Immigrants and Refugees: The Psychiatric Perspective

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ARTICLE

Immigrants and Refugees: The Psychiatric Perspective

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Abstract Psychiatric studies of immigrants have yielded contradictory findings regarding rates of mental illness. Current evidence suggests that rates of schizophrenia (and probably other disorders) among immigrant groups are low compared with native-born populations when sending and receiving countries are socially and culturally similar. The rates for immigrants are higher when sending and receiving countries are dissimilar, probably because of multiple social problems faced by immigrants in the receiving country. Refugees who flee their own country because of fears of violence or starvation often have had extremely traumatic experiences, which may result in PTSD and sometimes chronic impairment. Asylum seekers who arrive illegally to seek refuge in a foreign country also may have multiple traumas and experience further distress from their uncertain residency and legal status. Although much is known about the effects of migration, competent culturally sensitive services for migrants remain inadequate to meet the need.

Key words asylum seekers • clinical implications • immigrants • mental disorders • refugees

It is an honour to present an article to recognize Dr. Raymond Prince, a man I have known and respected for many years. His contributions to transcultural psychiatry are a major reason the field has advanced to its current high level of scholarship.

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In this report, I will discuss the current information and psychiatric implications of mass movement of people as immigrants, refugees, or asylum seekers. There are opposing forces in migration: The strong desire or need for people to move to improve or even save their lives is opposed by forces in developing countries to restrict migration for economic or security reasons. Societal fears, legal restrictions, and prejudices stemming from possible terrorists activities have placed migrants, refugees, and asylum seekers under increased scrutiny. The goals of this article are to briefly summarize the psychiatric information on immigrants, refugees and asylum seekers and the clinical implications of these data, and to provide suggestions for further research.

Immigrants

Migration, usually to seek economic or material improvement, has been an important human activity over the course of history. Currently, migration occurs through both legal and illegal paths, between countries and also within a single country. Large-scale migrations occur in the United States from Central and South America and in Europe from Africa and Asia. The amount of legal migration in the United States has varied greatly over the last 150 years. For the decade ending in 1890, over 5 million came to the United States compared with only 500,000 for the decade ending in 1940. It is estimated that 10,000,000 legal immigrants have come to the United States in the decade ending in 2000 (Immigration and Naturalization Service data).

Perhaps the largest migration has occurred within one country: China. There are about 120,000,000 migrant workers there, only about half who are registered (Thomas, 1998). This has been described in terms of a dichotomy of planned and unplanned migration (Fan, 1999). Unplanned migrants receive no services and make public health issues, such as AIDS, difficult to monitor.

Schizophrenia

Early in U.S. psychiatry it was reported that the foreign born had an increased rate of mental illness compared to the native born. Odegaard (1932), in a classic study in Minnesota, found a much higher admission rate in the state hospitals for Norwegian born compared to native born, and even a higher rate compared with Norwegians in Norway. This led to two competing theories of migration: (1) Those vulnerable to psychiatric disorders are more likely to migrate; versus (2) immigration and acculturation are stressful, leading to mental illness.

There are now many studies on the relationship of migration to schizophrenia, and recent findings have revived the controversy over the etiology of schizophrenia. Schizophrenia and mania have been reported to be higher among African Caribbean immigrants to England and other European countries (Harrison, 1990; Sharpley, Hutchinson, McKenzie, & Murray, 2001). As summarized by Eaton and Harrison (2000), 17 studies have reported a higher incidence rate of schizophrenia in people whose position in society is disadvantaged compared to the majority group of native born (relative incidence from 1.7 to 13.2). Studies of schizophrenia and migration have shown increasing methodological sophistication especially in Europe. A study in The Netherlands indicated an increased risk of schizophrenia (and other psychosis) for subjects born in Morocco, Surinam, and Dutch Antilles, but not for those from Turkey or western countries (Selten et al., 2001; Schrier, van de Wetering, Mulder, & Selten, 2001). A study in Sweden found an increased risk of schizophrenia-like psychosis among immigrants with the most marked increase from East Africa (Zolkowska, Cantor-Graae, & McNeil, 2001). The authors felt that the increased risk of psychosis was due to factors other than the migration process. Using the population of Surinam as well as Surinam population of The Netherlands, Selten, Cantor-Graae, Slaets, and Kahn (2002) found the relative risk of schizophrenia for Surnanese-born immigrants was 1.46. The authors conclude that selective migration could not solely account for the higher incidence of schizophrenia. Using the Danish Civil Registration System and the Danish Psychiatric Case Register, Cantor-Graae, Pedersen, McNeil, and Mortensen (2003) found a relative risk of developing schizophrenia – 2.45 and 1.92 among first and second generations respectively – and they also found a 1.60 relative risk among Danes with a foreign residence. These authors concluded that migration confers an increased risk of schizophrenia that is not solely attributable to selection factors and may be independent of foreign birth.

The implication of these findings has been discussed in several excellent reviews. Harrison (2004) argues that after two decades of a dominant model of biological factors in schizophrenia evidence from migration studies there is a need to integrate social experience into biological models of schizophrenia. Hutchinson and Haasen (2004) argue that ethnicity and difference in dominant language filtered through social disadvantage in an urban environment are major factors to account for the high rate of schizophrenia in some immigrant groups. In a thoughtful review Cooper (2005) presents evidence that social rather than genetic explanations account for the increased risk of schizophrenia among some migrant groups. Among the evidence supporting social explanations are the observation that rates of schizophrenia in Caribbean countries are similar to those in the UK, while immigrants have a higher rate of schizophrenia;

there is no evidence of selective migration; and the immigrants with the highest rates are socially and economically disadvantaged in terms of education, housing, and employment and are often subjected to racial discrimination. This raises the issue of social class as well as migration as having a role in the development of psychosis. In a similar vein, a recent study of children found that migration increased the risk of psychosis, but that the risk was greatly increased when there was a history of family dysfunction in addition to migration (Patino et al., 2005).

Nonpsychotic Disorders

The impact of migration on depression and other nonpsychotic disorders is not as straightforward as schizophrenia, with some immigrant groups having lower rates of depression than the native born (Bhugra, 2003). Surprisingly, those who are more acculturated (judged by language fluency) are more likely to be depressed. Carta et al. (2002) found that Sardinian immigrants to Paris had an elevated rate of depression and anxiety disorders. The second generation was particularly at risk for depression, drug abuse and bulimia. In Australia, treated prevalence rates of mental illness were highest among those born in Greece and lowest among those born in the UK, Ireland or Southeast Asia (Stuart, Klimidis, & Minas, 1998).

A study of survivors of the Second World War in The Netherlands compared samples of those who migrated to Australia after the war with Dutch who remained in The Netherlands. Those who were exposed to more severe war trauma were more common in the immigrant group, but there were comparable levels of PTSD in the two groups. This suggests that severe stress (from past war experience) – not migration – was the major factor in the development of PTSD (den Velde et al., 2000).

Among the 5 million Hispanics who immigrated to the US between 1981 and 1998, Mexican Americans compared to non Whites were less likely to have a psychiatric diagnosis (Ortega, Rosenheck, Alegria, & Desai, 2000). Acculturation stress had a greater risk of DSM-IIIR diagnosis for Mexican Americans than other Hispanics. There was greater risk of having a substance-abuse disorder among Puerto Ricans. Mexican immigrants to the United States are a heterogeneous group. Mexican Indians had a different risk of affective disorders and alcohol/drug dependence than non Indians. Mexican Indians seem to be more vulnerable to negative effects of exposure to U.S. society (Alderete, Vega, Kolody, & Aguilar-Gaxiola, 2000). Escobar and Vega (2000) point out that acculturation itself is a fuzzy concept, often meaning stressful life experiences after cultural change.

Implications of Research on Migration

There is now clear evidence that certain immigrant groups have a higher rate of schizophrenia than native-born subjects or those in their country of origin. The risk is low when sending and receiving countries are similar (western to western) and higher when sending and receiving countries are dissimilar (Surinam to The Netherlands; African and Caribbean to the UK). For some migration is very stressful resulting in psychosis and schizophrenia. However, other social factors such as language, poverty, unemployment, racism and family dysfunction are probably central to this increased risk. The studies on migration and schizophrenia have resulted in renewed interest for the part played by social factors in the etiology of schizophrenia.

PTSD does not seem to increase with migration but may influence the choice to emigrate. In other nonpsychotic disorders the evidence is less clear, with some finding increased rates of disorders among immigrants and some having reduced rates. Acculturation is a complicated process and in itself may be associated with an increased risk for depression and in some groups the second-generation subjects may have higher disorders than the first generation. There is such large ethnic and individual variation in symptom patterns that immigrant status alone does not necessarily help in identifying any given patient's diagnosis and treatment.

Refugees

In 2002, there were 19.8 million refugees in the world, that is, those fleeing their own country because of war, ethnic cleansing, or starvation (United Nations High Commission on Refugees [UNCHR], 2004). It is estimated that there are another 20 million internally displaced people not counted as refugees. The largest number of refugees is in Asia (8.8 million) and Africa (4.1 million). The main host countries are Pakistan, sheltering 2.2 million, Iran (1.9 million) and Germany (almost 1 million). The largest number of refugees, as of 2000, were from Palestine and Afghanistan. The internally displaced populations were largest in Sudan, Angola, Colombia, and Congo. The Indochinese war resulted in 700,000 refugees from Vietnam, Cambodia and Laos (Mollica, 1994). Civil wars in Nicaragua, El Salvador and Guatemala displaced 2 million people (Farias, 1994). Two million were also displaced from the former Yugoslavia (Leopold & Harrel-Bond, 1994).

Studies of Holocaust survivors of the Second World War found that massive psychological trauma could cause disturbing psychiatric symptoms, sometimes referred to as the 'concentration camp syndrome' (Kinzie & Goetz, 1996). It was not until the publication of the *DSM-III*

(American Psychiatric Association [APA], 1980) that the criteria for posttraumatic stress disorder (PTSD) were formulated and studies of PSTD in traumatized refugees began to be published. To my knowledge, the first study of PTSD in a refugee population was our work with Cambodian refugees (Kinzie, Fredrickson, Ben, Fleck, & Karls, 1984). Since that time multiple studies with different refugee groups have documented high rates of depression and PTSD among Cambodians (Carlson & Rosser-Hogan, 1991; Cheung, 1994; Kroll et al., 1989), Vietnamese and Mien (Kinzie et al., 1990), Chilean and Salvadorian refugees (Thompson & McGorry, 1995) and Ethiopian Jews immigrating to Israel (Arieli & Aycheh, 1992). A community sample of adolescent Cambodians found that half met criteria for PTSD and depressive disorder (Kinzie, Sack, Angell, Mason, & Ben, 1986). Over time, PTSD tended to persist and remain episodic, while depression tended to diminish (Kinzie, Sack, Angell, Clarke, & Ben, 1989; Sack et al., 1993).

The civil wars in Central America, especially El Salvador and Guatemala, have produced many thousands of refugees in the United States. Most Salvadorians attending a Community Mental Health Center had PTSD and 19% had depression (Molesky, 1986). The Central American refugee women caretakers and their children who witnessed much violence had increase rates of health problems. Many mothers were unaware of their children's psychological distress (Locke, Southwick, McCloskey, & Fernandez-Esquer, 1996). In a thorough premigration study of Somali refugees in the United Kingdom, anxiety and depression were more common with exposure to each premigration stress, such as shortage of food, loss in a war situation, being close to death and suffering serious injuries (Bhui et al., 2003). The use of the stimulant drug Qat also contributed to psychiatric symptoms. A study in Montréal among Latin American and African refugees found that separation from family as well as trauma had a significant impact on emotional distress (Rousseau, Mekki-Berrada, & Moreau, 2001). Among political detainees in Vietnam who experienced torture, there was a dose-related effect, supporting previous evidence that torture is a major risk factor for PTSD and depression (Mollica et al., 1998). Torture also was found to be a risk factor for PTSD after controlling for overall level of trauma exposure among Tamil refugees in Australia (Silove, Steel, McGorry, Miles, & Drobny, 2002).

Long-term Effects on Refugees

Studies are beginning to determine the long-term psychiatric effects of trauma, loss and migration on refugees. Among the Cambodian adolescents previously reported, the prevalence rate of PTSD fell from 52 to 32% at 6 years (Sack et al., 1993). There was change both ways in

diagnosis, with some individuals becoming ill, while for others the improvement was not constant. In a 3-year follow-up study of Bosnian refugees still in a camp in Croatia, 45% of those with PTSD or depression or both continued to have the diagnosis and 16% asymptomatic individuals developed one or more diagnoses (Mollica et al., 2001). Forty-six who met disability criteria remained disabled due to their psychiatric disorder. In a population-based study of Vietnamese refugees in Australia who had been in the country for over 11 years, about 8% had a mental disorder and trauma exposure increased the risk of mental disorder to 12% (Steel, Silove, Phan, & Bauman, 2002).

In a group of 23 severely traumatized and impaired Cambodian refugees treated for over 10 years, 13 were doing well on symptoms and disability ratings but 10 remained moderately to severely symptomatic (Boehnlein et al., 2004). A recent study of a community sample of massively traumatized Cambodian refugees, two decades after resettlement in the United States found that 62% still had PTSD and 51% had major depression (Marshall, Schell, Elliott, Berthold, & Chun, 2005). This is a much higher rate than that found among Cambodians living in Cambodia, where the prevalence of PTSD was 33% and mood disorders was 13% in a recent study (de Jong, Komproe, & Van Ommeren, 2003). This suggests that migration itself adds to the prevalence of these disorders.

Effects on Refugee PTSD After Terrorism

In a study of 45 Asian and Middle Eastern immigrants who were followed up after the Oklahoma City bombing, prior trauma exposure was predictive of current PTSD (Trautman et al., 2002). symptoms. The graphic TV images of the 9/11 World Trade Center tower attack provided much anxiety and confusion among patients at the Intercultural Psychiatric Program in Oregon. In a clinical study of Vietnamese, Cambodian, Mien, Bosnian and Somali refugees, the strongest reaction of fear and increase in nightmares and depression came from the Bosnian and Somalis (Kinzie, Boehnlein, Riley, & Sparr, 2002), perhaps because they were refugees from the most recent war and trauma. Also, as Muslims, they felt more vulnerable personally. The results of terrorism and the resulting Patriot Act increased security clearance requirements for refugees, resulting in a dramatic decline in refugee admissions to the United States. In the year 2000, there was a 70,000 quota for refugee admissions, but only 23,000 were actually admitted. These changes mean long separation for families and new fears for those who have already come to the United States.

Implications

There are huge numbers of refugees and internally displaced people in the world.

A high percentage, perhaps a majority, have suffered forced migration, starvation, near-death experiences, direct torture, disease, injury, and having close friends or family killed or lost in a war zone.

A high percentage of these (up to 60%) have PTSD and depression among both community and clinical populations. This tends to diminish over time, with depression declining more than PTSD. However, some people will remain chronically impaired despite intensive treatment. The level of trauma symptoms resulting from separation from family, and previous education and work experience will affect outcomes in refugees. Refugees remain very vulnerable to future stress, especially where violence is concerned as shown by the exacerbation of symptoms that followed the Oklahoma City bombing and the 9/11 TV broadcast.

Asylum Seekers

In the past, most refugees who arrived in North America, Europe or Australia were screened prior to arrival. Increasingly, a large number of refugees arrive without authorizations and then seeking asylum. In 37 countries reported on by UNHCR there were 587,400 applications for asylum in 2002. The top asylum-seeking countries in the world were the United Kingdom, the US, Germany, France, Austria and Canada. Per population, Austria, Norway and Sweden were the highest receiving countries. The primary countries of origin were Iraq (51,000), Afghanistan, Federal Republic of Yugoslavia, Turkey and China. In the United States, the largest asylum-seeking groups came from China, Mexico, Colombia and Haiti. In the decisions made in the year 2002, 34% of applicants in the United States received refugee status, compared to 58% in Canada and 14% in Australia.

The data are confusing because of clear differences in asylum seekers between those who have been traumatized and would be endangered if they returned to their own country and those who come for economic reasons claiming asylum status, often via expensive smuggling routes. However, for those from war-torn areas, the flight of an asylum seeker is difficult, as Derek Silove in Australia has shown. In addition to the marked experiences of trauma, they have an ongoing fear of being repatriated, have barriers to work and social service, are separated from families, and face the uncertain process of refugee claims (Sinnerbrink, Silove, Field, Steel, & Manicavasagar, 1997). In the United States, asylum seekers are not eligible for services or a work permit until it is judged that they could

receive a hearing, a process that can take many months. A group of Tamil asylum seekers in Australia did not differ from refugees in premigration trauma or symptoms but had higher postmigration stress related to insecurity about their residency status (Silove et al., 1997); 20% of the variance in trauma symptoms could be attributed to premigration exposure and 14% to postemigration status (Steel, Silove, Bird, McGorry, & Mohan, 1999).

Concerns about uncontrolled migration have resulted in more restrictive measures for those seeking asylum, including the use of detention centers and a narrower definition of 'refugee' (Silove, Steel, & Watters, 2000). There are also allegations of untreated medical and psychiatric illness, suicidal behavior, hunger strikes and violence among the asylum seekers. There is a need to inform government officials of the severe effects these harsh measures have on asylum seekers.

Implications

The task of sorting out 'real' asylum seekers from economic migrants is difficult, and is made even more difficult by human trafficking. Among 'real' refugees seeking asylum, the evidence suggests that their traumas are severe, and that their stress levels remain high due to uncertain services, residency status and possibility of deportation, and long legal proceedings. Repressive government measures have increased desperation and symptomatic behavior among refugees.

The U.S. government's response to 9/11 has greatly decreased the number of refugees admitted into the country. This may also occur in other countries as a result of the fear of terrorist attacks. The government has put increased pressure on Muslims in the United States, angering many in the community, without any noticeable increase in security.

Clinical Implications

Social psychiatric research has greatly expanded our knowledge of the mental health of immigrants and refugees. Unfortunately, there has not been a comparable development of psychiatric services. Many studies have documented low rates of utilization of mental health services by immigrants and refugees. Recently these have included Indochinese (Lam & Kavanagh, 1996), Russian refugees (Chow, Jaffee, & Choi, 1999), Mexicans (Peifer, Hu, & Vega, 2000), and undocumented Chinese and Asian immigrants (Law, Hutton, & Chan, 2003) and Asian Americans (Lin & Cheung, 1999). The general approach has been to suggest outreach programs and culturally sensitive services (Silove et al., 1997). This is at a time when cultural assessment has been emphasized as a training

requirement from psychiatrists (Group for the Advancement of Psychiatry, 2002). On the other hand, current state budgets in the United States have increasingly limited mental health services and many have limited psychiatrist time. The result has been even fewer basic services, let alone culturally sensitive ones. Clearly, it is easier to identify what needs to be done then it is to do it.

The Intercultural Psychiatric Program in Portland, Oregon has endeavoured to provide culturally sensitive services in this context. The program is unique in using psychiatrists to treat patients in a comprehensive manner with trained counsellors for each cultural group who serve as interpreters, case managers and counsellors. The services offered include socialization groups, rehabilitation services, legal support for asylum seekers, ready access to medical evaluation and above all, a consistent doctor–counsellor team for each patient. The program currently provides services to 1100 patients from 17 language groups, with the recent addition of services for children and families. Besides being a service system, it has been a pragmatic laboratory for studying actual clinical needs and developing acceptable clinical services.

Future Research Directions

The past three decades have seen real advances in cross-cultural research, both in methodological approaches and substantive findings. Studes have yielded intriguing information about migration and schizophrenia. Several key questions remain – first, why does only schizophrenia and not anxiety and depression seem to be increased in some immigrant groups? This is especially surprising since many of the factors involved in the risk for schizophrenia – poverty, unemployment, low education and racism – would seem likely to promote depression and anxiety symptoms rather than psychotic symptoms. Even more significant is the problem of understanding why more immigrant people do not have symptoms. What factors contribute to resilience?

In the case of traumatized refugees, it is becoming clear that a large percentage will have PTSD and depression. Again, the question remains, why don't all those exposed to trauma experience these negative effects? What factors contribute to illness and what factors provide protection? Studies with asylum seekers clearly demonstrate that postmigration factors contribute to symptoms. Increasingly, the larger political context is affecting immigrants, refugees and asylum seekers. The governmental response to terrorism has aggravated symptoms, anxiety, and realistic fears among immigrants, refugees and asylum seekers (see Kinzie, 2005). The degree of distress however needs to be documented by empirical research.

Questions about migration and mental illness have probably been framed too broadly. We need to look at intervening variables such as language skills, education, poverty, misdiagnosis, and especially the effects of racism. A good example of looking at multiple variables was the study by Patino et al. (2005) who found that family dysfunction and migration greatly increased the risk of psychosis among children. Some of our current work among traumatized refugee children has found that exposure to war did indeed affect many children but the impact of war trauma on parents and the physical and sexual abuse of children were more severe problems and were often overlooked in taking the child's trauma history (Kinzie, Cheng, Riley, & Tsai, 2006).

The most pressing issue remains why, despite the fact that the research on migration has become more sophisticated, services for immigrants and refugees continue to be so poor. It seems that it is easier to provide information than it is to help. Services for immigrants and refugees are difficult to start, require much psychiatric and cultural expertise and are expensive to maintain. Often the groups that are the most impaired have the fewest resources to pay for the services. At this point what seems to be needed most is research on how to provide practical support for psychiatric services for this vulnerable population. Model services can provide clinical knowledge and also serve as laboratories for future studies on migration and mental health.

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