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MIGRATION AND MENTAL HEALTH

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Forskningen och det professionella fältet har i flera årtionden haft en pessimistisk syn på trauma och migration. På grund av detta har fokus legat på (1) individen skild från sin kontext och (2) en pessimistisk syn på trauma och trauma återhämtning, med utgångspunkt i den traditionella medicinska tillgången. Meningen med den här artikeln är att illuminera de konsekvenser som detta haft på mental hälsa hos migranter. För att ge en ram till denna diskussion kommer en presentation av dagens universiella situation inom migrations området och forskningen inom detta fält göras. För att sedan gå mer in på djupet med detta problem område kommer de professionellas och forskares roll inom fältet diskuteras. Avslutningsvis kommer förslag dels ges på hur vi skulle kunna utveckla en ny tillgång och dels på hur vidare forskning skulle kunna utföras.

Introduction

> …we only live day by day, just like the baby birds who are only staying in the nest opening their mouths and waiting for the mother bird to bring the worms. Because we are like those baby birds who cannot fly yet…..I used to be a real man like any other man, but not now any longer. Things I used to do, now I can't do them here…
>
> …some nights the sleep hardly comes to me at all…I myself am to dumb/ignorant; any jobs they have require a literate person to get. We have the arms and legs but we can't see what they see…..because everything is connected to numbers and letters…

The above quotations, cited by Ruben Rumbaut (1985: 470) express the emotions of a Hmong refugee in his middle fifties who at the time had been living in the US for two years. The emotions expressed, however, are characteristic of many refugees and immigrants (Suedfeld, 1997).

This article will explore the subject of trauma and migration. First by presenting the universal situation of migration, secondly by presenting the re-

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search done within this field. Thirdly discussing the role of professionals and researchers within this field of mental health. Finally, my suggestions to how we can develop a new approach and suggestions as to where further research may be conducted.

The psychological and psychiatric literature on traumatic stress is voluminous and, until relatively recently, characterised by having two focal points. (1) the focus on the individual divorced from his/her history and psychosocial context and (2) the pessimistic view of recovery of traumatic stress, where statements like »the best one can hope for is that professional intervention can minimise the damage« (Suedfeld, 1997, page, 849) are frequent.

To even talk about 'minimising the damage' with regards to mental health is a non- acceptable solution but nonetheless a consequence of a pathological and individual oriented perspective of mental health. A possible consequence may be what the quotations above express: helplessness, loss of meaning and control.

Thus, it is important to move away from (1) the view of trauma as something sick or damaged with no hope at all if not helped by a professional, and (2) the individual as detached from the context that he/she is a part of.

So, what I am saying is that by treating the migrant as a sick and/or helpless person, the professional himself is characterising the migrant in a sickness and helplessness narrative. My point is therefore that to avoid getting the migrant stuck in a negative narrative and hereby also a »self-fulfilling prophecy« that is built by a pathogenic approach, the professional needs to change perspective to a salutogenic approach that focuses on the capacities of dealing with trauma and demanding personal and psychosocial situations. I.e. we should not forget that the migrants had the strength to make it to the host country for what ever reason and many of them have lived through torture, murders, and periods of hunger and thirst. Their strengths should not be ignored in intervention procedures but rather used for their own benefit. *The professional should not make the migrants (at the extreme) into institutionalised patients without will or belief that they can do anything by themselves but rather look upon what they actually can and will do if given a chance (Wiking, 2001; Antonovsky, 1990; Ekblad 1997).*

In my perspective trauma is not a pathological reaction to traumatic experience. Instead, it is a »normal« reaction to cruel and demanding situation(s) that has both personal and social implications for the individual's life, not denying though that his/her trauma can develop into a chronic condition. But the trauma should not a priori be diagnosed as a disease or as maladaptive behaviour.

Therefore I see a necessity for social science to move beyond the traditional (pathological) perspective of psychological distress and trauma. Since in this context the word trauma itself is borrowed from medicine postulating that: stress is bad, and traumatic stress is very bad; it is mentally and physically injurious and impairs the migrants' adjustment and functioning for the rest of their life, unless professional intervention is provided. This negative view of trauma has led to pessimistic research including focusing on what ways trauma is bad, what damages trauma cause. Attention to this fact was given by Aron Antonosky (1979) when he postulated that the *»salutogenic«-health-enhancing-aspect* of trauma and stress, indeed *need as much attention and understanding as its opposite*. Stressful situations could be and often are perceived as challenges (Selye, 1978), depending on both the resources of the person and the social contextual resources present. If one uses this framework when working within the mental health, trauma and migration research, aspects of strength, ability, resilience, coping in both the individual, community, the clinical resources and societal categorisations can be included. That is to say, to see the whole individual in the light of *his/her* own present standing point in regard to different aspects of life and the interactive social context that encircles and interacts with these different aspects, in a positive and resilient promoting way.

The following section will give an outline of the global migration situation and hence give an introduction to the frame of reference in which this article is written.

The present universal situation of migration

A consequence of today's armed conflicts is that they involve more and more the suffering of the public and hereby also the forced migration within and across borders. Since the end of the Second World War, according to Castles (1997), international migration has steadily increased and is now one of the most crucial factors in global change.

The number of people forced from their homes by violence and repression stood at more than 35 million at the end of 1999, compared to fewer than 29 million uprooted people in 1990 according to the World refugee survey 2000, reported by US Committee for Refugees (USCR). Within these numbers there is a hidden decline among the refugees[1] (people who flee outside their country in search for protection) by 1 million, from 15

1 A person who is forced to leave because of political or religious persecution or well-founded fears of immediate harm form others or from circumstances beyond his or her control Marsella, A.J.; Bornemann T.; Ekblad, S.; and Orley, J. (1998)

to 14 million. The modest decline in refugee numbers, was more than outweighed by 7 million more internally displaced persons[2] (USCR, 2000).

For the people who manage to escape outside the borders of their own country, the process of escape and relocation, is often associated with degradation, poverty, violence, dehumanisation, torture or death*, forcing them to live in an prolonged state of transit.* Regardless of how and why people arrive at a host country, common problems will have to be faced by newcomers to a new land.

Evidently, the migration situation today poses a serious threat to global mental health. What has the psychological research field achieved with regards to understanding and promoting mental health?

International research on refugee and immigrant mental health[3]

This section will present the current research findings within the field of migration and mental health. The purpose is to give the reader an overview of what has been done and what is deemed important to further develop.

Five recent Australian studies, particularly focusing on asylum seekers and their state of transit, showed consistently high rates of mental distress among asylum seekers, including depression, anxiety, and posttraumatic stress disorder symptoms. It was also found that the rates of posttraumatic stress disorder were many times higher than those found in the general population. The conclusion was that a high percentage of demoralisation, stress and fear, and suffering form horrifying memories of the past were interfering with the asylum seekers' concentration causing them to be anxious and withdrawn (Silove & Steel, 1998).

In Sweden, M. Edvall-Dahlgren et al. (1989) found that refugees' self-evaluated health did not improve during the time of organised refugee reception, and they showed poorer health profiles than randomly chosen host country population samples. The suggestion given by M Edvall-Dahlgren et al. (1989) in regard to improving this, is that it is very *important to analyse asylum seekers somatic and psychiatric need of care*.

When Ekblad et al. (1996) reviewed the phenomenon of refugee trauma experience, they discovered that the phenomenon was left out completely in as many as half of the 80 reports on refugee mental health analysed.

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2 These people are unable to escape their country because they lack the means to reach safer countries, local violence limits their ability to reach the border, restrictive asylum laws block their access to asylum countries, or they choose to remain inside their homeland despite the risks (for further review; WHO homepage).

3 In this article mental health is defined broadly as an individual's optimal functioning, well-being and capacity to adapt to the sociocultural context.

even though trauma is a large contributor to mental health problems in many parts of the world. The current estimates that underline the importance of including trauma when studying refugee populations well-being are the studies showing that 4-20 percent of the total refugee population has Post traumatic Stress Disorder/Post traumatic Stress Symptoms[4], according to recent epidemiological evidence (Silove, 1999, Silove, Ekblad & Mollica, 2000). Previous studies in refugee clinic populations (Kinzie et al., 1989) and in refugee camps (Mollica, 1998) have also found a relatively high prevalence of PTSD (greater than 50 percent).

Further, Ekblad et al., (1996) found that people who have migrated[5] demonstrate poorer mental health than the domestic population of the host country. With this mental health problem comes treatment costs, reduction of quality of life for individuals and their families, lowered social functioning and for society in large, loss of production. Ekblad (1996) concluded on the basis of this that there is a need for screening tools that identifies both the people with resources and risks at an early stage.

Basuglu (2000) sees the need of focusing on designing instruments since they are almost non-existent, a statement which is supported by both Ekblad (1996) and Jablensky et al (1998). Especially developing and refining instruments of assessing psychological well-being and satisfaction among refugees and immigrants is needed and hereby provide effective and early intervention.

According to Eugene Brody (1998), we need to see the asylum seeker as a unique individual with his/her *own personal characteristics* and *past experiences*.

According to Jablensky, A.; Marsella, A.J.; Ekblad, S.; Jansson, B.; Levi, L.; Bornemann, T. (1998), Social styrelsen SoS-rapport (2000) and Antonovsky (1996) the functional meaning of refugee vulnerability and resiliency is to be considered when developing rational policies regarding intervention, role of external aid and support.

Danish research within migration and mental health

In 1999, 6,467 asylum seekers filed applications in Denmark, almost 13 percent more than the previous year. The largest groups of asylum seekers arrived from Iraq (1,803), Slovakia (967), Yugoslavia (868) and Afghanistan (534) (USCR, 2000).

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4 PTSD/PTSS model Posttraumatic Stress Disorder (PTSD) model, is a debated concept in the research field, especially its applicability to refugee populations. For further review see chapter. 12, in Friedman, M. & Jaranson, J. (1998).

5 Including immigrants, displaced people and refugees.

Research done by the Danish Red Cross (DRC)'s Asylum Department, in regard to asylum seekers' well-being during their stay at the Red Cross Asylum Centres, include two studies and one literature review.

One study was done by Ebbe Munk Andersen in 1993, using Harvard Trauma Questionnaire screening for serious psychological problems, and another study was done by Mia Stæhr in 2000 using self evaluation questionnaire as a complement to the medical screening. Both studies focused mainly on *trauma exposure and PTSD.*

The literature review was done by Aake Packness, in 1998 pin pointing (1) *the importance of asylum seekers own view of their health and coping style,* (2) the severity of the trauma exposure and (3) the length of waiting time during the asylum phase.

Further, there have been other studies done within this field in Denmark, though not too many. A few of the most recent studies will be mentioned here to give a picture of where the focus has been. First a qualitative study done by Pernille Brodtkrob and Lisebet Almstrup Olesen (1994), describing the asylum time from an »asylum-seeker's own perspective«. In this research different approaches to coping with this period were highlighted as important aspects and needs for further research (for a review Brodtkrob, P. Olesen L.A. (1994). Second, Spragge's (1993) qualitative anthropological study charted the asylum-seekers experiences during the asylum process, *including their view* of how it was to live at the Red Cross Asylum centres. She underlined the need for research based on the asylum seekers own view of the situation. Third, a qualitative study done by Dorthe Staunaes, (1998) focusing on the methodology of how to get the asylum seekers' own view. To accomplish this, she came up with the idea of using the camera with which the asylum seekers could give their own picture of the pre asylum face (for further review see Staunaes, 1998).

The role of professionals and researchers within the field of migration and mental health

This section will deal with the role of professionals and researchers within the field of migration mental health. The theoretical framework is changing hence the practical implications *must* be redefined, and the purpose of this section is thus to attempt such a redefinition from a salutogenic approach.

It puzzles me that many professionals today, out in the field in their day to day practice, working with immigrants, refugees and asylum seekers only focus on the individual divorced from his context (individual history and personality, socio-economic factors, life situation, cultural/ethnic/religious background) and on the negative aspects of trauma. Thus missing

the strengths that are part of the individual (resilience, coping strategies) and the environment i.e. the social/economic context. The result is that the following may be neglected:

- our own role, as professionals, researchers and colleagues including culturally based assumptions, way of working and perspectives of health, collaboration and intervention
- reflection on the interaction / relationship between the professional and the migrant.
- the consequences of the negative and individual focus in practice
- the effect of psycho-social intervention – major questions that seek a resolution concern the effect of psychosocial interventions for traumatised and potentially traumatised individuals.

Another aspect of the migration mental health that has been neglected is »the user perspective«, i.e. the immigrnt's view of his/her own personal and psychosocial situation and her personal narrative(s). This perspective is not only relevant for the practitioner but also for the researcher and the assessor (Wiking 2001, Sachs, 1993).

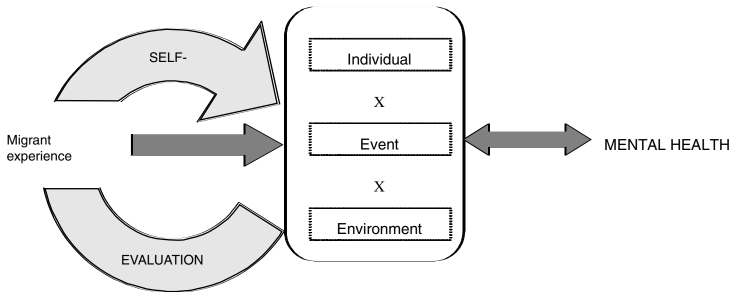
I would like to draw attention to this with help of what Lisbeth Sachs (1993) writes about the evil eye in relation to study about Turkish women's view of health. The Turkish women in the studied case are socialised within a »health culture« where »the evil eye« is perceived as the cause of an experienced illness. One sees it as if there has been made one or another »social« mistake which has attracted the »evil eye« power (a parallel can be drawn to the ancient Greek notion of committing »hybris« and then becoming subject to »nemesis«). Hereby one can not say that there is a *disagreement* about the characteristics of the symptom, but rather different opinions about the causal relationship. This disparate view of the link between cause and symptom will make prevention and intervention different. One can ask oneself if a professional would take part in helping a client to »remove« the »evil eye«, i.e. listen to his/her narrative and stand point. I do not see this as likely within the traditional approach, and therefore it makes it necessary to illuminate and develop the following:

- instruments and assessment tools that capture the migrant's own view of present, past and future in relation to psychological (resilience vs. vulnerability) and physical (bodily functions) well-being, events (including trauma experiences), symptoms and environmental factors (social, environmental) are non-existing.
- using a perspective of the migrant needs, problems and wants. I.e. seeing and listening to him/her as a whole person, with his/her views/perspectives and thoughts/feelings in the social interactive context where

this is taking place and have taken place before (including home-country, flight etc.).
- the importance of democratic participation among migrants and avoiding paternalistic and authoritarian professional relationships. (Though this presupposes that we have faith in the migrants' resilience amid great difficulties and their capacity to solve their problems given the right conditions).
- trying out alternative methods, looking beyond the traditional methods. I.e. can we meet the client/person where he/she is? (I refer here to what is said above).

Having said this, I will now turn the an alternative view of the migrant and the trauma, namely the salutogenic/holistic approach.

If we were to use a salutogenic/holistic model of trauma and trauma recovery we would take the starting point in the migrant experience on the basis of the person's own view and narrative(s). This is seen as being influenced by a combination of (1) the individual coping abilities[6] and health, (2) the aftermath of the events, and (3) the ability of the environment to help and support the migrant in the best possible way. The combination of the above is seen as influencing the person's present mental health if illuminated by this view (see figure below):



This gives the trauma and trauma recovery a much more specific and workable framework in which both the individual, the event and the environment are seen as pending factors that are needed to be taken into account when looking at prevention, screening and intervention possibilities (Harvey, 1996).

Furthermore this approach makes it impossible to pull down diagnosis

6 The resilience is in focus and seen as evident when one or more domains remain relatively unimpacted and when the trauma survivor is able to mobilise strengths in one domain to cope with vulnerabilities and secure recovery in others.

over the migrants head since he/she is in co-operation with the professional/researcher defining the problem/strengths etc. I.e. The person is seen as being within a demanding personal and psychosocial situation, but is not defined as pathological (Antonovsky, 1996).

The subject's own construction of the individual experience and strengths are in focus and the heterogensis of the individual are highlighted. I.e. the ability of the individual to use his/her own strengths or the strengths within the environmental strengths to deal with his/her weaknesses or stressor in the environment. Thus giving room to community intervention that if fitted correctly can foster resilience (Antonovsky, 1990).

Suggestions for further research:

- Trauma as a life story. How could develop a narrative research intervention method, where we take our starting point in an individual perspective and resilience and the holistic approach?
- Focus on development of early prevention and intervention methods in the migration context.
- Developing the holistic self-evaluation approach in the asylum seeker context.
- Reflect upon how we can make a better »fit« between intervention strategies and the individual – community.
- Investigate how we use our intervention resources today, and you could we use them differently?
- Look closer at the clinical and community resources and co-operation between the two, in relation to their direct influence of the migrant's psychosocial situation.
- Look closer at what the pathological framing of the migrant do to their mental health and our strategies to help them?

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