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Migration and Pathological Journeys: A Case Report of 5 Patients at the National Hospital in Niamey

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Abstract

This study aims to explore the unconscious motivations underlying migration in Niger, with an emphasis on understanding the phenomenon of pathological travel. Its aim is to identify the unconscious factors of pathological travel among migrants. Pathological travel, as discussed in the scientific literature on psychopathology, is characterised by movements initiated under the influence of delusions, hallucinations or other serious psychiatric disorders. The aim of this research is to contribute to our understanding of how these unconscious factors influence migration decisions. Using a retrospective analysis of five cases, this study examines the psychological and psychiatric dimensions of migration, particularly among patients referred to the psychiatry department of the Niamey National Hospital between 2017 and 2018. The five cases analysed, representing 12% of a cohort of 40 migrant patients, suffered from chronic psychotic disorders, including schizophrenia and chronic hallucinatory psychosis. By means of diagnostic interviews and categorical sorting, three main unconscious motivations were identified: the delusional state with themes of filiation and persecution, the hallucinations that dictated the travel behaviour, and the dissociative states manifested by depersonalisation and derealisation. It also emerges from this analysis that pathological travel often involves prolonged journeys on foot and without purpose. Thus, untreated mental illness plays a significant role in shaping and influencing individual and social behaviour. The results of this study have important implications for public health

and migration policy. They highlight the need to integrate health assessments into migration management systems, particularly in regions serving as transit hubs for migrants. The research also highlights the need for culturally sensitive psychiatric interventions to address the interaction between pre-existing mental disorders and migration. This study contributes to a better understanding of the psychological dimensions of migration by highlighting the importance of addressing mental health as an integral part of humanitarian action. The knowledge gained paves the way for future research to explore this understudied aspect of migration on a broader scale.

Keywords

Migration, Mental Illness, Pathological Journeys, Unconscious Psychological Motivations, Niger

1. Introduction

Migrating is a complex act that corresponds to a series of interrelated motivations, in varying proportions for each individual, making each story unique [1]. There will be an estimated 272 million international migrants in 2019, including 82 million refugees and asylum seekers. The mental health of migrant populations is a crucial global issue, influenced by the stresses and challenges encountered before, during and after migration. Psychological disorders, such as anxiety, depression, post-traumatic stress disorder (PTSD) and, in some cases, psychotic disorders, are more common among migrants and refugees than among local populations. Around 30% of migrant refugees suffer from mental disorders. [2]-[4] Several studies have explored the relationship between migration, mental health and associated phenomena, particularly pathological travel. Pathological travel in a migratory environment illustrates the complexity of the interactions between the migratory experience, cultural stress and psychiatric disorders. It is a specific problem that combines psychological, cultural, political and social factors linked to the migratory experience and mental disorders. [5]-[7]

There are two levels of psychological factors, one conscious and the other unconscious. In terms of conscious motivation, the decision to migrate is the culmination of a dream in which the future host country is idealised and the difficulties minimised, in a climate of genuine psychological contagion. The migrant's departure is as much a quest for himself as an attempt to regain his dignity through work and money. Under the influence of the unconscious, the migrant is either seeking to escape a dysfunctional family context or has a mental disorder.

The scientific literature on psychopathology is increasingly referring to pathological travel, which refers to travel underpinned by delusions or hallucinations, with or without mental automatism. Pathological travel is considered a symptomatic act [8]. The specific term "pathological travel" is less well-studied. Instead, studies focus on the mental health challenges faced by migrants during their trav-

els and resettlement phases. Despite the increasing recognition of mental health problems among migrants worldwide, there is limited understanding of how psychiatric disorders lead to Behaviours. This study aims to fill this gap by examining the phenomenon of pathological travel in Niger.

2. Background to the Study

Niger is at the crossroads of migration routes in Africa. It is a country with a long tradition of migration, which takes two main forms. Internal migration or rural exodus from the countryside to towns in the interior of the country and circular migration to other African countries, in particular to the countries of the Economic Community of West African States, Central Africa and the Maghreb countries [9] [10]. In addition to these two forms of mobility, there is transit migration and the forced return of migrants. This makes Niger a country of departure, reception and transit for migrants [11]. Faced with these multi-faceted migratory flows and refluxes, a national migration policy has been put in place in collaboration with non-state actors to deal with the economic, social, institutional and humanitarian aspects of the migration issue. The need to protect migrants' human rights, including their right to health, has been widely accepted over the last ten years or so, and is a growing international concern. The aim is to provide assistance to vulnerable migrants, many of whom suffer from illnesses of varying degrees of seriousness. These are the direct repercussions on their physical and mental health of the many forms of discrimination, violence and exploitation, or health problems that are poorly known or understood in their country of residence [12]. For example, some migrants suffer from mental disorders that require psychiatric treatment, sometimes including temporary hospitalisation. In Niger, the psychiatric department of the national hospital in Niamey is the only referral structure for the treatment of mental disorders. The non-state actors involved in the migration process who most often call on the psychiatric service to provide care for migrants are mainly the International Organisation for Migrants (IOM), the NGO COOPI and the Office of the High Commissioner for Refugees (HCR). The approach consists of proposing and implementing specialised and appropriate consultations, establishing a diagnosis, developing and implementing appropriate treatments and monitoring the care and stabilisation of patients.

3. The Patients

This was a retrospective analysis of five cases, representing 12% of a cohort of 40 migrant patients referred to the psychiatry department of Niamey National Hospital between 2017 and 2018. The patients' records were filled in throughout the process of their care during diagnostic and therapeutic interview sessions and follow-up. They contained the following information: the notion of pathological travel, and the report of the repatriation mission. All the patients were received on repatriation by at least one family member in addition to the humanitarian team. Information reported by the patient's family, after repatriation, concerning

their state of health prior to the migratory adventure was taken into account. The following ethical considerations were observed in all patients: The HNN administration gave written authorisation for the study to be carried out. Anonymity and confidentiality were respected. The recommendations on ethics, professional conduct and good practice as set out in the internal regulations of the Niamey National Hospital were taken into account. Diagnoses were established according to the tenth version of the International Classification of Diseases (ICD 10) [13]. A categorical cluster analysis was used to group the data and describe the cases according to the variables studied, *i.e.* socio-demographic, clinical, therapeutic, travel and repatriation characteristics. Table 1 shows the distribution of patients according to socio-demographic, clinical and therapeutic data.

Table 1. Distribution of patients by socio-demographic, clinical and therapeutic data.

Patients	A. E.	Y. G.	B. M.	S. M.	F. B.
Socio-Demographic Data					
Age (years)	52	65	32	50	60
Sex	Male	Male	Female	Female	Male
Nationality	Nigeria	Burkina Faso	Nigeria	Senegal	Sudan
Clinical Data					
Hand Symptoms	Dissociation, Delusion of parentage, Hallucinations	Dissociation, Delusion of persecution, Hallucinations, Influence	Dissociation, Manic Syndrome, Depersonalization, Derealization	Dissociation, Mystical delusion, Hallucinations, Influence	Delusion of persecution, Religious delusion, Hallucinations
Diagnostic CIM 10	F20.6	F20	F25	F20.6	F28
Therapeutic Data					
Hospitalization	Yes	No	No	No	Yes
Hospitalization Duration	One month	-	-	-	Twelve days
Medication	Antipsychotic (NAP)	Antipsychotic (NAP)	Antipsychotic Thymoregulator	Antipsychotic	Antipsychotic (NAP)
Compliance	Bad	Bad	Good	Good	Bad
Stabilization Period (months)	Seven	One	Five	Two	Three

3.1. Socio-Demographic Data

4 out of 5 patients were at least 50 years old. Males predominated, with a sex ratio of 1.5:1. The patients came from different countries, a total of 4 nationalities.

3.2. Clinical Data

Semiological analysis was used to establish the diagnosis in our patients. They all

suffered from chronic psychotic disorder, including 4 cases of schizophrenia and 1 case of chronic hallucinatory psychosis.

Key symptoms were identified for each patient that would explain the reason for the trip.

A. E. presented a delusion of filiation with an imaginative mechanism "*my father is a British academic*" associated with a denial of identity "*I am British*, *my name is H. E.*, *I'm* 81, *I'm travelling to find my father*".

Y. G. had a delusion of persecution with a visual hallucinatory mechanism and an influence syndrome: "*I see the kinkirsi* (*genies*), *some of them block my path*, *I fight with them*, *some of them guide me on the right path*".

B. M. presented with disorders of self-awareness and awareness of the environment, with depersonalisation, derealisation, false recognition and temporo-spatial disorientation.

S.M. had auditory and intrapsychic hallucinations with a syndrome of influence: "*voices guided me throughout my journey*".

For F. B., it was a persecutory delusion with an auditory-auditory-verbal hallucinatory mechanism: "*People denigrate me, they speak my mother tongue*, *the muezzins say the same thing instead of calling for prayer*" and an imaginative one: "*a video is circulating with the aim of sullying her father's reputation*". Support was unwavering, with reactions of flight (leaving the city for another) and hetero-aggression towards the designated persecutors.

3.3. Therapeutic Data

All our patients had undergone a physical examination and, if necessary, somatic treatment by a general practitioner before seeking psychiatric advice. No somatic antecedents were reported by the facility requesting the care. Once the diagnosis had been established, antipsychotics were prescribed for all patients. Non-compliance with treatment was the main reason for prescribing long-acting antipsychotics (3 patients) and for indicating hospitalisation (2 patients). All patients had a stabilisation time of at least one month. It was correlated with the length of hospitalisation.

3.4. Travel Features

4 patients reported the conditions of their journey. They did not use any usual means of transport. They admitted to having made the journey on foot, moving from town to town, with no known migratory destination. For the patient who had specified his destination, it was an integral part of the delusion.

3.5. Repatriation Data

All patients were repatriated to their countries of origin. At least one family member was present at the reception in addition to the humanitarian team. All the patients had a personal psychiatric history, some of whom (2 patients) were being followed up. Two others were declared dead after unsuccessful investigations (**Table 2**).

Table 2. Distribution of patients by repatriation data.

Patients	A. E.	Y. G.	B. M.	S. M.	F. B.
Repatriation Destination	Nigeria	Burkina Faso	Nigeria	Senegal	Sudan
Welcomed by	Wife and older brother	Wives and children	children	Father	Brothers
Mental Illness before Migration	Yes	Yes Sought in vain when he disappeared Was declared dead	Yes Had run away from her treatment place	Yes Was followed in Psychiatry	Yes Was declared dead after his disappearance

4. Discussion

The aim of this study was to contribute to the understanding of how unconscious factors influence migration decisions. This is the first study in a psychiatric setting in Niger. The study addresses the important issue of "pathological travel", which links migration and mental health. Pathological travel in this context is an important signal of the unmet mental health needs of migrants. This phenomenon highlights the need to combine psychiatric care with appropriate social and cultural measures. Despite the small sample size (five cases) which limits the generalisability of the results, the study provides a basis for integrating mental health considerations into migration policies.

This study took place in a humanitarian context where the pyramid of interventions for mental health and psychosocial support in emergency situations is used to prioritize the assistance needs of sick migrants. This pyramid is defined by the inter-organizational standing committee and has four levels. The top of the fourth tier calls for the use of specialist services to provide assistance to people suffering from severe mental distress or severe mental disorders [14]. The 40 patients cared for during the study period fit into this context.

The link between psychiatric disorders and pathological travel is well established. Many patients with pathological travel problems are found within a migrant population. Thus, travel is described as pathological when psychiatric disorders are the cause of the trip. Pathological travel is not a syndrome, but rather an inaugural or progressive symptom of a psychiatric pathology, particularly psychotic. It involves travelling to a greater or lesser extent or for a longer period of time, without any logical purpose. Although the diagnosis of pathological travel is not mentioned in the international classifications DSM IV and ICD10, it is a widely accepted concept [15]. The notion of pathological travel appeared in 1875 with Achille Foville, who demonstrated how travel, an act that is usually so well thought out and so rationally motivated, can in some cases be the sickly result of a delusional conception [16]. In the present study, the group of pathological travellers was made up of patients of four different nationalities. This finding is consistent with the migration context, which defines Niger as a hub of international migration. The patients were aged 50 and over, indicating the likely chronic na-

ture of the disease. This is an age beyond which migration for economic reasons is not an option in our context. This type of migration is more common among young adults who sacrifice themselves for their families and go on adventures in search of a better tomorrow. All the patients suffered from chronic psychotic disorders. The prevalence of psychotic disorders in migrant populations has been reported by several authors. In a meta-analysis of the prevalence of schizophrenia involving more than 180 studies in 46 countries, Saha *et al*. found figures 1.8 times higher among migrants than among non-migrants. Cantor-Graae and Selten, in a meta-analysis of 18 studies published between 1977 and 2003, concerning the first psychiatric hospitalisations and their incidence in various countries (Australia, United Kingdom, Netherlands, Sweden, Denmark), found a relative risk of schizophrenic disorders of 2.9 for all migrants. [17] Salvati B. *et al*. found in their study a very high percentage of psychoses and bipolar disorders in the group of pathological travellers. These data are in line with the definition of pathological travel, a psychotic act in which a patient travels to other cities or countries driven by a delusion to which he or she is fully committed [18]. Post-traumatic stress disorder, depression and severe anxiety disorders have also been reported as underlying pathologies associated with pathological travel. [19]-[21]

The analysis of the cases has enabled us to characterize the typical trip and to identify the various unconscious motivations behind it. As a result, the typical pathological journey took place on foot, without a precise migratory destination, in a schizophrenic known to be mentally ill prior to the migratory adventure. Most of the literature on this subject reports a positive correlation between migration and mental disorders, particularly schizophrenia. Pathological travel is the best-known example of the links between psychotic disorders and travel. This term, introduced in 1914 by Briand, Morel and Livet, refers to a symptom occurring in the context of a pre-existing psychotic disorder [10] [22]. The pathological traveller is described as a tireless walker who abandons family, friends and homeland, breaking with structures and habits to set off straight ahead, without a goal or destination. As they travel, they forget themselves, their loved ones and their own journey [23].

Three types of unconscious motivation for travel linked to mental illness among migrants in Niger emerge. *Travel motivated by delusions* is present in two of the patients. These are the delusions of filiation, in which the journey is undertaken to obey the delusional idea, and the delusions of persecution, in which the patient travels to escape his persecutors. Then, travel motivated by hallucinations as part of the influence syndrome: this type of trip is also present in two of the patients. The trip was ordered by the hallucinated pathways. For Caroli and Massé, the function of pure pathological travel is to obey the delusion or hallucination and to integrate with its content. Finally, *travel in the context of dissociation* in a dysthymic schizophrenic with temporo-spatial disorientation, depersonalisation and derealisation. During the trip, motivated by the dissociative disorder, the patient feels detached from himself and his environment. Episodes of depersonalisation

are characterised by altered perceptions, a loss of sense of one's own reality, experience or identity, altered memory processes, and relationships with the world or with oneself. In episodes of derealisation, the patient loses a sense of the external world, and things may change shape or dimension. Other motivations have been reported as factors that may encourage people to travel. These include hypervigilance and avoidance of trauma-related places in people suffering from post-traumatic stress disorder. The emotional instability found in depression and anxiety disorders leads some people to constantly change location in an attempt to relieve their distress. These data suggest that unconscious motivations play a significant role in triggering travel behaviour in a migratory environment.

Finally, humanitarian assistance for our patients was twofold: the administration of psychiatric care and repatriation. All patients received antipsychotic medication. Hospitalisation and treatment with a long-acting antipsychotic were indicated in 2 and 3 patients respectively, all in the context of non-compliance with treatment. According to Salvati B. *et al.*, less than half of the patients on pathological journeys accepted the care offered. These results reflect the clinical characteristics of patients on pathological journeys, who present a total adherence to delirium with a higher frequency of therapeutic non-compliance.

Psychiatric treatment helped to restore satisfactory mental functioning. In the present study, the stabilisation period was at least one month. In most cases, stabilisation was achieved after several months of treatment. All patients achieved a minimum level of stability, enabling them to begin the repatriation process. Psychotic states pre-existing to the migratory adventure were confirmed in all patients, reported by their family members on repatriation to their country of origin. Among the illnesses associated with travel, mental health is not given much attention, although the percentage of psychiatric problems that are the cause of early return, or even psychiatric repatriation, is far from negligible. The care of mentally ill migrants is long and complex. It requires a multi-disciplinary approach, from accommodation, provision of basic necessities, and access to medical care through to family reunification and repatriation. All these actions have a positive impact on the health of these populations by offering them access to better health services. Humanitarian action in the field of migration offers mentally ill migrants a rehumanising environment. Repatriation is a means of social reintegration for the patient and hope for the families to be reunited with a loved one who has most often been declared dead.

5. Conclusion

Pathological travel sometimes occurs among many migrants suffering from mental disorders. It should be systematically sought in all migrants requiring specialist psychiatric care. It is very important to take into account the pre-migration experience in order to understand this phenomenon. This study highlights the non-negligible role played by migrants' unconscious motivations for travelling. It highlights the need to examine the issue of pathological travel in a migrant environ-

ment in greater depth through studies that will shed light on all the pathologies and their implications.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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Appendix

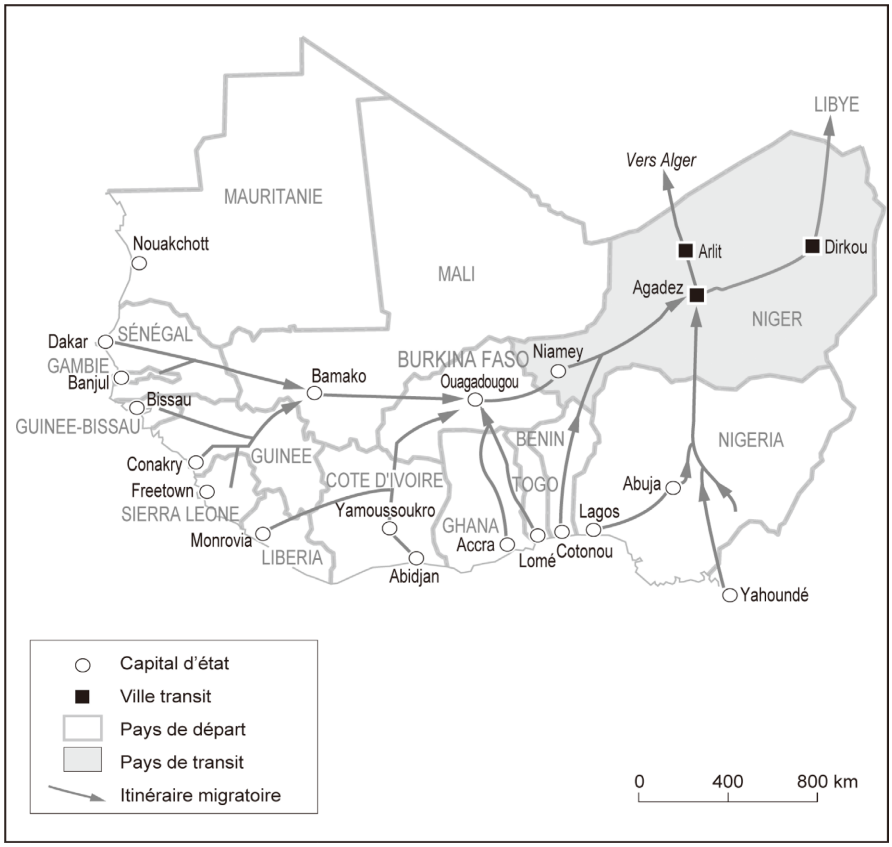

Figure A1. Map—Routes taken by sub-Saharan migrants heading for Libya and Algeria [24].