migration to the UK”.

Case example

Toshio spoke repeatedly of never considering that he was Japanese until he moved abroad to study English and then to work. Having lived in a fairly monocultural society, he found on coming to Canada that his identity was in question and he found this an unsettling experience which affected his wellbeing in that many of his cognitive schemas and world views were challenged, as his social context, conventions and the way people related to him were all different. The cultural norms and ways of behaving in some situations were new and challenging and he felt unsure of the appropriate protocols and expected behaviours. This, coupled with his lack of confidence in his spoken English felt very anxiety-provoking and infantilising. These experiences made him question his sense of self, of his perceived place in the world and his identity. He sought out therapeutic support. After some time and reflection, the passage of time and establishing more connections to the new country and a better understanding of cultural conventions and ‘how it worked’ things changed. Toshio was able to make sense of these differences and he was able to see the experience of living in another country for a period of time as ultimately a positive one, and enriching one.

The above example illustrates how identity may be assumed as well as prescribed and how migration can prove challenging in unexpected and quite fundamental ways which may affect well-being and mental health, clinicians need to be sensitive to this and consider this in their work.

Mental health, migration and culture

With regard to mental health there may also be a range of explanatory health models, (how people understand their health and well-being, may not fit with western constructions and might include

possession by spirits / jinn, notions of causality and heredity may be diverse) (Summerfield, 2012). Diverse idioms of distress (the way psychological distress is presented may be culturally located, for example through somatic symptoms) (Tribe, 2007). Whilst help-seeking behaviours, (how and from where might help be sought will vary and might include talking with elders, indigenous healers, rituals and very different pathways to care for example (Fernando, 2017; Lane & Tribe, 2017).

The diagnostic Statistical Manual-5 (DSM-5) (2013) and the International Classification of Disease (ICD) (2011) which are used to diagnose mental illnesses and frequently determine who received care were developed within high income countries for specific purposes and the issue of how culture has been considered within them, has a contentious and complex background, earlier versions were consistently criticised for not dealing with issues of culture adequately (Mezzich et al. 1996; Fernando, 2014). The DSM IV and V (APA, 2000, 2013) took a little more account of cultural differences and contained the Cultural Formulated Interview (CFI) and then the Outline for Cultural Formulation (OCF) with the objective of giving a framework for mental health practitioners to categorise material obtained as part of assessment, formulation and intervention work. It is not without its critics (Bredstrom, 2016; Ecks, 2016).

Our understanding of some manifestations and interpretations of mental health will be influenced and co-produced by a number of factors including what is defined as culture. As Summerfield (2002: 248) writes “The diagnostic Statistical Manual (DSM) and the international Classifications of Diseases (ICD) are not, as some imagine, atheoretical and purely descriptive nosologies with universal validity. They are western cultural documents, carrying ontological notions of what constitutes a real disorder, epistemological ideas about what counts as scientific evidence, and methodological ideas as to how research should be conducted”.

People from BAME communities, including migrants and people ascribed marginalised status (by a dominant group) are known to access mental health services less than other groups (Bhugra & Gupta, 2011). This lack of use may be interpreted by service providers as there being no requirement for services or in some cases or a view that people from certain communities ‘look after their own’,

though this is frequently a view which may be a racist stereotype and each family will decide how they manage mental health issues individually (Tribe, 2017, Katabama, et al, 2004). The need for equitable access to health for migrants formed a resolution at the World Health Assembly 2008. How services are offered is also an issue, for example what has been labelled horizontal equity, which means the same service is offered to everyone may not be the best way forward, research shows that vertical equity which means tailoring services to meet particular requirements may be more effective (Oliver & Moossias, 2004). Practitioners and commissioners of services need to consider innovative ways of using psychological theory and practices which foreground the requirements of service users and communities. Doing this may benefit all members of our society particularly those with a migrant or dual cultural heritage.

Key Issues to Consider when Working with Interpreters

In addition, some migrants will not have had the opportunity to learn the language of the country to which they migrate, though many will be bilingual or have English as a mother tongue. Therefore some people will benefit from having an interpreter provided. Equal opportunities legislation means that access to services (including mental health) should not be prevented by lack of language proficiency. There are courses available on working effectively with interpreters which may help prepare clinicians for working with interpreters. Comprehensive guidelines on working with interpreters in mental health can be located via the British Psychological Society (2017) and a short film available via YouTube at WWW.YOUTUBE.COM/WATCH?V=K0WZHAKYJCK

More experienced practitioners have reported the many positive aspects of working with an interpreter (Tribe & Thompson, 2009). These include improved clinical care and service users/clients saying that they feel understood (Angelelli, 2004). In a systematic review, Karliner et al., (2007) found that use of a professional interpreter can improve care that approaches or equals that for patients without language barriers. Working proficiently in partnership with interpreters is a skill that practitioners need to acquire as working with an interpreter may be the only way that some migrants are able to access services.

Major issues to consider when working with an interpreter are assessing the need to conduct a language audit for the geographical area served by any clinic or practice and considering how this service is prepared to meet the needs of this population (Tribe & Thompson, 2017). If the referral pattern of the service or practice does not reflect the local geographical population, it is important to consider why this might be and what might need to be done to change this. This may include taking a range of actions to address this.

Undertaking formal briefing and de-briefing of interpreters for the task of working within mental health are essential (Tribe & Thompson, 2017). The briefing would include the purpose of the meeting, the different roles, the boundaries of each role, whilst the interpreter /cultural broker would inform the practitioner of any cultural issues which they need to be cognisant of. It is important that this time is not rushed and that time is appropriately allocated to this. This briefing also allows the practitioner and interpreter to meet, develop a rapport and discuss working together. Whilst the de-briefing at the end of the session is to offer support and supervision as appropriate. Interpreters have not had the training of practitioners, do not receive clinical supervision and there is a duty of care towards them by the organisation and individual practitioner Tribe, (2002). The practitioner needs to be aware of the potential danger of vicarious traumatisation for interpreters when working with traumatic material and when conducting the briefing and de-briefing processes with the interpreter, the practitioner should have this in mind.

The practitioner always needs to be sensitive to the change in dynamics working with an interpreter can mean, including but not limited to issues of confidentiality and trust, this is particularly pertinent when working with service users/experts by experience

from small or divided language communities. Practitioners may need to formally clarify the professional boundaries of the interpreter's role. It may be useful to clearly state that the practitioner alone holds clinical or organisational responsibility for the consultation. It is important to develop an open and collaborative working relationship based on trust and mutual respect (Tribe & Thompson, 2017). Practitioners can find working with interpreters challenging at first but an enriching one. It can provide many positive aspects including understanding diverse cultural constructions around mental health and well-being, perhaps developing a critical evaluation of western constructions of mental health and issues relating to their generalisability. On a practical level it can lead to thinking and considering the language used. It can also provide time for reflection when the words are being interpreted.

If using any psychometric measures extreme caution is needed, as they may never have been validated for diverse groups and any results obtained may not be meaningful (International Test Commission Guidelines on Test Adaptation, 2000). Best practice would mean that a practitioner offers an interpreter in situations where one family member has good English but others do not.

Future directions

There has been a move towards the homogenisation of mental health across cultures, this has largely come from high income countries hoping to impose their ways of working onto lower income countries, without due attention to the rich traditions frequently located in low and middle income countries, (Summerfield, 2012, Fernando 2014, Tribe, 2014). Global mental health is a highly contested area, where differentials of power and resources are an issue. Whilst there are some counter-flows from low and middle income countries to high income countries, this flow is relatively small, this may be for several reasons including power imbalances and racism. The way that global mental health is frequently practiced has been considered to be a kind of medical imperialism or neo-

colonialism (Summerfield, 2013, Fernando 2014, Tribe, 2014). Many countries contain a range of cultures within them and there is much that could be learned from how mental health is considered in them that could be used as resources within high income countries. Migrant communities can contribute to the development of more culturally appropriate and informed services in a range of ways.

Conclusion

Whilst, training of all mental health practitioners needs to foreground issues of cultural diversity and to develop a more critical understanding of current practices, rather than viewing cultural diversity (or any form of diversity) as additional extras, which is often the case at present (Tribe, 2014; Fernando, 2017). All clinicians need to actively promote anti discriminatory practices which foreground the lived experiences and meaning of clients with migratory histories and not ignore these experiences or assume that they understand them. It is also important to remember that migration is part of a person's identity but not their identity. Further research is also required which adequately considers issues relating to migration and which foregrounds cultural diversity and mental health. Clinicians should also consider the socio-cultural and historical context which have given rise to potential marginalisation and how these may relate to mental health.

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