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Resilience, mental health and migration

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Summary

This chapter will explore mental health and resilience in the context of migration. The notion of resilience has received increasing attention recently as a way of making sense of how people cope with adverse events and hardship and as a possible protective variable which makes mental health difficulties less likely. At a time when healthcare providers and policymakers are attempting to come to terms with the high levels of international and intra-national movement of people in the early 21st century, it is appropriate to consider what resilience offers as a way of making sense of the psychological and psychiatric issues raised by migration and what it means for healthcare providers and migrants themselves. This chapter will therefore review the literature which has addressed resilience and migration, with a focus on low-to-middle income countries. We describe the life experiences and resilience of internal migrant communities in low income neighbourhoods in India, and the insights on resilience and migration in responding to the mental health needs of individuals and families who have migrated. In addition to different 'idioms of distress' we propose that it is important to be attentive to the different 'eudaemonic idioms' through which different cultural groups express the factors which are significant to them in maintaining happiness and promoting coping.

Key words: resilience, internal migration, idioms of distress, eudaemonic idioms,

Introduction: Resilience in cross cultural context.

As Windle (2011) says, definitions of 'resilient' tend to emphasize two related meanings: '1. (of a person) recovering easily and quickly from misfortune or illness; 2. (of an object) capable of regaining its original shape or position after bending or stretching.' Present day ideas about resilience have drawn from several academic areas including engineering and social-ecological systems theory but the use of the concept in fields such as health care and the social sciences has gained popularity in recent years. Definitions may vary between disciplines and sometimes within them and authors acknowledge that it is difficult to provide a precise definition of resilience (Windle, 2011).

In mental health scholarship, the idea of resilience was pioneered within developmental psychology and studies of stress-resistant children (Garmezy, 1985). (also see Chapters on pandemics and Disasters in this volume). Definitions of resilience in healthcare vary, but they usually include three key features: a) identification of risks or adversity, b) identification of sources or resources to help offset the effects of that adversity, c) avoiding the effects of the adversity or adapting positively to it (Coope et al 2020).

> *Resilience is the process of effectively negotiating, adapting to, or managing significant sources of stress or trauma. Assets and resources within the individual, their life and environment facilitate this capacity for adaptation and 'bouncing back' in the face of adversity. Across the life course, the experience of resilience will vary.* (Windle, 2011 p. 153)

Considering a public health and whole population perspective, Seaman *et al* define resilience as

> *the capacity for populations to endure, adapt and generate new ways of thinking and functioning in the context of change, uncertainty or adversity … The resilience perspective offers value to public health through supporting the development of strong communities … the resilience perspective provides a framework for enabling people and communities to not only bounce back but crucially, thrive beyond crisis*. (Seaman *et al.*, 2014, p. 3)

The implications of this for mental health service provision become apparent if we consider people's responses to trauma and adversity. As many authors have pointed out, trauma and adverse experiences are a commonplace part of the human condition (Raghavan and Sandanapitchai. 2019). Around 70% of adults globally (Benjet et al., 2016) experience at least one traumatic event in the course of their lifespan. The negative consequences of trauma, at least in some people, are widely documented. These may include psychological (Turner and Lloyd, 1995) and somatic symptoms (Chester and Holtan, 1992) (see Chapter on Trauma in this volume). Despite the high prevalence of adverse experiences, the rate of post-traumatic stress disorder, even in the United States where the condition was first characterised and most widely recognised, is just under 7% (Gradus, 2013), and is similarly low elsewhere in the world (Kessler et al., 2017). Of course, estimates of prevalence may involve under-reporting, but the relatively low prevalence of severe or enduring post traumatic symptoms is likely to reflect considerable resilience in the human population (Bonanno et al., 2011).

Early scholars saw resilience as an internal construct, relating to traits such as self-esteem and goal-orientation (Block and Block, 1980; Rutter, 1985). But as we shall see, the concept has been broadened to include family, community and even population-level conceptions of the idea.

The appearance of the concept of resilience in health can be viewed as part of a 'paradigm shift from pathological focus to the positive aspect' (Chen *et al.*, 2016), and the growing recognition that focusing too much on pathology may predispose an over-reliance on prescriptive expert-driven interventions:

> *Interventions that are based on the deficit, problems, or pathologies of individuals tend to direct the attention of professionals to only one view of the person … The emphasis on deficits or what a person is lacking leads to a cycle of focusing only on what needs to be repaired followed by reliance on prescribed resources or assumed solutions…* (Hammond and Zimmerman, 2012, p.4).

Resilience denotes the ability of individuals, places and populations to withstand stress and challenge. Seaman et al (2014) argue that for future public health, resilience thinking needs to go beyond preparing for isolated events to question the role that institutions, leaders and organisations play in creating vulnerabilities and in shaping society's ability to react to challenges, many of which are unpredictable. *They define resilience as the capacity for populations to endure, adapt and generate new ways of thinking and functioning in the context of change, uncertainty or adversity*. This resilience perspective offers value to public health through supporting the development of strong communities. In the face of a growing complexity in global trends and processes, the unpredictable nature of risk and where and what the next crisis or challenge might be, the resilience perspective provides a framework for enabling people and communities to not only bounce back but crucially, thrive beyond crisis. Beauty, conviviality and love can feature among the many important resources for existential meaning and resilience (Seaman et al 2014; Doppelt 2016).

Thus, there is a growing body of literature that sees resilience as extending beyond the individual to include aspects of a person's family, social and political setting. Luthar (2003), Luthar et al (2000), Fraser (1997), among others, have emphasized that resilience is not an individual trait, but related to the vulnerability and protective factors at play in a person's environment. Gilligan (2004) writes that

> "*While resilience may previously have been seen as residing in the person as a fixed trait, it is now more usefully considered as a variable quality that derives from a process of repeated interactions between a person and favourable features of the surrounding context in a person's life. The degree of resilience displayed by a person in a certain context may be said to be related to the extent to which that context has elements that nurture this resilience*" (p.94).

Likewise, Seccombe (2002, p. 385) makes the case for a concept of resilience that incorporates the environment as much as the individual:

> "*The widely held view of resiliency as an individual disposition, family trait, or community phenomenon is insufficient . . . resiliency cannot be understood or improved in significant ways by merely focusing on these individual-level factors. Instead careful attention must be paid to the structural deficiencies in our society*

and to the social policies that families need in order to become stronger, more competent, and better functioning in adverse situations".

Similarly, a recent paper by Ungar (2018) argues that the resilience literature is steeped in a Western-centric value system that emphasizes traits within the individual, and does not engage adequately with significant protective factors relating to culture and context. This western orientation may impede the study of resilience in cross cultural contexts because as Raghavan and Sandanapitchai (2020) point out, it tends to privilege the kinds of mental health symptoms found in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA 2013) and there may be culturally specific idioms of distress which are not well captured by assessments based on the symptoms listed there. Indeed, researchers and clinicians sometimes have to work quite hard to make people's problems fit the criteria. For example, in a classic study in rural Kenya, Ndetei and Muhangi (1979) reported that anxiety and depression were the commonest problems. Yet they also said that *'none of the patients complained of subjective symptoms of either apprehension or fearfulness in the case of anxiety*' (p.270). Likewise, there was a lack of *'sadness, guilt or nihilism in the case of depression*' (p.270). Even *'direct enquiry about these feeling states also failed to elicit positive responses*' (p.270). So, in some cases researchers and clinicians have to use considerable imagination to map the presenting problems of clients or research participants on to the mental disorders they are familiar with through their education or training. Likewise, in considering 'coping strategies', 'social support' or even 'resilience' itself in different settings, researchers and practitioners may have to undertake imaginative leaps to relate what local people tell them to the categories on their assessment scale or interview guide. This aspect of the research is often not described in detail in the eventual journal articles or books where the study is presented.

There may also be differences in how some of the basic terms are understood. In their study of resilience in young people across a number of different nations, Holtge et al (2020) note that questions about sources of support in difficult times meant different things in different countries. Some countries such as Jordan appeared to be rather low on whether participants felt they could call on sources of support in difficult times. But

this could just as easily reflect differences in the meaning participants attributed to the question, rather than meaning the country was unusually lacking in social support.

Therefore, there is a considerable weight of opinion in the literature that different cultures may understand, experience and exhibit resilience differently, and caution should be exercised, especially where resilience has been assessed with a single self-report measure, even if it is translated into local languages. It is valuable also to attend to the social ecology, the context, the local ways of expressing distress or talking about family, friendship community or spiritual ties.

Nevertheless, it is valuable from the point of view of health service provision to consider the various forms resilience can take and be expressed in differing cultural contexts. At the outset of the 21st century McGoldrick (2003) noted that "*mental health professionals everywhere are being challenged to develop treatment models and services that are more responsive to a broad spectrum of ethnic, racial, and religious identities*" (p.235). The near two decades since MGoldrick's claim have served to make this statement more important. There have been signs of ever greater mobility and migration, both within and between countries, greater mixing of cultures, more urbanisation as well as tension, polarisation and conflict. The 21st century practitioner may well be confronted with patients from very different backgrounds with different idioms of distress, differing patterns of family, religion and culture seeking to make new lives for themselves and obtain health care in unfamiliar places. It is important therefore, in service provision to consider strengths, capabilities and recovery as well as symptoms.

Migration and Resilience in Low- and Middle-Income Countries

Migration is a matter of emerging importance for Low- and Middle-Income Countries (LMICs), with international debate stepping up on the linkages between migration, development and poverty (Black et al 2007). Migration is the process of social change whereby an individual move from one cultural setting to another for the purposes of settling down either permanently or for a prolonged period (Schwarzweller and Seggar 1967) (See Chapters on geopolitical determinants and Migration in this volume). India

is the nation with the highest proportion of internal migrants among its population, with more than 300 million internal migrants reported in the census of 2011.
According to the 2011 Census of India, more than two-thirds (69%) of India's 1.21 billion people live in rural areas, but the country is rapidly urbanizing (Abbas and Verma 2014). The cities of Mumbai, Delhi, and Kolkata are all among the world's top ten most populous urban areas, and India has 25 of the 100 fastest-growing cities worldwide. A significant source of this growth is rural-to-urban migration, as an increasing number of people do not find sufficient economic opportunities in rural areas and move instead to towns and cities. Provisional 2011 census data show that for the first time, India's urban population has grown faster than its rural population since the last census in 2001. Thirty-one per cent of India's population is now classified as urban, up from almost 28 percent in 2001. In 2007-08, the National Sample Survey measured the proportion of migrants in urban populations at 35%.

Shrinking agriculture in rural areas and rapid industrialization and consequent increasing urbanization leads to a rise in internal migrants in search of livelihood for cities.

Pune in the state of Maharashtra is an old city is now home to many knowledge-based industries which has also spilled over to increases in construction and related industry. Pune is 8th in India in terms of GDP (Mckinsey Report 2011) and its per capita income (PCI) is higher by 50% than the country's PCI (PMC Environment Status Report, 2007-08). At the same time urban poor make up 50% of the city's population and there are 564 slums in Pune (2011 Census). These urban inequalities underscore the rift between the rich, burgeoning middle class and the people from the low socio-economic group in the city. Most of the population in these slums consists of migrants from rural areas from all over India in search of employment.

Internal migration and mental health

Literature on internal migration and mental health are somewhat limited. However, the indications are that migrant populations are exposed to many health problems,

including lack of or poorly organized public health services, limited awareness of the available local health services, the high cost of private health services, lack of social capital and social support systems, lack of basic civic amenities, poor living conditions, unstable housing, everyday risks of hunger and starvation, inability to withstand psychological stress, sexual health problems and exposure to high risk activities, food insecurity, road accidents and various other adversities of living in the slums, city pollution, climate and other environmental hazards. Migration to urban areas seriously affects the health of children with increased child mortality through factors such as malnutrition and low immunization coverage. In comparison to the general population, immunization coverage is low among migrants and lowest among the recently migrated population. Antenatal and maternity care is a major concern with low access or uptake of antenatal care (Abrol et al 2008). Most of the migrant women tend to deliver their child at home and only few are able to afford even traditional midwives for their delivery (Devasenapathy, et al. 2014).

Migrant populations are exposed to increased public health risk factors due to their lifestyle and socio-economic status. They are at risk of developing HIV/AIDS and form an important link in transmission of HIV to their native home villages (Saggurti et al 2011). Alcohol use among migrant population has been found to be associated with high-risk sexual behaviour (El-Bassel and Marotta, 2017). Migrant populations are also exposed to increased risk of developing cardiovascular diseases (Perini et al, 2018).

A 2016 survey of the literature to date in the *Indian Journal of Social Psychiatry* (Prasad et al, 2016) noted that problems such 'loneliness, frustration, increased household and social burdening are common among the migrants' and that factors that can have an impact on the mental wellbeing of migrants include: age, differences in climate between place of origin and destination, language, food, culture, whether one has migrated alone and whether migration was forced or voluntary. The authors also note how vulnerability to mental health problems appears most acute in the period immediately after arrival but also several years after settling at their destination. Seeking to explain this, the authors suggest many who migrate can be

> "*disheartened by the lack of achievement they had anticipated. This disappointment may result in lower self-esteem increasing susceptibility to depression or other psychiatric disorders*" (Prasad et al, 2016, p. 231).

Certain categories of people appear particularly susceptible to mental health problems. These include: women, children, old people, gay, lesbian, bisexual and transgender migrants. And some groups were susceptible to post traumatic stress syndrome. The authors also highlight a relationship between urban dwelling and increased susceptibility to psychosis:

> "*Urbanization is associated with a two-fold increased risk of psychosis. There are speculations that this may be due to loss of social capital and social fragmentation Rates of schizophrenia and other psychoses are elevated in migrant and minority ethnic populations … 'Nuclearization' of families and change in family structure may reduce social support for patients with psychosis*" (Prasad, *et al.*, 2016, p233).

While the potential problems of migration and their possible mental health sequelae are widely discussed there have so far been relatively few empirical studies of resilience and internal migration in low-to-middle-income countries. Coope et al (2020) provide a review of the substantive pieces of work to date and discovered through an extensive literature search 11 pieces of work on the subject, mainly originating from China but with other countries such as India Sri Lanka and Ghana represented. All of these pieces of work highlight the value of resilience, and say it merits further attention and identify factors including familial and community networks and individual hope or optimism.

The available public health literature and data largely pertains to metropolitan cities and HIV and AIDS, maternal and child health. There is scarce literature on the mental health issues of poor migrants. Stress is a major concern for migrants due to lack of job security, occupational hazards, low wages, inability to fulfil their own needs and exploitation by employers. Stress is a major in migration and as result is a major risk factor for their psychological and physical health (Bhugra 2004). Many migrants resort to alcohol use and this leads to mental health issues and domestic violence (they are also faced with loneliness, helplessness and experience both emotional and structural losses as they are separated from their family and familiar society (Bhugra and Gupta 2011). There is a higher prevalence of mental health disorders in the migrant population, but some of the studies show that the migrant communities may

experience better mental health when compared with the local populations (Wong and Leung 2008, Levecque et al 2009).

While this is true for migrant population worldwide, the picture in the Indian context with special reference to the internal migrants who live in slums warrants a closer look for the risk and resilience factors for mental health and wellbeing. Some of available the literature highlights that internal migrants who live in slums experience a higher burden of anxiety and depression (Subbaraman et al 2014).

To date then, the available literature highlights the value of resilience as a topic of inquiry and its relevance to migration studies. To illustrate how this might play out in practice we will now turn to a study the authors have recently undertaken looking at internal migrants who had arrived at a low-income neighbourhood of the city of Pune. In many western nations the term 'slum' has somewhat pejorative connotations, but in a number of LMICs it is a term widely used to denote residential areas with structural and social problems. In India it has been defined for the purposes of the census as 'residential areas where dwellings are unfit for human habitation by reasons of dilapidation, overcrowding, faulty arrangements and design of such buildings, narrowness or faulty arrangement of street, lack of ventilation, light, or sanitation facilities or any combination of these factors which are detrimental to the safety and health' (Census India, 2011). People arriving in a new city in search of work are, unless they are relatively privileged, likely to find themselves living in such neighbourhoods.

Current mental health narratives of internal migrants in India tend to focus on the prevalence of psychological distress and common mental health disorders such as anxiety and depression, but until the authors' study we knew relatively little about the resilience of migrant communities who are slum dwellers. The psychological distress and experiences as a result of migration can indeed be a risk factor for higher prevalence, but the lack of knowledge on how these migrants' mediate risk in the midst of adversities and construct resilience for positive living is an untold story.

Public health, resilience and slum dwelling migrants

Public health is concerned with the prevention of disease and with the promotion and protection of health in ways that promote social justice (DeSilva et al., 2013). Mental health is central to health (Herman and Jane-Llopis, 2005). The World Health Organization's (WHO) concept of mental health includes the promotion of mental well-being, the prevention and treatment of mental illness, as well as the rehabilitation of persons affected by mental illness (WHO 2014) (also see Chapter by Campion in this volume). Migrant communities who live in the slums are vulnerable to psycho-social distress (Prasad et al 2016). These migrants experience distress as they have been uprooted from their main occupation, mostly farming, and they experience an upstream challenge in the learning of new skills to obtain gainful employment in the city. Education for children and young people is a major struggle as they are handicapped by language and poverty and those who are able to reach schools and colleges struggle against severe discrimination and competition (Roy et al 2015). Arriving with rural identities, many of these people acquire urban aspirations fostered by dwelling so close to the developed city, only to then find themselves very far from tasting the fruits of 'development'. The World Migration Report (International Organization for Migration, 2015) stress that improving urban migrants' access to quality health services, and the conditions in which they live and work, is a prerequisite for achieving sustainable urban development. Not only is there a human right to health, ill-health also carries negative social and economic consequences for the individual, the family and larger society. Ill-health leads to lower educational attainment and lower employment, and therefore increases income poverty, which in turn has negative consequences for a person's physical and mental health and well-being (International Organization for Migration 2015).

Aims and Methodology of our resilience study

As mentioned above,our study was conducted in a slum area of Pune. It contained a number of elements, including a community theatre initiative involving local people and a theatre company, working together to create events and activities over the duration of the project and culminating in a theatre production which was performed in the neighbourhood and elsewhere. The theatre activities were informed by an interview study designed to elicit people's experiences of migration and their strategies

for resilience. Overall, the study was driven by a commitment to participatory methodology, embracing the principles of co-production (http://mhri-project.org/).

Our participatory research methods were geared towards planning and conducting the research process with the people whose life-world and meaningful actions are the focus of study. Our approach is based on the work of Fals-Borda and Rahman (1991) on action and knowledge, where they argue that participatory research should be conducted directly with the immediately affected persons; where the aim is the reconstruction of their knowledge and ability in a process of understanding and empowerment. This is recommended in working with marginalized groups whose views are seldom sought, and whose voices are rarely heard in mainstream debates about public health awareness and support.

Our aim was to develop life stories with participants using a method of biographical interviewing and interpretation popularized by Chamberlayne and Wengraff (e.g. Chamberlayne et al, 2000). In this approach, the researcher starts with a single question to elicit a person's life story: 'Tell me the story of your life' which aims to get the participant to talk in an unprompted way, from their earliest memories to the present. Follow up questions may also be asked to elicit further detail and elaboration; in this case these might include 'why did you decide to move to the city?' or explorations of important experiences, for example 'you said you missed your family'. In total 30 participants provided detailed narratives that underwent thematic analysis to identify sources and resources of resilience that they appeared to be using to build resilience to risk, hardship and adversity. Each narrative was analysed for how individuals identify risk and adversity, for sources and resources each participant used to overcome challenges they had faced and how they overcome adversity going forward in their life journey.

Thematic analysis highlighted two main dimensions of resilience (1) intra-individual factors and (2) outside-individual factors, outlined in Table 1. The first was a group of intra-individual factors which could be sub grouped into a further ten clusters. The second group of outside-individual factors could be subdivided into seven clusters. These clusters are useful for identifying what sources and resources are used to build and deconstruct resilience in real life adversity.

Table 1: A table to show the emerging themes of resilience from thematic analysis.

Resilience Themes	
Intra-Individual Factors	**Outside Individual Factors**
Acceptance	Children
Hope	Faith/spirituality
Wisdom from past experiences	Finding space through friends to vent out
Courage	Helping each other
Forgiveness	Work is worship attitude
Let go attitude	Financial savings for better future
Dreams and aspirations	Celebrations/festivals at family and community level
Persistent hard work	
Willingness to learn	
Hobbies	

To give a sense of how resilience was expressed, and the kinds of personal and community level resources people drew upon, we present below some examples from the narrative interviews which were carried out. It is important to note that these were not people who were seeking treatment for symptoms of mental ill-health, but rather, were ordinary people talking about their lives and the challenges they faced in the process of making a move to the city and in supporting their families.

To explore first the inner resilience resources mentioned by participants, a significant aspect was expressed by one man, the ability to accept what one has, however meagre. As he put it:

> *Being happy with whatever you have keeps you happy. If you have one rupee, then you need to spend half of it and spend the other the next day. One needs to find satisfaction with whatever one has. If you can have a meal twice a day, it is enough for you. Nothing more is required. One doesn't require a car, a bungalow or any big property. If both of you are happy, that's enough. And we*

are very happy. Even if only one of us go to work, we will have enough food. We both would have enough food (M, IDI 03, 33yrs).

Here, he is focusing on food, and on the immediate short term, being able to have enough for a couple of meals a day. The other goals he mentions are formulated as not being immediate necessities issues. Having a bungalow is clearly seen as a step up from the current family accommodation, but this as well as having a car, is less important than having enough food. So, there is a process of prioritization at work in his formulation of what the family's needs are.

A similar process of prioritization can be seen in another account of the origins of resilience. In some cases, it was not one's own betterment that was seen as important, it was hope for the next generation. The aspiration was expressed that they will have the opportunity for education and professional careers:

"I dream and wish that my children should do all those things which I was not able to do. They should be well educated and well settled. I wish that my daughter should become a lawyer, because she is very intelligent and my son should become a doctor. She (my daughter) is very smart... I will try to earn money as much as I can. I will earn something for my children. I will do everything possible for me. But I will make sure that my children are well educated" (F, IDI 07, 27yrs).

Here, the participant's own work is of value not because of any immediate benefit to her standard of living but what it means for her offspring. Whilst opportunities may be constrained for oneself and one's own generation, the rising generation is seen to have a better chance, conditional upon her continued labour. This deferral of hope to future generations makes the day to day tasks of work and childcare meaningful and valuable.

A further source of resilience for some people was their memories. That is, recollecting past times which were happier and more carefree appeared as a source of comfort when the present-day was filled with the more mundane toil of providing for one's family:

"I always recall my childhood days. In our childhood, we didn't have to earn money, no stress about anything. My parents used to work and earn. We used

to pass our time in playing, roaming around and so on. I just remember those moments only. However, at the moment I have become a little older, I have just spent my life in working, earning money and looking after my family. I haven't done anything else beyond this" (M, IDI 25, 32yrs).

While in this case he didn't talk specifically about long term aspirations for the younger generation, he sets the present-day experience of work against the relatively unencumbered early years he enjoyed – as if the two phases of his life were somehow in balance. Other participants too expressed strongly the importance of memory:

"I always remember my past, I never forget about it, and I can never forget about it also, whatever that has happened in the past, never!" (F, IDI 16, 33yrs).

It is as if there is an accumulated stock memory which helps one through the present. In some cases, the present-day might involve some privations but was contrasted favourably with what the participants remembered from the time when they first arrived in the city.

"There was a time when we just had one sari to sleep on. In day time we used it to sit on and in the night we used it to cover ourselves (pangharun). There was not enough space available. When she used to awake, I used to sleep. We had a very hard time. Now the situation has changed and we are living a peaceful life, having enough food, and a better married life" (M, IDI 03, 33yrs).

The peace and relatively plentiful food in the present is seen to represent an advance on the very limited resources in the past where his wife's sari also did duty as something to sit on and as bedding.

These then represent for our participants important factors in one's coping ability and the quest to make life better: small incremental material improvements, the value of memory or hope for one's children's education or careers. These represent what we might call 'eudaemonic repertoires', in other words, ways of thinking and talking that are conducive to happiness.

As indicated in Table 1, a number of sources of resilience were mentioned that were external to the individual and related to family, friendship or community ties which were seen as valuable. Resilience resources within one's immediate family were mentioned by several people. As a woman of 21 told the interviewers:

> *"You have to remain courageous. Though sometimes I think, why God gave us such a life. And even if he did, why is it that we've to face with so many difficulties. However, my mother is there with me, to help if there is something and support me"* (F, IDI 24, 21).

Sometimes the resources came from other members of the community and wider circles of friendship. For example, a woman described the help which came from a friend who was in a stronger financial position:

> "*Bhau [the friend] has really helped us. He is the only one, who has supported us when we shifted to Pune. And whenever I think about it, I bless him. You know, nobody has ever given us such kind of support; just not in Pune but in the world itself. My husband also did not have house. He had nothing. I did not have parents. Yet, despite being a stranger, he helped us, supported us. So, whenever I think about him, I bless him. He is the reason because of which we are alive. He also has given job to my husband. He helped him find other jobs also. We are very much grateful to him*". (F, IDI 29, 35yrs.)

The role of family and friendship can easily be mapped onto the role of social support which many authors have seen as being critical in creating resilience, as we have described above (e.g. Faizel et al 2012). The quotations above show that such relationships are recognized by the participants, and they well aware of the desirability of cultivating and maintaining them.

In making sense of the experience of distress or illness, the notion of 'idioms of distress' (Nichter, 1981) has been a popular one, which has gained ground in explaining how people in India express problems (Desai and Chaturvedi, 2017). In this literature the view is taken, for example, that patients' reports of bodily symptoms may be a way of expressing cultural conflicts and interpersonal difficulties. As well as the need to be sensitive to different cultures' ways of expressing illness and distress, it is equally important to be attentive to how different people express resilience and coping. Whilst life may be hard and involve many challenges, insecurities and hardships, the

picture is often not unremittingly bleak. As Subbharaman et al. (2013) said of their study of migrants in low income neighbourhoods in Mumbai '*while this paper sheds light on their tribulations, it fails to capture the joy and resilience that also constitute their lived reality*' (p.155). That is why we have coined the term 'eudaemonic idioms' to capture this phenomenon. Here, it might take the form of participants' comments about family relationships and friendships, memories or hope for their children's futures, but eudaemonic idioms need not be confined to these issues – they could potentially embrace a whole range of thoughts, relationships and activities that are a source of solace or build optimism.

Towards a Conclusion: The Eudaemonic idioms of resilience

We have reviewed some of the work that has been performed on the concept of resilience, with a particular focus on resilience and migration experiences. As we have seen, the focus of interest has embraced individual qualities and personal capacities as well as familial, social and cultural aspects of resilience. And as we have seen from our own study, people sometimes have particular ways of expressing what is important in sustaining them over the course of their own migration journey and life course. By analogy with the well-known idea of 'idioms of distress' it is also possible to speak of 'eudaemonic idioms' in which people express ideas about what they find conducive to happiness or wellbeing. These do not always map neatly on to Western-derived questionnaire measures of resilience, so as Ungar (2008, p. 234) argues, "*a degree of cultural sensitivity in how resilience is understood and, in the way interventions are designed to promote it is desirable"*. In Ungar's view this should involve researchers and practitioners becoming '*more participatory and culturally embedded to capture the nuances of culture and context*'. From this standpoint, the better we can understand people's own constructions of resilience, the more likely it will be that resilience-promoting interventions can build successfully on the specific aspects of resilience most relevant to health outcomes as defined by people in a particular cultural context. Raghavan and Sandanapitchai (2019) emphasise the need for culturally competent practitioners and recommend the incorporation of indigenous values and practices into clinical work. They argue that trauma survivors are likely to benefit from culturally tailored interventions and opportunities to draw upon cultural strengths in the recovery process.

As we have described, there have been investigations into factors which influence the resilience of migrants and the ease with which they make the geographic and cultural transitions involved. The experience of discrimination after having migrated and living in a poor neighbourhood increased the likelihood of suffering PTSD whereas a positive family situation and social support reduced that risk (Perreira and Ornelas, 2013). Fazel et al (2012) reviewed the literature on the mental health of refugee children who had resettled in high-income countries and found that their risk of developing mental health problems was greater if they had been exposed to trauma, if their parents had been exposed to violence, if they had lost of one or both parents, if there was limited family support, if they had faced violence and discrimination in the new host country, if they felt disconnected from school, and if there was neighbourhood violence. This underscores the observation made earlier that resilience is a feature not only of individuals but of social settings and social support networks too. Fazel et al (2012) also identified protective factors which were associated with enhanced resilience, including stable settlement and social support in the new host country, the psychological wellbeing of the parents or guardians, and the presence of religious faith. Again, this highlights the value of support and stability within the family and the role of faith congregations in promoting resilience. Fang et al (2017) found that as migrants from rural to urban areas in China became assimilated into their new circumstances and communities, their resilience improved. In addition, cross cultural contact can mitigate trauma and engender feelings of resilience (Lurie et al 2020).

Panter-Brick's (2014) work on young people in Afghanistan has added to this discussion of the role of personal and cultural factors in resilience. She likens resilience to a 'bricolage', and describes how it involves intellectual pursuits, social networks, business goals, religious values, and is always being negotiated via cultural values and dynamic goals. She cautions against viewing individuals in simple terms as 'resilient' or 'non-resilient', because these trajectories may depend significantly on context. Similarly, Reyes et al (2020) point out that the norms of a person's host culture can create particular risks as well as opportunities for resilience. On the one hand a more collective orientation, such as is believed to prevail in south Asian and south east Asian cultures can confer protective effects yet at the same time the strong desire to

save face where personal and family honour is at stake can provide an additional stressor.

Raghavan and Sandanapitchai (2020) conclude their review of cross-cultural studies of resilience with a plea for research on trauma and resilience to incorporate more specific and nuanced assessments of culture. This, they say, may not be difficult to do, and might simply entail asking participants about these issues in interviews, inviting participants to talk about their cultural background and the influence of culturally specific values. The experience in the literature is that when participants have the opportunity to do so, they often spontaneously disclose these value systems and beliefs, and in some cases appear proud to describe them as sources of strength. In the material reviewed by Raghaven and Sandanapitchai (2020), it was commonplace for participants to distinguish between individual- and community-level aspects of resilience, describing supportive factors in their social group or ethno-spiritual community, and as with our participants described above, resilience research may benefit from explicitly addressing these aspects to gain a more rounded picture of the phenomena.

Whilst cultural beliefs and values, as well as families and communities, may provide strong sources of support, they may also be a source of constraint or conflict. Eggerman and Panter-Brick (2010) have argued that although ‘family unity’ can aid resilience, it can also impede personal aspirations or freedoms, and that researchers exploring the role of culture should be wary of fetishizing cultural values. Groups of people are not homogenous and there may be friction and disagreement even in the most tight-knit communities. Reyes et al (2020) point out that the norms of a person’s host culture can create particular risks as well as opportunities for resilience. On the one hand a more collective orientation, such as is believed to prevail in south and south east Asian cultures can confer protective effects yet at the same time the strong desire to save face where personal and family honour is at stake can provide an additional stressor.

It is important to note that concepts of resilience have their limitations. As we have noted, many authors have argued that we need to look beyond individual traits towards the social ecology in which resilience occur. The family, the community, and the work

they do or the school they attend, or the religious group to which a person belongs have all been identified as having a role. However, as Raghavan et al (2020) have pointed out, there are often broader political issues at stake which a focus on resilience can deflect attention away from. The problems faced by migrants may have larger-scale economic and political causes which may be best addressed by political means. Failures of imagination on the part of policymakers, failures of investment or planning, or the tendency of mainstream politics to address the sectional interests of wealthier constituencies or lobby groups at the expense of the working classes – these all have a bearing on whether people migrate, yet are frequently not addressed in the resilience literature. In wealthier nations or sections of society people may change career or travel as part of their work, but do so in relative comfort, yet poorer people endure the hardship described by our participants – the kind of hardship which elicits 'resilience'. Similarly, international conflict, civil war or the reluctance of governments to address potential hazards which face their citizenry will also affect the 'resilience' of the population, and the likelihood that that people will be placed in situations where resilience is necessary.

Consequently, whilst the concept of resilience has yielded a number of interesting avenues for research and offers opportunities to build upon and celebrate people's and communities' strengths, it is important to bear in mind also the wider social and context within which resilience is embedded.

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