

Living with a long term physical health condition: Psychological experiences of older lifestyle migrants

Jane Simpson

Lancaster University

Sofia Triliva

University of Crete

Carol Thomas

Lancaster University

Gerasimos

Chatzidamianos

Lancaster University

Craig Murray

Lancaster University

An increasing number of people are living with at least one long term health condition or chronic illness (Ham, 2006). One concept within chronic illness research increasingly regarded as important is psychological adjustment. In this study this is understood as the result of a series of adaptations to

maintain a positive view of the self and the world in the face of a health problem' (Sharpe & Curran, 2006, p. 1161). One example of when successful psychological adjustment to a long term condition faces a number of additional challenges is when it is experienced in a different social context – for example as an expatriate or migrant living in a different country from that of birth and early life.

One area of migration which is of particular interest given its increase and relative lack of research is 'lifestyle' migration (Benson & O'Reilly, 2009). This type of migration is 'the very antithesis of being economically motivated, and [is] undertaken by those who prioritise quality-of-life and aesthetic concerns over income' (King, 2002, p. 100). Many lifestyle migrants tend to be older (e.g., retirees) (Huete & Mantecon, 2011) and many relocate from northern Europe to Southern Europe which, through the search for sunnier climates, has also been referred to as 'heliotropic migration' (King, Warnes, & Williams, 2000). Although figures are difficult to determine given the lack of data on specific types of migration within Europe, it is generally accepted that lifestyle migration in older north European citizens to

southern Europe is on the rise (e.g., King, 2002). Indeed, in a study looking at the number of foreign nationals in one part of Spain, the Costa Blanca, 78% of the inhabitants of one town are foreign nationals and 92% of those are from the EU. Consequently, the aim of the study was to provide an in-depth idiographic account of the psychological processes involved in the adjustment of older UK citizens with a long term physical health condition currently living in Crete, the largest of the Greek islands.

Method

Participants

Participants were 50 or over and had been born in the UK and spent a substantial part of their adult life there (see Table 1); ten participants (age range: 50-70; M = 62.3 years) were interviewed. All participants received health care on the IKA system, which is the public social security system. Many of the services covered by this system can be administered in private facilities. A large sector of people living in the country is insured under its auspices. There is recognized reciprocity with the British public insurance system and the costs incurred for procedures either within the IKA facilities or by private physicians are fully or partially reimbursed.

Procedure

The study received ethical approval from both universities involved in the research (universities of Lancaster and Crete). Participants were recruited from adverts in various fora set up for the expatriate community – newsletters, adverts in cafes etc. All

Table 1

Participant clinical and demographic details

Pseudonym	Age (years)	Long term condition/s	Time since onset of symptoms (years)	Time living in Crete (years)	Living situation	Care received in UK	Work status
Rory	60s	Musculo-skeletal, cardiovascular	15	3	Alone	GP appointments	Retired
Tina	50s	Cancer	2	8	With partner	Some surgery/chemotherapy received in UK	Part-time work
Mark	60s	Neurological disorder	3	7	With partner	None	Retired
Andrea	50s	Cancer	7	8	Alone	Surgical complications only	Retired
Thomas	70s	Neurological disorder/cancer	12	13	With partner	Neurological liaison	Involved in family business
Margaret	60s	Cancer	20	10	With partner	None	Retired
Lisa	50s	Cardiovascular / skin complaint	2	9	With partner	Outpatient consultations	Own businesses
Tricia	50s	Cancer	1	8	With partner	None	Retired
John	70s	Musculo-skeletal	20	10	With partner	None	Retired
Anne	70s	Cardiovascular, musculo-skeletal	6	20	Alone	None	Retired

participants were interviewed face to face in English by interviewers who had English as their first language. The interviews were all conducted individually - no spouses or partners were present - and ranged from 45 to 92 minutes in length ($M = 68$ minutes). Interviews were transcribed verbatim. Data collection occurred between April and June 2013. Interview data underwent an inductive, phenomenologically informed thematic analysis (see Braun & Clarke, 2006, for further details).

Results

Three themes were constructed from the data and are detailed below.

1. Reasons for migration inform coping strategies and adjustment

Participants had made the active decision to move to Crete for a number of 'pull' reasons -for example, the warmer weather, the physical beauty of the island, and the perceived characteristics of Cretans (friendly, direct, having more traditional family

values, more informal, less hierarchical). For most participants, these 'pull' factors helped efforts to cope and manage their illness.

"I mean I've come to the terms with the fact that, unless somebody comes up with bloody miracle cure in the next few years, I'm just gonna get worse, so make hay while the bloody sun shines and to hell with it." (Mark)

In addition to the physical features of the environment, the perceived characteristics of Cretan people were also important in the management of the illness. Health professionals were generally described as caring, efficient, "saintly" (Mark) and "brilliant" (Andrea). They were also, however, seen by the participants as being direct and not concerned with adhering to the rules when more flexible options might be better for the patient – in other words more patient-centric than rule-based in their care decisions. Indeed this reflected another common perception of Cretan society ('and there's a sense of we only obey the rules that make sense': Mark). For example, John, who as part of an operation had another procedure performed which he had not explicitly given consent for (but which had helped his condition), said:

"You know, when you ask them why they did something, they tell you why they did it, because it was better or... like, say, with this ankle, they'd chopped the small bone in my leg here, chopped it off here and did it there but didn't ask me or tell me, they just did it."

There is certainly 'continuity' in comparing the 'pull' factors behind migration with the coping strategies used by participants to manage their illness and this raises issues about the relevance of Bury's (1982) work in this particular context. For example, Bury's emphasis on chronic illness as 'biographical disruption' has been supported as a concept in many studies, although not without its critics (see Williams, 2000). However, maybe its opposite,

biographical continuity is more relevant here as participants in this study were determined not to let the advent or previous existence of a chronic illness impact in any meaningful way on their chosen lifestyle (Carricaburu & Pierret, 1995).

2. Differences in health care provision positively contributed to psychological adjustment.

All participants agreed that there were differences in the provision of health care between the UK and Greece but many of the experiences reported were positive, e.g., shorter waiting times. However, other examples of the differences cited were less obviously positive and, consequently, the psychological reaction to them more complex. One example cited by all participants was the difference in nursing care. In Greece, nurses were considered less visible on the wards and did not carry out personal care. However, this difference was usually commented on positively in that nurses were given a higher status and described as 'technicians' or 'mini-doctors'. Where nursing care was appraised negatively ('appalling', 'non-existent'), it was also described as not needed by those participants, so did not impact on their more global (and mostly positive) impression of the quality of health care they had received.

Another example of a difference which could have been more negatively appraised was the need for health care in Greece to be directed more by the individual (or their close family) as opposed to the health care system. However, this was mainly seen as a positive and a benefit psychologically. The participants stated that they find the control they need to take in order to get treatment for their medical problems contributes to a proactive stance and empowers them. The fact that they literally carry their medical records from one service provider to another and that they take specimens or test results from one specialist to another impacts the level of control they possess and makes them feel in charge of their lives and their illness. This aspect of the system which may be thought at negative in that it does not

buffer the patient from the stress of running about was paradoxically viewed and experienced as providing the participants with a push to taking an active or proactive stance and pushing them to engage actively, as one participant stated:

"... maybe you do have to fight more if you're somewhere like this where you're not in that, you're not cushioned by that system..... maybe that is a good thing because maybe that makes you a little bit more positive about stuff, that you've got to go forward and you can't just relax back into it."

Clearly the need to find a positive angle on the more unusual health experiences could be seen as an example of 'benefit finding', the psychological need to find positives from traumatic experiences (Tennen & Affleck, 2002) and which has been argued to reduce anxiety (Tomich & Helgeson, 2004). Tedeschi and Calhoun (2004) also argue that benefit finding is more likely with people with particular personality characteristics such as hardiness and optimism and these have been argued to typify lifestyle migrants (e.g., Warnes, King, Williams, & Patterson, 1999). For some participants, their insistence on the positives was difficult to accept uncritically as highlighted by contradictions in their accounts. For example, Margaret was very complimentary about her surgeon and described her surgery scars as 'fabulous'; however, she also later on in the interview talked about how her operation had left her 'mutilated'. It seems that the need to maintain a positive outlook is supported by a number of psychological processes which reduce any dissonance between conflicting cognitions (e.g., Festinger, 1957).

3. Health care decisions as a reflection of commitment to integration

Participants differed as to whether they received all their health care in Crete or had received some in Crete and some in the UK (e.g., one participant had had the operation in the UK but chemotherapy in Crete). However, all participants expressed either

their 'trust' or 'total confidence' in the Greek health care system and did not appreciate negative comments from friends and family in the UK. Decisions about where to have their health care reflected participants' commitment to their integration with their host nation and society to which they had chosen to immigrate. For John, despite the fact that aspects of his health care had been problematic, and even objectively potentially traumatising, he was completely positive about his experiences. This seemed tied up with his take on the need for integration:

"there's some Brits in that taverna and some [Greeks] in that taverna, in that like it happens in our village. I come along, I'll sit with the [Greeks] initially to have a cup of coffee, have a cup of coffee, and you see Brits, they'll come along, they won't go there... And that's what they are, you know... they alienate themselves, you know, which is... wrong."

He then interprets his decision not to seek health care in the UK as consistent with the need to integrate, to demonstrate his identity as an authentic and committed member of Cretan society. His illness experience had made him 'more integrated and more... yeah, more part of them, yeah. More part of the local society... yeah'.

In general the participants – none of whom considered themselves fluent in Greek – did not view their lack of command of Greek as problematic in navigating the health care system or as contributing negatively to their health care experience. Most commented how they managed using a mixture of Greek and English or emphasised that the doctors tended to speak English well. Indeed it is more likely that the fact that lack of language was not problematic bolstered their feelings of control and confidence in their own coping abilities but also reflected their trust in the health care system. For example, Margaret signed her surgical consent form (written in Greek) even though she could not

understand it.

The social psychological concept of 'ingroup-outgroup' categorisation is particularly relevant here (Social Identity Theory: Tajfel, 1982). This concept refers to the differences in behaviours and attitudes which are attributed to the preferred group (the ingroup) and the non-preferred or actively disliked (the outgroup). All participants in this study identified themselves with their local Cretan community. Some additionally also identified with a specific type of expatriate; this was one who wanted to integrate and was not just a 'Brit abroad' (cf. O'Reilly, 2000, for different motivations in UK lifestyle migrants to Southern Spain). Consequently for this latter group, their group norms reflected those of both ingroups - e.g., directness, care and a willingness to 'say what needs to be said' from the Cretan ingroup and a non-complaining, positive regard for their new way of life in Crete from the expat ingroup. The adoption of an outlook which closely conforms to the norms of a favoured group (or, in this study, favoured groups) has been argued to be one way of reducing stress (Kruglanski, 2004). It is also likely that dealing with the uncertainties and vagaries of a new healthcare system is made easier by a psychological process which has a net effect of reducing uncertainty and doubt.

Conclusion

This study has been the first to describe the psychological processes involved in older UK lifestyle migrants' successful adaptation to living with a long term health condition. Understandings from such research endeavours can be useful for healthcare practitioners working with lifestyle migrants or in medical tourism settings.

Acknowledgements

The authors wish to acknowledge the editorial assistance of Sarah Heard and the practical

contribution of Marta Surman, Mark Surman, Steve Woods and Anthony Yates to the completion of this research.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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Jane Simpson
Education Division of Health
Research Faculty of Health &
Medicine, Lancaster University,
Bailrigg, Lancaster, United Kingdom
j.simpson2@lancaster.ac.uk



Sofia Triliva
Department of Psychology, University
of Crete, Rethymno, Crete, Greece
triliva@uoc.gr



Carol Thomas
Centre for Disability Research (CeDR),
Centre for Gender and Women's
Studies, Health Research, Centre for
Ageing Research, International
Observatory on End of Life Care,
Lancaster University, Lancaster,
United Kingdom
cedr@lancaster.ac.uk



Gerasimos Chatzidamianos
Spectrum Centre, Lancaster
University, Lancaster, United
Kingdom
g.chatzidamianos@lancaster.ac.uk



Craig Murray
Department of Health Research,
Lancaster University, Lancaster,
United Kingdom
c.murray@lancaster.ac.uk