ROMANIAN IMMIGRANTS IN ITALY: MENTAL HEALTH AND POTENTIAL PROTECTIVE AND VULNERABILITY FACTORS

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Abstract

We investigated the mental health, in terms of reported Axis I psychiatric symptoms, of a sample of Romanian Immigrants in Italy, using the Psychiatric Diagnostic Screening Questionnaire (PDSQ). Moreover, we explored the association between psychological distress or specific disorders and a few demographic and cultural variables connected to the immigration process and identified as possible vulnerability/protective factors. Results showed a high frequency of above cut-off scores for Obsessive-compulsive disorder (45.8%, n=49), Psychosis (38.3%, n=41), Somatisation (35.5%, n=38), Generalized Anxiety (32.7%, n=35), PTSD (31.8%, n=34), Major Depression (30.8%, n=33) and Social Phobia (30.8%, n=33). Perceived ethnic discrimination and low language proficiency were identified as important vulnerability factors, predictive of clinical levels of anxiety and depression.

Keywords: Romanian immigrants, immigration and mental health, DSM-IV, protection and vulnerability factors immigration.

Introduction

Romanians are the largest immigrant community in Italy. This constantly growing presence translates into an increased number of psychological intervention requests for private and public structures. At the same time, a correct diagnosis and treatment of mental health problems within this population might be complicated by linguistic and cultural barriers and by stressful events

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specifically related to the migration and adaptation process. Possibly because of the geographical, cultural and linguistic proximity between Romania and Italy, or maybe because of the relative simplicity of the immigration process from a legal point of view, these difficulties appear to have been until now underestimated. Although in the past years there have been some sociological studies on a large scale (especially after the tragic events in 2007 which have brought Romanians at the center of mediatic attention) and some European studies which have also included Romanian subjects, the mental health of the Romanian community in Italy and in Europe in general has received very little attention.

Migration as a pathogenic process

A vast literature has been dedicated to the effects of the immigration process on the mental health of immigrants of various origins. Before, during and after migrating, it is generally acknowledged that subjects suffer exposure to a series of stressful factors (Pumariega *et al.*, 2005), or that they undergo a process of cultural loss or bereavement (Eisenbruch, 1990). However one chooses to describe it, this process appears to influence mental health by causing negative emotion and modifying health related behaviours, including the search for specialized help (Cohen & Kessler, 1995; Caponi *et al.*, 2012). In order to describe the mental health situation of a specific immigrant population, we need to start from the group of origin, from its traits and lifestyle, often characterized by a significant social-economic disadvantage. To these we can add difficulties related to leaving their families and the existing support system behind, as well as the migratory journey in itself.

Many American and Canadian studies, countries which have historically pro-duced the largest number of data on this topic, have found that the immigrants' physical and mental health appears to be, at least during this first phase (before and during the migration), superior to that of the population from the host country (Gilliver *et al.,* 2014), only to gradually deteriorate over the following years. This effect, known as the "*healthy immigrant effect*" can probably be explained by migration selection procedures and is not usually found in European studies, where immigrants' health appears inferior to that of people from the host country (Lindert *et al.,* 2008; Ng & Omariba, 2010; Domnich *et al.*, 2012; Abebe Lien, & Hjelde 2014; Bhugra *et al.,* 2014). Once arrived, the immigrants need to adapt to the new context and build a new social network, while often facing difficult life and work situations. During this post-migration phase, research has underlined the negative influence of perceived discrimination on health in general and mental health in particular (Schmitt *et al.*, 2014; Pascoe & Richman, 2009). Pascoe and Richman (2009), analyzing the results of 134 studies on this topic, concluded that perceived discrimination is correlated to depressive symptoms and psychiatric symptoms in general. Results show that a higher level of perceived discrimination

corresponds to a higher probability of clinical levels of mental illness. Schmitt, Branscombe and colleagues, in a subsequent review (2014) have confirmed the results observed by Pascoe and Richman, adding the importance of various factors that may modulate the relationship between the two variables, among which group identification, available social support and individual coping strategies.

These factors, together with many others such as language proficiency, are indicators of a wider concept, *acculturation*, or the acquisition of the culture or of some cultural traits belonging to another group. This process, inherited as a concept from anthropology and classical social sciences, is considered with increasing frequency as psychological and not just as a social process (Pumariega *et al.*, 2005), with its respective consequences on mental health.

Taking into consideration this complex framework of socio-cultural and individual factors it is not surprising that, when trying to understand the details of immigrant mental health in terms of specific diagnosis and symptoms, results are often contradictory and context-dependent. For example, at the moment there is convincing proof regarding the particularly high frequency of schizophrenia and other types of psychosis in many immigrant populations of different origin (Cantor-Grae & Selten, 2005, Morgan *et al.,* 2010), but the same coherence is not observed in the case of mood disorders, whose incidence and prevalence among immigrants can be similar, higher or lower than the native population (Carta *et al,*, 2005; Swinnen & Selten, 2007). Missinne and Bracke (2010), analyzing data from 23 European countries, have concluded that immigrants and representatives of ethnic minorities show more depressive symptoms with respect to the native population in some but not all of the countries included in the study (16 out of the 23, with highest values observed in Switzerland, Norway and Spain). The most relevant vulnerability factors appeared to be socio-economic conditions and perceived ethnic discrimination.

Other than psychosis, mood disorders and PTSD and anxiety disorders (mostly studied on refugee groups), studies on specific diagnostic categories and their comorbidity are still quite rare, especially in European countries. In order to at least partially simplify the complex interaction between factors that modulate the subjective experience of migration, the present study focuses on one specific community: Romanians in Italy and their general mental health, compared to that of the population of origin and not to the host country and using a tool translated and validated in Romania. The study has two main objectives: 1) describing the most frequent Axis I symptoms and diagnostic categories within the sample and 2) exploring possible connections between symptom prevalence and some vulnerability/protective factors.

Method

Sample

Participants included 115 subjects, selected through advertising on social networks and mailing lists belonging to Romanian associations in Italy. The sample consisted of 29 (25.2%) males and 86 females (74.8%), with a mean age of 42 (SD=9.44). All subjects were of age, residents in Italy (average of 11 years of residency in Italy) and of Romanian ethnicity. Education level was very high: 38.3% (n=44) had finished high school, while 58.3% (n=67) had a university or post-university degree. 62.5 % (n=70) affirmed they had a very good knowledge of the Italian language.

Measures

The *Psychiatric Diagnostic Screening Questionnaire* (PDSQ) is a self-report measure to screen for the most common Axis I (following DSM-IV criteria – DSM-IV-TR, 2000) psychiatric disorders. The questionnaire evaluates 13 different disorders divided across 6 domains: eating disorders (bulimia/binge eating), mood disorders (major depression, dysthymic disorder), anxiety disorders (panic, agoraphobia, PTSD, obsessive-compulsive disorder, generalized anxiety and social phobia), substance abuse/dependence (alcohol and drugs), somatoform (somatization and hypochondriasis) and psychosis. Each item is dichotomously rated (yes/no), corresponding to a 1/0 score.

The test requires 15/20 minutes for its compilation. Other than the specific scores for the 13 cited disorders, the 125 items can be summed to obtain a Total Score which can be used a general pathology indicator. Six items from the Major Depression scale indicate the presence of suicidal ideation. For this study, a version translated and standardized for the Romanian population was used (Ciuca *et al.*, 2011), in an online version.

The choice for this particular tool is based on two main reasons, other than its good internal consistency, reliability and validity (Ciuca *et al.*, 2011): the necessity of using a test that has been translated and standardized on the Romanian and not on the Italian population, in order to reduce errors due to linguistic and cultural variables and to allow a comparison with the population of origin; and the possibility of evaluating comorbidity on Axis I, a very important aspect when studying disorders on different cultures, where depressive and anxiety disorders might present themselves in different symptom combinations.

After the PDSQ, the participants had to answer a series of questions related to possible protection/vulnerability factors: length of their stay in Italy, language proficiency, current occupation and work satisfaction, connection with the Romanian community in Italy and perceived discrimination.

Limitations

Both the sampling method and the chosen screening tool have set certain limitations to the interpretation of our data. First of all, sample self-selection has probably led to an increase in symptom frequency and intensity. Furthermore, the online administration might have caused the exclusion of subjects who have no internet access and the selection of subjects with a higher education and/or a better socio-economic situation. The choice of the PDSQ as a screening tool has the advantage of speed and comorbidity evaluation, but it can only offer diagnostic indications in terms of probability and cannot substitute more detailed clinical interviews.

Statistical Analyses

The analyses performed on the available data tried to answer the following three questions: (1) *What is the psychological condition of subjects within the studied sample, described in terms of Axis I symptom prevalence, when compared to the population of origin?* (2) *Hypothesizing a diagnostic category for each participant, are there specific Axis I disorders that are more frequent or which deserve particular attention?* (3) *Is there a connection between the general psychopathology score/the presence of a specific disorder and demographic variables (sex, age, years since immigration) or immigration factors (language proficiency, connection with other Romanians abroad, perceived discrimination or workplace satisfaction)?*

In order to provide an answer to these questions, for each subject a Total PDSQ Score was calculated and transformed in T points. The probability of a specific diagnosis was obtained by calculating the score for each one of the 13 subscales, accompanied by the recommended cut-off scores. Based on the type of variable examined, Odd Ratios (OR), t-tests or chi-square test were used as appropriate, in order to explore the connection between global and subscale scores and demographic variables and possible vulnerability/protection factors.

Results

General psychopathology index

The Global PDSQ Score is based on the total number of psychiatric symptoms described by the patient and is the only score which allows a statistical comparison with a standard patient from a psychiatric ambulatory in Romania. A score between 40 and 60T indicated the presence of psychopathology and distress similar to the average of Romanian psychiatric patients, while scores between 60 and 70T are

rare and describe subjects with multiple psychiatric diagnoses (Ciuca, 2010). Within our sample, 39% obtained a score under 40T (n=42), 52% obtained a score between 40 and 60T (n=56) and 9% (n=10) reported a total score higher than 60T. Three subjects obtained scores higher than 70T, indicated by the PDSQ manual as a possible symptom exaggeration and were excluded from the analysis. Five more subjects were eliminated due to incomplete data, for a total of 107 subjects included in the final analysis. The results indicate that the majority of the participants in this study appear to have a rather high level of psychological distress, similar to that described by psychiatric patients in Romania.

Prevalence of Axis I disorders

The scores for each subscale are based on DSM-IV criteria and indicate the probability that the patient may be included in a specific diagnostic category. The authors of the Romanian version recommend a cut-off score for each subscale, indicating the scores with the smaller risk of producing false negatives. This preference has lead to a higher sensitivity than specificity of the cut-off scores for single subscales.

The following tables shows, for each subscale, the percentage of subjects who have obtained scores above the recommended cut-off, together with the cut-off point and its positive predictive value. The positive predictive value is the probability, as calculated by the test's authors, that a patient with a score higher than cut-off will actually be diagnosed with that disorder.

Table 1. Section point and percentage of subjects with scores superior to cut-off for single subscale

PDSQ subscale	Scores above recommended section point (%)	Section point	Positive predictive value (%)
Major depression	30.8	9	74
PTSD	31.8	5	22
Eating disorders	9.35	7	25
DOC	45.8	1	22
Panic	17.8	4	38
Agoraphobia	13.1	4	36
Social phobia	30.8	4	48
Alcohol abuse/dependence	22.4	1	27
Substance abuse/dependence	16.8	1	18
GAD	32.7	7	27
Somatization	35.5	2	6
Hypochondriasis	29	1	4
Psychosis	38.3	1	14

Within the sample, disorders for which scores were more frequently above cut-off were Obsessive-compulsive disorder (45.8%, n=49), Psychosis (38.3%, n=41), Somatisation (35.5%, n=38), Generalized Anxiety (32.7%, n=35), PTSD (31.8%, n=34), Major Depression (30.8%, n=33) and Social Phobia (30.8%, n=33).

Comorbidity between axis I disorders

Comorbidity (the number of subscales for which a subject has obtained higher than cut-off scores) varies with the Global Pathology Index: the higher the total score, the higher the number of subscales with above cut-off scores (Table 2). All the subscales are moderately correlated with the Total Score, except for Alcohol Abuse.

Table 2. Average number of scales above cut-off and Total Score

Total Score (T)	Average number of scales with above cut-off scores
<40	1
40-60	4,7
>60	10

Vulnerability/Protective factors

Demographical variables: Among the 13 PDSQ subscales, sex is only correlated with the Alcohol abuse subscale (chi square=30.144, df=5. p<0.001), with men appearing to have a higher probability of obtaining higher scores. Age does not seem to be correlated with the total number of symptoms and, among the various subscales, is only significant for Social Phobia, with higher scores for younger participants (r=-0.324, df=103, p<0.001).

Perceived discrimination: 69% of the participants has had the subjective perception, during their stay in Italy, of being discriminated based on their ethnicity. No correlation was observed between perceived discrimination and the total number of symptoms. On the other hand, having experienced discrimination increases the possibility of obtaining higher than cut-off scores for certain subscales (*Table 3*), in particular Social Phobia (OR=4.67, C.i. 1.49-14.68), Major Depression (OR=3.41, C.i. 1.18-9.85) and, less significant, PTSD (OR=2.73, C.i. 1.01-7.46) and Somatisation (OR=2.68, C.i. 1.03-6.95).

Table 3. Association between presence/absence of perceived discrimination and scores above section point for each subscale

PDSQ subscale	Odds ratio (OR)	95% CI	Significance
Major depression	3.41	1.18 to 9.85	P=0.0235*
PTSD	2.73	1.01 to 7.46	P = 0.0486*
Eating disorders	1.09	0.62 to 1.92	P = 0.1024
DOC	1.21	0.53 to 2.79	P = 0.6405
Panic	2.76	0.74 to 10.22	P = 0.1288
Agoraphobia	1.75	0.45 to 6.72	P = 0.4179
Social phobia	4.67	1.49 to 14.68	P = 0.0083*
Alcohol abuse/dependence	1.11	0.41 to 3	P = 0.8402
Substance abuse/dependence	0.87	0.3 to 2.56	P = 0.8019
GAD	2.26	0.87 to 5.9	P = 0.0950
Somatization	2.68	1.03 to 6.95	P = 0.0430*
Hypochondriasis	1.41	0.55 to 3.6	P = 0.4725
Psychosis	2.03	0.83 to 4.96	P = 0.1200

Language proficiency: Within our sample, an inferior knowledge of the Italian language was associated to a higher number of reported symptoms (r=-0.374, df=104, p<0.001) and thus to a more serious clinical condition. Looking at the single subscales, low language proficiency increases the probability to report clinical levels of depressive symptoms (Major Depression OR=4.09, C.i. 1.56-10.76) and anxiety (Agoraphobia OR=6.84. C.i 2.07-22.6; GAD OR=4.59 C.i. 1.74-12.15; Hypochondriasis OR=2.89, C.i. 1.1-7.54; Panic OR=3.49, C.i. 1.20-10.15; PTSD OR=4.9 C.i. 1.84-13.01) (*Table* 4).

Other immigration-related factors: The length of stay in Italy does not appear to have any correlation with the total number of reported symptoms, nor with the single subscales. The same can be said about the presence/absence of connections with other Romanians in Italy. Lack of satisfaction at work is associated only with higher levels of depression (OR=3.15, 95% CI 1.31-7.5).

Table 4. Association between low/high Italian language proficiency and above/below cut-off scores for single subscales

PDSQ subscale	Odds ratio (OR)	95% CI	Significance
Major depression	4.09	1.56 to 10.76	P = 0.0042*
PTSD	4.9	1.84 to 13.01	P = 0.0014*
Eating disorders	0.90	0.18 to 4.52	P = 0.8912
DOC	2.24	0.87to 5.77	P = 0.0940
Panic	3.49	1.20 to 10.15	P = 0.0217*
Agoraphobia	6.84	2.07 to 22.6	P = 0.0016*
Social phobia	1.58	0.60 to 4.13	P = 0.3514
Alcohol abuse/dependence	0.67	0.20 to 2.18	P = 0.4986
Substance abuse/dependence	1.49	0.47 to 4.74	P = 0.4942
GAD	4.59	1.74 to 12.15	P = 0.0021*
Somatization	1.19	0.46 to 3.1	P = 0.7109
Hypochondriasis	2.89	1.1 to 7.54	P = 0.0305*
Psychosis	2.55	1 to 6.54	P = 0.0510

Discussion

The present study aimed at examining the prevalence of Axis I symptoms and possible diagnostic categories, as described by DSM-IV criteria, in a sample of Romanian immigrants in Italy, and their association with certain factors of vulnerability/protection. Results show that Axis I symptoms were quite frequent in the studied sample. 61% of the subjects described psychiatric symptoms causing a level of distress similar or superior to that of the average Romanian clinical population. Caution is needed before extending these results to Romanian immigrants in Italy in general, considering that the sampling method might have brought a bias towards the self-selection of subjects with more serious clinical issues (Alshaikh *et al.*, 2014; Topolovec-Vranic, & Natarajan., 2016). On the other hand, the data offers us an interesting insight into the nature of the most common symptoms and diagnosis that we could encounter and their possible connection with a few selected vulnerability/protection factors. Estimated frequencies within the sample are higher for the following Axis I disorders: Obsessive-compulsive disorder (45.8%, n=49), Psychosis (38.3%, n=41), Somatisation

(35.5%, n=38), Generalized Anxiety (32.7%, n=35), PTSD (31.8%, n=34), Major Depression (30.8%, n=33) and Social Phobia (30.8%, n=33).

Data appears to confirm a significant presence of psychotic, depressive and anxiety symptoms, observed by many studies on immigrant of various origins (Hovey & Magana, 2000; Wittig *et al.*, 2008; Potochnick & Perreira, 2010; Bengi-Aslan, Verhulst & Crijnen, 2002; Beutel *et al.,* 2016).

The negative effect on mental health of risk factors such as the socio-economic situation and perceived discrimination - two especially relevant factors for immigrant populations - is well known in the literature (Pascoe & Richman, 2009; Berg *et al.*, 2011). The present study focuses on this second factor, perceived discrimination, confirming its role as a vulnerability factor for depression (Missinne & Bracke, 2010), PTSD and somatization (Paradies, *et al.*, 2015). Moreover, a strong correlation was observed between perceived discrimination and Social Phobia. Romanians in Italy have often found themselves at the center of mediatic attention and, considering that the questionnaire explored subjective perception of discrimination, it is plausible to hypothesize that the high frequency of this kind of symptoms might be connected to the fear of being negatively evaluated by Italians (Cionchin, 2009).

Another interesting piece of data, although difficult to interpret, is the particular type of anxiety symptoms reported and, in particular, we are referring to the prevalence of obsessive-compulsive and generalized anxiety symptoms. Further research, using more detailed diagnostic instruments, is needed in order to understand whether there actually is a specific vulnerability towards this kind of disorders within the examined population.

Low proficiency in the use of the Italian language appears to be a second risk factor connected to clinical levels of depression and anxiety, as well as a higher general pathology index. Again the result is not surprising, since language proficiency can be considered a proxy for measuring acculturation: language is an important aspect of ethnic identity and has often been used when measuring acculturation (Zane & Mark, 2003).

Conclusions

Few studies have focused on the mental health situation of Romanian immigrants in Italy, but this knowledge is essential when trying to provide adequate treatment and prevention measures for this group. Although the present study has significant limitations, it sketches a portrait of the typical Romanian patient seeking psychological help and suggests some of the critical aspects that might influence the course of the treatment. Further research on larger and more representative samples is needed in order to fully understand the epidemiology of

Axis I symptoms and disorders. While the vulnerability and protection factors here considered offer interesting insights, more detailed studies should analyze the acculturation process of Romanians in Italy, looking into other factors such as the role of family, personal coping strategies and post-immigration socio-economic conditions.

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