Canadian Guidelines for Immigrant Health

Common mental health problems in immigrants and refugees: general approach in primary care

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Abstract

Background: Recognizing and appropriately treating mental health problems among new immigrants and refugees in primary care poses a challenge because of differences in language and culture and because of specific stressors associated with migration and resettlement. We aimed to identify risk factors and strategies in the approach to mental health assessment and to prevention and treatment of common mental health problems for immigrants in primary care.

Methods: We searched and compiled literature on prevalence and risk factors for common mental health problems related to migration, the effect of cultural influences on health and illness, and clinical strategies to improve mental health care for immigrants and refugees. Publications were selected on the basis of relevance, use of recent data and quality in consultation with experts in immigrant and refugee mental health.

Results: The migration trajectory can be divided into three components: premigration, migration and postmigration resettlement. Each phase is associated with specific risks and exposures. The prevalence of specific types of mental health problems is influenced by the nature of the migration experience, in terms of adversity experienced before, during and after resettlement. Specific challenges in migrant mental health include communication difficulties because of language and cultural differences; the effect of cultural shaping of symptoms and illness behaviour on diagnosis, coping and treatment; differences in family structure and process affecting adaptation, acculturation and intergenerational conflict; and aspects of acceptance by the receiving society that affect employment, social status and integration. These issues can be addressed through specific inquiry, the use of trained interpreters and culture brokers, meetings with families, and consultation with community organizations.

Interpretation: Systematic inquiry into patients' migration trajectory and subsequent follow-up on culturally appropriate indicators of social, vocational and family functioning over time will allow clinicians to recognize problems in adaptation and undertake mental health promotion, disease prevention or treatment interventions in a timely way.

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Key points

- Among immigrants, the prevalence of common mental health problems is initially lower than in the general population, but over time, it increases to become similar to that in the general population.
- Refugees who have had severe exposure to violence often have higher rates of trauma-related disorders, including post-traumatic stress disorder and chronic pain or other somatic syndromes.
- Assessment of risk for mental health problems includes consideration of premigration exposures, stresses and uncertainty during migration, and postmigration resettlement experiences that influence adaptation and health outcomes.
- Clinical assessment and treatment effectiveness can be improved with the use of trained interpreters and culture brokers when linguistic and cultural differences impede communication and mutual understanding.

Changing patterns of migration to Canada pose new challenges to the delivery of mental health services in primary care. For the first 100 years of Canada's existence, most immigrants came from Europe; since the 1960s, there has been a marked shift, with greater immigration from Asia, Africa, and Central and South America.[1] The mix differs across the provinces, although nearly all immigrants settle in Canada's largest cities.[2] The task of preventing, recognizing and appropriately treating common mental health problems in primary care is complicated for immi-

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grants and refugees because of differences in language, culture, patterns of seeking help and ways of coping.[3–6]

In consultation with experts in immigrant and refugee mental health, we reviewed the literature to determine associated risks and clinical considerations for primary care practitioners in the approach to common mental health problems among new immigrant or refugee patients.[7–10] In this paper, we review the effect of migration on mental health, use of health care and barriers to care. We outline basic clinical strategies for primary mental health care of migrants including the use of interpreters, family interaction and assessment, and working with community resources.

Methods

We designed a search strategy in consultation with a librarian scientist to identify systematic reviews and guidelines that address clinical considerations for assessment, treatment and prevention of common mental disorders among immigrants and refugees in primary care. The search covered MEDLINE, HealthStar (Ovid), EMBASE, PsycINFO, CINAHL and the Cochrane Database of Systematic Reviews from January 1998 to December 2009. This search was supplemented by articles identified through evidence reviews conducted for other topics in the guidelines of the Canadian Collaboration for Immigrant and Refugee Health (CCIRH) (e.g., depression, post-traumatic stress disorder, intimate partner violence and child maltreatment). Articles were selected on the basis of relevance to key questions, recent publication and quality of evidence. Details of the search and selection strategy can be found on the CCIRH website (www.ccirh.uottawa.ca). We provide a descriptive synthesis and discussion of the results.

Results

The search identified 840 articles addressing detection, prevention and management of common mental health problems among immigrants and refugees in primary care. There were no published guidelines. After assessment for relevance and quality, we retained 113 articles, including 10 systematic reviews and 5 meta-analyses (Figure 1).

How does migration affect mental health?

Rates of mental disorders vary in different migrant groups, but these differences do not simply reflect the rates in the countries of origin.[11] Instead, prevalence of specific types of problems and rates of health care use in particular groups can be linked to migration trajectories in terms of adversity experienced before, during and after resettlement and to policies and practices that determine who gains admittance to Canada.[12] Table 1 lists some of the migration-related factors that influence mental health and that can be explored in a clinical assessment.[12–23] The effect of these factors varies greatly with their severity and with their specific meaning for patients, their families and their communities, as well as for the wider society. Postmigration factors that moderate the effects of premigration stress and that ensure employment and economic stability are especially important in ensuring good health outcomes.[22,23]

In general, population studies find that the health of immigrants tends to be better than that of the general population in both the sending and receiving countries.[24,25] Immigrants to Canada often show slightly lower rates of mental disorders than the general population.[26,27] The 2000–2001 Canadian Community Health Survey found that newly arrived immigrants (length of residence less than one to four years) had the lowest rates of depression (odds ratio [OR] 0.33, 95% confidence interval [CI] 0.26–0.41) and alcohol dependence (OR 0.05, 95% CI 0.02–0.12) compared with the Canadian-born population.[28] Rates in immigrants varied by region of origin, with the highest rates found among immigrants from Europe and the lowest among those from Africa and Asia.

The "healthy immigrant effect" reflects the fact that immigrants must pass through a variety of filters to achieve immigrant status. However, the health of immigrants tends to worsen over time to match that of the general population.[29,30] For example, a recent analysis of data from the United States found that rates of depression and other disorders were lower for new immigrants (OR 0.7, 95% CI 0.5–0.9) but rose over

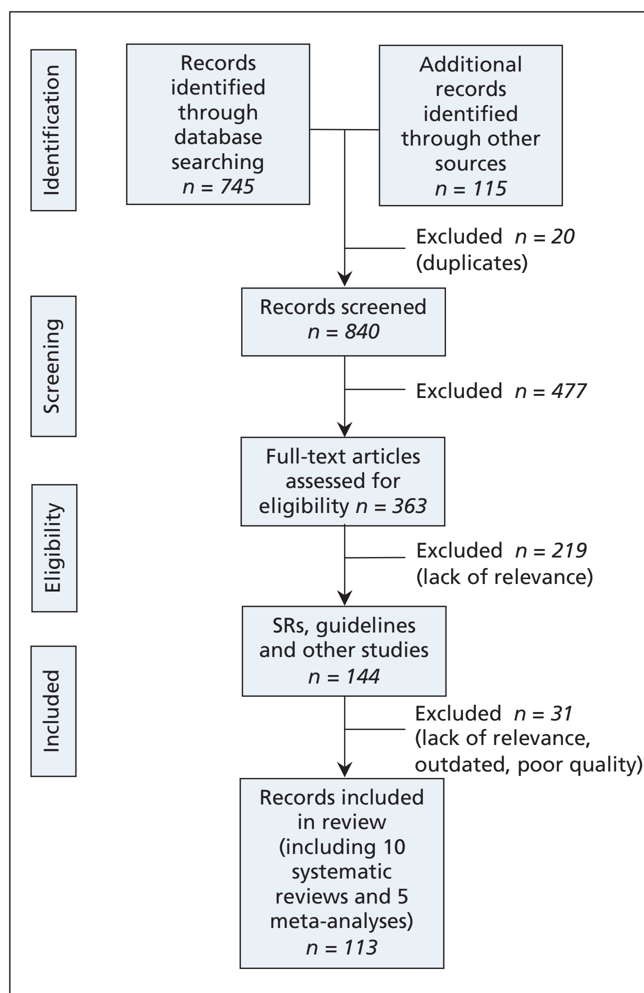

Figure 1: Search and selection flow sheet. Note: SR = systematic review.

time to local levels. Rates were similar to those in the general population for immigrants who arrived before age 12 and for the children of immigrants.[31] In contrast, systematic reviews and meta-analyses confirm that refugees are at substantially higher risk than the general population for a variety of specific psychiatric disorders — related to their exposure to war, violence, torture, forced migration and exile and to the uncertainty of their status in the countries where they seek asylum — with up to 10 times the rate of post-traumatic stress disorder as well as elevated rates of depression, chronic pain and other somatic complaints.[22,32–35] Exposure to torture is the strongest predictor of symptoms of post-traumatic stress disorder among refugees.[35]

Strong evidence shows that some groups of migrants have an elevated incidence of psychotic disorders after migration.[36–39] A recent meta-analysis found a mean weighted relative risk of schizophrenia among first-generation migrants of 2.7 (95% CI 2.3–3.2); even higher rates were found in the second generation.[40] Factors related to increased risk included coming from a developing country and an area where most of the population is black, suggesting that racism and discrimination have a role in elevated incidence. A similar effect of migration has not been found for mood disorders in the United Kingdom,[41] but there is evidence for an increase in the prevalence of common mental disorders among men (but not women) from the Caribbean after migrating to the US.[42] These issues have not been studied in Canada, although exposure to racism and discrimination has been shown to have negative effects on the mental health of immigrants and refugees.[43–45]

Migration involves three major sets of transitions: changes in personal ties and the reconstruction of social networks, the move from one socio-economic system to another, and the shift from one cultural system to another.[46,47] The migration trajectory can be divided into three components: premigration, migration and postmigration resettlement. Each phase is associated with specific risks and exposures. The premigration period often involves disruptions to usual social roles and networks. During migration, immigrants can experience prolonged uncertainty about their citizenship status as well as situations that expose them to violence.[19] Those seeking asylum in particular sometimes spend extended periods in refugee camps with poor resources and endemic violence. In some countries, asylum seekers are kept in detention centres with harsh conditions, which lead to a sense of powerlessness.[48] This sense can provoke or aggravate depression and other mental health problems.[18,49,50]

Once future status is decided, resettlement usually brings hope and optimism, which can have an initially positive effect on well-being. Disillusionment, demoralization and depression can occur early as a result of migration-associated losses, or later, when initial hopes and expectations are not realized and when immigrants and their families face enduring obstacles to advancement in their new home because of structural barriers and inequalities aggravated by exclusionary policies, racism and discrimination.[45,51,52] For example, some immigrants

Table 1: Factors related to migration that affect mental health[12–23]

Premigration	Migration	Postmigration
Adult		
Economic, educational and occupational status in country of origin	Trajectory (route, duration)	Uncertainty about immigration or refugee status
Disruption of social support, roles and network	Exposure to harsh living conditions (e.g., refugee camps)	Unemployment or underemployment
Trauma (type, severity, perceived level of threat, number of episodes)	Exposure to violence	Loss of social status
Political involvement (commitment to a cause)	Disruption of family and community networks	Loss of family and community social supports
	Uncertainty about outcome of migration	Concern about family members left behind and possibility for reunification
		Difficulties in language learning, acculturation and adaptation (e.g., change in sex roles)
Child		
Age and developmental stage at migration	Separation from caregiver	Stresses related to family's adaptation
Disruption of education	Exposure to violence	Difficulties with education in new language
Separation from extended family and peer networks	Exposure to harsh living conditions (e.g., refugee camps)	Acculturation (e.g., ethnic and religious identity; sex role conflicts; intergenerational conflict within family)
	Poor nutrition	Discrimination and social exclusion (at school or with peers)
	Uncertainty about future	

encounter difficulties in having their credentials recognized, which compromises their ability to find work commensurate with their education level.[33] Events that evoke elements of past trauma and loss can contribute to the re-emergence of anxiety, depression or post-traumatic stress disorder.[53] An extensive body of qualitative research of good quality and surveys with clinical and community samples suggests that the main domains of resettlement stress include social and economic strain, social alienation, discrimination and status loss, and exposure to violence.[17,18,54–56] Culture change itself poses distinct challenges for individual identity and family life.[47] Risk factors for mental health problems can differ for men and women; for example, language proficiency often has a greater influence on men's employment and subsequent mental health.[57]

In general, immigrants and refugees are less likely than their Canadian-born counterparts to seek out or be referred to mental health services, even when they experience comparable levels of distress.[58–63] This can reflect both structural and cultural barriers, including the lack of mobility or ability to take time away from work, lack of linguistically accessible services, a desire to deal with problems on one's own, the concern that problems will not be understood by practitioners because of cultural or linguistic differences, and fear of stigmatization.[64–68] In many developing countries, mental health services are associated only with custodial or hospital treatment of the most severely ill and psychotic patients. Partly as a consequence, and also because of specific cultural explanations of illness, mental disorders are highly stigmatized in most countries, and patients are extremely reluctant to attribute symptoms to a mental disorder. The stigma of a psychiatric diagnosis affects not only patients but also their siblings and other family members.

Adolescents and children

Research on the mental health of adolescents who are immigrants or refugees shows wide variation in rates across studies.[15,69] Although some studies from treatment facilities and small community samples find that migrant youth are at higher risk for psychopathologic disorders, including post-traumatic stress disorder, depression, conduct disorder (juvenile delinquency) and problems resulting from substance abuse, results from a few large-scale community surveys show that the rate of psychiatric disorder among immigrant youth is not higher than that of native-born children.[25,70] In fact, many immigrant youth do exceptionally well upon arrival and some surpass their native-born peers in aspiration and academic achievement.[71] Other studies reveal that many children coping with a history of exposure to war and political violence manage to have relatively good mental health.[72–74]

Studies in many countries including Canada find high levels of distress and depression among young refugees.[15,32,75–77] During the premigration period, most refugee children and their families face social upheaval and disruptions to their social and educational development. During migration, many youth are separated from their parents and no longer have the emotional, physical and financial support of their relatives. Unaccompanied minors and children with unstable living situations are at particularly high risk for mental health problems.[78–81] In the postmigration phase, youth often face acculturative stress and family poverty.[82] Even after being reunited with their families, children and adolescents must learn a new language, renegotiate their cultural identity, and deal with social isolation, racism, prejudice and discrimination.[83] As youth acculturate, many come into conflict with parents and relatives who hold ideals and values different from those being adopted by their children. Postmigration factors, including the quality of reception and support in the country of asylum, are important predictors of long-term outcome.[33,84,85]

Women

The many roles and responsibilities of immigrant women in the home and the workplace can impede their access to mental health services.[86] Immigrant women are at two to three times the risk of their Canadian-born counterparts for postpartum depression.[87–89] Women generally do not proactively seek help for postpartum depression.[90] Barriers to seeking help that could be more common or have a greater effect among migrant women include a lack of knowledge about postpartum depression and treatment options, reluctance to disclose emotional problems outside the family, unwillingness to undertake medical treatment for what is perceived as a psychosocial problem, concern that maternal mental illness will burden or stigmatize the family, feelings of shame at being labelled mentally ill, and fear of losing one's children to authorities.[90–92]

Refugee women seen in specialized clinics have high rates of exposure to violence and post-traumatic stress disorder that often have not been addressed clinically.[93] Experts emphasize, however, that exploring the history or sequelae of rape or other forms of sexual violence requires great clinical sensitivity and should always be guided by patients' needs and comfort levels.[53,94]

Seniors

Seniors make up a smaller proportion of the refugee and immigrant population in the initial migration, sometimes arriving later to join the family. Risk factors for psychological distress among newly arrived older immigrants include female sex, less education, unemployment, poor self-rated health, chronic diseases (heart disease, diabetes, asthma), widowhood or divorce, and lack of social support or living alone.[95–97] When seniors join an already settled family, issues can include slower rates of learning the language and acculturation; separation from extended family, peers and familiar surroundings; decreased social support and isolation because extended family and community networks are lost; increased dependency on others because of language and mobility difficulties; fewer opportunities for meaningful work and productivity; and loss of status as a respected elder in the new cultural context.[98,99]

Clinical considerations

Which clinical strategies are effective?

In general, the same methods that are effective in diagnosing and treating common mental health problems in primary care

for the general population can be extended to migrants from diverse backgrounds. However, experts in migrant mental health agree that, for maximum effectiveness, attention must be given to various contextual and practical issues that influence illness behaviour, patient–physician communication and intercultural understanding.[100] Specific challenges in migrant mental health include communication, cultural shaping of symptoms and illness behaviour, the effect of family structure and process on acculturation and intergenerational conflict, and the receiving society's facilitation of or impedance of adaptation and social integration.[25] There is limited but consistent evidence from qualitative studies and clinical experience in intercultural primary care that these challenges can be addressed through specific enquiry into social and cultural context, the use of interpreters and culture brokers, meetings with families and consultation with community organizations.[101–104]

How does culture affect health and illness?

Because migration often brings people together from very different cultural backgrounds, it is important to give explicit attention to cultural dimensions of the illness experience.[105] Place of origin can affect exposure to endemic diseases, childhood immunization and health care experiences. Culture can profoundly influence every aspect of illness and adaptation, including interpretations of and reactions to symptoms; explanations of illness; patterns of coping, of seeking help and response; adherence to treatment; styles of emotional expression and communication; and relationships between patients, their families and health care providers.[106] The outline for cultural formulation in the *Diagnostic and statistical manual of mental disorders*, fourth edition, provides a basic set of considerations that can be incorporated into assessment of patients to explore clinically relevant aspects of their identity, illness explanations, psychosocial environment and expectations for patient–physician relationships.[107–110]

Most patients in primary care with mental health problems present with physical complaints, which can lead to underrecognition and treatment of common mental disorders.[111] Patients with depression or anxiety sometimes focus on physical symptoms or use culture-specific bodily idioms to express distress.[111,112] Medically unexplained symptoms, particularly pain, fatigue, and gastrointestinal and genitourinary symptoms, are common in the community and in primary care.[113] When interviewed outside medical settings, more patients report psychosocial stressors, which they sometimes are reluctant to reveal to physicians because they think such stressors are inappropriate topics for medical attention or they believe that their situation will not be understood.[64,114] There is limited but emerging evidence that information about associated psychological distress and social predicaments can be elicited by enquiring about the effect of the physical symptoms or other presenting concerns on activities of daily living, stressors, social supports, functioning in work and family, or community contexts.[113,115–118]

Use of multiple sources of help is common among migrants, who may consult traditional forms of healing as well as biomedical practitioners.[119] In urban settings, patients make use of treatments from many traditions in addition to those related to their own cultural background or geographic region of origin.[120] If medications are being considered or prescribed, it is important to enquire about whether the patient is using any home remedy or complementary medicine that might interact with the metabolism and effectiveness of a prescribed drug.[121] Broad questions about use of any medication, food or substance taken for health or medicinal purposes can be followed by specific questions about the use of commonly available substances, such as St. John's wort (*Hypericum perforatum*) or *Ginkgo biloba*, and about whether patients receive medicines from family, friends or country of origin. Finally, questions about previous or ongoing consultations with a physician, healer or helper from their own or other communities can uncover medication use or other health concerns that can affect adherence, treatment response and coping.[6,122]

Working with interpreters and culture brokers

Although most immigrants to Canada have some knowledge of English or French, they might be limited in their ability to express their concerns, describe symptoms and social predicaments, and negotiate treatment. Any patient who has limited proficiency in the languages known by the clinician should be encouraged to use a medical interpreter. Failure to use interpreters has been identified as one of the most important barriers to accessing services for newcomers.[123] Professional interpreters should be used to facilitate communication; telephone interpreting services can be used when no local interpreter can be found.[124] Recent systematic reviews find that the use of professional interpreters, rather than ad hoc translators (e.g., family friends, children, staff), improves communication substantially and helps reduce disparities in use of a range of medical services.[101,103] Professional interpreters can improve communication and increase disclosure of psychological symptoms among asylum seekers,[14,125–127] and can be used to deliver psychosocial interventions.[128] Working effectively with interpreters involves a collaborative process and specific skills (Box 1).[6]

Except in urgent situations where there is no alternative, family members or untrained lay people should not be used as interpreters.[129] Several studies have documented the limits of nurses acting as interpreters. Because they are closer to the physician's position, nurses or other health professionals might not convey some of the doubts and concerns or requests made by the patient.[130]

Interpreters or other mediators can also take the role of culture broker and advocate, translating not language but cultural concepts or frameworks.[131] However, if patients have concerns about confidentiality vis-à-vis other members of their linguistic community, they could perceive the presence of an interpreter or culture broker as threatening. Each situation requires a specific assessment of the patient's needs and requirements for communication in the language in which he or she is most fluent and comfortable.

Working with families

Many newcomers to Canada come from cultural backgrounds where family members are usually consulted about

Box 1: Clinical approach to working with interpreters and culture brokers

Before the interview

- Meet with the interpreter to explain the goals of the interview.
- Discuss whether the interpreter's social position in country of origin and local community could influence the relationship with the patient.
- Explain the need for especially close translation in the mental status examination (e.g., to ascertain thought disorder, emotional range and appropriateness, suicide risk).
- Ask the interpreter to indicate when a question or response is difficult to translate.
- Discuss any relevant etiquette and cultural expectations.
- Arrange seating in a triangle so that the clinician is facing the patient and the interpreter is to one side.

During the interview

- Introduce yourself and the interpreter and explain your roles.
- Discuss confidentiality and ask for the patient's consent to have the interpreter present.
- Look at and speak directly to the patient; use direct speech (e.g., "you" instead of "she" or "he").
- Avoid jargon or complex sentence constructions; use clear statements in everyday language.
- Slow down your pace; speak in short units to allow the interpreter time to translate.
- Do not interrupt the interpreter; keep looking at the patient while the interpreter is speaking.
- Clarify ambiguous responses (verbal or nonverbal) and ask the patient for feedback to make certain that crucial information has been communicated clearly.
- Give the patient a chance to ask questions or express concerns that have not been addressed.

After the interview

- Discuss the interview and ask the interpreter to assess the patient's degree of openness or disclosure.
- Consider translation difficulties and misunderstandings and clarify any important communication that was not translated or was unclear, including nonverbal communication.
- Ask the interpreter if he or she had any emotional reactions or concerns of his or her own during the interview.
- Plan future interviews; whenever possible, work with the same interpreter or culture broker for the same patient.

More detailed information and resources for locating interpreters and culture brokers can be found at www.mmhrc.ca.

any health problem and accompany patients to physicians' visits. Migration can stress and fragment families; close members might be left behind, sometimes in dangerous circumstances. The tendency to focus on the patient in primary care must be supplemented by close attention to the family system and social network, which can include crucial members in other countries. It is important to acknowledge and welcome family members who accompany the patient. Rather than excluding them because of privacy, meeting family members together soon before meeting alone with a patient can be an important step to building trust and a source of valuable information.

Rules of confidentiality and disclosure should be applied in a way that respects cultural context. For example, although Canadian law protects confidentiality for youth older than 14 years and recognizes adult status at age 18, the cultural legitimacy of parental authority over adolescents should be taken into account. For counselling and treating youth, interventions should be framed in ways that avoid alienating family members or aggravating intergenerational conflicts. Similarly, disclosure of diagnostic issues and family "secrets" (e.g., about traumatic events) should be approached carefully, with an understanding of what is at stake for the family. Finally, when ambivalence toward treatment or nonadherence is an issue, involvement of such mediators as a key family member or trusted family ally in discussions of the different treatment alternatives can strengthen the therapeutic alliance, empower the family and provide necessary support to the patient.[124]

Working with community organizations

Resettlement after migration is strongly affected by the policies, practices and opportunities of the resettlement society as well as existing ethnocultural community organizations and religious institutions, which support migrants in work and in legal, religious and social aspects of their adaptation.[9,23,132] The presence of welcoming links within ethnic communities or religious congregations can buffer the effects of migration losses, isolation and discrimination. Migrant youth living in communities with a high proportion of immigrants from the same background are better adjusted, partly because they have positive role models, a stronger sense of ethnic pride and social support, which can help them deal with the stressors of poverty, discrimination and racism.[71] Becoming familiar with existing community and religious organizations can help practitioners identify and mobilize psychosocial support and other resources when needed.

In urban centres with large immigrant populations, community resources can be divided into two broad categories: multiethnic organizations that offer services related to settlement and integration, and groups specific to various ethnic backgrounds that provide a sense of belonging and support for a particular ethnocultural identity. Before referring a patient, it is important to identify which community he or she feels part of and not to assume that the patient necessarily will feel comfortable with a group that shares aspects of national, religious or ethnic identity.

It is useful for practitioners to have a list of community resources for specific needs (e.g., housing, food, language courses, social support) and of the ethnocultural groups these resources represent. However, a personalized referral (e.g., giving a specific name or calling the person in front of the patient) is much more likely to result in success, particularly in the case of a depressed, anxious and traumatized patient for whom re-establishment of a social network is difficult because of fear and distrust. In smaller communities, developing networks across social sectors and ethnocultural groups as well as with colleagues in other centres can be useful.[133]

Conclusion and research needs

Migration poses specific stresses, yet most immigrants do well with the transitions of resettlement. Systematic enquiry into the migration trajectory and subsequent follow-up on culturally appropriate indicators of social, vocational and family functioning will allow clinicians to recognize problems in adaptation and undertake mental health promotion, prevention or treatment interventions in a timely fashion.

Because the evidence is limited, research is needed to develop and evaluate primary care strategies for promoting mental health and preventing mental illness that respond to the increasing diversity of immigrants and refugees in Canada.

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Clinical preventive guidelines for newly arrived immigrants and refugees to Canada

This article is part of a series of guidelines for primary care practitioners who work with immigrants and refugees. The series was developed by the Canadian Collaboration for Immigrant and Refugee Health.

Information on accessing resources to assist with intercultural mental health care can be found through the Multicultural Mental Health Resource Centre at www.mmhrc.ca