7

Migration, Health, and Stress

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Until the 1980s and 1990s most migration theory was based on the widespread "individual relocation" approach which emphasized push–pull factors and focused on rational decision-making, transitions, and adaptation processes. These early theories were largely ahistorical and referred to tendencies to move from densely to sparsely populated areas, from low- to high-income areas, or in response to fluctuations in the business cycle. Political and religious threats or overt persecution generated populations of "refugees" which were distinguished from the category of "migrant." Early migration theory emphasized economic factors, social order and equilibrium, and focused on the inability of countries of origin to fulfill expectations. In considering the consequences of migration they tended to concentrate almost entirely on the countries of destination and assumed unilinear processes of acculturation and assimilation. Conflict was seen as a temporary expression of dislocation in the normal ordered state of host societies (Price 1969; Rose 1969; Mangalam and Schwarzweller 1970; Richmond 1984).

Migration in Postmodern Societies

With structural changes that have taken place in contemporary societies, more recent theoretical approaches to migration have taken the view that, in its broadest context, migration in the 1980s and 1990s can be been viewed as a stable, international phenomenon with a structure over space and time. It is widely believed that the massive dimensions of migration in the late 1990s will continue in future years, although the origins and destinations of the streams may change in accordance with shifts in economic and social conditions. Population pressures, environmental deterioration, poverty, wars, persecution, and

human rights abuses are among the ongoing causes of population movement. The continued disadvantages of the Third World and the end of the cold war, which opened the boundaries of East European countries, have exacerbated ethnic and national conflicts. These have combined to generate vast numbers of refugees and immense populations seeking to move. In 1995 the United Nations High Commissioner for Refugees estimated that 14.4 million persons are considered refugees, which means that they are outside their country of citizenship and are unable to return for fear of political persecution; another 36 million, who are not formally defined as refugees, have been displaced from their homes but remain within the boundaries of their countries. Thus it is clear that streams of international migration are ongoing and respond to political, social, and economic changes in an expanding global economy (Zolberg 1989; Heisler 1992; Castles and Miller 1993; Massey et al. 1993).

Recent thinking has referred to "international migration systems" theory, which proposes a dynamic, historically-based, globalist view in which many states are interdependent in the migration process (Zolberg 1989; Massey et al. 1993). Migration is driven by structural characteristics of societies and tends to generate its own dynamics. The principal structural issues that drive migration in the 1990s are global inequality, the refugee crisis in many parts of the world, use of cheap foreign labor, and liberalization of exit from the eastern European countries. The nation-state is a prime actor in contemporary migration theory, especially with regard to its role in policy formation and control of the flow (O'Brien 1992).

Migration theories can be roughly categorized into two groups: those that refer to the *initial* motivation for migration and those that refer to the ongoing nature of the migration process (Heisler 1992). In the former category there is an emphasis on globalization processes which are seen in the political and economic context of an expanding global economy. Migration is viewed as a response to the flow of capital, technology, institutional forms, and cultural innovations in an interactive process across the globe. In the second category are theories referring to the linkage of countries by flows and counter-flows of people in sets of networks which are both interdependent and independent of each other. These processes reflect the historical context of the links between origins and destinations which are based on earlier colonization, political influence, trade, investment, or cultural ties – as well as the present economic, social, and political contexts. The inherent social – rather than predominantly economic – quality of the process is emphasized by a focus on networks which are microstructures viewed by some theorists as the core of the process because of their role in providing assistance at the destination in job location, financial support, practical information, and a base for the migration of additional persons. The ongoing nature of the process is seen in the fact that the larger the number of people who migrate, the thicker the social networks at the destinations and the consequent amount of available help; this tends to decrease the costs and risks of migration for others from the same origin. Widespread policies of "family reunification" reinforce these networks. The "culture of migration" has made the process increasingly acceptable and cumulative in many parts of the world where the notion of migration is more and more of a community value (Fawcett

1989; Hammar 1989; Portes 1989; Salt 1989; Heisler 1992; Kritz and Zlotnik 1992; O'Brien 1992; Castles and Miller 1993; Massey et al. 1993; Teitlelbaum and Weiner 1995).

Postmodern migration is distinguished by its extreme diversification in terms of the many *types* of contemporary immigrants. These include a wide variety of cross-cutting categories and people may shift over time from one type to another. Some of the most prominent categories of migrants are: permanent settlers; temporary workers and seasonal workers; refugees and asylum seekers; legal and illegal immigrants; persons who come for purposes of family reunion; skilled and unskilled persons of varying social class backgrounds; professionals and managerial workers; persons of urban and rural origins; wage earners and entrepreneurs; many varieties of ethnic groups. In addition to the above types, there has been reference to immigrants from diasporas seeking to return to their homelands (Portes 1989; Shuval 1995, 1998; Carmon 1996).

With minor exceptions, host countries admit migrants selectively in terms of policies that consider unemployment rates, labor shortages or surpluses in specific sectors of the economy, potential social conflict, security issues, and family reunion needs. However, despite the fact that no country is obligated to accept refugees or migrants, many developed countries have recognized a moral, humanitarian responsibility to do so, within the limits of their self-interest.

Within this context, extensive illegal immigration characterizes many of the receiving societies. This phenomenon poses a major threat to the authority and power of the state since it represents a loss of control in the flow of people and goods over borders. The permeability of borders has become a major political issue in Germany, France, the United States, and Israel and is expressed in heated political debate. Efforts to control illegals have included penalties on employers who provide jobs for illegals as well as limitations on such benefits as welfare payments, tax and housing assistance, family support, student loans, and medical care. However, as long as there is widespread deprivation and unemployment in the sending countries and the demand for cheap labor continues in the formal and informal markets of the receiving countries, it is extremely difficult to contain or control illegal immigration (Baldwin-Edwards and Schain 1994; Center for Immigration Statistics 1995; Carmon 1996).

Illegals take the least desired jobs on the market, make their living in the "informal" sector and satisfy employers' demand for cheap labor. In western Europe, where there has been high unemployment during the 1980s and 1990s, there is fear that immigrants pose a job threat; there is also concern with rising Islamic fundamentalism and increasing crime rates. Humanitarian concerns have been compromised for security considerations by seeking to impose tighter controls on the entry of illegal immigrants while at the same time seeking measures to encourage policies in the countries of origin that will curtail the initial causes of the flow. It is widely believed that illegal immigrants are a source of narcotics trafficking, terrorism, prostitution, and crime. Fearing cultural differences, job competition at low wages, sky-rocketing costs for schools, welfare, health, and police, wide segments of the public in many countries do not distinguish between legal and illegal migrants, and express increasing hostility

and reluctance to admit all forms of migrants (Zolberg 1989; Teitelbaum and Weiner 1995).

Teitelbaum and Weiner (1995) note that in the long run a high proportion of temporary migrants become permanent settlers. Despite a system of fines on air companies which bring persons without entry visas to European points of entry, once a person manages to reach Europe he can be fairly confident that, with legal advocacy and civil rights protection, the sluggish process of asylum adjudication in democratic countries can last almost indefinitely (Massey et al. 1993; Teitelbaum and Weiner 1995).

When there are barriers to entry but large numbers of people seek to migrate, a lucrative niche is created for the establishment of special institutions relating to migration. These include private entrepreneurs who provide a variety of services and supports for legal and illegal migrants. They encompass business enterprises and humanitarian organizations but also an array of black market enterprises. These offer a variety of counseling, legal advice, social services, and protection to immigrants; such bodies provide labor contracts between employers and migrants, counterfeit documents and visas, arranged marriages, housing and credit for legal and illegal immigrants (O'Brien 1992).

If there are large numbers of immigrants, they may themselves constitute a political power in the host country. Their interests may dictate that they lobby for the admission of groups from specific countries of origin or for limitations in the numbers of immigrants. Large numbers make for influence and power on other public issues as well (Horowitz 1994).

What is Stress?

The stress model that appears to be most useful in the present context is the one developed in the 1970s by Levine and Scotch (1970). House (1974) has noted that "stress occurs when an individual confronts a situation where his or her usual modes of behavior are insufficient and the consequences of not adapting are serious." Stated most generally, this theory proposes a multi-linked chain among potential stressor situations, subjectively determined perception variables, and the availability and usability of personal and social coping mechanisms (Scott and Howard 1970; French, Rodgers, and Cobb 1974). Thus, homeostasis on the individual level will be disrupted when a person perceives a given situation to be disturbing, alarming, or threatening. If he or she is unable to mobilize personal or social resources to cope with the situation in such a manner as to restore homeostasis, that person's energy will be bound up dealing with this perceived disturbance; this preoccupation defines a stressful condition (Scott and Howard 1970).

Levine and Scotch's (1970) approach emphasizes the subjective definition of stress by making it clear that situations are not objectively stressful but are socially or psychologically constructed as such by individuals in terms of social and cultural norms. Thus, bereavement or divorce may be subjectively defined as extremely disturbing but also, under certain circumstances, as a relief or even as a positive challenge (House 1974). The conditional quality of the stress model also emphasizes the importance of coping mechanisms. These may be individual

(personal skills, personality traits, intelligence, knowledge) or social (formal institutions, informal groups, social norms and values). The availability and usability of coping mechanisms constitute the link that determines whether a situation that is perceived as disturbing will in fact result in stress for the individual. Indeed there is considerable evidence for the stress-mediating and stress-buffering roles of coping resources (Pearlin and Schooler 1978; Pearlin 1989; Ensel and Lin 1991).

Mechanic (1978) distinguished between two types of coping: defense processes, which are psychological mechanisms to redefine, deny, repress, or possibly distort a disturbing reality, and instrumental coping behavior, which utilizes skills and knowledge for problem-solving in an effort to change or ameliorate the stressful situation. Defense processes may enable the individual to live with a difficult situation, e.g. chronic illness, but in the long run neurotic or more serious consequences may result from this form of coping. On the other hand, instrumental coping seeks to alter or modify a disturbing situation. Coping skills are a function of early socialization and prior experiences with the given situation or with settings perceived as similar.

Antonovsky's Salutogenic Model (1993) derives directly from the above theoreticians but makes a unique contribution in its focus on the "Sense of Coherence" as a critical coping mechanism. He has argued that a strong Sense of Coherence (SOC) is crucial to successful coping with the ubiquitous stressors of living and hence for effective health maintenance. Antonovsky defined the SOC as a global orientation that expresses the extent to which one has a pervasive, enduring, dynamic feeling of confidence that: (a) the stimuli deriving from one's external and internal environments are structured, predictable, and explicable; (b) resources are available to meet the demands posed by these stimuli; (c) these demands are viewed as challenging and as worthy of energy and emotional engagement.

The strength of an individual's SOC is shaped by life experiences of consistency, by underload–overload balance as well as by participation in socially meaningful decision-making. Some of these issues have been explored by Ben-David in relation to the migration process (Antonovsky 1979, 1987: 19, 1993; Ben-David 1996).

In sum, stress is said to exist to the extent that an individual defines a salient situation as disturbing for himself or herself and is unable to recruit effective coping mechanisms to remove or reduce the disturbance. Two simultaneous conditions are necessary for stress to be present or to increase: a subjective definition of a situation as disturbing and an inability – for whatever reason – to cope with the condition. The centrality of social and psychological factors in determining stress is seen in the fact that both these conditions are largely socially constructed.

Migration and Stress

The relationship between migration and stress may be considered on two levels that differ analytically in terms of the assumed direction of cause and effect. On the one hand, stress of various sorts may be said to cause migration; on the other,

stress may be viewed as an outcome of migration. As noted, this distinction is essentially analytical since both processes may in fact occur with regard to any specific stream of migration.

Change is inherent in migration and may be considered a structural characteristic of the process. Such change may, under the circumstances proposed in the model above, be viewed as a potential stressor. Three forms of change characterize the migration process: physical, social, and cultural.

Physical Change

Migration involves movement from one geographical location to another. Such movement differs in magnitude depending on the distance of the destination from the origin. The migrant may experience changes in climate, level of sanitation, and dietary habits, as well as exposure to pollution, new pathogens, and endemic diseases. Changes in climate, in conjunction with the new culture, may induce changes in lifestyle that express themselves in patterns of sleep, nutrition, timing of meals (e.g. when the main meal of the day is taken), clothing, housing, or general pace of activity. All these physical changes may, under certain circumstances, serve as stressors (Wessen 1971; Hull 1977).

Social Change

All migrants disengage from a network of social relations in the society they are leaving. In the case of migration of whole kin groups, disengagement may be minimal, but in other cases there are numerous breaks in social relationships. Disruption of long-standing ties may or may not be perceived as disturbing by the migrant; accordingly, disengagement will cause the migrant to feel isolated and unsupported, or relieved and unencumbered. Separation may be viewed as permanent (e.g. when leaving aged parents behind in a society to which access is closed), or as temporary when the person left behind can come to visit the migrant in his or her new residence or the migrant himself can revisit his original home. In some cases, the disengagement may be perceived as disturbing only after a lapse of time: a young migrant, initially exhilarated by the freedom from ties of parents and other kin, may begin to feel disturbed by their absence after a period of separation. Experiences in the host society – difficulties in establishing new social networks, employment problems, or other frustrations – may sharpen the sense of loneliness at a later stage (Laffrey et al. 1989; MacCarthy and Craissati 1989).

The relevant coping mechanism for this feeling is a new social network that serves as a functional alternative to the earlier one. Immigrants experience different levels of difficulty in developing such alternative relations in their new location. When entire kin groups or whole communities migrate, membership within such groups provides considerable support (Kuo and Tsai 1986; Mavreas and Bebbington 1989), but meaningful primary relations with veterans in a new social context generally develop slowly (Gordon 1964; Haour-Knipe 1989). In many cases, social relations develop among migrants of the same origin, either because of residential proximity or because of deliberate choice.

But when migrants seek to move into the larger social context of the host society, their success will be determined by its receptiveness to newcomers (Rose 1969).

Cultural Change

All migrants need to learn new norms and values and to abandon or adapt their old ones. However, the extent of the culture gap between the places of origin and destination determines the amount of learning and relearning that must be undergone. But even when the gap is minimal, the sensitive migrant will nevertheless feel subtle culture changes. Learning skills, youth, flexibility, and readiness for change serve as individual coping mechanisms for this need. Individual coping by immigrants is mediated by attitudes and behavior of the host population, which may range from acceptance, tolerance, and encouragement to disdain, ridicule, or hostility toward immigrants' efforts to learn the new language, norms, and values. Some host societies in which the culture gap is large may provide formal institutions for instruction in the local language and culture, but most acculturation takes place informally (Baider et al. 1996).

An immigrant's entry into a new society is a gradual process. The length of the time span that is relevant depends on the parameters being considered. At what point in time does an immigrant turn into a veteran? The critical time span may be defined in terms of months, years, or even generations. What seems to be important is the dynamic quality of the process.

Different stages in the process have different characteristics, so that issues that are important at one stage may disappear at another. For example, knowledge of a new language has differential meaning in terms of behavior and interaction with others when an immigrant is in a new country 6 months, 5 years, or 20 years. The same is true for primary relations between immigrants and veteran members of the host society: these generally develop relatively late in the integration process (Gordon 1964). Even unemployment, downward mobility, and poverty may be perceived for a short period as transitional stages in the immigration process and therefore as acceptable (Munroe-Blum et al. 1989). Although the orderly progression described by Park and Burgess in their pioneering classic (1921), from contact to competition and conflict and finally to accommodation, does not seem to characterize all situations, the migrant's experience undoubtedly varies by stages (Hertz 1988).

There are a variety of approaches with regard to the conceptual definition of integration in a new social system (Richmond 1984). Terms such as socialization, resocialization, acculturation, accommodation, and normative behavior have been widely used but, in most cases, inadequately spelled out either conceptually or empirically (Bar-Yosef 1968; Price 1969). Does the term "integration" refer to the dispersal of immigrants in the institutional structure? To their conformity to the prevalent norms of the society? To an absence of pathological behavior among them? To their feelings of identification, well-being, familiarity, acceptance, hopefulness? To their interaction on a primary level with other members of the society? To lack of conflict between them and other groups? These issues refer to a variety of contents of the integration concept.

It is essential to establish which point of view is being considered with regard to the integration of immigrants. Several are undoubtedly relevant. One salient point of view is, of course, that of the immigrants themselves: How do they feel about the new society? Do they see it as their permanent home or is it more of a way-station in a series of moves? Do they feel at home? Do they have a sense of marginality? Another point of view is that of veteran residents: Do they accept newcomers or do they view them with hostility – as potential competitors or disrupters of the status quo? Are they apathetic? Finally, one may consider the viewpoint of the society as a whole in terms of its dominant values and their relationship to the issue of immigration. These values have both manifest and latent components expressed by more and less formal mechanisms.

It would seem essential to view integration into a new society as a multidimensional process which can be considered in terms of a variety of subprocesses, each focusing on a different aspect of life in the new society. Thus, there are many pathways and mechanisms by means of which immigrants enter a new social system. At any point in time integration in one life area is not necessarily correlated with integration in others: some areas are more highly correlated with each other than are others, but there seems to be no consistency across populations or situations to permit one to establish necessary correlations (Shuval, Markus, and Dotan 1975).

The implication of such a multidimensional approach is that little is to be gained from seeking one overall measure of integration. The problem is to establish which points of view are to be considered, which content areas are deemed relevant for understanding the process and to seek the empirical relationships among them at various points in time. Composite indexes of integration, such as the one used by Rose (1969), involve arbitrary weighting of the measures from which the composite is derived. They are, therefore, of limited use. It would seem preferable to focus on different meanings and factors depending on the temporal stage in a group's process of entry into the social system. Focusing on one specific area, for example, the occupational sphere, is legitimate provided one bears in mind that, despite its centrality, it is only one of several life areas that could be considered. While behavior and feelings in the occupational sphere are not positively correlated with behavior in *all* other areas, they are generally highly correlated with morale, identification, and feelings about the new society, which gives special salience to employment in the overall process of migration (Shuval, Markus, and Dotan 1975; Shuval and Bernstein 1997).

The integration process in all its dimensions may involve conflict no less than solidarity. The process does not necessarily re-establish an earlier equilibrium but may result in a re-definition of the social situation in terms quite different from those initially characterizing the society. Indeed, the differing interests and values that inhere in the meeting of groups and subgroups suggest that the process is unlikely to be smooth. One can assume that various groups are characterized by different interests and goals as a result of their differential position in the social system and these may not always be complementary. No less important are value conflicts inherent in the orientation of any one group.

Immigrants are just as likely – or even more likely – to come into contact with the problems and pathologies of the institutional structure of the host society as

they are to encounter its more stable elements. Chronic problems to which veterans have accommodated often plague newcomers during their initial stages in the society. It has even been suggested that acceptance of certain chronic pathologies of a society be used as one index of integration! Furthermore, weak or imperfectly functioning institutional structures may be strained by the arrival of an immigrant population, so that the group itself may contribute further to that institution's dysfunction. An example of this would be a social service that was over-utilized before the arrival of an immigrant group and is under even greater pressure as a result of an influx of additional clients. This phenomenon has been noted with regard to the health services in Israel (Shuval 1992). However, high utilization rates of immigrants tend to taper off after they have been in the new society for a period of time (Ben-Noun 1994, 1996).

In a rapidly changing society, newcomers are not always presented with a coherent set of norms to which conformity is expected. Differentiation of the host society in terms of ethnic, social class, regional, occupational, or political subgroups results in a variety of norms to which immigrants are differentially exposed depending on the groups with which they come into contact.

By channeling newcomers into specific subgroups or locations, a pluralistically structured society allows immigrants to learn the norms of one group but remain ignorant of the norms of others or of those held in common by all members of the society. If that subgroup happens to consist of other immigrants from the same place of origin, the familiarity and intimacy may provide a positive cushioning effect for some period but separation from broader segments of the host society may intensify feelings of isolation or conflict (Mavreas and Bebbington 1989).

Styles of interpersonal relations are culturally constructed and often require a process of readjustment. For example, expected levels of intimacy among friends, relations with officials in bureaucratic settings, and styles of politeness vary widely from society to society and may require migrants to change many patterns of behavior. An immigrant from the Soviet Union stated the issue poignantly with regard to the expected level of intimacy in his new home in the United States.

> [In the Soviet Union] life is hopeless and dark. So the relationship among people, relations of the "soul", is very developed and this adorns (ykrashchaet) the life of the individual. In America a man is free but alone in his little corner. In Russia there is no freedom, so in order to escape the influence of the environment, people hide in groups of two or twenty or thirty people.... When life became unbearable we banded together in groups and such strong friendships developed in these groups and there was so much self-sacrifice that spiritual contact was stronger than in family relations. This was the natural defense of the soul against tyranny. This cannot be repeated in a free country.... Here life is too multi-faceted (mnogogranna), but that's the price you pay for freedom in the West... (quoted in Gitelman 1982: 215)

In considering the relation between stress and migration, it should be noted that in some cases coping resources and mechanisms that were effective in the

countries of origin are also effective in the new society; in other cases such resources are absent, reduced, or less effective in the new society. The transformation of prior coping mechanism to meet new needs or the development of alternative ones geared to address unfamiliar situations, takes time and skill. It may therefore be assumed that many immigrants are characterized by stress for varying periods of time (Antonovsky 1979; Shuval 1992).

Certain subgroups among immigrants are at a relatively high risk. These include persons migrating on their own, children and adolescents, especially those unaccompanied by adults, mentally handicapped, elderly, single parent families, large families. Women, especially pregnant women and those who have recently given birth, are especially vulnerable (Hattar-Pollara and Meleis 1995; Carballo et al. 1996). Refugees who have suffered major traumas before migrating and during the transition are a high-risk group. It has been shown that asylum-seekers report severe stress because of their fear of repatriation to threatening places, barriers to work and social services, separation from family, and the complicated, frustrating process of pursuing refugee claims (Clinton-Davis and Fassil 1992; Muecke 1992; Sinnerbrink et al. 1997).

Refugees and others who have suffered traumas or torture carry scars of persecution for undefined periods of time. These people cannot quickly slough off the impact of their earlier experiences, the effects of which may be immediate or may become visible at a later date. Among such persons, earlier, traumatic experiences have weakened their coping skills and the ensuing stress makes them more vulnerable than others to local diseases and new stressors. For example: there is some evidence in Israel that the traumatic impact of the Gulf War was greater on Holocaust survivors than on others, despite the fact that many years had passed since the World War II (Hantman et al. 1992; Shuval 1992).With regard to post-traumatic stress disorders, in some cases the passage of time makes the situation worse.

Migration and Health

The link between stress and migration, makes clear the potential for disease as an outcome of the migration process. While inability to cope with stressors can have many results, one of the most direct is somatization and psychological distress. Indirect results include a variety of behaviors characterized by health risks such as smoking, alcohol consumption, drug use, and eating disorders.

Minority status or marginality can be viewed as stressor situations. The health status and behavior of immigrant populations is expressed in patterns of disease, health behavior, and utilization of health care services. Furthermore the response of the health care system to special needs of immigrant populations needs to be considered.

One of the most useful conceptual frameworks for the study of the relationship of the acculturative process to mental health has been developed by Berry and his colleagues (Berry and Kim 1988; Williams and Berry 1991). They have noted the role of social support found by immigrants in the host society and the importance of socioeconomic variables; pre-migration variables such as

adaptive functioning (self-esteem, coping ability, psychiatric status), knowledge of the new language and culture and motives for the move (voluntary or involuntary); cognitive variables such as attitudes toward the acculturative process and future expectations. They have also emphasized the degree of tolerance and acceptance of cultural diversity in the host society. All of these variables are viewed as "buffers" in the reduction of acculturative stress.

Studies of psychological well-being among recently arrived immigrants from the former Soviet Union in Israel show them to be characterized by more symptoms of anxiety, depression, and somatization than a comparable sample of veterans. They also show higher rates of somatization on the above symptoms than a comparable group of immigrants to the United States, even though the latter reported a greater improvement in their standard of living than the Israeli immigrants. A similar pattern of somatization has been shown among Korean immigrants (Flaherty et al. 1988; Kohn et al. 1989; Lerner et al. 1992; Koh 1998).

Most countries that accept immigrants pose health criteria for admission. These range from exacting requirements to lax prerequisites and are in many cases checked at the point of origin to avoid the complications of deportation of those not qualified for admission. The principal purpose of health criteria for admission is to prevent the spread of infectious diseases in the host society and to avoid increased burdens on the health care and social welfare systems which could result from both infectious and chronic disease. However it is not always possible to maintain the full gamut of health standards for admission because of the proliferation of illegal entries as well as the legal and humanitarian difficulties of deportation (Massey et al. 1993; Teitelbaum and Weiner, eds., 1995).

Despite formal health criteria for admission, refugees, illegals, and diaspora immigrants may import infectious and chronic diseases that were endemic in their countries of origin. Upon arrival in refugee camps and in urban areas where migrants tend to be located, living conditions are often conducive to the spread of infectious diseases as a result of crowding, poor sanitary facilities, contaminated water and food, and malnutrition. These may cause a breakdown of the health services and result in epidemics as well as long-term effects on mental health. Societies which have in the past successfully eradicated such diseases as tuberculosis, malaria, and measles have found that these (and others) have been imported by immigrants and are in danger of spreading to the local population. The spread of AIDS as a result of migration is one of the most critical contemporary issues (Kalipeni and Oppong 1998).

The extent of importation of chronic diseases is determined in major part by the age of immigrants and by the quality of health care in the countries of origin. High proportions of older persons among the immigrants result in a high frequency of chronic diseases. When treatment facilities in the countries of origin were deficient or did not reach major segments of the population, immigrants bring with them a variety of health problems that were inadequately treated for prolonged periods before they left (Field 1990; Garbe and Garbe 1990; Rowland and Telyukov 1991; Ben-Noun 1994).

Styles of life and environmental conditions in the countries of origin play a role in the health status of immigrants causing health problems that may not be

evident at the time they arrive but emerge over time. Among these are dental practices and oral health. Widespread use of abortion and ignorance of other means of birth control pose health problems for women immigrants from countries where family planning practices were not generally known or practiced; if alternative methods are available in the host society, it takes time for women to become acquainted with them and learn the procedures to gain access (Sabatello 1995). Norms and behavior regarding alcohol consumption, smoking, and drug use are also imported when they were endemic in countries of origin but may be intensified in new, stress-ladened settings. This phenomenon has been reported among Cambodian refugee women (D'Avanzo 1994).

Illegal immigrants are a high-risk group with respect to health. In many cases they are not covered by the prevailing health insurance systems. Their precarious status in the host society prevents their seeking health care through publicly sponsored or even private agencies because of fear of deportation. Furthermore their location in deprived, poorly serviced, or slum areas increases the likelihood of infectious disease among them. Children of illegals are especially vulnerable if they are not formally registered and attending schools in the host society.

There are cases in which immigrants underutilize the health care system. This occurs when they are not covered by health insurance and the charges are beyond their reach. This can result in delay of care for acute problems or of use of the emergency services rather than the appropriate community services. Immigrant women have been found to be more likely than non-newcomers to have ill infants with a high risk for infectious diseases. Mental health services may be underutilized because of the stigma felt by some immigrants; in such cases rates of utilization do not accurately reflect the mental health status of immigrants (Zambrana et al. 1994; Guendelman et al. 1995; Noh and Avison 1996).

Some Policy Issues Regarding Migration and Health

If the health care system is to be geared to meet needs and identify at-risk groups, a full assessment of the health problems imported by newcomers is essential. In addition to basic demographic data, this involves background information with regard to health practices and health care in the countries of origin. Immigrants are vulnerable to endemic diseases to which the host population has developed immunity. They also include high-risk groups – e.g. the elderly, childbearing women, persons with a background of psychiatric problems, individuals previously exposed to environmental hazards such as Chernobyl.

High-level policy decisions are required so that the host society can realign its resources to deal with these problems. In societies where there is ambivalence or resentment with regard to the desirability of immigration, a sense of deprivation is likely to be felt in the veteran population because of competition for scarce resources, e.g. housing, jobs, health care. Xenophobia accompanied by overt violence has been seen recently (1999/2000) in Germany and in other European countries against such a background and can only be controlled by stringent, unambiguous law enforcement.

The prevailing dominance of the medical profession has resulted in a biomedical definition of the health problems of immigrants. The first concern of host countries is to protect their own population from imported diseases and epidemics. Health care providers are therefore most concerned to provide patients with physical assessment, diagnosis, and treatment. Preoccupation with disease has resulted in a *medical* definition of immigrants' problems. Failure to utilize a bio-psychosocial model (Engel 1977) has resulted in a focus on repair of parts of physical bodies rather than a concern with the whole person or attention to mental and emotional problems. There is concern with emergencies and immediate survival issues but little interest in long-term effects of migration or rehabilitation. Ongoing medicalization has transformed many immigrants and refugees into "patients."

The ethnic heterogeneity of immigrants raises issues of meaningful communication between health care providers and immigrant patients. Health care, both preventive and curative, inevitably involves ongoing interaction between providers and receivers. Cultural distance results in problems of verbalizing the nature of health problems, of describing and explaining symptoms so that the full meaning of the illness experience can be transmitted from client to provider. Experience indicates that the provider–recipient relationship in health care is a sensitive one which requires indepth understanding of the nuances and meaning of cultural symbols, traditions, and body language (Pliskin 1987). There is a danger of elitist assumptions by providers regarding the "appropriateness" of health behavior of groups stemming from different cultural origins and a tendency on the part of health practitioners to denigrate what may appear to them to be "primitive" behavior. Indeed the patient role differs from society to society and migrants may be unfamiliar with the norms and expectations of providers.

The universalistic, culture-blind approach of western medicine has prevented particularistic orientations to the needs of specific ethnic groups. However there is more and more evidence that equality is not equity and this approach has resulted in less effective treatment to newly arrived groups with cultural patterns that differ from those of the providers. Karmi and Horton (1993) report that the British National Health Service, realizing that a "color-blind" approach results in failure to meet the needs of major parts of a multicultural population, offers patients the option to indicate their ethnic origin when they contact the health care services in an effort to assign them to a provider who speaks their language and can relate to their needs. Similarly, in Australia major segments of the health care services are structured to include practitioners from ethnic origins that match those of their clients. Such structures permit health policy makers to monitor how services are provided for different immigrant groups so as to set priorities and policies accordingly (Lerner et al. 1992; Karmi and Horton 1993).

The more general policy issue relates to questions of separatism of the health care services along ethnic lines as contrasting to a universal service which includes outreach programs focusing on specific groups. The latter carries the latent function of reinforcing a sense of identity and belongingness by means of a universal health care system which services the entire population, immigrants and veterans alike; the former – while it may provide effective services – promotes a sense of social separatism among newly arrived immigrants.

In addition to its culture-blindness, biomedicine tends also to be gender-blind. This is expressed in an "obstetrical definition" of womens' needs – a focusing on reproductive roles and "women's diseases" and an ignoring of the impact of gender as a more general organizing principle of life. Needless to say, this issue is not limited to the migration context; however, since migration poses special problems with health implications for women, gender blindness blocks attention to a variety of gender linked needs exacerbated or generated by the migration process: e.g. vulnerability to torture and sexual exploitation, malnutrition, single motherhood, exploitative employment conditions and discriminatory pay. In the context of a biomedical model, these issues are not perceived to be directly relevant to health while in the context of a bio-psychological-social model of health their relevance is self-evident.

As noted above, within the immigrant populations there are millions of illegal immigrants in numerous countries and their health status poses critical policy issues. Governments have found it extremely difficult to control the entry and ongoing presence of illegal immigrants who are protected by other immigrants and by local employers who are interested in exploiting them at low wage standards. In their efforts to avoid the authorities many "illegals" live in socially isolated, slum conditions in crowded, sub-standard housing often lacking basic amenities and services, with minimal access to social or health benefits. Some come from countries in which serious health problems including AIDS are endemic. One of the means utilized by governments to control illegal immigrants is to deny them access to public services including health care. The moral and ethical issues involved in such policies are extremely serious.

Health care providers are often characterized by "health oriented ethnocentrism," i.e. a conviction that there is only one way to care for health and that their own way is the "correct" one. There is not always sufficient awareness that alternative practices may be functional in the immigrants' cultural context even though they are different from the ones defined as acceptable in the host society. What is more, many traditional health practices and behaviors show remarkable tenacity over time. These include food preferences, patterns of nutrition, response to and expressiveness with regard to pain, traditions of infant and child care, personal health behavior, reliance on traditional and home remedies, patterns of solidarity and social support among family members, levels of dependency, occupational and gender roles, and others. Differential use of contraceptives and family planning is associated with religious orthodoxy and level of education but also with ethnic origin. Health educators who have sought to change patterns which are viewed by them as unhealthy, have frequently met with resistance and lack of success largely because some of these patterns are rooted in meaningful traditional culture contexts that remain viable in the host society.

In conclusion, I would like to refer again to the work of Aaron Antonovsky who emphasized issues of *salutogenisis* (1979, 1987). Indeed much of the discussion above has been a "litany of lament" which has focused on problems and pathologies. Antonovsky has turned our attention to the remarkable *resilience* of most migrants and to the need to learn more about the sources of that resilience which tends to promote health. In societies which have been admitting

large numbers of immigrants in recent years, analysts cannot help but be struck by the ability of these newcomers to restructure their lives in a new social context and, despite losses and stressors, to show high levels of social competence and functional adequacy. Rather than focusing entirely on pathologies, we would do well to consider the social construction of the immigrants' reality in terms of the meanings they attribute to change and their ensuing capacity to transform social roles. Research to elucidate these issues would undoubtedly contribute to our understanding of the relationship between migration and health.

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