

Psychotic Disorder and Migration: A Case Study of a Returning Migrant

Hugo Hermann Bohongwe Divahe^{1*}, Christian Eyoun^{2,3}, Yvette Arol Kouayim¹,
Abibatou Guene¹, Sokhna Seck^{1,4}

¹Moussa Diop Psychiatric Clinic, Fann National University Hospital Center of Dakar, Dakar, Senegal

²Mental Health Service, Laquintinie Hospital, Douala, Cameroon

³Faculty of Medicine and Pharmaceutical Sciences, University of Douala, Douala, Cameroon

⁴Faculty of Medicine, Pharmacy and Odontostomatology, Cheikh Anta Diop University, Dakar, Senegal

Email: *hugohermann@yahoo.fr

How to cite this paper: Bohongwe Divahe, H.H., Eyoun, C., Kouayim, Y.A., Guene, A. and Seck, S. (2026) Psychotic Disorder and Migration: A Case Study of a Returning Migrant. *Open Journal of Psychiatry*, **16**, 354-363.

<https://doi.org/10.4236/ojpsych.2026.164026>

Received: June 11, 2026

Accepted: October 12, 2026

Published: October 15, 2026

Copyright © 2026 by author(s) and Scientific Research Publishing Inc. This work is licensed under the Creative Commons Attribution International License (CC BY 4.0).

<http://creativecommons.org/licenses/by/4.0/>



Open Access

Abstract

Introduction: Complex and precarious migration processes increase the risk of psychological distress. Among exiles, psychotic disorders have a higher prevalence than in the general population, but their management is frequently hampered by diagnostic biases in a cross-cultural context. **Objective:** To report the clinical case of a migrant who returned to Senegal, in order to analyze the impact of the migration journey on the trajectory and sequential resolution of the diagnosis. Case Presentation: Mr. I. F., a 38-year-old tailor, experienced a 13-year migration journey marked by trauma (forced labor in Libya, a shipwreck at sea) and extreme precariousness (living on the streets in Spain). Upon his forced return, he presented with a combination of depressed mood, delusions of persecution, and auditory-verbal hallucinations. A major depressive disorder with psychotic features (DSM-5) was initially diagnosed and treated with a triple therapy regimen (fluoxetine, haloperidol, chlorpromazine). Following a six-month interruption in outpatient treatment and a relapse characterized by pure dissociative symptoms, the diagnosis was revised to schizophrenia according to the full DSM-5 criteria. The patient was successfully stabilized with haloperidol monotherapy. **Discussion:** This case illustrates the interaction between individual psychological vulnerability and cumulative environmental stressors (pressure from family redistribution, trauma, urban isolation). The longitudinal course underscores the need for a dynamic diagnosis in transcultural psychiatry to avoid overdiagnosis and tailor therapeutic strategies. **Conclusion:** Taking into account the patient's life story and migration experience is essential for refining the symptomatology, making an accurate diagnosis, and facilitating the reintegration of returning patients.

Keywords

Migration, Psychopathology, Schizophrenia, DSM-5, Transcultural

1. Introduction

Migratory processes play a part in the development of human civilisations and therefore have undeniable anthropological significance. Regardless of their motives, the movement of groups of individuals can lead to more or less permanent ethnological modifications linked to environmental changes [1].

In 2006, it was estimated that there were 200 million migrants worldwide. This figure could exceed 230 million by 2050. Every year, 700 million people cross borders worldwide. Migration is a key element of globalisation due to cultural, economic and political exchanges [2].

Despite the fact that mental disorders are the most common pathology encountered by exiles, particularly asylum seekers and refugees, according to the Comité Médical Pour Les Exilés (COMEDE), the mental health of precarious migrants is poorly understood by healthcare professionals. Factors contributing to this include violence suffered in the country of origin, the complexity of migratory journeys, exile, cumbersome administrative procedures, the length of regularisation procedures, language barriers, and limited access to housing and employment. All of these factors increase the risk of psychological distress, even though migrants rarely express a need for mental healthcare [3]. From an epidemiological standpoint, studies of migrant populations reveal a wide range of pathological manifestations, some of which are considered to be a direct consequence of geographical transplantation. Psychiatric disorders, in particular, are common and manifest in various ways. Psychotic states, which are frequently mentioned in the literature, are reportedly more prevalent among migrants than in the general population [1].

The return of certain migrants to their country of origin is the result of a mental health condition, and this journey is neither anticipated nor desired by those involved. This situation highlights a form of forced return that is distinct from repatriation, failed migration and planned return. Original data enable us to examine the impact of mental health on migratory journeys, revealing the extent to which family solidarity contributes to the realisation of the migratory project [4]. However, their identification is subject to biases (related to the heterogeneity of the studied groups and diagnostic errors likely to occur in a transcultural context), and questions remain about how to approach and treat them [1].

The aim of this paper is to report on the clinical case of a patient treated in the psychiatry department for a psychiatric disorder associated with a migratory experience and return to his country of origin.

2. Methodology

This is a clinical case study characterized by a sequential diagnostic revision. The

initial course of treatment was oriented toward managing a major depressive disorder with psychotic features (according to DSM-5 criteria); however, longitudinal follow-up of the patient and his readmission to the hospital revealed a profile consistent with schizophrenia, as part of inpatient care in a psychiatric ward. This case occurs within a specific context, marked by a prolonged experience of migration followed by a return to the patient's country of origin. The analysis employs a qualitative method, based on semi-structured interviews conducted with the patient during hospitalization, which allowed for the collection of his biographical narrative as well as the subjective progression of his symptoms. The clinical evaluation was conducted through a comprehensive psychiatric examination, combined with a physical examination and routine laboratory tests, to rule out any organic causes and confirm the diagnostic hypothesis. These findings revealed a clinical picture consistent with a schizophrenic disorder according to DSM-5 criteria.

2.1. Patient Presentation

Mr I. F. is 38 years old. He is married and has one child. He is a dressmaker by profession, but is currently unemployed. He is the youngest of five siblings (two boys and three girls).

He was referred to us by the outpatient department. His brother accompanied him throughout his hospitalisation.

From a medical standpoint, no specific somatic antecedents have been reported. In terms of psychiatry, he has no known personal history of mental health issues prior to the onset of his current disorders. However, there is a family history of behavioural disorders in a maternal uncle. Legally, Mr I. F. has been arrested three times in Spain for breaching local immigration laws. In terms of addiction, he started using cannabis at the age of 19, smoking one or two joints a day either alone or with others. He also smokes two to three tobacco cigarettes daily. His alcohol consumption (beer, wine and spirits) began later, at the age of 32, during his time in Spain.

Mr I. F.'s developmental history is marked by potentially traumatic events in his early years. He lost his father at the age of six, an event which he describes as difficult due to his lack of memories of the deceased and being separated from his siblings. Following his father's death, he was placed in the care of his maternal grandmother. He reports a period of mistreatment at the hands of his uncles and heavy farm work. At the age of thirteen, he returned to live with his brothers in a family environment that was economically precarious. He then undertook various apprenticeships: sheet metal work and car mechanics at fifteen, carpentry at seventeen, and sewing at twenty with his older brother in Dakar.

When he was twenty-five, he married a cousin in an arranged marriage, arranged by his older brother. He then emigrated to Mali to work as a dressmaker. He stayed there for around six years, supporting his family in Senegal financially and returning occasionally for religious and family celebrations. At the age of

thirty-one, and again at his brother's behest, he decided to emigrate to Europe. It was a long and arduous journey: He travelled through Senegal, Burkina Faso and Niger, before reaching Libya, where he lived in extremely difficult conditions and did forced labour to support himself. From there, he set off on a makeshift boat for Italy. The boat sank, killing several of his fellow passengers. He recounts seeing one of them drown before his eyes, helplessly. This episode seems to have left its mark, and he says that he had frequent nightmares during this period.

After being rescued by the coastguard, he was taken to the Italian border. He stayed in a refugee camp, doing odd jobs and continuing to sew. He managed to make contact with his family in Senegal and sent them modest financial support. Despite beginning to integrate, his brother suggested he join a friend in Spain. He was reluctant to do so, preferring to stay in Italy where he hoped to obtain his papers after a year and a half. Nevertheless, at the age of thirty-two, he finally travelled to Spain.

His six-year stay in Spain was said to be particularly difficult. He lived on the streets and did odd jobs, such as selling jewellery. He also complained of pressure and violence from influential groups. He reports that he was sometimes forcibly taken to unknown places and would wake up not knowing where he was. During this period, he experienced an episode of acute agitation which required him to be hospitalised for 24 hours. Although he was prescribed medication, he could not afford it.

This painful migratory journey, characterised by break-ups, trauma and precariousness, appears to be a significant cause of psychological vulnerability. He returned to Senegal seven to eight months before his first psychiatric hospitalisation, amid a worsening of his symptoms.

Upon examination, Mr I. F. Upon examination, Mr. I. F. exhibits a lack of personal grooming and neatness in his appearance. Contact is fairly good, though he is occasionally reticent. We observe hypomimia and a shifty gaze. His speech consists of hallucinatory dialogue. He experiences acoustico-verbal hallucinations (*"I hear voices talking to me. They're always there"*). He is in a sad mood, showing emotional blunting and bradypsychia. His speech revealed delusions of filiation (*"My mother is American. She left me here before going back to her country"*) and delusions of denial of filiation (*"My brother is not my brother. We don't have the same mother"*). Delusions of mysticism (*"I believe in God's power to protect me because my brother is a marabout"*) and delusions of persecution (*"The people at home only wanted to exploit me. As I have nothing left, they chased me out of the house"*).

2.2. Management and Outcome

During his hospitalisation, we observed palilalia and occasional signs of schizophrenia. There were also gestural stereotypies and behavioural oddities, such as keeping a bottle of water in his armpit at all times. His speech revealed feelings of guilt (*"It's my fault the debts weren't paid. They helped me, but I couldn't help*

them”) and self-deprecation (“*I’ve decided to leave home and never come back because I’m a mistake for the family*”). The diagnostic hypothesis was that of characterised depressive disorder with psychotic symptoms, according to the DSM-5. Treatment consisted of 20 mg of fluoxetine daily in the morning, 6 mg of haloperidol twice a day (3 mg in the morning and 3 mg in the evening) and 100 mg of chlorpromazine once a day in the evening. After 18 days, he was discharged and continued to receive outpatient treatment.

Six months later, he was admitted to hospital again due to irritability, verbal heteroaggression in the form of insults, and social withdrawal, following discontinuation of treatment and running away. On examination, he displayed a lack of curiosity, a fixed facial expression with unmotivated smiles, and stereotyped gestures. His train of thought was blurred and incoherent, with digressions and leaps of logic. There was emotional blunting. His speech revealed delusions of persecution (“*I have been mistreated, beaten and threatened by members of my family*”) and delusions of denial of filiation (“*These people are not members of my family*”).

The diagnosis was revised to schizophrenia according to the DSM-5. The treatment consists of haloperidol 20/00 drops (2‰), 6 mg in twice daily (3 mg in the morning and 3 mg in the evening). The clinical course, which showed no melancholic component, justified switching to a single neuroleptic medication upon re-hospitalization in order to optimize overall tolerance. Clinical improvement was favorable, and the patient was discharged after eleven days of hospitalization.

The timeline of major events is as follows: Age 19: Started using cannabis; Age 25: Married and left for Mali (6 years); Age 31: Journey to Europe (Libya, forced labor, shipwreck, camp in Italy); Age 32: Arrival in Spain, start of alcohol use, living on the streets, brief 24-hour hospitalization; ages 37 - 38: Forced return to Senegal, 2 months of wandering/running away, followed by first hospitalization (18 days) and follow-up: Discontinuation of treatment after 6 months, relapse, and second hospitalization (11 days) with a revised diagnosis.

The longitudinal clinical evaluation of Mr. I. F. confirms the diagnosis of schizophrenia, as he meets all the criteria required by the DSM-5:

Criterion A (Characteristic Symptoms): The patient exhibits at least two of the key symptoms of the active phase, persisting for a significant period of one month (and evident during both hospitalizations):

(from both hospitalizations):

1) Delusions (Positive symptom): Polymorphic delusions of persecution, delusions of parentage (that his mother is American), delusions of denied parentage (that his current family is not his own), and mystical delusions.

2) Hallucinations (Positive symptom): Persistent auditory-verbal hallucinations (“voices speaking to her”).

3) Disorganized speech (Disorganization): Presence of major disturbances in the course of thought characterized by vague thinking, rambling, non sequiturs, as well as palilalia and confirmed schizophasia.

4) Grossly disorganized or catatonic behavior: Behavioral oddities (constantly keeping a water bottle under his armpit), stereotyped gestures, episodes of acute agitation, and prolonged wandering/running away.

5) Negative symptoms: Marked emotional blunting (evident during both examinations), hypomimia/frozen facial expressions, and complete social withdrawal.

Criterion B (Social or Occupational Dysfunction): Since the onset of the symptoms and particularly upon his return to Senegal, the individual's level of functioning in a major area of life has been severely impaired, resulting in total occupational inactivity for this professional tailor, an inability to maintain his previous level of family support, and significant neglect.

Criterion C (Duration): The continuous signs of the disorder have persisted for several years. His six-year stay in Spain was marked by wandering, living on the streets, and an initial episode of acute agitation. Furthermore, the documented acute symptoms spanned a period of more than seven months between his return to his home country, his first hospitalization, and his relapse six months later, far exceeding the required six-month threshold (including the prodromal, active, and residual phases).

Criterion D (Exclusion of Schizoaffective Disorder or a Mood Disorder): A depressive or bipolar disorder with psychotic features has been ruled out. Although depressive symptoms (sad mood, guilt) initially led to a diagnosis of major depressive disorder, the course of the illness showed that mood episodes did not occur simultaneously with the active phase of psychotic symptoms, or accounted for only a small portion of the total duration of the active and residual periods. At the time of relapse, the clinical picture was purely psychotic and dissociative, without an affective component.

Criterion E (Exclusion of a Substance or General Medical Condition): A comprehensive physical examination and routine laboratory tests were normal, ruling out a direct organic cause. Although the patient has a history of cannabis use (since age 19) and alcohol use (since age 32), the disorder cannot be attributed to the direct physiological effects of a substance, given the persistence of hallucinations, disorganization, and delusions after several months away from the environments where he used substances in Spain and apparent withdrawal in Senegal.

3. Discussion

3.1. Reason for Migration

There are many reasons for migration. Political reasons account for 39% of cases, followed by social reasons linked to family or community conflicts (26%), notably mixed marriages in regions such as the Caucasus, where ethnic and religious boundaries are historically complex. Economic reasons (19%) and medical reasons (6%) complete the picture [3].

Our patient migrated for economic and family reasons. Aiming to improve his family's living conditions, he decided to migrate abroad at his brother's behest. Migrants are often indebted to their families, who have mobilised to make the

migration project a reality, according to a logic of redistribution. Migrants contribute to the health, education and economic activities of their relatives through migration income [4]. This explains why, as soon as he started earning an income, however small, our patient began sending money to his family.

3.2. Social Pressure, Family Assignment and Identity Conflict

Migration can exacerbate tensions related to identity, particularly among the younger members of society who are subject to the decisions of their elders.

As early as the late 1970s, the sociologist Storper-Perez (1976) used the term ‘universe of contradictions’ to describe the difficulties individuals experience in finding their place in a changing society. She observed that the onset of mental illness in a family member often forces the others to redefine their relationships.

A psychologist (NK, Ker Xaleyi Centre, CHNU Fann) notes the difficulty individuals have in fulfilling sometimes contradictory roles, such as being ‘a good son’, ‘a good migrant’ and ‘a good Muslim’, as well as being a modern husband. Social cadets, like our patient, are confronted with decisions imposed by family heads that directly affect their lives, often without justification [4].

Our patient, who is fatherless and the youngest of his siblings, was under the responsibility of his older brother, who became the head of the family. Migration decisions seem to have largely been imposed on him. He reports, “*I didn’t want to go. If I stayed in Italy for at least a year or a year and a half, I’d get my papers*”, in reference to his brother’s suggestion that he leave for Spain.

3.3. Homecoming, Narcissistic Collapse and Guilt

The return of a migrant is usually anticipated, appreciated and celebrated, as it symbolises social success. However, our patient returned to Senegal prematurely due to psychological problems. His return was not accompanied by the expected financial gains.

Migrants who are repatriated for health reasons arrive at Dakar airport, where an ambulance is waiting to take them to the CNHU de Fann [4]. Those who return of their own accord are often hurried by their families to the same establishment in order to avoid exposing their neighbours to the disease [4].

In this patient’s case, the return was at the family’s request. Five months later, he was brought in for a consultation following a two-month absence, during which he had been found wandering.

This unplanned return in a context of financial insecurity may have led to feelings of shame. In a migration situation, a long and uncertain wait can lead to a painful and sometimes persecutory experience that feeds narcissistic rage. Waiting can then become an extreme form of suffering where anguish and narcissism become intertwined [5].

This context of psychic reorganisation could explain the guilt and self-deprecation observed in our patient upon returning to his family.

3.4. Violence Experienced during Migration

Migrants are often exposed to physical, psychological and sexual violence. Gerbes *et al.* found that 76% of migrants had experienced violence, including 63% physical violence, 60% psychological violence and 26% sexual violence. This was also the case for our patient [3].

In Libya, he was forced to work in order to obtain food and shelter. In Spain, he was abused and pressured by influential individuals. Such experiences can lead to psychological distress and the onset of mental health conditions.

3.5. Psychiatric Diagnosis and Transcultural Issues

The diagnosis made for our patient was schizophrenia, which was confirmed during follow-up. Before confirming the diagnosis of schizophrenia in Mr. I. F., several alternative hypotheses were discussed. Despite his early use of cannabis (starting at age 19) and alcohol (starting at age 32), a substance-induced disorder was ruled out due to the persistence and structured nature of the psychotic symptoms after more than 7 months of returning to and withdrawing from substances in Senegal. Similarly, although the traumatic shipwreck in the Mediterranean initially caused nightmares, the course of the illness quickly went beyond the scope of a trauma-related disorder (PTSD) to center on complete dissociation. Finally, the absence of any mood-related symptoms during the relapse definitively ruled out the hypothesis of a mood disorder with psychotic features in favor of schizophrenia.

Our patient's diagnosis was schizophrenia, confirmed during follow-up. A study at the Centre National de Psychiatrie de Thiaroye revealed that 14% of patients presented with hallucinations and 15.94% with persecutory delusions. M'bousou has highlighted the prevalence of themes of persecution in certain sociocultural contexts in sub-Saharan Africa, often reflecting specific relational and community dynamics rather than a fixed identity trait. Along the same lines, Ahyi highlights the frequency of these delusional representations in cases of depression observed locally [6].

Baubet *et al.* [7] question the cross-cultural validity of Western diagnostic categories. More recently, Chessa and Sentissi [8] point out that the assessment of psychosis in a migrant requires a dynamic and cross-cultural clinical approach, given the risk of confusing expressions of cultural distress or accounts of complex trauma with symptoms of strict schizophrenic dissociation. Jedwab *et al.* report that diagnostic errors occur in transcultural contexts, particularly when symptoms are non-specific in migrant patients [1]. Mukherjee *et al.* found that young African-American or Hispanic-American patients with bipolar disorder were more likely to be misdiagnosed as having schizophrenia due to frequent hallucinations.

There is thus a high risk of overdiagnosis of psychosis and forced hospitalisation. According to the DSM-5, our patient's initial diagnosis was a depressive disorder with psychotic features. They were treated with antidepressants and antipsychotics.

Özek (cited by Hutchinson *et al.* and Baudet *et al.*) observed that many Turkish

patients diagnosed with schizophrenia in Germany showed marked improvement when taking antidepressants after returning to Türkiye [7].

In this case, the patient showed no improvement when taking antidepressants. Six months later, he was readmitted to hospital and received a definitive diagnosis of schizophrenia, to which he responded well with antipsychotic monotherapy.

Baubet *et al.* highlight a lack of stability in diagnoses made during initial consultations [7]. This observation highlights the importance of a dynamic diagnosis in psychiatry and the need for follow-up, particularly for migrant subjects.

Among the hypotheses explaining the high frequency of schizophrenia diagnoses among migrants, stress linked to confrontation with a culturally different environment is evoked. Our patient evolved in a hostile environment, marked by wandering and precariousness.

During his six years in Spain, he often lived on the streets and worked odd jobs (e.g., selling jewelry), which were insufficient to support himself. This precarious situation may have triggered a state of agitation with psychotic features, warranting hospitalization. Recent research by Morgan *et al.* [9] confirms the importance of these urban social determinants, demonstrating that prolonged exposure to environmental adversity, isolation, and hostility in host communities significantly increases the risk of psychotic decompensation among migrant populations.

Research by several authors suggests that migrants are more exposed to psychosocial risks (precarious living conditions, isolation, discrimination, family breakdown), which increases their vulnerability [1]. This is a typical situation in our patient's history. In this regard, the systematic review by Loumonvi [10] highlights that cumulative precariousness during the exile experience is directly correlated with more severe symptoms at admission and a high risk of discontinuing outpatient care after discharge.

4. Conclusion

Migration is an increasingly prevalent phenomenon in people's socio-cultural context. It is often seen as a way of improving personal and family living conditions. However, it can also lead to cognitive, emotional and behavioural changes, resulting in challenging physical and psychological experiences. This case study highlights the importance of considering the experiences of patients with mental health issues in the context of migration or returning from migration. In the long term, this will enable us to identify symptoms and make appropriate diagnoses, improving care and promoting the reintegration of patients with mental health problems in a migrant context.

Ethical Considerations and Consent

Free, informed, and written consent was obtained from the patient and his brother (primary caregiver) prior to the writing of this report. The data were fully anonymized to ensure medical confidentiality. This clinical case report, based on routine care, was exempt from formal approval by the local ethics committee, in accord-

ance with national guidelines.

Author Contributions

H.B. was the treating clinician and wrote the text and contributed to the literature search; S.S. reviewed and finalised the manuscript; All authors have read and approved the manuscript.

Funding Information

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflicts of Interest

The authors declare that they have no financial or personal relationship(s) that may have inappropriately influenced them in writing this article.

References

- [1] Jedwab, N. and Nguyen-Lamouri, C. (2015) Prise en charge des états psychotiques aigus chez les migrants: Cas particulier des mineurs isolés aux urgences psychiatriques. *L'Information Psychiatrique*, **91**, 29-37.
- [2] Guardia, D., Salleron, J., Roelandt, J.-L. and Vaiva, G. (2017) Prévalence des troubles psychiatriques et addictologiques auprès de trois générations successives de migrants: Résultats d'une étude menée en population générale. *L'Encéphale*, **43**, 435-443. <https://doi.org/10.1016/j.encep.2016.06.008>
- [3] Gerbes, A., Leroy, H., Leferrand, P., Michel, D., Jarno, P. and Chapplain, J. (2015) Mieux repérer la souffrance psychique des patients migrants primo-arrivants en consultation de médecine générale et limiter les ruptures de suivis psychiatriques. *L'information Psychiatrique*, **91**, 243-254. <https://doi.org/10.1684/ipe.2015.1323>
- [4] Petit, V. (2018) Retours contraints de migrants internationaux au Sénégal: Dilemmes familiaux face à la maladie mentale. *Revue Européenne des Migrations Internationales*, **34**, 131-158. <https://doi.org/10.4000/remi.10901>
- [5] Onguéné Ndongo, T. and Derivois, D. (2021) Migration familiale forcée et travail de somatisation en situation de longue attente: Une étude clinique. *Dialogue*, **231**, 139-158. <https://doi.org/10.3917/dia.231.0139>
- [6] Ahyi, R.G. (1977) Les états dépressifs au Sénégal: À propos de 246 observations. Thèse de Doctorat en Médecine, Université Cheikh Anta Diop de Dakar (UCAD), 141 p. <http://www.sudoc.fr/022513076>
- [7] Baubet, T., Rezzoug, C. and Moro, M.R. (2010) Les états psychotiques chez les jeunes migrants et enfants de migrants. *EMC-Psychiatrie*, **7**, 1-10.
- [8] Chessa, A. and Sentissi, O. (2024) CIM-11 (OMS): Nouvelle Révision Et Impact De La Classification Onusienne En Psychiatrie. *L'Encéphale*, **50**, 329-338. <https://doi.org/10.1016/j.encep.2023.10.003>
- [9] Morgan, C., Knowles, G. and Hutchinson, G. (2019) Migration, Ethnicity and Psychoses: Evidence, Models and Future Directions. *World Psychiatry*, **18**, 247-258. <https://doi.org/10.1002/wps.20655>
- [10] Loumonvi, K. (2020) L'impact Des Parcours Migratoires Sur La Santé Mentale Des Demandeurs D'asile. *e-Migrinter*, **21**. <https://doi.org/10.4000/e-migrinter.2459>