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Family Studies 232
12/4/18

The Migration Experience and Health: How Families are Affected by Crossing Borders

Immigration is currently a hot debate in the United States. Although many are open to immigration and immigrants, there are also many who believe that immigrants will prove detrimental to society. A majority of these debates center on whether or not immigrants will improve the community; not many people pause to consider how the community or the process of migrating might affect the immigrants. Immigrant and refugee families face a unique set of health issues when moving to a new country. Health care availability and health outcomes vary based on the status of the person attempting to move to the country. Mental health and physical health, specifically framed in terms of family struggles, have the potential to change over the course of the migration process and are important to study so that immigrants and refugees can have successful migration experiences. This paper aims to identify what current research has found about common physical health differences, mental health differences, and potential causes of these disparities between the immigrants and refugees in comparison to native-born citizens in order to provide insight on how the migration experience can affect families.

In general, immigrants tend to be in relatively good physical health when they first arrive in their new country. In Canada, newly arrived immigrants are actually likely to be in better physical health than their native counterparts (Edberg, Cleary, & Vyas 2011). They are 40% less likely to have diseases such as arthritis, cancer, heart disease, or chronic respiratory problems (Betancourt & Roberts 2010). Additionally, immigrants are approximately 30% less likely to be overweight when newly arrived in Canada (Betancourt & Roberts 2010). Of course, there are some deviations from this trend. For example, immigrants are 20% more likely to have diabetes and are also at increased risk of tuberculosis, nutritional deficiencies, and being behind on immunizations (Betancourt & Roberts 2010, Edberg et al. 2011). Another study looked specifically at children and found less pronounced differences in health between immigrant children and native-born children (Lane, Farag, White, Nisbet, & Vatanparast 2018). That same paper also found that adult immigrants were likely to have approximately similar instances of

heart disease, which contradicts Edberg et al.'s findings. Although there are some contradictory findings, the general trend is that immigrants are likely to have similar or better physical health when they first arrive in their new country. Beiser, Feng, Hyman, and Tousignant (2002) hypothesized that this could be the case because the immigration process is difficult and so many families who make it through the process tend to be well-educated and skilled, which puts them at an advantage to be in better physical health.

Once the family has become established in their new country, however, physical health tends to decline. The longer the family stays in the new country, the more likely that family's physical health is to be closer to a native-born person's physical health. In fact, Betancourt and Roberts (2010) found that it only took five years for the likelihood of having better health (or the likelihood of not having certain health problems) to drop from 60% less likely for immigrants to 30% less likely for immigrants. In only five years, the likelihood of not having certain health problems dropped to half of its original percentage for immigrants. This especially causes concern for parents who worry about the health of their children. Lane et al. (2018) offered a chance for immigrants to voice their concerns about health. As one parent fretted, "When we came here my son was just 5 years old and [my daughter] was just 3 and a half and they were in the range of normal weight, but now they are overweight, maybe because of the lack of physical activity and good food." On the other end of the spectrum, another parent was worried her daughter ate too little and is too "skinny, and she never puts on weight […] she doesn't like to eat too much and I am always insisting some more food and eat this and she doesn't like some things." Lane et al.'s main hypothesis is that the more the children try to acculturate, the more likely they are to gain weight, possibly to the point of obesity. Specifically focusing on weight and obesity in children, the changes that can come with acculturation and the migration experience can negatively affect both children's and adult's health over time.

Refugees have a different experience than immigrants when it comes to physical health. They are more likely to have worse health outcomes and they still experience a decrease over time (Edberg et al. 2011). Specifically, they are at a higher risk of mortality and infectious diseases (Lane et al. 2018). An additional point at odds with the immigrant experience is that children in refugee families are likely to be malnourished which can lead to stunted growth and developing chronic health issues (Lane et al. 2018). Although immigrants and refugees are

sometimes lumped into the same category, they have very different health issues in relation to their migration experience and should be given specialized treatment and care for their given situation. Settling into the new country is also a different experience than that of immigrants; refugees are less likely to have completed high school and more likely to be on assistance programs and be below the poverty line (Lane et al. 2018). Refugee families must struggle with not only the lower income associated with migration, but also their children's nutritional deficiencies and increased risk of disease and death. It is important to recognize this distinction between the experiences of immigrants and refugees in order to provide better, more personalized treatment.

Mental health is also an important factor in families' experiences during and after migration. The "healthy immigrant" phenomenon still applies to immigrants when considering mental health, as evidenced by lower rates of depression and alcohol dependence compared to native-born people (Kirmayer et al. 2011). Similar to the research on physical health, however, children or second-generation migrants seem to bear some of the burden. They are at a higher risk of schizophrenia than their parents, but groups especially at higher risk are families that come from developing countries and areas where a majority of the population is black (Kirmayer et al. 2011). These specific mental health problems depend on the migration process as well in terms of what the family faced during resettlement. Once again, it is believed that the better mental health upon arrival can at least partially be attributed to the selection process of who makes it through to successfully and legally move to the new country (Kirmayer et al. 2011). Although there is not much research on it, Edberg et al. (2011) also suggests that social supports (i.e., if the family finds a neighborhood supportive or similar to their home culture or people who help them) can affect the mental health of the family.

Mirroring the research on physical health in immigrants compared to refugees, refugees suffer from worse mental health than immigrants in general. They are much more likely to have higher rates of certain mental health problems including PTSD and depression than immigrants or native-born people (Lane et al. 2018, Kirmayer et al. 2011). This is for obvious reasons. First, many refugees have experienced war, violence, or even torture, which is highly associated with PTSD (Kirmayer et al. 2011). Second, the migration experience involves much uncertainty. Not only do refugee families have to worry about their citizenship status, but they also often

must spend long amounts of times in difficult environments like refugee camps (Kirmayer et al. 2011). Once again connecting to the other research, children seem to especially feel the impact; there have been many studies that indicate young refugees suffer from elevated rates of depression and distress (Lane et al. 2018).

The disparities between native-born people, immigrants, and refugees in terms of physical and mental health have been attributed to several factors. One of the main subjects of discussion is poverty; currently, approximately 21% of children from immigrant families are below the poverty line (Edberg et al. 2011). Beiser et al. (2002) expanded on this by studying the effects of poverty on immigrant families in a longitudinal study. In general, immigrant families are not as negatively affected by poverty as native-born people, but that hypothesized to be because immigrant families also believe their poverty is temporary and tend to work towards higher incomes (Beiser et al. 2002). It is only when an immigrant family stays poor over a long period of time that they will feel the impact of more negative effects of poverty. Poverty is a disparity that affects a great number of immigrant families when they move to a new country and has the potential to impact their long-term health. Because refugees are more likely to be poor (Lane et al. 2018), that means they most likely feel these effects even more than immigrants do. Although poverty is a wide-spread issue that affects more than just immigrants and refugees, it should also be a focus for organizations trying to alleviate the disparities between these groups.

Another big factor creating the disparities between the groups is healthcare access and the quality of healthcare received. The quality of care cannot be considered if families have no access in the first place. Up to 51% of non-citizens, including hopeful immigrants and refugees, do not have any healthcare coverage, which greatly limits their options (Edberg et al. 2011). Specifically, immigrants and refugees are also less likely to seek help from mental health services even if they are experiencing similar levels of stress to native-born people seeking out treatment (Kirmayer et al. 2011). Even if these families do have access to some sort of care, there are often many barriers in the way of quality care. For example, language barriers, lack of culturally competent care, mistrust, lack of knowledge regarding services, stigma, long wait times, and poor coordination between the hospital and community services have all been documented as problems in providing health care to immigrants and refugees (Edberg et al. 2011, Wylie et al. 2018). Many doctors are not sufficiently trained to help with problems

specific to refugee and immigrant families, especially with culturally competent care and understanding potential prior trauma. There are tools available for physicians to assess the "context of illness" and yet those tools are underutilized and often unknown (Wylie et al. 2018). More should be done to alleviate these problems, especially because family-based care has been shown to be helpful for mental health treatment for these populations (Wylie et al. 2018). Physicians should receive more training on how to effectively and sensitively help families with their health in the context of their migration experience, and there should be more interpreters available where necessary. Additionally, healthcare should be more widely available to these families so that they at least have the opportunity to use these resources.

Whether it is a single person or a large family going through the migration process, that experience can greatly affect their health and also impact their options for healthcare. Specifically for families, it can greatly impact children, but family-based therapy is proven to help alleviate some problems. Although immigrants may not feel as many negative repercussions of the move immediately, both refugees and immigrants feel the impact in the long term. There is currently not enough training for healthcare providers, but culturally competent care would be one highly beneficial way of helping reduce at least some of the disparities in access to care that does not involve fixing systemic problems like poverty or discrimination that immigrants and refugees may face. In a perfect world, there would be no such thing as "refugee" and every immigrant would retain their good health, but culturally competent care is a good start to help those who need it.

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