Related Topics

- ▶ Access to care
- ▶ Community programs
- ▶ Emigration
- ▶ Food insecurity
- ▶ Health barriers
- ▶ Health care
- ▶ Health care utilization
- ▶ Health disparities
- ▶ Housing
- ▶ Immigration status

Suggested Readings

Earner, I. (2007). Immigrant families and public child welfare: Barriers to services and approaches for change. *Child Welfare, 86*(4), 63–91. Retrieved from Academic Search Premier database.

Fennelly, K. (2006). Listening to the experts: Provider recommendations on the health needs of immigrants and refugees. *Journal of Cultural Diversity, 13*(4), 190–201. Retrieved from Academic Search Premier database.

Ghent, A. (2008). Overcoming migrants' barriers to health. *Bulletin of the World Health Organization, 86*(8), 583–584. Retrieved from Academic Search Premier database.

Jang, M., Lee, E., & Woo, K. (1998). Income, language, and citizenship status: Factors affecting the health care access and utilization of Chinese Americans. *Health & Social Work, 23*(2), 136–145. Retrieved from Academic Search Premier database.

Ngo-Metzger, Q., Massagli, M., Clarridge, B., Manocchia, M., Davis, R., Iezzoni, L., et al. (2003). Linguistic and cultural barriers to care. *Journal of General Internal Medicine, 18*(1), 44–52. doi:10.1046/j.1525-1497.2003.20205.x.

Suggested Resources

For information on the U.S. Citizenship and Immigration Services. http://www.uscis.gov

Social Stress

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International migration constitutes a significant life event, during which immigrants often face drastic differences in social norms, cultural beliefs, and language proficiency in the host society. Many use the term "acculturative stress" (i.e., the psychological, somatic, and social difficulties that may accompany acculturation processes) to describe stress experienced by immigrants as they adapt to the host society; however, some researchers have argued that (a) acculturation is not necessarily a stressful experience and (b) immigrants' experience of stress may or may not be related to the acculturation process.

Recent research has highlighted that stress is a socially constructed experience and is dependent on individuals' interpretation of their experiences. The interpretative nature explains the inconsistent findings in which some found an elation period for new immigrants and others found that emotional distress is highest during initial resettlement (particularly the first few to 18 months). Whereas some immigrants may find the challenges in the host society refreshing and exciting, others may view it as undesirable obstacles. Alternatively, an immigrant may consider some challenges stimulating and others agonizing. Differences at life stages may also influence individuals' interpretation. For example, young parents may feel proud and satisfied that their children are well assimilated, indistinguishable from native others in the host society; in contrast, elderly immigrants may experience a significant sense of loss and guilt recognizing that their native culture will be permanently lost to their future generations.

By situating stress in social contexts, researchers highlight individuals' experiences of stress as (a) consequences of their social circumstances and (b) a determinant for specific outcomes (e.g., psychological distress). Immigrants experience specific stress factors that are unique to their backgrounds and life experiences. Migration circumstances (e.g., asylum seekers versus economic-motivated settlers), socioeconomic status (e.g., professionals versus migrant farm workers), legal status (e.g., legal versus illegal immigrants), expected duration of stay (e.g., temporary versus permanent residence), ethnic group (e.g., ethnic majority versus ethnic minority), language proficiency, and host culture receptivity influence immigrants' adaptation process. For example, most of the immigrants who arrived to the United States after 1970 were from countries in Latin America and Asia. They often experience more entrenched prejudice and discrimination and fewer opportunities for economic advancement in comparison to those in earlier waves of

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European immigration. Length of time in the host society is also an important factor. Generally speaking there is initial euphoria when first arriving the host society; however, immigrants soon experience increased disenchantment and demoralization during the acculturation process, which often is accompanied by stress. The experience of stress may taper off as immigrants develop strategies to meet the challenges of the host society. Although there appears to be a U-shape trajectory of elation to depression to recovery, recent studies have suggested that duration of stay is a moderator, rather than a predictor, of immigrants' experience of stress, which can fluctuate over time due to immigration demands and their ability to meet those demands. Another factor is the location of settlement, which may have implications for the availability of social support and other resources (e.g., financial resources). Moving to a different country often entails a loss of one's support network, resulting in difficulties in meeting challenges in everyday life. On the other hand, if individuals are able to reunite with family members or to live in ethnic enclaves in the host society, they may adapt better and experience less stress due to the increased social support. Some researchers also have noted that pre-migration stress (e.g., exposure to violence) may also increase individuals' susceptibility to post-migration stress.

Immigrants' experience of stress may be reflected in their experience of depression and cardiovascular diseases, both of which are known to be sensitive to prolonged exposure to stress. Stress also is found to negatively influence the immune system and to be correlated to various medical conditions, including chronic pain, asthma, arthritis, hypertension, gastrointestinal disorders, and preterm labor, among others. Due, in part, to the self-selection of healthy people to immigrant, immigrants generally have better health status than average native-born residents in the United States. Some researchers also have argued that foreign-born immigrants may experience less stress and better health because their cultural values (e.g., strong family network and aversion to risky behaviors) and practices (e.g., healthy diet and physical activity) provide a buffering effect to their immigration demands and challenges; however, the cultural buffering effect tends to subside over time and across generations. For example, researchers have found that the stronger a Japanese immigrant adheres to the original Japanese culture, both during childhood and retention during adulthood, the lower the risks of coronary heart disease. First generation Hispanic women are less likely to have adolescent pregnancy or low birth weight children than the second generation. From these perspectives, it is important to recognize that first generation immigrants do not necessarily experience the highest level or amount of stress; rather, different generations of immigrants experience different stressors at fluctuating levels and at different stages of life as they meet their distinctive immigration demands in their adaption and acculturation processes.

Finally, it is important to note that the host society as a whole also experiences stress in its socio-structural systems as it attempts to accommodate and assimilate new immigrants. The influx of immigrants, along with their cultural values and social norms, can create significant pressure for the host society. These "stressful" events in the host society are subject to interpretation as well. Some host societies may view the demographic changes as an exciting inflow of resources to rejuvenate, strengthen, and/or diversify its international competitiveness. Others, however, may consider these changes as threats to contaminate their original cultural components and design policies to moderate or even prohibit the fusion and infusion of "foreign" cultures.

Related Topics

► Acculturative stress
► Social networking
► Stress

Suggested Readings

Aneshensel, C. S. (1992). Social stress: Theory and research. *Annual Review of Sociology, 18*, 15–38.

Berry, J. W. (2006). Acculturative stress. In P. T. P. Wong & L. C. J. Wong (Eds.), *Handbook of multicultural perspectives on stress and coping* (pp. 287–298). New York: Springer.

Caplan, S. (2007). Latinos, acculturation, and acculturative stress: A dimensional concept analysis. *Policy, Politics & Nursing Practice, 8*, 93–106.

Jasso, G., Massey, D. S., Rosenweig, M. R., & Smith, J. P. (2004). Immigrant health: Selectivity and acculturation. In N. B. Anderson, R. A. Bulatao, & B. Cohen (Eds.), *Critical perspectives on racial and ethnic differences in health in late life* (pp. 227–266). Washington, DC: National Academic Press.

Kramer, E. M. (Ed.). (2003). *The emerging monoculture: Assimilation and the "model minority"*. Westport: Praeger.

Levitt, M. J., Lane, J. D., & Levitt, J. (2005). Immigration stress, social support, and adjustment in the first postmigration year: An intergenerational analysis. *Research in Human Development, 2*, 159–177.

Zhou, M. (1997). Growing up American: The challenge confronting immigrant children and children of immigrants. *Annual Review of Sociology, 23*, 63–95.

Social Support

► Social networking

Socialized Medicine

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Socialized medicine (sometimes equated with universal health care) refers to a system of publicly funded health care, whose primary objective is to provide accessible, affordable, and quality health care services to all eligible members of the population. Benefits of socialized medicine include increased life expectancy, improved general health, and decreased infant and maternal mortality, to name a few. Socialized medicine is financed in a variety of ways, including taxation and contributions from workers and the government. Many countries have some form of socialized medicine, including industrialized nations (i.e., United Kingdom, Canada, and Australia) and developing countries (i.e., Ghana, Cuba). The United States is the only industrialized nation which does not have a universal health care system. However, in recent years some areas of the United States have moved toward implementation of state-wide, near-universal health care systems that mandate health insurance for all residents. Such systems may allow exceptions to be made for individuals meeting certain poverty-level criteria.

In recent times, there has been increasing controversy regarding whether immigrants (documented and undocumented) are entitled to any benefits of socialized medicine. Proponents for immigrant rights argue that from an ethical standpoint health care is a fundamental human right (supported by international human rights treaties), and therefore immigrants are entitled to benefits, regardless of whether they are legal or permanent residents. Such proponents view socialized medicine as a means of mitigating the racial and class inequalities in a given population. Opponents of immigrant rights argue that socialized medicine should be a privilege reserved for citizens and that any coverage of noncitizens will increase economic costs and diminish the quality of health care received (i.e., longer waiting lists, overworked physicians).

In some countries, there are regulations in place that allow immigrants access to socialized medicine under specific circumstances. For example, in the United Kingdom, refugees (displaced persons granted asylum in a foreign country as a result of war, violence, or fear of persecution taking place in their native country of residence), asylum seekers (persons who have formally applied for refugee status in a foreign country), and other overseas visitors who have had “lawful residence” in the country for at least 12 months prior to their need for health care are allowed to utilize the National Health Service, the United Kingdom’s socialized medicine system. However, this still does not account for the health care needs of undocumented (illegal) immigrants and failed asylum seekers.

In countries such as the United States, that do not have a formalized system of universal health care, legal immigrants are restricted (or prohibited entirely) from receiving benefits from social insurance programs such as Medicaid and Medicare; illegal immigrants are not eligible for Medicaid or Medicare services. Such restrictions may inevitably result in an increased dependence on emergency room visits as a source of primary care or deter immigrants from attempting to access any health care services, for fear of deportation or financial repercussions. Immigrant children and immigrant elders are perhaps the most affected by such decisions, given that they already represent particularly vulnerable subgroups across the world.

As a group, immigrants often arrive in their host countries with a health advantage over the general population. However, they undergo various environmental and lifestyle changes that place them at higher risk for disease. The process of adapting to a new

culture (acculturation) can be very stressful, particularly for those who left their country under adverse circumstances such as refugees, asylum seekers, and illegal immigrants. Furthermore, many immigrants live below the poverty level, and those who are noncitizens have higher poverty rates than naturalized citizens. This means, that in addition to the stressors of acculturation, immigrants may be forced to deal with less than desirable living conditions, malnutrition, and extreme financial hardships. Such factors may severely compromise their health and undermine any preexisting health advantage that they might have had. Chronic diseases such as obesity, diabetes, hypertension, and cancer are on the rise among immigrants. In addition, untreated infectious and parasitic diseases among immigrants remain a problem.

Currently, socialized medicine has had varying degrees of success in addressing the health care needs of immigrants. For those able to receive care, socialized medicine has been largely beneficial. However, the system is not without limitations. Language barriers and unavailability of interpreters impede necessary communication between immigrants and health care workers. This can be frustrating for immigrants who may perceive such barriers as culturally insensitive, while health care workers are frustrated by their inability to get information necessary for proper diagnosis and treatment. In addition, by the time immigrants come forward to receive care, their ailments are in advanced stages and treatment options may be limited. Also, conditions in an immigrant's native country (or sheer distance) often make it difficult for health care workers to access traceable history of disease or treatment; immigrants may not even be able to provide self-report information on such history. Finally, because of the ambiguity regarding entitlement to socialized medicine benefits, providers are unsure who is eligible, what care they can provide, and what penalties exist for providing care to ineligible individuals.

From a population health perspective, it would seem that granting immigrants access to socialized medicine would not only improve the overall health of communities, but also be more cost effective in the long run (i.e., preventive care can reduce long-term costs for untreated conditions).

Related Topics

- ► Acculturation
- ► Health barriers
- ► Health care
- ► Health disparities
- ► Health policy
- ► Language barriers
- ► Public health
- ► Refugee

Suggested Resources

Carrin, G., Evans, D., & James, C. (2005). *Achieving universal health coverage: developing the health financing system*. Technical briefs for policy makers, number 1. Geneva: WHO. Retrieved May 15, 2010, from http://www.who.int/health_financing/documents/pb_e_05_1-universal_coverage.pdf

Durairaj, V., D'Almeida, S., & Kirigia, J. (2010). *Obstacles in the process of establishing sustainable National health insurance scheme: insights from Ghana*. Technical Briefs for Policy Makers, number 1. Geneva: WHO. Retrieved May 15, 2010, from http://www.who.int/health_financing/PB_10_1.pdf

International Organization for Migration. http://www.iom.int/jahia/jsp/index.jsp. Accessed May 15, 2010.

United Nations Human Rights, Office of the High Commissioner for Human Rights. (1948). *Universal declaration of human rights*, G.A. res. 217A (III), U.N. Doc A/810 at 71. Retrieved May 15, 2010, from http://www.ohchr.org/EN/UDHR/Pages/Introduction.aspx

World Health Organization, Health Systems Center. http://www.who.int/healthsystems/about/en/. Accessed May 15, 2010.

Socioeconomic Status

► Poverty

Somatic Symptoms

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Somatic symptoms are body-related symptoms that are experienced by an individual. Sometimes individuals experiencing such symptoms may undergo numerous