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Mental disorders and emigration – a challenge of the 21th century

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ABSTRACT

The migration, the motivation of migration and it's duration will determine, directly, a significant stress on both, the individual and his family. Sometimes, this process is correlated with an increase in the prevalence of psychiatric disorders. Even if this process is carried out with the same intensity in all migration groups, there are some assumptions that consider the effect of migration on mental health. On the other hand, it should consider the impact that the migration of the population may have on health systems. For patients who have undergone a process of migration, assessment of symptoms should be done through the peculiarities of their ethnic and cultural issues, plus adaptability and attitude of the individual, both in relation to disease, but also with overall care. A whole series of other factors, such as the economic, educational, social ones and the age when migration was done, the modality of the migration, the self-esteem or feelings of inferiority are also important elements that can contribute either to trigger a mental disorder or at maintenance of symptoms. Thus, through this paper, we proposed an evaluation of the role of migration in the determinism of mental disorders and discuss some issues related to individual vulnerability especially that in the XXIst century, the migration is an important phenomenon of society.

KEYWORDS

emigration, mental disorders, vulnerability

People have migrated, since ancient times, from one place to another. In the XXth century, there were three major periods of emigration: during the First World War, during the Second World War and during the last decade of the century. Since 1975, studies show that the number of migrants has doubled and they live especially in Europe (56 million), but also in Asia (50 million) and North America (41 million) (1). In Romania, emigration has increased since 1990, with the establishment of a democratic regime. Between 1990 and 1996, preferred countries for migration were Israel, Turkey, Hungary and Germany, to which were added, since 1996, countries, such as Canada, Spain and the United States. Since 2002, due to their proximity to the European Union, Romanian immigrants were mostly channelled to countries such as Italy and Spain and, more recently, Great Britain, Ireland and the Nordic countries (2).

Migration and its motivation, where it was not final, will directly determine a particular stress on both, the subject and the family. This stress may or may not be correlated with an increase in the prevalence of psychiatric disorders, in their totality, however not with the same intensity in all migration groups. Nevertheless, we will try to present some assumptions regarding the effect of migration on mental health, to understand why some individuals or population groups are more vulnerable to psychiatric disorder and, at the same time, to consider the impact that population migration can have on health systems.

According to the *Explanatory Dictionary of the Romanian Language,* migration can be defined as a process of social exchange, in which an individual moves from one cultural space to another, permanently or temporarily. (3) Regarding the causes of emigration, it highlights certain patterns like living standards, geographic proximity, social and cultural networks, as well as historical factors. However, since the economic factor plays the most important role, it can be observed, in the field of labour migration, a trend to choose destinations of predecessors, which are Italy and Spain for Romanian people, as they facilitate the integration of newcomers, constituting a bridge between representatives of the two cultures. (1)

The process of emigration itself is inevitably stressful and stress can cause some psychiatric disorders. A wide range of pathologies could be explained by the diathesis-stress model, reformatted by Zubin and Spring in 1977 and more recently brought attention. (4, 5) The term “diathesis” comes from Greek and is synonymous with “vulnerability” and the term “stress” can be defined as any event or factor in a person's life that it is interpreted as very difficult or undesirable.

The preparing of emigration, the acceptance of the migrant by the host community and the migration process itself are some of the general factors that must be considered regarding the determination of the psychiatric condition. Individual factors are represented by personality traits, psychological resilience and adaptability, preserving

or not the cultural identity, social support and integration into their own ethnic group.

There are several possible classifications of migrants, after various criteria. One of these classifications divided the migrants into two distinct categories: the colonists (settlers) and the migrant workers. Reasons for leaving, as defined by Rack (1982), include both reasons that push you to go and reasons that attract you to the place of emigration ("push and pull factors"). The settlers, as political or war refugees, will bear very strict legal procedures that will test their psychological strength. If the migrant is in a war situation, one has to deal with more difficult situations. (6) Factors such as the difficulties of language and communication, social support will play an important role in adapting to initial adversity and later being assimilated into the local culture and society.

The diathesis – stress model argues that genetic inheritance influences the way of responding to environmental factors, so individuals with low risk will not express disease, unless they are exposed to high levels of stress, while subjects with high risk of disease will experience it after the action of relatively common stressors.

The migration process can be broken down into three stages. First, pre-migration phase lies in the person's decision to emigrate and establish a plan to achieve this goal. The second involves the migration process itself and the physical move from one place to another, with the involvement of all social and psychological resources. The third stage, post-migration phase, is characterized by the interrelationship between the individual and the new society, learning new social roles and cultural interest in transforming the ethnic group. The first emigrants are generally followed by others. Once settled in one place and once they have given birth to children, the second generation is one of immigrants, but will have some of the experiences of the parents, in terms of finding cultural identity and adaptive stress. We should still make some clarifications on this point. Even if we use the generic absolute terms "immigrant", in relation to mental disorder, this cannot explain the inherent heterogeneity that exists in each area of migration. Not all migrants will have the same experiences or the same reasons for emigrating and, certainly, the answer of the new society will not be the same for everyone.

There are some factors that are very important in the development process of mental disorders like the degree of vulnerability, the stressful life events that trigger or update the vulnerability and moderating variables such as social network, premorbid personality, coping skills, physical, social and cultural factors. As mentioned above, the onset of mental disorders in the context of emigration can be determined by vulnerability (genetic, biological and neuroendocrine ones), which is exacerbated by stress factors (psychosocial, chronobiology, economic and family factors). The genetic transmission for mental disorders is not a Mendelian one because it doesn´t concern the transmission of a specific mental disorder, but the predisposition to have some personality traits from the spectrum in question. Therefore, we can say that genetic vulnerability plays a role in the development of any psychiatric pathologies, reinforced by numerous studies.

The literature states that schizophrenia has a significant genetic component. Studying

the human genome, several genes, that increase the risk of this disorder, even with 30 percent, were revealed. (7) This theory is supported by studies done on twins, showing that the likelihood of both monozygotic develop schizophrenia is between 30 and 50 %, while the probability that both dizygotic twins (fraternal) and non-twin brothers (of different ages) is about 15 %. In the general population, the likelihood of developing schizophrenia is 1 %. (8)

For a considerable amount of time, it was believed that the countries from which migrants came have a higher rate of prevalence and incidence of schizophrenia, thus suggesting that there is a level of biological vulnerability correlated with the disorder. Studies have shown that one cannot make such a statement and that there is higher prevalence rates of schizophrenia in their home countries. (9, 10, 11, 12) All this suggests that it is less likely a biological cause, even if biological vulnerability, caused by exposure to environmental factors cannot be completely excluded. There are no studies to indicate that biological factors such as abnormal development of neuropsychiatric complications of pregnancy or labour and genetic vulnerability would be different in certain ethnic groups.

The so-called process of "selective migration" was considered to be a possible hypothesis for a plausible higher rate of incidence of schizophrenia in the population migrating through that, and would feature greater instability and inner tension. This assumption could not be validated for several reasons. First, higher prevalence of schizophrenia was found more in the second generation of immigrants. (13) Secondly, the physical demands inherently involved in the migration process, but also the difficult procedures involving both the implementation of official acts and relationship with the institutions of the host state represent such stressful tasks that a patient with a mental disorder, the more a patient with schizophrenia could not carry them out. And thirdly, if such the case, the illness rate should be raised in all groups migration, which obviously is not the case.

An important issue is to identify if the migration itself acts as a stressor and can cause increased rates of schizophrenia or stressors come later, after the onset of this disorder. Rates of schizophrenia increased 10 or 12 years after migration, so the migration process appears to be less involved in developing of this disorder. Additionally, there is a strong link between the occurrences of any psychiatric disorder rate among all migrant groups. Constant stress and difficulties of life in societies, where racism is present at individual and institutional levels, can be a persistent stressful. In turn, all of these factors will interact with others such the lack of employment or adequate housing (13). When referring to mental disorders, in general, PTSD (posttraumatic stress disorder) will, obviously, have a higher prevalence on refugees. (14) In light of the situation that led to forced migration, refugees should receive special attention on mental health in order to identify the appearance of symptoms of PTSD and differentiated approach, depending on the specific experiences of culture, ethnicity and the situation that led to emigration. Migration phases, confounding significant events in one's personal life and difficulties, as well as on personality factors (self-esteem, adaptability) and relational factors (social support, cultural

identity) should be considered separately and continuously.

Numerous studies support that there is a correlation between biorhythm disturbances and the occurrence of mental disorders. The immigrants, who move to countries with big lag, have common difficulties of adaptability caused by a temporary asynchrony. Several studies on emigrants have highlighted changes on electroencephalographic routes, sleep disorders and other biochemical parameters underlining the impaired circadian rhythm. (15)

Regarding the use of psychoactive substances, some studies have shown that the rate of addiction among those immigrants is significantly increased compared to those of the country of origin. Some researchers have suggested that emigrants must adapt to a new culture, but also they manifest feelings of guilt and disloyalty to the family he left it. (16) Another theory, the theory of confidence, supports the emergence of consumption of these substances by people who consider themselves inferior, weak, inadequate. Thus, in the context of emigration, these feelings are common, because most of them had none resources, none knowledge of adoptive country language or no professional recognition, which meet the challenges of the new company. (16) All this theory considers that without achieving proposed objectives, feelings of inferiority may arise or be exacerbated, causing anxiety or depression and the advantage of this drug is that it offers people "a little break" from fear of failure. For an immigrant, the major objective is the economic stability and a "better life" for him and his family. (16) Sometimes, all this can be added to the availability of drugs, especially neo-liberal countries, offering consumers the freedom to access any kind of drug. These countries believe that such consumer will weigh options and take an informed decision. (17)

Socio-economic studies show that individuals who belong to poor socioeconomic classes are prone to develop an addiction. For example, the persons who work in areas where the use of physical labour are prone to pathological alcohol consumption compared to the ones working in an intellectual environment. This can be explained by the fact that, due to a low level of education, they do not know the risks and long-term effects of alcohol consumption. (18) Another stressor could be represented by the lack of social stability. There are numerous stairs of social stability. The simplest is developed by Straus and Bacon (1951), which argues that the existence of two of the four social factors predicts the occurrence of alcohol consumption in a person. The four factors are: marital status, not staying single, stable employment for at least three years and a permanent home for at least two years. Thus, in the case of migrants who are just getting started in a new country, dependable two of the four factors are encountered, thus highlighting the increased risk of alcohol consumption. (19) Furthermore, stress, like that of moving into a new society can produce an increase in cortisol levels. On the short term, it enables the body to accommodate to the new situation, but in long term, it can cause negative effects and some studies claim that the emergence of dementia would be one of them. Thus, it is considered that it would play a role in the emergence of the degenerative process in the brain and that it would cause neuroendocrine and immune dysfunctions. (20)

CONCLUSION

Assessing symptoms, adaptability, both individual attitudes about the disease, but also in healthcare through the ethno-cultural peculiarities, should be considered in patients who have undergone a migration process. Economic, educational, social, personal expectations of the patient, linguistic fluency, integration or, on the contrary, social isolation, unemployment, lack of social support should be considered both, punctual and dynamic. As age, gender, age at which migration was realized, how migration was done, alone or in groups, preservation or cultural identity, self-esteem or feelings of inferiority are also important factors that may contribute either to the outbreak of disease or even maintenance of symptoms. Social support and social network are important in understanding the role of culture and the impact that migration has on the phenomenon of social structures. As a result of the increased ethnic density, social support may become more common to everyone and can be an advantage for certain societies, but can also have a negative impact on others, especially if there is an underlying cultural conflict. Therefore, the clinician will need to assess any social support of each individual, but also, the social and cultural type where they come from.

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