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Mental Disorders in Iranian and Afghan Immigrant Women: the impact of acculturation

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ABSTRACT

Background: There are many mental health challenges associated with immigration. Culture has a notable impact on the mental health of immigrants. The inability to adapt to the new culture is effective in developing mental health problems. Acculturation is a dynamic process that involves multiple aspects of adjustment to a new environment. Various acculturation levels and processes are associated with mental health problems. However, this association is complex and can vary for different groups of migrants. The primary goal of the present study was to study the relationship between acculturation and mental health among Afghan immigrant women compared to Iranian women.

Methods: The study included about 400 immigrant Iranian and Afghan women. Participants answered questions regarding age, marital status, education, occupation, religion, length of stay in Iran (in the Afghan participants), study in Iranian schools (in the Afghan participants) and the neighborhood characteristics where you live (with a majority of Iranian neighbors, a majority of Afghan neighbors and an equal population of both) and economic status. Information about mental health status and acculturation was also obtained through a self-administered questionnaire.

Results: The severity of mental illness among the three groups of Iranians, Afghans with low acculturation, and Afghans with high acculturation was significantly different ($0 < 0.001$). While mental disorders among Afghan women with high and low acculturation differed, this difference was not statistically significant. Some of the demographic features, such as widowhood, neighborhood features, socioeconomic status, and religion, had affected mental disorders in the two acculturated groups.

Conclusion: In societies with strong cultural similarities, individual factors and ethnic solidarity seem to be more crucial to the mental health of immigrants.

Keywords: Immigrant, Afghan, Iranian, Women, Mental disorder, Acculturation

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Introduction

Humans frequently migrate because of repulsions, such as poverty, illness, political problems, food shortages, natural disasters, war, and insecurity. Other reasons for migration may be better attractions, such as health, economic, political, and social conditions. Migration is not just a geographic transfer; it is also a psychological and social issue. Immigration and certain economic and sociocultural factors may be risk factors for mental illness, particularly in the context of lower socioeconomic status and poor residency state, such as conditions of refugee claimants (1-3). Mental health is a state of well-being in which a person realizes his or her capacities, can adapt to the ordinary stresses of life, can work beneficially and is able to create a commitment to his or her community (2).

Difficult conditions before and during migration can lead to feelings of helplessness, frustration, depression, substance abuse, suicidal ideation, behavioral problems and other mental health issues (4-7). The issues associated with accepting the features of the new culture can exacerbate mental health problems and make them more severe and complex (7-9). Once immigrants enter a foreign society, they are also confronted with problems such as housing, individual prejudice, discrimination and racism (4-5).

Afghanistan has been suffering decades of war, civil strife, and terrorist attacks that have led to the exodus of many people. The existence of such accidents has compromised the mental health of afghan people. According to the Afghan National Health Survey, in 2018, over 66 percent of Afghans experienced at least one traumatic experience. More than 77 percent participated in one or more of these events (10). Studies indicate that psychological problems are widespread among Afghan refugees and Middle Eastern refugee groups and are characterized by depression, anxiety, and dysphoria (11-14). After migration, social networks will change, and socioeconomic and cultural systems will transform into another system (15, 16). The suspension between the two cultures, which results from an incomplete disconnect from the original culture and a complete incompatibility with the host society's culture, puts much psychological pressure on immigrants (17, 18). Acculturation is a dynamic process experienced among groups and individuals facing cultural change and a new culture (17, 19, 20). The relationship between acculturation and mental health issues depends on the demographic, cultural, and social characteristics (11, 19, 21). Korean and Muslim immigrants with low western acculturation in the US reported higher rates of depression (12). While Latin American immigrants, who were more prone to the American culture of origin, had more depressive symptoms in the new society than those in their native culture (21- 23). Different acculturation styles lead to intergenerational misunderstandings, identity challenges, family conflicts, loss of communication, change of role, and isolation (24, 25). Cultural and linguistic barriers also impact the capacity of asylum seekers and immigrant families to receive appropriate health care (26). Several studies show that women are very vulnerable to stressful situations such as migration. When they do not change women's roles, the disintegration of social networks, low economic and social participation has a significant negative impact on women's health. The main outcomes of many surveys are described in the section on cultural transition, employment, housing, intimate partner violence, access to health care and mental health and well-being. Foreign-born women faced economic, cultural, language and systemic barriers that prevented them from accessing health, social and economic resources. Nevertheless, several studies have found successful coping strategies and support networks that have facilitated their transition into the new society (11, 13, 27, 28).

According to UNHCR statistics, about three million Afghans live in our country. Iran is home to the greatest number of Afghan refugees after Pakistan (29). Except for common borders, Iran and Afghanistan exhibit profound cultural similarities in language, religion, history, rituals, and architecture. Nevertheless, there are significant differences between the two nations. Ninety-seven percent of Afghan immigrants live in urban and rural areas, while three percent live in camps controlled by the government and the UNHCR (30). Much research on Afghan immigrants in Iran has focused on physical problems, especially infectious and non-communicable diseases, and a small portion on mental health problems (31-34). Considering that Iran has been welcoming Afghan immigrants for almost four decades, this study aimed to compare the impact of culture on the mental health of Afghan and Iranian women.

Materials and Methods

Study design and population

This study was conducted in Kerman (The center of the largest province in Iran), which receives many Afghan immigrants due to its relative proximity to Afghanistan and working conditions. This descriptive and cross-sectional study is part of a broader study entitled "Social determinants of health among Afghan women." approved by Kerman University of Medical Sciences (Ethical code: IR.KMU.REC.1399. 642). The research sample comprised 199 Afghan and 209 Iranian women. The inclusion criteria were being a woman, being Afghan, being over 15, and living in Kerman. The Iranian women in the control group lived in their neighborhood. To overcome female illiteracy or the need for additional explanations, an Afghan woman familiar with both dialects (spoken in Iran and Afghanistan) helped with data collection.

Measurement of the study variables

The survey questionnaire contained several sections:

1- Demographic variables: Questions related to age, marital status, educational attainment, occupation, and religion. In Afghan participants with a residence permit, the duration of stay in Iran and Studying in Iranian schools and the neighborhood have also been asked. All participants asked to choose their economic status from the low, middle, good and excellent options.

2. Mental disorders:

It should be noted that mental disorders refer to the existence of issues that interfere with the feeling of mental wellbeing.

In the present study, mental disorders were measured by the "Questionnaire on the symptoms of mental disorders (SCL-25)" developed by Najarian and Davoodi (35). This Questionnaire has sub-scales measuring physical complaints, obsessive-compulsive disorder, depression, anxiety, morbid fear, paranoid thoughts, psychosis, and interpersonal sensitivities. The severity of the mental disorders was categorized as mild (score: 25-50), moderate (score: 50-75) and severe (score: >75).

According to the Najarian and Davoodi (35) study, the Questionnaire has a significant correlation with SCL-90. The correlation between the subscales of these two questionnaires ranged from 0.95 to 0.80 showing it is a valuable tool to measure the symptoms of mental disorders. Cronbach's alpha for the Questionnaire was 0.97, indicative of its acceptable reliability.

3-Acculturation

To evaluate the level of cultural acceptability, we integrated some of the elements of several acculturation scales. The validity and reliability of this section of the survey were approved. The questions were about interpersonal relationships (*I believe the people of Afghanistan understand me better than the people of Iran, my closest friends are Afghans*), behavioral and communication preferences (*I think it is better for Afghans to share their feelings and behave in a way that conforms to Iranian norms*), Ease of language use (*I can joke with others in both languages, I am afraid to talk to others in Iran because I do not speak their language very well*), belonging to a new culture, and stigma (*I think the Afghans understand me better than Iranians*) (19, 36, 37).

Based on the obtained scores, Afghan women were categorized into the two groups. Individuals with a score of less than 121 were considered as low acculturated group, and individuals with a higher score as high acculturated.

Statistical analysis

Statistical analyses were performed through SPSS-22 software. The results were reported as frequency and mean (± standard deviation) for describing variables. Chi-square and ANOVA - t - test were used for data analysis. The level of statistical significance was defined as p-values of less than 0.05.

Results

From 408 women participated in the study, 48.8% (199) were Afghan women. Mean mental health scores of Iranian and Afghan women with high and low acculturations were 44.42 (±16.8), 35.89 (±11.9) and 33.09 (±11.4), respectively. The severity of mental disorders among these three groups varied significantly ($0 < 0.001$). Figure 1 illustrates the distribution of participants across various mental disorder severity groups.

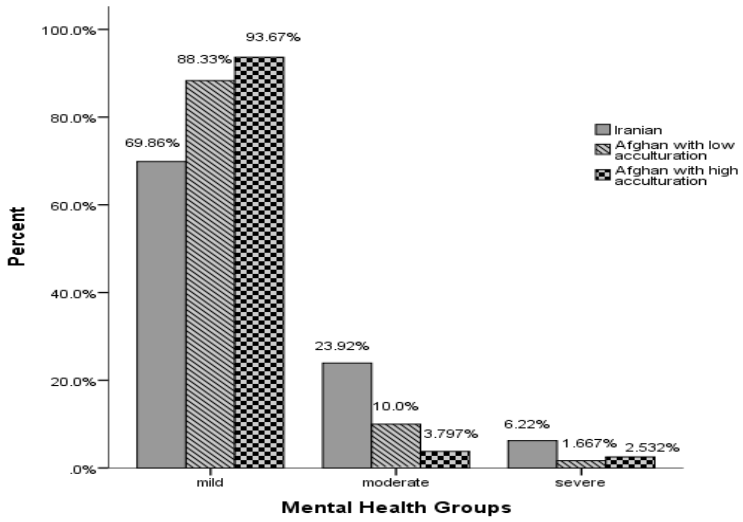

Figure 1. Distribution of mental health severity among participants

Descriptive information on mental health based on demographic variables is presented in Table 1. In this table, the number of people and the mean and standard deviation of the mental health score in each subgroup of demographic variables are shown. The descriptive information presented in this table applies to all Afghan women with low or high acculturation levels and to Iranians separately. In general, the mean mental health score was higher for widows under the age of 30 and educated persons. The number of educated in Afghan women was very low, with the majority going to school in Iran. The majority of low-accultured women lived in areas where most of their neighbors were Iranians. Most Afghan women were Sunnis. There were more widows in Afghan group than in Iranian group, and they had lower acculturation. Most of them had been living in Iran for less than five years and the lower level of acculturation was associated with a short stay.

Table 1. Mental health score based on demographic characteristics of participants

Variable		Afghan with low acculturation			Afghan with high acculturation			Iranian		
		Number	Mean	SD	Number	Mean	SD	Number	Mean	SD
Marital status	Single	9	31.89	6.83	6	31.33	3.44	5	39.80	10.18
	Married	101	34.13	9.35	67	31.46	7.74	200	44.38	16.99
	Widow	10	57.3	16.79	6	53.00	26.47	2	52.00	4.24
Age	<30	45	39.11	15.67	18	33.44	13.84	57	47.95	18.84
	30-40	48	33.65	8.55	33	33.91	12.87	106	43.83	16.51
	>40	27	34.52	8.09	28	31.89	7.36	46	41.41	14.14
Job	Employed	6	37.83	11.05	4	29.25	4.35	11	47.55	19.59
	Housewife	114	35.79	11.92	75	33.29	11.61	192	44.52	16.73
Socio-economic Status	Low	93	34.05	9.80	69	31.78	9.75	45	53.00	15.43
	Moderate	23	42.57	16.62	9	40.44	17.49	155	42.10	16.46
	High	2	49.00	5.67	1	57.00	-	7	46.14	16.30
Education	Illiterate	101	33.30	7.99	70	31.14	8.17	15	36.07	14.54
	Literate: Primary							24	49.46	16.04
	Literate: Middle school	18	50.94	17.94	9	48.22	19.84	41	49.98	17.98
	Literate: Diploma							107	42.19	16.11
	Literate: College							21	45.71	16.94
Religion	Sunni	88	33.48	9.69	65	30.60	7.90	-	-	-
	Shia	20	39.30	9.36	12	38.75	8.82	-	-	-
Staying time	<5 years	87	33.91	9.88	56	30.09	5.78	-	-	-
	5-15 years	19	42.37	10.81	15	40.87	17.03	-	-	-
	>15 years	9	41.56	23.56	7	41.00	19.67	-	-	-
People of the neighborhood	Mostly Iranian	98	34.52	10.04	67	30.69	5.64	-	-	-
	Mostly Afghan	9	44.44	11.66	6	51.33	23.91	-	-	-
	Equally Afghan and Iranian	9	32.78	6.69	6	41.67	21.46	-	-	-

Table 2 shows comparison of mental health problems in different sub-groups of demographic variables for Afghan and Iranian women. As it is seen, among Afghan women with low acculturation, mental health problems were different based on marital status and socioeconomic status. The rate of mental illness among Afghan widows was significantly different than that of unmarried women (P = 0.001) and married women (P <0.001). The rate of mental illness in the socio-economic status subgroups of Afghan women with high and low acculturation varied.

The socio-economic status of women with low acculturation and high acculturation (P = 0.020) was significantly different. As shown in Table 2, the rate of mental health problems varies between literate and illiterate Afghan women. Religion and education in Iran were other variables associated with mental health problems among Afghan women. In Afghan women with low acculturation, mental disorder in adult females who lived in Iran for less than five years was different from women living between 5 and 15 years (P = 0.002). In addition, among these women, the rate of mental disorders in the neighborhood with an Iranian or Afghan majority was significantly different (P = 0.021).

In high acculturated women, the rate of mental disorders was different in those who lived under five years in Iran than those who lived between 5 and 15 years (P = 0.044) and more than 15 years old (P <0.001). Moreover, the rate of mental disorders among highly acculturated Afghan women living in predominantly Iranian neighborhoods was different from that of those living in predominantly Afghan neighborhoods.

Table 2 shows that among Iranian women, mental health was different among subgroups of socioeconomic status and educational levels. Mental health score of Iranian women with low socio-economic level was significantly different than that of the moderate socio-economic group (P <0.001). Moreover, the rate of mental illness of illiterate Iranian women significantly differed from that of women with primary school (P = 0.021) and middle school (P = 0.013) educational levels.

Table 2. Comparison of the mean score of mental disorders in various sub-groups of demographic variables among Afghan and Iranian women

Variable		Afghan with low acculturation			Afghan with high acculturation			Iranian		
		Mean Rank	Test statistics	P-value	Mean Rank	Test statistics	P-value	Mean Rank	Test statistics	P-value
Marital status	Single	51.44			44.08			94.60		
	Married	56.52	21.31	<0.001	37.78	5.76	0.056	103.79	1.22	0.544
	Widow	108.80			60.75			148.25		
Age	<30	66.14			36.69			115.55		
	30-40	55.57	2.17	0.338	41.39	0.511	0.775	102.88	2.71	0.258
	>40	59.85			40.48			96.80		
Job	Employed	72.42	-0.863	0.388	40.44	0.459	0.482	101.54	-0.47	0.640
	Housewife	59.87			31.75			110.05		
Socio-economic Status	Low	54.31			37.00			138.57		
	Moderate	76.57	11.43	0.003	59.00	9.87	0.007	93.35	19.90	<0.001
	High	104.75			76.00			113.29		
Education	Illiterate	53.47			37.00			65.73		
	Literate Primary							126.50		
	Literate Middle school	96.67	24.08	<0.001	63.33	10.57	0.001	124.12	16.17	0.003
	Literate Diploma							96.11		
	Literate College							11.50		
Religion	Sunni	50.23	2.98	0.003	34.73	3.91	<0.001	-	-	-
	Shia	73.30			62.12			-		
Educated in Iran	No	74.13			56.18			-		
	Yes	52.55	3.21	0.001	32.97	4.00	<0.001	-	-	-
	Yes	75.42			59.62			-		
Staying time	<5 years	52.60			32.62			-		
	5-15 years	81.08	11.55	0.003	58.07	18.50	<0.001	-	-	-
	>15 years	61.50			54.71			-		
People of the neighborhood	Mostly Iranian	56.24			36.69			-		
	Mostly Afghan	87.72	7.45	0.024	63.67	9.83	0.007	-	-	-
	Equally Afghan and Iranian	53.83			53.25			-		

Figure 2 shows the mean mental health scores in Iranian and Afghan women with low and high acculturation with a 95% confidence interval. Although mental health problems among Afghan women with low and high acculturation were different, this difference was not statistically significant. However, the rate of mental health issues among Iranian women was different from that of Afghan women with low (P <0.001) and high (P <0.001) acculturation.

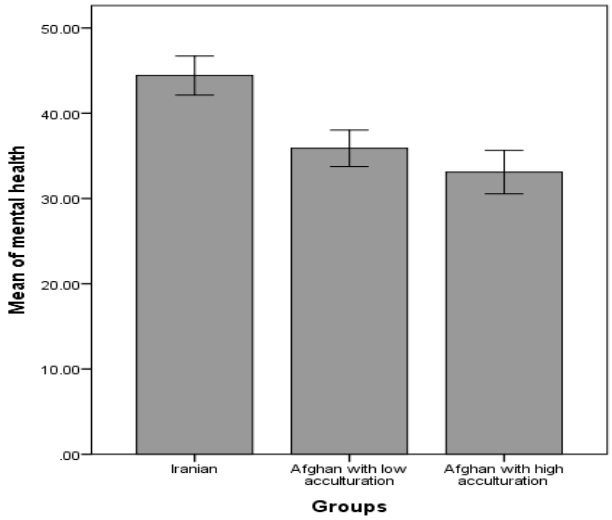

Figure 2. Comparison of mean score of mental disorders in participants

Discussion

Research shows that cultural adaptation plays an important role in the relationship between migration and mental health (21). However, cultural adaptation and social support predicted other psychological problems like depression (14, 38). In a study in Australia (14), Afghan women expressed traumatic experiences to contribute to psychological problems ranging from anxiety, minor depression, and feelings of shame, anger, guilt, and fear in a relationship to severe post traumatic stress disorder (PTSD). In another survey, Afghans living in San Diego experienced psychological distress, including depression and anxiety, concentration problems, and physical disorders, all of which are more common in women. Although mental health symptoms are likely to improve over time, psychosocial stress factors were likely to be a risk factor after years of residence in the destination country (39, 40).

The survey of two groups of Iraqi asylum seekers who had enforced a residence permit for less than six months and more than two years indicated that the prevalence of mental disorders was 42% and 66.2% in the two groups, respectively. Anxiety, depression, and somatoform disorders were much more prevalent in the second group. PTSD incidences were not different between the two groups. Based on all risk factors, long-term residency increased the risk of psychiatric disorders (41).

Iranian studies on the mental health status of immigrants yielded different results. In a study among Afghan refugees resettled in Bushehr province, the prevalence of social dysfunction, mental health problems, anxiety, and depression were 80.1%, 48.9%, 39.3%, and 22.1%, respectively. In this study, the overall prevalence of mental health disorders was 88.5% (42). Another study's findings showed that the prevalence of mental disorders among Afghan immigrants was 6.55% (9.19% in men and 7.35% in women) (43). There is a positive correlation between mental health indicators of refugees and their physical health and social functioning. The mental health of the subjects was not associated with education or marital status. Life years in Iran have not been meaningfully associated with General Health Questionnaire (GHQ) indices (44, 45).

A study of Afghan refugees living in the Bardsir refugee camp in Kerman province found that the overall prevalence of depression was 53%. The highest severity of depression was prominent among persons with periods of asylum of 150-141 months (46). Another study conducted in Iran showed that the second generation of Afghans has different models of adaptation. Integration is the most common model of adjustment and acculturation (35.8 percent), followed by separation (33.3 percent), absorption (17.1 percent), and marginalization (13.8 percent) (47).

Significant cultural and religious differences impact psychological stress. These differences have more significant implications for the Muslim population in western countries (48, 49). Even Afghan immigrants in Pakistan (the first place of migration for Afghans) face numerous cultural problems and differences, including linguistic problems (39). But, the similarities in the language and religion with the Iranian population are expected to lead to a greater acculturation.

In this study, significant results may be expressed as follows. Mental health issues were more prevalent among Iranian women than Afghan women. These women were similar to Afghan women in terms of their socioeconomic situation, except for their level of education. As a result, mental disorders in low socioeconomic status groups are expected to be more severe than in the general population. Most of these women (Iranian women questioned) had come from lower social classes, economically incapable, unqualified and alienated by urban lifestyles and values.

These problems resulted in an increase in mental illness in this group (50). According to Durkheim's correlation theory, the values of traditional societies and the cultural and normative characteristics of solidarity disappear in broader and more advanced societies (51).

Durkheim believes that in social solidarity, the individual's identity is known by society's characteristics, and individuals find complete relation with society through psychological cohesion and with the help of cultural, religious, legal, and social categories (52). In the internal migration (our Iranian women group), the loss of the previous social network and the inability to adapt to the new society led to mental disorders. Whereas, the Afghan refugee population, getting rid of the harsh conditions of war, terror, and long-term problems, felt more secure in the new society. The two factors of maintaining contact with the community of origin and similarities between the community of origin and destination may have reduced the severity of psychological trauma caused by migration in our Afghan group.

It is not surprising that acculturation had no effect on mental health. Because Afghan refugees living in Iran have a chain of contact with their Afghan family and friends in various ways. The study also found that the level of cultural acceptance was lower among women whose neighbors were mostly Iranians. It seems, living in quasi-extended families, participating parties, and continuing to meet each other, has created a shield against the psychological damage caused by immigration and living in the new country. The relative proximity of Kerman to the borders of Afghanistan and the Ease of travel between the two countries is another factor that reduces the profound breakdown of their social solidarity.

Although many languages and cultural similarities between Iran and Afghanistan fill this cultural gap, specific cultural factors that help maintain Afghan refugees' health may include access to extended families and friendship networks and relatively easy access to their country. According to Durkheim, religion and society are inseparable and necessary for each other. Commom religious beliefs between communities and groups may provide an environment where members are free from the disturbing and frustrating experience of social disruption. The enduring elements of religion, as a social phenomenon, are associated with the necessary moral nature of all social relationships such as hospitality (51). Islam, as a shared religion, promotes solidarity between immigrants and Iranian society. This correlation may contribute to the reduction of psychological harm. The profound cultural, religious, and linguistic similarities between Iran and Afghanistan are other vehicles that protect against blows and psychological stresses caused by migration.

Moreover, proximity and common borders, Islamic religious beliefs, access to mosques as meeting places, maintaining identity, access to adequate food, housing, and financial resources, and speaking in individuals' primary language may be reduce psychological pressures.

It should be considered that immigrant women are more diligent than their husbands in adapting to the local language and culture and use it, as a tool, better to adapt themselves and their families to the environment (53). This finding is seen in some other studies emphasizing the association between acculturation and mental disorders (21, 22, 26).

Although acculturation does not generally affect immigrants' mental health, individuals` demographic characteristics in the high and low acculturated groups were influential. Widowhood was a risk factor in low acculturated Afghan women, which can show the role of a spouse and guardian as the only supporter. Of course, we must not overlook the role of stress

caused by events such as war and terrorism, which led to their widowhood. Low educated Afghan participants make it impossible to comment on the role of education. However, among Iranian women, education appears to have a protective role against mental illness. The majority of the Iranian community is Shia (an Islamic branch), and all Iranians in our study were Shia. Despite the culturalization, the Mean score of psychiatric disorders among Shi'ites Afghan women was higher compared to Sunnis (an Islamic branch) Afghan women. This can be attributed to more difficult living conditions of the Shiite tribes in Afghanistan or their higher exposure to war issues due to living in certain areas, and so on. The neighborhood features affect the Mean score of psychiatric disorders. External relations seem to be more effective in psychological conditions than peer relations. However, studying the type of neighborhood relationships in acculturation and its impact on mental health requires more studies. Socioeconomic status as a determining factor in all groups played a decisive role in mental disorders. Responses to questions about the socioeconomic status of an immigrant population may not be reliable due to the expectations of support from the government and related organizations.

The findings may be summarized as follows. The focus on factors influencing mental disorders shows the effect of marital status, education, place of study, length of stay in Iran, socio-economic status and religion on mental health status. Income and socioeconomic status are recognized as the most important components affecting mental health at all ages.

The marriage is a supportive factor for mental health issues. Moreover, the role of accompanying factors in widowhood in certain traditional cultures, associated economic problems, and lack of employment should also be mentioned as aggravating factors. In addition, the role of accompanying factors in widowhood in certain traditional cultures, associated economic issues, lack of employment should also be mentioned as aggravating factors.

Higher education is associated with greater capacity to learn a new language, access to more resources and the opportunity to find more suitable jobs. All of those things can improve the mental health of the population.

The nationality of neighbors has affected mental health status. This is in favor of the greater effect of intra-group communication between these people and their fellow citizens and solidarity within the project.

Individuals who have lived in Iran for 5 to 15 years have the highest rate of mental illness. It can be attributed to the fact that getting into a safer place for people who are forced to migrate due to difficult and exhausting conditions can give them peace of mind and after a longer stay (more than 15 years), adjustment to the environment has improved and people are more serene.

Conclusion

Accidents and disasters affect mental health on various dimensions. Culture is one of the things that can modify or intensify these effects. In this study, it is surprising that the mental health issues of immigrants were not related to their level of acculturation. This finding could be explained by the strong cultural similarities between the host community and the immigrant community. Individual factors also seem to be more important than acculturation in such cases. Immigrants can experience a high quality of life if the differences of the two societies' cultural values do not stress them. These experiences result from variables such as social network existence, increasing similarities, and social support. Development of mechanisms for identifying vulnerable upon arrival in the host country, groups upon arrival, protectionist approach, and empowerment of migrants, especially illegal immigration, and protectionist policies are essential in destination countries' strategy.

Limitation

The use of a self-administered questionnaire was one of the limitations of this study. While the language of all individuals was Persian, individuals were not differentiated according to dialects and language skills in this study. Exploring defense and coping mechanisms in individuals and traumatic experiences in early society could provide more accurate results. A gender-based mental health assessment may provide a more comprehensive picture of this problem among immigrants.

Availability of data and materials

Data are available.

Ethics approval and consent to participate

This study is approved by the Kerman University of Medical Sciences (Ethical

code: IR.KMU.REC.1399. All women had consented to participation.

Consent for publication

All of the authors had consented to publication.

Conflict of interests

There was no conflict of interests.

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