e-ISSN: 0976-822X, p-ISSN:2961-6042

Available online on http://www.ijcpr.com/

International Journal of Current Pharmaceutical Review and Research 2025; 17(8); 1454-1463

Original Research Article

The Silent Struggle: MIRAGE Study (MIRAGE = Mental Illness and Related Adversities in Global Emigrants)

D. Sunitha[1], Vishalakshi[2], Ch. V. N. Saritha[3], M. Sree Charitha[4], Vishnu Prasad P.[5]

[1]Associate Professor, Department of Psychiatry, Institute of Mental Health-Kadapa
[2]Assistant Professor, Department of Psychiatry, Institute of Mental Health-Kadapa
[3]Assistant Professor, Department of Psychiatry, Institute of Mental health-Kadapa
[4]Junior Resident, Department of Psychiatry, Institute of Mental Health-Kadapa
[5]Senior Resident, Department of Psychiatry, Institute of Mental Health-Kadapa

Received: 01-05-2025 / Revised: 15-06-2025 / Accepted: 21-07-2025
Corresponding author: Dr. Ch. V. N. Saritha[3]
Conflict of interest: Nil

Abstract

Background: Migration is a complex process often driven by the pursuit of better livelihood, financial stability, and improved opportunities. However, its hidden cost is frequently paid through mental health challenges. Emigrant workers, especially those in labor-intensive and low-income sectors, face significant psychological stressors such as cultural displacement, job insecurity, poor living conditions, and social isolation. Language barriers, cultural differences, and acculturation pressures further complicate their mental well-being. The MIRAGE study (Mental Illness and Related Adversities in Global Emigrants) investigates the prevalence of psychiatric disorders and assesses how stress impacts the quality of life among emigrant workers. These individuals often endure internalized and unspoken struggles—what we term a "silent struggle"—exacerbated by stigma, limited awareness, and inadequate mental health support. The aim of the study is to assess psychiatric morbidity, determine the prevalence of specific psychiatric disorders, and evaluate the impact of migration-related stress on the quality of life in emigrant workers.

Methodology: It is a hospital based cross sectional study conducted in Institute of mental health Kadapa, Andhra Pradesh. Sample size of the study is 60. The socio-demographic details of reverse migrants were noted down. Self-Reporting Questionnaire (SRQ) of the World Health Organization was used to determine the presence of a common mental disorder, Perceived stress scale assessment of distress. WHOQOL BREFfor quality -of -life assessment. MINI for diagnosis and Pittsburgh sleep quality indexfor sleep quality assessment

Results: A total of 60 emigrants were included in the study. The prevalence of major depressive disorder, alcohol use disorder, and generalized anxiety disorder are higher than general population. The prevalence of depressive disorder is highest with 55% that is 15 out of 60 participants. Nearly two-third (39) of study population experience moderate high perceived stress in perceived stress scale.55% of people participated in study have some level of psychological distress. In Pittsburgh sleep quality index overall quality of sleep is Poor in 22 individuals. Quality of life is impaired with psychological, physical and social domains taking major hits.

Conclusion: The study concludes that prevalence of major depressive disorder, alcohol use disorder and other psychiatric illness in emigrant population is significantly higher than the general population. They experience significant distress and poor quality of sleep resulting in an impaired quality of life.

Introduction

Migration, whether driven by economic, social, political, or medical reasons—can significantly impact mental health. The transition between cultural environments often leads to stress, shaped by challenges such as language barriers, cultural differences, acculturation pressures, and lack of social support. These factors affect migrants' adjustment and can trigger or worsen psychiatric conditions. The migration process involves multiple layers of loss—familiar surroundings, customs, and social networks—especially in cases of forced migration. According to the stress-diathesis model, such stress, combined with individual vulnerabilities, can precipitate disorders like depression and anxiety. Migrants may present symptoms differently, often with somatic complaints that can be missed if assessed using Western diagnostic frameworks. Studies have shown higher psychiatric hospital admission rates among certain migrant populations, influenced by culture shock, unmet expectations, and cultural

conflict. This underscores the need for culturally sensitive mental health care and interventions.

Several studies have examined the relationship between migration and psychiatric symptoms. Cochrane (1977) found that immigrants in England and Wales had nearly double the hospital admission rates for psychiatric conditions compared to the native population. This heightened vulnerability was attributed to multiple factors, including acculturative stress, social isolation, and socioeconomic challenges. Similar findings have been noted by Kuo (1976), who highlighted the role of social isolation and culture shock in causing psychological distress among migrants. He emphasized the need to understand the cultural and environmental challenges migrants face when assessing psychiatric symptoms.

Cultural factors play a significant role in the manifestation and reporting of psychiatric symptoms. Murphy et al. (1967) reported cross-cultural variations in depressive symptomatology, highlighting that symptoms such as fatigue, loss of appetite, and self-accusatory ideas differ in prevalence and presentation across cultures. This suggests that traditional Western diagnostic tools may not always accurately capture the psychiatric experiences of migrants. Jablensky et al. (1981) identified core depressive symptoms consistent across cultures but emphasized the importance of recognizing culturally specific expressions of distress.

Research also shows that cultural identity and acculturation levels influence mental health outcomes. Nazroo (1997) conducted a community-based study in Britain and found that depressive neurosis rates were higher among certain migrant groups, such as the Irish and African-Caribbean populations. However, rates among Indian and Pakistani migrants were relatively lower, and language fluency appeared to serve as a protective factor. These findings highlight the impact of acculturation and suggest that those who are more integrated into the host culture experience better mental health outcomes.

Additionally, the concept of culture shock has been widely explored. Oberg (1960) and later Furnham (1988) defined culture shock as a multifaceted stress response arising from exposure to a new culture, encompassing feelings of loss, confusion, and rejection. This can result in anxiety, depression, or apathy until the individual reaches a level of adjustment. For migrants, these experiences are compounded by the need to adapt to new societal norms, language, and expectations, which can exacerbate psychiatric symptoms. Babu, G. R., Jotheeswaran, A. T., Mahapatra, T., et al. (2019). Mental health issues among internal migrants in India: A comprehensive review, revealing high prevalence rates of depression (15-20%) and anxiety (10-15%) among migrant workers. Contributing factors included harsh working conditions, lack of job security, and poor living environments. The authors emphasized the need for policies that address the social determinants of health among internal migrants.

Kumar, S., & Kumar, N. (2021). Psychological distress among migrant laborers in Gujarat during the COVID-19 pandemic. It found that more than half of the respondents experienced high levels of stress and anxiety, driven by job losses, financial insecurity, and fear of infection. The study highlighted the importance of psychological support and social safety nets for vulnerable populations during crises.

Nair, M. K., & Jain, A. (2017). The prevalence of common mental disorders in urban migrant populations: A study from Kerala. Findings showed that nearly one-third of participants reported depressive symptoms, with significant associations found between psychiatric symptoms and factors like poor housing and lack of social integration. The authors called for improved housing policies and community-based mental health programs.

Overall, the literature emphasizes the need for culturally sensitive psychiatric assessments and interventions tailored to the unique experiences of migrants. There is a consensus that migration-related stressors, combined with individual vulnerability factors, play a crucial role in the development of psychiatric symptoms. The MIRAGE study (Mental Illness and Related Adversities in Global Emigrants) investigates the prevalence of psychiatric disorders and assesses how stress impacts the quality of life among emigrant workers. These individuals often endure internalized and unspoken struggles—what we term a “silent struggle”—exacerbated by stigma, limited awareness, and inadequate mental health support. The aim of the study is to assess psychiatric morbidity, determine the prevalence of specific psychiatric disorders, and evaluate the impact of migration-related stress on the quality of life in emigrant workers.

Material and Methods

It is a descriptive hospital based cross sectional study.

Source of data:

1. Patients and their attenders who attend psychiatry op.
2. People from neighborhood (door to door survey)

Sample size of 60 is considered based on the observation of number of emigrants attended

psychiatric OP in last year to Institute of mental health –Kadapa. The study duration is 6 months.

Sampling Criteria

Inclusion criteria:

- Subjects who are above 18 years and are both genders
- Subjects who are travelling abroad and those with history of travelling abroad.
- Subjects must be in abroad for a minimum duration of 6 months.
- Subjects who gave written informed consent.

Exclusion Criteria:

- Subjects with other comorbid general medical conditions requiring urgent medical attention.
- Subjects who are not willing to give written informed consent for the study.
- Subjects with acute psychotic episode where patient is not cooperative and lack insight.

Data Analysis: The data were pooledusing MS excel 2019 version and statistically analysed using IBM SPSS 26 Software. The socio demographic profile and the prevalence of the different symptoms of PCOS, anxiety, and depression have been expressed in terms of frequency.

Percentages and Chi-square tests were used for data analysis.

Results

Table 1: Sociodemographic Features

Demographic Variable		Frequency	Percentage
Age (>18 Yrs Age)		**Mean Age: 41.65 +/- 8.7**	
Gender	Male	40	66.7
	Female	20	33.3
Address	Rural	32	53.3
	Semi Urban	24	40.0
	Urban	4	6.7
Occupation	Chef	3	5
	Daily Labour	16	26.7
	Driver	11	18.3
	Employee	14	23.3
	Maid	5	8.3
	Student	11	18.3
Socio Economic Status	Lower Class	12	20.0
	Lower Middle	34	56.7
	Upper Class	6	10.0
	Upper Middle	8	13.3
Religion	Christian	13	21.7
	Hindhu	17	28.3
	Muslim	30	50.0
Reason For Returning India	Attending Function/ Cremation	4	6.7
	Settle Down In Native Place	13	21.7
	Visiting Family Members	43	71.7
Abroad Place	China	3	5.0
	Dubai	14	23.3
	Kuwait	32	53.3
	Usa	11	18.3

The demographic characteristics of the study participants indicate a mean age of 41.65 years with a standard deviation of ±8.7, suggesting that the population predominantly consisted of middle-aged adults. In terms of gender distribution, 66.7% (n=40) were male and 33.3% (n=20) were female, highlighting a male-dominant sample. When considering the residential background, the majority of participants came from rural areas (53.3%), followed by semi-urban residents (40%), and a small proportion from urban settings (6.7%). The occupational status of the respondents varied, with daily labourers forming the largest group (26.7%), followed by employees (23.3%), and both drivers and students accounting for 18.3% each. A smaller proportion worked as maids (8.3%) and chefs (5%), indicating a broad representation of semi-skilled and unskilled labour backgrounds. In terms of socioeconomic status, more than half (56.7%) of the respondents belonged to the lower-middle class, while 20% were from the lower class, 13.3% from the upper-middle class, and only 10% were in the upper class, reflecting a predominantly modest economic background. The religious

composition showed that half of the participants were Muslim (50%), followed by Hindus (28.3%) and Christians (21.7%). When asked about the reason for returning to India, a majority (71.7%) reported visiting family members, followed by 21.7% who intended to settle down in their native place, and a smaller group (6.7%) returned for attending functions or cremation ceremonies. Regarding their country of residence abroad, over half the participants (53.3%) had lived in Kuwait, while others had returned from Dubai (23.3%), the USA (18.3%), and China (5%), indicating that the sample had significant exposure to Gulf and Western countries.

Table 2: Clinical History

Variable		Frequency	Percentage
Family H/O Of Psychiatric Illness	No	75.0	75.0
	YES	25.0	25.0
Medical Illness/ Comorbidity	Dm	7	11.7`
	HTN	9	15
	HTN+DM	4	6.7
	NO	40	66.7
Any Dissatisfaction in Life Regarding	Family	14	23.3
	No	28	46.7
	Relationship	9	15.01
	Work	9	5.0
Have You Ever Felt Isolated from Your Peer / Family	No	38	63.3
	Yes	22	36.7
Haveyou Ever Felt That Suicide Might Be Answer To the Situation You Have Faced	No	49	81.71
	Yes	11	8.3

Participants, 25% reported a positive family history of psychiatric illness, while the majority (75%) did not report any such history, indicating that most of the respondents were not genetically predisposed to psychiatric conditions.

When evaluating medical comorbidities, 11.7% had diabetes mellitus (DM), 15% had hypertension (HTN), and 6.7% had both HTN and DM, while a significant majority (66.7%) reported no existing medical illnesses, suggesting relatively good physical health in two-thirds of the study group.

In terms of life dissatisfaction, nearly half of the participants (46.7%) reported no dissatisfaction, while 23.3% expressed dissatisfaction related to family, 15.01% with relationships, and 5% related to their work environment, indicating that family-related concerns were the most prominent source of dissatisfaction among those who reported any. Social and emotional well-being was further assessed by asking participants if they had ever felt isolated from their peers or family. While 63.3% denied experiencing isolation, a notable 36.7% acknowledged feeling isolated, highlighting the presence of social disconnection in more than one-third of the sample. When asked about suicidal ideation, 81.7% denied ever feeling that suicide could be a solution to the problems they faced, whereas 18.3% affirmed having such thoughts, pointing to a concerning level of psychological distress among a small but significant portion of the participants.

Table 3:

Variable		Frequency	Percentage
Reason For Travelling Abroad	Higher Studies	11	18.3
	Job	49	81.7
Accommodation In Abroad	Own	24	40.0
	Provided By Company	36	60.0
Financial Aid	Loan	21	35
	Self	23	38.3
	Sponsored	6	26.7
Language Proficiency of The Place Travelling / Abroad	Good	29	48.3
	Poor	24	40.0
	Very Good	7	11.7

Among the study participants, the primary reason for travelling abroad was overwhelmingly job-related, with 81.7% (n=49) of individuals migrating for employment opportunities, while a smaller proportion, 18.3% (n=11), travelled for higher studies, indicating economic motives as the dominant driver of migration. With regard to accommodation arrangements while abroad, 60%

(n=36) had their housing provided by the company, whereas 40% (n=24) arranged their own accommodation, reflecting varying levels of institutional support. When examining sources of financial aid, 38.3% (n=23) were self-financed, 35% (n=21) relied on loans, and 26.7% (n=16) were sponsored, showing a fairly balanced distribution among different financial support methods, though self-funding was slightly more common. Concerning language proficiency in the host country, 48.3% (n=29) rated their proficiency as good, 40% (n=24) reported poor proficiency, and only 11.7% (n=7) rated their skills as very good. This data indicates that a significant number of participants faced moderate to major language barriers while abroad, which could have had implications for their social integration and mental well-being.

Psychiatric morbidity among emigrants: The emigrants were initially assessed with subjective awareness of distress they are experiencing with the self-reporting questionnaire (neurotic symptoms) the outcome shows 33 (55%) having distress of some level, with mild being more common, which is shown the fig 1.

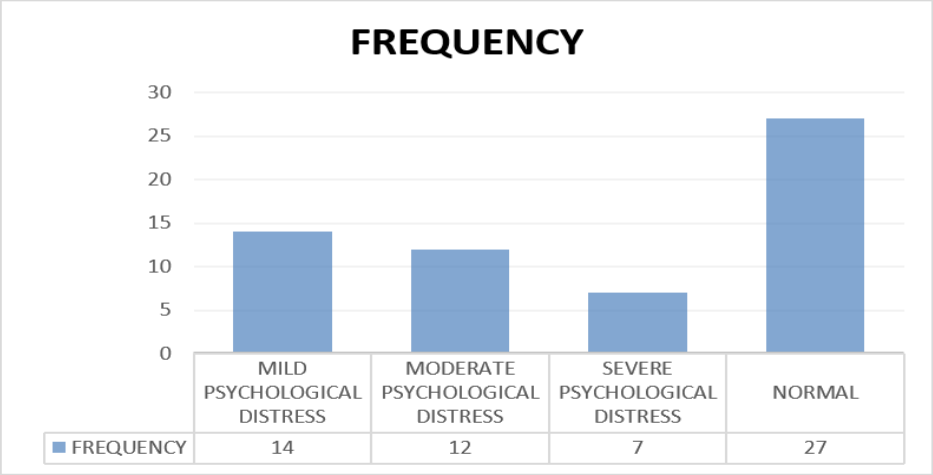


Figure 1: Frequency of Psychological Stress

Perceived stress scale was used to assess the stress they experienced which can be attributed to environmental factors in the abroad. 2/3rd of the subjects experienced moderate to severe stress. As shown in the fig 2 pie chart.

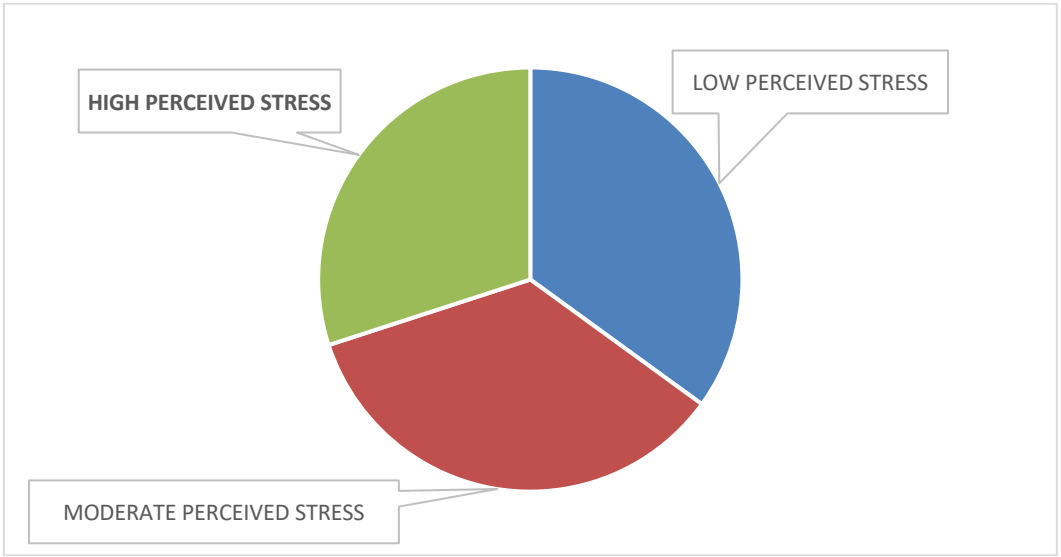


Figure 2: Pie Chart of Perceived Stress

Diagnostic evaluation using the MINI interview identified major depressive episodes in 25% of the participants, alcohol use disorder in 13.3%, bipolar affective disorder (BPAD) and generalized anxiety disorder (GAD) in 11.7% each, PTSD and social phobia in 6.7% each, and dysthymia in 3.3%. Only 1.7% each were found to have psychotic syndrome and mood disorder with psychotic features, and 18.3% were free from any psychiatric morbidity (Figure 3)

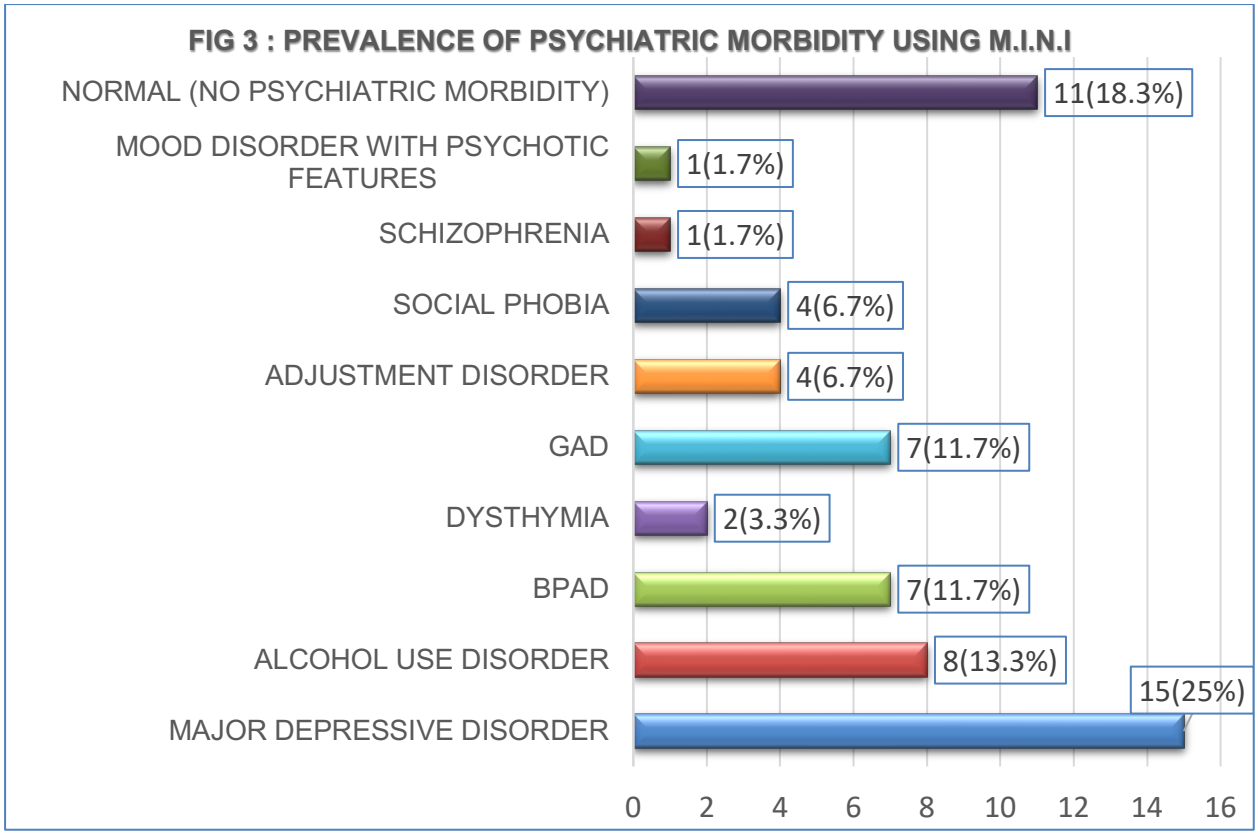
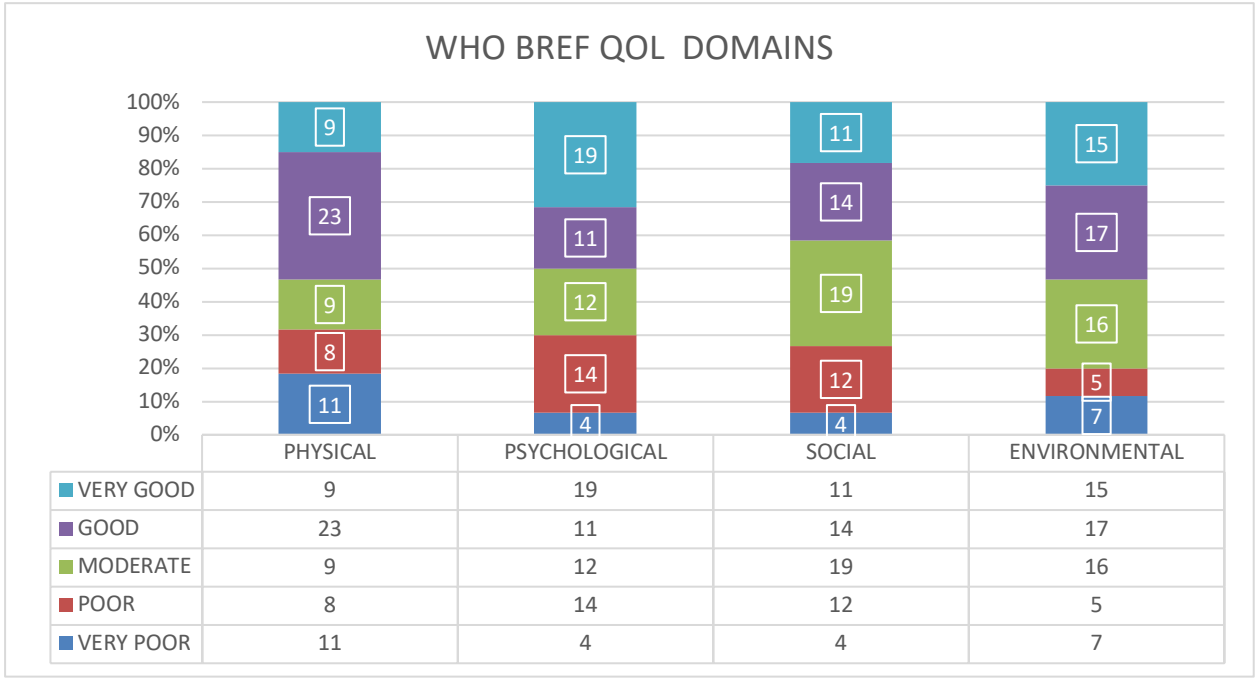


Figure 3: Prevalence of Psychiatric Morbidity Using M.I.N.I

Quality Of Life of emigrants is assessed using Who BREF QOL, which reflects 4 domains physical, psychological, social, environmental. Higher the transformed score better the quality of life. The following image shows the transformed score in the current study, among the 60 subjects 25 to 32 subjects were good and very good. 19 subjects noted poor and very poor QOL, 18 subjects in psychological, 16 in social and 12 in environmental domains.

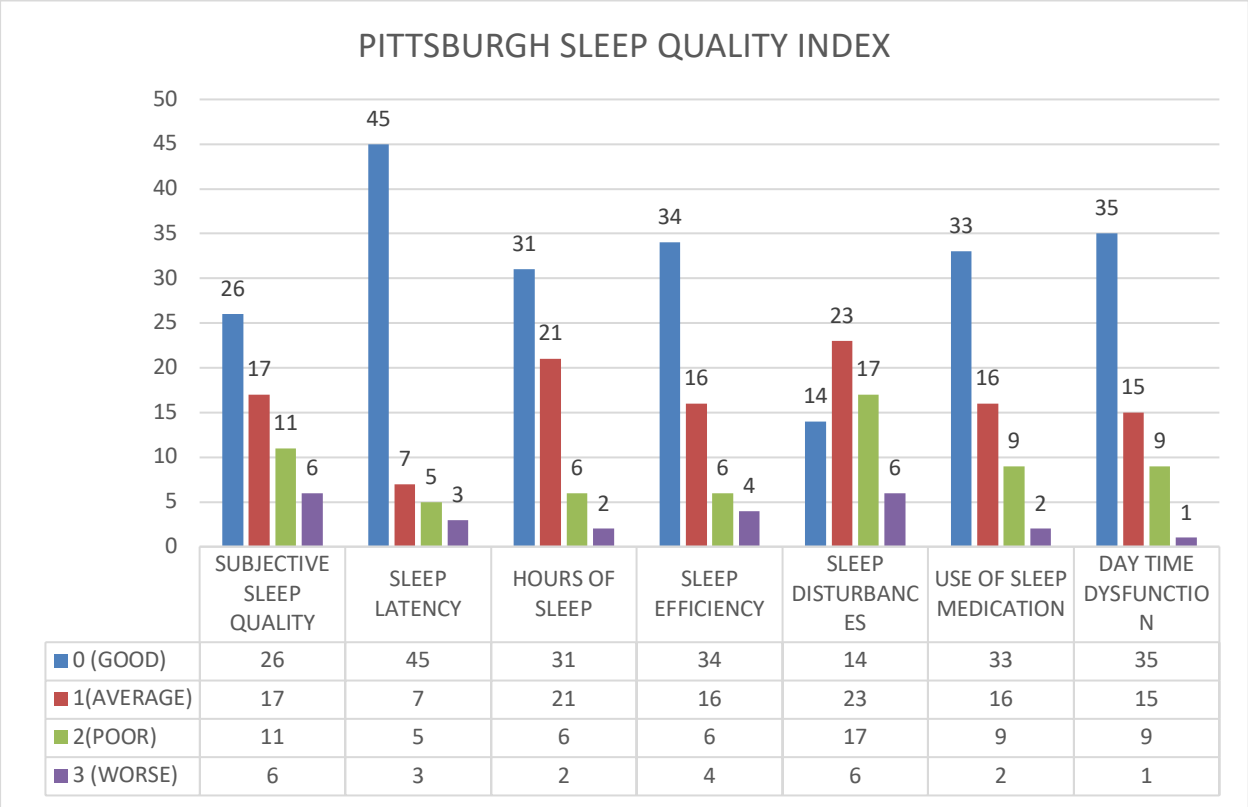
Which shows the accommodation, work environment was good and satisfactory (Figure 4).



	PHYSICAL	PSYCHOLOGICAL	SOCIAL	ENVIRONMENTAL
VERY GOOD	9	19	11	15
GOOD	23	11	14	17
MODERATE	9	12	19	16
POOR	8	14	12	5
VERY POOR	11	4	4	7

Figure 4: Who Quality Of Life Graph

Since sleep quality was not assessed with MINI, PSQI used to identify the sleep quality. Sleep quality as measured by the Pittsburgh Sleep Quality Index (PSQI) was further broken down into components. Most participants had good subjective sleep quality (43.3% scored 0), and 75% had minimal sleep latency. The majority reported adequate hours of sleep and sleep efficiency. However, sleep disturbances and daytime dysfunction were observed in several cases, and 45% had used sleep medication at least occasionally. Overall, 63.3% were found to have good sleep quality, while 36.7% had poor sleep quality (FIGURE 5)



	SUBJECTIVE SLEEP QUALITY	SLEEP LATENCY	HOURS OF SLEEP	SLEEP EFFICIENCY	SLEEP DISTURBANCES	USE OF SLEEP MEDICATION	DAY TIME DYSFUNCTION
0 (GOOD)	26	45	31	34	14	33	35
1(AVERAGE)	17	7	21	16	23	16	15
2(POOR)	11	5	6	6	17	9	9
3 (WORSE)	6	3	2	4	6	2	1

Figure 5: Pittsburgh Sleep Quality Index

Cross Tabs SRQ and PSS: The relationship between psychological distress (as measured by the Self-Reporting Questionnaire) and perceived stress levels (as measured by the Perceived Stress Scale) among the participants. Among those with mild psychological distress (n=14), 5 individuals experienced high perceived stress, another 5 had moderate perceived stress, and 4 reported low perceived stress. In the moderate psychological distress group (n=12), 6 participants reported high stress, 4 had moderate stress, and 2 experienced low stress. Interestingly, all 7 individuals with severe psychological distress were found to have high perceived stress, indicating a strong association between the severity of psychological symptoms and elevated stress perception. In contrast, those who were classified as psychologically normal on the SRQ (n=27) exhibited a different pattern. None of them reported high perceived stress; instead, 12 had moderate levels of perceived stress, while 15 reported low stress. This distribution suggests that individuals with no evident psychological distress tend to perceive less stress in their daily lives.

Overall, the findings highlight that while perceived stress levels vary across different degrees of psychological distress, high stress is predominantly seen in those with moderate to severe psychological symptoms. This suggests that assessing both psychological symptoms and perceived stress may offer a more comprehensive understanding of an individual's mental health, especially for early identification and intervention in high-risk groups.

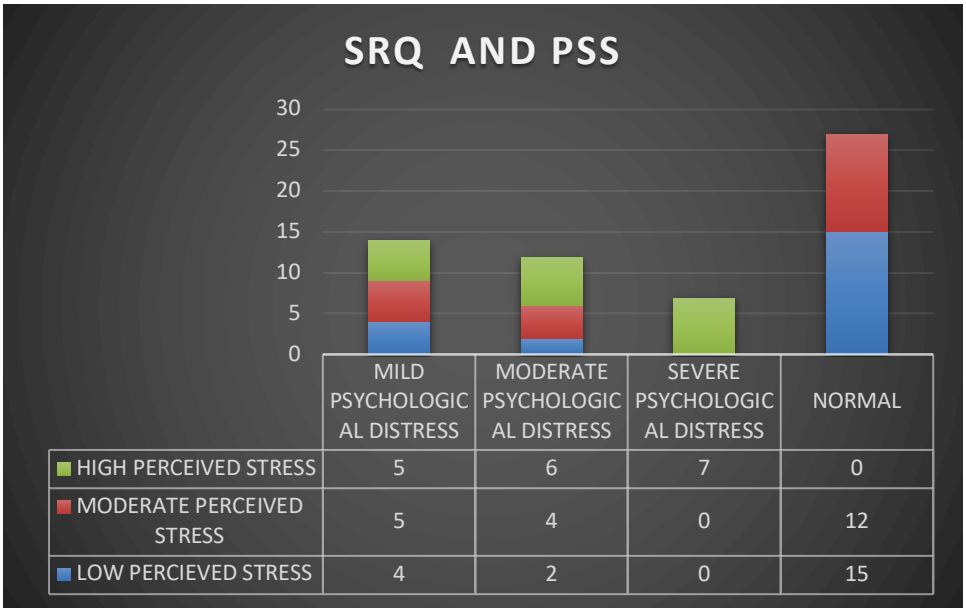


Figure 6: cross TABS SRQ AND PSS

Discussion

The present study found a notably high prevalence of psychological issues among participants, with 65% experiencing perceived stress, 31.6% reporting psychological distress, and 25% diagnosed with major depressive disorder (MDD). These findings are consistent with previous literature, including the systematic review and meta-analysis by Hasa Si et al., 2021, which reported an overall prevalence of depression (38.99%) and anxiety (27.31%) among migrant workers across 17 countries. The observed rates of depression (25%) and generalized anxiety disorder (11.7%) are relatively comparable to the global estimates in that population. However, the prevalence of dysthymia (33%) and psychological distress (31.6%) in our sample suggests a potentially higher burden of chronic and subclinical mental health conditions, which may be underrepresented in broader epidemiological studies.

Our study identified a considerable burden of mental health concerns among participants, with 65% experiencing moderate and severe perceived stress, 31.6% reporting psychological distress and sleep disturbances in 36.6%. In contrast, the BJSQ and K6-based study by Sindhu Thankachen et al in Ireland through social media reported moderate to high job stressors but surprisingly low stress responses and low psychological distress (K6 mean = 7.2), suggesting a discrepancy between external stress exposure and subjective emotional impact in that sample.

This contrast is particularly noteworthy considering that both groups were exposed to work-related and psychosocial stressors, yet the internal psychological responses varied. In our study, high levels of psychological morbidity (including 33% dysthymia and 11.7% GAD) indicate a more clinically significant impact of stress exposure. Conversely, despite high physical workloads (mean 3.08/4) and demanding job conditions (e.g., quantitative overload: 8.7/12, mental demands: 10.45/12), the BJSQ respondents showed relatively low levels of anxiety, irritability, depression, and lack of Vigor, suggesting potential coping mechanisms, adaptation, or underreporting due to cultural or contextual factors as target sample is health care workers.

One key difference lies in perceived social support. Both studies reported poor workplace social support, particularly from supervisors and co-workers. However, the BJSQ study indicated relatively higher support from family and friends, which may serve as a buffer against psychological symptoms. In contrast, our findings emphasized quality-of-life impairments across all domains, particularly social (58.3%) and psychological (50%), suggesting that social isolation or insufficient external support systems may have amplified the psychological burden in our sample.

The assessment of Quality of Life (QoL) using the WHOQOL domains in our study revealed that a significant proportion of participants experienced reduced well-being across all areas. Specifically, 46.6% of respondents reported poor QoL in the physical domain, 50% in the psychological domain, 58.3% in the social domain, and 46.6% in the environmental domain. These findings point to a broad-based compromise in quality of life among the surveyed population.

In comparison, the Kerala-based study by Jineesh Cyriac on North Indian migrant workers provides mean scores for each QoL domain rather than

prevalence percentages. Using percentile interpretations provided in that study (25% = poor, 50% = moderate, 75% = good), the average QoL levels were as follows: Physical health: Mean = 21.3 → Moderate (50th percentile); Psychological health: Mean = 15.7 → Below moderate; Social relationships: Mean = 7.6 → Moderate; Environment: Mean = 21.3 → Moderate. These results indicate moderate QoL in most domains among Kerala-based migrants, with the psychological domain falling below moderate, signalling greater emotional and mental health strain. Both studies highlight psychological health as a vulnerable domain. In our study, half of the participants had poor psychological QoL; similarly, the Kerala study rated psychological QoL below moderate. Social relationships were more negatively impacted in our sample, with 58.3% reporting poor QoL, while Kerala migrants scored in the moderate range. This may be explained by Kerala migrants' higher likelihood of living with friends and relatives (61.3%), potentially providing emotional and social buffers. Both studies report similar environmental and physical QoL levels—rated as moderate or near the 50th percentile, though our study highlights a larger proportion experiencing poor outcomes in these domains, possibly reflecting worse housing conditions, access to basic services, or greater job-related physical strain.

In our study 36.6% reported sleep disturbances, and significant impairments were observed across all domains of quality of life, especially in the social (58.3%) and psychological (50%) domains. In comparison, the SRQ-20-based study by Sudhir Babu Sriramalu et al showed similarly high levels of psychological distress: 64% of respondents scored ≥8, a threshold indicating a need for psychosocial care. Item-wise analysis revealed that: 83% reported feeling unhappy and nervous,75% had sleep disturbances,71% had trouble thinking, and39% had suicidal thoughts. These figures reinforce the findings of our study and further highlight the psychological vulnerability of migrant worker populations. Both studies reveal overlapping symptoms, especially emotional dysregulation, fatigue, cognitive strain, and somatic complaints, underlining the multidimensional impact of stress and socio-economic adversity on mental health.

Notably, sleep disturbances were higher in the SRQ-20 study (75%) than in our sample (36.6%), suggesting possibly more acute distress or different living/workplace conditions. Similarly, loss of interest (65%), decision-making difficulty (64%), and poor appetite (60%) were highly prevalent in that group, aligning with the 25% MDD and 33% dysthymia in our study, which reflect clinical thresholds of depressive disorders

In comparison to the study done by Rock B Et al in Bangalore urban District, Karnataka, India where 21% of migrant workers reported alcohol use, with 4% engaging in abuse, 2% experiencing withdrawal symptoms, and 1% suffering from alcohol dependence, the present study identified 13.3% of participants meeting the diagnostic criteria for Alcohol Use Disorder as per the MINI interview. While the overall prevalence appears slightly lower in our sample, the clinical identification through standardized diagnostic tools likely reflects a more accurate and conservative estimate of comorbid alcohol-related disorders. Moreover, the reference study observed a significant association between mental morbidity symptoms (MMS) and alcohol misuse patterns, a trend that aligns with our findings where alcohol use disorder frequently coexisted with major depressive episodes, generalized anxiety disorder, and other psychiatric conditions. This highlights the intricate interplay between alcohol use and mental health in migrant populations, underscoring the need for integrated screening and treatment approaches in this vulnerable group

Conclusion

The MIRAGE study highlights the significant burden of psychiatric morbidity among emigrant workers, with depression being the most prevalent condition, followed by alcohol use disorder, bipolar affective disorder, schizophrenia, and other psychiatric illnesses. Perceived stress levels were notably higher among individuals experiencing family dissatisfaction and social isolation. Of the 60 subjects studied, 32 reported dissatisfactions in life, with 43–56% (14–18 individuals) within this subgroup exhibiting psychiatric symptoms. Quality of life (QOL) was found to be moderate to very poor across all domains, underscoring the profound impact of emotional dissatisfaction, lack of social support, language barriers, and financial strain on mental health outcomes.

These findings emphasize that migration is not only a physical or economic journey but also a deeply psychological one. The silent struggle faced by many migrants calls for urgent and culturally sensitive mental health interventions. Improving access to mental health services, promoting language and social integration programs, strengthening family and peer support systems, and reducing stigma through awareness initiatives are essential steps to mitigate psychiatric morbidity and enhance quality of life among emigrant populations.

Strengths: The MIRAGE study is one-of-a-kind study where we comprehensively assessed the subjective stress and diagnosed psychiatric morbidity with clinician rated, covering both point of views. Since the subjects in the place of study

were more frequently traveling abroad and more frequently to middle east countries for work purpose will give more insight in to the stress and its impact on QOL. Standardized, validated tools and cross-tabulated stress/distress correlations provide robust insight.

Limitations: There are some limitations in the current study as it covers small population and didn't consider nature of work, duration of work and workplace amenities and availability of health services which will limit the strength of the study. Most of the psychometric assessment done was self-rated so bias was seen in some questions like "reason for returning from abroad.?' The bias is due to stigma of fear of being labelled with mental illness, hence such variables were removed, even though some bias may exist.

Future directions: By considering additional parameters related to work nature, duration of work, workplace amenities and health services would give more insight in to QOL emigrants facing. Behavior of peers, locals in the abroad will give more insight in to social adaptation of migrated workers.

Acknowledgement: We are thankful to our Head of department, principal, superintendent, and member secretary of the institutional ethics committee. We are thankful to all patients who participated in this study for their kind cooperation.

References

1. Myrna M. Weissman, Ph.D., Gerald L. Klerman, M.D., Jeffrey S. Markowitz, Ph.D., and Robert Ouellette, M. Phil. Suicidal Ideation and Suicide Attempts in Panic Disorder and attacks list of authors.November2, 1989N Engl J Med 1989; 321:12091214DOI:10.1056/NEJM198911023211801
2. Jitender Sareen, MD, FRCPC; Brian J. Cox, PhD; Tracie O. Afifi, MSc; et alron de Graaf, PhD; Gordon J. G. Asmundson, PhD; Margreet ten Have, PhD; Murray B. Stein, MD, MPH Anxiety Disorders and Risk for Suicidal Ideation and Suicide Attempts Population-Based Longitudinal Study of AdultsArch Gen Psychiatry. 2005; 62(11):1249, 125. doi:10.1001/archpsyc.62.11.1249.
3. Joseph M. Boden, David M. Fergusson and L. John Horwood. Anxiety disorders and suicidal behaviours in adolescence and young adulthood: findings from a longitudinal study published online by Cambridge University Press: 17 November 2006.
4. Hawgood, Jacinta; De Leo, Diego Anxiety disorders and suicidal behaviour: an update January 2008 - Volume 21 - Issue 1 - p 51–64doi: 10.1097/YCO.0b013e3282f2309d.
5. Hasan SI, Yee A, Rinaldi A, Azham AA, Mohd Hairi F, Amer Nordin AS. Prevalence of common mental health issues among migrant workers: A systematic review and meta-analysis. PLoS One. 2021; 16(12):e0260221.
6. Thankachen S, et al. Occupational stress and mental health among migrant healthcare workers in Ireland. J Migr Health. 2025; 11:100325.
7. Mucci F, et al. Migrant Workers and Psychological Health: A Systematic Review. Sustainability (Basel). 2020; 12(1):120.
8. (Hopkins Checklist subset in Hasan et al. above).
9. Zhao X, et al. Reliability and validity of the Defeat Scale among internal migrant workers in China. 2022.
10. Wu Q, Yamaguchi Y, Greiner C. Factor's related to mental health of foreign care workers in Japan during COVID-19. Int J Environ Res Public Health. 2022; 19(24): 16491.
11. Cho HJ, Kang K, Park KY. Health-related quality of life of migrant workers: A systematic literature review. BMC Public Health. 2023; 23:1004.
12. Henderson S, et al. Development and validation of STAR-MH screening tool for asylum-seekers. BMC Psychiatry. 2018; 18: 1660.
13. Nguyen T, et al. The mental health of migrants living in limbo: A mixed-methods systematic review. Psychiat Res. 2024.
14. Marchi M, et al. bridging the gap: Interventions to address barriers in migrant mental health care access. Psychiatry Int. 2024; 5(4):883-903.