Migration, distress and cultural identity

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When people migrate from one nation or culture to another they carry their knowledge and expressions of distress with them. On settling down in the new culture, their cultural identity is likely to change and that encourages a degree of belonging; they also attempt to settle down by either assimilation or biculturalism. In this paper, various hypotheses explaining the act of migration and its relationship with mental distress are described. A new hypothesis is proposed suggesting that when sociocentric individuals from sociocentric cultures migrate to egocentric societies they may feel more alienated. In order to assess and manage migrants, the clinicians need to be aware of the pathways into migration.

Introduction

Migration is a process of social change where an individual, alone or accompanied by others, because of one or more reasons of economic betterment, political upheaval, education or other purposes, leaves one geographical area for prolonged stay or permanent settlement in another geographical area. It must be emphasized that migration is not only a trans-national process but can also be rural–urban. Any such process involves not only leaving social networks behind (which may or may not be well established) but also includes experiencing at first a sense of loss, dislocation, alienation and isolation, which will lead to processes of acculturation. A series of factors in the environment combined with levels of stress, the ability to deal with stress, and the ability to root oneself according to one's personality traits, will produce either a sense of settling down or a sense of feeling isolated and alienated.

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Rural–urban migration is more likely to be for economic or educational reasons, whereas migration across nations may be for social, educational, economic or political reasons. Thus reasons for migration, prior preparation to the act of migration and social support will all enhance an individual's coping mechanisms. In addition, acceptance and welcome by the new nation will also be significant in the genesis of stress and how the individual deals with such stress. In this paper, the focus is on migrants and not refugees and asylum seekers who have a different set of problems.

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Migration and mental disorder

In a classic study, Ödegaard[1] reported that the rates of schizophrenia among Norwegians who had migrated to the USA were higher when compared with Norwegians who had stayed back in Norway. This study set the standard for further studies comparing rates of schizophrenia and other psychiatric illnesses as well as for comparing those who had migrated and those who had been left behind or who had not chosen to migrate. Although Sashidharan[2] has argued that the same principles of migration and its impact on whites cannot be considered exactly similar to the stress and impact on African–Caribbeans, it can be argued that the process of migration, sense of dislocation and alienation must contribute to the stress on the individuals and their families even though their experiences of alienation and dislocation will be different both at individual and group levels. Several studies in the UK have demonstrated high rates of schizophrenia among the migrant groups especially African–Caribbeans in the UK. These studies have shown consistently high rates of schizophrenia[3]. Cochrane and Bal[4] postulated four hypotheses, in order to explain the increased rates of schizophrenia among migrants. To these I would add a fifth; these are shown in Table 1.

Hypothesis one

The first hypothesis for the high rates of schizophrenia among migrants states that the countries from which migrants originate themselves have high rates of schizophrenia. This hypothesis, although superficially attractive,

Table 1 Five hypotheses of elevated rates

	Phenomena		Assessment
1.	High levels of morbidity in the country of origin		Rates in country of origin
2.	Difficulties: Language Personality	Selection	Personality Inventories
3.	Loss of social support Cultural identity Family history	Migration experience	Life events
	Stress of adaptation Discrimination Economic/material difficulties Rootlessness	Post-migration	Racial discrimination Cultural identity Achievement *versus* expectation
4.	Misdiagnosis		Standardized *versus* culturally sensitive
5.	Ethnic density		

has no evidence in reality. The World Heath Organization has enabled good quality multi-centre data collection on this topic and from this, Jablensky *et al*[5] reported that rates of narrow definition (core) schizophrenia were not dissimilar across different cultural settings.

The study included three centres in developing countries, and these showed no difference in incidence rates of core schizophrenia, although there were wide variations in rates of broad schizophrenia. The rates from India are not dissimilar[5] compared with Western rates.

Recent studies from Jamaica[6], Trinidad[7] and Barbados[8] have all demonstrated lower rates of schizophrenia when compared with rates among African–Caribbeans in the UK. Had the rates in the sending countries been genuinely higher, it would have been possible to explain some of the variation on the basis of genetic vulnerability, pregnancy and birth complications or neurological factors. However, no such increase has been demonstrated.

Hypothesis two

The second hypothesis of self-selection suggests that those who are predisposed to mental illness (especially schizophrenia) are more likely to migrate. Such mobility can be attributed to inherent restlessness as a prodrome of the illness or a feeling of wanting to get away from a community that may be stigmatizing the mentally ill individual. The migration of patients with schizophrenia into urban areas confirms the drift hypothesis, and yet the fact that the urban environment may well contribute some yet unknown vulnerability has not been totally disproved.

Although the hypothesis that psychologically vulnerable people tend to migrate is superficially attractive, it fails to provide a full explanation. If this were indeed the case, then the rates would be much higher in the first generation of migrants and then gradually drop in subsequent generations, which is not the case. Also the rates are not elevated in all migrant communities—only in some[9].

It can be argued that the individual has to be particularly healthy in order to jump all the hoops of immigration that are put in their way. The first phase of migration (lasting the first few years) appears to show relatively few health problems owing to the younger age structure of the migrant. In the next phase lasting from 5 to 10 years, when the individual has settled, the problems of acculturation and alienation may contribute to development of stress, which may produce psychological symptoms. In the following phase after 10 years or so in the new setting, the migrant may feel worse especially if they have not been successful in meeting their aspirations and are impeded by social constructs such as racism, and social structures such as unemployment, poor housing and the like.

Hypothesis three

This hypothesis states that migration in itself produces stress, which, in vulnerable individuals, leads to psychological morbidity. Theoretically this should lead to a proportionate increase in common mental disorders as well. However, available data do not support this. Also, as the rates of schizophrenia appear to be higher 10–12 years after migration has occurred, it would appear that there may be other intermediary factors that contribute to stress and elevated rates.

It is conceivable that it is not the stress of migration but the stress of living in an alien culture that may be more relevant. Furthermore, factors such as cultural identity, self-esteem, patterns of attachment and prolonged periods of separation from one or both parents may play some role in the genesis of mental disorders.

Hypothesis four

It has been argued cogently and repeatedly that elevated rates of schizophrenia among migrant groups are the result of misdiagnosis because clinicians fail to understand the cultural background of their patient and do not take into account cultural explanations of the groups they are either treating or diagnosing. However, this remains a spurious argument. Most of the research studies that have recruited patients from various migrant groups have done so on the basis of symptoms rather than research diagnosis[10]. The emphasis on symptoms and not diagnosis may enable the clinician to overcome some of the problems experienced.

Hypothesis five

An additional possible explanation that was not discussed by Cochrane and Bal[4] but that is very probable is the ethnic density effect. It is likely that where migrants live together, especially with others from the same community around them, this may work as a protective factor for some psychiatric illnesses. Although shown in one study only, the comparable equal rates of schizophrenia among Asians and whites may be explained by the fact that there were large numbers of Asians living in the particular geographical areas—the population reaching 50% in some parts. However, high population density may well lead to other psychiatric conditions such as common mental disorders or increased rates of deliberate self-harm, through the mediation of an underlying culture conflict[3].

When political and economic upheavals and natural crises lead to mass migration, this may produce a sense of hopelessness and helplessness in

the individual leading to a depressive effect. Social assimilation may be affected and may not occur for a number of reasons[11].

Therefore a sense of deculturation or alienation emerges that further adds to the sense of failure, loss and poor self-esteem. In these conditions it is likely that the migrants and their dependants develop depressive symptoms. If there are additional factors such as discrepancy between achievement and expectation, it is likely to contribute to a sense of dejection, leaving the migrant psychologically vulnerable. Why this vulnerability leads to psychosis in general and schizophrenia in particular is difficult to explain and deserves to be studied in its own right in relation to social networks and support systems[12].

When individuals migrate from one nation state or culture to another, be it for temporary or permanent residence or for economic, political or educational purposes, there is every likelihood that aspects of that individual's cultural and ethnic identity will change. The degree of alteration will be determined by a number of factors—individual, kinship and societal. The changes may be transient, semi-permanent or permanent; some individuals may not undergo any changes in identity at all.

Migration and cultural identity

In this section, the focus is on cultural identity among black and ethnic minority groups in the UK. However, it is essential that we are clear about the definitions of ethnicity being applied. Ethnic identity depends upon the cultural or physical criteria which set the group apart. An ethnic *group* may set itself apart using superiority or inferiority on the basis of real or alleged physical characteristics[13] and/or placed on cultural criteria, which set the group apart[14]. Ethnicity is a common heritage shared by a particular group and will include history, language, rituals, preference for music and food[15]. Although there may be an overlap between race and ethnicity each has a different social meaning[16].

Racial identity refers to a sense of group or collective identity based on the perception that the individual shares a common racial heritage with a particular racial group[17]. With racial identity, individuals are seen as inside or outside a particular biological group. This differentiation between ethnic and racial group is helpful to a degree but can also be criticized for helping to create stereotypes and over generalizations, thereby further compounding the complexity of the problem[17]. In practice, the concepts of ethnic, racial and cultural identities are often not easily distinguishable. Berry[18] recommends using the term *ethnocultural identity*. When studying migrants, and their health and health behaviour, acculturation (the adoption of the values and behaviours of the surrounding culture) and cultural identity have to be studied at both individual and group levels.

Migration and acculturation

When individuals migrate they do not leave their beliefs or idioms of distress behind, no matter what the circumstances of their migration. Their beliefs influence their idioms of distress, which influence how they express symptoms and their help-seeking behaviour. For example, a study of Punjabi women who had been in the UK for a number of years found that they maintained the belief that depression was not a medical condition[19]. Although they recognized its symptoms and also identified various aetiological and perpetuating factors, their method of help-seeking was related to their explanatory models—which led them to seek help from religious practitioners and by reading scriptures rather than seeking medical help from statutory services because they believed that this stigmatizes them and their families. They saw depression as a part of life's ups and downs and there was nothing that doctors could do about it.

When two cultures come in contact, then a number of events may occur. Berry[18] suggests that the process of acculturation is akin to the psychological models of moving towards, moving against and moving away from a stimulus. This change will correspond to adaptation or simulation, rejection and deculturation. The process of acculturation requires two cultures to come into contact and both cultures may experience some change. In reality, however, one cultural group will often dominate the other group.

Acculturation has been defined as a 'phenomenon' which results when groups of individuals from different cultures come into continuous first hand contact with subsequent changes in the original culture patterns of either one or both groups[20]. For clinicians, it is helpful to have a notion of acculturation so that the individual's psychological distress can be understood in the context of what is happening to them and their cultural changes in identity.

Berry[21] has identified assimilation (where cultural differences disappear), although others have argued that assimilation and acculturation are similar[22]. Gordon[22] differentiates between structural, identification and behavioural assimilation. Berry[18] recommends looking at the exposure between two cultures in terms of rejection (the individual or the group withdraws from the larger society) and deculturation (loss of cultural identity, alienation and acculturative stress). In rejection, the extreme outcome may be apartheid or segregation and in deculturation, the outcome may lead to ethnocide. The individual and group identities may well respond in different ways at different levels.

At an individual level in terms of behaviour, six domains have been identified which can be linked with acculturation[23]. These include language, religion, entertainment, food and shopping habits. Other areas, which may be more difficult to identify and measure, include cognitive styles, behavioural patterns and attitudes.

These elements of the concept of acculturation are very closely linked with self-esteem and identity of the self as culture and personality are inter-linked[24]. In a study of Puerto Ricans in the USA, Cortes[25] found that feelings of nostalgia and disillusionment were linked with beliefs about depression. Childhood or early experiences and socialization may also play a role; child rearing differences across cultures too will contribute to this. Clinicians must remember that none of these acculturative processes are static and these acts keep occurring and the individual keeps responding to these acts.

With acculturation, some aspects of identity are likely to change, including the concept of self, and this will be dependent upon the cultural context. A person's identity is defined as the totality of one's self—formed by how one construes oneself in the present, how one construed oneself in the past and how one construes oneself as one aspires to be in the future. Two points need to be emphasized here. Firstly that racial, ethnic and cultural identities form part of one's identity, and secondly, the development of identity and the resulting changes owing to migration and acculturation will change the construction of identity. Gender, familial and socio-economic factors also contribute to identity.

Acculturation can occur at the psychological level as well as at the cultural level. The changes are illustrated in Figure 1. There are a number

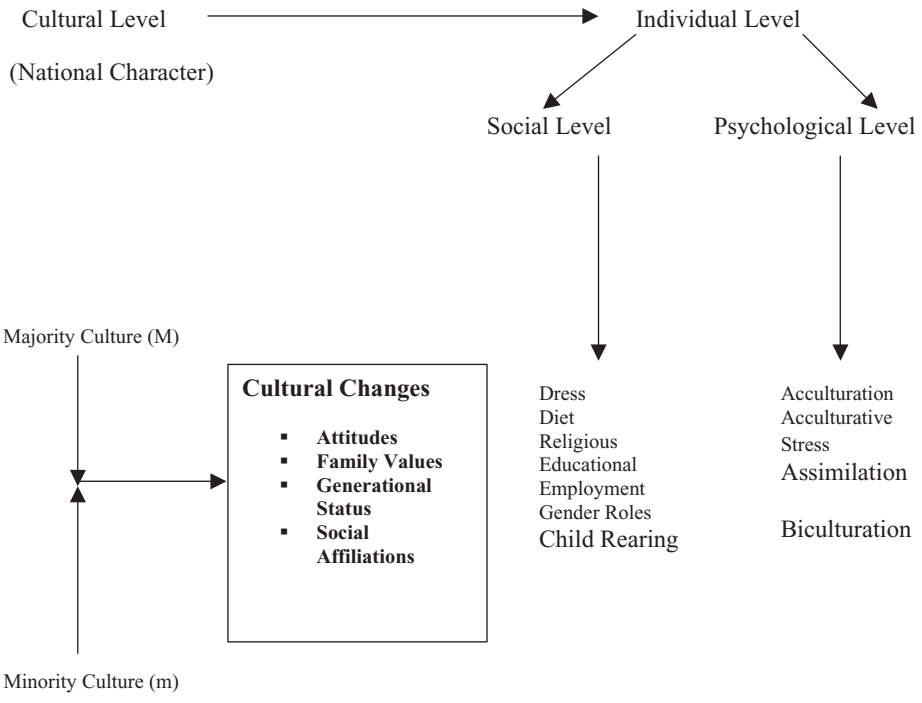

Fig. 1 Levels of acculturation.

of reasons why understanding the process of acculturation is important for those who may be concerned with the health of migrants. Persistent problems in cultural adaptation are associated with a higher risk for long-term mental health problems.

Many factors play a role in the process of acculturation: the effects of pre-migration trauma, post-migration factors such as loss of social roles, confidants, attitudes, *etc.*, socio-demographic factors such as age, sex, education and economic status, and the effects of cultural orientation, *e.g.* assimilation (becoming a part of the majority culture), separation (becoming alienated), biculturalism (feeling reasonably comfortable in both the cultures) and marginalization (becoming withdrawn and isolated from both the cultures) and acceptance from the host society. The role of spirituality and religiosity also has to be understood. Assessing the relationship between acculturation and mental health thus poses important theoretical and empirical challenges. Many mental health measures have been developed for American and European groups but are frequently used for minorities without any adaptation. This raises questions as to the validity of such measures when used in this way (referred to as category fallacy[26]).

However, a further important point is that of Hofstede's descriptions of cultures[27,28] as individualistic and collectivist. *Individualism* refers to a society where the ties between individuals are loose and everyone is expected to look after himself/herself and his/her immediate family. *Collectivism* refers to a society in which people from birth onwards are cohesively integrated and which throughout their lifetime continues to protect them from aggression from outsiders in exchange for unquestioning loyalty[27]. Hofstede[28] suggests that individualistic societies emphasize 'I' consciousness: autonomy, emotional independence, individual initiative, the right to privacy, pleasure seeking, financial security and the need for specific friendship and universalism.

Collective societies stress 'we' consciousness: collective identity, emotional inter-dependence, group solidarity, sharing, duties and obligations, the need for stable and predetermined friendships, group decisions and particularism. These are paralleled at the individual psychological level by *idiocentrism* and *allocentrism*, respectively[29].

Individualistic societies support the basic tenets of liberalism whereas those of collectivist societies support traditionalism. The former assumes that individuals are rational and able to use reason to make personal choices and therefore they should be given individual rights to choose freely and to define their own goals. At the interpersonal level, the individuals are seen as discreet, autonomous, self-sufficient and respectful to the rights of others. From a societal point of view, these individuals are abstract and universal and their status and role defined by their achievement (*e.g.* occupational, economic and educational status). The individual members' interaction with others is based on equality, equity, non-interference

and detachability. Collectivist societies, therefore, prioritize common good and social harmony over individual interests. Individuals are bound by relationships, which emphasize a common fate. Individuals are encouraged to put other people and the group's interest before their own. Concession and compromise are essential ingredients in promoting role-based and virtue-based conceptions of justice, and institutions are seen as an extension of the family—and paternalism and legal moralism reign supreme. Triandis[30] differentiates between the individualistic self—'I am kind, my strengths are…' and the collectivist self—'my family expects me to be kind', 'my co-workers believe that my strengths are…' Individualism has been shown to be related to high levels of GNP but extreme individualism can lead to several forms of social pathology such as high crime, suicide, divorce, child abuse, emotional stress and physical and mental illness[28].

Allocentric persons tend to have happy marriages and are more likely to receive social support that acts as a buffer for life change stresses[29]. Allocentric individual defines self in terms of in-group relationships and knows more about others than selves. In-group goals have primacy over personal goals and cognitions are context-dependent. The way people think for example for procreation and partnerships is influenced by cultural norms. The attitudes of allocentric individuals reflect interdependence and their values are that of security, obedience, and duty, in group harmony, hierarchy and personalized relationships. A major calamity for this group is ostracization by others. Their values are of pleasure, achievement, competition, freedom, autonomy and fair exchange[30].

Thus, it is likely that allocentric individuals from a collectivist society will face different types of stresses if they migrate to an individualistic society and their social links are with idiocentric individuals. Similarly idiocentric individuals from collectivist society who migrate to individualistic societies and come across idiocentric individuals may have different experiences. Schwartz[31] further described mastery, hierarchy, conservatism, harmony, autonomy-intellectual or affective and egalitarian commitment. In order to understand the impact of migration on an individual, the characters of their group and the groups they originate from have to be studied with respect to these concepts. Not surprisingly, the People's Republic of China scored high on mastery and hierarchy and other Western nations such as France, Israel, Portugal and Switzerland scored highly on autonomy, conservatism and egalitarian commitment. Hofstede[27,28] demonstrates that such cultural concepts can be unpackaged into a set of interpretable etic (an outsider's understanding of another culture) dimensions on which specific nations and cultures can be compared.

It is worth using the same concepts for understanding both the aetiology and management of psychiatric problems in different migrant groups; interaction with acculturation comes into play as well.

Ethnic diversity *versus* ethnic identity: a new hypothesis

As discussed at the beginning of this chapter, it is clear that the rates of schizophrenia amongst African–Caribbeans are elevated. Although it has been argued that all migrant groups to the UK have higher-than-expected rates, this has not been a consistent finding. It has been suggested that South Asians in the UK are more likely to be living in high-density areas where there are other Asians with possibly more social contact and traditional (collectivist) views which may explain low rates of schizophrenia in this group[3].

Boydell *et al*[32] reported that low ethnic density of black individuals in an electoral ward may contribute to an increase in the incidence rates of schizophrenia. These rates nearly doubled if the population density of ethnic minorities fell to one-third of the base population in particular electoral wards. Rosenberg[33] described the context of dissonant religions in high schools in New York. After stratifying the populations of public schools, the students were given three questionnaires. Respondents were asked about the religious affiliations of the neighbourhood they had lived in the longest and found that the experience of living in the context of a dissonant religion had certain psychic consequences for the individual. In every case, Rosenberg found the students who had been raised in a dissonant context were more likely than those who had been reared in a consonant or mixed religious environment to manifest psychic or emotional disturbance.

Catholics raised in non-Catholic neighbourhoods were more likely than Catholics raised in predominantly Catholic or half Catholic neighbourhoods to have low self-esteem, to feel depressed and report many psychosomatic symptoms. These results indicate that whether everyone in the neighbourhood is of one's group is less important than whether there are enough of them to give one social support the degree of which needs to be determined. An additional factor was that those in the minority were more likely to be discriminated against and feel alienated.

Racial and cultural identity, along with congruity, is an ecological issue. Such a contextual dissonance or consonance refers to the discrepancy or concordance between the individual's social characteristics and those of the population by which the individual is surrounded. The deleterious effects of contextual dissonance on self-esteem may also be meditated by the nature of dissonant communications and cultural environments and comparison reference groups. Low self-esteem has been well demonstrated with depression but it is likely that this may also be a pathway into the genesis of other psychiatric disorders if other vulnerabilities, biological, psychological or social exist for the individual.

Social isolation compounded by unemployment, poor housing, and low social and economic status, compounded in turn by chronic difficulties

related to alienation, poor coping strategies and biopsychological vulnerabilities, may all contribute to the genesis of schizophrenia. My contention is that ethnic and cultural congruity combined with interaction patterns and cultural identity is a more useful concept in understanding the concept of schizophrenia in migrants. It is possible that if individuals come from collectivist cultures and migrate to individualistic cultures and are of allocentric nature, their beliefs about themselves, their aspirations *versus* achievements and self-esteem, are likely to be harder hit. This dissonance may explain some of the stress individuals experience and have to deal with.

It is possible that acculturative stresses, discrimination and disadvantage further compound the problem. The feelings of alienation and attempts to belong to one group may act as a chronic continuing difficulty making vulnerable individuals more prone to psychosis.

Conclusions

The relationship between migration and its processes and impact on individuals and their development of psychological or psychiatric conditions is a complex one and deserves to be teased out. Within the process of migration, where possible in prospective studies, it is important to study the pre-migratory phase, the preparatory phase, the personality of the individual, the amount of social support and network and preparation for the process of migration. Subsequently, the process of migration itself and the migratory and post-migratory stresses may need to be studied. These should include life events, racial and socio-economic discrimination and factors such as housing, employment, status, *etc.* Furthermore, cultural identity and measures of acculturation will be worth assessing to understand the stresses and supports an individual feels and how these interact with other life events. Achievement *versus* expectation, self-esteem, ethnic density and cultural patterns of development and attachment and periods of separation from one or both parents deserve to be studied further. Biological factors such as neurodevelopmental anomalies must be studied further in general populations to ascertain the rates of biological assault and must be correlated with social disadvantage.

Future studies must look at the distribution of symptoms across different ethnic and cultural groups, and the similarities as well as differences must be studied to understand the role of cultural factors.

Pathways into medical and psychiatric care can also give a clue to the differential rates of schizophrenia in different groups. Socio-economic factors may well prove to be more significant than ethnicity or migrant status alone.

In conclusion, there is little doubt that the rates of schizophrenia are higher among some migrant groups; this increase may well be linked with

a number of complex factors and interactions. Race, ethnicity and an alien cultural group may function as vulnerability factors and continuing socio-economic disadvantage, discrimination and alienation may work as chronic difficulties, making vulnerable individuals develop psychosis. A deep sense of alienation, loss and failure may contribute to poor self-esteem, which may contribute to distorted images of the self. Broader social factors play a role and deserve to be studied in the specific context of the influence of migration on the development of schizophrenia.

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