



VIEWPOINT

Life training for aging and migration

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Abstract

Immigrants tend to have better mental health than their host country-born counterparts, despite disadvantaged socio-economic status—the so-called immigrant paradox. The acculturation hypothesis suggests a decline in their mental health over time in the host country. Increased perceived discrimination and family cultural conflict are pathways by which acculturation might relate to deterioration of mental health for immigrants. In this paper we will present an intervention approach, which proposes that a strategy for ensuring maintenance of mental health for immigrants is changing lifestyle. This approach called “Life Training: My 7 Core Areas of Health” is based on the theoretical model of Ralf Schwarzer—The Health Action Process Approach and works on psychological processes that are under behavioral change in seven areas of health: physical, psychological, social, spiritual, financial, family and leisure. This is a discussion paper in which two claims are made. First, that some migrants’ health can worsen as they age which is associated with their migrant status. Second, that there may be, as yet untested in this respect, models of health behavioral change, which can mitigate these risks.

Keywords: Immigrants, Mental health, Aging, Life training, Health behavior change, Health action process approach.

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Citation: Gonçalves et al. Life training for aging and migration. International
Journal of Clinical Neurosciences and Mental Health 2016; 3:7

DOI: <https://doi.org/10.21035/ijcnmh.2016.3.7>

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Received: 14 Nov 2016; Accepted: 16 Dec 2016; Published: 26 Dec 2016



Open Access Publication Available at <http://ijcnmh.arc-publishing.org>

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Introduction

Having in mind that studies on immigrants might focus on different ethnic groups in different countries and that immigrants are a very diverse group from different cultural backgrounds, place of origin and host country, let us concentrate in this paper on Portuguese immigrants within Europe (e.g. France, Belgium, Germany and Switzerland and Luxembourg), as are the ones we are more connected with.

One of the reasons Portuguese immigrants leave their country of origin towards a new country is because they are in search of better conditions. When they arrive at the host country, many hope to return home one day. Though in pre-retirement stage, their intention tends to be related with the location of offspring. Within Europe, after retirement, even when Portuguese immigrants return to their home country, they tend to travel back to the host country to use the host country healthcare and social system, the so called mobile or back and forth strategy. For example, in a study in France, De Couloun and Wolf [1] found among pre-retirement immigrants that their preferred intention after retirement was to return to their country of origin rather than stay in the host country when their children live in the country of origin.

When they reach the age of 50–60 years old, the pre-retired period, many of them suffer from anxiety and depression [2], consequence of increased perceived discrimination and family cultural conflict, fact that suggests the need of prevention interventions for immigrants during integration [3], as it will be discussed further in this paper. Though from the direct contact with different stakeholders that offer Portuguese immigrants different services, we know that older members of Portuguese immigrant communities are hard to motivate. For example, in interactions we had with stakeholders working with older adult immigrants we were confronted with this example: Immigrant retired people asked for a course to finally learn the host country language but when provided—even considering it was aimed at people with less school attendance—no one showed up with excuses of lack of time or going to home country for holidays. According to these stakeholders the most successful programs with these immigrants are organized walks or parties with meal. At the same time retired people from the host country express not wanting to mix in senior clubs with immigrants due to different social class.

Immigrant paradox, acculturation hypothesis & salmon bias hypothesis

The “immigrant paradox” states that immigrants, despite their disadvantaged socioeconomic status, have better mental health than their host country-born counterparts [4]. Studies testing the “acculturation hypothesis” suggest that the longer the immigrant stays in the host country, the more their mental health declines [3, 5]. Studies testing the “salmon bias hypothesis” [6] demonstrate that im-

migrants who fall ill may desire to return to their home country to be in the company of their families. Cook et al. [3] concluded that increased perceived discrimination and family cultural conflict seem to play a significant role in the association between time in the host country and the likelihood of developing psychiatric disorders. These results can be explained by the increasing evidence [5] that differences in contextual and interpersonal circumstances (acculturation/assimilation/social feedback) account for the immigrant paradox and not nativity alone. The immigrant paradox might explain on the one hand immigrant groups’ desire to maintain their cultural heritage [7] as a way to buffer against potentially negative effects that assimilation can have on their mental health. The decline in mental health over time in the host country might imply that interventions are needed for immigrants during their integration process to preserve these buffers, and prevent discrimination and family erosion [3]. Foreign nativity and family factors (e.g. family harmony) seem to be protective only for some immigrants [8]. Some here relate to the US study referred, which found for Mexicans but not for Puerto Ricans. The longer immigrants remain in their country of origin, the less cumulative risk of psychiatric disorders [8]. Risk of psychiatric disorders is the result of differences in immigrants’ length of residence in the host country and age at arrival. Immigrants compared to their host country-born counterparts may have on the one hand a higher intergenerational conflict [9] as they try to combine the traditional values, beliefs and socialization practices of their home country with the ones of the host country [10]. On the other hand, immigrants compared to their host country-born counterparts may have higher emotional distress and increased acculturative stress due to higher social stress and less quality of life due to low citizenship status, low skills acquisition (e.g. host country language) and low peer network/social support, less safe neighborhood, and associated racial/ethnic-based discrimination. Considering the one paradox and the two hypotheses discussed before, in this paper we will present an intervention approach, which proposes that a strategy for ensuring maintenance of mental health for immigrants is changing lifestyle based on the The Health Action Process Approach of Ralf Schwarzer.

The Health Action Process Approach

The Health Action Process Approach [11] is a model originally developed in the late 80s by the integration of several theories and its application to health behavior change. These theories are the social-cognitive theory [12], the theory of reasoned action [13], and the volition theories of Heckhausen, Gollwitzer, and Kuhl [14, 15]. The Health Action Process Approach, which has been supported by empirical evidence [16–20], includes mediators post-intention to overcome the gap between intention and behavior. The Health Action Process Approach distinguishes be-

tween the first stage of pre-intention motivation processes and the second stage of post-intention volition processes.

The first stage of pre-intention motivation processes includes risk perception, positive outcome expectancies and perceived self-efficacy. The second stage of post-intention volition processes includes task self-efficacy, maintenance self-efficacy and recovery self-efficacy as well as action planning and coping planning [21]. The stage of pre-intention motivation process is to generate a motivation, i.e. an intention to change behavior. This first stage is related to risk perception and perceived self-efficacy. Risk perception is the awareness of one's own risk in respect of certain problem or the degree of symptoms experienced. Perceived self-efficacy is the conviction one can perform certain behaviors despite anticipated hurdles. The stage of post-intention volition process is to plan behavioral change even when obstacles arise. This second stage is related to action and coping planning. Action planning are the concrete conditions when, where and how the target behavior is to be implemented. Coping planning are strategies to master efficiently possible hurdles and anticipated difficulties. According to Wiederman et al. [22] interventions should target intentions as precondition or in combination with planning, as action planning mediates between intentions and health behaviors when people hold sufficient levels of intentions. Intentions moderate the planning-behaviour relation, as people with high intentions are more likely to enact their plans.

The Health Action Process Approach could particularly help immigrants improve their mental health situations by improving their quality of life and well-being by helping them stepwise changing their lifestyle. Therefore we will next present an intervention approach, which proposes that a strategy for ensuring maintenance of mental health for immigrants is changing lifestyle based on The Health Action Process Approach. We did not find any intervention using the Health Action Process Approach with older adult immigrants. The closest intervention we found was a recent community-based participatory approach intervention program of Zhou et al. [23] to increase targeted behaviors to enhance family relationships, which also derived materials and exercises from the Health Action Process Approach.

Life Training: My 7 Core Areas of Health

For the World Health Organization [24] active aging means a process that implies autonomy and control, independence, quality of life and healthy life expectancy from a bio-psychosocial perspective being determined not only by the individual (e.g. characteristics, behavior), but also by the family (e.g. social support) and by the society, which the individual belongs to (e.g. economy, health and social services): “the process of optimizing opportunities for health, social participation and security in order to enhance the quality of life during aging”.

Therefore we assume that in order to promote their health immigrants whose entire life project revolved around the home and work need to change their concept of retirement from overprotection and passivity to active and participative aging and social or familial commitments through interventions to prevent perceived discrimination and family cultural conflict [3]. Retirement for them may bring passivity and reluctance to engage in social activities outside of their routine. They may need to learn new techniques in the post-retirement period related to how to be useful in family, neighborhood and society, to take advantage of technology and to reorganize and relearn. At the same time, most cultures demonstrate nowadays a strong ageism, discrimination against age [25]. A new intergenerational learning paradigm with reciprocal benefits [26] and intergenerativity [27] is urgently needed.

Regarding immigrant families, children are expected to assist their parents more than would have been true in their country of origin due to their higher cultural competency in the host country. This dependency can potentiate ambivalence and conflict, leading to less active support of elders and a poorer prognosis for intergenerational learning [9, 10]. Albert et. al. [9] found an acculturation gap in Portuguese mother-daughter dyads regarding obligations toward the family.

The cultural change of aging as positive, as well as of the new intergenerational paradigm with reciprocal gains [26] can benefit not only immigrants from different generations but also the host and the home countries.

Based on the The Health Action Process Approach of Ralf Schwarzer, the Life Training Approach: My 7 core areas of health can help immigrants to decrease potential fears and comfort zone barrier, isolation, impulsivity and aggression. It can also help them to increase initiative, time and decision management, assertiveness and functionality of social support network. Finally by working on psychological processes that are under behavioral change, it can lower, consequently, health and social care costs for both governments—the host and the home. This approach requires an intersectorial and interdisciplinary partnership within and between science, policy, care and civil society. This partnership guarantees its components of awareness, assessment, training, counseling and evaluation in seven health areas—physical, psychological, social, spiritual, financial, family and leisure. It can be applied individually or in-group by an intergenerational specialist.

Immigrants older than 60 years tend to be retired people under higher risk of isolation, depression and dementia [3, 5]. This step approach based on Schwarzer HAPA model may be very useful given the difficulty to motivate elder members of the immigrant community.

The proposed methodology with tests adapted to the host country population and immigrants can add self-reflection and behavior change to national health promotion programs that include workshops and activities. Participants are divided in three intervention groups depending

Table 1. Intervention approach in pre-intender group.

Session Number	Activity	Aims/content
1	Pre-test & introduction	Evaluation: several psychometric scales Presentation: program and participants
2	Life tree	intergenerational exchange processes Culturally sensitive strategies
3	My 7 healths	Risk perception
4	Three 8h periods	
5	10 + 10 minutes	
6	Comfort activities	Perceived self-efficacy
7	25 lists	
8	Positive Defendant	
9	Storm	Positive outcome expectancies
10	Self-letter	
11	My 7 healths & Life Tree	
12	Conclusion & post-test	Conclusion: program and participants Evaluation: several psychometric scales

on a previous evaluation if they are pre-intender, intender or actor in relation to behavior change. The intervention offers twelve sessions once a week fifty-five minutes with evaluation at pre-time, post-time and follow-up at three months according to the stage of the participant towards behavior change (Table 1–3). Based on evaluation, participants can move forwards or backwards through the three intervention groups. Intervention the pre-intender group

Table 2. Intervention approach in the intender group.

Session Number	Activity	Aims/content
1	Pre-test & introduction	Evaluation: several psychometric scales Presentation: program and participants
2	Life tree	intergenerational exchange processes Culturally sensitive strategies
3	My 7 healths	Action planning
4	Three 8h periods	
5	10 + 10 minutes	
6	Comfort activities	Task self-efficacy
7	25 lists	
8	Positive Defendant	Coping planning
9	Storm	
10	Self-letter	Maintainance self-efficacy
11	My 7 healths & Life Tree	
12	Conclusion & post-test	Conclusion: program and participants Evaluation: several psychometric scales

Table 3. Intervention approach in the actor group.

Session Number	Activity	Aims/content
1	Pre-test & introduction	Evaluation: several psychometric scales Presentation: program and participants
2	Life tree	Intergenerational exchange processes Culturally sensitive strategies
3	My 7 healths	Action control
4	Three 8h periods	
5	10 + 10 minutes	
6	Comfort activities	Maintainance self-efficacy
7	25 lists	
8	Positive Defendant	Ressources & barriers
9	Storm	
10	Self-letter	Recovery self-efficacy
11	My 7 healths & Life Tree	
12	Conclusion & post-test	Conclusion: program and participants Evaluation: several psychometric scales

will focus on risk and resources communication and motivational support filling the gap of goal setting and motivation. Intervention in the intender group will focus on the strategic planning filling the gap of goal pursuit and volition. Intervention in the actor group will focus on the relapse prevention. Evaluation instruments are several Schwarzer's short psychometric scales: the 10-item General Self-Efficacy Scale [28], the 8-item Proactive Attitude [29], the 10-item Self-Regulation [29], the 17-item Berlin Social Support Scales [30].

Conclusion

Although there might be limitations to behavioral change techniques, this is a discussion paper in which two claims are made. First, that some migrants' health can worsen as they age, which is associated with their migrant status. Second, that there may be, as yet untested in this respect, models of health behavioral change, which can mitigate these risks. The aim of this paper was to present the intervention approach "Life Training: My 7 Core Areas of Health" as a strategy for ensuring maintenance of mental health for immigrants. This approach is based on the theoretical model of Ralf Schwarzer – The Health Action Process Approach. It presents benefits for the transnational responsibility of care concerning aging and migration. These benefits are related to the work on psychological processes under behavioral change in seven areas of health. These are physical, psychological, social, spiritual, financial, family and leisure. With this approach we may answer the question of what are the specific needs for the immigrant community in terms of the integration of older immigrants.

This approach if used in different cultures in Europe, including immigrants in different cities, may be also useful to compare profiles between home country and host country, e.g. psychosocial situation: mental health indicators, worries in age, cognitive conditions, physical health data. We might also think about the creation of a European Specialization on Intergenerational Community Leadership as intergenerational family solidarity in Europe is a determinant of wellbeing, having benefits for education, work, health and human development and is influenced by gender, ethnicity, religious background, immigration history, marital status, employment situation, geographical proximity, socio-economical factors and health.

Competing interests

The author declares no conflict of interest.

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