PSYCHIATRIC PROBLEMS OF AFGHAN REFUGEES IN DELHI: A STUDY ON 152 OUTPATIENTS

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SUMMARY

A brief review of literature on psychiatric morbidity associated with migration is presented, with particular emphasis on the problems of political refugees. Initial experiences with 152 Afghan nationals attending the psychiatric outpatient department of a general hospital in Delhi during a period of 18 months are described supported by retrospective data from the records. Problems encountered in adequate assessment and management of these patients are highlighted. Need for prospective and longitudinal research on this group of patients is pointed out.

Effect of severe environmental stress on the mental health of the population exposed is an important area of research in psychiatry. Involuntary international migration of large populations because of unstable or hostile conditions in the parent country is one such example of severe stress. This phenomenon has been aptly called 'uprooting'. Uprooting refers to the separation of the individual from the affective, social, ethnic, ideological and other attachments that constitute his milieu. Forced migration may ultimately have negative as well as positive effects on the individual and the society, depending on various factors. However, the immediate effects of such migration on the mental health of individuals are predominantly negative.

As no recent review is available on this topic in the Indian psychiatric literature, a brief review is being attempted in the following section.

REVIEW OF LITERATURE

As early as 1921, Krepehin used the word 'uprooting' and described its effects on adults as well as children and adolescents. Odegard (1932) studied mental hospital admission rates for Norwegian-born population of Minnesota and found it to be considerably higher than American-born population. Malzberg (1936) investigated mental illness in migrant Negroes of New-York state and found it higher than native population. However, these studies have been criticized for their methodology as well as for the conclusions drawn.

More recently a large amount of data has been collected on the various types of human migratory behaviour and their consequences on various psychological, psychiatric and social parameters. A few standard sourcebooks of collected works have also appeared (Murphy, 1955; Kantor, 1963; Zwingmann and Pfister-Ammende, 1973), which give original data as well as explanatory theories in this complex area of research. Concepts like 'culture shock' and 'social disintegration' have been examined in their relevance to migration (Parker, et al., 1969; Kojak, 1974).

Psychiatric problems of political refugees have also been studied by a number of workers. Pfister-Ammende (1973a) presented findings based on her extensive work on refugees. This included 700 case histories of refugees suffer-
ring from mental disturbance, socio-Psychological observations on about 2000 refugees from the Soviet Union and study of 300 ‘normal’ refugees. The author describes the process of flight and the phases of reactions in the refugees camps consisting of aggressive and apathetic behaviour. The psychopathology of uprootal as well as its determinant factors are discussed in detail. In another article Pister-Aummende (1973b) describes the mental health priorities and needs of refugee population. Apart from treatment and rehabilitation of mentally ill, desirability of collaboration of mental health specialists with the administrative set-up is emphasised. Krupinski, et al., (1973) reported results of their investigations on psychiatric disorders in east-European refugees settled in Australia. A sample of 209 psychiatric patients was compared with a non-patient sample of 138 refugees. These authors have commented on factors like sociocultural background, family settings, war experiences, educational and work histories and adjustment problems in their relation to the psychiatric morbidity. Rumbaut and Rumbaut (1976) have studied Cuban expatriates in the United States. They have emphasised the comparatively successful nature of adjustment of these exiles in the host country. According to these authors “expatriation is always traumatic and produces “casualties”, but mastery of the struggles it involves can lead to personal growth and expanded horizons”.

Some studies have also been reported from India in the general area of migration and mental illness. Bhaskaran, et al., (1970) studied the prevalence of psychiatric and psychosomatic illness in 100 migrant industrial workers and compared it with the prevalence in a randomly chosen matched group of 100 local workers. The prevalence was found to be much higher in the migrant group than in the control group and the prevalence in both these groups seemed to be higher than in the general population. These authors conclude that the socio-psychological stresses associated with immigration seem to be significantly related to the increased psychiatric morbidity in the immigrants, although the role of other factors cannot be altogether ruled out.

Sethi et al., (1972) in a study on the psychiatric morbidity of immigrants from West Pakistan to India found a significantly larger number of psychiatrically disturbed families as well as psychiatric patients among migrant when compared to non-migrant families. The disorders which were clearly more common in the immigrant population were psychoneurosis, depression and enuresis. However this study was conducted about 20 years after the migration of the families and so the immediate effects of migration were unclear.

Nandi et al., (1978) in a mental morbidity survey of uprooted community of low socio-economic status found that the ‘stress dependent mental disorders’ (neuroses, psychosomatic illnesses and depression) were more common in this group when compared to the same in a native-born control community. Thus it appears that migration is associated with increased psychiatric morbidity in the population concerned. This morbidity seems to be especially significant in case of forced international migration of large populations. However, there does not seem to be a clear consensus on the types of mental illness as well as on the exact factors which determine the onset, course and the duration of these illnesses.

In the last few years an unprecedented influx of Afghan nationals has taken place in India and particularly in Delhi. Our interest in this area was aroused by the large number of these people attending our psychiatry O. P. D. The present paper summarises our initial experience with this group of patients.
METHOD

Case records of all Afghan patients attending the psychiatry department of the AIIMS Hospital, New Delhi, between January 1981 and June 1982 were reviewed. Sociodemographic and clinical details were coded and analysed. Psychosocial stresses experienced by the patients and any special problems encountered in the assessment and management of the patients were specifically noted down. A selected number of patients were interviewed and studied in detail for gaining insights into the stresses and other antecedents of their help-seeking behaviour.

RESULTS

(i) **Number:** A total of 152 Afghan patients attended the O. P. D. during the study period of 18 months. This was 1.94 per cent of the total attendance to the O. P. D. and was 92 per cent of the attendance by all foreign nationals.

(ii) **Sociodemographic data:** The sex and age groups of these patients are given in Table I.

| Age (in yrs.) | Males  | Females | Overall (% of Total) |
|--------------|--------|---------|---------------------|
| Less than 15 | 4 (2.6%) | 106 (69.7%) | 110 (72.2%) |
| 15 to 24     | 22 (14.4%) | 46 (30.3%) | 68 (44.7%) |
| 25 to 34     | 33 (34.8%) | 22 (14.4%) | 55 (36.3%) |
| 35 to 44     | 45 (29.6%) | 22 (14.4%) | 67 (44%) |
| 45 to 54     | 22 (14.4%) | 6 (3.9%) | 28 (18.4%) |
| 55 or above  | 6 (3.9%) | 22 (14.4%) | 28 (18.4%) |

Most of these patients came from the city or suburbs of Kabul and hailed from the middle or higher socioeconomic class.

With respect to their official status in India, the patients belonged to one of the following categories:

(a) Certified refugees registered with the United Nations.
(b) Came on visa, but overstayed without permission.
(c) No valid papers available, arrived by clandestine routes.
(d) Possessing valid visa—came for treatment.

(iii) **Clinical data**

Symptoms—Majority of patients presented with anxiety, depressive or somatic symptoms. The most frequent symptoms are listed in Table II.

| Presenting Symptoms |
|---------------------|
| Lack of concentration, forgetfulness. |
| Nervousness, restlessness. |
| Irritability, violent outbursts. |
| Sleeplessness, excessive dreams. |
| Loss of interest. |
| Pessimism, sadness, hopelessness. |
| Headache, pain abdomen. |
| Impotence, Premature ejaculation. |

**Table II. Presenting Symptoms**

Dignoses—Clinical diagnoses (ICD-9) of these patients are presented in Table III.

Management—A variety of treatment modalities were used in the management of these patients. Eighty per cent were given drugs which consisted of antianxiety drugs (62.5 per cent), anti-
TABLE III. Clinical Diagnoses (N=152)

| Diagnosis                | No. | Percentage |
|--------------------------|-----|------------|
| Anxiety neurosis         | 47  | 30.9%      |
| Depressive neurosis      | 45  | 29.6%      |
| Adjustment reaction      | 11  | 7.2%       |
| Psychoses (MDP, Schiz.)  | 6   | 3.9%       |
| Mental retardation       | 4   | 2.6%       |
| Personality disorders    | 4   | 2.6%       |
| Others                   | 20  | 13.2%      |
| No psychiatric illness   | 11  | 7.2%       |
| Not recorded             | 4   | 2.6%       |

Depressant drugs (29.6 per cent) and other drugs (9.2 per cent). Counselling and supportive psychotherapy sessions were provided by the treating psychiatrists to majority of patients although no prolonged or formal psychotherapy could be undertaken because of several problems described later.

Follow-up—Sixty per cent of the patients visited the outpatient department only once, while 14 per cent came four or more times. Average period of treatment was 25 days. Sixty-eight per cent of the patients who reported for follow-up had benefited by the treatment. Eighteen per cent were referred to other specialities for investigations and treatment of physical disorders. Only three patients required treatment as inpatients in the psychiatry ward.

(iv) Problems Encountered

A multitude of problems were encountered in the assessment and management of these patients.

Communication was a major difficulty as most of the patients spoke little or no English or Hindi. In spite of frequent use of interpreters interviews were difficult, time-consuming and unsatisfactory. This factor also limited the usefulness of psychotherapy, which could have been the treatment of choice for many patients. Adequate evaluation of stress was another difficulty encountered. Many of these patients recounted their long tales of political harassment, loss of job, imprisonment, physical torture, actual combat, loss of family members, etc. It was impossible to either confirm or contradict the reliability of this account. Even if these stresses were really experienced, their effects and whether the symptoms were directly related to them are issues which cannot be settled easily.

Social and administrative problems were very frequently reported, often more disturbing to the patients than the clinical symptoms. These included financial problems, housing difficulties, worries about the well-being of family members in Afghanistan and problems associated with the expiry of visa, acquisition of official refugee status etc. Frequently patients insisted upon detaining certificates from the hospital to help them in the abovementioned difficulties.

A close contact was maintained with the United Nations Development Programme, the agency which is actively participating in the rehabilitation of refugees. This proved to be of considerable help in solving the social and financial problems of these patients.

DISCUSSION

The results of this study reveal that the number of Afghan nationals seeking psychiatric help from a general hospital psychiatric unit in Delhi is unusually large. Majority of the patients included in this study were males, most frequently in the 25 to 44 years of age group. They presented usually with anxiety, depressive and somatic symptoms. Diagnostically most of them were placed in the ICD-9 categories of anxiety neurosis, depressive neurosis and adjustment...
reactions, although other diagnosis were applicable for some of the patients. Psychotic illness were uncommon and this contrasts with the overall diagnostic pattern of the psychiatry O. P. D., which shows a substantial proportion of psychotic mental illnesses like schizophrenia and manic-depressive psychosis. Similarly, Afghan patients did not show hysterical fits or other manifestations of Hysterical neurosis which are otherwise seen commonly in the psychiatry O. P. D.

Most of these patients had undergone severe stresses before and after their migration; however adequate assessment of these factors was difficult in the hospital setting. Similarly satisfactory clinical work-up and management became difficult in view of problems associated with language and diverse cultural background. Cox (1976) has highlighted the problems associated with psychiatric assessment of immigrant patients and the need to sort out the different etiological factors by prolonged interviews and observation. While agreeing with these assertions, we would like to emphasise the importance of good social work-up and social support to provide much needed help to this group of people. Liaison with the administrative authorities is also essential so that while providing help where needed, a misuse of facilities can be prevented.

The present study is hospital based and essentially retrospective. Hence no valid conclusions can be drawn about the prevalence of psychiatric disorders in Afghan nationals residing in Delhi. However, judging from the large number of cases presenting to the hospital, the psychiatric morbidity in this population is likely to be substantial. Similarly in absence of any control group it is difficult to conclude that a causal relationship existed between the social stress and the psychopathology. However even if we take the concept of rapidly occurring changes in life, requiring readjustment, acting as non-specific stressors as enunciated in life event research (Holmes and Rahe 1967) this group of people can be expected to show a high prevalence of psychiatric as well as physical morbidity.

Academically this group of patients provides a rare opportunity of studying effects of extreme social stress simultaneously on a large number of people. Apart from psychopathology, the coping mechanisms used by these people towards integration in an alien culture is a fertile area for research. Long-term follow-up of these families will also be a highly informative exercise.

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