Original Article

Psychopathology in a Migrant Population Visiting a Psychiatric Outpatient Clinic in Punjab, India

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Abstract

Background: Migration is a risk factor for psychosis in international migrants. **Objectives:** We compared the psychiatric morbidity in first and second generation interstate migrants in India. **Methods:** Psychiatric morbidity was assessed in 18–64-year-old first and second generation migrants of both the gender using Mini International Neuropsychiatry Interview. Total 70 subjects were included in the study. Males and females of both the generation compared. **Results:** Mood disorders are found to be most common disorder in second generation migrants. Where females of second generation migrants have a major depressive episode with melancholic features, as compared to males who have manic episode significantly higher in second generation migrants. **Conclusion:** Migration is a risk factor for mood disorders especially in second generation migrants. As adversity of migration, discrimination, and acculturation faced from birth and early life leads to higher rates of psychiatry morbidity in second generation migrants.

Key Words: *Generation, migration, mood disorders*

Introduction

It is estimated that 1% of the population has been displaced either from their home town or their home country.[1] In early 1970s, ushering in green revolution created an unprecedented demand for labor in agriculture; leading to an influx of labor migrants from rural Punjab, India. The new job opportunities, better daily wages, education, personal development attracted migrants to Punjab.[2] The industrialization and liberalization further contributed to immigration in Punjab.

Migrant population have shown over time that they have more frequency of mental disorder than their similar counterparts in their native land, supporting the risk of increased psychiatric morbidity associated with migration. Among Mexican immigrants in the United States, 33.8% had some form of lifetime psychiatric disorder, whereas the prevalence rate among Mexicans in Mexico was 24.7%.[3] Italians in Paris had more depressive episodes (17.6% vs. 13.6%) and dysthymia (7.1% vs. 4%) in their lifetime than the population in their country of origin.[4] The estimated rate of minor psychiatric disorders among Japanese-Brazilians in Japan was 17.8% and 3.2% among Japanese-Brazilians in Brazil.[5]

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Among the mental disorder, schizophrenia and other psychotic disorders are found to be more prevalent. It was first evidenced by a study on black migrants, in 1960.[6,7] However, apart from psychosis, other psychiatric disorders are also found to be prevalent. As in a study on adult Kashmiri migrants in Jammu, psychiatric morbidity was found to be more in migrant population than in controls. The most prevalent disorders were found to be posttraumatic stress disorder, depression, and other mental health problems.[8]

As compared to the west, migrants in Punjab face less communication problems and have better social support. The exposure to stress and illness are different in Punjab than in developed nations. The present study has been planned to assess the psychopathology in the first and second generation migrants in Punjab.

Methodology

Prior permission of Institutional Research Committee was taken to start the study in December 2010. The current study was conducted on adult migrants reporting to Psychiatry Department, Dayanand Medical College and Hospital, Ludhiana, Punjab. Migrants, both male and female, of the age group of 18–64 years, were included in the study. They were divided into two groups according

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to the generation. First generation was the migrants who were born out of Punjab but migrated to Punjab and second generation was those who were born in Punjab but their parents belong to migrant category.

Total 70 subjects were recruited, 38 from first generation and 32 from the second generation who were in the age group of 18–64 years and were able to give consent for the study. They were assessed using Mini International Neuropsychiatry Interview (MINI). The results were compared using Z-test and Chi-square test. $P < 0.05$ was taken as significant.

Results

Maximum number of subjects in both the groups was of the age group of 26–35 years. Gender wise distribution of migrants in first generation group shows that both males and females were equal in number that is, 50% each whereas the second generation group comprise of 78.13% males and 21.88% females, and the result was statistically significant at $P = 0.011$.

Maximum number of migrants in the current study was followers of Hindu religion followed by Muslim and Sikh. In first generation, 92.11% subjects were Hindu by religion whereas in the second generation 96.88% were followers of Hindu religion. Majority of subjects in both the groups were married, 84.21% in the first generation and 68.75% in the second generation.

When both males and females of all the age groups were assessed using MINI, the results showed that mood disorders were significantly more common in second generation migrants. About 12.50% migrants of the second generation had a major depressive episode (MDE) with melancholic features compared to 0% in first generation migrants ($P = 0.044$). Along with depressive episode, the manic episode is also significantly higher in second generation migrants (40.63%) as compared to first generation migrants (18.42%) with $P = 0.048$ as in Table 1.

The males of the second generation presented with the manic episode (40%) were significantly higher in number than of first generation males (10.53%) with $P = 0.045$ as in Table 2.

When females of first generation were compared with females of second generation, it was seen that MDE with melancholic features was present significantly more frequent in second generation (28.57%) than in first generation (0%) with $P = 0.040$ as in Table 3.

Table 1: MINI - distribution of all the subjects

MINI - modules	First generation *n* (%)	Second generation *n* (%)	*P*
MDE	8 (21.05)	6 (18.75)	0.688
MDE with melancholic features	0 (0.00)	4 (12.50)	0.044
Dysthymia	1 (2.63)	0 (0.00)	0.179
Suicidality risk-low	2 (5.26)	1 (3.13)	0.375
Suicidality risk-medium	3 (7.89)	2 (6.25)	0.611
Manic episode	7 (18.42)	13 (40.63)	0.048
Hypomanic episode	1 (2.63)	0 (0.00)	0.179
Panic disorder	1 (2.63)	0 (0.00)	0.179
Obsessive-compulsive disorder	5 (13.16)	2 (6.25)	0.172
Alcohol dependence	6 (15.79)	2 (6.25)	0.132
Substance-dependence	5 (13.16)	3 (9.38)	0.330
Psychotic disorders	4 (10.53)	6 (18.75)	0.168
Mood disorder with psychotic features	10 (26.32)	5 (15.63)	0.151
Generalized anxiety disorder	4 (10.53)	3 (9.38)	0.931

MINI: Mini International Neuropsychiatry Interview, MDE: Major Depressive Episode

Table 2: Distribution of male subjects according to MINI

MINI - modules	MINI codes	First generation *n* (%)	Second generation *n* (%)	*P*
MDE	A-1	2 (10.53)	4 (16.00)	0.317
MDE with melancholic features	A-2	0 (0.00)	2 (8.00)	0.131
Suicidality risk-low	C-L	1 (5.26)	1 (4.00)	0.188
Suicidality risk-medium	C-M	1 (5.26)	1 (4.00)	0.188
Manic episode	D-1	2 (10.53)	10 (40.00)	0.045
Obsessive-compulsive disorder	H	4 (21.05)	2 (8.00)	0.132
Alcohol dependence	J-1	4 (21.05)	2 (8.00)	0.132
Substance-dependence	K-1	5 (26.32)	3 (12.00)	0.135
Psychotic disorders	L-1	2 (10.53)	5 (20.00)	0.194
Mood disorder with psychotic features	L-2	2 (10.53)	5 (20.00)	0.194
Generalized anxiety disorder	O	4 (21.05)	2 (8.00)	0.132

MINI: Mini International Neuropsychiatry Interview, MDE: Major Depressive Episode

Discussion

The study was conducted over a period of 18 months with the aim of looking into psychopathology in first and second generation migrants. The study included a total of 70 migrant population visiting Psychiatry Department (migrants constitute 22.70% of the outpatient population in our hospital). Population was of age between 18 and 64 years.

The study showed psychopathology in second generation significantly higher than in first generation in the form of mood disorders. Migration is an important risk factor for schizophrenia.[1] Along with that, history of migration is also an independent risk factor for depression.[9] The common source of stress on the members of ethnic minority associated with migration and sociocultural adjustment are important determinants of increased incidence of mania.[10] It was observed that ethnic minority groups were at increased risk for psychotic illnesses, and it was seen that African-Caribbeans and Black Africans were at high risk for mania too.[11] As migrants become

Table 3: Distribution of female subjects according to MINI

MINI		First generation *n* (%)	Second generation *n* (%)	*P*
A-1	MDE	6 (31.58)	2 (28.57)	1.100
A-2	Mde with melancholic features	0 (0.00)	2 (28.57)	0.040
B	Dysthymia	1 (5.26)	0 (0.00)	0.266
C-L	Suicidality risk-low	1 (5.26)	0 (0.00)	0.266
C-M	Suicidality risk-medium	3 (15.79)	1 (14.29)	0.933
C-H	Suicidality risk-high	2 (10.53)	0 (0.00)	0.185
D-1	Manic episode	4 (21.05)	1 (14.29)	0.423
D-2	Hypomanic episode	1 (5.26)	0 (0.00)	0.266
E	Panic disorder	2 (10.53)	0 (0.00)	0.185
H	Obsessive-compulsive disorder	2 (10.53)	0 (0.00)	0.185
L-1	Psychotic disorders	4 (21.05)	1 (14.29)	0.423
L-2	Mood disorder with psychotic features	6 (31.58)	2 (28.57)	1.100
O	Generalized anxiety disorder	3 (15.79)	1 (14.29)	0.098

MINI: Mini International Neuropsychiatry Interview, MDE: Major Depressive Episode

acculturated to the foreign land they are at high risk for mental disorders.[12] Similarly having more cultural barriers and a higher level of identification with one's native land cultural values make themselves more vulnerable to depression.[13] Explaining the high incidence of mood disorders in migrants, increasing generational status was strongly associated with risk for mental disorder that is, second generation migrants have higher rates of morbidity as compared to first generation and further third generation have still higher rates than second generation.[7]

When the results were compared to see the variation according to the gender, it was seen that MDE with melancholic features was found to be significantly high in second generation women. The increased prevalence of depression in second generation women is because of the deprivation of their culture and social support by being born and brought up in a foreign culture.[14]

Male population of the current study showed manic episode significantly higher in the second generation as compared to first generation as migration is also found to be a risk factor for psychosis and mood disorders.[10,15] Negative consequences of migration on the mental health of migrants are also seen in Dutch population in the form of mood disorder and nonaffective psychosis.[16] A study was conducted on interstate migration in Jammu and Kashmir in India which showed that psychopathology was significantly high in migrants than in controls especially major depressive disorder, posttraumatic stress disorder, and generalized anxiety disorder.[8]

The migrants and the native people of Punjab are exposed to high level of competition for work and food making the vulnerable for mental illnesses. The racial, caste, color discrimination has led various medical professionals to over-diagnose schizophrenia than mood disorders.[17] The increased risk of mood disorders than psychotic disorders can be due to the difference in reason to migrate and to share almost similar culture and the environment in interstate migration. Though all efforts were made to make the study scientific and accurate, there are some limitations of the study: (i) Small sample size, (ii) study was confined to people visiting a psychiatric outpatient clinic in Punjab, and (iii) no comparison was made with nonimmigrant (local) psychiatric outpatients during the study period. We believe, however, that these limitations do not invalidate the major findings of our study.

Conclusion

It is concluded from the above findings that migrations whether international or national (as in the current study) is an important risk factor for various psychiatric disorders. It forms the important etiology of mood, psychotic, and substance use disorders in migrants. Both sexes and both the generations are at risk. Home away from home, lack of social support even discrimination could also contribute to the psychopathology in national migration. However, further extensive work is required in the field of interstate migration to establish the theoretical and clinical relationship between internal migration and psychiatric morbidity.

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Conflicts of interest

There are no conflicts of interest.

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