

Psychosocial health among immigrants in central and southern Europe

Stefania Toselli¹, Emanuela Gualdi-Russo², Daa Marzouk³, Jan Sundquist⁴, Kristina Sundquist⁴

1 Department of Biomedical and Neuromotor Sciences, University of Bologna, Bologna, Italy

2 Department of Biomedical and Specialty Surgical Sciences, University of Ferrara, Italy

3 Department of Community, Environmental and Occupational Medicine, Ain Shams University, Cairo, Egypt

4 Department of Clinical Sciences, Center for Primary Health Care Research, Malmö, Sweden

Correspondence: Gualdi-Russo Emanuela, Department of Biomedical and Specialty Surgical Sciences, University of Ferrara, Corso Ercole I d'Este 32, 44121 Ferrara, Italy, Tel: +39 0532293793, Fax: +39 0532293793, e-mail: emanuela.gualdi@unife.it

Migration exposes people to a number of risks that threaten their health, including those related to psychosocial health. Self-perceived health is usually the main indicator used to assess psychosocial health. Electronic databases were used to examine the literature on the psychosocial health of immigrants in Europe and of North Africans living in their own countries. Immigrants of various ethnic groups show a similar risk of psychosocial disorders but generally present a higher risk than the local population. This risk is related to gender (being higher in women), poor socio-economic status and acculturation, discrimination, time elapsed since migration and age on arrival in the new country. Although the stressors and situations the different ethnic groups experience in the host country may be shared, the way they deal with them may differ according to cultural factors. There is a need to collect detailed data on psychosocial health among the various immigrant groups in Europe, as well as to monitor this aspect in North African residents who lack access to specific services.

Introduction

European countries, initially exporters of migrants, have been the destination of immigration for several years. Migration is a fundamental force of demographic change in Europe and has biological, economic and social implications. The transformations that follow immigration are complex, as everything that surrounds the person changes, including diet, social and family relationships, climate, language and culture.^{1,2}

Immigrants are exposed to a series of risks, including psychological ones such as stress resulting from migration and integration, the breakdown of existing social ties and adaptation to their life in a new social and cultural environment.³ Immigrants often escape their poor and under-developed society, characterized by a lack of social and health systems. Morbidity and mortality in the countries of origin are often significantly higher than those of the local populations of the host countries. The effect of migration on health is a subject of debate, as some studies report better health and a similar or lower mortality than the local population^{4,5} while other studies have found poorer health.^{6–8} Some authors have also reported the so-called 'healthy migrant effect' related to selective migration, according to which newly arrived immigrants tend to be healthier than the host population.^{9–11} However, it has also been reported that the health of migrants deteriorates some time after settling into their new host country.^{11–13}

The health of immigrants is influenced by various factors, such as those related to cultural influences of the country of origin (acquired risk factors over and above migration, healthy lifestyles), factors in the country of destination (related to social class and behavioural risk factors such as poor diet, smoking or alcohol consumption) and the effects of selection (such as the 'healthy migrant effect').

The relationship between socio-economic status (SES) and health is well known and complex. Sometimes it is indicated as 'epidemiological paradox' (higher SES are not associated with better health) or 'immigrant health paradox' (foreign-born people are more healthy than native-born ones despite their lower SES).¹⁴ SES is usually measured by the level of income, education and type of employment. It is an important determinant of health and is used in the study of health inequalities.^{15,16} The relation between health

status and SES is often overlooked, providing results affected by confounding factors. Educational status gives access to employment and to better health, while unemployment is associated with premature mortality. However, the extent of SES based on objective data may not reflect the real situation.^{17,18} The level of educational attainment in the country of origin is usually not recognized in the host country, and immigrants often have to share their salaries with dependent family members remaining in their countries of origin.

Subjective social status is defined as the person's belief concerning his position on the social ladder.¹⁹ As it includes both socio-economic factors and the individual's perception of his own social position, it predicts health^{18,20} better than socio-economic status. Another parameter to be considered is acculturation among the groups. Acculturation and enculturation are intertwined and represent important psychosocial factors that influence health status. Acculturation is generally associated with adverse health effects, and vice versa with enculturation.¹⁰ Other factors affecting health status are housing conditions, living in disadvantaged areas, feeling discriminated or the absence of social support. Moreover, being a single woman is a risk factor for increased morbidity and mortality.²¹

In addition to legal immigrants, there are illegal/irregular immigrants whose presence is a well-established fact in most European countries. They usually perform badly paid, physically and psychologically stressful jobs in highly qualified service economies and welfare states.²

Illegal immigrants have to deal with stress deriving from the illegal nature of their arrival, residence or work and the fear of being detained and possibly punished by state authorities. These immigrants feel permanently insecure if not in danger. The hard conditions of today's migration, both legal and illegal, seem to lead to deterioration of the mental health of immigrants. Many of them suffer high levels of stress, which in some cases are even inhumane.²

Self-perceived health is one of the leading international health indicators of a person's general subjective perception of health. As defined by the European Community Health Indicators & Monitoring: 'Self-perceived health is a subjective assessment that the people make about one's own health state, more commonly

called subjective health or self perceived health. Subjective health is a global measurement including several health dimensions (physical, social and emotional).⁸ Self-perceived health is considered a strong, independent and reliable predictor of morbidity, health care utilization and mortality.⁸ Knowledge of the self-perceived health of immigrants can help to comprehend the health status and needs of these groups, which is essential to improve equity and integration.

The present review assesses the perceived health, perceived quality of life, stress, psychological discomfort and well-being in various immigrant communities in Europe to identify the most informative factors and any possible differences between groups.

Methods

We examined the literature on the psychosocial health of immigrants in Europe and of North Africans living in their own countries. Electronic databases were searched using key word combinations to identify psychosocial features in immigrants in central and southern Europe.

The data are discussed separately for the different countries.

Results

Central and Southern Europe

Spain

Spain is the country of central and southern Europe where studies relating to psychosocial aspects are best represented, allowing a more accurate analysis. Spain has historically been a country of migrants and over the past centuries a large proportion of its population has migrated, mainly to Latin America and Europe.²² These aspects allow us to separately consider the various factors involved.

Different results for self-perceived health status were found depending on the country of origin (figure 1). Men from Argentina, Catalonia and Colombia showed the lowest values of poor self-reported health, while the highest values were presented by Bolivian males followed by Moroccans and Peruvians.^{23,24} Low values were also observed in Latin Americans, Romanians, Spaniards coming from outside Catalonia and foreigners.²⁵ The differences among females were smaller (figure 1), but low values were observed in women from Catalonia, Latin Americans and Moroccans.^{23–25}

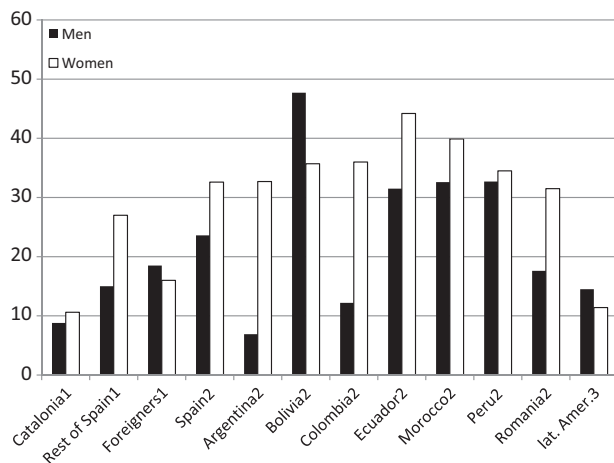


Figure 1 Incidence of poor health perception among immigrants in Spain

1: Borrell *et al.*, 2008²³; 2: Villaroel and Artazcoz, 2012²⁴;
3: Gonzales-Lopez *et al.*, 2013²⁵

In the study by Sevillano *et al.*,²⁶ the physical health of natives did not differ from that of immigrants. Sub-Saharan Africans and Colombians reported better physical health than natives. These studies indicate the advantage of Latino immigrants, which, as reported by Sevillano *et al.*,²⁶ might be a result of the cultural proximity of these groups to the local culture. As regards to differences in poor mental health status among countries (figure 2), Bolivian males presented the highest prevalence, while Romanian and Moroccan men were more likely to report good mental health status. Differences among men from the other countries were smaller. Among the women, Bolivians and Ecuadorians had the poorest mental health, while only small differences were found for the other countries.²⁴ The immigrants studied by Font *et al.*²⁷ and the Romanians studied by González-Castro and Ubillos²² were considered as a whole without divisions between the sexes. These samples presented poorer mental health than the other groups, with the exception of the Bolivians and Ecuadorians reported by Villaroel and Artazcoz.²⁴

In the study by Sevillano *et al.*,²⁶ the immigrants to Spain (Colombians excepted) had poorer mental health than the natives, especially African men and Bolivian women. Natives had better mental health than some immigrant groups, i.e. Bolivians, Romanians, Moroccans and sub-Saharan Africans, whereas Colombians showed mental health indices similar to those of natives. Females usually reported poorer perceived health than males (figure 1) and the perception of a higher level of discrimination.²⁸ Women from Spain, Argentina, Colombia, Ecuador and Romania reported poorer self-perceived health status and mental health, whereas there were no gender differences in Peruvians and Moroccans.²⁴ The opposite situation was found for Bolivians, 'foreigners' (immigrants born outside of Spain) and Latin American males, who reported poorer health outcomes than females^{23–25} even though the proportion of 'excellent' health status declared by Latin American males was almost three times than that observed in women.

There was a similar situation for poorer perceived mental health (figure 2): women from Spain, Argentina, Colombia, Ecuador, Morocco and Romania reported higher values than men, while there were no significant gender differences in mental health among Peruvians.²⁴ As discussed previously, the data reported by González-Castro and Ubillos²² and Font *et al.*²⁷ allow an overall assessment of the two sexes but not an analysis of gender differences. Socio-economic factors had the greatest influence on health status. Migrants with lower incomes had a significantly higher level of

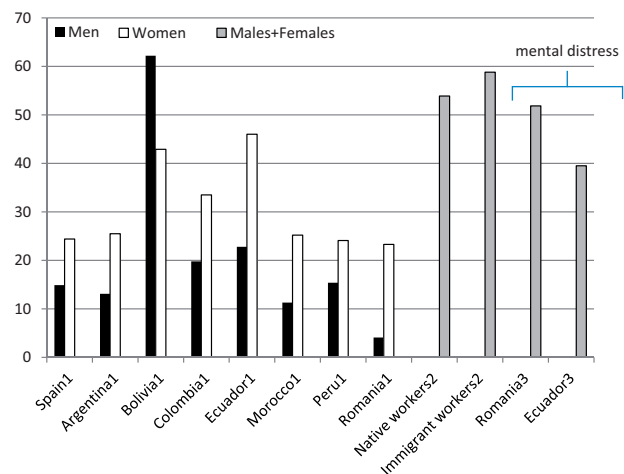


Figure 2 Incidence of poor mental health and mental distress perception among immigrants in Spain

1: Villaroel and Artazcoz, 2012²⁴; 2: Font *et al.*, 2012²⁷;
3: González-Castro and Ubillos, 2011²²

mental distress,²² while higher incomes were related to fewer symptoms.

González-López *et al.*²⁵ reported the importance of educational parameters: individuals with high school education or above had higher proportions of satisfaction with health status than those with elementary education or less. Working conditions were also connected with health: unskilled workers always reported poorer health²³ and a higher prevalence of perceived discrimination.²⁸

Immigrants usually have a more adverse social class profile, poorer working and living conditions and poorer health status, and these differences are greater among women. The case of immigrant women working as managers, supervisors and professionals but reporting poor health status is interesting. Poor health among these women is not explained by the variables used to describe working conditions but could be a result of the difficulties of working in such positions. According to some authors,^{18,26} SES predicts better physical and mental health among immigrant men but not among immigrant women. For immigrant women, indicators of SES may have different meanings than for the general population: the educational level and the experience or professional qualifications obtained in their home countries were often not recognized, so they were forced to accept jobs that required low skills and they had to share their wages with other dependent family members.¹⁸ Subjective social status would explain differences in perceived health better than SES in the group of immigrant women.

Another factor associated with perceived health status is the length of stay in the new country^{25,29,30}: the results revealed a higher proportion of dissatisfaction among immigrants who had lived in Spain for 5 or more years. The rapid reduction of perceived health status by immigrants after the first 5 years was explained by Newbold³¹ as the product of reduced optimism when faced with the cultural and socio-economic reality of the host country.

France

In France, immigrants generally declare worst health status than native French.^{32,33} The immigrants' poorer health is partly explained by their unfavourable socio-economic situation.

There is a marked diversity in the health status of the immigrant population, with substantial differences even among immigrants from different regions of the same continent. In comparison with French, immigrants from Central and Southern Europe, Turkey, North Africa, sub-Saharan Africa and Asia reported worse health status, while immigrants from Northern Europe declared better subjective health status.³²

According to Vaillant and Wolff,¹³ immigrants from southern Europe (14.1%) were more likely to have poor health status than immigrants from northern Europe (4.1%), while the situation of eastern Europeans was intermediate (11.2%). On the other hand, southern Africans were less likely to report poor health status (7.4%) and more likely to claim that they were in good or very good health than northern Africans (14.6%). Also in France, male immigrants to France indicated that they were in good or very good health more often than females (55.8% vs. 48.3%).

Abu-Rayya³⁴ pointed out the importance of acculturation styles for the well-being of immigrants: immigrants identifying with their home country/ethnic group showed higher degrees of maladjustment in terms of loneliness and depression than those identifying with France.

Italy

Despite the high rate of migration to Italy in recent years, there is little information on the physical and mental health status of immigrants.¹ The study by Toselli and Gualdi-Russo¹ showed that,

among males, Tunisians were significantly more stressed than Senegalese, Pakistanis and Roma. The last group was the significantly least stressed one. This could be because of its nomadic nature, being accustomed to moving more than the other ones. Females reported higher stress levels than males of the same ethnic group, with statistically significant differences. Tunisians reported the lowest values of well-being. Although the differences in well-being between the groups were small, Senegalese, Kosovar and Roma males differed significantly from Moroccan, Pakistani and Tunisian males. In females, there were no differences among groups, just as there were no differences between males and females within the same group. The Tunisians reported significantly higher levels of discomfort than all the other groups, with the exception of Moroccans who had a high discomfort score. The Senegalese, Kosovars, Pakistanis and Roma reported less discomfort, being significantly different from the Tunisians and Moroccans. The perception of discomfort was higher in females than males, but a significant difference was observed only in the Roma.

Among males, Tunisians were least satisfied with their quality of life, followed by Moroccans and Senegalese, while the other groups were quite satisfied with their situation: the scores for the Tunisians, Moroccans and Senegalese differed significantly from those of the Pakistanis, Kosovars and Roma. Females were generally more satisfied with their quality of life than males (except in the Roma group), although the difference between males and females was significant only in Moroccans.

Germany

Immigration has also influenced psychosocial health in Germany: according to Nesterko *et al.*,³⁵ immigrants reported slightly lower values of satisfaction with physical health and of satisfaction with life compared with native-born Germans, while no significant differences were observed for the mental health component. The younger immigrants (≤ 30 years) reported better rates for the mental and physical health components and greater satisfaction with life than older immigrants (> 30 years). The length of stay in Germany was another factor influencing satisfaction with life: both newly arrived immigrants and those living in Germany for > 30 years reported the lowest scores. The country of origin showed a significant association with the physical health component and with overall life satisfaction. In both cases, immigrants from Turkey reported the lowest rates, while immigrants from western European countries reported the highest scores for the physical health component and for satisfaction with life. Immigrants with German citizenship indicated higher satisfaction with life than those without it.

In their study evaluating emotional distress in women of German or Turkish descent residing in Berlin, Aichberger *et al.*³⁶ found that working conditions were an important factor in emotional distress: unemployment was associated with increased levels of emotional distress in all women, with the highest distress level in the group of unemployed Turkish women. The stratified analyses showed that being unemployed and of higher age were associated with emotional distress in the Turkish group. The stratified analyses of the German and Turkish groups revealed that the overall SES contributed to a high level of emotional distress in the Turkish group but not in the German one.

Discussion

Multi-ethnic societies in Europe are faced with many difficulties, including the health needs of groups of different origin. Immigrants generally have poorer psychosocial health than non-immigrants, with women generally presenting a higher risk, even though differences among groups are observed. The negative effect of low SES may particularly impact the association of ethnicity and

psychosocial health, with income, working inequality and the increasing social gap between immigrants and non-immigrants in Europe being the main factors. In addition, racism, ethnic discrimination, acculturation or acculturative stress and greater exposure to stressful events have been proposed as possible predictors of psychosocial disorders in immigrants.

The picture described in this article for central and southern Europe is in accordance with the data from northern Europe. Studies from Sweden and Norway found that first- and second-generation immigrants to Europe showed great heterogeneity in the risk of hospitalization for mental disorders when categorized into subgroups.^{37–40} In first-generation immigrants, the risk of self-perceived poor health increased with increasing age at migration to Sweden, after adjustment for potential confounders.³⁸ Male refugees born in Iran and Turkey had a threefold risk of poor health status than men born in Sweden, while the risk was five times higher for women. These high risks of poor health status seemed to be mediated by poor SES, poor acculturation to Swedish society and discrimination.⁴¹

In addition to the psychosocial difficulties among immigrants living in Europe, we must also mention the difficulties faced by populations living in developing countries. People who live in countries where there is a lack of access to mental health services are less likely to be diagnosed, and poor access to services could affect the rate at which depression is diagnosed. This could explain the low recorded rate of depression in countries with political conflicts and instabilities, such as Tunisia, Libya and Egypt in North Africa, as well as the stigma acquired because of mental or psychological disorders. Ferrari *et al.*⁴² found that people suffering depression numbered more than five per cent in the Middle East, North Africa, eastern Europe and sub-Saharan Africa. The prevalence of depression in women was double than that in men.

The prevalence of depression has increased in North African/Middle Eastern countries, leading to a higher burden because of the political conflicts raging since 2011. Clinical depression is also linked to an increased risk of suicide and ischemic heart disease. Cost-effective interventions to reduce the burden of depressive disorders should be a public health priority.

In conclusion, it is important to point out that immigrants are heterogeneous groups in terms of their ethnic and historical roots, culture and health practices. Migration is a multi-faceted experience that differently affects people of different cultural backgrounds, their perceptions of their previous lives, the reasons that pushed them to migrate or the value attributed to the income they earn. Although stressors and experiences may be common to various cultures, the ways they are interpreted may be different. In addition, vulnerabilities and risk factors may be specific to the considered group. One difficulty with the self-rated health outcome is that this measure may not be comparable across ethnic groups because of cultural and linguistic differences. There is a clear need to collect more detailed data on health in the various ethnic groups living in European countries.

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Key points

- Ethnic differences in the perception of health pose different groups of immigrants in Europe at different risk of psychosocial disorders. The literature data are still lacking to fully understand this aspect, especially in countries of recent immigration.
- In North Africa, the lack of access to mental health services does not allow to recognize mental or psychological disorders.
- The women, both immigrants and North Africa residents, and the people belonging to low SES are at higher risk of psychosocial disorders and need more attention and valuation in order to implement planned interventions. This is a public priority to reduce the risk of suicide and ischemic heart disease.

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