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The Psychology of Immigration, Relief or a Burden? Immigrant Need and Use of Psychiatric Care

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1. Introduction

The diversity we meet both in the group of immigrants and in the recipient countries is bewildering. In areas, both in Europe and further away from Europe or North America, the emigration rates were higher from areas where the welfare of the individual's nuclear family was the deciding economic factor[1]. Such a decision was driven by a sense of hopelessness and lack of prospect of a better future. When the family no longer could feed all the members, there was an exodus in great numbers. This inability to concert activities beyond the immediate family may aptly be called amoral familism, which for instance in remote areas of Italy was produced by three factors. They were, acting in combination to achieve such a state: a high death rate, certain land tenure conditions, and the absence of the institution of the extended family. During much of the 19th century almost a million people emigrated from Norway to the US (similar numbers also for Ireland). A Norwegian psychiatrist investigated large groups of these emigrants, and found increased incidence of severe mental illness after some years, thus indicating that the emigration process had its costs [2].

The big colonial powers of the 19th and 20th century had rules giving citizens of the colonies easier access to the mother country. Great numbers of people from Surinam in the Netherlands, Indians in Great Britain and Algerians and people from colonies in Sub Saharan countries in France are examples of a special type of immigration. Psychiatric needs of these immigrants compared to other immigrants have not been studied. Today the big colonial powers have restricted the access of citizens from the colonies.

1.1 Conflicts within emigrating countries are chaperons after immigration

Scandinavians, Germans and Japanese immigrants to the US were mainly rural whereas Irish, Chinese and Italians were urban [3]. Immigrants to Western Europe today are similarly divided, and give rise to different challenges as most are settled in urban areas. This meant and means a change also for the people already present in the host country. During the 1820th immigration of German Ashkenazi Jews to the US changed the situation for the then settled Sephardic Jews. The newly arrived Ashkenazi did not accept the Sephardic synagogues and several new synagogues had to be built. Discrimination in home countries led to emigration, but when immigrated the new group maintained a

discriminatory attitude towards others within the same faith. Coping skills including the necessity of discrimination were perpetuated in the new setting. German and Irish Catholics did not immediately commute with the American Catholic communities. Refugees from Viet Nam were divided between those who escaped because they had supported the Americans, and others because they had fought against the government in the south. Several groups of Muslims repeat the divides from their home countries by entering non-cooperating helping facilities representing their Muslim faith. Help with adaptation and your religious or ethnic compatriots may thus not be as straightforward as you would expect after exodus.

1.2 Multiculturalism as a solution?

Multiculturalism is one conceptualisation of society with many diverse ethnic groups. The recipient countries in the Western world differ greatly in this respect. Australia, Canada and the US are countries based on immigration from all over the world, to such an extent that the existing cultural rules are a mixture of all foreign influences. Canada seems to be the country where the immigration process has led to less criminality, less interracial conflicts and a great flexibility in accommodating new entrants. Countries as Finland and Norway are more homogenous societies with little influx of immigrants. They are met by publicly organized affluent facilities catering for housing, language skills and health care, but with a backdrop of xenophobia in the population. The double communication from the host country may be bewildering [4]. Present immigrants are starting to reshape the countries in a more accepting and multi-ethnic direction, although far-right ethnocentric groups exist and grow. Fear of foreigners (xenophobia) is greater in such countries and will drip down on the immigrants as part of their identity adjustment challenges. This is aptly described in immigrant novels covering the apparently contradictory impulses of class, privilege and standing [5].

2. Immigration as relief

Emigration from hardship, poverty and small prospects of change was a relief for groups leaving Europe from Ireland and Norway during the 19th century. Arriving in USA they were investigated thoroughly and only the “fit and able” were accepted. Though starting at bottom level, a majority managed to attain a level of living conditions exceeding the one they left. Emigrating persons from Turkey, South West Asia and India today may be of the same category, whereas immigrants of African or Roma decent have greater hardships after entering countries as Spain, Greece and Italy. Whether the last groups in the end feel that emigrating was a relief has not been studied yet.

2.1 Why do some refugees conquer extreme hardship with intact mental balance?

It is observed that the capacity of humans to adapt to new environments and rules is high. Sufficient clarifications of who will adapt are not given by observable characteristics of the persons as educational level, age and somatic and mental health status. The American sociologist Aaron Antonovsky developed a theory of salutogenesis after encounters with survivors of concentration camps during World War II. His point of departure was the observation that some people seemed to adapt well to life after the traumatising and death threatening experiences, often combined with loss of several members of own family. He

wanted to advance the understanding of the relations between life stressors, coping and health[6]. An emphasis on pathogenic (disease giving) factors has been and is still in use to explain lack of health and behaviours in biomedical as well as social science disease research. Antonovsky's salutogenic model looks to find signs of adaptive coping. According to the model this is the secret of movement towards the healthy end of the sick - healthy continuum. People develop resistance resources, and this is a perfect frame to understand the process of the psychology of emigration. The resources were wealth, ego strength, cultural stability and social support [7]. After immigration many people have little wealth, cultural instability and lack the former, natural social support, even if they maintain ego strength. An example is the observation that immigrant minorities in New York in the US have higher cancer rates than the majority population [8]. The authors explain this by stating: "immigrants face cancer care and research access barriers, including economic, immigration status, cultural, and linguistic barriers".

Notwithstanding, some maintain that people emigrating often constitute a resource rich and rather healthy part of the population in the country they left. The poor and feeble do not have the strength or endurance to flee or move. Those who fared well after immigration or great trauma had according to Antonovsky the ability which he called Sense of coherence. The construct encompasses more than concepts as self-efficacy, internal locus of control, problem oriented coping, or the challenge component of hardiness. The sense of coherence concept has been shown to be less bound by particular subcultures, thus useful in an immigration context [7]. When sense of coherence is low, the future risk of morbidity and mortality in drug abusers increase [9] [10]. In order to counter the effect of low sense of coherence in immigrants German researchers advocate the establishment of a complementary system of health care in order to give a sustainable medical care for small migrant groups or not optimally integrated immigrant populations [11].

3. Immigration as a burden

Forced emigration during conflicts, either internally in own country or to a neighbour country is initially a burden. Depending on experiences before an emigration, during the flight and the reception in a new country, disease may develop and the immigration may pose grave problems in accommodating to a new life.

An Australian initiative organised multidisciplinary primary healthcare for newly arrived humanitarian entrants [12]. The clinic achieved to see and investigate the refugees within a median of five days. GPs were present at the clinic, but later transfer of the patients to outside GPs in the community remained problematic.

Goth et al studied whether the engagement of GPs is sufficient. She studied immigrants' use of primary health care in the form of contact with general practitioners or emergency services in two recent papers from Norway [13, 14]. Immigrants to Norway tend to use emergency primary health care services more than the registered GP, despite the fact that every citizen by law has a designated GP. There is lack of relevant information in several languages; immigrants use key informants from their own group to partly overcome this. There is also a reluctance to accept the democratic attitude of Norwegian GPs, who involve the patients in decisions of treatment, and even a lack of confidence in the quality of the doctor if he/she consults handbooks or colleagues. Her most striking finding is, however, that the group of immigrants is very diverse both in health literacy, attitude towards peers and language skills.

3.1 The different generations of immigrants

Several generations of a family may emigrate. Either at one time point, or as a result of family reunion some time after the immigration of a part of the family. There are often strong bonds between the generations and they depend on each other. Eventually the oldest generation needs more support from their children or grandchildren. The meaning of family support among older Chinese and Korean immigrants to Canada has been studied [15]. The authors found that the immigrants above 60 years had the following perspectives on the family life:

1. They had become more peripheral family members
2. Parents were no longer authority figures in the family
3. The older generation was more independent in the sense that they had a changed economic environment, were living alone and had a social network beyond the family

This all promoted a move to biculturalism. A statement of one of the participants underscores this: "I believe we should not depend on them...I suggest we should save enough money for our future when we are young...if you had better apply for living in senior houses so that the children can drop by when they are free". Such a view is in contrast to what cultural obligations from the emigration country would prescribe. In another small study from Australia aging Chinese immigrants valued financial security and an active lifestyle as the most important aspect of getting old, whereas the Anglo-Australians regarded growing old gracefully and accepting the limitations of life as important aspects of successful aging [16].

Internet-usage of immigrants may enhance the intercultural adaptation when they accommodate to host country sites [17]. Thus it is important to guide immigrants to local sites where knowledge and understanding of the new host country may be established.

Immigrants from certain countries have a low acceptance rate for mental health problems. This is a cultural question, but also a question of possible access to mental health care. Number of psychiatrist per 100,000 inhabitants is for instance around 8 within the European Union, 35 in Norway, but only 0.3 in India. Integration of primary health care and psychiatry for immigrants may improve acceptability to receive mental health guidance and treatment, as shown by Yeung et al. in Boston [18]. They used a specially trained nurse to bridge the patients between primary care and the psychiatric services, thus increasing the number of patients turning up at the mental health clinic after referral.

One expression of felt strain in life may be suicidal ideation. This was studied in adolescents in the Netherlands [19]. Turkish adolescents had higher levels of suicidal ideation than both the majority and other minority group adolescents. Turks and Moroccans enjoyed being at home less than the Dutch. On the other hand, having a good relationship to mother and father had a protective effect against suicidal ideation. Many factors play a role here. The authors also concluded that discussing their problems at home increased suicidal ideation in Turkish adolescents, but had a protective effect in Dutch and Moroccan adolescents. Having a friend was a buffer. Different coping strategies in families may be the important factor, whether or not the family and its surroundings is of native or foreign descent.

4. Understanding illness behaviour in a new culture

Transcultural psychiatry is difficult. Understanding the verbal and social aspects of people in need of psychiatric care demands knowledge of aspects of culture, race, religion and expectations in both the caregivers and the recipients of care, as described in for instance

Fernando “Mental health, race and culture” [20]. The Western European psychiatric tradition in most countries receiving immigrants may be less understanding when exposed to spiritual healing, Chinese medicine and the use of the family group as a treatment arena.

4.1 Case

An Albanian woman from Macedonia was referred to the acute psychiatric facility with a diagnosis of psychosis. She told the doctor on duty that her aunt had put an evil spirit in her body, and she could not get rid of him. The psychiatrist in training categorized her notion of an evil spirit as a sign of a paranoid psychosis. Later it turned out that she only was in severe conflicts with her family members. Treating her with antipsychotic medication only made her very tired, her opinion of evil spirits did not subside.

Immigration is a risk factor for developing mental disorders. This risk can be viewed as a combination of a demographic divergence from the host population, increased psychosocial stress, and environmental factors as housing and cultural difficulties in giving a proper diagnosis to the patient. Torture survivors may be prone to post-traumatic stress disorder. Immigrants from Surinam and Morocco to the Netherlands were shown to have a fourfold relative risk of schizophrenia, purportedly due to the rapid change in lifestyle [21, 22]. On the other hand, immigrants seem to have a lower rate of substance abuse than the host population [23]. This was also corroborated in a cohort study from a Norwegian acute psychiatric facility [24].

4.2 Referrals of migrants to psychiatric acute resident care

Most immigrants, as most other inhabitants are not referred to acute psychiatric care. Acute onset of mental illness may illuminate special problems brought to an extreme level. Some aspects of extreme behaviour would be cultural, socioeconomic or religious in origin. By studying specifically referrals to acute care, many general aspects of differences between immigrants and native populations could be demonstrated. Two papers from Norway are described in the following in some detail.

All patients referred during a year were grouped as immigrants or native Norwegians [24]. There were more men among the immigrants (68.8% versus 43.3%), they were somewhat younger, but more referrals under compulsion (75.5% versus 51.9%) according to the Mental Health Act. Suicide attempts or suicidal ideation were equal between immigrants and native Norwegians. Multiple referrals were not different as shown in the table below.

<i>Referrals in one year</i>	Immigrants (N=80) <i>Patients (% of 80)</i>	Other referrals (N=335) <i>Patients (% of 335)</i>
2	12 (15.0%)	50 (14.9%)
3	4 (5.0%)	14 (4.2%)
4	1 (1.3%)	5 (1.5%)
5	1 (1.3%)	2 (0.6%)
6	0	4 (1.2%)
9	0	1 (0.3%)
Total	18	76

Table 1. Multiple referrals during a year of individual patients to an acute psychiatric facility in Oslo according to ethnicity

The clinicians had an impression that relatively more immigrants were referred. As shown in the table below this was not the case. The rate of referrals from the catchment area, three boroughs in the capital, was 0.0049 for immigrants and 0.0052 for native Norwegians ($X^2 = 0.1$; $p = 0.74$), i.e. the same fraction of the immigrants and the native population were acutely referred to the hospital.

Borough	3	5	6
	Number (%)	Number (%)	Number (%)
Total population	28678	26857	25682
Non-Western immigrants	1993 (6.9)*	6144 (22.9)*	8038 (31.3)*
Other immigrants	1854 (6.5)	1442 (5.4)	1196 (4.7)

*) The material for the study was from three boroughs, where borough 3 was more affluent, and thus with a lower rate of immigrants.

Table 2. Population in the catchment area for an acute psychiatric facility in Oslo and number of immigrants according to borough

4.3 What may explain these findings?

Slightly more women than men are in general referred to acute psychiatric care and to ambulatory psychiatric treatment in Western societies. How come that more men were referred to the clinic in Oslo? There are several possible explanations to this. More men than women emigrate; men or young boys are the vanguards for later family reunion. Accept or even recognition of mental disorders is less among immigrant groups. Thus men, who are frequently the breadwinner in the family, must conform to the standards of working life in the host country, whereas the women, who stay at home, only are referred to psychiatric treatment when they cannot fulfil their homely tasks. The expression of severe mental illness is non-conform to the host culture, often with gesticulating and noisy or culturally awkward behaviour. That may be the reason for the clinicians' impression of more severe illness among immigrants.

Psychometric tests at entry to an acute facility may improve diagnosis and subsequent treatment [25]. Such tests are seldom employed in Norway, and even less so among immigrant patients, probably due to language barriers and culturally biased tests.

Immigrants have different expectations of the future depending on their status when emigrating; as asylum seeker, refugees or more or less a poverty-driven exodus [26]. A significantly higher proportion of asylum seekers than refugees had nightmares, feelings of guilt and feelings of hopelessness. Similarly asylum seekers had more sleeping problems, nightmares and reduced appetite than immigrants. More asylum seekers than refugees maintained that life would be better over time. Surprisingly, more refugees than asylum seekers indicated problems judging life ten years from now.

Involuntary psychiatric admissions are widespread among patients with an immigrant background, although the exact rules by law are different from country to country [27]. In Norway some 75% of immigrants are referred under compulsion, whereas 50% of ethnic Norwegians. In a three-year follow up of referrals to two psychiatric clinics in two different cities 32% of the immigrants were involuntarily admitted. The characteristics of these admissions were: significantly higher in men than in women, 73% versus 27%. The mean

length of stay was shorter for the voluntarily admitted immigrants. Not at all surprising, immigrant patients with psychotic disorder were involuntarily admitted to a greater extent than non-psychotic patients, and even greater than in ethnic Norwegians. Many of the misunderstandings and attitudes interpreted as aggressive or violent behaviour in immigrant patients may decrease if the treatment of the patient both outside the hospital and at referrals gave him a feeling of getting through to staff with his message.

In another study the level of non-Western immigrants' use of acute psychiatric care compared with ethnic Norwegians was studied over an 8-year period [28]. One of the purposes of the study was to test the impression among clinicians in the wards that an increasing number of immigrants were referred for treatment in an acute setting. In table 3 below the total population in the catchment area is shown for each year, and also the proportion of non-Western immigrants calculated in two ways. There were relatively fewer women among the non-Western immigrants compared to the ethnic Norwegians, 6% versus 50%, respectively. The table shows that no increase in the proportion of non-Western immigrants was observed.

	2000	2001	2002	2003	2004	2005	2006	2007
A - Total population	94581	95080	96260	96716	98086	100824	103670	107848
B - Non-Western immigrants	19481	19593	19558	20048	20315	23020	21729	-
B / A %	20.6	20.6	20.3	20.7	20.7	22.8	21.0	
B / (A-B) %	25.9	30.9	25.5	26.1	26.1	29.6	26.5	

B/A shows the proportion of non-Western immigrants as a percentage of the total population
 B/A-B shows the proportion of non-Western immigrants as a percentage of the ethnic Norwegian population in the catchment area

Table 3. Total catchment area population and non-Western immigrants as a percentage of the total population and total minus non-Western immigrant population

The number of referrals changed from year to year, as can be seen in table 4 below. 19 patients were referred in year 2000, whereas 40 in 2007, but the increase in proportion was not so impressive as can be seen from the two lowest rows in the table.

	2000	2001	2002	2003	2004	2005	2006	2007
A - Ethnic Norwegian	122	89	107	148	128	193	246	184
B - Non-Western immigrants	19	17	21	25	30	34	41	40
C - Other immigrants	3	8	3	2	6	2	11	14
B / A %	15.6	19.1	19.6	17.0	23.4	17.6	16.7	21.7
B / (A+C) %	15.2	17.5	19.1	16.7	22.4	17.4	16.0	20.2

Table 4. Number of referrals to acute psychiatric care in a sector of Oslo according to status as non-Western or other immigrant

The age of the immigrants was lower in all years, table 5. This is a consequence of the observation that people who emigrate usually are young, and if older people emigrate, then they come with a larger family group.

	2000	2001	2002	2003	2004	2005	2006	2007
Ethnic Norwegian	38.1	36.7	39.4	37.0	39.1	41.1	38.6	43.4
Non-Western immigrant	35.2	32.7	35.2	35.1	30.6	35.6	34.8	36.5

Table 5. Mean age of ethnic Norwegians and non-Western immigrants among patients referred to an acute psychiatric care facility in Oslo

Mean length of stay in the acute department was lower for ethnic Norwegians, indicating that at least no discrimination of immigrants occurred. They all seemingly got a length of stay commensurate with the illness they had at referral. As the fraction of psychotic illnesses among non-Western immigrants was higher, a longer stay may very well be good treatment. If the prevalence of mental disorders is the same or higher in immigrants than in the original population, this study indicates that they are under-represented among referred patients from the catchment area population. This seems to be the case especially for women.

Immigrants may have problems accessing psychotherapeutic treatment in an outpatient setting, as a prerequisite for psychotherapy would be sufficient language skills. It would be expected that immigrants to a greater extent get pharmaco-therapeutic treatment, but this question has not been studied in Norway.

5. Who should or could adapt within a new setting

What do we know about the ability of diverse groups of immigrants to integrate and assimilate a new culture? Is multiculturalism a positive solution or a cul-de-sac?

In a large group of Puerto Rican, Cuban, Mexican and other Latino immigrants to the US a registration of psychiatric disorders during the past year was done by Alegria et al. [29]. When adjusting for age, sex, nativity and age of arrival of immigrants, there were no significant differences between the four Latino groups. On the other hand, family conflict and burden were consistently related to the risk of mood disorders.

Successful adaptation into the US society is a multidimensional process. It includes maintenance of family harmony, integration in advantageous US neighbourhoods, and positive perceptions of social standing.

5.1 Ghettoization

Letting immigrants settle in urban disadvantaged areas, as is often allowed or specifically wished by the immigrants, may contribute to slower integration. Language skills and knowledge of health care systems and rules of everyday life are not learned. You may in many such areas meet immigrants who have spent several years there without being able to communicate in the language of their new home country. Such instances of ghettoization you find with people from many countries, not at all only among disadvantaged groups. Examples are Chinatowns, Italian or Greek district, Jewish or Muslim settlements, or

Moroccan or African dominated areas. Although the integration may be slow, such areas also contribute to a more diversified culture, which is used to a great extent by the native population.

Spreading the newly arrived immigrants to more remote areas, with very few immigrants at each place is done in Norway. The effect is controversial. The small immigrant groups may or may not be readily accepted at the new dwelling, and over time there has been a movement back to urban areas. It is not settled whether the adaptation of immigrants must be any different from the adaptation of young, not well-to-do natives during the first years.

5.2 Case

A Palestinian young man seeks asylum in a European country. His background is education at college level and he was the only family member getting an education above high school. His asylum application was rejected, but he appealed. He had to live in a special camp for asylum seekers as long as the decision was pending. His frustration ended in a referral to an acute psychiatric clinic for purported psychosis and suicidal ideation. Initially his mental status was difficult to evaluate and staff had diverse hunches. After some weeks observations and psychotherapeutic evaluations, including psychometric testing, no severe mental illness or post-traumatic stress reactions could be confirmed. His frustration at the unresolved situation, and the probable expulsion was understandable. Given an asylum, he would most probably find a job and assimilate as an immigrant.

5.3 Is there a healthy migrant effect?

Stafford et al. [30] have studied a purported healthy migrant effect in Canada. Immigrants to Canada report less depression compared to the non-immigrant population. The likelihood of depression decreased with increasing percentage of immigrants in the area for visible minority persons but not for white minority persons. A corollary to this finding would be not to press immigrants to settle in remote areas of the country.

6. Unreturnable asylum seekers

The burdens described above give special problems for asylum seekers who cannot be returned. Either because there is doubts about the identity of the asylum seeker or because returning these people to countries where they could be threatened with life sentences or a death penalty, is not accepted in the country of dwelling. The mental problems they have accrued are perpetuated, as shown for instance by Mueller et.al in *European Journal of Public Health* 2010; 21: 2. Taking care of unreturnable asylum seekers is an unsolved problem in Europe. Different solutions for other groups of the "sans papier" have been tried out.

6.1 Case

A mullah from Northern Iraq fled to Norway with his family because of threats of persecution, as he had been the leader of an opposition group to the then government in Iraq. If returned to Northern Iraq, where his group had its main action area, he would certainly be detained and probably sentenced because of the violent actions of his group. Thus with the civilized rule of not returning people who would get a life or death sentence, he is staying. However, he is continuing his work of splinter group action over the Internet,

editing a site the content of which would have been illegal in Iraq. And he is also threatening politicians in his country of residence. This is an example of stalemate immigrant policy.

7. Work as a means of inclusion in the new society

Work and educational experience and level among immigrants are not always appreciated. This has been studied in a large sample (N=2685) from Canada [31]. Four years after they arrived in Canada 52% of the immigrants were judged to be overqualified for their jobs based on their educational levels, with a lesser extent being overqualified based on experience, 44%, or their expectations, 43%. When the authors included job satisfaction and perception of employment situation in their calculations, over-qualification increased mental health problems. Asian Americans report similar results for mental, but not for physical health with a negative relation between increasing employment frustration and self-rated mental health [32]. The mainstay of American immigration policy has been giving or demanding work from the new citizens. This policy has probably increased the speed of adaptation and integration, and at the same time reduced the risk of mental illness. Immigrants from some countries have differing views on what they can do, and some have problems getting their former qualifications accepted, and develop a negative or paranoid attitude to the country of residence. Some cultures do not allow women to take on work, which would be in contrast to the expectations of the host country. On the other hand, when young girls are allowed to take an education, they perform better in schools and universities than their young brothers. Mental illness has a great impact on labour supply [33]. It is an established fact that mental illness negatively influences labour market performance, especially in cases with long-term psychotic and some neurotic diseases. In the study by Ojeda et al. with recent US data, she shows that mental illness is associated with lower rates of work among US-born males but not immigrant males and females. This is contrary to the belief of health and social care workers and researchers alike. Most people with mental illness work, but symptom severity reduces labour supply among natives especially. A more solid family and social network among natives may be the reason why labour supply with mental illness is reduced. Another adaptation is indicated in the next section.

The use of precarious employment in illegal immigrants, which abounds in countries like Spain, Italy and the US, is a greater threat to the workers [34]. Even when they initially do not have mental health problems, many develop this during the time with work where they are grossly exploited. The illegal immigrants to Spain were from Romania, Morocco, Ecuador and Colombia.

7.1 Cases

After the coup against president Allende in 1973, many politically active persons had to flee. A group came to Norway via the help of the Norwegian embassy in Santiago. One year later I saw, as a then high school teacher, three Chileans washing the school windows on long ladders. They had got this job at the public job centre. One was an architect, the other two astrophysicists. More qualified jobs were not attainable at the time.

Immigrants often start their work career with precarious jobs and meagre employment conditions. In a sample of more than 2000 workers a Spanish group observed that immigrant workers in Spain were present at work also when sick, i.e. sickness presenteeism compared to Spanish born workers [35]. Among the immigrant workers men, those with a

stay < 2 years, with a university degree and salaries between 750 -1200 € per month had higher rates of sickness presenteeism. The authors conclude that immigrant workers should have the same standards of social security as Spanish born workers. This is not always easy to achieve. Polish construction workers in Norway often work as subcontractor employees with the firm based in Poland. Despite fierce protests from Norwegian trade unions, this way of giving immigrants lower pay is difficult to eradicate. The clandestine workers in Italy and Spain for instance fair even worse on the labour market.

The unemployment rate of immigrants is higher than for native born, as seen in the figure from the Economist. In Spain and Belgium the rate is much higher, whereas in the US it is fairly equal. The situation in the former East-European countries Hungary and Czech Republic is special. They have attracted few low skilled immigrants, and the small group of immigrants are specially invited high-skilled labour. The disadvantage of being immigrant is not very high, judged by the numbers in the figure, thus lending hope for many over time. From the Economist July 16th 2011, page 89



Fig. 1.

8. Adaptation to copious social welfare systems

Some countries in Northern Europe have copious social welfare systems as the result of social democratic achievements in Parliament and Unions over the last hundred years. The basis of these welfare systems has been for instance that sickness leave with up to full pay for up to a year is regarded as a right. It is cumbersome enough to be sick as you still would need your salary for your daily life. Everybody is a member of the public health care and social security system. You get what you need of treatment and contributions as a solidarity action from all. In some countries you would call this socialism. The confirmation of an existing illness is the joint responsibility of the patient and his medical doctor. The rules did not foresee that someone would present a non-existent illness to the doctor, and for the doctors some symptoms are not readily observable. Thus he has to rely on the patient telling the truth.

Some groups of immigrants accept such welfare payments without any of the urge to do your best and not exploit the system, as has been the main axis in the use of the welfare systems in host countries. Especially people coming from countries with an anomic culture, easily accept being financially supported for longer periods of time through public means. The solidarity aspect of public arrangements and entitlements may be forgotten.

8.1 Case

Somali man, age 37, arrived five years ago, married with three children. He has not learned any usable Norwegian, despite compulsory language courses over several hundred hours. Public agencies have subsequently not found any work or other activity for him giving more access to adaptation to the Norwegian society. On the contrary he is according to his family obligations doing well as long as he gets monthly transfers from the social welfare system. He and his family would get even more if he pro forma divorced his wife. Then she would get higher allowances as a single mother. Such behaviour is, however, not found in all Somali or other refugees to Norway.

8.2 Cases

The Norwegian health care system gives allowances to women giving birth every month for each child into to the teenage period. Single mothers also get an allowance for the extra costs of upbringing. There have recently been several cases among people of Roma decent and others presenting birth certificates and other documentation of non-existing children. The rules do not readily disclose this, so allowances have been paid for many years. Such cases are unwanted effects of a public social welfare system built on solidarity and truthful interaction with treatment and welfare staff. These cases amounted to fraud against public sources of more than 1 million euro.

8.3 Addendum

This chapter has not given a clear answer to the question in the title “the psychology of immigration, relief or burden?”. Depending on the group of immigrants we look at, the answer may be both yes and no to both the immigration process being a relief and a burden.

- Some leave their home country to save the life of one self and family. Getting accepted in the new country gives relief. After some years, a few return because they miss the good side of their country of birth. The mental health of this group is fairly good, despite symptoms of PTSD in some.

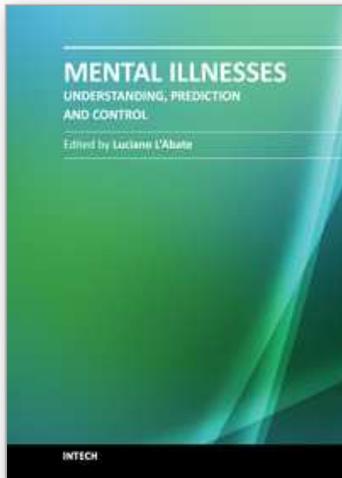
- Some leave because there is no chance of a job or a decent life in the home country. The immediate relief depends on getting a more acceptable life in the host country. Illegal immigrants (sans papier) are an example of people who have to endure further hardship. The mental health of this group is unresolved and some develop more signs of disease than before emigrating.
- Some leave to join the family or to get married (of free will or forced by family). Older immigrants miss the routines and respect of life in birth country. Forced marriage is a route to undiscovered depression and somatoform disease. The old may be, also undiscovered, depressed.

Emigration is a significant step in the life of every person. Many factors must be in place to make good living in the new country. The fact that so few emigrated persons return permanently and that it is doubtful whether emigration in its own right increases the rate of mental illness, we may conclude that emigration is an important, but positive change in life. It is a challenge for the host country to get most out of their immigrant groups. US and Canadian experiences are the good examples, as those countries are built on emigration.

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In the book "Mental Illnesses - Understanding, Prediction and Control" attention is devoted to the many background factors that are present in understanding public attitudes, immigration, stigma, and competencies surrounding mental illness. Various etiological and pathogenic factors, starting with adhesion molecules at one level and ending with abuse and maltreatment in childhood and youth at another level that are related to mental illness, include personality disorders that sit between mental health and illness. If we really understand the nature of mental illness then we should be able to not only predict but perhaps even to control it irrespective of the type of mental illness in question but also the degree of severity of the illness in order to allow us to predict their long-term outcome and begin to reduce its influence and costs to society. How can we integrate theory, research evidence, and specific ways to deal with mental illness? An attempt will be made in the last conclusive chapter of this volume.

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