Systemic and Psychological Factors Impacting Migrant Mental Health in the UK

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Thesis Portfolio: Candidate Declaration

Title of degree programme	Professional Doctorate in Clinical Psychology
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Declaration and signature of candidate
I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work. I confirm that the decision to submit this thesis is my own. I confirm that except where explicitly stated, the work has not been submitted for another academic award. I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis. Signed:  Date: 21/04/2024

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The body of research that is to follow would not have been possible without the support, love and patience of the people around me.

I take this moment to sit in humility and thank my parents, Michalis and Persefoni and brother, Nektarios. This thesis portfolio has been inspired by experiences we have had and continue to have as a family. Thank you for your sacrifices, I stand on the shoulders of giants.

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In memory of my loving yiayia, Eleni Saraidari – Sextou, who described education as a gold bracelet and always encouraged me to persevere and follow my dreams (and get a lot of bracelets). I first became acquainted with migration through her stories of our family who became refugees following the tragic fire and genocide of Smyrna in 1921. Through those stories I started to develop my understanding of struggle, systemic inequality and human potential in the face of adversity.

"Ithaka gave you the marvellous journey.

Without her you wouldn't have set out."

Excerpt from C. P. Cavafy., 1975. "Ithaka" Translated by Edmund Keeley.

Contents

Thesis Abstract

This thesis explores factors impacting on migrant's well-being in the UK through both the literature review and empirical research. In contributing to the literature basis, it is hoped to inform future service structures and provisions to better support the growing migrant population of the UK.

Paper 1 presents a scoping literature review of qualitative and quantitative studies examining barriers migrants face in accessing mental health services in the UK. Across fourteen studies, the review identified two factors encompassing five key barriers. 'Pull factors' referring to factors reducing help-seeking behaviours in the migrant population and pulling individuals towards alternative and community-based solutions. These include self-and-community-stigma, trust, alternative support and gender. 'Push factors' refer to issues regarding service structure and delivery, cultural competence of services and stigma that pushes migrants away from services. The review concluded that service level changes as well as outreach familiarisation programmes are warranted.

Paper 2 is a cross-sectional, quantitative research study exploring whether migratory grief, acculturation, years since migration, gender, education, employment or relationship status predict psychological well-being for Greek and Greek Cypriot migrants in the UK. An online survey was completed by 152 individuals. A correlation and multiple regression analysis showed that migratory grief negatively predicted well-being. Low acculturation through maintaining a high ethnic Greek identity, predicted more positive well-being. The interaction of migratory grief and acculturation has a moderating effect on their predictive relationship of well-being. Clinical implications, limitations and future recommendations are considered.

Paper 3 is an executive summary, written for the Greek and Greek Cypriot UK population, the wider migrant population of the UK, and systems and individuals involved for providing care to migrants. It gives an overview of background, method, findings, implications, limitations, and recommendations. It was co-produced with three UK Greeks to ensure readability and cultural responsiveness.

Paper 1: Literature Review

Barriers to Accessing Help from Mental Health Services for Migrants in the UK: A Literature Review.

Word count: 7970

This paper is intended for publication in the Journal for Cross-Cultural Psychology and has been formatted for submission. Appendix A outlines the journal's submission guidelines. Further edits may be made before submission to the journal.

Abstract

This literature investigates the main barriers for migrants in accessing mental health services in the UK. A literature search was completed using an online database. Searches were restricted to peer reviewed journals and evaluated according to pre-defined inclusion and exclusion criteria which yielded 14 papers. There were no criteria regarding publication date constraints. Qualitative, quantitative and mixed-method papers were critically appraised and synthesised using the Mixed Methods Appraisal Tool (Hong et al, 2018). Themes were derived following analysis and comparison of findings regarding existing barriers where two factors encompassing five key barriers were identified. 'Pull factors': factors reducing help-seeking behaviours and pulling individuals towards alternative solutions. These include self-and-community-stigma, trust, alternative support, and gender. 'Push factors': issues regarding service structure and delivery, cultural competence of services and stigma pushing migrants away from services. Overall quality was high, with strong cultural sensitivity but sample generalisability was partially compromised. The review concludes that system structures discourage migrants from seeking support and 'pull factors' contribute to barriers. Findings call for services to be designed with the diverse cultural needs of migrants in mind. Clinicians need to provide care sensitive to the factors that might prevent migrants from accessing services; anti-stigma programmes should be available to professionals; support in understanding how to navigate NHS services should be automatic. The above should be supported by changes to mental health policy. Future research should focus on addressing the migrant population heterogeneity through sampling to address generalisability issues.

Keywords: migrant, mental health services, UK, access, barriers

Barriers to Accessing Help from Mental Health Services for Non-Refugee Migrants in the UK: A Literature Review.

There are systemic and systematic inequalities in health outcomes (Marmot, 2010) in our society. Social determinants of health include "the social, political, economic, and cultural conditions in which people live and work and the structural drivers of these conditions" (Baum, 2009, p. 1). Health inequalities are not caused by the National Health Service (NHS) however, its policies and practice can contribute to societal health inequalities. One of the ways to address this is by ensuring health care access is equitable (GOV UK, 2022). The UK government has outlined policies to address these inequalities. These include creating equality of access and outcomes based on protected characteristics as determined in the Equality Act (2010); tackling stigma and discrimination; ensuring service design is based on humanity, dignity and respect (Department of Health and Social Care, 2012).

Domains of health inequality are categorised by protected characteristics, socio-economic deprived populations, vulnerable groups and geography (GOV UK, 2022). Migrants are at risk of health inequalities, although intersectionality leads to differences in health outcomes. The term 'migrant' refers to an individual living outside one's country of birth (Moore et al., 2019). At the 2021 Census, approximately 15% of the population of England and Wales were foreign-born, amounting to approximately 10 million people (Office for National Statistics, 2021). Mainstream mental health services may be difficult to access for the migrant population of the UK (Salami et al., 2019) which is concerning considering its size.

Migratory groups are consistently shown to be at an increased mental health risk when compared to native citizens and individuals of the same ethnic background who have not emigrated (Carta et al., 2005; Islam et al., 2014; Virupaksha et al., 2014; Yang, 2019). Migrant populations are categorised as 'hard-to-reach' meaning they are less likely to receive

mental health support compared to the average population. 'Hard-to-reach' is a contested term as it assumes homogeneity between groups that hold no reasonable similarities; it "defines the problem as one within the group itself, not within your approach to them" (Smith, 2006 as cited in Brackertz, 2007, p. 1). Conceptualising migrants as 'hard-to-reach' (Shaghaghi et al., 2011) in public health discourse, poses an ethical issue as a group more likely to experience mental health difficulties is less likely to be able to access NHS support thus, going against NHS' equity-driven values. It puts migrant individuals at a disadvantage to native individuals, as not accessing mental health support can have cascading effects on other aspects of social and physical well-being, such as the ability to obtain and remain in employment.

Understanding factors impacting migrants' ability to access mental health services is important for informing strategies to reduce health inequality and prevent migrant social and physical well-being from being compromised. International research has identified stigma, competing cultural practices, discrimination, language barriers, cost, service constraints, cross-cultural communication issues and service structure as barriers to access (Blignault et al., 2008; Saechao et al., 2012; Satinsky et al., 2019). For example, Chinese migrants in Australia identified that language barriers are not limited to direct translation issues, but also encompass differences in conceptual understanding of idioms and cultural references (Blignault et al., 2008).

Research on UK barriers has identified that only 33% of UK Eastern European migrants know how to register with their GP (Spencer et al., 2007). This is critical as the GP connects primary care with mental health services. Long wait times to services are a UK-specific access issue (Satinksy et al., 2009) compared to other European countries. Hostile environments, lack of resources, communication difficulties, service delivery inconsistencies and lack of trust (Pollard & Howard, 2021) are further barriers. There are gaps in the

literature of understanding UK specific barriers for migrants to accessing mental health services (Pollard & Howard, 2021).

Limitations with Existing Reviews

The existing literature is limited by several issues. Burns et al. (2021) highlight that many studies use small, unrepresentative samples, which do not disaggregate the migrant population into subgroups, such as refugees and non-refugees. This distinction is important in relation to mental health, as refugees often experience significant trauma following forced displacement, conflict and persecution, which can lead to high prevalence of difficulties such as post-traumatic stress disorder (PTSD) (Silove, 1999; Fazel et al., 2005). The difference in trauma experiences results in refugees experiencing distinct difficulties to non-refugee migrants (Sam & Berry, 2006, pp 349-367).

Non-refugee migrants are compelled to move for a variety of reasons such as improved opportunities regarding employment and education (Czaika & De Haas, 2017). They may experience mental health difficulties related to migration, such as depression (Ahn, 2006; Chang, 2015) and grief (Casado et al., 2010). If reviews fail to distinguish between refugee and non-refugee populations, it risks obscuring differences in factors impacting access to services. A further limitation is the predominance of quantitative studies (Satinsky et al., 2019; Selkirk et al., 2012). However, authors have noted a sharp increase in qualitative studies concerning UK migrant groups since 2015 (Burns et al., 2021), which reviews have not considered.

Lastly, although there are common barriers to mental health care access across countries (Blignault et al., 2008; Saechao et al., 2012; Satinsky et al., 2019; Spencer et al., 2007), health systems differ internationally, hence why it is important to examine factors affecting non-refugee migrant access to mental health services in a UK context. This

literature review aims to examine the shift to qualitative methodology to inform NHS organisations in developing policy and practice that is responsive to diversity, by exploring:

- What are the factors affecting non-refugee migrant access to NHS mental health services?

Method

Design

A literature review conducted in a systematic way was used to explore factors that act as barriers to migrants accessing mental health services in the UK.

Search Strategy

Searches took place between January 2023 and March 2023 by the author.

To ensure the most relevant papers were identified, these strategies were employed:

- Using Boolean operators "AND" and "OR" and "$" with search terms
- Asterisks to truncate words allowing associated terms to be included, for example *migrant

Search terms were developed using the CHIP (Context, How, Issues, Population) tool. Keywords were produced using a mind-map and a thesaurus to identify keyword synonyms. Different string combinations were collated and ran through the database to produce a comprehensive final literature sample. The final five search strings were inputted through a range of databases, with the 5 that yielded most results outlined in the PRISMA diagram (Figure 1). For the full list of databases see Appendix B.

1. UK AND mental health service* AND access AND *migrant$ NOT refugee*
2. UK AND mental health service* AND barrier* AND *migrant$ NOT refugee*

3. United Kingdom AND mental health service* AND barrier* AND *migrant$ NOT refugee*
4. UK AND mental health service* AND utilisation AND *migrant$ NOT refugee*
5. UK AND well-being service* AND access AND *migrant$ NOT refugee*

Existing literature reviews were cross-referenced against eligibility criteria and retrieved articles to ensure no relevant articles were missed. Excluding duplicates, no eligible articles were identified.

Eligibility Criteria

Inclusion criteria: 1) UK based research because the review is focused on UK mental health services, 2) participants should be migrants meaning their country of birth cannot be the UK, 3) UK based research involving professionals working with people holding a migrant status because the review focuses on migrant experiences, 4) the research should focus on access to mental health services to understand challenges, 5) articles must be peer reviewed in the interest of reporting findings that have been through high scientific rigor. No criteria regarding publication date.

Exclusion criteria: 1) research whose participants were below the age of 18 due to potential parental dependency in accessing services, 2) systematic reviews, editorials or non-empirical papers, 3) foreign language publications, due to the cost and funding involved in translation, 4) refugee research because they are a distinct migrant subgroup with potentially different experiences.

Screening

Following duplicate removal, articles were screened in two stages. The first stage involved screening by title and abstract against the eligibility criteria. If not possible to evaluate based on the title and abstract, a full-text screening took place.

Methodological Quality Assessment

The remaining publications were critically appraised for quality. Due to the variety of methodologies present in the collection of eligible publications, the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018) was used to ensure consistency in the appraisal tool across the articles (see Appendix C).

Although identified as an appropriate overall appraisal tool for this review, the brevity of some of the MMAT questions is recognised as a potential limitation. For this reason, supplementary notes were collected in an Excel document and have been included in the table of characteristics and narrative of this review. The question "Are participants, and their voices, adequately represented" from the JBI qualitative critical appraisal tool (Lockwood et al., 2015) was included to capture sample representativeness as this was outlined as an area of weakness in the body of research.

In recognition of publication bias, a grey literature search was undertaken on the Ethos, Open Gray and Dart Europe databases. As the eligibility criteria stipulating for included articles to be peer reviewed, the screened grey literature was excluded from the synthesis. Four papers were identified as relevant and will be mentioned in the discussion. This is important as views may differ to those presented in published research due to an increasing trend in psychological research to exclusively publish positive results (Fanelli, 2012).

Results

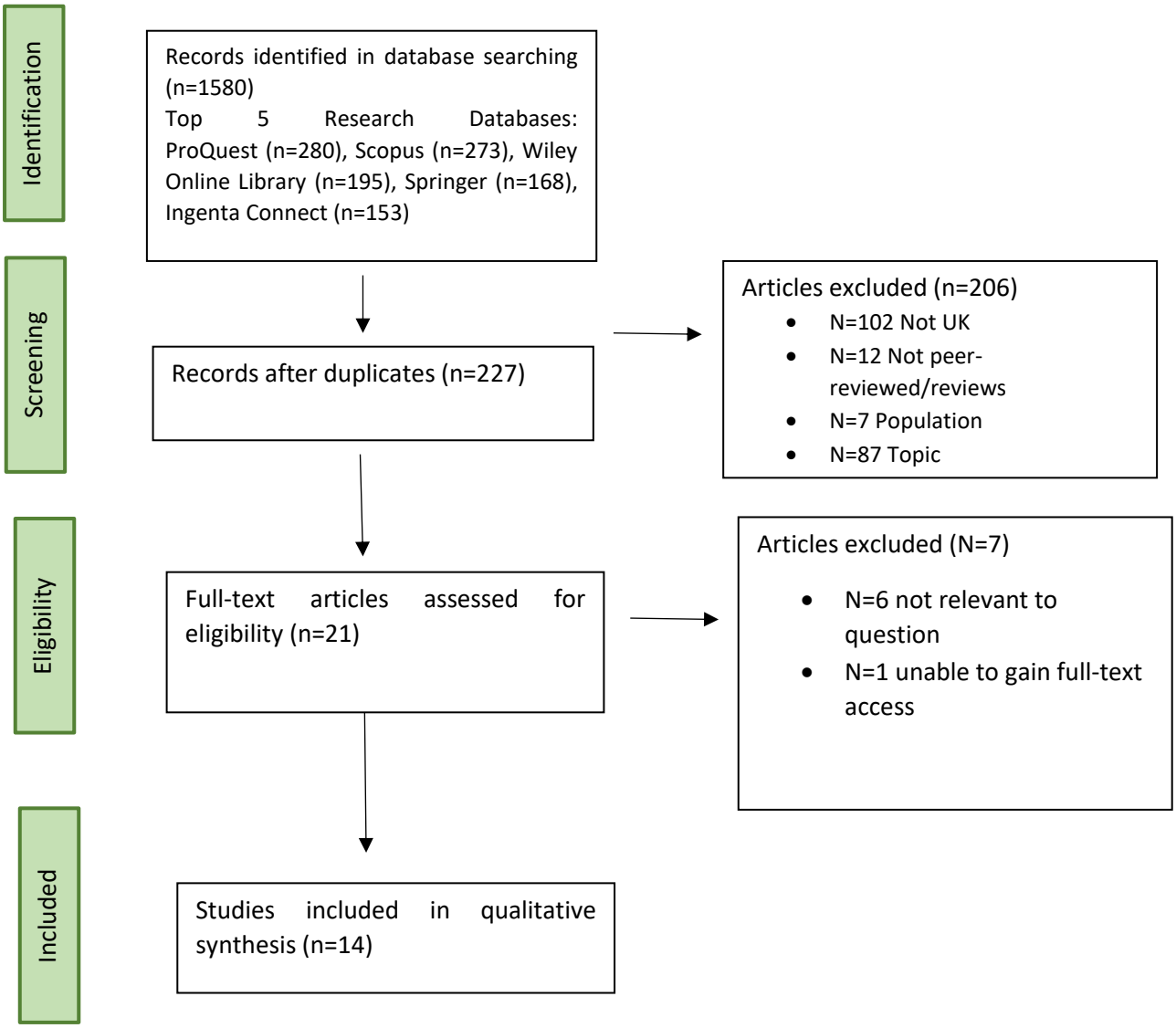
Study Selection

Search terms yielded 1580 results, with 227 remaining after removing duplicates (see Figure 1). The PRISMA diagram (Page et al., 2021) shows that following screening, 206 articles were not eligible. Five full-text articles lacked direct relevance to the question. An

article was excluded due to inability to access a full-text copy. Fourteen publications focusing on the barriers migrants face in accessing mental health services in the UK remained.

Figure 1

PRISMA Diagram



Synthesis

A summary analysis of the selected papers is outlined in Table 1. The final sample included 10 qualitative, three quantitative and one mixed-methods papers covering a range of contexts and participants with overall quality of the literature being relatively high based on

the MMAT (Appendix C). All included studies had clear aims with appropriate research methodology. Four studies specifically focused on accessibility and barriers of services for migrants. Nine explored mental health beliefs and help-seeking motivations in different migrant groups. Qualitative studies used interviews, an appropriate methodology for more in-depth understanding. Two investigated the accessibility of existing therapies and current service structures through interviews or questionnaires with migrants and staff members who work with migrants. These methodologies were satisfactory in cultural sensitivity, with half of the papers offering interviews or research materials in the native language of the participants (Worth et al., 2009; Li et al., 2014; Onyigbuo et al., 2016; Fox et al., 2017; Christodoulou et al., 2018; Këllezi et al., 2021; Simkhada et al., 2021; Troccoli et al., 2022).

Authors employed techniques to enhance trustworthiness and credibility. One of the steps taken by researchers was ensuring data was analysed by, at minimum, a second reviewer (Li et al., 2014; Fox et al., 2017; Christodoulou et al., 2018; Bramley et al., 2020; Këllezi et al., 2021; Simkhada et al., 2021). Worth et al. (2009) and Troccoli et al. (2022) do not explicitly refer to a second reviewer. Worth et al. (2009) discussed emerging themes with their project steering group at regular intervals to enhance trustworthiness of findings. The use of established analysis protocols such as thematic analysis was utilised by Onyigbuo and colleagues (2016), Simkhada et al. (2021) as well as Bramley et al. (2020) and Troccoli et al. (2022) although no further information on the analysis process was documented for the latter two. Some researchers (Li et al., 2014; Fox et al., 2017; Këllezi et al., 2021) used the NVivo qualitative data management software for data management to increase credibility of coding and findings. Patni (2007) briefly outlines that themes were identified from interview transcripts. In the absence of clear analysis methodology, findings are to be interpreted with caution.

Services represented ranged from community mental health services and neurodiversity services to gambling support services, immigration removal centres and end of life services. As the MMAT tool does not assess for representativeness, the additional question from the JBI qualitative critical appraisal tool was used, identifying compromised representativeness in some of the qualitative studies, echoing the observed compromised generalisability in quantitative papers. This was partly due to small samples (Patni, 2007; Li et al., 2014; Onyigbuo et al., 2016). However, sampling strategies contributed to this issue. In Gondek & Kirkbride (2018), the findings may be more reflective of young, educated, Polish females due to social media used for recruitment. Pilkington et al. (2012) identify their sample was not generalisable to the general South Asian Muslim population when compared for education levels. Additionally, sampling from specific geographical regions in the UK such as the South of England (Simkhada et al., 2021), South-East London (Bhavsar et al., 2021), Immigration Removal Centre (Këllezi et al., 2021) can compromise transferability because statutory provisions can differ based on local funding and community culture. It is an expected constraint due to the heterogeneity included within the term 'migrant population'.

A strength across the quantitative studies is the clear, detailed description of data analysis, offering transparency. Confounders were adequately addressed. Gondek & Kirkbride (2018) controlled for potential confounders such as having a partner, length of stay and age within the adjusted linear regression analysis. Pilkington et al. (2012) and Bhavsar et al. (2012) utilised regression models to account for the impact on different factors on intention to access services. However, Bhavsar et al. (2021) identified confounders of socioeconomic status and previous psychological treatment but did not collect sufficient data to include in the analysis.

Qualitative and quantitative findings were transformed into a descriptive format (Ryan, 2013), coded and developed into themes in relation to barriers UK migrants face in

accessing mental health services (Table 2). Risk of publication bias was low as the grey literature is in line with peer review findings.

Table 1

Summary of Included Studies

Paper No.	Author (s) & Date	Aim	Research Design	Sample	Strengths	Limitations	Key Results
1.	Bhavsar et al. (2021)	Assess ethnic and migration-related differences in incidence of IAPT-based psychological treatment use. Examine whether differences in psychological treatment use are explained by reasons for migration, or by English proficiency.	Quantitative Cohort study.	**1455** – cohort sample: 543 first generation, 912 born in the UK. White (934), Black Caribbean (116), Black African (187), South Asian (48), Other (168), Missing (2)	Findings not exclusively reliant on self-reports. Routine outcome measures and IAPT database also used. High proportion of migration in the sampling area.	Non-generalisable to non-urban areas of the UK. No measure of acculturation.	Migrants living in the UK for less than 10 years access services less than those born in the UK. Language not a contributing barrier. Migrants less likely to access services but when accounting for ethnicity and length of stay findings are not clear. The migrant community has complex distinctions and factors impacting the way they are accessing services.
2.	Bramley et al. (2020)	To obtain insights about the accessibility of UK MH gambling support services from the perspectives of individuals and organisations supporting migrants experiencing gambling-related harm	Qualitative interviews. Face to face focus groups. Thematic analysis.	**32** - 20 migrant gambling service users from Turkey, Latvia, China, Poland, Romania, Slovakia, The Netherlands, Somalia, Ghana, Guyana, Spain, Syria, Chile, India and	Sampling across many migrant communities reflecting heterogeneity of UK migrant population	As stigma is one of the main barriers, a focus group setting might have stopped people from sharing. No information on participants' socio-economic background. Participants were already interested in the topic.	Barriers to help seeking: lack of awareness of available services, information about services not available in other languages/language proficiency issues, lack of trust towards the services, fear that accepting support will bring forward the associated shame/stigma for them and their families, fear of confidentiality breach, physical health & disabilities affecting access to services.

				South Africa. 12 English front-line workers			There is an interplay between, apprehension in seeking services and lack of accessibility of the services.
3.	Christodoulou et al. (2018)	To understand Turkish speaking service-users experience of a guided self-help intervention.	Qualitative Discovery interviews. Face to face. Thematic coding.	**34** – Turkish migrant service users	All interviews conducted in mother tongue, better for emotional content. Researchers were Turkish speakers so no risk of interpreters changing content	Style of interviews was seen as difficult and too open-ended by participants and led to short interview length.	Limited self-efficacy, confusion and anxiety within the service. Ambivalent help-seeking characterised by confusion, doubt of therapy benefits, desire to protect privacy due to cultural stigma about mental health and general social withdrawal. Felt lack of clarity of procedural aspects of the service accentuated by miscommunication about things like discharge.
4.	Fox et al. (2017)	To gain a better understanding of Somali perceptions, experiences, and support needs of Autism and experiences of services.	Qualitative. Semi-structured interviews. Thematic analysis.	**15** – Somali migrant parents of a child with Autism	Two rounds of targeted sampling allowed for increased variation in the sample. Interviews offered in English and Somali, and all resources offered bilingually.	Dual role of interviewer meant they were aware of discrepancies between reported difficulties and real day-to-day difficulties. Suggests an element of mistrust from participants meaning validity and generalisability of findings may be compromised.	Fear and stigma about autism within the Somali community as well as language barriers and lack of trust towards professionals affect help-seeking.
5.	Gondek & Kirkbride (2018)	To understand the factors making help-seeking more likely in the Polish community, looking at predisposing, enabling and need factors in terms of past help-	Quantitative cross-sectional. Online questionnaire survey.	**536** – Polish general population	Large sample	Result discrepancies using the multiply imputed sample and complete cases only. Some non-validated measures due to back translation. Social media opportunity	Help-seeking increases in older age. Factors affecting this: self-stigma, family networks, length of stay in the UK. No relationship between acculturation, language proficiency and help-seeking. Earlier life experiences of services can impact access to services in older age.

		seeking and intentions for future help-seeking.				sample -affected generalisability.	Greater knowledge of the NHS increases access.
6.	Këllezi et al. (2021)	To investigate barriers to and enablers of healthcare access among migrants in immigration removal centres. Specifically, how the group's stigmatised nature shapes their experiences, help-seeking motivations/behaviours and relationships with healthcare providers.	Qualitative. Semi-structured interviews. Thematic analysis.	**61** – 40 immigration removal centre residents (Africa-18, Asia-8, Europe-3, America-7, Middle East-2, Unknown-2), 21 staff	Sampling considered both points of views (migrants and staff). Looked into convergence of the two sample groups understanding of issues. Interviews in native language where needed.	Interview questions varied between participants. Non-generalisable sample as detention centres differ based on geographical area.	Lack of trust, stigma from professionals leading to non-help-seeking.
7.	Li et al. (2014)	Provide a greater insight into the knowledge and attitudes of Cantonese speaking older people towards mental illness.	Qualitative interviews. Face to face. Grounded Theory.	**8** – Chinese general population migrants	Offers novel knowledge. Large reviewer team with triangulation of data. Culturally sensitive sampling method. Interviews conducted in Cantonese.	Small non-representative convenience sample. No control of what the equivalent British people's views were.	Stigma can prevent help-seeking. Interventions not culturally sensitive to Chinese conceptual understanding of mental illness. Somatisation of MH. Hierarchy of stigmatisation of MH diagnoses and cultural camouflage. Western vocabulary for mental illness does not directly translate to Cantonese concepts. Stigma plays a big role in the community and help-seeking is affected by its implications.
8.	Murphy et al. (2020)	To understand NHS workers' understanding of the impact charging regulations have on their clinical practice and health care access of migrant children and their families.	Mixed methods. Online survey questionnaire.	**200** - Children's health practitioners in the UK	Variety of recruitment methods utilised. Outlines clinical impact of NHS regulations with clear recommendations.	Potential sample bias of over-estimation of phenomenon. Absence of patient voice.	Charging regulations are changing the ease with which migrants can access services. Mistrust of migrants towards health services as seen complicit with government regarding information sharing. Not accessing healthcare due to lack of understanding of rights to access, fears of racial profiling, hostile environment experiences.

9.	Onyigbuo et al. (2016)	To explore the perceptions, attitudes and responses to symptoms/illnesses of Nigerian migrants in the UK.	Qualitative interviews. Face to face focus group. Thematic analysis.	**10** – Nigerian general population migrants	Culturally sensitive sampling. Mix of one-to-one and focus group interviews allows for rich data.	Participants' English proficiency was unclear, but interviews held in English with potential of misinterpretation. Having a focus group on a topic including stigma could have affected reflections. No record of time since migration to consider integration to the UK culture.	Religious and cultural beliefs form the basis for responses to illness. Mental health addressed through herbal or spiritual remedies. More trust in abilities of clinicians from the same cultural background. Religious beliefs affect the meaning making and experience of help-seeking in migrants of the same country.
10.	Patni (2007)	To discern beliefs about support networks of adult mental health service users of South Asian origin? To understand solidarity attitudes, how they help and how they are available for this population.	Qualitative, face to face, semi-structured interviews. Thematic analysis.	**6** – migrant professionals from India (4), East Africa, Bangladesh	Purposive sampling based on research questions. Interviews instead of a focus group so that power dynamics did not hinder responses. Offers direct links between cultural beliefs and actions.	Small sample (6). All settled in one geographical area (London). Generalisability is potentially compromised; conclusions are drawn too broadly.	Barriers included gender stereotypes and reluctance, socio-economic status, using other avenues e.g. religious institutions, astrology, family structure, distrust towards non-South Asian professionals, lack of cultural sensitivity within services (inpatient food). Leaning into the in-group is a result of increased importance placed on solidarity within the south-Asian community. Comment that voluntary sectors are focusing more on SA needs compared to the statutory sector. Observation that with second generation SA being in the roles of health care professionals, some barriers are being lifted.

11	Pilkington et al. (2012)	To identify the factors that predict intention of accessing psychological help amongst British Muslims of South Asian origin.	Quantitative, cross-sectional. Online and paper questionnaire surveys.	**94** – general population of South Asian Muslims (predominantly Pakistan n=82) 33 first generation, 61 second generation	Thorough analysis of different factors. Novel study to look at help seeking behaviours through the cultural lens of 'izzat' (shame).	Only English language measures used potentially limiting the sample to those educated or integrated into British culture. Response bias as self-report forms more likely to be completed by educated people. Western measures used on a non-western population.	Migration is a moderating factor to intention to accessing help. Longer stay in the UK (more acculturation) correlates with higher intent to access services. Holding more biological beliefs about MH less intent to access services. Higher education more intent. Higher izzat less intent. There is a difference between first generation (migrants) and second generation to their intent to access help. Shows that it is not just due to cultural differences.
12.	Simkhada et al (2021)	To explore the relationship between culture and access to mental health services among Nepali and Iranian migrants in the UK.	Qualitative telephone and face to face interviews. Thematic analysis.	**21** - 6 English community mental health workers, 8 Iranians & 7 Nepali service users	Novel research, culturally sensitive data analysis with native researchers.	Participants only from one area of the UK so cautious generalisability.	Stigma, fear, gender, language, tradition, culture, family involvement and cultural awareness in health workers influence access to MH services. Somatic presentation of MH issues. Somatic symptoms are more readily accepted in Asian communities. Frequent discontinuation of anti-depressant medication. Cultural awareness training for staff is beneficial. There are split views on whether a professional from the community is helpful, fear of gossip and stigma.
13.	Troccoli et al. (2022)	To explore how Polish migrants help-seek within and beyond national borders.	Qualitative. Semi-structure telephone	**32** – Polish migrants caring for someone or	All interviews were conducted in Polish. Insight into help-seeking	There was lack of variability within the sample so reduced generalisability.	Lack of familiarity, judgments of inadequacy, accessing private health care in home country affect help-seeking in the NHS.

			interviews. Thematic coding.	with a chronic health condition	attitudes of the largest migrant group in the UK.	Majority of women living in the UK between 5-14 years.	
14.	Worth et al. (2009)	To determine the barriers in accessing services and their impact for South Asian Muslim patients and their families.	Qualitative. Longitudinal. Face to face, semi-structured interviews.	**92** - South Asian Sikh (7) and Muslims (18) with life limiting conditions (26), family carers (18) and professionals (20)	Interviews offered in English and native languages. Multilingual information tools. Staff, patient and family views included. High retention rate (96%).	Not always possible to know when a patient is at end-of-life so sudden end-of-life patients were excluded.	Language fluency, lack of culturally competent care, cultural beliefs, mistrust towards people outside of the community, concerns of stigma from the community, length of stay in the UK can all act as barriers to help-seek or access services.

Table 2

Theme Distribution in Included Studies

Theme	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Stigma	*	*	*	*			*	*		*			*	*
System Structure	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Trust		*			*					*	*	*	*	*
Alternative Support	*			*		*			*	*	*	*		
Gender	*				*									

Note. * indicates the presence of the theme within the studies included in the synthesis

Key: Pull Factors | Push Factors | Both Factors

The themes are conceptualised as belonging in two groups, 'push' and 'pull' factors acting as barriers to accessing mental health support. 'Pull factors' referring to factors reducing help-seeking behaviours in the migrant population and pulling individuals towards alternative and community-based solutions. These include self-and-community-stigma, trust, alternative support and gender. 'Push factors' refer to issues regarding service structure and delivery, cultural competence of services and stigma that pushes migrants away from services.

'Push factors'

System Structure

The structure of mental health services acts as a barrier to support for migrants for the following reasons.

Familiarity with System Structures

Lack of familiarity with the NHS system structures leads to difficulties in navigating access to support. There is uncertainty within the migrant population of availability of

services and the procedural aspects of accessing a service, such as the purpose of each appointment. Individuals feel "overwhelmed by their lack of understanding" (Fox et al., 2017, p. 311) and report that "When you're new to a country, it's just impossible for you to find all the different services available." (Fox et al., 2017, p. 311). Individuals from the Turkish community reflect on procedural anxiety regarding touchpoints within the service, such as referral and waiting periods, affecting their care access and experience (Christodoulou et al., 2018). There is further confusion around entitlements to free healthcare and relevant regulations (Bramley et al., 2020; Murphy et al., 2020).

This barrier appears to become less prominent as the length of stay in the UK increases (Pilkington et al., 2012; Gondek & Kirkbride, 2018; Bhavsar et al., 2021) possibly due to better awareness of services (Gondek & Kirkbride, 2018; Bhavsar et al., 2021). However, Pilkington and colleagues (2012) illustrate a nuanced relationship between length of stay and service access, with a positive relationship between years in the UK and intent to help-seek.

Language

Migrants' English proficiency is variable as some speak no English. Therefore, the absence of service information in languages other than English can act as the first barrier in acquiring knowledge of what support is available (Worth et al., 2009; Fox et al., 2017; Christodoulou et al., 2018; Bramley et al., 2020; Murphy et al., 2020; Simkhada et al., 2021). Migrant service users report that some of the leading UK providers' websites do not have "functionality to change its language" from English (Bramley et al., 2020, p. 25). Once in the service, language barriers can lead to miscommunications, leaving individuals feeling isolated. This is exacerbated by services' inability to access interpreters at short notice (Worth et al., 2009). In contrast, it appears that under-utilisation of mental health services is

present without the effect of language proficiency (Gondek & Kirkbride, 2018; Bhavsar et al., 2021). However, Gondek and Kirkbride's sample was mainly comprised by highly educated, young participants so it may be that language proficiency holds different significance for different groups.

Nonetheless, literature indicates that language can act as a barrier beyond the level of someone's fluency and ability to communicate without a translator present. Specialist language used within services and society to describe mental health does not always have a direct translation in other languages (Li et al., 2014; Christodoulou et al.,2018). In fact, in some instances the concept of mentally ill health can exist in such a different way that its presentation within the population differs to western-centric norms. This review identifies somatisation presentations of mental illness such as depression (Li et al., 2014; Simkhada et al., 2021) suggesting that experience, conceptualisation and therefore language used to describe mental health can vary between cultures. This can lead to uncertainty as to which service is needed as well as confusion within services regarding the advice or treatment being offered, diagnosis of symptoms and therapy processes (Worth et al., 2009; Fox et al., 2017). Thus, leaving individuals to have to "get a dictionary" to effectively participate in their care (Fox et al., 2017, p. 311).

Often, individuals will depend on family members to act as translators at the risk of information being withheld from professionals or misinterpreted (Worth et al., 2009) leaving the person seeking support isolated. Issues with language and feeling invisible are echoed in grey literature (Chojnacki, 2020; Peñuela-O Brien, 2020).

Cultural Competency

"There is nothing for me here" (Patni, 2007, p. 12) is how the lack of consideration to cultural needs is experienced by migrants. Culturally inappropriate care is observed on both a

service and individual level. Culturally specific needs according to religion, food, interpreters, modesty, and cleaning facilities are identified as practical barriers leading to a culturally insensitive environment as identified by migrants, their families and professionals. This leads individuals to feel discriminated against and treated with lack of respect (Worth et al.,2009) and experiences of "hostile environment[s]" discourage future help-seeking (Murphy et al., 2020, p. 5). Despite this, hope for a better experience for the second-generation migrants is expressed by a South-Asian individual (Patni, 2007).

Professionals working within the services are part of service structure. Migrant clients and health care professionals report lack of cultural awareness in health workers (Worth et al., 2009). Clinicians expressing a desire to develop their cultural practice do not receive training as part of their job role (Simkhada et al., 2021). Equality and Diversity Inclusion training is criticised as non-effective in making a practical difference in the way that care is provided (Worth et al., 2009) as issues of racism and discrimination are systemic.

Systemic Stigma

Stigma and discrimination from service providers in this review refers to the experience of migrants receiving differential treatment compared to their non-migrant counterparts. Këllezi and colleagues (2021) report that on occasions when the individual attempted to access mental health support through services, they felt stigmatised by the system and health professionals. Service providers are experienced as prejudiced, when staff become angry at patients and family members, neglect cultural needs and threaten to report to immigration services (Worth et al., 2009). Strained relationships and experiences of discrimination from staff are reported as specific reasons in not seeking help (Këllezi et al., 2021).

'Pull factors'

Self-Stigma

One of the most prominent barriers to accessing mental health services for migrants in the UK is self-stigma. For the purposes of this review, stigma refers to negative social attitudes attached to mental health difficulties and seeking support for mental health (Pattyn et al., 2014). The individual or group that holds these attitudes and beliefs often places disapproval on the individual which can become internalised shame (Gondek & Kirkbride, 2018; Këllezi et al., 2021; Simkhada et al., 2021). The individual seeking support carries the fear that in doing so, they will bring forward the associated shame for them and their families (Worth et al., 2009; Bramley et al., 2020). This is of particular importance when considering cultural dynamics where the actions of one family member impact the community social standing of the entire family (Bramley et al., 2020). Literature shows a direct relationship between levels of stigma related shame ("izzat") and intention to access services (Pilkington et al., 2012, p. 3). This could be explained by the implications accepting support might have for the social standing of an individual's family, particularly regarding a "taboo" issue as gambling addiction is described as by Muslim migrants (Bramley et al., 2020, p. 25). In not seeking support, the privacy of the family remains intact (Christodoulou et al., 2018) and is not stigmatised as a "bad genes" family (Li et al., 2014, p. 79).

Reluctance in help-seeking has led to "cultural camouflage" (Li et al., 2014, p. 84) of mental health difficulties where in-group strategies and narratives are being prioritised to manage difficulties within the community (Fox et al., 2017) to prevent becoming the subject of gossip if they seek help (Bramley et al., 2020). For example, the Chinese community operates on a hierarchy of stigmatisation where diagnoses such as dementia are preferable compared to schizophrenia (Li et al., 2014) as the former is seen as a natural part of ageing compared to the genetic understanding of the latter, which would bring more shame to the

family. This can influence delayed recognition and diagnosis, resulting in missed prevention opportunities (Li et al., 2014; Fox et al., 2017).

Trust

Lack of trust is a two-fold barrier to accessing services. One element of trust addresses the efficiency and expertise of the systems (Fox et al., 2017; Troccoli et al., 2022). Believing NHS treatment is inefficient because of lacking specialism or duration of treatment, leads some migrants to avoid NHS services (Troccoli et al., 2022). This lack of trust is expressed in direct comparison to services available in their home country.

Additionally, lack of trust refers to whether the professional will put them at risk. Personal or community level past experiences cultivate concerns that in accessing mental health services their ill health will be interpreted as fabricated to remain in the country (Këllezi et al.,2021) or that it will act as supporting information in their deportation from the country (Worth et al., 2009; Murphy et al., 2020). These beliefs along with the interplay of legal frameworks professionals are bound by, reduce help-seeking. Migrants have repeated experiences of not being believed by staff, being discriminated against, or treated differently because of their migrant status with threats of "paint[ing] a horrible picture […] and report[ing] […] to immigration" (Worth et al., 2009, p. 8). This discrimination can discourage from future help-seeking (Murphy et al., 2020). Migrant discrimination experiences of mental health services within immigration removal centres (Këllezi et al., 2021) mirror those reported in NHS settings (Worth et al., 2009; Murphy et al., 2020).

Literature reports that for south-Asian migrant distrust extends past White mental health professionals and is generalised to all non-South Asian professionals (Patni, 2007; Worth et al., 2009). However, studies also show lack of trust exists towards professionals

from the same background as the help-seeker, due to fear of confidentiality breach within the community (Bramley et al., 2020).

Alternative Support

Migrants, particularly from some Asian cultures, expressed that offering help is a family, not service expectation, with people from the Nepali community often taking over the care of relatives with mental ill health (Simkhada et al., 2021). This tradition leads to reduced or delayed help-seeking from services (Patni, 2007; Worth et al., 2009).

Religious beliefs such as "Allah God can change anything" (Fox et al., 2017, p. 310) and general spiritual healing (Onyigbuo et al., 2016) are characteristic of some alternative avenues to healthcare utilised by communities. One healthcare professional identifies "religion and mental health […] in the South Asian community are […] 'majorly' intertwined" (Patni, 2007, p. 9). Natural herb medicines are self-prescribed and encouraged within communities and by religious leaders (Li et al., 2014; Onyigbuo et al., 2016) with migrants holding greater efficacy beliefs towards these methods compared to western practices.

Polish participants in Troccoli et al. (2022) report that many choose to engage in medical tourism instead of accessing UK services as accessing private healthcare in their home country is cheaper than UK private healthcare and faster than the NHS.

Gender

Literature on gender was varied. Men and women are reported to have access to different opportunities regarding mental health support (Patni, 2007). Cultural roles of masculinity potentially lead individuals to delay seeking mental health support or under-utilising it "due to the perceived impact on their social status and job" (Simkhada et al., 2021, p. 1612) or a general "macho image" (Patni, 2007, p. 8). The belief that accessing mental

health support constitutes an individual as weak (Simkhada et al., 2021) was present for male and female genders with no mention of non-binary individuals. However, females appear to be more comfortable discussing mental-health compared to men (Simkhada et al., 2021) despite this belief, suggesting that there is an interplay between gender-specific cultural norms and seeking support.

Discussion

This literature review aimed to identify the difficulties non-refugee individuals migrating to the UK encounter when seeking support for their mental health through statutory services. The selected papers were of overall high quality. From this review, barriers to access can be categorised in push-and-pull factors. The interplay between these factors indicates a complex landscape in increasing migrant access to services. Most of the papers utilised qualitative methodology; in contrast with international reviews on migrant health, potentially indicating a methodological shift as suggested by Burns et al. (2021). Qualitative exploration of limited-service use has allowed for a nuanced understanding of barriers.

A 'push factor' is discrimination experienced within services. Stigma and racism from professionals are present across NHS and immigration removal centre mental health services (Worth et al., 2009; Chojnacki, 2020; Peñuela-O Brien, 2020; Këllezi et al., 2021). This echoes the Bennett Inquiry (2003) which highlights "the presence of institutional racism in the mental health services" (p. 67). Addressing institutional racism through individual training practices will therefore have limited success and be "superficial" (Younis, 2021, p. 1835) as the issues lie within system structures. Professionals question the availability and effectiveness of cultural awareness training (Worth et al., 2009; Simkhada et al., 2021). These experiences reinforce mistrust within the migrant population, pushing them away from

statutory services and increasing the strength of the 'pull factors' in decision making regarding mental health support.

Mental health stigma narratives are present across society but more prominent within minoritised groups (Mak et al., 2007). The influence self-stigma has on help-seeking is partially guided by the individual's role within the family structure (Simkhada et al., 2021) and how shame may affect family honour (Pilkington et al., 2012). This decision-making duality behind help-seeking for mental health support is not unusual. Gilbert (1992) argues that social status within the community holds equal importance towards an individual's emotional well-being as accessing a service. Thus, leading some to avoid services to avoid stigmatisation. However, not all individuals internalise this stigma (Corrigan & Watson, 2002) suggesting individual differences interact with the strength of 'pull factors' as barriers, calling for future research on this topic.

Not accessing services can be a choice. Migrants have lived experience of successful ways in addressing mental ill health that differ from the NHS medical model. Humans under stress seek familiarity, particularly in the context of moving (Oishi et al., 2012) which could explain the pull towards accessing avenues familiar from their home country. With knowledge of alternative support not dissipating upon migration, it stands to reason that familiar practices are utilised when struggling with mental health (Patni, 2007; Worth et al., 2009; Li et al., 2014; Onyigbuo et al., 2016; Troccoli et al., 2022). Additionally, grey literature introduces self-sufficiency as a characteristic of Central and Eastern European migrants (Peñuela-O Brien, 2020) which could increase how much familiar strategies are used. Conceivably, familiar practices act as 'pull factors' particularly in the presence of negative experience of UK services acting as 'push factors'.

When individuals from migrant communities seek mental health support, they are met with complex systems, inaccessible language and hostile environments (Li et al., 2014; Fox et al., 2017; Christodoulou et al., 2018; Murphy et al., 2020). Nevertheless, these issues are not limited to migrant populations. Language adaptations in mental health services are essential in working with people from lower socio-educational backgrounds and people with learning disabilities, (Surley & Dagnan, 2018; Gunn et al., 2021). This suggests there is universality in some of the migrant barriers; addressing them could benefit many vulnerable groups. Identifying an adaptation with wide-reach benefits is important when considering service user intersectionality and warrants future research.

Strengths and Limitations

This review presents the first UK specific understanding of non-refugee migrant barriers to services, presenting a novel classification of factors influencing access. A strength is the variety of migrant groups represented in the selected papers allowing for themes considering different cultural aspects of migration.

Limitations include the absence of triangulation, as research was examined by only one reviewer. Using standardised critical appraisal tools minimised the effect of this however, it cannot be eliminated. The addition of the 'representativeness' criterion from the JBI appraisal tool strengthened the analysis and revealed that the literature focus on migrant subgroups reduces the representativeness of findings to wider groups. This limits the implications that can be drawn from this review as it cannot be ascertained whether the push-and-pull factors and subsequent recommendations would also apply to non-refugee migrant subgroups not mentioned in the studies. Compromised representativeness and generalisability remain a long-standing issue within migration literature, potentially due to the heterogeneity of the population.

This review attempted to highlight the migrant groups as individual cultural entities but factors such as the prevalence of each community within the geographical area, cultural and individual differences inevitably affect the degree to which themes can be reflective of all migrant groups. The quantitative literature detailed how such confounding factors were considered. This was not reflected in the qualitative papers. Despite this heterogeneity, overlap of the barriers in accessing mental health services was observed suggesting that addressing the identified themes could form the infrastructure for culturally literate mental health provisions. Randomised control trials were not represented which could have addressed sampling limitations.

Implications for Future Research, Policy and Practice

Future research should employ targeted sampling which disaggregates the migrant population into subgroups, so all migrant voices and experiences are represented. Future research should also it should also explicitly address confounding variables that may influence migrants' experiences.

An improved understanding of somatisation presentations in some migrant groups could educate healthcare professionals to signpost certain physical presentations for mental health support. Somatisation is when psychological distress is expressed through physical-health challenges. It was a present but weak theme within this review (Li et al., 2014; Simkhada et al., 2021). Physical health challenges carry less stigma within some migrant communities meaning this presentation might be an unconscious defence to community and self-stigma. Mistrust based on discriminatory, culturally inappropriate and stigmatising experiences reduces help-seeking. Introducing stringent, anti-stigmatising and cultural awareness programmes that expand beyond training seminars and address the systemic challenges present, could address these issues.

The author advocates the need for additional support for migrants in expediting understanding of service structures and access entitlements, as service structure poses less of an access barrier to mental health services as the length of stay in the UK increases (Gondek & Kirkbride, 2018). Additionally, having link workers with the same language or cultural background as the migrants could ease this process (Fox et al., 2017).

This review draws together recommendations to improve migrants' access to statutory mental health services. However, ethnographic grey literature (Brenman, 2019) suggests the need to reformulate the problem of 'access'. Marginalised individuals, such as migrants, have additional needs. Mainstream services, in needing inclusion criteria, label the nature of need they can address, limiting the flexibility of their service offer. Voluntary organisations may be better suited to focus on targeted audience whose needs deviate from the mainstream (Giacco et al., 2014). Thus, calling for a greater government focus in supporting third sector provisions and a re-conceptualisation of need. There are 'hidden minority migrants' (Peñuela-O Brien, 2020) whose additional needs may not be recognised and will find themselves receiving help from mainstream services which need to have an awareness and flexibility to acknowledge the effect of migration and work with those needs.

Conclusion

This review aimed to explore existing research to increase understanding of the barriers faced by migrants in accessing mental health services within the UK. It highlighted the presence of 'push-and-pull' factors contributing to barriers. Predominantly, findings highlight the need for structural changes in the delivery of services. Clinicians require training on the 'push-and-pull' factors affecting migrants. Additionally, findings call for anti-stigma and cultural awareness programmes on a systemic level where the focus moves beyond training material and towards structural changes with closely monitored targets.

Finally, support for migrants to build an understanding of the NHS structures, their entitlements and how to navigate the system should be offered automatically. Changes to mental health policies addressing the above recommendations would support the national framework to improve mental health (Department of Health and Social Care, 2012) in tackling stigma and discrimination, ensuring equality of access and outcomes and creating a service design based on humanity, dignity and respect.

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Appendices

Appendix A
Journal Submission Guidelines

Full submission guidelines for the Journal of Cross-Cultural Psychology can be found at https://journals.sagepub.com/author-instructions/JCC .

The submission guidelines do not specify an overall maximum word count for submitted papers other than for the paper to be within 15 to 35 double-spaced, typewritten page limit. The current paper adheres to the requirements that the abstract be 150–250 words and that 4–6 keywords be provided.

In accordance with journal guidelines, the manuscripts has been prepared according to the most recent edition of the American Psychological Association Publication Manual (see https://apastyle.apa.org/products/publication-manual-7th-edition).

Some information required by the journal (e.g., author information, affiliations and declarations) has been omitted for the purpose of this thesis but will be added before submission of the paper.

The journal guidelines for referencing are broadly in line with APA 7th edition referencing style. Therefore, APA referencing was used in this paper. It should be noted that the Journal of Cross-Cultural Psychology specifies that manuscripts which have not yet been accepted for publication, are cited in the text but not included in the reference list.

Appendix B
Databases Searched

BMJ (14)	ProQuest (280)
Cambridge University Press & Assessment (36)	PubMed (123)
DOAJ Directory of Open Access Journals (125)	SAGE Journals (10)
EBSCOhost (51)	Scopus (273)
Elsevier (30)	Springer (168)
ERIC (6)	Taylor & Francis (15)
Ingenta Connect (153)	Wiley Online Library (195)
Ovid (101)	

Appendix C
MMAT Analysis Table

Qualitative	Simkhada et al., 2021	Bramley et al., 2020	Patni 2007	Christodoulou et al., 2018	Li et al., 2014	Onyigbuo et al., 2016	Fox et al., 2017	Troccoli et al., 2022	Këllezi et al., 2021	Worth et al., 2009
Are there clear research questions?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Do the collected data allow to address the research questions?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is the qualitative approach appropriate to answer the research question?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Are the qualitative data collection methods adequate to address the research question?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Are the findings	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

adequately derived from the data?										
Is the interpretation of results sufficiently substantiated by data?	Yes	Yes	Yes (some interpretations too broad to be based on the data)	Yes	Yes	Yes (not a lot of interpretation of themes)	yes	Yes	Yes	Yes
Is there coherence between qualitative data sources, collection, analysis and interpretation?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Are participants, and their voices, adequately represented? (JBI appraisal tool question)	No	Yes	No	Yes	No	No	Yes	No	No	Yes

Mixed methods	**Murphy et al., 2020**
Are there clear research questions?	Yes
Do the collected data allow to address the research questions?	Yes

Is there an adequate rationale for using a mixed methods design to address the research question?	Yes
Are the different components of the study effectively integrated to answer the research question?	Yes
Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Yes
Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Yes
Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Yes
Are participants, and their voices, adequately represented? (JBI appraisal tool question)	Yes

Quantitative Descriptive	**Gondek & Kirkbride 2018**	**Pilkington et al., 2012**
Are there clear research questions?	Yes	Yes
Do the collected data allow to address the research questions?	Yes	Yes
Is the sampling strategy relevant to address the research question?	Yes	Yes
Is the sample representative of the target population?	No	No
Are the measurements appropriate?	Yes	Yes
Is the risk of non-response bias low?	Can't tell (financial incentive used)	No (only 10% response rate)
Is the statistical analysis appropriate to answer the research question?	Yes	Yes

Quantitative non-randomised	**Bhavsar et al., 2021**
Are there clear research questions?	Yes
Do the collected data allow to address the research questions?	Yes
Are the participants representative of the target population?	Yes
Are the measurements appropriate regarding both the outcome and intervention (or exposure)?	Yes
Are there complete outcome data?	Yes
Are the confounders accounted for in the design and analysis?	Yes

Paper 2: Empirical Paper

Psychological Predictors of Greek and Greek Cypriot Migrant Well-being: The Role of Migratory Grief and Belonging.

Word count: 7378

This paper is intended for publication in the Journal for Cross-Cultural Psychology and has been formatted for submission. Appendix A outlines the journal's submission guidelines. Further edits may be made before submission to the journal.

Abstract

UK Greek and Greek Cypriots are an under-researched, migrant group. Clinicians are being called to respond to the psychological needs of a population without evidence-based recommendations. Migratory groups are at an increased mental health risk compared to their native counterparts but show low access rates to mental health services. Migratory grief is implicated in this increased risk but is under-researched. This study aims to address the gap in the literature regarding ethnic Greek's well-being in the UK alongside the wider gap on migratory grief. Hypotheses: (a) Higher levels of migratory grief will predict poorer psychological well-being (b) High levels of acculturation with host culture will predict better psychological well-being in this group. The study utilised a quantitative, cross-sectional design comprising of three online questionnaires (Migratory Grief and Loss Questionnaire; Greek American Acculturation Scale; Warwick-Edinburgh Mental Well-Being Scale). The sample was recruited via social-media (N=152) seeking first generation, UK-based Greek and Greek Cypriots. It comprised of a female majority (69%) holding a higher education degree (89%). Data was analysed using multiple regression. High levels of migratory grief predicted poor psychological well-being. Levels of acculturation predicted well-being in the opposite direction to the hypothesis. A higher sense of belonging with home culture (lower acculturation) was linked with higher well-being. This study highlights a potential moderating effect of belonging on the predictive strength of migratory grief on well-being. It indicates interventions using grief models and community initiatives to strengthen home culture bonds as important in supporting Greek migrant psychological well-being.

*Keywords: m*igratory grief; migrant psychological well-being; acculturation; Greek migration

Psychological Predictors of Greek and Greek Cypriot Migrant Well-being: The Role of Migratory Grief and Belonging.

Migration Landscape

International migration is increasingly common where 3.6% of the global population are estimated to be migrants (World Migration Report, 2022) and individuals often move more than once in their lifetimes (Bhugra, 2004). The 2021 UK Census approximates that 15% of the population in England and Wales were foreign-born (Office for National Statistics, 2021). This equates to approximately 10 million people.

The international definition for 'migrant' refers to an individual living outside one's country of birth (Moore et al., 2019). Forced migration refers to "a person subject to a migratory movement in which an element of coercion exists…e.g. movements of refugees and internally displaced persons" (Home Affairs European Commission, n.d.). These experiences leave them at increased risk of mental health difficulties such as post-traumatic stress disorder (PTSD) (Silove, 1999; Fazel et al., 2005). Voluntary migration refers to individuals who were able to make a choice regarding their move (Ottonelli & Torresi, 2013), usually in the interest of improved opportunities. The difference in trauma experiences establishes a distinctly different profile in the challenges faced by refugees and voluntary migrants (Sam & Berry, 2006, pp 349-367). This article will explore migrant well-being behind voluntary migration.

Migrant Well-being

Well-being holds many definitions. Eudaimonic well-being is conceptualised as growth and fulfilment which is influenced by people's context. Therefore, an individuals' opportunities for self-realisation and positive well-being vary across humans based on personal context. Additionally, it is linked with the regulation of multiple psychological

systems (Ryff & Singer, 2008) including affective-emotional aspects, cognitive-evaluative dimensions and psychological functioning (Tennant et al., 2007).

Aspects of the migration process are related to well-being. Migration has been described as a process of cumulative traumas (Tummala-Narra, 2011). Migratory groups are consistently at an increased mental health risk compared to natives and compared to individuals of the same ethnic background who have not emigrated (Carta et al., 2005; Islam et al., 2014; Virupaksha et al., 2014; Yang, 2019). This discrepancy is associated both with contextual factors (public policies, opportunities, societal stigma and barriers) and individual factors (Berry, 2005; Shinn & Toohey, 2003). Jibeen and Khalid (2010) outline a conceptual model using the stress-health outcome framework, to predict psychological well-being for migrant groups which identifies socio-demographic, and acculturation related variables linked with health outcomes. Within this model, acculturative stress, demographic factors (age, gender, income, education), coping resources and strategies are directly linked with psychological well-being. These findings are echoed, with the addition of religion, marital status, acculturation and length of stay, in research by Chirkov (2009), Myers & Diener (1995), Paloma and colleagues (2016) and Simich and colleagues (2006). Having more economic resources; feeling employment is meaningful; actively engaging with religious traditions; being married and satisfied with social circles; being physically healthy and outgoing; incorporating cultural elements of the host country as well as maintaining home country traditions are all corelated with positive well-being. Attitudes towards migration differ across and within societies. Even in cases where culturally pluralistic societies are welcomed, acceptance and stigma vary for specific religious and racial groups (Berry & Kalin, 1995).

Alongside socio-demographic and acculturation predictors of well-being, there are also psychological variables. Grief of loss of home country is comparable to the feelings

associated with losing a loved one (Stroebe et al., 2015). One of the indicators of increased risk of psychological distress for migrants is cultural bereavement (Bhugra & Becker, 2005). Literature connects migratory grief, length of stay in host country, level of employment and level of preparation prior to migration to psychological distress (Casado & Leung, 2002; Ahn, 2006; Khawaja & Mason, 2008).

Poor psychological well-being has reliably been established as a predictor for physical health problems, social problems and general day to day functioning difficulties (Huppert, 2009). As migratory groups are at an increased risk of mental health distress, they are also at risk of wider negative impact to their quality of life. Despite the recognised increased risk to well-being, migrant groups show low rates of access to mental health services, possibly perpetuating challenges to well-being. A recent literature review identified issues regarding service structure, delivery, and cultural competence (Kourtidou-Sextou, 2024, manuscript in preparation) as some of the leading factors behind the low access rates. Therefore, it is imperative to conceptualise factors affecting migrant well-being to deliver support that addresses the need.

Migratory Grief

Migratory grief as defined by Casado et al. (2010) is universal "grief issues associated with immigration […] that might be contributing to immigrants' adjustment difficulty or emotional distress" (p. 1). The experience of loss is categorised into tangible and symbolic loss, both of which are present during migration. It has also been theoretically linked to attachment loss (Bowlby, 1961). Grief is a process which typically follows loss and is essential to move on from it (Rando, 1984). On occasions when a loss is not recognised or grieving is not socially acceptable, an individual can experience disenfranchised (Doka, 1999) or complicated grief (Arizmendi & O'Connor, 2015). This kind of grief is significantly associated with poor mental health and well-being outcomes (Craig et al., 2008; Li et al.,

2019; Marques et al., 2013). Migratory grief is a form of complicated grief as preoccupation of survival in the host community, expectations of adjustment, shame and ambiguity of the loss can interfere with the ability to acknowledge or process the grief of the tangible and symbolic loss of home, relationships, identity, culture and places (Chan, 2013; Chang, 2015). It differs from other stressors associated with migration such as acculturative stress as it relates to feelings of what has been lost. Migratory grief is a significant, but under-researched aspect of the migration journey (Yoon et al., 2023). In the scarce literature available, high levels of migratory grief have been identified to be predictive of depression in a sample of elderly first-generation Chinese Americans (Casado & Leung, 2002) and Korean Americans (Ahn, 2006). To date, no study has looked at migratory grief and well-being in Greek migrants or migrants to the United Kingdom (Renner et al., 2024).

Acculturation

Acculturation is "the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members" (Berry, 2005, p. 698). It considers the psychological processes of adjustment a person undergoes when they change cultural environments. The acculturation process is argued to be universal across different cultural groups (Chirkov, 2009) in a similar way that animals biologically adapt to a new, physical environment. This assumption supports that there are core similarities in the process and effect acculturation has on well-being across all humans. A critical view of acculturation measurement might stipulate that different immigrant groups will have dynamic acculturation processes influenced by each group's unique characteristics. For example, research shows Asian migrants are more susceptible to acculturative stress compared to their European counterparts (Kaul, 2001). Berry (2005) suggests the acculturation process lies somewhere in-between. This meaning there are

universal stages and processes of acculturation which are participated in different degrees based on cultural group and individual factors.

Variables associated with acculturation and identified as determinants of well-being include length of stay in the host country, reasons behind migration and degree of similarities between home and host culture (Jibeen & Khalid, 2010). Berry (2005) outlines four processes of acculturation: (a) assimilation, (b) separation, (c) marginalisation, (d) integration. Assimilation refers to the process of not maintaining characteristics of the home culture and seeking daily interaction with the host culture. Separation refers to the opposite practice of only valuing home culture traditions and avoiding interactions with the host culture. In instances with little possibility or interest to maintain aspects of culture of origin and engage with host culture characteristics, marginalisation occurs. When there is active interest and engagement with both home and host culture traditions and interactions, integration is reached which is associated with positive well-being. Integrated individuals are reported to experience reduced discrimination (Berry et al., 2006) and adapt better both psychologically and socio-culturally as evidenced in a meta-analysis by Nguyen and Benet-Martínez (2013), possibly due to access to dual resources from both cultures. Although evidence indicates integration is associated with the most positive mental health, separation and assimilation also have benefits (Berry & Hou, 2016). This is because a sense of belonging is known to maintain positive well-being (Haslam et al., 2009). Being a member of an in-group works towards establishing a social identity which is pivotal in developing a sense of agency, purpose and belonging, as indicated by the social identity theory (Tajfel & Turner, 2004). These processes are associated with positive well-being, with an example being that migrants with higher acculturation and ethnic identity scores show higher rates of positive psychological well-being (Balidemaj & Small, 2019). Maintaining a strong social identity is theorised to act as a buffer to negative consequences associated with being part of a group

such as migrant discrimination (Espinosa et al., 2018; Mossakowski, 2003; Smith & Silva, 2011; Urzúa et al., 2021). When considering acculturation strategies, both separation and assimilation offer a sense of belonging and can therefore offer the associated well-being benefits to the migrants who adopt them.

The integration process is considered from the perspective of the migrant, the non-dominant group. Only when the host society is open to cultural diversity can migrant groups freely choose to reach integration thus, acculturating successfully. Otherwise, oppressive conditions and discrimination force migrant groups into assimilation or separation (Flannery et al., 2001; Sam & Berry, 2010) which have been associated with poor well-being (Phinney et al., 2001). LaFromboise and colleagues (1993) stipulate that successful acculturation is "the key to psychological well-being" (p. 402). Improving understanding of acculturation's effects on migrant well-being is essential for policy makers (Esses et al., 2015) to enact changes to promote successful cultural integration of migrant groups in their host countries.

Greek Migration

The Greek diaspora is recognised as one of the paradigmatic historical diasporas (Tziovas, 2009). There is limited literature exploring Greek migrant experiences in the USA and Australia (Argyropoulos, 2011; Grypma, 2020; Kiropoulos et al., 2004; Niles, 2000) with little to no research on this population in the UK. UK Greeks are characterised as "invisible" White migrants (Kallis, 2017). They are traditionally identified as European migrants in research which assumes homogeneity between populations that hold no reasonable similarities. There is a gap in the literature on the migration of the ethnic Greek migrant population in the UK and its implications on psychological well-being of this group of UK residents. The population of Greek and Greek-Cypriot nationals in the UK in 2021comprised of 73,000 and 21,000 people respectively (Census, 2021) meaning clinicians are being called to respond to psychological needs of a population without evidence-based recommendations.

Understanding this relationship and factors influencing it is clinically important in being able to appropriately adapt interventions and psychological or practical support in the community.

Current Study

The purpose of the current study was to examine predictors of Greek and Greek Cypriot migrant well-being. This study was conducted in the UK where there is no related body of literature on this population. Specifically, it aims to contribute to the gap in wider literature on migratory grief. The focal predictors selected were migratory grief and acculturation. Given the established literature on the interaction gender, relationship status, employment, education and years since migration have with well-being (Ahn, 2006; Jibeen & Khalid, 2010; Simich et al., 2006), it is recognised they could be enacting a confounding effect on the focal predictors and therefore, are also considered within this study.

Aims and Hypotheses

This current study aimed to investigate rates of migratory grief, acculturation and its relationship with the well-being of first-generation Greek and Greek Cypriot migrants. Additionally, years since migration, employment, education, marital status and gender were considered as potential confounding factors to this relationship. The following hypotheses were tested:

1. High levels of migratory grief will predict poor quality of psychological well-being in first generation Greek and Greek Cypriot migrants.
2. High levels of acculturation with host culture will predict better psychological well-being in first generation Greek and Greek Cypriot migrants.
3. Migratory grief and acculturation will be predictive of well-being when accounting for other demographic factors, such as years since migration, employment, education,

marital status and gender, which already have an established relationship with well-being in the literature.

Method

Design

This was a quantitative study with a cross-sectional design. It considers relationships between previously un-researched continuous variables. An a priori power calculation was done. G*Power (Faul et al., 2007) was used to calculate the smallest sample size to detect a meaningful relationship between the main study variables via by multiple linear regression. To achieve 80% power for detecting a small to medium relationship ($f^2 = 0.15$), at a significance level of $\alpha = .05$, the calculation was N=107. Thus, a sample of size of N=107 is assumed to be sufficient to test the principal hypotheses.

Participants

Eligibility criteria for this study included being a first-generation Greek or Greek Cypriot. This means being born in Greece or Cyprus as well as being an ethnic Greek. Participants also had to be over the age of 18. Ethnic Greeks who were born in the UK were not included as the study was exploring the process of migration.

In total, 152 individuals participated and provided responses with no or minimal missing values. Participants were mostly female (69.1%), under full-time employment (69.7%) and had completed a form of higher education (89.4%) (see Table 1).

Table 1

Demographic Characteristics of Participants

Characteristic	*n*	%
Gender (*n* =152)		
- Male	44	28.9%
- Female	105	69.1%
- Prefer not to say	3	2%
Relationship status (*n* =152)		
- Single	65	42.8%
- Married	56	36.8%
- In a domestic partnership	28	18.4%
- Divorced	3	2%
Education (*n* =152)		
- Less than GCSEs	3	2%
- GCSEs	3	2%
- A-Level	8	5.3%
- Bachelor's Degree	35	23%
- Master's Degree	64	42.1%
- PhD	37	24.3%
- Other	2	1.3%
Employment (*n* =152)		
- Employed full-time	106	69.7%
- Employed part-time	24	15.8%
- Unemployed (looking for work)	6	3.9%
- Unemployed (not looking for work)	1	0.7%
- Student	14	9.2%
- Retired	1	0.7%
Location (*n* =152)		
- England	131	86.2%
- Scotland	17	11.2%
- Wales	2	1.3%
- Northern Ireland	2	1.3%

Procedure

Data was collected through an online survey on research platform Qualtrics (https://www.qualtrics.com) . Participants were required to complete non-identifiable demographic information as well as three self-report questionnaires measuring migratory grief and acculturation (predictor variables) and psychological well-being (outcome variable).

This study protocol was approved by the ethics committee of Staffordshire University (Appendix B). During survey development, feedback was provided regarding the material by three Greek migrants known to the researcher regarding readability and content. No necessary changes were identified at that stage and recruitment commenced. Since no changes were made to the test material, their responses were included in the final sample.

The present study recruited participants via poster using a combination of voluntary response and snowballing sampling. The poster (Appendix C), information sheet (Appendix D) and participation link were distributed through online forums created by Greek and Greek Cypriot migrants for the use of the communities e.g. Facebook, Instagram.

The overall duration of the survey was approximately 20 minutes. No incentives were provided. Participants were able to access the online information sheet via a link from the poster or by scanning a QR code. This directed the participants to an online information sheet where informed consent (see Appendix D) was required to progress to the questionnaires page. Once accessed, the link presented participants with the Greek-American Acculturation Scale (GAAS), Migratory Grief and Loss Questionnaire (MGLQ) and Warwick-Edinburgh Well-Being Scale (WEMWBS) measures along with non-identifiable demographic information. Participants were informed that withdrawal of responses was not possible as no identifiable data was collected.

The survey was open between 29th March 2023 – 31st October 2023. A final sample of N = 152 was recruited. Within this sample, n=37 cases had incomplete data that was less than 10%. Although the sample was larger than required to power the analyses, no responses were excluded on this basis, due to ethical concerns.

Measures

All measures were administered in English as some of the questionnaires used in this study had not previously been translated into Greek. Given the scope of this research project, it was not possible to conduct validation studies to translate the measures. The questionnaire total score was calculated separately for each questionnaire, for each participant and was used in the analysis.

Demographics

Participants provided non-identifiable demographic information of gender, education and employment status, location, marital status and year of migration to the UK (see Appendix E). Information was gathered to describe the sample. All information apart from location were included in the main analysis.

Acculturation

The Greek American Acculturation Scale (GAAS) (Harris & Verven, 1996) measured the level of acculturation. It consists of 56-items describing different aspects of Greek culture. Participants rate the degree to which the statements reflect their attitude towards Greek culture, using an 8-point scale (*0 = not applicable, 4 = neutral, 7 = strongly agree*). It yields a total score that can range from 0 to 392. A higher score indicates a more traditional cultural orientation with strong ties to the home culture. In Berry's (2005) terms, a higher score is indicative of separation whereas a lower score is indicative of assimilation. The scale is presented to have validity and reliability and indicated for non-US Greek populations

(Harris & Verven, 1996). The internal consistency of the GAAS has been shown to be acceptable for each of the homogenous dimensions with the following value range, Cronbach's alpha = .80 - .93 (Harris & Verven, 1996).

Well-being

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) (Tennant et al., 2007) measured psychological well-being. This instrument offers an overview of a participant's well-being, with a higher score indicating better well-being. It consists of 14-items exploring feelings and thoughts, using a 5-point scale (*1 = none of the time, 5 = all of the time*). It yields a total score ranging from 0 to 70. The WEMWBS has shown to be valid across different cultures. Internal consistency is shown to be good (Cronbach's alpha = .91) in the general population (Tennant et al., 2007).

Migratory Grief

Migratory Grief and Loss Questionnaire (MGLQ) (Casado et al., 2010) measures the experience of grief and loss experienced with migration. It consists of 18-items, where each item has an intensity and a frequency subscale. It uses a 4-point scale (*0 = never, 3 = always*) with possible scores ranging from 0 to 108 with a higher score indicating a more intense level of grief. The MGLQ has been shown to have high internal consistency (Cronbach's alpha = .94) leading to it being a reliable scale (Casado et al., 2010). It is the main measure of migratory grief in the literature (Renner et al., 2024).

Questionnaire Permissions

Explicit permission was granted for the use of the WEMWBS (see Appendix F). Permissions for the GAAS and MGLQ were requested via emails to authors, without securing

a response. Both measures were available to open access online with no indication of restriction of usage.

Data Analysis

All data was analysed using IBM SPSS Statistics Version 29.0. Descriptive statistics outlined the sample's demographics (see Table 1) and questionnaire scores (see Table 2).

'Reason behind migration' was excluded from all analysis due to inconsistencies in interpretation. The respondents' gender, employment, education and relationship status were transformed from nominal variables into dummy variables to allow for parametric analysis. Bivariate correlations between all variables were conducted. A multiple regression analysis was conducted between psychological well-being and predictors that showed a significant correlation with psychological well-being.

Missing Data and Data Cleaning

A missing value analysis was conducted to identify missing data. Where the dataset was completely blank, data was assumed to be missing due to a participant accessing the survey, not giving consent and automatically exiting the survey. Partial missing data was found only in the responses collected early on in the recruitment period before a 'forced choice' mechanism was activated on the Qualtrics survey later into the study. This leads to the reasonable assumption that partial missing data was due to participant's ability to skip questions when the survey was first opened. More than 10% of data missingness can lead to biased results (Bennett, 2001) therefore, in those instances, casewise deletion took place, leaving N=152. Within this sample, n=37 cases had incomplete data that was less than 10% meaning treatment of incomplete data was needed. Further missing value analysis using Little's test produced non-significant (chi-square = 3683.474, DF =3692, p =.536) results. This indicates that data is missing at random (MAR), therefore, multiple imputation is

indicated as a method of treating missing data (Papageorgiou et al., 2018). See Appendix G for details of the imputation model.

Statistical Assumptions

Normality checks (see Appendix H) were conducted to determine whether there was violation of the regression assumptions, including multicollinearity, normality, linearity and homoscedasticity (Field, 2018). The assumption of independent residuals was met, indicated by a range of Durbin-Watson scores lower than 2 (see Appendix H). The tolerance values were all above 0.2 and the variance inflation factor (VIF) values were below 10 across all of them indicate no issues with multicollinearity. No cases had undue influence on the model, indicated by all cases having Cook's distance less than 1.

P-P plots indicated no deviations from normality with the dots lying close to the line and histograms show normal distribution (see Appendix I). Scatterplots of standardised predicted value against regression standardised residuals were reviewed for homoscedasticity and produced no evidence this was violated, meaning the variance in the residuals is constant (see Appendix I).

Internal consistency was tested using a Cronbach's alpha analysis for the measures used with this sample. High levels of internal consistency were present across all measures. The Greek American Acculturation Scale produced a Cronbach's alpha = .89. The Migratory Grief and Loss Questionnaire produced a Cronbach's alpha = .96. The Warwick Edinburgh Mental Well-Being Scale produced a Cronbach's alpha = .91.

Results

Descriptives

Table 2

Descriptive Statistics for Key Variables in the Regression Model

Measure	*M*	*SD*	*Range*
Acculturation: (GAAS)			
Original data (n=146)	269.70	42.27	167-388
Imputed data (N=152)	269.53[a]	42.18 – 42.33 [b]	167-388 [c]
Migratory Grief: (MGLQ)			
Original data (n=120)	48.03	22.42	3-104
Imputed data (N=152)	48.29 [a]	21.80 – 22.11 [b]	(0-3)[d] –104 [b]
Measure	*M*	*SD*	*Range*
Psychological Well-being: (WEWMBS)			
Original data (n = 151)	49.60	8.96	21-70
Imputed data (N=152)	49.49 [a]	9.03 – 9.07 [b]	21-70 [c]
Years since migration			
Original data (n=134)	9.18	6.63	0-38
Imputed data (N=152)	9.98 [a]	6.34 – 9.32 [b]	0-38 [c]

Note. [a] Pooled statistics following multiple imputation. [b]Standard deviations differed for each imputation, highest and lowest values presented. [c]Range was the same across iterations. [d]Range values differed across iterations and are presented within the brackets.

Correlations

Bivariate Pearson *r* correlations were conducted between the outcome variable of psychological well-being and all potential predictor variables (see Table 3). Correlation analyses dictate variables must be continuous, not categorical (Field, 2018). For this reason, dummy variables were computed for Gender, Relationship Status, Employment and

Education (see Appendix J). The variable 'Year of Migration' was re-interpreted as 'Years Since Migration' to produce a continuous variable.

Years since migration (r = .156, p = .105), Gender (r = .146, p =.073), Education (r =.088, p =.284), Employment (r = .052, p =.526) and Relationship (r = .051, p =.530) status were not significantly correlated with psychological well-being.

There were strong significant correlations between the main predictor variables and psychological well-being, as outlined in Table 3.

Table 3

Pearson's r Bivariate Correlations Between all Variables in the Regression Model

	1	2	3	4	5	6	7	8
1. Year Since Migration	-							
2. GAAS[a]	.045	-						
3. MGLQ[b]	-.133	.374**	-					
4. WEMWBS[c]	.156	.224**	-.247**	-				
5. Gender	.000	.029	-.157	.146	-			
6. Education	-.050	-.035	-.061	.088	-.017	-		
7. Employment	.046	.018	.131	.052	-.109	.015	-	
8. Relationship Status	.213*	.036	-.178*	.051	-.009	.036	.084	-

Note. *p < 0.05; **p < 0.01; ***p < 0.001. Values are derived from pooled statistics following multiple imputation. [a]Greek-American Acculturation Scale, [b]Migratory Grief and Loss Questionnaire, [c]Warwick-Edinburgh Mental Well-Being Scale.

Multiple Regression

A multiple regression analysis was conducted to examine the effect of acculturation and migratory grief on psychological well-being. Years since migration, Gender, Employment, Education and Relationship provided no positive correlations with psychological well-being (Table 3) and were not included in the regression.

A multiple regression analysis including acculturation and migratory grief as predictors was run, using the imputed data. Table 4 presents the results of this analysis. The mean proportion of variance in psychological well-being was 17.7% using average pooled statistics ($R^2 = 0.177$, $F[2,149] = 16.068$, $p < .001$ with the adjusted R^2 value being 16.6%. Full statistics for each imputation are in Appendix H.

Migratory grief was a significant negative predictor of psychological well-being (β = -.377 – -.392; $p < .001$), in line with Hypothesis 1. Higher scores of the GAAS which indicate low acculturation significantly predicted higher psychological well-being (β = .362 – .377; $p < .001$), not supporting Hypothesis 2.

Table 4

Multiple Regression Analysis Predicting Psychological Well-Being (N=152)

	B[b]	SE B[b]	t[b]	β[c]		p[b]	95% CI	
				Lower	Upper		Lower	Upper
Constant[a]	35.894	4.343	8.265			<.001***	27.382	44.406
Migratory Grief and Loss Questionnaire (MGLQ)	-.158	.033	4.590	-.377	-.392	<.001***	-.223	-.094
Greek American Acculturation Scale (GAAS)	.079	.017	-4.794	.362	.377	<.001***	.045	.112

Note. 95% CI = 95% confidence intervals for B. R^2 = 17.2% – 18.1%; adjusted R^2 = 16.1% – 17.0%. [a]Warwick-Edinburgh Mental Well-Being Scale. [b]Pooled values. [c]Range of values across the imputations. * $p < .05$, ** $p < .01$, *** $p < .001$.

Post-hoc Analysis

Although the hypothesis that acculturation predicts well-being was supported, this was in the opposite direction to expectation. Additionally, there is a significant, positive correlation

between migratory grief and acculturation (Table 3) which indicates potential for a more complex relationship between predictors and outcome variables. To test this, an interaction term was included in the model MGxGAAS to examine a potential moderation effect.

Table 5 presents the results of this analysis. The mean proportion of variance in psychological well-being was 21.3% using average pooled statistics (R2 = 0.213, *F*[2,148] = 13.378, p <.001 with the adjusted R2 value being 19.7%. Full statistics for each imputation are in Appendix K.

The interaction between migratory grief and acculturation and their relationship with psychological well-being was significant, suggesting a possible buffering/moderation effect. When including the interaction variable, there is a direction change of the relationship between acculturation and psychological well-being, as illustrated in Table 5. Furthermore, acculturation is no longer a significant predictor of psychological well-being (β = -.030 – -.073; p = .775). Migratory grief remained a significant predictor of psychological well-being (β = -1.454 – -1.559; p<.001).

Table 5

Post-hoc Moderation Multiple Regression Analysis Predicting Psychological Well-Being (N=152)

	B[b]	SE B[b]	*t*[b]	β[c]		*p*[b]	95% CI	
				Lower	Upper		Lower	Upper
Constant[a]	59.049	9.902	5.964			<.001***	39.642	78.456
Migratory Grief and Loss Questionnaire (MGLQ)	-.622	.182	-3.418	-1.454	-1.559	<.001***	-.979	-.265

Greek American Acculturation Scale (GAAS)	-.011	.039	-.286	-.030	-.073	.775	-.087	.065
MGLQxGAAS Interaction	.002	.001	2.590	1.287	1.414	.010**	.000	.003

Note. 95% CI = 95% confidence intervals for B. R^2 = 20.6% – 21.7%; adjusted R^2 = 19.0% – 20.1%. [a]Warwick-Edinburgh Mental Well-Being Scale. [b]Pooled values. [c]Range of values across the imputations. * p <.05, ** p <.01, *** p <.001

Figures 1 and 2 graphically illustrate the nature of the moderation effect as the presence of strong ethnic identity (high GAAS score) reduces the strength of the predictive relationship of migratory grief on well-being.

Figure 1

Post-hoc Simple Slope Graph Illustrating the Predictive Relationship of Acculturation on Psychological Well-Being Across Different Levels of Migratory Grief

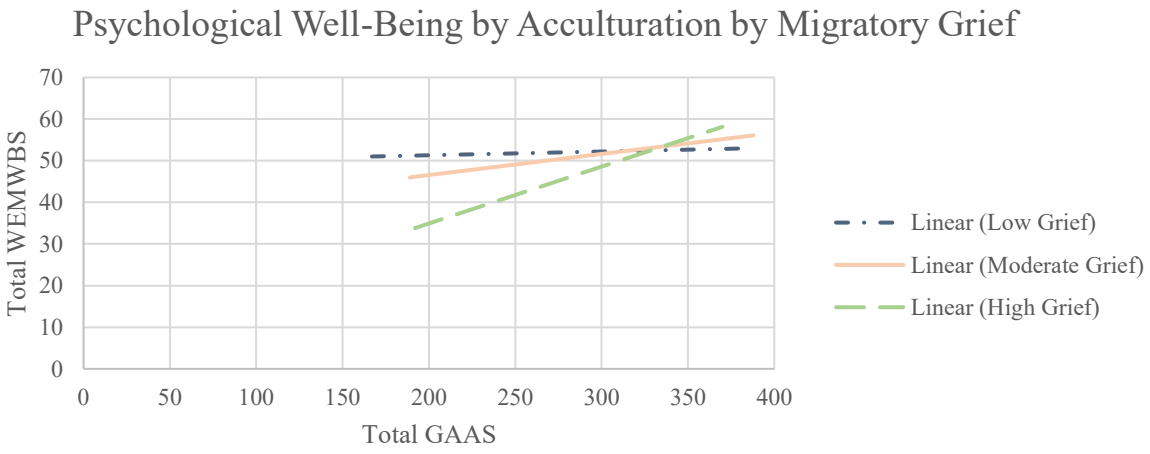
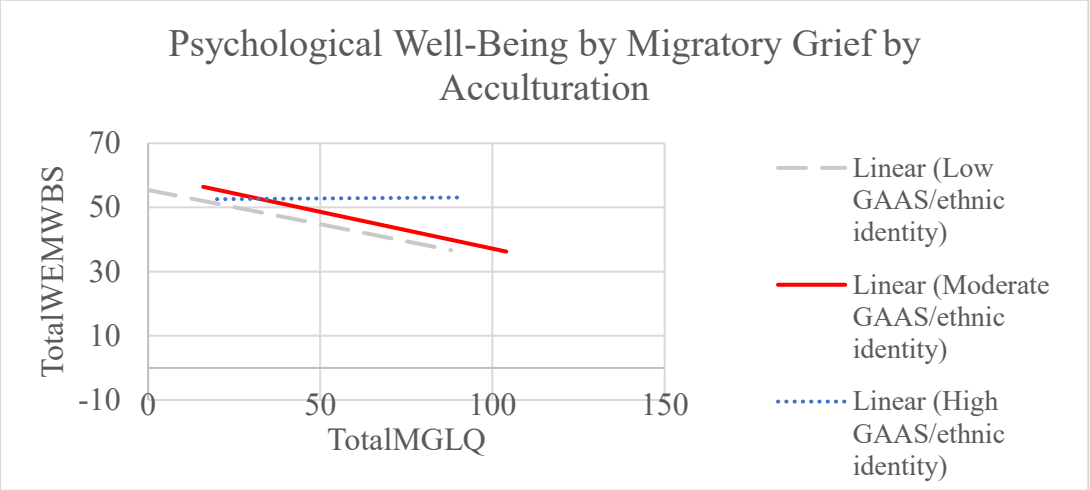


Figure 2

Post-hoc Simple Slope Graph Illustrating the Predictive Relationship of Migratory Grief on Psychological Well-Being Across Different Levels of Acculturation



Discussion

This research focused on investigating predictors of well-being for the Greek and Greek Cypriot migrant population in the UK. It explored migratory grief and acculturation as potential predictors of well-being while considering other factors that have been identified as predictors in previous research such as years since migration, gender, employment, education and relationship status. Contrary to expectations, the sociodemographic variables were not predictive of well-being. However, the main hypotheses of the study were supported. Migratory grief and acculturation are significant predictors of well-being when other variables are considered, explaining a significant portion (17.7%) of the total variance associated with psychological well-being in the Greek and Greek Cypriot first-generation population in the UK. The findings support the assertion that migratory grief and acculturation represent different contributions to migrant well-being and there is value to exploring both further, from a clinical and social perspective. The findings also introduce a novel moderating relationship of acculturation on migratory grief and psychological well-being.

High levels of migratory grief predicted poor quality of well-being in first generation Greek and Greek Cypriot migrants. These results are in line with existing research in other populations indicating migratory grief predicts negative affect and depression (Chang, 2015; Chang et al., 2023). The findings are novel and illustrate the role of migratory grief as a predictor of well-being for Greek UK migrants for the first time in literature. The presence of migratory grief aligns with existing knowledge that the migration process can trigger feelings of loss and bereavement (Bhugra & Becker, 2005; Stroebe et al., 2015). This loss can be symbolic or concrete and is characterised as complicated (Achotegui, 2019; Kokou-Kpolou et al., 2017).

The results from this study are consistent with conclusions drawn by Chang and colleagues (2023) with a group of first-generation Korean immigrants in the USA. This shows a universality between the experience of migratory grief and its effect on well-being, in line with Chirkov's (2009) theory of universality in factors influencing migrant well-being. It is particularly significant, as a comparison between Greek and Korean culture profiles (Hofstede Insights, 2023) outlines clear similarities between each culture's relationship with power, individualism and uncertainty avoidance. There were clear differences in all other comparison categories (motivation towards achievement, long-term orientation and indulgence). These similarities might indicate cultural patterns that when present, migratory grief has a more profound effect on well-being. Future research could explore this across different cultural migrant groups.

The interaction between migratory grief and well-being is important as there is a vast body of literature on psychological processes surrounding grief that can be used when working with migrants. This study calls for practitioners to recognise migratory grief and acculturation as unique factors affecting well-being that are relevant to consider when offering psychological support. Processing grief related to migration may benefit Greek

migrants' well-being, as is the case with all grief, rather than attempting to discount or reduce it.

It was hypothesised that high levels of acculturation would be predictive of positive well-being. The research findings were not consistent with the hypothesis, they show a reverse relationship. This being, that individuals with more traditional cultural orientations (higher scores on the GAAS) had higher quality well-being. This study reaffirms that acculturation may be linked to well-being in different ways, depending on culture. According to Berry (2005), placing high value on home culture traditions is indicative of separation. However, according to the definition, to determine separation, avoidance of interacting with the host culture needs to be confirmed. The content of the GAAS questions is focused on maintenance of traditional Greek values and traditions rather than avoiding interaction with UK culture. Therefore, a high score does not rule out the possible presence of integration in the sample. These findings provide contradictory evidence from previous literature findings (Jibeen & Khalid, 2010) as to the negative impact unsuccessful acculturation has on well-being. This may be understood by the fact that by following traditional cultural orientations, individuals are maintaining a sense of belonging with their home culture. Berry and Hou (2016) present a similar trend of separation being predictive of positive well-being. They conceptualised this as "reactive identification" (p. 260) where if rejected by the host culture e.g. through discrimination, the individual will in turn reject the host culture and turn to the in-group. This is in line with known positive psychological effects of belonging to an in-group according to the social identity theory (Tajfel & Turner, 2004). It is also observed in other migrant groups, such as Colombians in Chile, where ethnic identity is seen to be associated with positive psychological well-being (Henríquez et al., 2021). It could be stipulated that maintaining strong links with the home culture and ethnic identity can act as a buffer between negative experiences of migration and their effect on well-being (Espinosa et

al., 2018; Mossakowski, 2003). Separation being a preferred strategy of acculturation is not unique to the Greek and Greek Cypriot population of this sample. Sam and Berry (2010) found the majority of a Turkish population sample had adopted the separation strategy.

The stronger the ties to ethnic identity (low acculturation), the more grief was experienced in this population. Those individuals may have stronger emotional connections to Greece and Cyprus, meaning the sense of loss and grief linked to migration is more pronounced compared to those with weaker ties to their home country. Another assertion could be that those with strong ethnic ties may find adapting to the host cultural environment more challenging, contributing to feelings of migratory grief. The interaction between acculturation and migratory grief has a moderating effect on psychological well-being. This is a novel finding, not explored previously in literature and thus, the precise nature of the moderation process is unclear. A graphic plotting of the interaction indicates that stronger ties to ethnic identity may act as a moderator or buffer between migratory grief and well-being. It is observed that well-being remains high in the presence of high migratory grief when individuals show low levels of acculturation. Conversely, in the absence of strong ethnic ties, high migratory grief is predictive of poor psychological well-being. This may perhaps be associated to positive psychological effects of belonging to an in-group (Tajfel & Turner, 2004). There are clinical and social implications of understanding the moderation process in more detail.

The length of time that had passed since migration was hypothesised to predict psychological well-being. However, in this study, this was not supported. This implies that psychosocial adjustment is contributing to changes in well-being rather than just the length of time since migration. Some literature suggests that years since migration predict well-being due to the negative relationship between length of stay in host country and migratory grief (Anh, 2006; Casado et al., 2010) however this relationship is not observed in research by

Chang and colleagues (2023) or this current study. Chang et al. (2023) hypothesises this disparity across research may be related to sampling differences. Studies that have observed this relationship recruited a sample of elderly participants whereas when there was greater range in the sample age, the relationship was not observed. This could be related to normal processes of aging and cohort effects. Tonkin's model of grief (1996) could contribute to this understanding of the effect of length of stay as it specifies that as time passes, life grows around the grief minimising its impact on daily life and well-being. This effect may be expected to be more prominent in the elderly. This would suggest that Tonkin's model is transferable to explain migratory grief experiences and future research on this could be indicated.

In terms of socio-demographic factors, it was hypothesised that employment, education, gender and relationship status would be predictive of psychological well-being. This was not supported, with the influence of all socio-demographic factors having low, non-significant influence on psychological well-being. This may indicate there is not a lot of variation in the stress-potential between these factors (Akhtar & Kroener-Herwig, 2019). Additionally, Khumalo and colleagues (2012) argue that there are inconsistencies across the literature as to the predictive role of sociodemographic variables on psychological well-being, largely caused by differences in construct definition, measurement tools and context.

Limitations

Constraints on Generality

Females and university educated individuals comprised the majority of the sample. As there is no data on the gender split or general education attainment of the Greek and Greek Cypriot first-generation population in the UK, it is not possible to establish whether this is a true reflection of the population or an over-representation. Migrant populations are typically

shown to have lower well-being compared to the general population. This was not the case for this sample. These limitations may have contributed to this deviation from the usual findings on migrant well-being. Taking the above limitations into consideration as well as the fact that findings are consistent with literature on other cultures, generalisability should be considered with caution.

Measurement & Methodological Limitations

The results of this study should be considered in the context of its limitations. There is discourse in the literature that measuring acculturation is beyond the capacity of quantitative tools (Chirkov, 2009). This is further substantiated by the fact the Greek American Acculturation Scale (GAAS) does not directly address the different processes within acculturation (assimilation, separation, marginalisation, integration) as outlined by Berry (2005) leaving interpretation vague. However, it does measure a range of cultural behaviours, beliefs and ethnic identity as opposed to relying on acculturation by proxy measures, such as place of birth, which is a limitation of many acculturation measures (Alegria, 2009). The GAAS questions fall into two factors: attachment to homeland and identity discontinuity. The correlation between the acculturation and grief measures may suggest that inadvertently, elements of the concepts explored within the measures may capture some overlapping processes. However, the moderation effect of acculturation on grief may suggest that a substantially different concept is captured.

Self-report measures receive criticism for their lack of objectivity and bias (Demetriou et al., 2015; Rosenman et al., 2011) however, as the processes participants were asked to report on are internal, subjective processes, self-reporting was appropriate (Lucas, 2018). The GAAS was developed and validated for the USA based Greeks. In this study it was distributed to UK based Greeks and Greek Cypriots. Nuances in host cultures and their

potential effect on degree of acculturation are acknowledged. Despite these limitations, this scale was the only available for this specific ethnic population and was therefore deemed appropriate. Not providing Greek language questionnaire may have skewed our understanding of the Greek migration processes and findings should be generalised to non-English speaking Greek and Greek Cypriot migrants of the UK with caution.

This was a cross-sectional study therefore, causality cannot be inferred (Burbridge, 1999). This presents a limitation as the processes of grief develops across time. As such, it would be beneficial to study this longitudinally in future.

Clinical Implications and Future Research

Based on the findings, the researcher calls for practitioners, therapists and researchers to recognise migratory grief and acculturation as distinct factors related to Greek migrant well-being in the UK. It highlights a novel moderation relationship where the ethnic identity moderates the strength of the predictive relationship between migratory grief and psychological well-being. This should be explored in future research. It is also an invitation to explore these psychological processes in other cultural migrant groups.

The identified predictor of migratory grief provides implications for clinical practice as does the finding that maintaining ties to the home culture ethnic identity has a positive predictive effect on psychological well-being. Clinicians working with Greek and Greek Cypriot migrants presenting to services with challenges to their well-being should consider the presence of grief or absence of ethnic identity in their formulations and care planning to offer grief-informed care. If the presenting concern is identified to be solely focused on themes of loss and cultural bereavement, then a grief intervention should be offered. Grief-informed care could consider Bowlby's attachment loss theory (1961) which stipulates that attachment processes are activated during bereavement. Reflecting on Tonkin's model of

grief (1996) which indicates re-engagement with life minimises the effect of grief, could be beneficial for this ethnic group. In the case of migration, life refers to the host country. Additionally, not relinquishing attachment to what was lost could be considered in line with Berry's (2005) and Kosminsky & Jordan's (2016) views on acculturation and grief respectively.

Maintaining a bond with their ethnic identity is shown to be beneficial for Greek migrants' well-being. Proactive community level interventions focusing on a positive sharing of cultural practices between Greek migrants and potentially UK natives or other migrant groups, could support the maintenance of ethnic identity. At present, the existing initiatives are mainly aimed at refugees, potentially excluding other migrant groups, such as the one identified in this study. Initiatives such as the Culture Kitchen by Culture Connect charity allow migrants to celebrate their cultural food and also interact with the local community. The Refugee Council offers psychosocial groups to strengthen relationships with ethnic peers. The proposed community level intervention would be more cost-effective compared to individual psychological therapy as it could be offered on a group or community level. Initiatives could be facilitated by professionals and community members as responsibility of migrant well-being does not only sit with psychological therapists. Reactive identification suggests there is a community responsibility to create a hospitable, non-discriminatory environment in which the migrant population can integrate. This is contingent on the host society being open to cultural diversity (Berry, 2005) which necessitates structural change to cultural attitudes. Therefore, psychologists should be engaging in structural advocacy for Greek immigrants, and potentially migrants of other cultures, to support an integrated acculturation process.

This present study established the negative interaction between migratory grief and psychological well-being. Existing literature has outlined migratory grief as predictive of

depression (Ahn, 2006; Casado & Leung, 2002). Future research could focus on specific areas of well-being to contribute to the evidence-base and further develop intervention possibilities. Additionally, the results seem consistent with international findings of other culture migrant groups, despite heterogeneity of migrant groups which indicates more research to determine the generalisability and universality of the findings is required.

Conclusion

The main aim of the current study was to investigate potential predictors of psychological well-being post migration for Greek and Greek Cypriot migrants in the UK. This was in the interest of contributing to a scarce literature. The current findings implicate key areas to consider for intervention (a) grief-informed care and specific bereavement support offers to Greek migrants struggling with their well-being, (b) community level initiatives focusing on supporting maintenance of ethnic traditions. This research calls psychologists to engage in structural advocacy for this migrant group. It further highlights potentially universal processes of migration. Future research to explore these processes with other cultural migrant groups as well as the novel moderation relationship is warranted to inform policy and practice.

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Appendices

Appendix A
Journal Submission Guidelines

Full submission guidelines for the Journal of Cross-Cultural Psychology can be found at https://journals.sagepub.com/author-instructions/JCC .

The submission guidelines do not specify an overall maximum word count for submitted papers other than for the paper to be within 15 to 35 double-spaced, typewritten page limit. The current paper adheres to the requirements that the abstract be 150–250 words and that 4–6 keywords be provided.

In accordance with journal guidelines, the manuscripts has been prepared according to the most recent edition of the American Psychological Association Publication Manual (see https://apastyle.apa.org/products/publication-manual-7th-edition).

Some information required by the journal (e.g., author information, affiliations and declarations) has been omitted for the purpose of this thesis but will be added before submission of the paper.

The journal guidelines for referencing are broadly in line with APA 7th edition referencing style. Therefore, APA referencing was used in this paper. It should be noted that the Journal of Cross-Cultural Psychology specifies that manuscripts which have not yet been accepted for publication, are cited in the text but not included in the reference list.

Appendix B
Ethical Approval

School of Health, Science and Wellbeing

ETHICAL APPROVAL FEEDBACK

Researcher name:	Eleni Kourtidou-Sextou
Title of Study:	SU_22_067 'Migration and Mental Health of the Greek and Greek - Cypriot Communities in the UK.'
Award Pathway:	PGR
Status of approval:	Approved

Your project ***proposal has been approved*** by the Ethics Panel and you may commence the implementation phase of your study. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal. This approval is only valid for as long as you are registered as a student at the University.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site.

The Ethics Committee wish you well with your research.

Signed: **Date: 23.03.2023**

Dr Jade Elliott

Ethics Co-ordinator
Psychology
School of Health, Science and Wellbeing

Appendix C
Recruitment Poster

Appendix D
Information Sheet, Consent and Debrief Form

Information sheet

'Psychological Well-being and Migratory Grief for Individuals Moving from Greece or Cyprus to the UK.'

I would like to invite you to participate in this research project which forms part of my Doctorate for Clinical Psychology research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The main purpose of the study is to explore the relationship between migrating from Greece or Cyprus to the UK and psychological well-being. I am also interesting in looking at potential factors that interact with this relationship. Understanding more about the relationship between migration, well-being and contributing factors will contribute to the body of literature. It will increase understanding and might help improve psychological

support available.

Why have I been invited to take part?
This is a research study on the experiences of first generation Greek and Greek-Cypriot migrants. As your country of birth is either Greece or Cyprus and you moved to the UK at a time point following your birth, you fit into this criteria.

What will happen if I take part?
You will be asked to complete 3 short questionnaires in an online format which should take between 15-20 minutes to complete. The online platform will be easily accessible via a phone, tablet, laptop or PC computer with internet connection. There will be some general questions e.g. your age and reason behind migration. You will be given 18 statements regarding your homeland which you will be asked to rate in how often you experience them and with what intensity e.g. "I dream about going back". You will also be given 14 statements to rate in frequency regarding your general well-being e.g. "I've been feeling cheerful". In answering the above questions, numerical data is created. The answers are kept anonymously, meaning they do not appear next to your personal information. This means that most answers you provide will be in the form of a number. These numbers will be analysed with software to identify if there are any patterns and relationships between the different questions. This is necessary to do in order to answer the research question of whether there is a relationship between migratory grief and well-being and if other factors are affecting it.

Do I have to take part?
Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in anyway. Once you have read the information sheet, please contact us if you have any questions that will help you make a decision about taking part. If you decide to take part we will ask you to sign a consent form and you will be given a copy of this consent form to keep.

What are the possible risks of taking part?
Some of the questions will be asking you to rate statements about your homeland and experience of migration. This has the potential to bring forward difficult memories or feelings that you might not experience in your day to day life. Information on people and services that can provide support should you need it following taking part in this research study will be outlined at the end of the study.

What are the possible benefits of taking part?
There are no explicit benefits of taking part in this research study. In taking part you will be helping contribute to research that is looking to increase the understanding of the Greek and Greek-Cypriot experiences in the UK. Data handling and confidentiality Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR).

You will not be asked to provide any identifiable personal information. Therefore, there is no possibility of tracing your identity from the content of any of your replies. This means your

answers will be completely anonymous. All information will be kept confidentially in password protected files and only the research team will have access to them. Information will not be shared with third parties, making it confidential. The only circumstance under which the researcher will connect your personal information, unique identifier code and answers will be if you withdraw consent and ask for all of your data to be deleted. Data will be collected for 10 years after collection as per university policy at which point it will be deleted. Data becomes anonymised automatically therefore, will be stored and retained anonymously.

Data Protection Statement The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you. You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What if I change my mind about taking part?

You will not be asked to provide any identifiable personal information in the questionnaires. Therefore, there is no possibility of tracing your identity from the content of any of your

replies. This means your answers will be completely anonymous and data withdrawal is not offered.

What will happen to the results of the study?
Results will form part of my PhD thesis. The intention behind this thesis is to be published in peer reviewed journals. The findings of this research will also be collated in a summary report which will be made publicly available. This summary report will be shared with the same channels through which you were recruited.

Who should I contact for further information?
If you have any questions or require more information about this study, please contact me using the following contact details:
Principal Investigator: Miss Eleni Kourtidou-Sextou, k026291l@student.staffs.ac.uk
Chief Investigator: Dr Gary Lee, gary.lee@staffs.ac.uk

What if I have further questions, or if something goes wrong?
If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information: Dr Jim Radcliffe Chair) Faculty of Health Staffordshire University Blackheath Lane Beaconside Stafford ST18 0AD E-mail J.Radcliffe@staffs.ac.uk Telephone +44 (0)1782 353701

Thank you for reading this information sheet and for considering taking part in this research.

Consent Form

	Yes	No
I have read and understood the information sheet.	○	○
I have been given the opportunity to ask questions, and I have had any questions answered satisfactorily.	○	○
I understand that my participation in this study is entirely voluntary and that I can withdraw at any time without having to give an explanation.	○	○

All data will be sorted safely on a password protected computer (electronic data), or locked away securely (hard copies of data) for 10 years before being destroyed	○	○
I understand that no identifiable personal information will be collected, there is no way of tracing my answers to my identity and therefore, the option to withdraw data is not available.	○	○
I hereby give consent to take part in this study	○	○
I consent that data collected could be used for publication in a scientific journal and could be presented in scientific forums (conferences, seminars, workshops) or can be used for teaching purposes. I understand that all data will be presented anonymously.	○	○
I agree that data will only be used for this project 'Psychological Well-being and Migratory Grief for Individuals Moving from Greece or Cyprus to the UK.', although the data may also be audited for quality control purposes	○	○

Debrief Form

Migration and Mental Health of the Greek and Greek - Cypriot Communities in the UK.

I would like to thank you for your involvement in this research study.

This study is looking to explore if there is a relationship between level of migratory grief, acculturation and psychological well-being. Migratory grief is "grief issues associated with immigration…that might be contributing to immigrants' adjustment difficulty or emotional distress" (Casado et al., 2010). It is also exploring potential factors that might be interacting with this relationship such as gender and motivation behind move. You were asked to answer questions and rate statements on your experiences of these topics. Your answers have been recorded and will be analysed to explore the hypothesis that there is a relationship between degree of psychological well-being, acculturation and degree of migratory grief.
Your data is anonymous and confidential. All data will be sorted safely on a password protected computer for 10 years before being destroyed.

If you have been affected by the questions and statements in the study, you can contact the main researcher: Miss Eleni Kourtidou-Sextou k0262911@student.staffs.ac.uk , the research project supervisor: Dr Gary Lee gary.lee@staffs.ac.uk or your GP.
Alternatively you contact the following services for support:

Mind UK
www.mind.org.uk
0300 123 3393

British Red Cross
www.redcross.org.uk
0808 196 3651 (10am-6pm daily)

Hub of Hope
www.hubofhope.co.uk

Appendix E
Non-identifiable Demographic Information

What gender do you identify with?

- ○ Male
- ○ Female
- ○ Non-binary / third gender
- ○ Prefer not to say

What is the highest level of education you have completed?

- ○ Less than GCSEs
- ○ GCSEs or equivalent
- ○ A-Level,BTEC,skilledapprentershiporequivalent
- ○ Bachelor's degree
- ○ Master's degree
- ○ Doctorate
- ○ Other

Employment Status

- ○ Employed full time (40+ hours a week)
- ○ Employed part-time (less than 40 hours per week)
- ○ Unemployed (currently looking for work)
- ○ Unemployed (not currently looking for work)
- ○ Student
- ○ Retired
- ○ Home-maker

Location

- East Midlands
- East of England
- London
- North East and Cumbria
- North West
- Northern Ireland
- Scotland
- South East
- South West
- West Midlands
- Wales
- Yorkshire and Humber

Marital Status

- Single
- Married
- In a domestic partnership
- Divorced
- Widowed

What year did you move to the UK? (YYYY)

Appendix F
Permission to Use Measures

Thank you for completing the registration for a Licence to use WEMWBS for non-commercial purposes.
You now have access to the scales and the associated resources here on our website: https://warwick.ac.uk/wemwbs/using/register/resources
We suggest you bookmark this page for future reference.
The information declared on your Registration Form is documented below. Please retain a copy of this email as a record of your Licence together with the Terms and Conditions you have accepted.
https://warwick.ac.uk/wemwbs/using/non-commercial-licence-registration/shrink-wrap_licence_-wemwbs_non-_commercial_v3_8.9.20.pdf.
If you have any questions please contact us via email:
wemwbslicence@warwick.ac.uk

Question: Type of use
Answer:
Survey

Question: If other, please specify
Answer:

Question: Type of intervention (if applicable) *Tick all that apply*
Answer:

Question: If other, please specify
Answer:
Research thesis project

Question: Field of Use
(Tick all that apply)
Answer:
Community
Church or spiritual organisation

Question: Preferred version of WEMWBS
(Note – both versions of WEMWBS can be used under a single licence)
Answer:
WEMWBS - 14 item scale

Question: Age of Participants (*Tick all that apply*)
Answer:
18-64
65+

Question: How many participants are you planning to use WEMWBS with? (Scale of use)
Answer:
101-250

Question: Start Date
Answer:
14/11/2022

Question: End Date
Answer:
31/10/2023

Question: Territories of Use: In which geographical areas will you be using WEMWBS? *(tick all that apply)*
Answer:
United Kingdom

Question: In which language(s) are you planning to use WEMWBS?
Tick all that apply Please note that we may not be able to offer a translation into every language you require
Answer:
English
Greek

Question: If other, please specify
Answer:

Question: Organisation name
Answer:
Staffordshire University

Question: Type of organisation
Answer:
University

Question: If other, please specify
Answer:

Question: Size of Organisation (no. of employees)
Answer:
>5001

Question: Organisation Address
Answer:
College Rd, Stoke-on-Trent ST4 2DE

Question: Country of Organisation
Answer:
UK

Question: Website
Answer:

Question: Contact Name
Answer:
Eleni Kourtidou-Sextou

Question: Job Title
Answer:
Trainee Clinical Psychologist

Question: If other, please specify
Answer:

Question: Email
Answer:
[redacted]

Question: I have read and agreed to the terms of the Non-Commercial Licence
Please print and retain a copy for your reference
Answer:
Yes

Question: I agree to my contact details being shared with third parties for the purposes of product development of WEMWBS
Answer:
No

Appendix G
Details of the Multiple Imputation Model

Multiple imputation was conducted using SPSS Version 29.0. The model included all variables that would be included in the main regression analysis (Enders, 2010). The variables were entered as follows:

1. Auxiliary Variables (used for prediction only)
    a. Gender
    b. Education
    c. Employment
    d. Location
    e. Relationship
    f. Years Since Migration
2. Analysis variables with no missing values (used for prediction only)
    a. GAAS Q2
    b. GAAS Q4
    c. GAAS Q6
    d. GAAS Q8
    e. GAAS Q9 - 15
    f. GAAS Q17-19
    g. GAAS Q24
    h. GAAS Q26-32
    i. GAAS Q34
    j. GAAS Q37
    k. GAAS Q40-50
    l. GAAS Q52-56
    m. MGLQ Q1a
    n. MGLQ Q1b
    o. MGLQ Q2b
    p. MGLQ Q4a
    q. MGLQ Q4b
    r. MGLQ Q7a
    s. MGLQ Q10a
    t. MGLQ Q10b
    u. WEMWBS Q1-13
3. Analysis variables with missing values (imputed and used for prediction)
    a. Years since migration

b. GAAS Q1
c. GAAS Q3
d. GAAS Q5
e. GAAS Q7
f. GAAS Q16
g. GAAS Q25
h. GAAS Q33
i. GAAS Q35-36
j. GAAS Q38-39
k. GAAS Q51
l. MGLQ Q2a
m. MGLQ Q3a
n. MGLQ Q3b
o. MGLQ Q5a-6b
p. MGLQ Q7b-9b
q. MGLQ Q11a-18b
r. WEMWBS Q14

The sample (N=152) was treated using multiple imputation. Conventions of 20 imputations (van Buuren, 2018) and 10 iterations (Buuren & Groothuis – Oudshoorn, 2011) were used. The variable 'Reason Behind Move' was excluded from the imputation analysis due to it's qualitative nature. The outcome variable (WEWMBS) was included as not doing so could introduce "biased estimates" (Graham, 2009). The variable 'Year of Migration' was re-interpreted as 'Years Since Migration' to produce a continuous variable which was used in the imputation. The model type for scale variables was changed from the default 'linear regression' setting to 'predictive mean matching (PMM)' because PMM does not assume a linear relationship between variables and is more robust in the eventuality of violated normality (Bailey et al., 2020). Following the imputation, data was pooled using Rubin's rules (Rubin, 1987). No special transformation of statistics prior to pooling was indicated.

References

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Rubin, D. B. (1987). Multiple imputation for nonresponse in surveys. New York: Wiley. https://doi.org/10.1002/9780470316696

van Buuren, S. (2018). *Flexible imputation of missing data* (2nd ed.). Bookdown. https://stefvanbuuren.name/fimd/

Appendix H
Normality Checks SPSS Regression Table

Table H1

Model Summary[b]

Imputation Number	Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics R Square Change	F Change	df1	df2	Sig. F Change	Durbin-Watson
Original data	1	.426[a]	.181	.167	8.077	.181	12.406	2	112	<.001	1.818
1	1	.418[a]	.175	.164	8.297	.175	15.774	2	149	<.001	1.897
2	1	.421[a]	.177	.166	8.261	.177	16.028	2	149	<.001	1.901
3	1	.416[a]	.173	.162	8.271	.173	15.570	2	149	<.001	1.902
4	1	.418[a]	.174	.163	8.286	.174	15.741	2	149	<.001	1.909
5	1	.421[a]	.177	.166	8.261	.177	16.036	2	149	<.001	1.909
6	1	.424[a]	.180	.169	8.236	.180	16.327	2	149	<.001	1.906
7	1	.421[a]	.177	.166	8.261	.177	16.027	2	149	<.001	1.899
8	1	.420[a]	.176	.165	8.252	.176	15.967	2	149	<.001	1.901
9	1	.424[a]	.179	.168	8.249	.179	16.289	2	149	<.001	1.899
10	1	.415[a]	.172	.161	8.298	.172	15.494	2	149	<.001	1.893
11	1	.425[a]	.181	.170	8.243	.181	16.423	2	149	<.001	1.894
12	1	.422[a]	.178	.167	8.282	.178	16.099	2	149	<.001	1.890
13	1	.424[a]	.179	.168	8.238	.179	16.283	2	149	<.001	1.903
14	1	.425[a]	.180	.169	8.244	.180	16.406	2	149	<.001	1.905
15	1	.422[a]	.178	.167	8.243	.178	16.182	2	149	<.001	1.901
16	1	.420[a]	.177	.166	8.263	.177	15.994	2	149	<.001	1.899
17	1	.419[a]	.176	.165	8.256	.176	15.889	2	149	<.001	1.896
18	1	.420[a]	.177	.166	8.263	.177	15.976	2	149	<.001	1.900
19	1	.425[a]	.180	.169	8.234	.180	16.376	2	149	<.001	1.888
20	1	.426[a]	.181	.170	8.229	.181	16.482	2	149	<.001	1.895

a. Predictors: (Constant), TotalMGLQ, TotalGAAS
b. Dependent Variable: TotalWEMWBS

Table H2

Coefficients[a]

Imputation Number	Model		Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Correlations			Collinearity Statistics		Fraction Missing Info.	Relative Increase Variance	Relative Efficiency
			B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF			
Original data	1	(Constant)	30.925	5.170		5.982	<.001	20.682	41.168								
		TotalGAAS	.097	.021	.439	4.550	<.001	.055	.139	.264	.395	.389	.785	1.274			
		TotalMGLQ	-.147	.038	-.377	-3.906	<.001	-.222	-.073	-.173	-.346	-.334	.785	1.274			
1	1	(Constant)	36.013	4.355		8.269	<.001	27.407	44.619								
		TotalGAAS	.078	.017	.364	4.548	<.001	.044	.112	.225	.349	.338	.865	1.156			
		TotalMGLQ	-.157	.033	-.379	-4.738	<.001	-.222	-.091	-.245	-.362	-.353	.865	1.156			
2	1	(Constant)	35.893	4.333		8.284	<.001	27.331	44.456								
		TotalGAAS	.079	.017	.368	4.593	<.001	.045	.112	.226	.352	.341	.862	1.160			
		TotalMGLQ	-.157	.033	-.382	-4.779	<.001	-.222	-.092	-.246	-.365	-.355	.862	1.160			
3	1	(Constant)	35.912	4.346		8.263	<.001	27.324	44.501								
		TotalGAAS	.078	.017	.367	4.563	<.001	.044	.112	.224	.350	.340	.857	1.167			
		TotalMGLQ	-.157	.033	-.378	-4.699	<.001	-.223	-.091	-.239	-.359	-.350	.857	1.167			
4	1	(Constant)	35.945	4.358		8.248	<.001	27.333	44.556								
		TotalGAAS	.078	.017	.365	4.550	<.001	.044	.112	.222	.349	.339	.859	1.165			
		TotalMGLQ	-.158	.033	-.382	-4.753	<.001	-.223	-.092	-.244	-.363	-.354	.859	1.165			
5	1	(Constant)	36.014	4.348		8.283	<.001	27.422	44.606								
		TotalGAAS	.078	.017	.365	4.563	<.001	.044	.112	.224	.350	.339	.865	1.156			
		TotalMGLQ	-.158	.033	-.383	-4.795	<.001	-.223	-.093	-.249	-.366	-.356	.865	1.156			
6	1	(Constant)	35.972	4.327		8.313	<.001	27.421	44.524								
		TotalGAAS	.079	.017	.368	4.604	<.001	.045	.112	.225	.353	.342	.863	1.158			
		TotalMGLQ	-.159	.033	-.387	-4.847	<.001	-.223	-.094	-.251	-.369	-.360	.863	1.158			
7	1	(Constant)	36.040	4.334		8.315	<.001	27.476	44.605								
		TotalGAAS	.078	.017	.366	4.575	<.001	.044	.112	.223	.351	.340	.861	1.161			
		TotalMGLQ	-.158	.033	-.384	-4.800	<.001	-.223	-.093	-.248	-.366	-.357	.861	1.161			

8	1	(Constant)	35.930	4.338		8.283	<.001	27.359	44.501								
		TotalGAAS	.079	.017	.369	4.592	<.001	.045	.113	.223	.352	.341	.856	1.169			
		TotalMGLQ	-.159	.033	-.385	-4.792	<.001	-.225	-.094	-.245	-.365	-.356	.856	1.169			
9	1	(Constant)	36.140	4.334		8.339	<.001	27.577	44.704								
		TotalGAAS	.078	.017	.364	4.567	<.001	.044	.112	.222	.350	.339	.865	1.156			
		TotalMGLQ	-.159	.033	-.388	-4.862	<.001	-.224	-.095	-.254	-.370	-.361	.865	1.156			
10	1	(Constant)	36.092	4.355		8.288	<.001	27.486	44.697								
		TotalGAAS	.078	.017	.362	4.516	<.001	.044	.112	.223	.347	.337	.863	1.159			
		TotalMGLQ	-.155	.033	-.377	-4.695	<.001	-.220	-.090	-.243	-.359	-.350	.863	1.159			
11	1	(Constant)	35.515	4.332		8.199	<.001	26.955	44.075								
		TotalGAAS	.081	.017	.377	4.689	<.001	.047	.115	.227	.359	.348	.852	1.174			
		TotalMGLQ	-.160	.033	-.389	-4.845	<.001	-.225	-.095	-.244	-.369	-.359	.852	1.174			
12	1	(Constant)	35.742	4.358		8.201	<.001	27.130	44.354								
		TotalGAAS	.079	.017	.369	4.606	<.001	.045	.113	.225	.353	.342	.859	1.164			
		TotalMGLQ	-.158	.033	-.385	-4.799	<.001	-.223	-.093	-.246	-.366	-.357	.859	1.164			
13	1	(Constant)	35.774	4.333		8.256	<.001	27.212	44.336								
		TotalGAAS	.079	.017	.371	4.634	<.001	.046	.113	.226	.355	.344	.859	1.164			
		TotalMGLQ	-.159	.033	-.386	-4.826	<.001	-.224	-.094	-.247	-.368	-.358	.859	1.164			
14	1	(Constant)	35.793	4.338		8.251	<.001	27.221	44.365								
		TotalGAAS	.080	.017	.372	4.630	<.001	.046	.114	.222	.355	.343	.854	1.170			
		TotalMGLQ	-.160	.033	-.392	-4.884	<.001	-.225	-.095	-.250	-.371	-.362	.854	1.170			
15	1	(Constant)	35.903	4.332		8.287	<.001	27.342	44.464								
		TotalGAAS	.079	.017	.369	4.613	<.001	.045	.113	.225	.354	.343	.860	1.163			
		TotalMGLQ	-.159	.033	-.386	-4.815	<.001	-.225	-.094	-.247	-.367	-.358	.860	1.163			
16	1	(Constant)	35.849	4.343		8.255	<.001	27.268	44.430								
		TotalGAAS	.079	.017	.369	4.595	<.001	.045	.113	.224	.352	.342	.858	1.165			
		TotalMGLQ	-.158	.033	-.384	-4.786	<.001	-.223	-.093	-.245	-.365	-.356	.858	1.165			
17	1	(Constant)	35.932	4.338		8.283	<.001	27.360	44.504								
		TotalGAAS	.078	.017	.367	4.578	<.001	.045	.112	.225	.351	.341	.862	1.160			
		TotalMGLQ	-.157	.033	-.381	-4.755	<.001	-.222	-.092	-.245	-.363	-.354	.862	1.160			
18	1	(Constant)	35.836	4.351		8.236	<.001	27.238	44.433								

		TotalGAAS	.079	.017	.367	4.587	<.001	.045	.113	.225	.352	.341	.861	1.161			
		TotalMGLQ	-.157	.033	-.382	-4.774	<.001	-.222	-.092	-.246	-.364	-.355	.861	1.161			
19	1	(Constant)	35.721	4.330		8.250	<.001	27.166	44.277								
		TotalGAAS	.080	.017	.373	4.655	<.001	.046	.114	.226	.356	.345	.856	1.168			
		TotalMGLQ	-.160	.033	-.389	-4.846	<.001	-.225	-.095	-.247	-.369	-.359	.856	1.168			
20	1	(Constant)	35.863	4.326		8.289	<.001	27.314	44.412								
		TotalGAAS	.079	.017	.370	4.635	<.001	.045	.113	.226	.355	.344	.862	1.160			
		TotalMGLQ	-.159	.033	-.389	-4.868	<.001	-.224	-.095	-.251	-.370	-.361	.862	1.160			
Pooled	1	(Constant)	35.894	4.343		8.265	<.001	27.382	44.406						.001	.001	1.000
		TotalGAAS	.079	.017		4.590	<.001	.045	.112	.224	.352	.341			.002	.002	1.000
		TotalMGLQ	-.158	.033		-4.794	<.001	-.223	-.094	-.247	-.366	-.356			.002	.002	1.000

a. Dependent Variable: TotalWEMWBS

Table H3

ANOVA[a]

Imputation Number	Model		Sum of Squares	df	Mean Square	F	Sig.
Original data	1	Regression	1618.847	2	809.423	12.406	<.001[b]
		Residual	7307.275	112	65.244		
		Total	8926.122	114			
1	1	Regression	2171.935	2	1085.968	15.774	<.001[b]
		Residual	10257.959	149	68.845		
		Total	12429.895	151			
2	1	Regression	2187.625	2	1093.812	16.028	<.001[b]
		Residual	10168.349	149	68.244		
		Total	12355.974	151			
3	1	Regression	2130.014	2	1065.007	15.570	<.001[b]
		Residual	10191.979	149	68.403		
		Total	12321.993	151			
4	1	Regression	2161.531	2	1080.765	15.741	<.001[b]
		Residual	10230.410	149	68.660		
		Total	12391.941	151			
5	1	Regression	2188.563	2	1094.281	16.036	<.001[b]
		Residual	10167.411	149	68.238		
		Total	12355.974	151			
6	1	Regression	2215.023	2	1107.512	16.327	<.001[b]
		Residual	10106.970	149	67.832		
		Total	12321.993	151			
7	1	Regression	2187.544	2	1093.772	16.027	<.001[b]
		Residual	10168.430	149	68.244		
		Total	12355.974	151			
8	1	Regression	2174.784	2	1087.392	15.967	<.001[b]
		Residual	10147.209	149	68.102		
		Total	12321.993	151			
9	1	Regression	2216.835	2	1108.418	16.289	<.001[b]
		Residual	10139.138	149	68.048		
		Total	12355.974	151			
10	1	Regression	2133.460	2	1066.730	15.494	<.001[b]
		Residual	10258.481	149	68.849		
		Total	12391.941	151			
11	1	Regression	2231.848	2	1115.924	16.423	<.001[b]
		Residual	10124.126	149	67.947		
		Total	12355.974	151			

12	1	Regression	2208.689	2	1104.344	16.099	<.001[b]
		Residual	10221.206	149	68.599		
		Total	12429.895	151			
13	1	Regression	2210.140	2	1105.070	16.283	<.001[b]
		Residual	10111.853	149	67.865		
		Total	12321.993	151			
14	1	Regression	2229.895	2	1114.947	16.406	<.001[b]
		Residual	10126.079	149	67.960		
		Total	12355.974	151			
15	1	Regression	2198.859	2	1099.429	16.182	<.001[b]
		Residual	10123.135	149	67.941		
		Total	12321.993	151			
16	1	Regression	2183.823	2	1091.912	15.994	<.001[b]
		Residual	10172.150	149	68.269		
		Total	12355.974	151			
17	1	Regression	2165.971	2	1082.985	15.889	<.001[b]
		Residual	10156.023	149	68.161		
		Total	12321.993	151			
18	1	Regression	2181.747	2	1090.873	15.976	<.001[b]
		Residual	10174.227	149	68.283		
		Total	12355.974	151			
19	1	Regression	2220.492	2	1110.246	16.376	<.001[b]
		Residual	10101.501	149	67.795		
		Total	12321.993	151			
20	1	Regression	2232.183	2	1116.091	16.482	<.001[b]
		Residual	10089.811	149	67.717		
		Total	12321.993	151			

a. Dependent Variable: TotalWEMWBS

b. Predictors: (Constant), TotalMGLQ, TotalGAAS

Appendix I
SPSS Histograms, Normal Probability Plots and Scatterplots

Figure I1

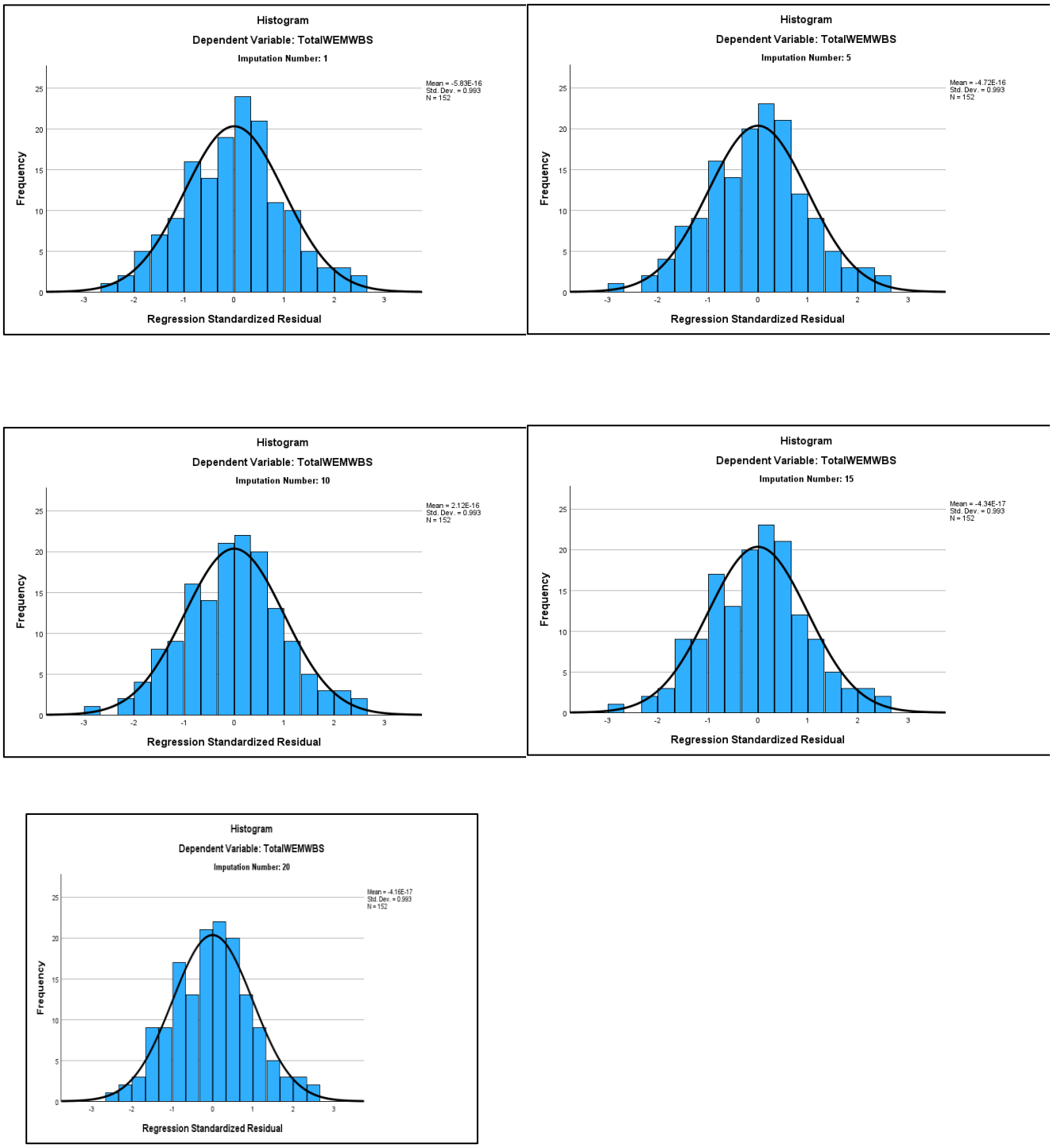
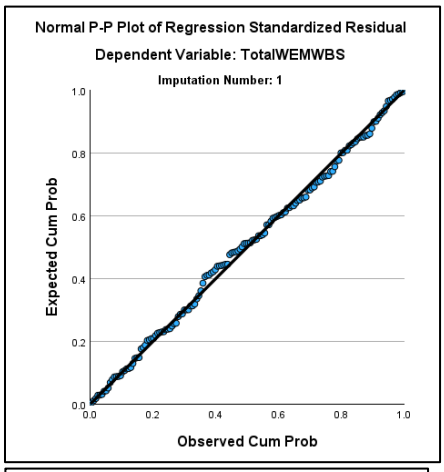
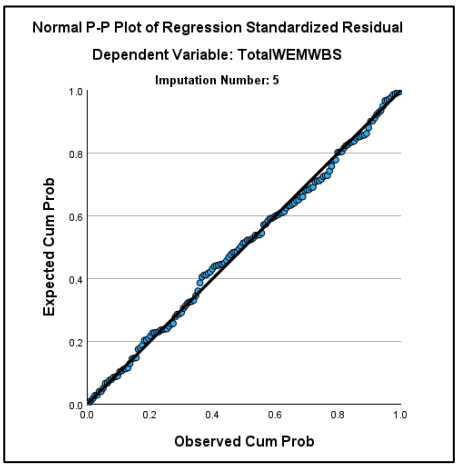
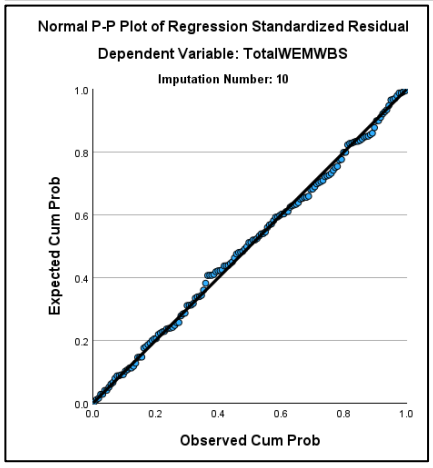
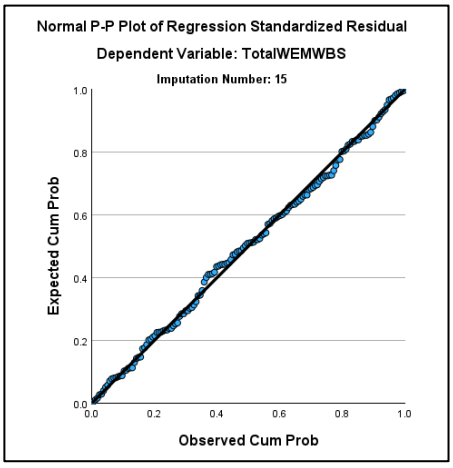


Figure I2


Normal P-P Plot of Regression Standardized Residual
Dependent Variable: TotalWEMWBS
Imputation Number: 1
Expected Cum Prob
Observed Cum Prob


Normal P-P Plot of Regression Standardized Residual
Dependent Variable: TotalWEMWBS
Imputation Number: 5
Expected Cum Prob
Observed Cum Prob


Normal P-P Plot of Regression Standardized Residual
Dependent Variable: TotalWEMWBS
Imputation Number: 10
Expected Cum Prob
Observed Cum Prob


Normal P-P Plot of Regression Standardized Residual
Dependent Variable: TotalWEMWBS
Imputation Number: 15
Expected Cum Prob
Observed Cum Prob

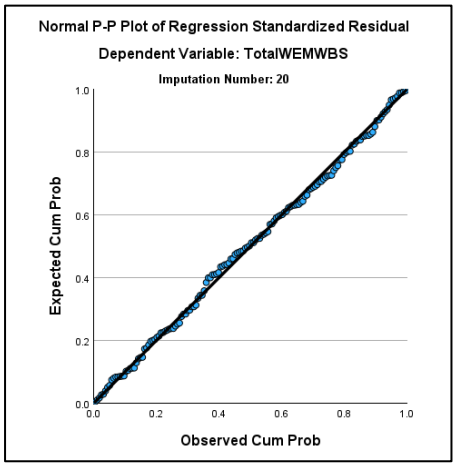
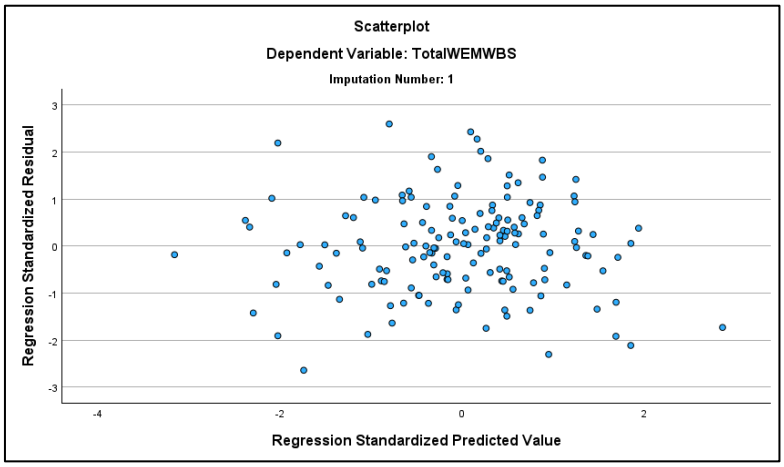
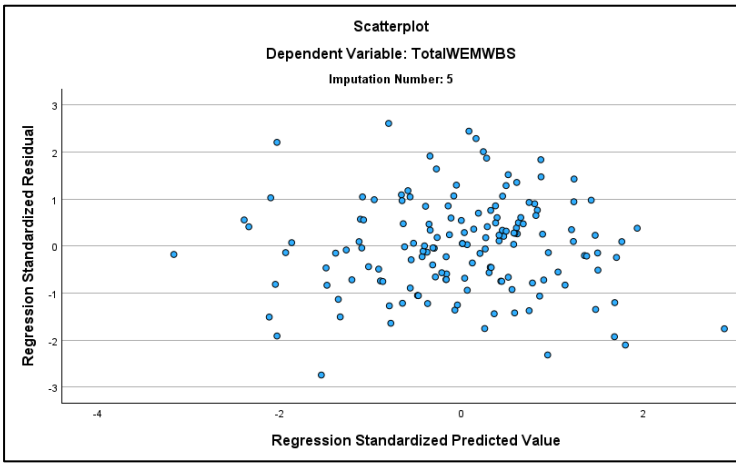
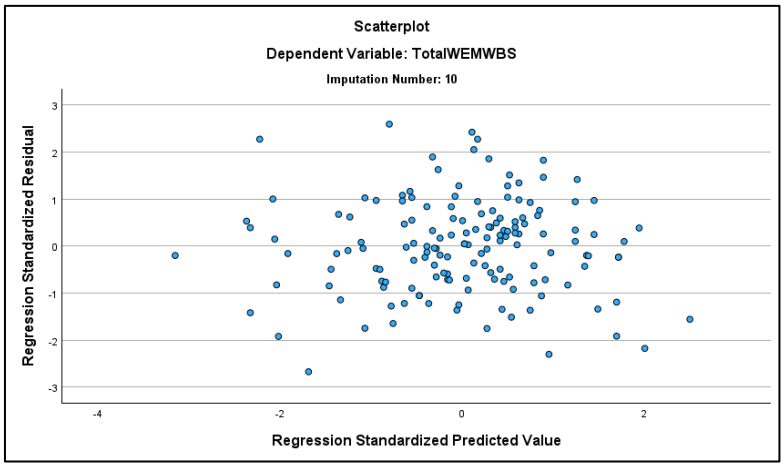
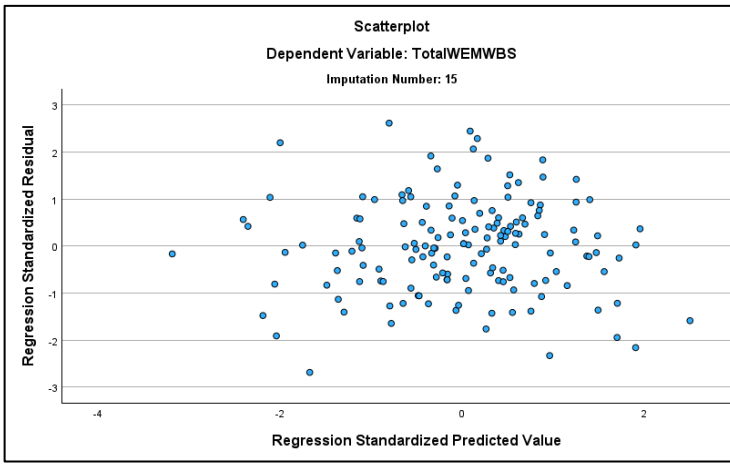

Normal P-P Plot of Regression Standardized Residual
Dependent Variable: TotalWEMWBS
Imputation Number: 20
Expected Cum Prob
Observed Cum Prob

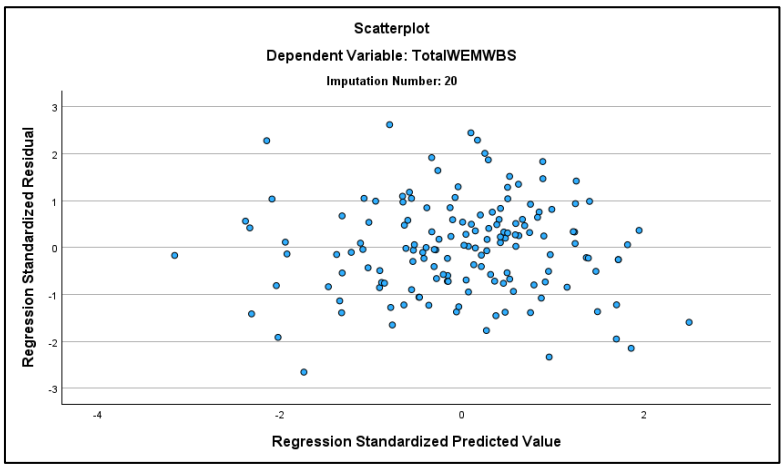
Figure I3


Scatterplot
Dependent Variable: TotalWEMWBS
Imputation Number: 1
Regression Standardized Residual
Regression Standardized Predicted Value


Scatterplot
Dependent Variable: TotalWEMWBS
Imputation Number: 5
Regression Standardized Residual
Regression Standardized Predicted Value


Scatterplot
Dependent Variable: TotalWEMWBS
Imputation Number: 10
Regression Standardized Residual
Regression Standardized Predicted Value


Scatterplot
Dependent Variable: TotalWEMWBS
Imputation Number: 15
Regression Standardized Residual
Regression Standardized Predicted Value


Scatterplot
Dependent Variable: TotalWEMWBS
Imputation Number: 20
Regression Standardized Residual
Regression Standardized Predicted Value

Appendix J
Dummy Variable Creation

Gender: male (1), female and prefer not to say (0). There were only 3 prefer not to say and as the majority 105 vs 44 were female in the sample the unknowns were assumed to be female.

Education: below degree (0) with degree (1). The 'other' was placed as 0 because the standard degrees were already included as options so assumption made it was not a degree.

Employment: in employment (1), not in employment (0). Students put as 1 because they are establishing relationships with others in society. Homemakers and retired put as 0 because they could be isolated from relationships with others in society. These decisions were made based on literature on the functions of work that contribute to well-being that is critical for immigrants and that is the ability to "establish relationships with others in the society." (Aycan & Berry, 1996).

Relationship: without a partner (0), with a partner (1).

References

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Appendix K
Multiple Imputation Statistics for Moderation Analysis

Table K1

Model Summary[b]

Imputation Number	Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics R Square Change	F Change	df1	df2	Sig. F Change	Durbin-Watson
Original data	1	.455[a]	.207	.186	7.984	.207	9.680	3	111	<.001	1.870
1	1	.463[a]	.214	.198	8.123	.214	13.453	3	148	<.001	1.913
2	1	.462[a]	.213	.197	8.104	.213	13.381	3	148	<.001	1.920
3	1	.458[a]	.209	.193	8.113	.209	13.074	3	148	<.001	1.921
4	1	.462[a]	.214	.198	8.114	.214	13.412	3	148	<.001	1.920
5	1	.465[a]	.217	.201	8.088	.217	13.633	3	148	<.001	1.927
6	1	.465[a]	.216	.200	8.079	.216	13.597	3	148	<.001	1.924
7	1	.457[a]	.209	.193	8.125	.209	13.057	3	148	<.001	1.915
8	1	.459[a]	.210	.194	8.108	.210	13.146	3	148	<.001	1.925
9	1	.463[a]	.214	.198	8.098	.214	13.465	3	148	<.001	1.921
10	1	.454[a]	.206	.190	8.153	.206	12.809	3	148	<.001	1.907
11	1	.466[a]	.217	.201	8.086	.217	13.657	3	148	<.001	1.912
12	1	.461[a]	.212	.197	8.133	.212	13.310	3	148	<.001	1.907
13	1	.464[a]	.216	.200	8.081	.216	13.563	3	148	<.001	1.928
14	1	.462[a]	.213	.197	8.104	.213	13.376	3	148	<.001	1.922
15	1	.463[a]	.214	.198	8.088	.214	13.458	3	148	<.001	1.922
16	1	.458[a]	.210	.194	8.122	.210	13.109	3	148	<.001	1.915
17	1	.463[a]	.214	.198	8.088	.214	13.461	3	148	<.001	1.915
18	1	.464[a]	.215	.199	8.095	.215	13.526	3	148	<.001	1.917
19	1	.465[a]	.216	.200	8.078	.216	13.610	3	148	<.001	1.911
20	1	.463[a]	.214	.198	8.087	.214	13.464	3	148	<.001	1.914

a. Predictors: (Constant), MGLQxGAAS, TotalGAAS, TotalMGLQ
b. Dependent Variable: TotalWEMWBS

Table K2

ANOVA[a]

Imputation Number	Model		Sum of Squares	df	Mean Square	F	Sig.
Original data	1	Regression	1850.996	3	616.999	9.680	<.001[b]
		Residual	7075.125	111	63.740		

		Total	8926.122	114			
1	1	Regression	2663.260	3	887.753	13.453	<.001[b]
		Residual	9766.635	148	65.991		
		Total	12429.895	151			
2	1	Regression	2636.311	3	878.770	13.381	<.001[b]
		Residual	9719.663	148	65.673		
		Total	12355.974	151			
3	1	Regression	2581.422	3	860.474	13.074	<.001[b]
		Residual	9740.571	148	65.815		
		Total	12321.993	151			
4	1	Regression	2648.814	3	882.938	13.412	<.001[b]
		Residual	9743.127	148	65.832		
		Total	12391.941	151			
5	1	Regression	2675.251	3	891.750	13.633	<.001[b]
		Residual	9680.723	148	65.410		
		Total	12355.974	151			
6	1	Regression	2662.292	3	887.431	13.597	<.001[b]
		Residual	9659.701	148	65.268		
		Total	12321.993	151			
7	1	Regression	2585.886	3	861.962	13.057	<.001[b]
		Residual	9770.087	148	66.014		
		Total	12355.974	151			
8	1	Regression	2592.633	3	864.211	13.146	<.001[b]
		Residual	9729.360	148	65.739		
		Total	12321.993	151			
9	1	Regression	2649.389	3	883.130	13.465	<.001[b]
		Residual	9706.585	148	65.585		
		Total	12355.974	151			
10	1	Regression	2554.330	3	851.443	12.809	<.001[b]
		Residual	9837.611	148	66.470		
		Total	12391.941	151			
11	1	Regression	2678.886	3	892.962	13.657	<.001[b]
		Residual	9677.088	148	65.386		
		Total	12355.974	151			
12	1	Regression	2641.026	3	880.342	13.310	<.001[b]
		Residual	9788.868	148	66.141		
		Total	12429.895	151			
13	1	Regression	2657.159	3	885.720	13.563	<.001[b]
		Residual	9664.835	148	65.303		
		Total	12321.993	151			
14	1	Regression	2635.514	3	878.505	13.376	<.001[b]

		Residual	9720.460	148	65.679		
		Total	12355.974	151			
15	1	Regression	2640.919	3	880.306	13.458	<.001[b]
		Residual	9681.074	148	65.413		
		Total	12321.993	151			
16	1	Regression	2594.029	3	864.676	13.109	<.001[b]
		Residual	9761.945	148	65.959		
		Total	12355.974	151			
17	1	Regression	2641.405	3	880.468	13.461	<.001[b]
		Residual	9680.588	148	65.409		
		Total	12321.993	151			
18	1	Regression	2658.749	3	886.250	13.526	<.001[b]
		Residual	9697.225	148	65.522		
		Total	12355.974	151			
19	1	Regression	2664.264	3	888.088	13.610	<.001[b]
		Residual	9657.729	148	65.255		
		Total	12321.993	151			
20	1	Regression	2641.881	3	880.627	13.464	<.001[b]
		Residual	9680.113	148	65.406		
		Total	12321.993	151			

a. Dependent Variable: TotalWEMWBS

b. Predictors: (Constant), MGLQxGAAS, TotalGAAS, TotalMGLQ

Table K3

Coefficients[a]

Imputation Number	Model		Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Correlations			Collinearity Statistics		Fraction
			B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF	Missing
Original data	1	(Constant)	50.626	11.518		4.395	<.001	27.802	73.451						
		TotalMGLQ	-.528	.203	-1.352	-2.602	.011	-.931	-.126	-.173	-.240	-.220	.026	37.805	
		TotalGAAS	.020	.045	.093	.454	.650	-.069	.110	.264	.043	.038	.170	5.879	
		MGLQxGAAS	.001	.001	1.187	1.908	.059	.000	.003	-.043	.178	.161	.018	54.171	
1	1	(Constant)	60.220	9.843		6.118	<.001	40.769	79.671						
		TotalMGLQ	-.643	.181	-1.554	-3.551	<.001	-1.001	-.285	-.245	-.280	-.259	.028	36.098	
		TotalGAAS	-.016	.038	-.073	-.409	.683	-.091	.060	.225	-.034	-.030	.167	5.985	
		MGLQxGAAS	.002	.001	1.410	2.729	.007	.001	.003	-.107	.219	.199	.020	50.322	
2	1	(Constant)	59.049	9.826		6.010	<.001	39.632	78.466						
		TotalMGLQ	-.623	.181	-1.515	-3.440	<.001	-.981	-.265	-.246	-.272	-.251	.027	36.500	

		TotalGAAS	-.011	.038	-.053	-.295	.769	-.087	.064	.226	-.024	-.021	.166	6.025
		MGLQxGAAS	.002	.001	1.360	2.614	.010	.000	.003	-.108	.210	.191	.020	50.940
3	1	(Constant)	59.500	9.965		5.971	<.001	39.809	79.191					
		TotalMGLQ	-.627	.183	-1.514	-3.434	<.001	-.988	-.266	-.239	-.272	-.251	.027	36.380
		TotalGAAS	-.013	.039	-.060	-.333	.739	-.090	.064	.224	-.027	-.024	.162	6.157
		MGLQxGAAS	.002	.001	1.370	2.619	.010	.000	.003	-.102	.210	.191	.020	51.221
4	1	(Constant)	60.072	9.842		6.104	<.001	40.624	79.520					
		TotalMGLQ	-.643	.182	-1.559	-3.545	<.001	-1.002	-.285	-.244	-.280	-.258	.027	36.403
		TotalGAAS	-.015	.038	-.070	-.393	.695	-.091	.061	.222	-.032	-.029	.167	5.989
		MGLQxGAAS	.002	.001	1.414	2.721	.007	.001	.003	-.107	.218	.198	.020	50.866
5	1	(Constant)	59.798	9.703		6.163	<.001	40.623	78.973					
		TotalMGLQ	-.640	.180	-1.555	-3.561	<.001	-.996	-.285	-.249	-.281	-.259	.028	36.024
		TotalGAAS	-.014	.038	-.065	-.367	.714	-.088	.061	.224	-.030	-.027	.172	5.829
		MGLQxGAAS	.002	.001	1.402	2.728	.007	.001	.003	-.112	.219	.198	.020	49.911
6	1	(Constant)	59.037	9.780		6.036	<.001	39.710	78.364					
		TotalMGLQ	-.623	.180	-1.520	-3.455	<.001	-.980	-.267	-.251	-.273	-.251	.027	36.554
		TotalGAAS	-.011	.038	-.051	-.286	.775	-.086	.064	.225	-.023	-.021	.167	5.984
		MGLQxGAAS	.002	.001	1.359	2.618	.010	.000	.003	-.114	.210	.191	.020	50.882
7	1	(Constant)	58.128	9.951		5.842	<.001	38.464	77.792					
		TotalMGLQ	-.598	.182	-1.454	-3.286	.001	-.958	-.238	-.248	-.261	-.240	.027	36.628
		TotalGAAS	-.007	.039	-.035	-.193	.848	-.084	.069	.223	-.016	-.014	.162	6.156
		MGLQxGAAS	.002	.001	1.287	2.456	.015	.000	.003	-.111	.198	.180	.019	51.378
8	1	(Constant)	58.780	10.015		5.869	<.001	38.989	78.572					
		TotalMGLQ	-.615	.184	-1.488	-3.347	.001	-.978	-.252	-.245	-.265	-.244	.027	37.055
		TotalGAAS	-.010	.039	-.046	-.252	.802	-.087	.067	.223	-.021	-.018	.160	6.247
		MGLQxGAAS	.002	.001	1.331	2.521	.013	.000	.003	-.108	.203	.184	.019	52.224
9	1	(Constant)	59.082	9.895		5.971	<.001	39.529	78.635					
		TotalMGLQ	-.619	.182	-1.509	-3.403	<.001	-.979	-.260	-.254	-.269	-.248	.027	37.036
		TotalGAAS	-.011	.038	-.051	-.285	.776	-.087	.065	.222	-.023	-.021	.164	6.091
		MGLQxGAAS	.002	.001	1.344	2.568	.011	.000	.003	-.117	.207	.187	.019	51.592
10	1	(Constant)	58.745	9.968		5.893	<.001	39.047	78.443					
		TotalMGLQ	-.604	.182	-1.468	-3.330	.001	-.963	-.246	-.243	-.264	-.244	.028	36.252
		TotalGAAS	-.010	.039	-.048	-.266	.791	-.087	.066	.223	-.022	-.019	.163	6.120

		MGLQxGAAS	.002	.001	1.314	2.516	.013	.000	.003	-.106	.203	.184	.020	50.824
11	1	(Constant)	59.028	9.946		5.935	<.001	39.374	78.682					
		TotalMGLQ	-.625	.181	-1.520	-3.458	<.001	-.982	-.268	-.244	-.273	-.252	.027	36.511
		TotalGAAS	-.011	.039	-.050	-.277	.782	-.087	.066	.227	-.023	-.020	.161	6.214
		MGLQxGAAS	.002	.001	1.367	2.615	.010	.000	.003	-.105	.210	.190	.019	51.646
12	1	(Constant)	58.633	9.923		5.909	<.001	39.023	78.243					
		TotalMGLQ	-.616	.182	-1.496	-3.387	<.001	-.975	-.256	-.246	-.268	-.247	.027	36.655
		TotalGAAS	-.009	.039	-.044	-.244	.807	-.086	.067	.225	-.020	-.018	.165	6.069
		MGLQxGAAS	.002	.001	1.336	2.557	.012	.000	.003	-.109	.206	.186	.019	51.297
13	1	(Constant)	58.936	9.820		6.001	<.001	39.530	78.342					
		TotalMGLQ	-.627	.182	-1.521	-3.452	<.001	-.986	-.268	-.247	-.273	-.251	.027	36.623
		TotalGAAS	-.011	.038	-.049	-.275	.784	-.086	.065	.226	-.023	-.020	.166	6.030
		MGLQxGAAS	.002	.001	1.363	2.616	.010	.000	.003	-.109	.210	.190	.020	51.182
14	1	(Constant)	57.914	9.870		5.867	<.001	38.409	77.420					
		TotalMGLQ	-.603	.181	-1.473	-3.331	.001	-.960	-.245	-.250	-.264	-.243	.027	36.785
		TotalGAAS	-.006	.039	-.030	-.167	.867	-.083	.070	.222	-.014	-.012	.164	6.083
		MGLQxGAAS	.002	.001	1.302	2.485	.014	.000	.003	-.114	.200	.181	.019	51.622
15	1	(Constant)	59.214	9.924		5.967	<.001	39.604	78.824					
		TotalMGLQ	-.626	.182	-1.514	-3.432	<.001	-.987	-.266	-.247	-.271	-.250	.027	36.682
		TotalGAAS	-.011	.039	-.053	-.292	.771	-.087	.065	.225	-.024	-.021	.163	6.131
		MGLQxGAAS	.002	.001	1.358	2.600	.010	.000	.003	-.109	.209	.189	.019	51.438
16	1	(Constant)	58.252	9.946		5.857	<.001	38.598	77.907					
		TotalMGLQ	-.605	.182	-1.470	-3.322	.001	-.965	-.245	-.245	-.263	-.243	.027	36.705
		TotalGAAS	-.008	.039	-.038	-.208	.835	-.085	.069	.224	-.017	-.015	.163	6.141
		MGLQxGAAS	.002	.001	1.308	2.494	.014	.000	.003	-.109	.201	.182	.019	51.537
17	1	(Constant)	59.659	9.773		6.104	<.001	40.346	78.972					
		TotalMGLQ	-.635	.180	-1.541	-3.523	<.001	-.991	-.279	-.245	-.278	-.257	.028	36.025
		TotalGAAS	-.014	.038	-.063	-.356	.722	-.089	.062	.225	-.029	-.026	.168	5.955
		MGLQxGAAS	.002	.001	1.393	2.696	.008	.000	.003	-.106	.216	.196	.020	50.273
18	1	(Constant)	59.599	9.784		6.091	<.001	40.264	78.934					
		TotalMGLQ	-.636	.180	-1.545	-3.527	<.001	-.992	-.280	-.246	-.278	-.257	.028	36.200
		TotalGAAS	-.013	.038	-.062	-.349	.727	-.088	.062	.225	-.029	-.025	.168	5.936

		MGLQxGAAS	.002	.001	1.396	2.698	.008	.000	.003	-.108	.217	.196	.020	50.445	
19	1	(Constant)	59.140	9.934		5.953	<.001	39.509	78.771						
		TotalMGLQ	-.625	.181	-1.520	-3.447	<.001	-.983	-.267	-.247	-.273	-.251	.027	36.730	
		TotalGAAS	-.011	.039	-.053	-.290	.772	-.088	.065	.226	-.024	-.021	.161	6.200	
		MGLQxGAAS	.002	.001	1.365	2.608	.010	.000	.003	-.108	.210	.190	.019	51.744	
20	1	(Constant)	58.201	9.887		5.887	<.001	38.664	77.738						
		TotalMGLQ	-.605	.181	-1.477	-3.343	.001	-.963	-.247	-.251	-.265	-.244	.027	36.761	
		TotalGAAS	-.008	.039	-.036	-.198	.843	-.084	.069	.226	-.016	-.014	.164	6.112	
		MGLQxGAAS	.002	.001	1.308	2.503	.013	.000	.003	-.114	.202	.182	.019	51.421	
Pooled	1	(Constant)	59.049	9.902		5.964	<.001	39.642	78.456						.004
		TotalMGLQ	-.622	.182		-3.418	<.001	-.979	-.265	-.247	-.271	-.250			.006
		TotalGAAS	-.011	.039		-.286	.775	-.087	.065	.224	-.024	-.021			.004
		MGLQxGAAS	.002	.001		2.590	.010	.000	.003	-.109	.209	.189			.006

a. Dependent Variable: TotalWEMWBS

Paper 3: Executive Summary

Word count: 1669

Exploring the effects of loss and belonging on the well-being of Greek and Greek Cypriot migrants in the UK.

Eleni Kourtidou-Sextou

The following is a condensed version of a research study that contributed to the author's doctoral work in Clinical Psychology. It has been written for the research participants, the Greek and Greek-Cypriot diaspora, the broader UK migrant community, and those engaged in migrant care. It integrates feedback from five first-generation Greek migrants known to the author, enhancing its clarity and expression.

Background

Every year, more people are living outside their country of birth, now making up 3.6% of the world's population. This trend is highlighted in the World Migration Report of 2022.

Migrants are at a greater risk for mental health issues compared to those who don't migrate, as noted by multiple studies over the years (Yang, 2019). Well-being is influenced by a mix of factors like age, gender, income, education, and relationship status(Casado & Leung, 2002; Ahn, 2006; Jibeen & Khalid, 2010). But there's also migratory grief and acculturation to consider.

Migratory grief is felt universally by migrants due to the loss of their home, relationships, identity, culture, and familiar places (Casado et al., 2010). Its full impact on mental health isn't completely understood yet, but it's recognized as a depression indicator among Chinese and Korean communities(Casado & Leung, 2002; Ahn, 2006).

Acculturation, which involves adopting new cultural traits while keeping those from one's homeland (Berry, 2005), helps to feel a sense of belonging. Belonging is key for positive mental health (Haslam et al., 2009).

The Greek diaspora, historically one of the largest migrant groups (Tziovas, 2009), has a particularly under-explored story of migration and well-being, especially in the context of the UK.

This Study

The research focused on understanding the factors that influence the psychological well-being of first-generation Greek and Greek Cypriot immigrants in the UK. The study hypothesised that:

1. Higher levels of migratory grief would predict lower psychological well-being among these migrants.

2. Greater acculturation, would be associated with improved psychological well-being.

3. It was also predicted that migratory grief and acculturation would be significant predictors of well-being, even when considering other demographic variables like time since migration, employment status, educational background, marital status, and gender, which are known to impact well-being according to existing literature.

Study Design

The research adopted a cross-sectional design, gathering all data at a single timepoint. Ethical approval was provided by Staffordshire University. Data collection was executed through a survey on Qualtrics, with a pilot test conducted by three first-generation Greek residents in the UK.

Participants & Recruitment

From March 29th to October 31st, 2023, this survey study focused on Greek and Greek Cypriot migrants in the UK was carried out. It was promoted via posters on community-specific online forums, including Facebook and Instagram. Anyone over the age of 18 who identified as Greek or Greek Cypriot and had moved to the UK could participate. Out of the 152 respondents, the majority were women (69.1%), in full-time employment (69.7%), and had higher education qualifications (89.4%). For a visual breakdown, refer to Figure 1.

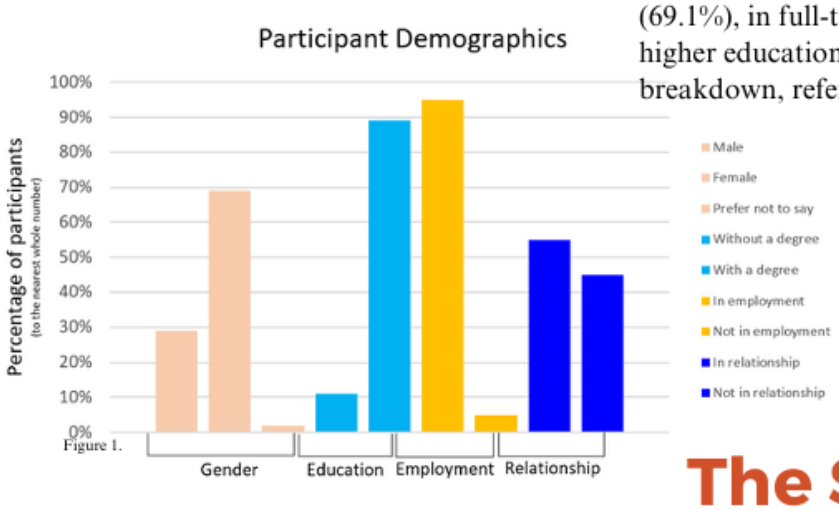

Figure 1.

The Survey

Individuals who clicked on the link or scanned the QR code were asked to read an information sheet. To participate, they had to complete an online consent form before accessing the survey. They were first asked their gender, location, years since migration, employment, education and relationship status. They then completed three questionnaires in the order shown below:

1. **The Greek-American Acculturation Scale** (GAAS) (Harris & Verven, 1996) measured attitudes and sense of belonging towards Greek culture. Participants rated 56 statements (e.g. I listen to Greek music, I would not date anyone who is not Greek) using an 8-point scale from "Not applicable" to "Strongly agree".

2. **Migratory Grief and Loss Questionnaire** (MGLQ) (Casado et al., 2010) measures the experience of grief and loss experienced with migration. Participants rated 18 statements (e.g. I miss my homeland, I feel upset about being far away) on a 4-point scale from "Never" to "Always" in terms of how often and with what intensity.

3. **Warwick-Edinburgh Well-Being Scale** (WEMWBS) (Tennant et al., 2007) measured psychological well-being. participants rated 14 statements (e.g. I've been feeling loved, I've been feeling useful) on a 5-point scale from "None of the time" to "All of the time".

Analysis

Demographic information was analysed using a correlation. **Correlation** testing looks at whether there is a relationship between two variables (e.g. employment and well-being) without being able to tell us if one is causing that relationship. Then, a statistical method called **multiple regression** was used. It tests whether scores on one measure can predict scores on another measure (e.g., does the level of grief predict a person's well-being?). *It was used to test whether participants' scores of migratory grief and acculturation could predict psychological well-being.* A follow-up analysis was completed to test whether the relationship between migratory grief and acculturation influenced how strong their prediction of well-being is.

Findings

MIGRATORY GRIEF

As predicted, participants with scores showing high levels of migratory grief had scores suggesting poorer psychological well-being.

ACCULTURATION

Opposite to what was expected, individuals with high levels of belonging to the Greek culture (low acculturation) had scores associated with more positive well-being.

MODERATION

The follow-up moderation analysis showed that when there is a strong ethnic identity, the predictive relationship of migratory grief on psychological well-being is weaker.

DEMOGRAPHICS

Opposite to the prediction, there was no relationship between years since migration, employment, education, marital status, gender, and well-being.

Conclusions & Recommendations

Overall there are some new findings compared to previous studies which could be interesting to look into further, both with this population as well as other cultural migratory groups.

- First study to show the role migratory grief plays in predicting psychological well-being for Greek and Greek Cypriots living in the UK.
- The more a person was grieving as a result of moving countries, the worse their well-being.
- There are very few studies on the role of migratory grief.

Any Greek or Greek Cypriot migrant presenting with challenges to their well-being should be offered grief-informed care and assessed for the presence of grief.

Further explore migratory grief in more migratory groups.

- First study to reveal that for Greeks and Greek Cypriots in the UK, lower levels of cultural assimilation correlate with greater psychological well-being.
- Those with a strong connection to their Greek heritage and ethnic identity tend to experience better psychological well-being.
- May be because belonging to a group is linked with positive well-being (Haslam et al., 2009; Tajfel & Turner, 2004). Holding onto their Greek identity, offers psychological benefits of group membership, regardless of how accepted they feel by the broader UK society.
- This connection to Greek culture may serve as a protective shield against negative experiences, such as discrimination (Espinosa et al., 2018).

Further explore the role of belonging in acculturation in other cultures.

Community level interventions celebrating cultural identities while interacting with the local community could be beneficial.

- First study to show the relationship between migratory grief and acculturation are shown to have a moderating impact on their predictive relationship of well-being.

Further research is needed to understand the moderation.

Limitations

The acculturation questionnaire designed for Greeks living in the USA may not capture the differences between Greek communities in the UK and the USA. The participant pool skewed towards females with higher education degrees, which raises questions about its representativeness of the broader Greek and Greek Cypriot population in the UK. Additionally, since all measures in the study were taken at the same time, it's uncertain whether the identified predictors are the actual cause of the observed differences in well-being.

What will happen now?

This summary will be shared on all social media platforms that were used to advertise participation. A detailed report of the research will be submitted for publication to the Journal for Cross-Cultural Psychology.

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