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ACCULTURATION STRESS, IDENTITY, AND SUICIDALITY: PSYCHIATRIC PERSPECTIVES ON MIGRATION AND BELONGING

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ABSTRACT. Migration significantly reshapes psychological identity, social belonging, and mental health trajectories. Acculturation stress, cultural bereavement, and identity disruption are widely discussed determinants of psychological distress among migrant populations and may contribute to increased vulnerability to suicidality. However, the relationships among these processes remain insufficiently synthesized despite the continuing growth of global migration. This structured narrative review examines peer-reviewed literature published between 2017 and 2025 to explore how acculturation stress and identity disruption interact across pre-migration, migration, and post-migration phases in shaping suicidality among migrant populations. A literature search was conducted in PubMed, PsycINFO, and Web of Science. Thirty-nine studies were thematically analyzed across theoretical frameworks, epidemiological patterns, vulnerable subgroups, clinical assessment approaches, and intervention strategies. Evidence suggests that acculturative stress represents an important psychosocial factor associated with suicidality among migrants, particularly when combined with identity disruption, discrimination, and social marginalization. High-risk subgroups include early-age migrants, refugee populations exposed to trauma, and migrant women facing culturally mediated social pressures. While culturally adapted psychotherapeutic approaches demonstrate promising outcomes for migrant mental health, suicide-specific prevention evidence remains limited. Effective suicide prevention in migrant populations likely requires culturally informed psychiatric assessment and multilevel interventions addressing both clinical and structural determinants of mental health.

Keywords: acculturation stress; identity disruption; migration; suicidality; cultural psychiatry; culturally adapted interventions.

INTRODUCTION

Problem Statement and Relevance

Migration represents one of the most profound social and psychological transformations individuals may experience. Beyond geographic relocation, migration frequently entails substantial changes in cultural environment, social roles, identity formation, and access to social support networks. In recent decades, global migration has increased dramatically, with more than 280 million international migrants worldwide and hundreds of millions more internal migrants [1]. These demographic shifts have intensified scholarly attention to the mental health consequences of migration and the psychosocial processes associated with cultural adaptation.

Mental health outcomes among migrant populations are heterogeneous and influenced by a wide range of structural, social, and individual factors. Migrants often encounter stressors related to language barriers, socioeconomic marginalization, discrimination, family separation, and uncertainty regarding legal status. These experiences can significantly affect psychological well-being and contribute to increased vulnerability to depression, anxiety disorders, and suicidal behavior [2,3].

The relationship between migration and suicidality is complex and has generated substantial debate in the epidemiological and psychiatric literature. Some studies report lower suicide rates

among certain first-generation migrant populations compared with host-country majority populations—a phenomenon often described as the *immigrant paradox* [4,5]. However, this pattern is not universal and varies considerably across migrant groups, host-country contexts, and migration categories. Longitudinal research suggests that suicide risk may change over time, particularly as migrants experience prolonged exposure to discrimination, socioeconomic disadvantage, and cultural dislocation.

To understand these mental health outcomes, researchers have developed several conceptual frameworks addressing the psychosocial processes associated with migration. Among the most widely studied constructs are acculturative stress, cultural bereavement, and identity disruption. Acculturative stress refers to the psychological strain experienced during adaptation to a new cultural environment, including challenges associated with language acquisition, social integration, and cultural value conflicts [12–14]. Cultural bereavement describes grief related to the loss of familiar cultural environments, traditions, social roles, and community structures following migration [6,7]. Identity disruption refers to difficulties maintaining a coherent sense of personal and cultural identity during cultural transition and adaptation [8,9].

Although these concepts are often studied independently, they frequently interact in complex ways. Cultural bereavement may intensify feelings of identity instability, while identity conflicts may exacerbate acculturative stress when migrants struggle to reconcile heritage cultural values with expectations in the host society. These interrelated psychosocial processes can influence emotional well-being and may contribute to increased vulnerability to suicidal ideation and behavior.

Migration-related mental health outcomes are also shaped by broader structural determinants. Experiences of discrimination, legal insecurity, and limited access to culturally appropriate mental health services may amplify psychological distress among migrant populations. Consequently, understanding suicidality among migrants requires an integrated perspective that considers both individual psychological processes and structural social determinants of health [26,27].

Given the increasing global relevance of migration and mental health, synthesizing existing evidence on the relationships between acculturation, identity processes, and suicidality is an important task for contemporary psychiatric research. A comprehensive understanding of these processes may support the development of culturally informed mental health assessments, preventive strategies, and clinical interventions tailored to the needs of diverse migrant populations.

Purpose of the Article

This review aims to synthesize contemporary research on the relationships between acculturation-related processes and suicidality among migrant populations. Specifically, the objectives of this study are:

1. To examine theoretical frameworks explaining acculturation, cultural bereavement, and identity disruption in migrant populations.
2. To analyze epidemiological evidence concerning suicidality among migrants and identify vulnerable subgroups.
3. To review culturally informed approaches to psychiatric assessment of suicide risk.
4. To evaluate evidence regarding culturally adapted therapeutic and preventive interventions addressing migrant mental health.

By integrating theoretical, epidemiological, and clinical perspectives, this review seeks to clarify the psychosocial mechanisms linking migration experiences to suicidality and to identify implications for culturally responsive psychiatric practice.

Methodological positioning

A structured literature search was conducted across PubMed, PsycINFO, and Web of Science for studies published between 2017 and 2025. The primary search combined terms related to acculturation (“acculturation stress,” “acculturative stress,” “acculturation”), suicidality

("suicide," "suicidal ideation," "suicide attempt," "self-harm," "self-injury"), and migration ("migrant," "immigrant," "refugee," "asylum seeker," "expatriate").

Supplementary targeted searches addressed key constructs including Berry's acculturation model, cultural bereavement, identity disruption, the DSM-5 Cultural Formulation Interview, and culturally adapted psychotherapeutic and family-based interventions.

The review focused primarily on peer-reviewed publications examining the relationships between migration-related psychosocial processes and mental health outcomes, particularly suicidality among migrant populations.

Earlier publications were included when considered conceptually seminal or necessary for defining core theoretical constructs in migration studies and cultural psychiatry [10,11].

Eligibility Criteria. Included studies were peer-reviewed empirical research, systematic reviews, meta-analyses, and clinical frameworks examining migrant or refugee populations and reporting outcomes related to suicidal ideation, suicide attempts, completed suicide, non-suicidal self-injury, or related mental health outcomes. Eligible exposures included acculturation stress, acculturation strategies, identity disruption, cultural bereavement, and migration-related stressors. Non-peer-reviewed articles, studies focused exclusively on non-migrant ethnic minorities, interventions not involving migrant populations, and non-English publications were excluded. Pre-2017 studies were included only if considered seminal.

Data Extraction and Quality Appraisal. Data extracted included study design, population characteristics, migration type, theoretical framework, assessment tools, outcomes, and key findings. Methodological quality was appraised using ROBIS for systematic reviews, study-design hierarchy for empirical research, and evidence-base relevance for clinical frameworks.

Synthesis. Studies were thematically synthesized across five domains: theoretical frameworks, epidemiological patterns, risk and protective factors, clinical assessment, and interventions. Findings were organized according to suicidality outcomes and migrant subgroups in order to identify common mechanisms linking migration-related psychosocial processes with mental health outcomes.

PRESENTATION OF THE MAIN RESEARCH MATERIAL

1. Understanding Acculturation and Its Psychological Impact

Defining Acculturation and Acculturative Stress

Acculturation encompasses the psychological and sociocultural changes individuals undergo when navigating between cultures, including shifts in values, behaviors, identity, social roles, and sense of belonging [12–14]. At the individual level, acculturation reflects both the degree to which migrants adopt host-country cultural practices and the extent to which they maintain engagement with their heritage culture. Contemporary scholarship increasingly conceptualizes acculturation as a bidimensional process, rather than a unidirectional transition toward assimilation [15–17].

Acculturative stress refers to the subjective psychological strain that may arise when individuals attempt to reconcile cultural differences between their heritage culture and the host society. This stress can emerge from multiple sources, including language barriers, perceived discrimination, social isolation, economic marginalization, and difficulties accessing culturally appropriate social support systems [12–14].

Empirical research demonstrates that acculturative stress may significantly influence mental health outcomes among migrant populations. For example, studies examining migrant youth and ethnoracially minoritized populations have identified associations between acculturative stress and increased risk of depressive symptoms, anxiety disorders, and suicidal ideation [12,13]. Similarly, research focusing on migrant worker populations highlights the cumulative psychological burden associated with precarious employment conditions, social marginalization, and limited access to mental health care [14].

These findings suggest that acculturative stress represents an important psychosocial mechanism linking migration-related experiences to mental health outcomes.

2. Berry's Acculturation Model: Theoretical Framework

Berry's acculturation model remains one of the most influential theoretical frameworks for understanding cultural adaptation among migrant populations [15]. The model conceptualizes acculturation as a dynamic process shaped by two fundamental dimensions: the degree to which individuals maintain their heritage cultural identity and the degree to which they engage with the host society.

Based on these two dimensions, Berry identified four primary acculturation strategies. These strategies of cultural adaptation are summarized in Table 1.

Table 1. Berry's Four Acculturation Strategies and Their Psychological Implications

Acculturation Strategy	Heritage Culture	Host Culture	Typical Outcomes
Integration	High	High	Bicultural identity and psychological adaptability
Assimilation	Low	High	Adoption of host culture with reduced heritage attachment
Separation	High	Low	Maintenance of heritage culture with limited host engagement
Marginalization	Low	Low	Disconnection from both cultural contexts

Source: *Adapted from Berry (2017) [15].*

The framework presented in Table 1 illustrates how different patterns of cultural orientation may shape migrants' psychological adaptation. Research suggests that integration is generally associated with more favorable mental health outcomes, whereas marginalization is frequently linked to higher levels of psychological distress and social isolation [16–18].

However, the psychological consequences of different acculturation strategies may also depend on contextual factors such as host-country integration policies, social acceptance of migrants, and access to culturally sensitive mental health services. In environments characterized by discrimination or structural exclusion, even individuals attempting cultural integration may experience elevated psychological distress.

Empirical Evidence Linking Acculturation and Suicidality

A 2023 scoping review examining acculturation and suicide-related risk among ethnoracially minoritized youth in the United States analyzed 27 empirical studies with diverse methodological designs. The review found that 19 studies reported a positive association between acculturation—particularly when operationalized as acculturative stress—and increased suicidal ideation or suicide attempts. Three studies reported negative associations, while five found no statistically significant relationship between acculturation and suicide-related outcomes [19].

Overall, the predominant pattern across the literature indicates that acculturative stress, rather than acculturation strategy alone, appears to be the more consistent predictor of suicidal ideation and attempts. These findings suggest that the psychological strain associated with cultural adaptation may constitute an important mechanism linking migration-related experiences with suicidality [19].

The bidimensional structure of acculturation strategies and their relationship to engagement with both heritage and host cultures is illustrated in Figure 1.

The model highlights that migrants' psychological adaptation is shaped by the interaction between two cultural orientations: engagement with the host society and retention of heritage cultural identity. Different combinations of these orientations produce distinct acculturation strategies, each associated with varying implications for psychological well-being and social integration.

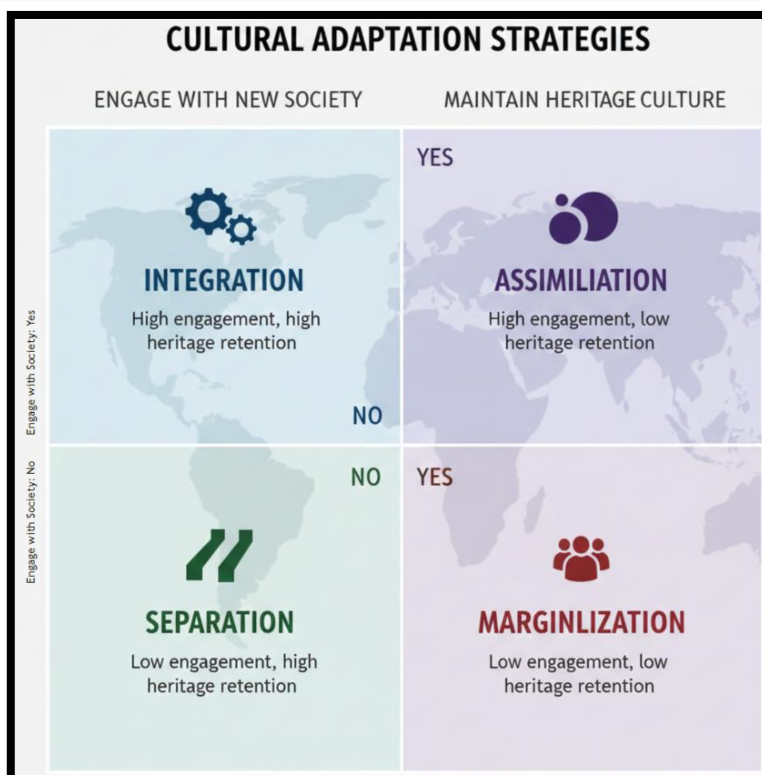

Figure 1. Berry's Four-Dimensional Acculturation Model

Source: *Adapted from Berry (2017) [15].*

Note: *The diagram illustrates the bidimensional structure of acculturation strategies based on the degree of engagement with host society and maintenance of heritage culture.*

3. Cultural Bereavement and Identity Disruption

Cultural Bereavement

Migration frequently entails the loss of familiar social environments, cultural practices, language contexts, and community networks. Bhugra and Becker introduced the concept of cultural bereavement to describe the grief associated with these losses [6].

Cultural bereavement differs from conventional grief in that the loss is often ambiguous and ongoing. Migrants may continue to maintain emotional connections to their cultural heritage while simultaneously confronting the challenges of adapting to a new sociocultural environment. This experience can manifest in feelings of nostalgia, social isolation, and identity uncertainty [6,7].

Studies examining refugee populations have demonstrated that cultural bereavement may contribute to psychological distress when individuals struggle to maintain meaningful cultural connections following displacement [7].

Identity Formation in Migration

Identity formation represents another central psychological process affected by migration. Identity is shaped through interactions between individuals and their social environments, and migration may disrupt previously stable identity structures [8,9].

Migrants frequently face the challenge of reconciling multiple cultural identities, particularly when heritage cultural values differ from those of the host society. This process may lead to identity negotiation, where individuals attempt to integrate elements of both cultural contexts into a coherent self-concept.

Research suggests that identity-related challenges may be particularly pronounced during adolescence and early adulthood, developmental periods during which identity formation is already a central psychological task [20–22].

4. Intergenerational Acculturation Gap and Family Dynamics

Migration may also influence family relationships through the emergence of intergenerational acculturation gaps. Children and adolescents often adapt more rapidly to host

cultures through school and peer interactions, while parents may maintain stronger connections to heritage cultural norms.

These differences in acculturation trajectories can produce family tensions related to values, expectations, and behavioral norms [18]. Studies examining migrant families have shown that such intergenerational conflicts may contribute to psychological distress among both parents and children [23,24].

In some contexts, these family dynamics may increase vulnerability to mental health problems, particularly when combined with external stressors such as discrimination or socioeconomic disadvantage.

5. Suicidality and Migration: Epidemiological Patterns

The relationship between migration and suicidality has been the subject of increasing attention in epidemiological and psychiatric research. Empirical findings suggest that suicide risk among migrant populations varies considerably depending on migration status, country of origin, host-country context, and duration of residence. These variations reflect the complex interaction between individual psychological factors and broader structural determinants of health.

One frequently discussed phenomenon in the literature is the "immigrant paradox," which refers to the observation that some first-generation migrant populations demonstrate lower suicide rates compared with native-born populations in host countries [4,23]. This pattern appears paradoxical given that migrants often experience significant socioeconomic adversity, discrimination, and psychosocial stressors following migration.

Several explanations have been proposed for this phenomenon. Early-stage migrants may benefit from protective cultural factors, including strong family cohesion, community support networks, and cultural norms discouraging suicidal behavior. Migration itself may also reflect a selection effect, whereby individuals who migrate are generally healthier or more resilient than those who remain in the country of origin [23].

However, longitudinal research indicates that the protective effect associated with the immigrant paradox may diminish over time. Studies examining refugee and migrant populations in European countries have shown that suicide risk may increase with prolonged residence in the host country, gradually approaching or sometimes exceeding rates observed among native-born populations [4,27].

This shift has been attributed to cumulative exposure to acculturative stress, discrimination, social marginalization, and economic disadvantage. Over time, migrants may experience erosion of the protective social and cultural structures that initially buffered psychological distress following migration.

Furthermore, suicide risk is not evenly distributed across migrant populations. Epidemiological evidence suggests that certain subgroups demonstrate heightened vulnerability to suicidality. These groups include refugees and asylum seekers exposed to pre-migration trauma, migrants experiencing prolonged legal uncertainty, and individuals facing persistent barriers to social integration [27,32].

Gender differences have also been observed in migrant suicidality patterns. While suicide completion rates remain higher among men globally, several studies report elevated suicide attempt rates among migrant women in specific cultural contexts. These patterns may reflect gender-specific stressors such as cultural role conflict, family expectations, and limited autonomy within certain sociocultural environments [32].

Taken together, the epidemiological evidence indicates that suicidality among migrant populations is shaped by a dynamic interaction between migration-related stressors, identity processes, and structural determinants of health. Understanding these patterns is essential for developing culturally informed suicide prevention strategies and improving mental health outcomes in increasingly diverse societies.

6. Suicide Outcomes by Migrant Category: Vulnerable Subpopulations

Suicide risk varies markedly across migrant subgroups and is shaped by developmental timing, gender, migration type, and legal context. Adolescent migrants, particularly those migrating

before the age of 12, demonstrate particularly high vulnerability. Longitudinal registry and cohort studies report a 5–8-fold increased suicide risk compared with adult migrants, which may reflect identity disruption during sensitive developmental periods and prolonged exposure to acculturative stress [4,26].

Non-European immigrant women—especially those of South Asian and Black African origin—have been shown to exhibit disproportionately elevated rates of suicide attempts. These patterns may reflect the intersection of gendered cultural expectations, family dynamics, and acculturation-related stressors experienced during migration and settlement [32].

Forced migrants and refugees also represent a particularly vulnerable group. Exposure to pre-migration trauma, post-migration stressors, and legal insecurity may contribute to elevated psychological distress and suicidality. In several studies, suicide attempts among refugee populations appear to occur more frequently than suicidal ideation, suggesting high-intent behavior among individuals facing severe psychosocial adversity [33].

Second-generation migrants may also demonstrate elevated suicide risk in certain contexts. As protective cultural structures associated with first-generation migration weaken, second-generation individuals may experience increased exposure to discrimination, identity conflict, and social marginalization. In some studies, suicide risk among second-generation migrants approaches or exceeds that observed among native-born populations [4,5,31].

Additionally, asylum seekers with unresolved legal status may experience particularly high levels of psychological distress. Prolonged uncertainty regarding legal status, restricted access to employment and services, and social isolation may contribute to increased suicidal ideation and suicide attempts within this group.

7. Gender-Specific and Longitudinal Patterns

Gender patterns in migrant suicidality diverge in important ways from global suicide trends. Although suicide completion rates remain higher among men worldwide, migrant women in certain cultural contexts demonstrate higher rates of suicide attempts, particularly among non-European migrant populations [32].

These patterns may reflect culturally mediated stressors such as honor-related conflict, coercive family expectations, gender-role pressures, and limited autonomy within some sociocultural environments.

Longitudinal evidence also indicates that the protective effect associated with the immigrant paradox may erode over time. Studies suggest that suicide risk may increase after 10–30 years of residence in the host country, as early protective factors—including social cohesion, identity clarity, and migration-related purpose—gradually weaken [4,5].

8. Migration-Phase Risk and Protective Factors

Suicide risk among migrant populations is shaped by interacting factors that operate across different phases of migration. Pre-migration factors such as exposure to trauma, adverse childhood experiences, and pre-existing mental health conditions can substantially elevate vulnerability to psychological distress and suicidality, particularly among forced migrants and refugee populations [32].

Peri-migration stressors, including family separation, prolonged uncertainty during migration processes, and exposure to violence or instability during transit, may further compound psychological vulnerability.

Post-migration risk factors frequently include discrimination, language barriers, occupational down-mobility, social isolation, intergenerational acculturation gaps, and immigration-related legal stress. These stressors can accumulate over time and contribute to increased psychological distress and suicide risk among migrants.

At the same time, several protective factors may mitigate these risks. Social integration, strong family cohesion, culturally congruent support systems, economic stability, positive cultural identity, and access to culturally adapted mental health care have all been associated with improved mental health outcomes among migrant populations.

Understanding how risk and protective factors operate across different migration phases is essential for developing effective suicide prevention strategies and culturally responsive mental health interventions.

9. Psychiatric Assessment and Risk Stratification

Building on the epidemiological patterns and subgroup vulnerabilities discussed above, accurate clinical assessment of suicide risk among migrant populations requires careful consideration of cultural, social, and migration-related factors.

Understanding epidemiological patterns of suicidality among migrant populations has important implications for clinical practice. Accurate assessment of suicide risk requires careful consideration of cultural, social, and migration-related factors that may shape the presentation of psychological distress.

Standard suicide risk assessment tools have largely been developed and validated within majority-culture populations. As a result, these instruments may not fully capture culturally specific expressions of distress or the psychosocial stressors experienced by migrants. Language barriers, differences in help-seeking behavior, stigma surrounding mental illness, and mistrust of institutions may further complicate clinical assessment and contribute to underrecognition of suicide risk in migrant populations [28,30].

One important framework designed to address cultural context in psychiatric evaluation is the DSM-5 Cultural Formulation Interview (CFI). The CFI provides a structured set of questions that help clinicians explore patients' cultural identity, explanatory models of illness, psychosocial stressors, and patterns of social support [29]. By incorporating cultural context into clinical assessment, the CFI supports a more nuanced understanding of how migration-related experiences influence mental health and suicide risk.

Studies examining the implementation of the Cultural Formulation Interview have demonstrated that it can improve communication between clinicians and patients from diverse cultural backgrounds and enhance the cultural sensitivity of psychiatric evaluation [29,31]. The structured format of the interview allows clinicians to explore how patients interpret their symptoms, how cultural beliefs influence coping strategies, and how social environments shape mental health outcomes.

In the context of migration, culturally informed assessment should also consider factors such as migration history, experiences of displacement or trauma, legal status, family separation, and social integration in the host country. These factors may significantly influence both the manifestation of psychological distress and the individual's willingness to seek help.

Integrating culturally sensitive assessment frameworks into suicide risk evaluation can therefore improve diagnostic accuracy and support the development of more effective and culturally appropriate mental health interventions for migrant populations.

10. Therapeutic and Preventive Interventions

Effective suicide prevention among migrant populations requires interventions that are sensitive to cultural context and migration-related stressors. Conventional mental health interventions may be less effective when cultural beliefs, migration experiences, and social determinants of health are not adequately considered in treatment design.

Research indicates that culturally adapted psychological interventions can significantly improve mental health outcomes among migrants and refugees. Cultural adaptation typically involves modifying therapeutic approaches to reflect patients' cultural values, language, explanatory models of illness, and social contexts. Such adaptations may include the integration of culturally relevant metaphors, involvement of family or community structures, and recognition of migration-related stressors in therapeutic dialogue [32].

One of the most widely studied approaches is culturally adapted cognitive behavioral therapy (CBT). Evidence from clinical trials and intervention studies suggests that culturally adapted CBT can reduce symptoms of depression, anxiety, and trauma-related distress among refugee and migrant populations [33,36]. These interventions often incorporate culturally

appropriate coping strategies and address migration-specific stressors such as identity conflict, social isolation, and discrimination.

Group-based interventions have also demonstrated potential benefits for migrant mental health. Group therapy formats may facilitate peer support, normalization of shared experiences, and the reconstruction of social networks that were disrupted during migration. Research on culturally informed group interventions indicates that such approaches can enhance psychological resilience and social integration among migrant populations [35].

In addition to psychotherapeutic interventions, community-based prevention strategies are increasingly recognized as important components of suicide prevention. Programs that involve community leaders, cultural mediators, and migrant organizations can improve mental health literacy, reduce stigma surrounding psychological distress, and encourage help-seeking behaviors among migrant communities [37].

Structural and policy-level interventions are also relevant. Addressing barriers to employment, improving access to education and health services, strengthening legal protections, and promoting social inclusion may indirectly reduce suicide risk by improving overall psychosocial well-being among migrants. Research on migration and development highlights the importance of intersectional approaches that recognize the interaction between social, cultural, and economic determinants of mental health [38].

Emerging digital mental health interventions may also offer new opportunities for reaching migrant populations who face barriers to traditional mental health services. Mobile applications, telepsychiatry platforms, and culturally adapted online mental health resources have demonstrated potential for expanding access to psychological support across diverse populations [39].

Taken together, these findings suggest that effective suicide prevention among migrant populations requires multilevel interventions that integrate culturally adapted clinical care, community-based support systems, and broader social policies addressing structural determinants of mental health.

Evidence Gaps and Policy Implications

Despite the growing body of research examining migration, acculturation, and mental health, several important gaps remain in the literature. One significant limitation concerns the scarcity of suicide-specific intervention studies targeting migrant populations. While numerous studies document elevated levels of psychological distress among migrants and refugees, relatively few interventions have been designed or evaluated specifically for suicide prevention in these groups.

Another limitation involves the lack of longitudinal research examining how suicide risk evolves across different stages of migration and settlement. Although existing studies suggest that suicide risk may change over time—particularly as the protective effects associated with the immigrant paradox diminish—more longitudinal evidence is needed to clarify the long-term trajectories of mental health outcomes among migrant populations.

Current research also demonstrates limited representation of certain vulnerable subgroups, including LGBTQIA+ migrants, undocumented migrants, and individuals experiencing compounded forms of social marginalization. Intersectional research approaches are therefore necessary to better understand how gender, ethnicity, legal status, and socioeconomic position interact to influence mental health and suicidality among migrants.

Another important research gap concerns the development of culturally sensitive assessment tools. Many widely used psychiatric screening instruments were developed within majority-culture contexts and may not fully capture culturally specific expressions of psychological distress among migrant populations. Expanding culturally adapted assessment frameworks remains an important priority for future research and clinical practice.

From a policy perspective, these findings highlight the need for multilevel strategies addressing both clinical and structural determinants of migrant mental health. Strengthening cultural competence training for mental health professionals, improving access to interpreter

services, and integrating culturally informed assessment tools into routine clinical practice may improve diagnostic accuracy and treatment outcomes.

Policy initiatives should also focus on addressing broader structural determinants of mental health among migrants. Enhancing access to education, employment opportunities, housing stability, and legal protections can reduce the psychosocial stressors associated with migration and social marginalization.

Finally, collaboration between health systems, community organizations, and migrant-led initiatives may play an important role in strengthening culturally responsive mental health support systems. Community-based approaches can improve mental health literacy, reduce stigma, and facilitate earlier access to care among migrant populations.

CONCLUSIONS

Migration profoundly reshapes psychological identity, cultural belonging, and mental health. Acculturation stress, cultural bereavement, and identity disruption constitute core mechanisms linking migration to suicidality. Although first-generation migrants often exhibit lower suicide rates than native-born populations (the "immigrant paradox"), longitudinal evidence indicates that this protective effect erodes with prolonged host-country residence, cumulative discrimination, and intergenerational conflict, with suicide risk converging toward or exceeding native-born levels within 15–30 years post-migration.

Across studies, acculturative stress emerges as the most consistent mediator of suicidal ideation and attempts, exceeding the predictive value of acculturation strategy or cultural identity alone. Suicide risk is unevenly distributed, with heightened vulnerability among early-age adolescent migrants, non-European immigrant women, forced migrants with pre-migration trauma, and second-generation migrants, underscoring the importance of developmental timing, gender, and migration context. Risk trajectories are non-linear, necessitating longitudinal and phase-specific frameworks rather than cross-sectional assessment. Standard suicide risk assessment tools frequently underestimate migrant risk. Integrating migration-specific inquiry and the DSM-5 Cultural Formulation Interview allows more accurate risk stratification and culturally responsive intervention planning. While culturally adapted CBT, family-based interventions, and group psychoeducation demonstrate meaningful symptom reduction, robust suicide-specific prevention evidence remains limited. Effective suicide prevention in migrant populations therefore requires a multilevel approach, combining culturally informed clinical care with health-system reform, community engagement, and immigration- and equity-focused policy interventions. Addressing migration-related identity disruption as a modifiable risk factor is essential for advancing equitable, evidence-based suicide prevention in increasingly diverse societies.

Clinical Implications for Practice:

Psychiatrists and mental health professionals should recognize migration-related identity disruption as a modifiable risk factor for suicidality. Effective clinical practice requires deliberate cultural humility and alliance-building, systematic integration of migration history and acculturation stressors into assessment, and routine use of the DSM-5 Cultural Formulation Interview to contextualize symptom presentation. Interventions should be culturally adapted and target migration-specific risk drivers, including acculturation stress, intergenerational family conflict, discrimination, social isolation, and trauma. Coordination with community organizations, faith-based groups, and immigration services is essential to reduce structural barriers and strengthen protective supports.

In an increasingly globalized context, cross-cultural psychiatry is a core clinical competency, not a subspecialty. Integrated psychiatric, psychological, social, and policy-informed approaches can transform acculturation from a source of distress and suicide risk into an opportunity for identity integration, resilience, and improved mental health outcomes among migrant populations.

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