Case Report

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FACTORS THAT INFLUENCE MENTAL HEALTH IN MIGRANTS: A CASE REPORT

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SUMMARY

This case report deals with a 30-year-old Brazilian woman who became anxious and depressed after her migration to Italy and two years of living there. At psychiatric assessment, she presented with mood deflection, difficulties in sleeping, sadness, anxiety and many somatic symptoms that began after her arrival in Italy and progressively worsened, eventually requiring psychiatric intervention.Today an increased number of mental disorders and somatisation symptoms tend to be observed among migrants, which are often related to stressful pre-migratory life events and Post-Migration Living Difficulties (PMLD). Management of these kinds of patients should be part of a program for Transcultural Psychiatry that integrates both medical treatment (pharmacological and non-pharmacological) and addresses cultural differences to improve individual conditions of the patients.

Introduction

Over the last 30 years, the spread in world globalization has greatly increased the migration phenomenon. As the number of migrants – forced or voluntary – increases, there is a growing need to understand how negative events in the country of origin influence those residing abroad [1] and their Post-Migration Living Difficulties (PMLD) [2].

The process of migration has been broadly described as occurring in three stages [3]. The first one is pre-migration, involving the decision and preparation to move. The second stage, migration, is the physical relocation of individuals from their original country to another. The third stage, post-migration, is defined as the "absorption of the immigrant within the social and cultural framework of the new society" [3]. Migrants meet many difficulties during the moving and the integration process and sometimes their conditions can lead susceptible subjects to mental disorders. The initial stage has a lower risk of illness compared to the latter stages [4].Each phase is involves different circumstances that impact risk of illness: pre-migration factors (e.g. personality structure, forced migration), migration factors (e.g. cultural bereavement), post-migration factors (e.g. culture shock, discrepancy between expectations and achievement, integration in the new country) [5].

All of these circumstances can be considered risk factors for mental disturbances in migrants.

We report the case of a Brazilian woman with several risk factors who experienced mood deflection after migration.

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Case report

F.O. is a 30-year-old woman born in Brazil. She spent her unhappy childhood in a convent, where her mother left her at the age of 6, and where she remained until marriage at age 20. She had a child at 23, but 4 years later her husband left her for a younger woman, so they divorced. The unexpected betrayal and the worsening of the economic situation triggered the intention of leaving Brazil; so she came to Italy with her son. In Italy, she worked as caregiver for an old woman, but her job was very stressful for her because she couldn't speak Italian very well and also because of difficulties in taking care of her child; she then began to complain of insomnia and fatigue.

In the same period, F.O. met an Italian man and after few months, in August 2011, they married. She left her work and they went to live in the husband's house, together with his relatives. According to the patient, the mother-in-law and the sister-in-law have never accepted her and they neither considered her feelings and needs, nor included her in any decision. Then she started believing that they were ashamed of her; this made her feel unhappy and marginalized. She would spend all day at home and with no social interactions. Based on this situation, one year later, she and her husband decided to go live in another house. Despite the removal from the stressful situation, her conditions didn't improve because, according to her, her husband wasn't demonstrating his love for her. Their house was isolated and this made her feel alone because she still had no social relationships; she also felt sadness and guilt towards her son because she was not very present and didn't feel she was taking care of him enough. It was then that she decided to consult a psychiatrist and came to our outpatient clinic.

At her psychiatric evaluation, she appeared sad, didn't speak much and had a very low tone of voice with reduced gestures. She reported generalized tremors, difficult in sleeping with vivid nightmares and her thoughts were focused on her condition of sadness. She explained that her symptoms began several months after she had arrived in Italy when she started complaining about anxiety. Living with her husband's relatives worsened her somatic condition and she began suffering form chest pains, persistent headaches and insomnia; even after removal from the stressful living situation, she still presented anhedonia, daily crying, feelings of loneliness, and weight loss. She felt alone and unwelcome by people and, despite her expectations, she thought that her life in Italy was less happy than in Brazil.

We prescribed a daily pharmacotherapy of Paroxetine 20mg and Clonazepam 2mg to control her anxiety and the depression. She also started weekly psychotherapy sessions to overcome her difficulties in the integration process and to face all the changes in her life.

At the beginning it was difficult for her talking about her feelings and she required several sessions before showing improvement. After two months of both pharmacological and psychological treatments, as well as her husband's involvement in the therapy, she began to feel better.

Today her somatic symptoms have reduced. She has also gained weight and can sleep almost 7 hours per night. Her mood has also improved, so she is able to better care for her son. She also found a part time job as waitress in a restaurant near her house and created some social relationships.

Discussion

Mental health care is one of the most frequently reported health needs of migrants in EU countries. Previous research has showed that somatisations are quite frequent among immigrants treated in primary care, with prevalence rates ranging between 25.6% and 35.2% [6].

In many cases, these patients report symptoms such as indistinct pain, fatigue, dizziness and gastrointestinal disturbances: all of these might be reframed as somatisations, defined as "a tendency to experience and express somatic distress and symptoms unaccounted for by pathological findings … that become manifest in response to psychosocial stress brought about by life events that are personally stressful to the individual" [2]. Most patients describe their distress as sadness, anxiety, nervousness, anger and fear. They particularly ascribe their somatic symptoms (such as headaches) and their general medical problems to "stress" [7]. In our case, F.O. showed symptoms of somatisation (tremors, chest pains, persistent head-

aches), as well as anxiety and sadness.Psychosocial stressors can possibly explain the increased tendency of immigrants to somatise and their heightened vulnerability to mental illness when they suffered pre-migratory traumatic experiences [8], such as economical, social or political situations [9]; stressful life events and post-migration living difficulties (PMLD)[2] such as loss of roles and identification, lack of support within the home community, a poor social network, discrimination, difficulties with language, cultural shock and poor socio-economic conditions in the host country [9]. According to our patient, she was abandoned by her mother, had a hard childhood in the convent and was also abandoned by her first husband; she also had several post-migration difficulties due to living with her husband's family and social isolation.

Previous studies have shown a close interplay between pre-migratory traumas, PMLD and psychopathological symptoms underlining those traumatic experiences as key factors in immigrants' psychopathology [2]. Even in cases of non-forced migration, PMLD might be a significant source of distress, because the experience of migration is often a traumatic event related to poor adjustment in the hosting country [2].

Voluntary immigrants have chosen to undertake the migration journey in the hope that they will be able to improve their circumstances and futures. For them, migration is an opportunity that is worth the stress and sacrifices endured [7], but when they realize that improvements haven't been made, it's possible they become depressed. In the case we analyzed, the patient had mood deflection after voluntary migration because of the disappointment of unmet expectations and a change for the worse in her life due to the difficulties of living in a foreign country.

Conclusion

Migrants represent a social group with a high-risk of developing mental distress. It would be appropriate, for the care of these patients, to consider all the factors (cultural and social) that led to the onset of their disorder. Considering this, management of migrant patients must be part of a program of Transcultural Psychiatry that deals with the comparative study of treatment and illness procedures in different cultures. It is essential that pharmacological therapy is accompanied with psychotherapy: in this case, it meant coming into contact with people whose frames of reference were different in some ways from our own.

Psychological models based on western societies cannot be transferred without examination and adaptation, and since a therapist is unlikely to have a through understanding of all cultures, one risks falling back on stereotypes that can distort perception of the individual patient. Therefore, in most cases, it can be useful to support the therapist with an interpreter, who plays a major role in clarifying cultural differences and communicating specific questions: a resource that should be made use of in the form of a brief exchange after every session [10].

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