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The generational gap: Mental disorder prevalence and disability amongst first and second generation immigrants in Australia

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ABSTRACT

Despite unprecedented numbers of migrants internationally, little is known about the mental health needs of immigrant groups residing in common countries of resettlement. The majority of studies support the 'healthy migrant hypothesis', but few studies have examined: 1) shifts in prevalence patterns across generations; 2) how prevalence relates to disability in immigrant groups. Our study examined the prevalence of common mental disorders and disability in first and second generation migrants to Australia. Twelve-month and lifetime prevalence rates of affective, anxiety, and substance use disorders were obtained from the Australian National Survey of Mental Health and Wellbeing (N = 8841). First generation immigrants (born overseas) and second generation immigrants (both parents overseas) from non-English and English speaking backgrounds were compared to an Australian-born cohort. Disability was indexed by days out of role and the WHO Disability Assessment Schedule (WHODAS12). First generation immigrants with non-English speaking (1G-NE) backgrounds evidenced reduced prevalence of common mental disorders relative to the Australian-born population (adjusted odds ratio 0.5 [95% CI 0.38–0.66]). This lower prevalence was not observed in second generation immigrant cohorts. While overall levels of disability were equal between all groups ($p > 0.05$), mental health-related disability was elevated in the 1G-NE group relative to the Australian-born group ($p = 0.012$). The findings challenge the overarching notion of the "healthy migrant" and suggest a dissociation between reduced prevalence and elevated mental health-related disability amongst first generation immigrants with non-English speaking backgrounds. These findings highlight the heterogeneous psychiatric needs of first and second generation immigrants.

1. Introduction

One quarter of Australia's current population was born overseas, with this proportion expected to grow to over 30% by 2050 (Minas et al., 2013). A further 20% comprise a second generation immigrant group with at least one parent born outside Australia (Australian Bureau, 2012). Since Federation in 1901, Australia has adopted a healthy migrant program, particularly since 1945, where it expanded to include humanitarian entrants. The proportion of Australians born overseas from English speaking backgrounds (i.e. United Kingdom and New Zealand) has steadily declined from 79% in 1947 to 32% in 2006 (Phillips et al., 2010). At the same time, the diversity of migrants to Australia has increased. During the 1960s and 1970s, non-English speaking migrants were predominantly from Europe including Greece, Italy and Yugoslavia, as well as the Middle East (e.g. Lebanon). By 2006, the top 10 countries where Australians were born included four Asian countries - China, Vietnam, India and the Philippines (Phillips et al., 2010). Despite high multicultural constituencies, little is understood about the mental health needs of both first and second generation immigrant groups in Australia, as well as other countries of resettlement (Minas et al., 2013). This lack of evidence represents a major barrier to care, with migrants generally under-utilizing mental health services (Pole et al., 2008; Steel et al., 2005) due to poor access, high costs (Snowden and Yamada, 2005), and possibly misaligned service delivery models (Minas et al., 2013).

Epidemiological studies have demonstrated mixed findings regarding the prevalence of common mental disorders (CMDs) – encompassing affective (mood), anxiety and substance use disorders – amongst immigrants. Most studies support a pattern of reduced prevalence of CMDs across immigrant groups reflecting

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the 'healthy migrant hypothesis' (Alegria et al., 2008; Escobar et al., 2000; John et al., 2012; Liddell et al., 2013; Salas-Wright et al., 2014; Shrout et al., 1992; Steel et al., 2009b; Tan, 2014; Vega et al., 1998). The 'healthy migrant hypothesis' attributes lower prevalence rates to the notion that it is the most adjusted and healthy that elect to migrate and thus, are able to adapt well to their new cultural and social environment (Alati et al., 2003). In contrast, other studies support a 'migration-morbidity' model, with higher rates of CMDs amongst immigrant cohorts (Aichberger et al., 2010; Breslau et al., 2007; Missinne and Bracke, 2012; Sagara et al., 2013; Sieberer et al., 2012). Research also points to the importance of specific demographic factors and experiences in moderating these prevalence patterns. A number of these studies have found that pre-migration trauma and stress exposure (Leavey et al., 2007; Sagara et al., 2013; Steel et al., 2009a), as well as post-migration adversity (Sagara et al., 2013), including socioeconomic difficulties and discrimination (Missinne and Bracke, 2012), are major drivers of increased risk for depression in migrants. A U.S. study revealed that migrants with substantial language barriers showed elevated poor health, whereas migrants without such acculturation barriers showed similar levels of risk to the U.S. population (Ding and Hargraves, 2009). Indeed, John et al. (2012) found that fair to poor English language proficiency, as well as perceived discrimination and marital status, explained elevated rates of 12-month CMDs amongst first generation Asian American immigrants.

Research findings on the mental health of second generation immigrants to date are also mixed, with some studies suggesting that first generation immigrants are at reduced risk relative to the second generation (Alati et al., 2003; Harker, 2001; Salas-Wright et al., 2014; Takeuchi et al., 2007), whereas others report elevated prevalence of depression amongst female first and second generation immigrants from mixed backgrounds relative to the host country (Sieberer et al., 2012). The only study investigating second generation migrants in Australia focused on children, finding evidence of fewer externalising symptoms (e.g. behavioural problems including aggression) relative to children of Australian-born parents, but that these differences reached parity the longer migrant families resided in Australia (Alati et al., 2003). Furthermore, few studies have compared generations of migrants from different regions of origin. Salas-Wright et al., 2014 reported that overall, immigrants from European backgrounds evidenced higher rates of mood and anxiety disorders compared to immigrants from Asian and African backgrounds. They also found that immigrants from non-Caucasian backgrounds showed reduced risk for mood and anxiety disorders amongst both first and second generation cohorts (Salas-Wright et al., 2014). On the whole, these findings suggest mental health risk patterns amongst immigrants shift intergenerationally, which may to some extent, be attributed to acculturation processes (Katsiaficas et al., 2013).

Acculturation is defined as the behavioural, emotional and cognitive changes that occur when an individual bridges two cultural groups (Berry, 2003). It is a dynamic and complex process, dependent on cultural congruency, social context and levels of practical and emotional support. For example, language proficiency is one of the key behavioural changes underlying a cultural learning approach to acculturation, with compatible language and cultural skills improving acculturation outcomes (Schwartz et al., 2010). For the most part, acculturation is a challenging process, with advanced acculturative stress linked to poor adaptation – reflected in reduced psychological wellbeing and compromised sociocultural competence (Sam and Berry, 2010). A longitudinal study found that as acculturation stress increased over time amongst a young immigrant cohort, so too did symptoms of depression and anxiety – a pattern that was consistent between first and second generation migrants (Sirin et al., 2013a, b). While high levels of social support appears to moderate the impact of acculturative stress on depression and anxiety symptoms in general (Sirin et al., 2013a), other studies have found that first and second generation migrants may engage in different coping strategies to navigate acculturation challenges (Mena et al., 1987). This suggests processes by which first and second generation immigrants acculturate vary and are multifaceted (Rogers-Sirin et al., 2014). One important aspect of acculturation is in terms of cognitive changes in the perception and appraisal of emotional distress (Sam and Berry, 2010), and may also include assimilation to frameworks pertaining to reporting psychological distress (Rogers-Sirin et al., 2014). Previous psychiatric epidemiological studies with immigrant groups have emphasized various stages of the acculturation process as a potential key factor underpinning reported mental disorder prevalence rates (Salas-Wright et al., 2014; Steel et al., 2009b).

While most migrant studies have focused on prevalence to date, there is some evidence to suggest that there may be a dissociation between psychological symptoms and mental health-related disability amongst immigrant cohorts (John et al., 2012; Schrier et al., 2010). This distinction is important because, although CMD prevalence rates may be lower amongst immigrant groups in accordance with the healthy migrant effect, this might mask differences in mental health-related disability. To date however, no study has examined both prevalence and disability together when considering immigrant mental health.

This study therefore aimed to examine prevalence rates of CMDs and disability among first and second generation immigrants to Australia. We were also interested in the impact of language background on prevalence and disability patterns. Drawing on a nationally representative survey of mental health and wellbeing, we first examined estimated 12-month and lifetime prevalence rates of CMDs in first and second generation immigrant groups relative to the Australian-born population, adjusted for other known risk factors including gender, trauma exposure, socioeconomic status. The immigrant groups were further separated into those who immigrated from English and non-English speaking countries. We also tested whether time in Australia was associated with increased prevalence rates amongst first generation migrants. Second, we investigated whether group level and disorder-related functional impairment and disability differed between the immigrant groups.

2. Methods

2.1. Sample

Participants were drawn from the National Survey of Mental Health and Wellbeing (NSMHWB) conducted by the Australian Bureau of Statistics (ABS) in 2007. A full overview of the sampling methods is presented elsewhere (Slade et al., 2009). In brief, the survey followed a stratified, multistage strategy administered Australia-wide of persons aged 16–85 years. One respondent was randomly selected per dwelling sampled, weighted to the youngest and oldest household members. The response rate was 60%, consisting of 8, 841 respondents. Respondents provided informed written consent in accordance with ethics approval obtained by the ABS, and the authors obtained approval from the ABS to access the data in order to conduct the present study.

2.2. Immigrant group

Five groups were identified from the total sample to encompass both first- and second-generation immigrants, and an Australian-born cohort. The two first generation immigrant groups were both defined as being born outside Australia, with one group from a