

# Migration and mental health – the perception of mental health issues and services among migrants

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## Declaration of conflicting interests

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The authors of the two relevant studies declare, that there is no conflict of interest to be reported.

The basis for this presentation are two studies which were carried out as projects of the Austrian Public Health Institute (GÖG), one of them in cooperation with an Austrian women health center, located in Vienna (FEM Süd).

The projects were financed by the Austrian Ministry of Health resp. a common fund for health projects (Gemeinsame Gesundheitsziele aus dem Rahmen-Pharmavertrag), which is based on an agreement between the Austrian Social Insurance and PHARMIG.

According to the compliance-guidelines of the Austrian Public Health Institute, all employees have to fill in a COI-formular each year.

## Qualitative study

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**Cooperation of GÖG and FEM Süd** (women health center located in Vienna, e.g. with outreach services for migrants)

**Methods:** systematic and focused literature search (PubMed und PsycINFO), semi-structured interviews and focus groups with 54 migrants and 16 experts from Vienna

**Participants from direct target group:**

- 1st generation migrants (adults),
- Turkey, Somalia, Afghanistan and arabic-speaking countries,
- socially resp. socioeconomically disadvantaged
- Approached through FEM Süd and MEN
- Interviews carried out in mother tongue and translated afterwards
- Average duration of stay in Austria from 5 / 6 years (Afghan/Somali group) to 32 years (Turkish group)

**Non-objective:** to estimate prevalence rates

## Migrants understanding of mental health

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- ❖ Mental health for most is a rather **abstract construct**, in several languages even **no equivalent term** exists
- ❖ Perceived and reported **connections between social determinants and well-being** also correspond to the model of health determinants or the bio-psycho-social model
- ❖ At the same time, the "**external**", which influences one's own fate, plays a very important role
- ❖ This "supernatural" loses its significance in the course of the **acculturation process** – if personal life situations and experiences support this
- ❖ Mental health problems are associated with **fear**:
  - » to be crazy or to become crazy
  - » to be classified as incurable
  - » to be stigmatised, discriminated against and ultimately possibly locked away

## Gender differences observed

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- ❖ Family health **traditionally a matter for women** -> more strategies for seeking help
- ❖ Women are often very worried about their functioning because they feel responsible for the family -> if they can no longer fulfil this function, they **panic**
- ❖ Men, on the other hand, often associate psychological problems with not being able to feed the family -> **tantamount to losing face**
- ❖ **Different socialisations worldwide:** Women learn to express emotions better, can talk about their feelings better. Men are often paralyzed, do nothing and just hang around, carry depression to the outside, often in combination with increased aggressiveness. Women's image of men from chosen countries of origin leads to psychological challenges
- ❖ Turkish Group: Younger women are granted less psychological problems than older women

## Where do the interviewees seek support?

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- ❖ Within the **family** (UMR: not possible)
- ❖ General with (**general**) **physicians** (UMR: rarely mentioned)
- ❖ In the case of **special professional support services** (UMR: rarely seen as option)
- ❖ On the **Internet**
- ❖ In **religion** or **rituals**
- ❖ Within the **Community** (UMR: friends or peers with same experiences → ambivalent)
- ❖ **Not at all**, they rather
  - » try to distract themselves,
  - » to solve problems themselves,
  - » to set activities that make you feel good

## Positiv experiences with psychosocial support

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- ❖ Great **relief** and **reassurance** of one's own person, also through diagnosis
- ❖ Get practical **tips**
- ❖ Changing one's own view of problems, developing more **self-confidence**
- ❖ **Medication** experienced as helpful
- ❖ Partially positive effect only experienced for a limited time (also with medication)
- ❖ Intensive examination of **underlying causes** (e.g. differences to country of origin, dealing with tradition and religion) experienced as helpful
- ❖ **Change of behaviour**: E.g. different way of dealing with one's own children
- ❖ **Change in life situation**: E.g. Women report that they were able to get divorced as a result – to get out of violent relationships.

## Barriers to the utilisation of psychosocial support

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- ❖ Lack of knowledge about services/treatment, but also about the functioning and effects of such methods
- ❖ Language/understanding problems
- ❖ Experiences of discrimination (in the health care system)
- ❖ Distrust due to past experiences
- ❖ Costs are too high
- ❖ Waiting times
- ❖ Compatibility with work/everyday life
- ❖ Difficulty in finding the right person/specialist
- ❖ Different expectations (of persons concerned and specialists)
- ❖ Precarious life situation
- ❖ Stigmatization in the own community
- ❖ Strong family ties
- ❖ Specific obstacles in the inpatient setting
- ❖ Experienced side effects of medication



## Experiences of specialists/experts

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- ❖ Strong tabooing / stigmatization -> difficult to address issue
- ❖ Insights into health systems of countries of origin are helpful
- ❖ Almost always mediators / facilitators necessary to seek/accept support after all
- ❖ Many explanations / health education needed
- ❖ Legal framework very obstructive for group of asylum seekers – in terms of daily structure, employment, education, ...
- ❖ Fast and low-threshold access needed
- ❖ Talk therapy basically suitable, but not for everyone -> sometimes more non-linguistic methods needed
- ❖ Treatment of trauma only by well-trained professionals
- ❖ Treating person: women are sometimes preferred, but not always
- ❖ Structural obstacles: Lack of psychiatrists, places for mental rehabilitation, processes to link persons in need with adequate services, ...

## Recommendations

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- ❖ Training courses to **raise awareness** for the need of culturally sensitive work among professionals
- ❖ Adaptation of psychosocial services in order to work more **culturally sensitive**
- ❖ Encourage **early recognition** of psychosocial issues among other professionals
- ❖ Identifying and changing **negative reinforcing processes**
- ❖ Extending **low-threshold services**
- ❖ Promoting **health literacy** and **destigmatisation**
- ❖ **Strengthening families / communities** as mediators
- ❖ Spreading **positive experiences** within migrant communities
- ❖ Promoting **self-help groups**
- ❖ **Improving the education** and **living conditions** of people with a migration background

# Thank you for your attention !

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