

MENTAL HEALTH AMONG AFGHAN REFUGEES SETTLED IN SHIRAZ, IRAN¹

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Summary.—This study was designed to investigate the mental health of Afghan refugees settled in Shiraz, the capital of a southern province of Iran. They were mostly refugees from Afghanistan by reason of internal war during the last two decades. A version of the General Health Questionnaire (GHQ-28) in Persian was administered on a group of randomly selected Afghan refugees ($n=81$) from a pool of Afghan residents in the Shiraz district. 34.5% of the subjects scored high enough to be considered as having psychiatric problems. There was a significant positive correlation between refugees' years of age and GHQ-28 factor scores, i.e., Physical Health and Social Functioning. The mental health of the subjects was not related to education or marital status. The years of settling in Iran were not significantly correlated with any GHQ-28 indices. The overall findings suggest that the rate of psychiatric problems in the refugees is higher than in the native population.

Being forced to immigrate from one's home can produce stressful changes for refugees and may affect mental health. The economic and cultural problems in the host land together with separation from relatives at home, and the sociopolitical factors which force one to flee from the native country could be first ranked stresses for refugees. With a population of about 9.1 million and of about 647,497 square km, Afghanistan lies to the northeast of Iran. Iran and Afghanistan have 945 km of common border. The two neighbors have more or less the same language, religion, and climate. During the last two decades, internal war in Afghanistan has forced 6 to 7 million residents to immigrate into neighboring countries. The estimated Afghan refugee population in Iran is about one million, although it may be much higher since many refugees are unregistered. This population is widely distributed in Iran and may mostly live and work under stressful conditions such as construction and black market jobs.

Several prior studies addressed the mental health of refugees in different host countries. Khavarpour and Rissel (1997) studied a group of Iranian migrants in Sydney using the General Health Questionnaire (GHQ) and reported about 37% of the sample suffered from psychiatric problems. De Almeida (1975) also conducted a survey on 1,000 migrants of different countries who settled in France and reported the higher prevalence of psy-

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chiatric problems in contrast to the native population. Among the most common mental problems are difficulties with identity, depersonalization, neurosis, psychosis, and psychosomatic complaints. Other studies almost always emphasized the higher rate of psychiatric problems in migrants as compared with comparable native people (e.g., Pinter, 1978; Sutter & Scotto, 1984; Stuart, Klimidis, Minas, & Tuncer, 1993).

Researchers have reported the mental health status of Iran native samples and have been mostly reported in Persian sources (Bahador Khan, 1994; Javidi, 1994; Kokabeh, 1994; Bagheri Yazdi, 1995). These studies concerned the prevalence of psychiatric problems to be 12.5 to 16.7% in various rural and urban areas of Iran. They utilized a Persian translation of the General Health Questionnaire-28 as a screening measure. The earliest report on mental health of a sample of Fars residents (a southern province of Iran) stated 18.64% of the total sample suffered from some psychiatric problem (Bash & Bash, 1974). This study utilized a different method for screening, i.e., psychiatric interview, than those cited earlier in this paper. The main objective of the present study was to give preliminary information about the health status of Afghan refugees settled in Shiraz, Iran.

METHOD

One hundred men, Afghan refugees and residents of Shiraz, were randomly selected from the parts of the city in which concentration was highest. Among the data collected, those for 18 subjects were dropped from analyses for incomplete information or the persons were over 70 years of age. A version of the General Health Questionnaire (GHQ-28; Goldberg & Williams, 1988) in Persian was administered. This Persian translation of GHQ-28 was prepared by Mosavi (1998) in London for the Afghan and Iranian populations. Since the majority of the subjects had low education, the questions were read aloud to them, and their responses were recorded by the interviewer. The interviewer, A. Ostovar, was a student in the last year of medical education. The General Health Questionnaire has clusters of questions in the areas of Perceived Physical Health, Anxiety, Social Functioning, and Depression. Each cluster has items and uses a rating of 0 to 3, so the scores are for four subscales and a total. The case ascertainment cutoff was a score above 5 according to 0-0-1-1 scoring of ratings for each item of the test suggested by Goldberg and Williams (1988).

RESULTS

The mean age of the subjects was 29.0 yr. with a standard deviation 9.9 (range 18 to 68 years). Among these subjects, 56.8% (46 subjects) were illiterate and 27.2% (22 subjects) had elementary school education (low education total was 84%). The rest had more than elementary school education (16 subjects or 16%). The marital status of the subjects had three levels: sin-

gle (20 subjects, 24.7%); married living with spouse (32 subjects, 39.5%); or married but the spouse is resident in Afghanistan (29 subjects, 35.8%). Multivariate analysis of variance was carried out on scores for the four factors of the General Health Questionnaire-28 (within factors). Variables between factors were two levels of education (low education, $n=68$, and more than elementary education, $n=16$) and three categories of marriage as mentioned above. The means and standard deviations of General Health Questionnaire-28 scale scores are shown in Table 1.

TABLE 1
MEANS AND STANDARD DEVIATIONS OF GHQ-28 SUBSCALE SCORES
BY EDUCATION AND MARITAL STATUS

Characteristic	<i>n</i>	Factor					
		Physical Health	Anxiety	Social Functioning	Depression	Total	
Education							
Low	<i>M</i>	68	3.75	4.54	7.57	4.04	19.91
	<i>SD</i>		3.41	4.01	2.72	5.02	12.39
Beyond	<i>M</i>	13	4.00	4.92	7.85	4.00	20.77
	<i>SD</i>		3.44	5.39	1.99	5.02	13.40
Total	<i>M</i>	81	3.79	4.60	7.62	4.04	20.05
	<i>SD</i>		3.39	4.22	2.61	4.99	12.47
Marital Status							
Single	<i>M</i>	20	4.20	4.35	7.55	4.35	20.45
	<i>SD</i>		3.72	3.79	2.35	5.58	11.97
Married Living Together	<i>M</i>	29	3.75	3.72	8.00	4.78	20.25
	<i>SD</i>		3.03	3.70	3.01	5.46	13.25
Married Spouse Lives in Afghanistan	<i>M</i>	32	3.55	5.76	7.24	3.00	19.55
	<i>SD</i>		3.62	4.87	2.32	3.91	12.34

The analysis indicated no main effect for education ($F_{1,79}=0.99$, ns) or marriage ($F=0.84$, ns) and no interaction ($F=0.88$, ns), but univariate analyses for the interaction of the two independent variables and scores for each of the subscales showed a significant effect for Physical Health scores ($F=3.42$, $p=.04$). As shown in Table 1, subjects with more than elementary school education and those who were single had higher scores on perceived physical health, which actually indicated they were *less* healthy, than married refugees with lower education.

The Pearson correlation coefficients between age and the number of years the subject had been settled in Iran are given in Table 2. There were positive correlations between age and scores on Perceived Physical Health, Social Functioning, and Total GHQ scores, indicating that with increasing age the physical health, social functioning, and general health of the subjects decrease. The number of years the subjects had been in Iran was not significantly correlated with any of the GHQ-28 factors.

TABLE 2
PEARSON CORRELATION COEFFICIENTS BETWEEN AGE AND
YEARS RESIDENT IN IRAN WITH GHQ-28 SCORES

	GHQ-28 Factor				Total
	Physical Health	Anxiety	Social Functioning	Depression	
Age	.24*	.11	.29†	.15	.23*
Years in Iran	.03	-.08	.07	.16	.06

* $p < .04$. † $p < .01$.

The GHQ-28 can be scored in a form of Likert-type format (0-1-2-3) or for case ascertainment (0-0-1-1) for its ratings. The latter scoring system was used for the people who might need psychiatric services. According to the Goldberg and Williams suggestion (1988), those who had a score of 6 or above were considered as in need of psychiatric care. In this respect, 34.6% of the sample scored 6 or above and so had a psychiatric problem that might need special care. The prevalence of psychiatric problems was not different across marital status ($\chi^2 = 0.30$, ns) or education ($\chi^2 = 0.1$, ns).

DISCUSSION

The present study was designed to investigate the mental health status of a sample of Afghan refugees settled in Shiraz. Earlier studies reported the rate of psychiatric problems in the native population of Iran to be 12.5 to 16.7% (Bash & Bash, 1974; Bahador Khan, 1994; Javidi, 1994; Kokabeh, 1994; Bagheri Yazdi, 1995). The rate of psychiatric problems in the present sample was 34.6%, about twice that of the native Iranian population. Khavarpoor and Rissel (1997) who studied a group of Iranian migrants in Sydney, using the same method, found about the same rate of problems (37% in contrast to 34.6%; $\chi^2 = .0003$, $p > .05$). In fact, samples of both studies had more or less the same cultural background (Moslem and Persian language). The chief inference is that other factors in immigration may play major roles in the psychological health of immigrants and refugees rather than just the previously mentioned cultural elements. This notion is also supported by earlier reports which concerned various group of refugees in different countries (De Almeida, 1975; Pinter, 1978; Sutter & Scotto, 1984; Stuart, *et al.*, 1993). Various short-term and long-term stressors may affect refugees' mental health, including lower socioeconomic status in contrast to natives, social isolation, involvement in stressful and heavy duty jobs, social discrimination, inadequate social support and security, and worries concerning unstable political and economical conditions of the native country (Ferradi-Noli, 1997).

The present results showed subjects with education beyond elementary school and single people had higher scores for perceived physical health (indicating they were less healthy) than those with lower education and who

were married. Being single could have several advantages and disadvantages; this factor was not associated with General Health Questionnaire-28 factors for the present sample. In fact, the combination of being single and having higher education was related to less perceived physical health.

There were positive correlations between age and scores for perceived physical health, social functioning, and GHQ-28 Total scores. These findings suggest that with increasing age the scores on physical health, social functioning, and general health of the subjects tended to decrease. The number of years the subjects had been in Iran was not significantly correlated with scores of any of the General Health Questionnaire-28 factors.

Further investigation may involve clinical interviews with people who are identified as needing psychiatric help to identify causes and stressors. Utilizing questionnaires and inventories that could indicate the type of psychiatric diagnosis are particularly important. The investigators may compare different samples of refugees from the same country to specify the variables that attribute to better psychological health. Further, different host countries may present different influences on the mental health of refugees of the same origin so further understanding will require cross-cultural studies (cf. Ferradi-Noli, 1997).

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