Depression and Anxiety in Transnational Migrants – A Public Health Opportunity

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ABSTRACT

Transnational migrants often enter Germany and the United States to work. They revitalize aging populations and challenge cultural expectations. Mental illness plagues migrants, specifically anxiety and depression. Among all of Germany's migrants, Turks experience the highest degree of anxiety and depression symptoms, and demonstrate a higher likelihood for developing depression. Across the Atlantic, despite the "Hispanic Paradox," some studies declare that a majority of all Mexican migrants to the U.S. experience anxiety and depression. Researchers cite several possible causes for increased risk, including disrupted social support, poverty, discrimination, poor health care access, inadequate language skills, personality traits and cultural clashes. Myriad explanatory frameworks motivate patchwork responses. Both Germany and the U.S. marginalize and exclude, expel and segregate their migrants. This paper argues for integrative policy as a clear solution for both nations. While meeting human rights and public health imperatives, integration also reduces the negative impact of acculturation and ultimately lays a foundation for healthy social evolution.

Health, Environment & Education, 2013; 6, 32-41.

Introduction

The United States (U.S.) and Germany both warily eye an aging population. As the ranks of social security beneficiaries swell and birth rates of the native-born slow, transnational migration invigorates the population and economy by expanding a youthful and productive workforce. Programs to encourage newcomers often respond to migrants' economic motivations (Benson & O'Reilly, 2009; Haug, 2008). But, opportunities for gainful employment only provide an impetus, scarcely outlining the lives that will follow. Migrants offer a unique research opportunity to understand health consequences associated with location, ethnicity and culture, and the age-old migration process itself (Huijts & Kraaykamp, 2012; Oliver Razum, 2006).

The term 'migrant' embraces refugees, asylees, and their children born in new locations, voluntary entrepreneurs, forced sex workers, day laborers in agriculture and construction, the new medical workforce, students, and unauthorized or undocumented individuals. Yet, as a "psycho-social process of loss and change," transnational migration has profound effects on health (Carta, Bernal, Hardoy, & Haro-Abad, 2005). Seven losses in the migratory experience undergird a prolonged grieving process and concomitant chronic stress: "family and friends, language, culture, homeland, loss of status, loss of contact with the ethnic group, and exposure to physical risks" (Carta et al., 2005). Migrants generally perform fewer behaviors that contribute to disease (Razum & Samkange-Zeeb, 2008), but several common factors in the migration experience contribute to *Ulysses syndrome*, or chronic and multiple stress syndrome (Carta et al., 2005). Specifically, navigating new educational, financial, housing and health care institutions; 'wasting' their brains in menial and low-skill jobs that often fail to resemble professions for which they were trained; communicating illness to providers across language and belief systems; ethnic, racial and gendered discrimination; and past traumatic experiences may yolk today's migrants (Razum & Samkange-Zeeb, 2008). "Immigrants are an especially vulnerable group in Western, developed countries. Not only because diseases tend to be more prevalent in immigrant populations, but also because these populations show poorer therapeutic results for psychological and psychosomatic disorders and tend to face more barriers to access appropriate health care" (Franz et al., 2013).

American migrants overwhelmingly originate from Mexico. In Germany, behind the *Spätaussiedler*, or ethnically German 'resettlers,' Turks form the largest migrant group. These transnational migrants pose a complex public health dilemma. A so-called "paradox," Mexican migrants hold a mortality advantage over non-Hispanic whites, assumed to originate in the U.S. Similarly, Turkish migrants to Germany enjoy lower all-cause mortality rates than either Turks or German nationals (Oliver Razum, Zeeb, Akgün, & Yilmaz, 1998). Yet mental illness burdens both migrant groups (Carta et al., 2005).

Mental disorders rob the world of the most disability adjusted life years and cause the largest disease burden (Heinz & Kluge, 2012). This paper seeks to address four lines of inquiry into depression and anxiety among transnational migrants to the U.S. and Germany to lay a foundation for healthy public policy: What do migrants experience? What shapes these experiences? How have nations responded? Which approach best supports healthy social change?

Migrants' Mental Health

In the 1950s and 1960s, then 'West Germany' invited *Gastarbeiter*, guest workers, from Turkey. Assuming workers would stay temporarily, policies and practices tended to exclude newcomers from civic life. In the 1990s, with Germany reunited and the native-born population slowly waking to the idea that its 'guests' were actually neighbors, policies shifted to teach German, provide a road to citizenship, and tackle seemingly Turk-specific public health challenges, such as mental health.

Among all of Germany's migrants, Turks experience the highest degree of anxiety and depression symptoms, and demonstrate a higher likelihood for developing depression (Bermejo, Kriston, Hölzel, & Härter, 2012). Depression, a stigmatized condition in Germany, is significantly correlated with psychological distress, and somatic symptoms (Heredia Montesinos et al., 2012). Turk migrants report the lowest levels of satisfaction with life, compared to other migrant groups and native Germans (Nesterko, Braehler, Grande, & Glaesmer, 2012), and significantly lower personal control, treatment control, or coherence than German patients (Franz et al., 2013). Once diagnosed, they perceive that diagnosis reduces earning potential, perhaps because Turkish migrants make more annual visits to general practitioners, spend more days in the hospital per year, and take more days for disability per year (Franz et al., 2013; Glaesmer et al., 2011). Arab women name high levels of psychological stress as the most pressing community health problem (Irfaeya, Maxwell, & Krämer, 2008). They identify loneliness, communication difficulties, low levels of cultural adaptation and family problems as stressors related to depression. Tellingly the women believe "their lives as migrants" exacerbated or started the symptoms (Irfaeya et al., 2008).

Subgroups experience gender-, age-, and region-specific trials that impact health. For example, Turkish women experience high levels of emotional distress, especially when unemployed (Aichberger et al., 2012). In fact, though all Turks are more at risk for suicide attempts, combining young age, foreign-born status and feminine gender identity increases the risk threefold (Grube, 2004). Social support from an intimate relationship and higher SES seem to mediate emotional distress for women (Aichberger et al., 2012).

Those over age 45 have a higher relative risk for chronic illness and predictors of mental illness (Kotwal, 2010; Wengler, 2011). The elderly, often first-generation *Gastarbeiter* in former West Germany, report more feelings of emptiness, a predictor for depression, and assess themselves in poor health (Kotwal, 2010; Wengler, 2011). They also report higher levels of loneliness than elderly German peers (Fokkema & Naderi, 2013).

Across the Atlantic, at least 500,000 people migrate from Mexico the United States each year (Familiar, Borges, Orozco, & Medina-Mora, 2011). Mexicans comprise most of the nation's foreign-born residents, comprising roughly two-thirds of Latinos from over 40 Hispanophone countries (Valencia-Garcia, Simoni, Alegría, & Takeuchi, 2012). "Whereas some areas of the country such as California, Texas and Arizona have had a substantial Latino population (predominantly Mexican) long before there was an Anglo population, the growth of the Latino population in other parts of the country, such as the Upper Midwest and the Southeast, is a phenomenon of the 1990s" (Grzywacz et al., 2006).

Both Mexican migrants to the U.S. and Turkish migrants to Germany experience a "complexity and multiplicity of factors that affect migrant workers' living conditions and social environment" such as poor working conditions and low pay, crowded housing, unsafe neighborhoods, unequal health care treatment, and racial discrimination (Alderete, Vega, Kolody, & Aguilar-Gaxiola, 2000; Flores et al., 2008). Yet epidemiologic data does not reveal parallel responses. After accounting for age, gender and socioeconomic status (SES), Mexican-born migrants are less likely to experience depression or post-traumatic stress disorder than U.S.-born Mexican-Americans or non-Hispanic

white Americans (Alderete et al., 2000; Alegría et al., 2008; Escobar, Nervi, & Gara, 2000). Called the "Hispanic Paradox," the effect does not hold for all ethnic groups categorized as 'Hispanic.' Rather, strong health outcomes despite individual and structural barriers may be more appropriately labeled a 'Mexican-origin protective effect.'

Mexican migrants experience relatively low rates of psychiatric disorders. However, depression, anxiety and co-occurring mental illness impact upwards of 40 percent of migrant workers (Crain et al., 2012; Grzywacz et al., 2006). Roughly half of Mexican migrant farmworkers "could be classified as having clinically meaningful depressive symptoms," and reported caseness for mild, moderate or severe anxiety (Crain et al., 2012; Hiott, Grzywacz, Davis, Quandt, & Arcury, 2008). A majority of migrants report at least one experience with *nervios*, *coraje* or *susto*, three "culture-bound" distress syndromes that correspond to depression (Donlan & Lee, 2010). Another study declares "migrants were at a higher risk for depressive disorders, inclusive of major depression and dysthymia, GAD, and social phobia" (Breslau et al., 2011).

Age of arrival may predict depression and anxiety among Mexican migrants: "An increase in risk of suicide-related outcomes occurred exclusively among migrants who arrived in the United States as children (i.e., prior to age 13 years)" (Borges et al., 2009). Overall, suicide ideation, plans and attempts are more prevalent among Mexican migrants installed in the U.S. before age 13 (Borges et al., 2009). "There is evidence of negative mental health selection, that is, that individuals who migrate have less favorable childhood mental health profiles than individuals who do not migrate" (Breslau et al., 2011).

Duration of stay is also an important predictor. Recent migrants to the U.S. born in Mexico show lower prevalence rates for psychiatric disorders than those who have spent several years in the States, while the most acculturated show the worst rates of mental illness (Escobar et al., 2000). Stays of at least four years significantly increase the risk for depressive symptoms compared to those who never enter the U.S. (Familiar et al., 2011). Mexican migrants are more likely to have any disorder than Cuban and 'other Latinos' (from Colombia, Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua and Peru), but are less likely to demonstrate disorders than Puerto Ricans (Alegría et al., 2008). In fact, both Puerto Rican and Mexican migrants are more likely to spend over 70% of their lives in the U.S., while Cubans are likely to spend 30% or less of their lives in country. Acculturation threatens migrants' mental health, and is specifically linked to higher rates of phobias, antisocial behaviors, drug use and abuse, and alcohol abuse and dependence.

In fact, substance disorders represent the largest depression-related discrepancy. Mexico-U.S. migration is associated with escalating use and abuse of alcohol or hard drugs (Alderete et al., 2000; Alegría et al., 2008; Escobar et al., 2000). One study finds a risk of alcohol dependence over 50% higher for Mexicans with depressive symptomology or anxiety (Familiar et al., 2011). Another names substance abuse a significant predictor for worse mental health functioning (Farley, Galves, Dickinson, & Perez, 2005). There is some evidence that U.S. residency introduces the concept of substance use as a coping strategy (Farley et al., 2005). The 'buzz' is short-lived: more than one in three who turn to this coping mechanism become dependent (Hiott et al., 2008).

Explanatory Frameworks

Limited to data from mostly cross-sectional studies of modest sample size, the underlying causes for migrants' high rates of anxiety and depression are poorly understood. Qualitative research with mental health care providers across Europe pinpoints language and culture, obstacles to trust and increased risk of marginalization as three salient obstacles to providing quality care (Sandhu et al., 2013). Epidemiologic data supports a variety of speculations.

General facility with the host nation's main language, and health literacy may lend meaning to differences in healthcare utilization (Bermejo, Hölzel, Kriston, & Härter, 2012; Glaesmer et al., 2011). Language barriers also lead to reduced access and quality in care due to "longer visit time per clinic visit, less frequent clinic visits, less understanding of physician's explanation, more lab tests, more emergency room visits, less follow-up, and less satisfaction with health services" (Lindert, Schouler-Ocak, Heinz, & Priebe, 2008). At least one study corroborates the concern that Turkish migrants lack adequate German skills or health knowledge to understand during inpatient hospital stays (David, Borde, & Kentenich, 2000; Giese, Uyar, Uslucan, Becker, & Henning, 2013). Turks "have lower self-rated German language skills, a reduced comprehension of medical information and show a greater uncertainty in the face of medical procedures" that require consent (Giese et al., 2013). Further, "Lower probability of medical referral, frequent involvement of the police and emergency services and high proportions of compulsory and secure-unit

admissions" impede migrants' attempts to navigate a new health care system (Lindert et al., 2008).

Some see Turkish migrants' disproportionate mental health burden as a consequence of confrontations between 'Eastern collectivist' "cultural peculiarities," such as a preference for home remedies, (Bermejo, Hölzel, et al., 2012) and 'Western individualist' perspectives (Arens, Balkir, & Barnow, 2011; Irfaeya et al., 2008). "Different cultural or traditional ways of life […] may lead to differences in health-related habits" and the distribution of risk factors (Spallek, Zeeb, & Razum, 2010). Proponents see role strain at the heart of epidemiologic imbalances: "The impact of socioeconomic hardship appears to be complicated by social roles and the expectations related to them" (Aichberger et al., 2012). In Germany, researchers posit that Turkish women, faced with expectations to nurture, experience gender role strain when they follow the 'German model' – pursuing lives without intimate relationships, and based on independent income.

Cultural explanations also abound for the protective effect of Mexican origin, such as lower levels of demoralization. Experiencing relative deprivation and inequality in Mexico may lead migrants to attend less to low status, low income and discrimination upon arrival to the U.S. (Alegría et al., 2008). Likewise, fatalist and resigned attitudes to negative outcomes may prevent migrants from internalizing social injustice, low opportunities or hardship as personal failure. Others claim that fatalism is not a cultural proclivity, but a typical migrant's response to reduced access to care (Razum & Samkange-Zeeb, 2008). More likely to use denial and religion to cope, "In general, Mexican immigrants seem to process stress in more beneficial ways than do non-Hispanic whites" (Farley et al., 2005). However, teaching new problem-focused coping and self-efficacy helps farmworkers address chronic stressors and prevents the onset of mental illness: a one-unit increase in self-efficacy reduced the odds of anxiety by eleven percent (Crain et al., 2012).

Others note the centrality of family in Mexican and Turkish culture as an underlying factor (Grzywacz et al., 2006; Vardar, Kluge, & Penka, 2012). Social networks may buffer and socially insulate from discrimination. Proximity to family may decrease intergenerational conflict, sustain a sense of belonging, and reduce isolation (Alegría et al., 2008). In contrast, the tension created by leaving a "cultural context that emphasizes familism" for gainful employment may be at the heart of Mexican migrants' mental health woes (Grzywacz et al., 2006). Men who hold contradictory feelings about family and economic responsibilities, sensing each duty pull them to opposite sides of the Mexico-U.S. border, exhibit higher levels of anxiety. Left unresolved, "post immigration adjustment" may persist and compound in a "lifetime cumulative disadvantage" for depression in migrants over age 75 (Gerst, Al-Ghatrif, Beard, Samper-Ternent, & Markides, 2010). Whether a protective or risk factor, family is consistently and strongly associated with migrants' mental health.

Indeed, Mexico-based families of migrants display higher risk for anxiety and depressive symptoms (Familiar et al., 2011) and more suicidal behavior than families with no history of migration (Borges et al., 2009). As with the migrants themselves, longer stays predict higher risk, and families with phone contact at least once per week are more likely to report depressive and anxiety symptoms than families with infrequent contact (Familiar et al., 2011). Widowed, divorced and separated people in Mexico-based families with a migrant member are more at risk for both depression and anxiety, while married people are more at risk for anxiety (Familiar et al., 2011).

Mental illness related to migration may ripple through social networks (Borges et al., 2009). With migrants more likely to be male, and relatives in Mexico more likely to be female, transmission may follow gender roles; women are more likely to report depression-related conditions such as *susto*, *nervios* and *coraje* (Donlan & Lee, 2010), which may reveal expectations about gendered acceptability of mental illness (Flores et al., 2008). Perhaps, like Turkish women, Mexican women experience role strain, taking on tasks and responsibilities typically assigned to absent migrant family members. Stress may influence women more acutely: "women who reported higher levels of stress were more depressed than women or men with low stress levels, and men with high stress levels showed moderate levels of depression" (Flores et al., 2008). Grzywacz et al. (2006) eloquently state: "Contradictory social forces […] push men to migrate for the benefit of their families yet require men to remain because their departure will compromise their families' well-being [and therefore] contribute to psychological tension among those who must resolve the social contradiction." Whether men or women, these problem-solvers take on stress, and become susceptible to depression and anxiety.

Several ideas undermine 'culture' as an explanation for differential health outcomes. First, using "culture" as a proxy for 'ethnic difference' can ultimately stigmatize and exclude (Heinz & Kluge, 2012). For instance, many think Mediterranean people are more likely to somatize distress. This position "can lead to

misunderstandings, misdiagnosis, and finally –again– stigmatization. Also these dynamics may lead to poor treatment and lack of acceptance of the treatment interventions" (Heredia Montesinos et al., 2012). Second, assuming that cultural differences underlie health issues, assimilation appears to be a desirable process. But in Europe and the U.S., "acculturated individuals are more likely to be depressed" (cited in Lindert et al., 2008). Additionally, culturally-specific conceptions of distress, *coraje*, *susto* and *nervios*, reliably correspond with Western biomedical interpretations of depression (Donlan & Lee, 2010). Thus, although patients and providers do not always use the same language, they often name the same phenomena (Vardar et al., 2012). Finally, cultures evolve, especially because "immigrants are often highly motivated and open-minded concerning changes, e.g. to adapt to a changed life situation" (Spallek et al., 2010).

Individual personality traits may better explain how mental illness is mediated. The 'big five' elements of current personality research include "openness to experience, conscientiousness, extraversion, agreeableness, and neuroticism" (Franz et al., 2013). In particular, neuroticism more accurately predicts depressive symptoms in late life than health or social factors, and is more often found in Turkish migrants (Franz et al., 2013; Steunenberg, Beekman, Deeg, & Kerkhof, 2006). In addition, as a celebrated personality trait in Germany's individualistic culture, extraverted Turks may have more hardy social relationships and social support (Bromand et al., 2012). A focus on personality traits allows providers to tailor treatments to emotional and cognitive dimensions. To avoid "the cultural trap," providers should use open-ended questions to discuss symptoms, causes, and avenues for treatment with a patient's language (Vardar et al., 2012). Another set of researchers advise: "individual treatment of the person seeking help regardless of the cultural background and assumptions about culture-specific characteristics is an eminent part of professional attitudes towards all patients" (Heredia Montesinos et al., 2012).

Both Mexican and Turkish migrants appear to "regress to the mean" state of mental health in the destination country. "Contexts and lifestyles unique to the United States appear to result in higher rates of psychiatric disorders" (Alegría et al., 2008). Specifically, U.S.-born white participants report higher rates of disorders compared to white or Latino migrants, including major depressive episode, dysthymia, any depressive disorder, generalized anxiety disorder, social phobia, posttraumatic stress disorder, any anxiety disorder, alcohol dependence, any substance disorder, and any disorder" (Alegría et al., 2008). Moreover, after arrival "migrants are at higher risk than Mexicans who did not migrate, even after accounting for selection factors. Individuals of Mexican origin, whether born in Mexico or the United States, who spend their childhood in the United States are at roughly equally high levels of lifetime risk as the general U.S.-born population" (Breslau et al., 2011). About 27% of adults in Turkey have depression or anxiety, and more than one in four Turkish migrants in Germany is symptomatic. But second-generation Turks often report fewer feelings of emptiness, and reflect prevalence rates more like ethnic Germans (Bilgel, 2008; Karaçam & Ançel, 2009; Kotwal, 2010; Toros et al., 2004).

Finally, marginalization may underlie poor mental health among transnational migrants. Lindert and colleagues (2008) assert, "Structural racism and anti-immigrant practices determine […] the poor working conditions, living conditions, and health of migrants." Marginalization is also intimately tied to poverty; Devicienti and Poggi (2011) contend that poverty and social exclusion are "mutually reinforcing," inseparable. Data suggests that structural exclusion traps many Turks: poor education tends to result in unemployment, low earning potential and low SES. When combined with cultural isolation and poor social support, many aspects of the typical migration experience are associated with more psychiatric diagnoses (Franz et al., 2013; Kotwal, 2010). After controlling for stress, age, gender, SES and acculturation, Mexican migrants' perceptions of discrimination are significantly related to elevated depression (Flores et al., 2008).

Capitalist motivation contributes to marginalization. With care organized around reimbursement, physicians have an economic interest to serve patients they perceive as relatively wealthier; assumptions about migrant patients' status may mean lower quality care (Glaesmer et al., 2011). Joined with poor health literacy, "women who cannot adequately express their complaints and symptoms to the health personnel receive less attention or are discriminated against" (Irfaeya et al., 2008). Normative values and rhetoric also exclude. Both Germany and the United States currently seek to identify and authorize 'qualified' migrants to fulfill specific professional roles and act out the 'right' ethics. For example, Germany's priority citizenship for *Spätaussiedler* devalues guest workers and the former East German contract workers from 'brother nations,' 1990s-era Balkan refugees, or European Union members seeking economic security.

U.S. Congressional fear of political backlash around "immigration reform" stalls more than activism against drone warfare, growing national debt, or new abortion policy. Narrow definitions of a 'deserving' migrant, and ethno-specific, nationalist conceptions of identity clash with the reality of globalization, inspiring easily exploited "diasporic ghettoes" (Cohen & Sirkeci, 2005).

Responses

Transnational migration forces healthcare systems to evolve: "intergroup contact can lead to genocide, assimilation, segregation and integration" (Bhugra, 2003). Fear of change and difference is a powerful motivation. Healthcare providers plagued with the idea of an 'ideal' patient respond with dehumanization: "I do veterinary medicine with these people" (Sandhu et al., 2013). For psychologists and psychiatrists, sinking without the buoy of a shared language to discuss mental health experiences or treatment, *Tarçanka*, "Tarzan German" or "silent medicine" remedies "problem patients" (Castañeda, 2012). Fear of 'exotic' infectious diseases in "defective classes" also leads to legislation demanding screening, and selective restrictions on migration (Escobar et al., 2000; Spallek et al., 2010).

Another approach relies on punishment. Germany's Residence Act § 87.2 outlines a penalty of up to five years imprisonment for "assisting" illegal persons and failing to report them for seeking public services (Castañeda, 2012). Medical staff is not pursued for providing "humanitarian" services in "emergency" situations, yet "the Social Services Office that handles reimbursements is still required by the § 87.2 law to relay information to the Foreigner's Office, leading to arrest and deportation" (Castañeda, 2012). For addicts, uncertainty, pressures and inconsistent application of drug and migration laws around deportation have been linked to reduced access to treatment (Hoffman, 2006).

With a slipshod health insurance market, access to physicians and preventive medicine is spotty for many migrants to the U.S. too, especially unauthorized residents. As in Germany, the undocumented often replace primary care with emergency room (ER) services. Neither U.S. migrant patients nor providers expect that seeking or proffering care will lead to deportation. However, many lament migrants' "overutilization" of the ER, care that is often under-reimbursed with federal funds. Targeting the undocumented and indigent, states legally redefine "emergency" to narrow care. The Patient Protection and Affordable Care Act, or "Obamacare," explicitly denies the unauthorized access to state health exchanges, and continues to bar them from public health insurance programs. Most documented migrants anticipate a years-long wait for eligibility for public services.

In both Germany and the U.S., "separate but equal" economies deal with segregation. *Bodega clinicas* in California serve "a vast number of uninsured Latino residents" with cash-only services, often meeting limited needs (Varney, 2013). In urban centers throughout Germany, volunteer doctors informally confer mirrored services (Castañeda, 2012). Health officials have difficulty determining whether the care provided is competent, adequate or comparable to services available in more regulated businesses (Castañeda, 2012; Varney, 2013). In fact, despite exclusionary federal policies, even state employees are compelled to provide care and expand access. In Germany, *humanitäre Sprechstunde*, humanitarian office hours in public health departments, clandestinely welcome the uninsured. Federally qualified health centers in the U.S. attract a similar population, providing care without demanding identifying documentation or immediate reimbursement.

Adequate health care is a human rights issue, a public health imperative, and an economic investment (Rousseau et al., 2009). Marginalizing policies place a greater burden on taxpayers, emotionally stress care providers, and threaten the health of migrants. Since transnational migration is rapidly becoming one possible step along the journey to self-realization, each nation must move from an *Überfremdung*, or 'over-foreignization,' reactionary mindset to pragmatic and responsive policies. Integrative policy means innovating public health services to meet the needs of changing populations and returning to the foundational concept behind the 'American Dream' or "first world paradise" – migrant status need not damn subsequent generations into a life of poverty and illness.

A policy of integration calls for practitioners and patients alike to practice "diversity management," or "continuous consideration (mainstreaming) of diversity" (Spallek et al., 2010). That means acute consciousness of social roles, the aspects of intersected identities that carry privilege, and strategies for upsetting expectations without threatening each other's wellbeing. In research, integrative policy demands attention to new variables beyond race and ethnicity, gender, age, duration of residency, and facility with language skills. These categories reflect values important to dominant groups in Germany and the U.S., and are nearly always situated within one person. New epidemiologic inquiry should explore larger units of study, and especially social networks. For both

Mexicans and Turks, family ties and social support emerge as constant themes correlated with mental health. New technology to map social networks may be better suited to determining the causal pathways that contribute to mental illness and wellness in these groups. Two studies provide a model: the first investigated the impact of migration on family units (Familiar et al., 2011), while the second explored the impact of family units on mental health both before and after migration (Grzywacz et al., 2006). Healthy public policy will create new frameworks for programs that explicitly seek to establish social capital and maximize beneficial relationships.

An integrative framework embraces collaboration as inherently valuable, as well as a strategy for issues at many levels in the socioecologic model. Treatment must be coupled with prevention, biomedical responses with spiritual ones. Although individual mental health care providers were eager to fashion 'practical solutions,' "the application of simple solutions at the service provider level alone might not be enough to tackle these challenges" (Sandhu et al., 2013). Social support at the individual level can be mirrored in institutional cohesion. European mental health providers offer system-wide responses to overcome marginalization (Sandhu et al., 2013). A Spanish provider articulates, "The practitioner should collaborate with social services in order to link the patient to a social network" (Sandhu et al., 2013). A Polish practitioner asserts, "If this person came to the country without her family, lack of social support would be a serious problem. We should try to provide a substitute for such support—encouraging involvement of social services or people from her neighbourhood or community" (Sandhu et al., 2013).

Proponents of a cultural explanation for migrant health inequity advocate for ethno-specific training of medical and emergency personnel, and support Germany's substantive shifts in nursing curricula, as well as the use of interpreters (Castañeda, 2012). They also encourage validation of diagnostic tools in a variety of languages and cultural groups (Lindert et al., 2008). Literacy and health literacy initiatives address the cultural viewpoint, as well. For instance, in the education arena, Germany has realized that teaching the native *Deutsch* to migrants grounds successful social integration; the 'Dream Act' has opened higher educational institutions on a state-by-state basis to undocumented youth in the U.S.

Because "social isolation may have greater potential effect on anxiety symptoms," community health workers may also "solve the problem of lower access of immigrants due to language or cultural barriers" (Spallek et al., 2010). Hannover's Ethno-Medical Centre and a health insurance company developed "*Mit Migranten für Migranten*" ("With Migrants for Migrants"). Workers organize informational events and recruit based on a shared cultural background. *Promotoras de salud*, or hispanophone community health workers, have also been gaining widespread popularity in the States. These programs strengthen migrant communities and networks (Hiott et al., 2008). As advocates for "coherent [and] responsive communities," *promotoras* act as a bridge to the medical institution, positively impacting "health behavior and/or health status" (Ayala, Vaz, Earp, Elder, & Cherrington, 2010). These health workers are often trained community members, so migrants trust them to play the role of liaison and report positive rapport with *promotoras* trained to help screen and guide treatment for depression (Waitzkin et al., 2011). When the same principles of integration are codified in state policy, improved access leads to better health outcomes. Utah's driver privilege card and San Francisco's identity card spur local leaders to reconsider how to better include migrant populations (City and County of San Francisco; Korinek & Smith, 2011; Marrow, 2012).

Transnational migration requires Germany and the U.S. to rethink social capital, looking beyond individuals and old borders. Benjamin (2009) paints a picture of a "post-nationalist" society, in which "political outlook, personal affinities, and cultural tastes are no more aligned with another American's than, say, a Spaniard's or a Singaporean's." If indeed part of the United States' – and Germany's – "comparative advantage […] is being able to weather both globalization and aging," it behooves each nation to "safeguard a cosmopolitan outlook" (Benjamin, 2009). Integrative policy makes 'allies,' 'networks' and 'resources' synonymous, with residents holding close national allegiance yet 'protecting our common security and advancing our common humanity,' as Obama called for in his 2008 Berlin speech (Benjamin, 2009).

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