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Mental Disorders Signs in Afghan Immigrants /Refugees

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ABSTRACT

Introduction: The goal of the study was to identify mental disorders signs in Afghan immigrants/refugees who lived in Tehran, Iran. Materials & Methods: In this research 453 Afghan immigrants/refugees (227 male and 226 female) were selected by cluster sampling from different areas of Tehran city. Instruments were a demographic questionnaire and a Persian translated version of the General Health Questionnaire-28 (GHQ-28) that completed by Afghan interviewers. Data were analyzed using descriptive analysis. SPSS software was used for analysis. Results: Findings showed that on the subscales of GHQ-28, prevalence of mental disorders signs in Afghan immigrants/refugees was high. Prevalence of Somatic signs was from 15/1% to 6/3%, Social dysfunction signs was from 16/7% to 3/2%, Anxiety/insomnia signs was from 16/3% to 7/5%, and Severe Depression signs was from 21/8% to 2/8%. The most common psychiatric disorders signs on the subscale of Somatic symptoms were theses statements: Feel run down and out of sorts (15/1%), and getting any pains in the head 11/9%), on the subscale of Anxiety/insomnia were theses statements: Loose of much sleep over worry, feel constantly under strain social dysfunction (each of them 16/3%), feel nervous and strung-up all the time (14/3%), getting edgy and bad-tempered (12/3%), on the subscale of Social dysfunction was statement of being able to enjoy your normal day-to-day activities (16/7%), on the subscale of Severe Depression were theses statements: Feel that life is entirely hapless (21/8%), feel that life isn't worth living (19/4%), find yourself wishing you were dead and away from it all (15/9%), and being thinking of yourself as a worthless person (10/7%).Conclusion: Mental disorders signs had high prevalence in Afghan immigrants/refugees. Attention to mental health of them is necessary. Mental health care, psychiatric and psychological interventions are recommended for the Afghan immigrants/refugees. In providing of comprehensive and widespread mental health services, attention to religion, spirituality, and religious/spiritual interventions, is very important, which consequently will increase self-efficacy and in turn will promote mental health in Afghan immigrants/refugees. It should be taken a community approach to giving such interventions. In the community approaches, primary

prevention, treatment and rehabilitation are doing in any level of health services in inner of immigrant/refugee community. Specific aspect of this approach is insistence on participation in collective action, training in prevention of mental disorders and psycho educational training.

Keywords: Afghan immigrants/refugees, mental disorders signs, GHQ-28, Intervention, Tehran, Iran.

1. Introduction

Iran is a host country in the Middle East. Iran is one of Afghanistan's neighbors. Iran has accepted and supported Afghan immigrants and refugees for many years. Some studies have been carried to assess mental health problems among Afghan immigrants/refugees in Iran, especially those who are resettled in camps and marginalized around of deferent cities and provinces of Iran, for example Shiraz in Fars Province (Kalafi, Hagh-Shenas, & Ostovar, 2002), Bardsir in Kerman Province (Moatamedi, Nikian, & Rezazadeh, 2003), Tehran in Tehran Province (Mohammadian, Dadfar, Bolhari & Karimi Keisami, 2005), and Dalakee in Bushehr Province (Azizi, Holakoie Naieni, Rahimi, Amiri, & Khosravizadegan, 2006). These researchers have used various instruments in their studies for instance Beck's depression inventory (BDI), General Health Questionnaire-28 (GHQ-28) and so on.

Kalafi, Hagh-Shenas, and Ostovar (2002) reported that 34.5% of Afghan refugees settled in Shiraz, Iran scored high enough to be considered as having psychiatric problems. There was a significant positive relationship between refugees' years of age and GHQ-28 subscales scores, for instance Physical health and Social functioning. Their mental health was not related to education or marital status. There was no a significant relationship between years of settling in Iran and total/subscales scores of GHQ-28.

Moatamedi, Nikian, and Rezazadeh (2003) reported that on the BDI**,** in Afghan refugees resettled of Bardsir Refugee Camp in Kerman Province of Iran, total prevalence of depression was 53%. The most severity of depression was in age group 20-29 years but there was no significant difference between depression and age. There was a significant relationship between depression and sex. Depression rate among single Afghan refugees was more than married Afghan refugees ,but this relationship was not significant. The most severity of depression in relation with refuges duration was found in the people with refuges period of 141-150 months.

Mohammadian, Dadfar, Bolhari, and Karimi Keisami (2005) reported that on the GHQ-28, prevalence of mental disorders among Afghan immigrants was 55.6% (19.9% in males, 35.7% in females). Social dysfunction, Anxiety/insomnia, and Somatic subscales scores were higher than the Depression subscale score.

Azizi, Holakoie Naieni, Rahimi, Amiri, and Khosravizadegan (2006) reported that on the subscales of a Persian version of the GHQ-28, the prevalence of Social dysfunction, Psychosomatic problem, Anxiety/insomnia and Depression in the Afghan refugees of Dalakee Refugee Camp in Bushehr Province in Iran were 80.1%, 48.9%, 39.3% and 22.1%, respectively. Total prevalence of mental health disorders in this camp was 88.5%. Male gender, living with more than eight persons per house, and being age ten or under at migration time were associated with higher level of social dysfunction. Higher rate of Psychosomatic problem was associated with unemployment, being born in Iran, being age ten or under at migration time, and having no entertaining programs. Having 1-3 children, living with more than eight persons per house, and positive history of chronic disease were associated with higher level of Anxiety/insomnia. Having no entertaining programs, and family members; death during migration were associated with higher level of Depression.

Psycho-social distance among Afghan workers who working in Iran was a function of their annual income (Mahler, 1994). The need for immigration usually depends on complicated relations between economical, social, familial and political factors. Unavailability to education, occupation, services and respecting to primary human rights are the most important factors in immigration (Moatamedi, Nikian, & Rezazadeh, 2003, Li, Mao, & Zhang, 2008, Shaterian, & Ganjipour, 2009). Demographic characteristics and mental health problems are related with together, for example there was a significant association between mental disorders and demographic characteristics except for family size, and a significant association between mental disorders and type of residence (i.e. centered vs. non centered), but there was no significant relationship with the duration of stay in Iran, reason for migration and place of residence (Mohammadian, Dadfar, Bolhari, & Karimi Keisami, 2005).

Attention to issue of mental health and epidemiological studies, are the most important attempts to designing of preventive programs and providing of treatment and interventional programs. Providing of mental health of immigrants and refugees needs to know information about their mental health problems

(World Health Organization (WHO), 1992, Bolhari, & Palahang, 1995, Canadian Task Force on Mental Health Issues (CTFMHI), 1998, Bolhari, & Dadfar, 2000, International Organization for Migration (IOM), 2005, Gerritsen, Bramsen, Devillé, et al. 2006, Sadock, & Sadock, 2010, Hansson, Tuck, Lurie, & McKenzie, for the Task Group of the Services Systems Advisory Committee, Mental Health Commission of Canada (TGSSAC, MHCC), 2010).

Regarding to immigrants and refugees especially women and children are the most vulnerable persons in any of community, so the study and investigation of mental problems in these groups, have a very importance on the regards of planning for their mental health promotion (Dadfar, Kolivand, & Asgharnejad Farid, 2014). Study of their mental health provide some guidelines for researchers and therapists that on that basis can consider some attempts for planning of public health in primary prevention in order to mental health needs of immigrants and refugees, and on that basis can attend to community approaches in the treatment of their mental health (Dadfar, Atef Vahid, Asgharnejad Farid, & Kolivand, 2014). The goal of the study was to identify mental disorders signs in Afghan immigrants who lived in Tehran, Iran.

2. Materials & Methods

This study was a cross – sectional. The subjects were Afghan immigrants/refugees of 15 years and older who were living in settlements and neighborhoods of North, South, East, West and Center areas of Tehran city in Iran, with a population of over 111500 household. In this research 453 Afghan immigrants/refugees (227 male and 226 female) were selected by cluster sampling. Data gathering was done using a demographic questionnaire and a Persian translated version of the General Health Questionnaire-28 (GHQ-28). First settlements and neighborhoods of Afghan immigrants/refugees resident in Tehran were determined by Afghans interviewers under support of the Society for Support of Refugee Women and Children in Iran. Then questionnaires were set and approved by the researchers. Training of interviewers during two short courses by a pilot study of the questionnaires and resolve of problems about sampling were began. Interviewers consisted of 11 Afghan students of courses of medical sciences, humanities, and engineering and they were introduced by the Society for Support of Refugee Women and Children in Iran. Sample size was estimated 453 by a sample size formula. Then, using cluster sampling method, 453 families and from each family 1 person including 227 males and 226 females, were selected.

Demographic questionnaire was including age, sex, marital status, educational status, employment status, number of households, place of residence (assembled, & marginality of city), type of residence (centralized, & decentralized), and length of stay in Iran, type of migration/refuge (legal, & illegal), and reasons of migration/refuge (internal war, opposition to the regime, seeking better conditions, and family pressure).

GHQ-28 was made by Goldberg and Hillier (1979), is a self- administered, self-report questionnaire. It is used for the detection of psychiatric distress related to general medical illness (Chan, 2013). GHQ-28 is a screening device for identifying minor psychiatric disorders in the general population and within community or non psychiatric clinical settings such as primary care or general medical outpatients. Suitable for all ages from adolescent upwards – not children, it assesses the respondent's current state and asks if that differs from his or her usual state. Respondents indicate if their current "state" differs from his or her usual state- thereby assessing change in characteristics and not lifelong personality characteristics. Subjects base their responses on their health state over the past two weeks. It is therefore sensitive to short-term psychiatric disorders but not to long-standing attributes of the respondent. It is focuses on two major areas: 1) The inability to carry out normal functions, and 2) The appearance of new and distressing phenomena. It is an ideal screening device for identifying non psychotic and minor psychiatric disorders to help inform further intervention. GHQ-28 designed to assess 4 aspects of distress: 1) Depression, 2) Anxiety, 3) Social impairment, and 4) Hypochondriasis (Sterling, 2011, Chan, 2013). In other words, GHQ-28 have four subscales and it assesses Somatic symptoms, Anxiety/insomnia, Social dysfunction and Severe depression (Zare, Sharif, Dehesh, & Moradi, 2015, Ghodsbin, Sharif Ahmadi, Jahanbin, & Sharif, 2015).

Number of items is 28. Its administration time is usually approximately 5 minutes. Scoring of GHQ-28 is a calculation of total score. Different scoring methods of scoring are possible, which will affect the total score. The traditional scoring method provided assigns a score of 0 for responses 1 and 2 ("not at all" and "no more than usual") and a score of 1 for responses 3 and 4 ("rather more than usual" and "much more than usual"). Another scoring method in use assigns a score of 0 for response 1 and a score of 1 for response 2-4 for the 18 negative items, and a score of 0 for responses 1 and 2, a score of 1

for responses 3 and 4 for the 7 positive items. Total score range from 0 to 28. Higher scores indicate a greater probability of a psychiatric distress. Total scores that exceed 4 out of 28 suggest probable distress (Chan, 2013). Another scoring method is that each of four subscales contains 7 items scored on a Likert scale. GHQ-28 has a 4-item response with 'Not at all', 'No more than usual', 'Rather more than usual', and 'Much more than usual'. Several scoring methods are available; In the study we used the Likert scale to show the symptoms' severity with scores between 0–3 (0–1–2–3, subscale range 0 to 21). A greater score indicates lower health. Cut of points and normative data have been established for the Iranian population. Optimal threshold concept is more useful for estimating the prevalence in large population than screening for individual cases. In study of Shahrokhi (2003), Zare, et al (2015), Ghodsbin, et al (2015), Iranian participants were classified using the cutoff point of 7 for probable mental disorder and 14 for severe mental disorder in each domain and 23 for the GHQ total score in an Iranian version by Shahrokhi, 2003, Zare, et al, 2015, Ghodsbin, et al, 2015). In the study we used the cutoff point of 21 for the GHQ-28 total score, as suggested by Palahang, Nasr Esfahani, Barahani, & Shah Mohamadi, 1996).

GHQ-28 translated into 38 languages including Persian language. There is no special training is required for GHQ-28. The GHQ-28's subscales represent dimensions of symptomatology and not distinct diagnoses. As the scales are not independent of each other, the total score has better utility to indicate general psychological disorder than the individual scores do to screen for specific psychological disorders. Only one study has assessed the construct validity of the GHQ-28 among Iranian populations. The GHQ-28 is appropriate for individuals who are at least 11 years of age. Values have been reported for the reliability of the GHQ-28 for the deferent population (Griffiths et al. 1993, Sterling, 2011, Chan, 2013) and Iranian population (Palahang, et al, 1996, 28-item The General Health Questionnaire. 2015, Zare, et al, 2015, Ghodsbin, et al, 2015).

Ethical considerations were considered including: Try to trust and cooperation of the Afghan immigrants/refugees by explanation of goals of the study to them, informed consent and confidentially of their name. The Afghan immigrants/refugees who did not agree to participate in this research, were excluded. Data were analyzed by descriptive analysis. SPSS software was used for analysis.

3. Results

Findings showed that 32/9% of Afghan immigrants/refugees had less than 20 years old. Educational status was 25/2% illiterate, and 21/6% middle school. 48/3% were married, 46/9% single, and 4/8% divorced. Employment status was 42/4% employed, 22/7% housewife, and 22/7% student. Number of households was 7 persons and higher (44/8%), and 4-6 persons (39/3%). Place of residence was assembled (75/9%), and marginality of city (24/1%). Type of residence was centralized (76/4%), and decentralized (21/9%). Length of stay in Iran was less than 5 years (18/3%), 5-10 years (20/1%), 16-20 years (11/5%), and higher than 21 (19%). Type of migration/refuge was legal (51/2%), and illegal (48/8%). Reasons of migration/refuge were including: Internal war (64/7%), opposition to the regime (21/2%), seeking better conditions (11/5%), and family pressure (1/1%).

On the subscales of the GHQ-28, prevalence of mental disorders signs in Afghan immigrants/refugees was high. Prevalence of Somatic signs was from 15/1% to 6/3%, Social dysfunction signs was from 16/7% to 3/2%, Anxiety/insomnia signs was from 16/3% to 7/5%, and Severe Depression signs was from 21/8% to 2/8%. The most common psychiatric disorders signs on the subscale of Somatic symptoms were statements of 3: Feel run down and out of sorts (15/1%), and 5: Getting any pains in the head 11/9%), on the subscale of Anxiety/insomnia were statements of 8: Loose of much sleep over worry, 10: Feel constantly under strain social dysfunction (each of them 16/3%), 14: Feel nervous and strung-up all the time (14/3%), 11: Getting edgy and bad-tempered (12/3%), on the subscale of Social dysfunction were statements of 21: Being able to enjoy your normal day-to-day activities (16/7%), on the subscale of Severe Depression were statements of 23: Feel that life is entirely hapless (21/8%), 24: Feel that life isn't worth living (19/4%), 27: Find yourself wishing you were dead and away from it all (15/9%), and 22: Being thinking of yourself as a worthless person (10/7%) (See Table 1).

Table-1. Psychiatric symptoms on the subscales of GHQ-28 in Afghan immigrants/refugees

Subscales/Items	F (%)	Subscales/Items	F (%)
Somatic symptoms Have you recently 1. Been feeling perfectly well and in good health? 2. Been feeling in need of a good tonic? 3. Been feeling run down and out of sorts? 4. Felt that you are ill? 5. Been getting any pains in your head? 6. Been getting a feeling of tightness or pressure in your head? 7. Been having hot or cold spells?	21 (8/3) 23 (9/1) 38 (15/1) 24 (9/5) 30 (11/9) 16 (6/3) 20 (7/3)	Social dysfunction Have you recently 15. Been managing to keep yourself busy and occupied? 16. Been taking longer over the things you do? 17. Felt on the whole you were doing things well? 18. Been satisfied with the way you've carried out your task? 19. Felt that you are playing a useful part in things? 20. Felt capable of making decisions about things? 21. Been able to enjoy your normal day-to-day activities?	15 (6) 26 (10/3) 8 (3/2) 18 (7/1) 14 (5/6) 15 (6) 42 (16/7)
Anxiety/Insomnia Have you recently 8. Lost much sleep over worry? 9. Had difficulty in staying asleep once you are off? 10. Felt constantly under strain? 11. Been getting edgy and bad-tempered? 12. Been getting scared or panicky for no good reason? 13. Found everything getting on top of you? 14. Been feeling nervous and strung-up all the time?	41 (16/3) 25 (9/9) 41 (16/3) 31 (12/3) 24 (9/5) 19 (7/5) 36 (14/3)	Severe Depression Have you recently 22. Been thinking of yourself as a worthless person? 23. Felt that life is entirely hapless? 24. Felt that life isn't worth living? 25. Thought of the possibility that you might away with yourself? 26. Found at times you couldn't do anything because your nerves were too bad? 27. Found yourself wishing you were dead and away from it all? 28. Found that of the idea taking your own life kept coming into your mind?	27 (10/7) 55 (21/8) 49 (19/4) 11 (4/4) 16 (6/3) 40 (15/9) 7 (2/8)

4. Discussion

Afghan immigrants/refugees in Tehran city of Iran had high mental disorders signs. These findings are according to other studies, for example in study of Kalafi, Hagh-Shenas, & Ostovar (2002), rate of mental health problems in the Afghan refugees was higher than in the native population. Prevalence of depression among Afghan refugees in Iran except sex didn't relate with demographic factors and mainly the factors after migration affected the prevalence of depression (Moatamedi, Nikian, & Rezazadeh, 2003). Mental disorders had high prevalence in Afghan immigrants in Tehran (Mohammadian, Dadfar, Bolhari, & Karimi Keisami, 2005). Mental health problems related to immigration and living in camps, were common among Afghan refugees in Dalakee of Iran (Azizi, Holakoie Naieni, Rahimi, Amiri, & Khosravizadegan, 2006).

Many studies have carried on immigration and mental health in different countries for example (Pernice, & Brook, 1996, Khavarpoor, & Rissel, 1997, Gernaat, Malwand, Laban, et al. 2002, Naeem, Mufti, Ayub, et al, 2005, Fazel, Wheeler, & Danesh, 2005, Gerritsen, Devillé, Van der Linden, et al. 2006, Desouzan, 2006, Gerritsen, Bramsen, Devillé, et al, 2006, Takeuchi, Alegría, Jackson, &

Williams, 2007, Miyasaka, Canasiro, Abe, Otsuka, Tsuji, Hayashi, at al, 2007, Bhugra, Craig, & Bhui, 2010, Lu, 2010, Guruge, Collins, & Bender, 2011, Missinne, & Bracke, 2012, Lu, Hu, & Treiman, 2012).

In the process of migration occurs acculturation. Some studies have addressed to this issue or other related issues among immigrants and refugees in different countries. such as acculturation and mental health (Khabaz Beheshti, 2001, Moghaddas, & Amiri, 2006, O'Mahony, & Donnelly, 2007, Kheikhah, 2007, Iman, & Moradi, 2009, Kuo, 2011, Yoon, Chang, Kim, Clawson, Cleary, Hansen, & Gomes, 2012, Gupta, Leong, Valentine, Canada, 2013, Kuo, Arnold, & Rodriguez-Rubio, 2013, & Kuo, 2014), acculturation strategies and depressive and anxiety disorders **(**Ünlü Ince, Fassaert, De Wit, Cuijpers, Smit, Ruwaard, & Riper, 2014), stress and coping strategies (Yakushko, Watson, & Thompson, 2008, Iman, & Moradi, 2010, Yakushko, 2010, Kuo, 2011, Kuo, 2013, Dadfar, Dadfar, & Kolivand, 2014).

According to the findings of the studies mentioned above, including the findings of our study on Afghan immigrants/refugees, attention to mental health of immigrants/refugees population, is necessary.

Mental health care, psychiatric and psychological interventions are recommended in a cultural context and framework of Iran (Atef Vahid, 2004, Bolhari, Ahmadkhaniha, Hajebi. Bagheri Yazdi, et al, 2010, Dadfar, Kolivand, & Asgharnejad Farid, 2014, Dadfar, Atef Vahid, Kazemi, & Kolivand, 2014). There are various mental health interventions and health care services for immigrants/refugees population (Gerritsen, Bramsen, Devillé, et al, 2006, Bemak, & Chung, 2008, Murray, Davidson, & Schweitzer, 2010, Multicultural Mental Health Australia (MMHA), 2011). In this respect, observance of principles and standards of professional behavior and ethics to provide psychological services are necessary (Atef Vahid & Dadfar, 2014).

In providing of comprehensive and widespread mental health services, attention to religion, spirituality, and religious/spiritual interventions is very important (Iman, & Moradi, 2006, Abdel-Khalek, & Lester, 2009, Abdel-Khalek, 2010, Remezani Farani, Kazemi, Kolivand, Dadfar, & Bahrami, 2014, Dadfar, & Lester, 2014, Abdel-Khalek, 2014, Bahrami, Dadfar, Lester, & Abdel-Khalek, 2014, Abdel-Khalek, 2014, Bahrami, Dadfar, Unterrainer, & Zarean, 2014). Such interventions can increase level of self-efficacy (Kolivand, Dadfar, Dadfar, & Kazemi, 2014), which consequently will promote mental health in immigrants and refugees ()Dadfar, Kolivand, & Asgharnejad Farid, 2014).

Also it should be taken a systemic, holistic, community approach to giving such interventions (Bolhari, 2013, Dadfar, Atef Vahid, Asgharnejad Farid, & Kolivand, 2014). In the community approaches, primary prevention, treatment and rehabilitation are doing in any level of health services in inner of immigrant and refugee community. Specific aspect of this approach is insistence on participation in collective action, training in prevention of mental disorders and psycho educational training.

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