Global /

MENTAL HEALTH AND VULNERABILITY AMONG ELDERLY REFUGEES

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Generally speaking, there are still relatively few studies in the field of psychology that focus on elderly populations. This is even truer, when it comes to elderly refugees*, one the most vulnerable groups within refugee populations. While the media landscape increasingly covers the reality of refugees throughout the world, attention is still rarely put on the migration experiences of older refugees. Yet, a study recently found that 65% of older refugees in Lebanon showed symptoms of psychological distress – a rate three times higher than among refugees from other age groups. Unfortunately, the mental health care needs of older refugees often go undetected and untreated.

MENTAL HEALTH PROBLEMS OF REFUGEES IN GENERAL

A "refugee" is a person who is outside the country where he or she was born or lives, and who is unable to return to his or her country of origin for fear of persecution and the impossibility of local protection due to race, religion, nationality, or membership in a particular group or political opinion. The imminent danger that led refugees to flee is often that of war and generalized violence. Refugees from these circumstances are particularly vulnerable to mental health issues because they often experienced pre-migration trauma associated with conflict, in addition to post-migration traumas in the host country. The most common mental health problems experienced by refugees of any age are: post-traumatic stress disorder (PTSD), depression, anxiety, sleeping disorders, and survivor guilt. Studies on depression have shown that the rate of prevalence among refugees is four times higher than in the American host population.

HEALTH AND DISABILITY

When it comes to the specific group of elderly refugees, mental health issues are all the more present. One-third of older Syrian refugees in Lebanon indicated that they were feeling anxious (41%), depressed (25%), insecure (24%), and lonely (23%), and that they felt these negative emotions were caused by their inability to do what was expected of a healthy person of their age. Before arriving in the host country, whether in refugee camps or during their displacement, older refugees often have difficulty accessing general humanitarian assistance aimed for refugees, especially when the services or facilities are not suited to their specific needs. When older refugees have a disability or a chronic condition, this reality is even more exacerbated, especially because they had to stop treatment or specialized care during their displacement. Upon arrival in the host country, the primary healthcare needs of older refugees are usually met – with the continuation of treatment for chronic illness or the use of assistive devices. However, psychological distress may remain if coping mechanisms are not developed to deal with their new reality.

SOCIOECONOMIC STATUS, DEPENDENCY, AND SYMBOLIC LOSSES

The precarious or uncertain status in the temporary or host country, financial problems, loss of social support and cultural ties, adjustment to a new culture, and the language barrier are some of the stressors influencing the risk of depression in elderly refugees. Populations of immigrants often occupy lower socio-economic layers, thereby experiencing what is called the "double burden", meaning they not only are exposed to higher stress levels but also that fewer resources are available or accessible to them in order to address these stress factors. This is particularly troubling, when we know that the wellbeing of seniors especially is positively associated with education and income levels.

In several Western host countries, older refugees arrive mainly via two migration schemes: family reunification or refugee sponsorship. For younger, working-age refugees, the arrival of elderly parents can bring psychological comfort in the possibility of an expanded social network and support system. Yet, for elderly refugees, problems related to past conflicts and separations, as well as a feeling of 'debt' – towards the younger family members they depend on and towards the host country – as well as a loss of autonomy and rejection could emerge from these two migratory paths. Some older refugees may feel as though they burden the younger generation – materially and psychologically – welcoming them in their new country, which can further contribute to greater psychological distress.

Besides various concrete losses (funds, possessions), older refugees also experience "symbolic" losses driven by their migratory experience. Indeed, loved ones left behind, lost or insufficient social support, customs and cultural practices, or the native language they can no longer speak everywhere can all generate a drop in self-esteem, identity confusion, and a lower psychological well-being among older refugees. According to an article published by Casado & Leung in 2002 in the Journal of Gerontological Social Work, these types of "migratory mourning" are a significant predictor of depressive symptoms among elderly migrants.

CULTURAL AND LINGUISTIC ELEMENTS

The way individuals view their own mental health issue, its causes, and the appropriate treatment towards healing varies from person to person and from culture to culture. In some traditions, suffering is seen as inherent to life and to the human experience, which may result in an attitude of resignation and modesty, and reduced help-seeking behavior. Mental health care practitioners may therefore have difficulty distinguishing behaviors determined by culture from psychopathological behaviors, due to the lack of awareness about the socio-cultural references which could otherwise help them better support older refugees living in psychological distress.

Generally, older refugees do not work or go to school upon arrival in the host country. This can lead to lower opportunities for intercultural exchange with the host community, while younger refugees enjoy more opportunities to be exposed to the culture and language of their host community. In addition, some older refugees have never had a formal education in an academic institution in their country of origin and, as a result, enrolling in language courses can represent a significant challenge. Furthermore, the lower fluency of elderly refugees in the language of their host country, compounded with the reduced opportunities to speak their own native language both contribute to the potential for isolation in older refugees. This is especially true for refugee communities whose population is small in the host country, as they tend to have less access to shared places of cultural expression that would otherwise strengthen their sense of belonging and collective identity.

OLDER REFUGEE WOMEN

An overview of the specific mental health realities of older refugees would not be complete without the gender angle. Indeed, older refugee women are subject to various forms of discrimination:

ageism and sexism, in addition to the stereotypes and stigma related to being a foreigner. These women are frequently exposed to victimization, often considered merely through the violence they have previously experienced, – either in their country of origin or during their migratory journey – which gives them a label to which they are forever associated in their interactions with others. Moreover, older refugee women may also undergo various forms of ageism, such as isolation and age-associated poverty. In Western societies, where the 'cult of the young and the beautiful' rules, according to a specific standard portrayed in mass media, older refugee women can see their self-esteem affected as a result of these messages from the host society.

"Older refugee women belong to a generation of women who gave (and still give) great attention to family, especially children". Consequently, it is often refugee grandmothers who play the role of guardians and transmitters of the culture of origin to their refugee grandchildren, whose parents are currently concerned with access to employment and comfortable housing, the recognition of their diplomas, and learning the host language rapidly. "Women transmit, create and update knowledge, memory and insertion practices, adaptation and support". Refugee women are often carriers of the role of transmitting knowledge related to family history, the memory of the community, with cultural references and values. This newly acquired role can positively influence their self-esteem and sense of identity.

INHOSPITALITY IN THE HOST COUNTRY AND AGEISM

It is important to note that once the danger has been eliminated, the attitude of the host society plays a leading role in the sense of belonging and integration of refugees. Indeed, although the majority of symptoms are articulated around the traumatic experiences themselves, they are amplified when there is a great level of inhospitality in the host country.

In their home countries, some older individuals were seen as "wise" individuals and played a role as "community advisors" and keepers of valuable knowledge. Upon arrival in the host countries, particularly in Western societies, being confronted with a burst of this deep respect towards elders and a depreciation of their knowledge can definitely cause a certain form of culture shock or distress. Furthermore, the "successful aging" model, – widely valued within Western societies – whereby the elderly must lead an active life full of social interactions, high-energy activities, and impeccable physical health is often far from the common reality of most older individuals. For instance, older refugees who are unable to work or whose situation does not coordinate with this successful aging model can thus be prone to psychological distress.

CONCLUSION

The path of exile amplifies separations, losses, and pain, while at the same time heralding the opportunity for renaissance. Despite the mental health challenges faced by older refugees, giving in to the tendency of victimizing their experience would be a mistake, for a new life can be constructed in the host country and contribute to their psychological well-being. Indeed, many refugees who arrive in old age do find a sense of psychological wellbeing, through the various coping mechanisms of adaptation and integration.

Having fled their native land, older refugees face both pre-migration stressors and post-migration stressors and often the local polarized attitudes about their arrival. Of course, discriminatory attitudes, at both the individual and systemic levels, do not change over the course of only a few years. As a result, anti-ageism campaigns and actions could be beneficial to bring a change of mindset. To better assist older refugees and reduce their risk of maintaining or developing psychological disorders, a "pedagogy of the reality of refugees," including older refugees, could be developed to generate increased tolerance towards their situation. In this way, the more positive aspects of their reality could be highlighted and their needs better met.

*It should be noted that research on refugees and elderly immigrants usually considers individuals 50 years of age and older as "elderly", taking into account the lower life expectancy of the refugees' countries of origin compared to that of host countries.